CRITERIA AND STANDARDS FOR PERFORMANCE OF AMBULATORY (SAME DAY) SURGERY PERFORMED IN AMBULATORY OR DEDICATED SURGICAL SUITES

1. PURPOSE: This Veterans Health Administration (VHA) Handbook defines the scope of ambulatory surgery.

2. SUMMARY OF CHANGES:

3. RELATED ISSUES: VHA Directive 1102 (to be published).

4. FOLLOW-UP RESPONSIBILITY: Director, Surgical Service (111B), is responsible for the content of this Directive. Questions may be referred to 202-273-8505.

5. RESCISSIONS: Circular 10-91-113, Directive 10-93-019, and Directive 96-046 are rescinded.

6. RECERTIFICATION: This document is scheduled for recertification on or before the last working day of May 2008.

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CRITERIA AND STANDARDS FOR PERFORMANCE OF AMBULATORY (SAME DAY) SURGERY IN AMBULATORY OR DEDICATED SURGICAL SUITES

1. PURPOSE

This Veterans Health Administration (VHA) Directive defines the scope of performance regarding ambulatory (same day) surgery in ambulatory or dedicated surgical suites.

2. BACKGROUND

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a. Technological advances, cost concerns, and other factors have markedly changed the delivery of health care in recent years. Indeed, while the hospital continues to provide essential services for serious illness, much health care has become primarily an ambulatory activity. Even the practice of surgery has been transformed so that more than half of all surgery in the United States is performed on an ambulatory basis. VHA Central Office had established a goal that at least 50 percent of surgical procedures (exclusive of invasive diagnostic procedures) be performed on an ambulatory basis by December 31, 1997. By 2000, this goal had exceeded 60 percent and this level is now recommended. In today's environment of constrained resources it is essential that hospital beds be utilized only for those patients who truly require the support and services of inpatient care.

b. The Ambulatory Surgery Program Criteria and Standards have been developed to meet the planning needs of VA facilities and Veteran Integrated Service Networks (VISN)s and for use by VA Centeral Office in the uniform review of ambulatory surgery program proposals.

c. The criteria and standards for ambulatory surgery are reviewed by VA Central Office periodically, or at least every 2 years, and revised as necessary based upon further analyses and experience. In addition, it is recognized that in certain circumstances local conditions may exist which justify an adjustment to these standards. Such adjustments will be reviewed by VHA Central Office on a case-by-case basis when accompanied by supportive information justifying the need for the proposed adjustment.

d. The goal of ambulatory surgery is the provision of a high quality, cost-effective alternative to inpatient surgical care for patients.

3. DEFINITION

Ambulatory surgery refers to surgical or invasive diagnostic procedures performed by qualified providers in ambulatory or dedicated surgical suites with pre-procedural and immediate post-procedural care on the same day, or observation admissions without hospitalization.

4. SCOPE

a. VHA provides patient care in the most economical manner possible without compromising the quality of care. Most diagnostic and the majority of surgical procedures can be performed on an outpatient basis, and ambulatory surgery is the norm for many of these procedures. Observation admissions or overnight admissions may be required for some patients. Administrative direction needs to be the responsibility of the Chief, Surgical Services, or designee.

b. This Directive encourages the use of ambulatory surgery (same day surgery) to include the use of general and regional anesthesia in all patients for which it is clinically appropriate.

c. Each VA medical center with a Surgical Service must develop plans for ambulatory surgery. The local planning must be coordinated with the VISN or local network. ***NOTE:*** *All VA facilities offering surgical services must provide ambulatory surgery, but not all facilities providing ambulatory surgery will provide inpatient surgical services.*

5. CHIEF, SURGICAL SERVICES

a. Ambulatory surgery will be performed only by, or under the supervision of, qualified credentialed and privileged personnel as determined by the Chief of Surgery through a policy mechanism established by the facility for provision of appropriate surgical care. These procedures must be performed in the main operating room or a dedicated ambulatory surgical suite.

b. The Chief, Surgical Service, or designee, at each station is responsible for developing policies for ambulatory surgery which specifically address:

(1) The handling of patients not at American Society of Anesthesiologists (ASA) Class I or II anesthetic risk.

(2) Sterile techniques, which must be practiced at all times.

