

Improving Quality and Risk Management in Outpatient Surgery

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Introduction

The purpose of this paper is to explain the outpatient program that has been introduced in the Sévigné Clinic, a Private General Hospital, at Cesson, Sévigné (FR-35) with the support of the Brittany Regional Union of Private Doctors "*Union Régionale des Médecins Libéraux de Bretagne*" and the Regional Health Insurance Fund "*Union Régionale des Caisses d'Assurance Maladie, URCAM*" through the provision of Funding for Assistance in Quality Outpatient Care "*Fonds d'Aide à la Qualité des Soins de Ville*".

The program covers the improvement in quality and risk management in the interaction between a health care establishment and the non - hospital patient care. The emphasis is on caring for outpatients undergoing surgery in the light of the desire to develop this activity and to enlarge its area of application. The development of outpatient care is also concerned with the effectiveness of some of the other solutions under consideration for protecting the French Health Insurance system.

1. Context

Over the last ten years, outpatient surgery has been developed through:

1. Progress in anaesthetic and surgical techniques that have led to changes in practice,
2. The demand for quality where financial and human resources are limited,
3. The reorganisation in recent years of the range of techniques used, particularly in private hospitals, under the Optimal Quality Network "*Objectif Qualifié National, OQN*".

By comparison with OECD countries, outpatient surgery is suffering from significantly delayed development in France and the Brittany region is no exception to this

generalisation. Yet this treatment method has both organisational and financial advantages. Thus, developing the use of outpatient surgery is one of the aims for surgical operations in the Regional Health Care Plans ("*SROS III, Schemas régionaux d'organisations sanitaire*").

However, developing outpatient surgery requires:

1. Firstly, that outpatient surgical units are individualised and the availability of continuous care is organised 24/24 hours for patients operated during that day (decree 92 - 1102 of 2nd October 1992)
2. And secondly that the patient is properly cared for at home in the days following the operation. This is actually a crucial period during which patients may present post-operative complications at a time when they are not directly under the eyes of the monitoring surgical and anaesthesia team.

To ensure patients receive the necessary quality of post-operative care, it is essential to:

1. Have available an information system that provides medical information in real time (report on the operation, discharge record, prescription, invoicing data base, etc...);
2. Inform patients and increase their understanding;
3. Inform and train the General Practitioner (GP) concerned;
4. Have a risk management procedure that ensures patients receive quality care, particularly when at home. This procedure must include identifying and analysing incidents (post-operative complications) in order to improve the unit's organisation, the quality of care provided and the interaction with the GP concerned.

From January 2005, the Sévigné Clinic started developing its program for outpatient surgery, putting emphasis on improving quality and risk management. A multidisciplinary team was formed in partnership with the Brittany Regional Union of Private Sector Doctors (RUPSD).

The aim of the project is to provide conditions that ensure the quality and safety of patient care while the operational method is being developed (enlarging indications, increasing the number of patients) with greater effectiveness in care and with greater patient comfort.

2. Planned Method and Procedure

2.1 Method

In the literature, the main cause of over 80% of undesirable events is generally attributed to the organisation itself, with problems arising at the point of interface between people or between medical departments and activities.

Risk management enables the risks to patients to be reduced.

The development of an analytical approach to procedures and practice means that issues that might give rise to risk can be identified and the usual operational methods challenged.

This information is used for purposes of organisational improvement. Collating and analysing information collected by members of the institution provide opportunities to

strengthen confidence between people, bringing to the fore their knowledge and increasing their understanding of the system.

The Sévigné Clinic also sought to apply the concept of risk management to outpatient surgical care.

2.1.1 Checking the existing system: Telephone survey conducted by the Sévigné Clinic and fact finding by the RUPSD centre.

The telephone survey conducted by the Sévigné Clinic in 2005 confirmed that a number of complications occurred after discharge and that there was potential for improving pain management.

Enquiries by the RUPSD indicated there was good acceptance of outpatient surgery and satisfactory cooperation between the GP and the Clinic staff, as well as confirming the importance of post-operative monitoring and pain management: these two latter points being considered influential in greater acceptance of outpatient surgery.

2.1.2 Analysis of the procedure

A multidisciplinary working party, comprising hospital staff, the outpatient care team and the quality engineer, sought to analyse the outpatient care procedures at the Sévigné Clinic with the aim of better identifying possible deficiencies at interface points in order to improve patient safety.

However, by its nature, outpatient care extends beyond the responsibility of the hospital as it also falls into the GP's domain.

For this reason, Dr Le Hétét, program initiator and coordinator, suggested to the Regional Union of Private Sector Doctors that general practitioners be included in the initial program study.

2.1.3 Inclusion of GPs in the working party.

Including GPs in the working party brought another point of view to the study group and thus contributed to the implementation of a care program suited to non - hospital treatment with better transmission of information between the hospital department and the non - hospital service, thereby ensuring improved patient follow - up.