(3) Standard procedures such as skin preparation, proper gowns, gloves, and drapes must be used as indicated by the Chief of Surgery.

c. The Chief, Surgical Service, or designee, in consultation with facility management, including Nursing Service and Anesthesia Service where applicable, is responsible for the location and required equipment for the performance of ambulatory surgery when performed away from the main operating room (and not in an ambulatory suite or center).

6. HEALTH ADMINISTRATION SERVICE (HAS)

The Chief, Health Administration Service (HAS), or other appropriate designee, is responsible for determining the veteran's legal eligibility prior to scheduling or performing a

procedure. Ambulatory surgery is an outpatient service and the provisions of VHA Manual M-1, Part I, Chapter 16, apply with respect to eligibility and priority considerations.

7. ANESTHESIA

a. Minor surgery of the "lump and bump" type requiring only limited local anesthesia may be performed in the outpatient area in a special procedure room fully equipped for patient safety in that setting. ***NOTE:*** *If these procedures are to be performed in a dedicated ambulatory surgery suite (ambulatory surgical center), the operating room needs to be of appropriate size and equipped to the same standards as the main operating room suite.*

b. Qualified assistance to the surgeon, including a registered nurse circulator and scrubbed assistant will be provided when indicated. ***NOTE:*** *Supervision of personnel under training must be adequate to the individual circumstances as outlined in VHA Handbook 1400.1; and in accordance with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards; those personnel qualified to perform surgery will be documented by name.*

c. Pre-operative evaluation by the anesthesia staff must be available for patients undergoing procedures requiring general, spinal or epidural anesthesia or for patients judged at-risk for more minor procedures. Appropriate selection and evaluation of patients for ambulatory surgery may be performed up to 30 days before the procedure.

d. The use of general and regional anesthesia in satellite ambulatory care centers or independent outpatient clinics must be guided by the same criteria and standards as hospitals. Use of general or regional anesthesia in ambulatory care centers not located in the operating room complex must meet the requirements for communication, quick response, supplies and equipment as specified by JCAHO.

e. A separate anesthesia record is required when attended by a qualified anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or other qualified personnel.

f. All patients who receive anesthesia (defined, for the purpose of this Directive, as general, spinal, epidural, regional nerve block and intravenous sedation) must be recovered in the main post anesthesia recovery room (PARR) or in a fully-monitored other PARR staffed by a trained PARR nurse (RN) as required by JCAHO. After all procedures, except those under local anesthesia where no sedation or analgesia other than oral non-steroidal anti-inflammatory drugs (NSAID) have been given, a responsible person must accompany the patient home. Staff must verify the availability of this person before the start of the operation and before the patient is released. In addition to those receiving anesthesia, patients receiving intravenous sedation must receive an appropriate preanesthesia assessment and be monitored by a qualified individual.

8. DOCUMENTATION

a. Surgery is performed only after an appropriate history, physical examination, and any indicated laboratory and radiologic examinations have been completed and the pre-operative diagnosis has been recorded in the medical record.

b. Documentation of informed consent is mandatory. Signed and dated consent for performance of the operation must be obtained from the patient or the patient's representative in accordance with the Informmed Consent Handbook, 1004.

c. Pre-operative patient instructions must be documented. Adequate description and documentation of the procedure must be recorded in the patient's medical record, and an operation report completed.

d. All specimens must be sent to the laboratory for appropriate examinations, and the results of these examinations must be entered into the patient's medical record.

e. Written follow-up instructions, medications, and emergency telephone numbers will be given to the patient before the patient leaves the hospital or clinic. These instructions must be documented in the patient's medical record.

f. An accurate and complete description of the techniques and findings of the operative procedure must be dictated or written immediately following surgery and authenticated by the individual who performed the procedure. All operative and invasive procedures classified as ambulatory must comply with good practices and JCAHO guidelines, including minimum required data elements for patient record content and documentation.

g. In the interest of monitoring quality of care, certain information concerning patients treated by a surgical procedure on an ambulatory basis must be entered into the Veterans Health Information Systems and Technology Architecture (VistA) Surgical Package (see par. 9).

9. VISTA SURGICAL SOFTWARE PACKAGE

a. Scheduling all surgical procedures through the VistA Surgical Package provides Surgical Service a single data base for determining surgical workload and surgical outcome. This information is essential in order to monitor the quality of patient care. Further, cost-analysis and cost-recovery mechanisms depend upon the information generated by the VistA Surgical Package.

b. All procedures performed are scheduled and/or entered into the VistA Surgical Package

(1) As a method of determining valid surgical workload.