Thus the working party defined care procedures intended to ensure the safety of the process, not only within the hospital but also at home with post-operative patient monitoring. Following analysis of the situation, the group produced communication and evaluation aids for improving the monitoring and exchange of information: advice from hospital doctors to the GP and vice versa

2.2 Outpatient admissions procedure

2.2.1 Description of the procedure

After having described the institutional framework and drawn up a schedule of the arrangements for outpatient surgery, we now turn to the work conducted in the Sévigné polyclinic by the project team.

The necessary prerequisites for putting in place a project include analysing the existing system. Thus, it seemed vital to us to first describe the procedure for admitting outpatients. This procedure, detailed below, can also be summed up diagrammatically as in Appendix 3.

2.2.1.1 Consultation with the GP

The patient sees their GP their admission for outpatient surgery to be arranged. The GP or referral physician diagnoses a pathology requiring surgery that is suitable for outpatient treatment. The referral physician alone may entrust the patient to the surgeon.

2.2.1.2 Consultation regarding surgery

The surgeon diagnoses the pathology and suggests surgery as an outpatient. Information on the health risks of this surgery are given to the patient. The operation is programmed and a place in the outpatient department is reserved. The patient is asked to see the anaesthetist for a consultation.

2.2.1.3 Pre-anaesthesia consultation

The purpose of this consultation is to determine the type of anaesthetic to be used for the surgery indicated and to check that this anaesthesia can be carried out under outpatient conditions. The anaesthetist informs the patient of the risks, the need to fast beforehand and the continued peri - operative treatment. The anaesthetist may also prescribe biological, cardiac and/or x - ray examinations. Biological examinations may be carried out during the pre-anaesthesia consultation.

2.2.1.4 Pre-admission

Pre-admission consists of reserving an outpatient bed on the day of the patient's operation. It enables all the relevant administrative data to be brought together. It is the stage at which the patient is advised of the time for admission to the outpatient department.

2.2.1.5 Outpatient admission

Admission is conducted by paramedical staff to ensure correct preoperative preparation, fasting, and administration of prescribed medication. Before the operation the nurse also checks that the patient will be accompanied on discharge to return home and will not be alone on the night following surgery.

The nurse arranges availability of the anaesthetist's prescription at the time of the pre-anaesthesia consultation concerning cardiac consultation and conducting x-ray and/or biological examinations.

An anaesthetist examines the patient at the time of the pre-anaesthesia visit basically to check that the need for fasting is understood and to find out whether they have suffered any recent pathology that might compromise anaesthesia. The anaesthetist notes the information resulting from the cardiac consultation and the biological and x-ray examinations. They authorise outpatient anaesthesia, and where another anaesthetist is to perform the anaesthesia, pass on the information to that anaesthetist.

2.2.1.6 Operating suite admission

The patient is received by a stretcher-bearer at the operating suite, and is next taken by stretcher to the anaesthesia and surgical preparation room for induction, and then to the operating suite. At the end of the operation, they are taken to the recovery room, and returned by stretcher to the outpatient department.

Please note that a chart shows the need for the operating suite to respect the stipulated timetable for patient discharge and meets regulatory requirements.

2.2.1.7 Return to the outpatient department and discharge

A nurse monitors the patient to check for any possible surgical complications, and implements the treatment prescribed by the surgeon and the anaesthetist and evaluates the suitability for patient discharge and return home (pain, nausea and vomiting etc). The patient is discharged at the time stipulated by the anaesthetist and after being visited by the surgeon.

Information is given to the patient on treatment, post operative effects and possible complications.

Discharge is validated by the surgeon together with any requisite prescriptions. If discharge is not possible, secondary hospitalisation is obligatory.

2.2.1.8 Return home

The patient may contact the hospital by phone in the event of a problem. They may also call their GP to find a solution for any post operative complication. Home care by a nurse may be prescribed by the surgeon and/or the GP.

2.2.2 Identifying risks at every stage in the outpatient procedure

After having described the outpatient procedure, potential and recorded risks must be identified at every stage.

Risks have been identified through practical experience as well as by analysing reports of undesirable effects.

It must be said that this list is not exhaustive and will be developed as undesirable effects are recorded and as medical techniques change.