(2) To allow appropriate quality of care oversight. Individual facilities will monitor policy for performance of ambulatory surgical or invasive diagnostic procedures not performed by surgical staff but performed in the surgical suite. This includes performance of endoscopic procedures and insertion of pacemakers by medical staff. These procedures will be scheduled/entered in the VistA Surgical Package and recorded as Surgical Service workload but identified and categorized separately from surgical procedures.

c. This ensures all patient information is collected and maintained for periodic review and reporting. This data needs to include any patients that require unplanned overnight observation

in the hospital, admission to the hospital within 14 days of the surgery due to a surgical or anesthetic complication and deaths that occur within 30 days of ambulatory surgery. A quarterly review and/or audit of this program to include morbidity and/or mortality statistics must be reported as part of the Quarterly Report of Surgery to VHA Central Office, Surgical Service (111B) in the same manner for patients operated in the main OR, ambulatory surgical suite, minor operating room, procedure room, or satellite clinic. ***NOTE:*** *These monitors need to be part of the facility Quality Management Program.*

10. AMBULATORY SURGERY PROGRAM SITE CONSIDERATIONS

a. A VA medical center Ambulatory Surgery Program may provide ambulatory surgery services in one or more of the following locations: the main surgical suite with properly equipped operating room(s), a dedicated ambulatory surgical suite with properly equipped operating room, or a properly equipped and staffed procedure room in an ambulatory care clinic.

b. When it can be demonstrated that these existing resources do not have sufficient capacity to accommodate the projected ambulatory surgery workload, renovation of existing space for a dedicated ambulatory surgery suite may be necessary. Analysis of current and projected operating room (OR) capacity needs to be accomplished using the VHA Operating Room Planning Model (ORPM).

c. **Staffing Qualifications.** All personnel responsible for the performance or supervision of ambulatory surgery must meet the requirements for credentialing and privileging at each medical center. Ambulatory surgery must be performed with the same high standards of quality as would occur if the patient were operated on as an inpatient in the main operating room. ***NOTE:*** *Staffing for all disciplines needs to be based on this principle.* Physicians performing or assisting in performing procedures in the main OR or other dedicated operating rooms such as endoscopic procedures must be approved by the Chief of Surgery, and must meet all of the requirements for credentialing and privileging which pertain to members of the surgical staff. The workload generated must be reported as surgical workload, but identified and categorized separately from surgical procedures.

11. DEDICATED AMBULATORY SURGERY SUITES

a. Each dedicated stand alone ambulatory surgery suite will have a minimum of two operating rooms (in order to allow for decontamination and effective use of staff time).

b. As a guideline, dedicated ambulatory surgery suites consisting of two operating rooms should require a minimum total volume of 1,000 surgical procedures per year. Dedicated ambulatory surgery suites consisting of three operating rooms should require a minimum total volume of 2,000 surgical procedures per year. Three procedures per room per day should be a minimum figure intended to include a mix of operations performed under general, regional, topical, and local anesthesia. The actual number of operating rooms required needs to be determined using the VHA ORPM.

c. Hours of operation are to be determined by local demand.

12. SPACE GUIDELINES FOR DEDICATED AMBULATORY SURGERY SUITE

a. A dedicated ambulatory surgery suite (new construction) must meet all related JCAHO standards and VA space criteria. Dedicated ambulatory suites should be located, whenever possible, adjacent to the main OR suite. ***NOTE:*** *A location near the Intensive Care Unit (ICU) or related support services should be considered as an alternate site.*

b. VA Handbook 7610, Chapter 286, provides a list of suggested rooms appropriate for a stand alone, dedicated, ambulatory surgery suite. See VA Handbook 7610, Chapter 265, VHA - Independent VAOPC/SOC for room sizes.

c. Space allocations need to be determined dependent on local factors such as: whether the ambulatory surgery is part of a hospital surgical suite, a dedicated ambulatory surgery suite adjacent to a hospital surgical suite, or a stand alone ambulatory surgery suite. VA Handbook 7610, Chapter 265, VHA - Independent VAOPC SOC or VA Handbook 7610, Chapter 286, VHA - Surgical Service, are available to determine space requirements. The recommended location of a dedicated ambulatory surgical suite (new construction), adjacent to the main OR suite, provides for efficient access to emergency and ancillary services and possible sharing of staff with the main OR suite. Location must consider flow of patients and staff to ensure operational cleanliness and sterility; especially when using existing OR suite facilities, patient flow from change area to preparatory area to OR suite is crucial.

d. The suggested functional space requirements are based on JCAHO requirements and the interpretations of VA surgeons as to what constitutes reasonable space for a safe functional environment and for adequate storage area.

13. STAFFING GUIDELINES FOR A DEDICATED AMBULATORY SURGERY SUITE

a. The following listing suggests personnel for staffing a dedicated ambulatory surgery suite having two OR's and is operational 5 days a week.

Personnel	Number of Full-time Equivalent (FTE)
Surgeon	2.00 FTE
Anesthesiologist/Anesthetist	2.00 FTE
Registered Nurse (RN) (Circulation)	2.00 FTE
RN (Post-Anesthesia, Recovery Room)	1.00 FTE
Technician (Scrub person)	2.00 FTE
Social Worker	.25 FTE
Clerk	1.00 FTE
Housekeeping	.25 FTE

b. This gives a total of 8.5 FTE plus Title 38, Title 5, leave time.

c. For staffing qualifications, refer to paragraph 10c.

14. SATELLITE OUTPATIENT CLINIC (SOC) AMBULATORY SURGERY PROGRAMS

The minimum considerations for the development of SOC ambulatory surgery programs are as follows:

a. Ambulatory surgery may be performed at SOCs where projected surgery workload makes it possible to be efficient and cost-effective. ***NOTE:*** *The development of ambulatory surgery services at free-standing or independent outpatient clinics will be considered by each VISN office.*

b. Patient safety requirements described must be met.

(1) Adequate emergency back-up services (VA or non-VA hospital) available within 15 minutes rush hour driving time from the satellite facility; and

(2) Ambulance services must be readily available.

c. The SOC Distributed Population Planning Base (DPPB) must be used for ambulatory surgery workload projection.

15. PROGRAM PROCEDURES

a. Minimum pre-operative work-up needs to include history and physical and laboratory procedures as deemed appropriate for each facility.

b. All operative scheduling must be through the Surgical VistA Package as a method of determining surgical workload and for oversight of the quality of patient care.

c. If the patient has had a major procedure or major anesthesia (requiring more than local infiltration) minimum post-operative care is to include: departure from ambulatory suite after approval by anesthesia; appropriate discharge counseling including post-discharge medications in the company of a competent adult; may not drive for 24 hours or as otherwise specified; must return to home with a competent adult; and must be reachable by phone for 48 hours.

d. A staff RN must call the patient following the patient's return to residence to ascertain the patient's status and/or problems and provide instructions for return visit.

e. A checklist of the procedures follow:

(1) Pre-operative work-up including request for surgery (i.,e., consent).

(2) Discuss anesthesia.

(3) Schedule operation through VistA including site, side, and implant, if applicable.

(4) Confirm the Five-Step Process: The Five-Step Process for ensuring correct surgery in VHA is:

(a) **Days to Hours Before Surgery**

1. **Step 1. Consent Form.** The consent form must include:

a. Patient's full name,

b. Procedure site,

c. Name of procedure, and

d. Reason for procedure.

2. **Step 2. Mark Site.** The operative site must be marked by a physician or other privileged provider who is a member of the operating team. ***NOTE:*** *Do not mark non-operative sites.*

(b) **Just Before Entering the OR**

1. **Step 3. Patient Identification.** OR staff must ask the patient to state (not confirm) the patient's:

a. Full name,

b. Full SSN or date of birth, and

c. Site for the procedure.

2. Check responses against the marked site, ID band, consent form, and other applicable documents.

(c) **Immediately Prior to Surgery**

1. **Step 4. "Time Out."** Within the OR when the patient is present and prior to beginning procedure, OR staff must verbally confirm through a "time out" the:

a. Presence of the correct patient,

b. Marking of the correct site,

c. Procedure to be performed, and

d. Availability of the correct implant.

2. **Step 5. Imaging Data.** If imaging data is used to confirm the surgical site, two or more members of the OR team must confirm the images are correct and properly labeled.

(5) Post-operative care.

(6) Discharge planning and/or counseling.

(7) Release patient to competent adult.

(8) No driving for 24 hours.

(9) Reachable by phone for 48 hours.

(10) Follow-up appointment.