Stage in the procedure	Potential and recorded risks
Consultation with the GP	Inadequate knowledge of the GP of the possibility of outpatient treatment for their patient, depending on the surgical indication and the patient's profile.
Consultation regarding surgery	Risk of the surgical operation being impracticable due to the patient's profile in respect of anaesthesia.
Pre-anaesthesia consultation	Outpatient anaesthesia criteria not met. Fasting and treatment advice not provided. Preoperative examinations not effected before admission.
Pre-admission	Risk of lack of punctuality for arrival time.
Outpatient admission	SRN: Lack of pre-operative preparation, fasting verification, carrying out and receiving results of complementary examinations, failure to ascertain patient return to home arrangements. Anaesthetist: Failure to pass any special requirements to the operating suite anaesthetist.
Admission to the operating suite	Failure to keep to the operating timetable causing admission to operating suite to be too late Erroneous identification of the patient
Return to the outpatient department and discharge	SRN: Inadequate monitoring with poor knowledge of surgical complications (inadequate staff training); lack of treatment continuity; inadequate evaluation of return home conditions; inadequate information to the patient on post operative treatment; the possible complications and action to be taken; patient discharged without respecting the time given by the anaesthetist, without surgeon's visit. Surgeon: Inadequate treatment continuity with lack of discharge prescriptions and any possible nursing care; lack of visit with no discharge authorisation being given. Anaesthetist: No discharge time given. Risk of obligatory secondary hospitalisation when no standard hospital bed is available
Return home	Risk of inadequate understanding of a post operative complication; inability to reach the appropriate hospital contact. Lack of information on managing peri-operative treatment. Risk of lack of treatment availability - discharge late in the day when pharmacies are already closed. Risk of disruption in SRN care. Risk of being unable to access case notes on emergency rehospitalisation.

2.3 Putting a risk management system in place within the procedure

Having identified risks inherent in outpatient admission procedure, a system for managing these risks must now be put in place. Two complementary approaches need to be examined: management of risks prior to surgery and management of risks subsequent to surgery.

2.3.1 Management of risks prior to treatment

Risk management prior to treatment consists of implementing measures before an incident or accident occurs. The project team, after identifying risks arising from the admissions procedure, suggested a number of actions.

2.3.1.1 Physician's liaison notes

These notes would provide information, depending on the type of surgical operation, of the possible post operative complications and the course of action to be taken.

2.3.1.2 Patient case notes

These notes would inform the patient of possible sequels and give them early warning of a complication.

2.3.1.3 Chart showing how the outpatient department functions

This depicts the organisation of the department, giving the specific hours for outpatient admission. It foresees the possible risk of secondary hospitalisation in the event that discharge is not possible.

2.3.1.4 Chart showing how the operating suite functions

This chart depicts the special arrangements for outpatient admission and takes into account the limitations in the timetable for entering the operating suite (start of the actual operating procedure).

2.3.1.5 Staff training of the outpatient department routines through to post operative monitoring and the identification of possible complications.

2.3.1.6 Putting in place protocols for pain and post operative nausea and vomiting prevention.

These protocols should reduce individual variability on admission and limit risks.

2.3.1.7 Transfer of patient case notes to the emergency service on the evening of surgery so that they may be consulted by the duty physician and any complication can be better managed.

2.3.1.8 Improved communication

The same telephone number of the outpatient department duty individual to be given to both the patient and their GP for use should problems arise.

2.3.1.9 Editing a liaison file

This system furthers care continuity and sharing information relating to the management of peri - operative treatment, with the aim of improving the use of the medication and reducing risks in peri operative treatment management. This liaison file can be consulted by the SRN and improves nursing care and treatment continuity.

2.3.2 Risk management subsequent to treatment

The organisation set up for improving quality and the management of outpatient risks must also have a system for alerting the occurrence of undesirable events.

How can this information on malfunctioning, not only of patient admission to the hospital establishment, but also of events occurring after discharge from the clinic?

2.3.2.1 Internal system

Undesirable event alerting forms (Covir forms) are already available to all the care staff and the doctors. They are collated and analysed by the Risk Monitoring Committee. The Committee deals with malfunctioning within the hospital establishment in order to reduce outpatient admission risks (see appendix 4).

2.3.2.2 External system

It is essential that the hospital establishment gathers information on events occurring after the patient is discharged from the outpatient department.

The working party drafted patient and GP questionnaires, aids that are discussed in the section on "Implementing the Project".

A surveillance unit has to be put in place in order to analyse the questionnaires received and to set up the necessary actions for reducing malfunctions.

3. Care Protocol and Supporting Documents

The Sévigné Clinic, together with the Brittany RUPSD, developed a protocol for identifying and then testing the conditions that would ensure the quality and safety of patients being cared for at home.

For this purpose, doctors from the Clinic formed a working party and were subsequently joined by a number of GPs. The working party's ideas led to:

Suggesting a new system of shared responsibility for patient care and for strengthening cooperation between the GP and the surgical team

1. When outpatient surgery is decided upon, the patient attends a pre anaesthetic consultation approximately one week prior to the operation. The anaesthetist gives the patient a letter suggesting they make an appointment with their GP for the day after the operation.
2. The anaesthetist also sends a letter of notification to the patient's GP which requests all relevant details concerning the patient. A description of post-operative follow - up is attached to this letter or sent by fax.

3. A liaison file is given to the patient on discharge from the hospital.
4. At the consultation on the day after surgery, the GP completes a clinical assessment sheet on the patient and sends it to the hospital.
5. The hospital analyses the assessment sheet in order to improve and adjust the care provided.
6. The patient's opinion on the care they received is also collected and analysed.

The documents and aids designed to optimise care and disseminate information to both the patient and the GP are:

1. A liaison file;
2. An information sheet on the surgical operation (standard follow - up required, any particular action to be taken and so on);
3. The telephone number of a contact within the hospital team;
4. An assessment questionnaire to be returned to the hospital;
5. A monitoring unit to implement the care improvements indicated by data from the GP's consultation

3.1 The liaison file

The liaison file (attached in appendix) has been designed to ensure the continuity of information within the hospital (inter-service continuity) and outside the hospital (continuity with the GP and/or health care unit).

This file records information relating to the patient, the operation carried out and the follow - up provided.

Thus, it includes

- Details of the patient's identity;
- The names of those involved in the operation (surgeon and anaesthetist), the type of operation, the type of anaesthetic used and any comments regarding the operation itself;
- The treatment broken off prior to the operation, the subsequent treatment prescribed, the suggested resumption date, and the relevant method;
- The pain assessment prior to discharge;
- The treatment prior to discharge (analgesic, anti - nauseant, other) with the precise name, unit dose, frequency and duration of treatment and the last time it was administered in the hospital;
- Discharge treatment (anticoagulants, platelet suppressive agents), the treatment terminated prior to the operation and the conditions for its resumption;
- Any other comments.

3.2 The information sheet regarding the operation

An information sheet on the operation is given to the patient with similar information being sent to their GP. These sheets are based on the same principles but use two different styles depending on whether addressed to the patient or the GP.

For each operation the indications are stated, the method to be used, the normal follow - up, any risks and possible complications and the action to be taken in the event of a complication arising (treatment adjustment, person to be contacted).

Information sheets to be addressed to patients were checked by user representatives - the League against Cancer and the Ostomate Association of Brittany "*Ligue contre le cancer et l'Association des stomatisés de haute Bretagne*" - to ensure that the documents were unambiguous and easy to read.

3.3 Contact telephone number

The GP is given a single outpatient contact telephone number which facilitates contact when requiring further information or notifying a problem.

3.4 Assessment sheets for the patient and their GP

In order to collate information on the care provided, assessment sheets laid out in a similar manner for the patient and the GP, are to be completed and returned by them to the hospital. These sheets include pain assessment, food eaten, sleep, raised temperature, return home, acceptance of the treatment and the outpatient care satisfaction rating.

3.5 The monitoring unit

The monitoring unit, comprising hospital doctors, the outpatient department's para - medical team, GPs and a quality engineer, analyses the returns and decides any necessary improvement action to be taken.

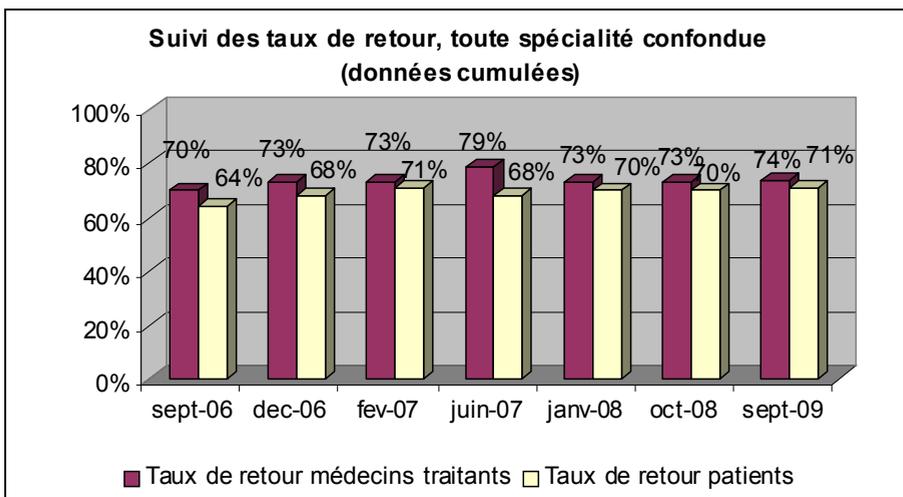
4. Results

The monitoring unit assessed the indicators provided by the GP regarding day 1, and the information on the patient questionnaire. The unit met every six months in the period from the end of 2005 up to 12th November 2009. During this period it introduced improvements and, together with its various members has, among other things, suggested improvements regarding discharge prescriptions and the sharing of information.

Descriptive data for patients is included.

4.1 Inclusion in the outpatient system

Inclusion of patients began in June 2006 and by end - September 2009, 2197 patients had been included in the system.