16. REFERENCES

a. Accreditation Manual for Ambulatory Health Care, JCAHO.

b. Comprehensive Accreditation Manual for Hospitals, JCAHO, TX. 2, 1995.

c. M-1, Part I, Chapters 5 and 16.

d. M-2, Part I, Chapters 7, 23, and 26.

e. M-2, Part XIV, Chapter 1.

f. VA Handbook 7610, Chapter 265, VHA Independent VA Outpatient Clinic (OPC) Satellite Outpatient Clinics (SOC).

g. VA Handbook 7610, Chapter 286, VHA Surgical Service.

h. VHA Handbook 1400.1, Resident Supervision.

i. VA Handbook 1004, Informed Consent.

j. M-1, Part I, Chapter 16, subparagraphs 16.74 and 16.75.

PATIENT SELECTION CRITERIA FOR AMBULATORY (SAME DAY) SURGERY

To ensure patient safety, the criteria to be utilized for determining patients' suitability for ambulatory surgery must include, but not be limited to, the following:

1. SELECTION FACTORS

a. **Simplicity of the Procedure.** The operative procedure to be performed must be of short duration (usually less than 90 minutes) and entail only minimal bleeding and minor physiological derangement.

b. **Incidence of Post-operative Complications.** The potential incidence of post operative complications should be reliably low. This is a more important restriction in the selection of the cases than the simplicity of the procedure. The anticipated recovery period should be minimal (45 minutes to 2 hours) with no post operative complications expected.

c. **General Good Health of the Patient.** The patient should be in good health or have a systemic disease which is under good control. The Chief, Surgical Service, or designee at each station must develop policies for ambulatory surgery which will specifically address the handling of patients not in American Society of Anesthesiologists (ASA) Class I or II. The classifications of the ASA categories are as follows:

(1) **Class I.** The patient has no organic, physiological or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and does not entail a systemic disturbance. Example: A patient relatively free of significant health problems with an inguinal hernia.

(2) **Class II.** The patient has mild to moderate systemic disturbances caused either by the condition to be treated surgically or by other pathophysiological processes. Examples: Only slightly limiting organic heart disease, mild diabetes, essential hypertension, or anemia. Some might choose to include extremes of age as a factor for inclusion in this Class even though no discernible systemic disease is present.

(3) **Class III.** A patient with severe systemic disease that limits activity (stable angina pectoris, prior myocardial infarction, obstructive pulmonary disease.)

d. **Reliability of the Patient.** Patient must be capable of understanding and be willing to follow specific pre-operative and post-operative instructions related to outpatient surgery.

e. **Psychological Acceptance by the Patient.** Patient must agree to have the surgery performed on an ambulatory basis. The patient should be aware that additional observation may become necessary because of an unforeseen complication. The attending physician may require the patient to remain in the hospital until release is deemed safe.

f. **Informed Consent**. In all cases, an informed consent for the performance of the operation must be obtained from the patient or the patient's representative. The patient must be provided with information describing possible complications of the surgical procedure or of the type of anesthesia to be used. Alternative forms of treatment other than the proposed operation must be explained fully to the patient.

g. **Anesthesia Review.** Anesthesia personnel must review risk potential for those patients scheduled for major procedures or major anesthesia such as general or spinal. They need to participate in the selection of a safe mode of anesthesia for those patients scheduled for more major procedures or who are in a Class III.

h. **Home Situation of the Patient.** This must be carefully considered. For example, patients are often viewed as not suitable candidates for ambulatory surgery because there is no one to take care of them upon arrival at home following their surgery. However, the lack of a patient support system need not result in the automatic rejection of the patient for ambulatory surgery. The need for family support at home in order to safely perform ambulatory surgery needs to be determined on a case-by-case basis. If family support is not available, the home situation must be evaluated as necessary by a social worker. Other support services such as visiting nurses, etc., should be considered. A VA medical center telephone number needs to be provided. Likewise, the VA medical center needs to know the patient's phone number.

i. **Travel Problems.** Where there are patient travel problems due to inclement weather, transportation problems, lack of hospital bed availability or patient scheduling at the VA medical center, VA medical centers may refer patients for temporary lodging or Hoptel services (see M-1, Pt. I, Ch. 16, subpars. 16.74b and 16.75b). Social workers can assist veterans with travel arrangements.

2. EXCLUSION FACTORS

Patients with Infections. Patients who have serious infections should not be accepted for ambulatory surgery. This type of patient requires an isolated recovery area.