Sep - 06 Dec - 06 Feb - 07 Jun - 07 Jan - 08 Oct - 08 Sept - 09
 □ rate of return by GPs □ rate of return by patients

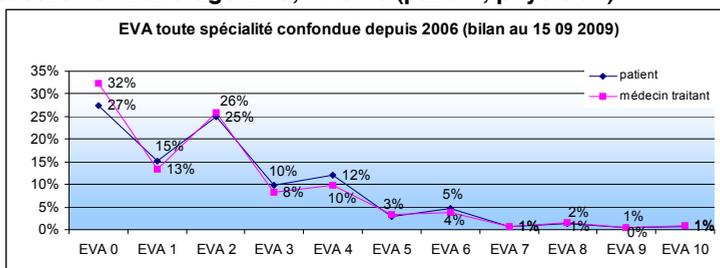
The rate of returns completed by the GP after clinical examination and of the questionnaires completed patients, was high at the outset and was confirmed in September 2009 at nearly 74% from GPs and 71% from patients.

4.2 Patients included by specialisation (for which a return was made by the GP)

Of those involved in the experiment, nearly half were ENT (Oto Rhino Laryngology) patients (41.7%, or 680 patients), 21.4% or 382 vascular patients, 10.8% or 176 urology patients, 9.5% or 155 stomatology patients and finally, 12.1% or 197 digestive surgery patients.

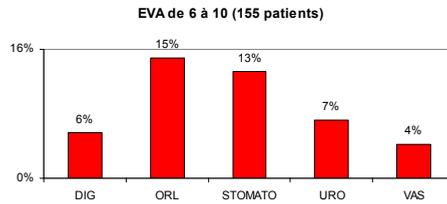
In ENT the vast majority of cases handled were childhood tonsillectomy, vascular surgery of unilateral or bilateral varix and stomatology included wisdom tooth extraction; digestive surgery was mainly for unilateral or bilateral inguinal hernia.

4.3 Pain measurement: average VAS, VAS >3 (patient, physician)



VAS - all specialisations combined from 2006 (total at 15 September 2009)

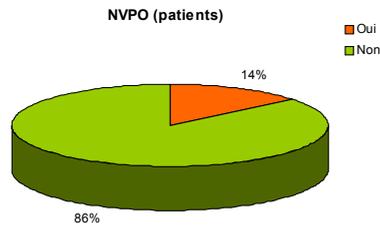
Where VAS was greater than or equal to 3 for all specialisations combined it was assessed at 33% by patients and 29% by GPs.



VAS at 6 - 10 (155 patients)

A total of 155 patients experienced very severe pain (VAS at 6 to 10), most of them having undergone ORL or stomatology surgery.

4.4 Eating problems (patient, GP)



Patients mention post-operative nausea and vomiting in 14 % of completed questionnaires.

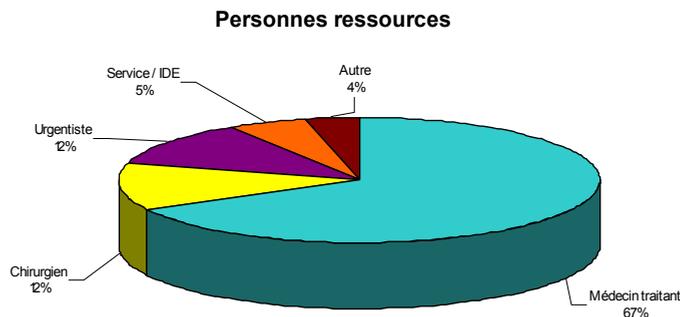
4.5 Problem on returning home (patients only) Source: patients' questionnaires (12% of patients experience a problem on returning home) Some examples of the problems experienced by patients

Eight days after the operation, bleeding emergency, post-operative treatment insufficient + lack of explanation, otitis media, tongue fungus, superinfection, allergic reaction to drug, varicella the next day, return to emergency (swollen foot), allergy to a drug (noted on the questionnaires), frenulum bleeding (the GP cauterised with silver nitrate), hypotension and vertigo.

4.6 Problem on returning home (GP only) Source: GP questionnaire A few examples of problems reported by the GP

Asthmatic bronchitis, superinfection after waiting for 3/4 of an hour before the operation, vasovagal syncope, venous hematoma, vasovagal syncope on rising in the morning, bronchitis. small blood clot stuck to pharynx, pharyngitis superinfection, brief vasovagal syncope in the morning, serious bilateral otitis (RHS very swollen), hypotension and vertigo, nausea, vertigo and vomiting when taking Monalgic

4.7 Level of problem resolution: 97%

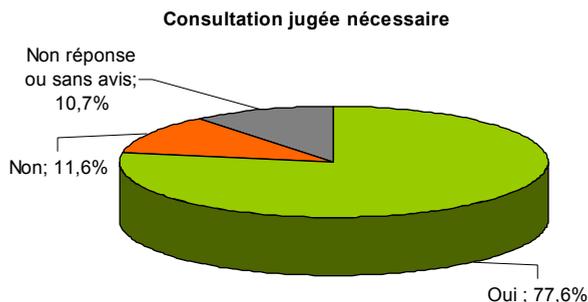


People resources

Surgeons 12%/Emergency services 12%/SRN services 5%/Other 4%/GP 67%

In 67% of cases it was the GP who identified the problem, with a resolution rate of 97%. Others were the specialists, the duty doctor, the emergency doctor, the pharmacist, the home visiting SRN, the patient's own entourage.

4.8 Consultations deemed essential by the GP (n=550 GPs)



Consultation deemed essential

Not 11.6%/No response or no opinion 10.7%/Essential 77.6%

Of a total of 550 responses, GPs deemed the consultation essential in 77.6% of cases.

4.8.1 Reported examples of subjects raised with the GP during consultation (x n)

Post-operative monitoring, complication identification, safety, check of state of health, infectious and hemorrhagic risk, venous examination, bandage check and wearing support stockings check ... (x178)

Reassurance, peace of mind (x180)

Information, explanation of risks (phlebitis), further explanation of treatment, further explanation of care "the patient claims not to have understood properly at the clinic, he was

"out for the count," prescription reformulation, explanations a little rapid on discharge, advice reminder, guidance (on meals, hydration, care and so on), response to questions (x65)
Pain and tolerance assessment, effectiveness check and analgesic adjustment, restate the need for systematic administration of analgesic, clarify the drugs and dosage (2 different analgesics issued) (x39)

Correction of postoperative side effects, allergy; cessation of badly tolerated treatment, reassessment and adjustment of treatment, prescription adjustment, best therapeutic observance (x20) well being / comfort (x18)

Avoiding hospitalisation, early discharge facilitated (x8)

Check of vital functions (x5)

More reliable, better care (x3)

Repositioning the band, the tourniquet, removing stitches (x3)

Enabling care to be organised

4.8.2 Reported examples of consultations deemed unnecessary by the GP (x n)

No discernable problem / anticipatory consultation in the event of complication, anomaly only / normal progress / GP's surgery unnecessarily crowded when no problem has arisen (x21)

Nursing follow - up (x3)

Too soon (x2)

Patient autonomous, observant, vigilant, young (x3)

The advice given to the patient on discharge should be sufficient (x1)

Patient nurse and benign operation (x1)

Double the normal monitoring following an operation (x1)

VAS prior to discharge not completed

If the consultation was necessary, an information meeting and the involvement of the care organisation would be preferable

Despite this: of the GPs considering consultation unnecessary, some recognised patient benefits:

Reassurance (x23)

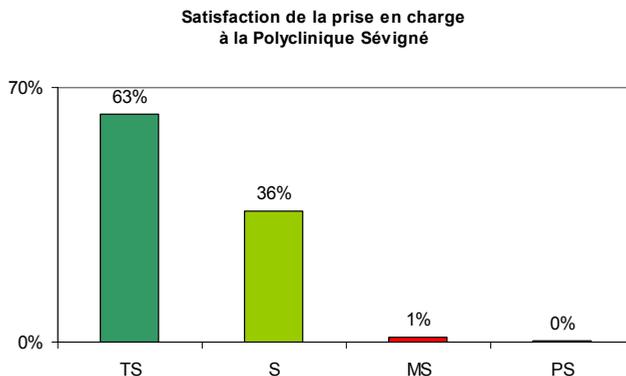
Comfort (x2)

Pain monitoring check (x1)

Explanation of side effect (x1)

Better suited and better tolerated treatment (x1)

4.9 Level of satisfaction with care at the Clinic



Satisfaction with the care received at the Sévigné Private Hospital

TS= CS (Completely Satisfied), S = S (Satisfied), MS = FS (Fairly Satisfied), PS= D (Dissatisfied)

Patient satisfaction with the care received at the Clinic was 99%.

4.10 Advantages of the approach

4.10.1 Advantages to the patients

Patients seem more confident, particularly for a procedure involving their child (ORL). They were reassured by the information provided by the GP on a number of issues. They spoke of their satisfaction at seeing their GP again on the day after the operation.

4.10.2 GP satisfaction and advantages to their practice

On the whole, GP reaction was very positive.

Reaction to the reporting system was positive; it was described as a precise, useful, practical follow - up sheet.

According to the GP, the associated care was very good. It also improved the quality of their contact and their relationship with the patient.

Coordination between specialists improved the GP's working environment. One of them even mentioned care "without anxiety" through this communication.

An isolated comment by a GP referred to fear of medical - legal liability being transferred from the specialist to the GP. This aspect had been raised by the working party with the possible need to have someone available in the hospital 24 hours a day; this means that liability would remain totally with the hospital with improved risk management through improved communication.

4.10.3 Incorporation in the ambulatory 2009 Formal Expert Recommendations of the French Society for Anaesthesia and Reanimation

Some aspects of the program were included (in chapter 7 covering the coordination of those involved in care continuity and in chapter 8 on the assessment and management of risk) in the 2009 Formal Expert Recommendations of the French Society for Anaesthesia and Reanimation (www.sfar.org) "*Société Française d'Anesthésie et de Réanimation, SFAR; Recommendation Formalisées d'Experts, RFE*".

5. Future Developments

The program has facilitated the development of outpatient surgery in association with the general practitioner, providing a high-quality, efficient, structured approach, which focuses on the patient and is in compliance with the recommendations of French Society for Anaesthesia and Reanimation "*Société Française d'Anesthésie et de Réanimation, SFAR*", the French Society for Ambulatory Surgery "*Association Française de Chirurgie Ambulatoire, AFCA*", the National inter-regime program, the National Health Insurance Fund "*Union Nationale d'Assurance Maladie, UNCAM*", and the International Association for Ambulatory Surgery.

In practical terms, the Brittany Regional Union for Freelance Doctors and the Sévigné Clinic will advise other health establishments in the region of this approach to outpatient surgery within the framework of the Regional Health Authority.

To this end, several actions are being undertaken:

- Providing information to the presidents of the Hospital Medical Team "*Commission Médicale d'Etablissement, CME*" and the coordinators of outpatient surgery units.
- Putting the aids developed on-line and making them accessible through a Google site with the possibility of further improvements to meet the needs of a variety of teams working in outpatient surgery.
- Developing discussions between the outpatient surgery teams and GPs through secure messaging such as Apycript.

Furthermore, following the request expressed by GPs in the consultation questionnaires on Day 1, and also following fact finding by the RUPSD Centre, we have set up training on Medical Continuity for GPs in the network plus the specialist hospital doctors.

A file requesting approval has been accepted by the Management Authority thus enabling the training to be carried out by the Association for Training Private Sector Doctors "*Association de Formation des Médecins Libéraux, AFML*".

This program has prepared the way for putting in place two other programs: firstly, outpatient catheter - administered perineural post-operative analgesics, and secondly, the liaison protocol for GPs supervising outpatient chemotherapy.

Implementing this program for improving quality and risk management for outpatient treatment has remained true to the actual program definition. "This program is a dream transformed by collective imagination for strategic goals."

6. Conclusion

This article represents the fruit of efforts of a team working with a participative management style in order to produce guidelines for liaison case notes as a tool for sharing information among those involved in coordinating care.

The individuals in the team contributed a mixed range of skills concerned with the observable and required to take into account the actual linkage with an institutional and legal framework. Their goal was achieved by integrating the regulations and the surveillance recommendations of learned societies. Such a coordination network in this matter validates the regulatory duties covered by the Evaluation of Professional Practices (EPP) of the doctors taking part, with the support of the Brittany Regional Union of Private Doctors (URML), the French Collegiate of Anaesthesia and Recovery (AFAR), the Senior Health Authority (HAS), and in compliance with Prof. Berwick's EPP principles. This means that hospital establishments can validate their certification, at the same time as meeting the associated regulatory requirements.

This mixed skills team formed a working party that put forward ideas for discussion in meetings, in a lucid, open manner, committed to a joint interest in sharing the task of designing a procedure for quality improvement. The team thus suggested, an effective scheme for Further Education for General Practitioners, taking account of their stated wishes and those of the Senior Health Authority.

This coordinated approach also applied to improving the overall use of medication and reviewing the priorities expressed in the Health Minister's "pain plan".

The team worked in the field of the non negotiable or invisible; those taking part were united in achieving a common objective. The team was able to fulfil its goal in the development of outpatient services by inviting local GPs to join an organisation that was centered on the patient, and complied with the recommendations of the French Association for Quality Assurance (AFCA), the French Society for Anaesthesia and Recovery (SFAR), the National Inter - Regime (public/private health insurance) programme, National Union of Health Insurance Funds (UNCAM) and International Association for Ambulatory Surgery (IAAS).

The team also laid the groundwork for two other projects: firstly, that of post operative outpatient analgesia by perineural catheter and secondly, that of outpatient chemotherapy case notes for clinic - GP liaison.

Putting in place this project for improving the quality of outpatient services and risk management has proved to meet the very definition of a project. "The project is a dream transformed by the collective imagination for strategic goals."

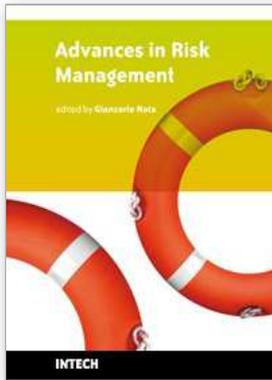
The project thus fulfils a dream where the essential element, as Antoine de Saint Exupéry wrote, is invisible to the eye.

7. References

- Banduret, JF., Conférence de consensus sur la chirurgie sans hospitalisation, hospitalisation privée, 1993, No 317. France
- Berwick DM, Godfrey AB, Roessner J. Curing healthcare: new strategies for quality improvement. A report on the National Demonstration Project on quality improvement in health care. San Francisco: Jossey Bass Publishers; 1991. USA

- Berwick, D. Notion for developing motion on improving health care. BMJ, 2004. GB de Saint - Exupéry, Antoine, Le petit Prince, Gallimard, 2006. - 1., 98 p. France
- Evin, C., Poutout, G., Houdart, Le traité pratique des réseaux de santé. 2005. - 1. France
- Fletcher, D., Analgésie en ambulatoire: un problème en évolution, Annales Françaises d'Anesthésie et de Réanimation, 2003, 22, No 8, pp 689 - 690. France
- Jarrett Paul E., Wetchler Bernard V., Editorial d'ambulatory surgery. 2003, Vol 1, n°1. France
- Johnson, G., Scholes, K., Whittington, R., Fréry, F., Stratégique. - (7ème édition). Pearson Education France, 2005. - 1., 732 p. France
- Gatecel, C., Approche systémique de la gestion des risks en chirurgie ambulatoire, Risks et Qualité. 2006, Vol 3, No 1, pp 39 - 48. France
- Kolb, F. Essai sur l'évolution des techniques de management. Edition Vuibert. France
- Mahieu, A., Raffy - Pihan, N., La chirurgie ambulatoire en France, bilan et perspectives. CREDES, 1997. - 1., 126 p. France Organisations and Institutions
- Agence Régionale de l'Hospitalisation de Bretagne, SROS III - 2006/2010, chirurgie ambulatoire, 2006.
- Coter de chirurgie ambulatoire, Direction Régionale du Service Médical de Bretagne, 2006. - 1., 420 p.
- EPP : Programme d'Amélioration de la qualité des soins pour le suivi de patients ayant bénéficié d'une intervention en ambulatoire (PAQ - ambu), CFAR.
- Etude sur la chirurgie ambulatoire en région Centre : quelle place ce mode opératoire occupe - t - il dans la pratique du médecin généraliste libéral ? URML Centre, 2004. - 1., 19 p.
- Haute Autorité de Santé, L'évaluation des Pratiques Professionnelles dans le cadre de l'accréditation des établissements de Santé, Direction de l'accréditation et de l'évaluation des pratiques, 2005. - 1., 56 p.
- Impact médecine, Réseaux de santé. 2006. - 1., 38.-No 146.
- Journal Officiel - (No 125). Décret n°99 - 444 du 31 mai 1999 relatif aux conditions de création de places d'anesthésie ou de chirurgie ambulatoire et modifiant le code de la santé publique, 1999. p 8111.
- Journal Officiel - (No 206). Décret n°95 - 993 du 28 août 1995 portant diverses dispositions relatives à l'organisation et à l'équipement sanitaires et modifiant le code de la santé publique, 1995. p 13172.
- Journal Officiel - (No 234). Décret n°92 - 1101 du 2 octobre 1992 relatif aux structures de soins alternatives à l'hospitalisation mentionnées à l'article L.712.2 du code de la santé publique, 1992.
- Journal Officiel - (No 234). Décret n°92 - 1102 du 2 octobre 1992 relatif aux conditions techniques de fonctionnement des structures de soins alternatives à l'hospitalisation mentionnées à l'article L.712 - 2 du code de la santé publique en application de l'article L.712 - 9(3o) de ce même code, 1992.
- Les premières Assises Bretonnes de l'Evaluation des pratiques professionnelles, La revue du Praticien, Médecine générale, 2006, tome 20, No 730/731, pp 528 - 532.
- Manuel d'accréditation des établissements de santé, 2^{ème} procédure d'accréditation. ANAES, 2004. - 1., 131 p.
- Mise en place d'un programme d'amélioration de la qualité dans un établissement de santé, Principes méthodologiques. ANAES, 1996. - 1., 67 p.

- Ministère de la Santé et des Solidarités, Charte du patient hospitalisé, Principes généraux, circulaire DHOS/DGS, 2004, No 451.
- Ministère de la Santé et des Solidarités, Plan d'amélioration de la prise en charge de la douleur, 2006. - 1., 36 p.
- Principes d'évaluation des réseaux de santé. ANAES,1999. - 1., 139 p.
- Programme national inter régime, Conditions du développement de la chirurgie ambulatoire, Volet Synthèse et mise en perspective, 2003, - 1., 83 p.
- Réanimation, 2003, 22, No 8, pp 689 - 690.
- Recommandations concernant l'anesthésie du patient en ambulatoire - SFAR, 2009 - www.sfar.org
- Toute la Formation Médicale Continue, Le nouveau paradigme FMC - EPP, 2006, n°63, 146 p.
- Trait d'union, 2^{ème} Forum médical Générale de Santé, 2003, No 15, pp 1 - 3. www.parhtage.sante.fr



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