

Constructing information booklets for day-case patients

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Abstract

As modern surgical and anaesthetic techniques develop even greater capabilities, the time in which to adequately undertake such nurse/patient discussions has past and will never return. Information provision is thus a challenge for day surgery. Many studies have suggested patients require differing levels of information i.e. full, partial and minimal disclosure. Future information booklets may need to be constructed in a more patient centred manner. This article attempts to provide a methodical approach to the required level of information, a guide to the construction of information booklets and suggestions for their application in day surgery. © 2001 Elsevier Science B.V. All rights reserved.

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1. Introduction

Classical studies over two decades, ago associated pre-operative nursing intervention with the copious provision of procedural, behavioural and sensory information. [1–7] The public's preference for day surgery, the lack of time to ask questions, the added emphasis on medical fitness, rapid post-operative recovery and home convalescence have all contributed to one of the most pressing challenges currently facing day surgery – information provision [8,9]. This is supported by the Audit Commission [10] who state one of the main complaints within day surgery to be the lack of information, especially written information. The Royal College of Surgeons of England and East Anglia R.H.A. [11] conducted a comprehensive study in which data were collected from 10 day surgery units, 30 consultant surgeons and 1434 patients. Patients voiced many concerns, but pre-operative information provision was the greatest. Lindén and Engberg [12] surveyed 105 patients undergoing a variety of day surgery procedures and concluded 36% were dissatisfied with the information they received. Furthermore, dissatisfaction with infor-

mation was associated with increased post-operative morbidity. In a study by Pollock and Trendholm [13] 110 days surgery patients were interviewed and information provision was again a noteworthy source of criticism. Menon [14] interviewed 78 days surgery patients to discover 66% required more information: being provided with adequate information at all stages of their care was associated with rating the day surgery unit as excellent or good. Leinonen and Leino-Kilpi [15] in a review of the literature on peri-operative care (pre-, intra- and post-operative care) highlighted information provision as a considerable challenge for both inpatient and day patient surgery.

It must be clearly emphasised that information provision alone is insufficient for the effective psychological preparation of patients undergoing day surgery [16–18]. Information must be provided within a formalised framework of care and delivered in a structured manner. Only the specific elements relating to the quality of information booklets will be examined here. The complete pre-operative psychological preparation of patients for day surgery has been reported elsewhere [17] (Table 1). Concerning information provision, what is clearly required is a closer examination of the required level of information, a systematic method of constructing information booklets and advice on how such booklets can be best employed in day surgery.

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2. Level of information disclosure

One of the main obstacles to adequate information provision has been the lack of guidance as to the most effective method of conveying the necessary information. Numerous reviews have established differing types of information provision to be most effective [5–7,19,20], (Table 2). This disagreement has resulted in a stalemate and the consequent absence of any formal pre-operative anxiety management plan. In less contentious areas of nursing care formalised plans are commonplace. For example, the physical nursing intervention required by a breathless, unconscious or immobile patient has been well documented, has broad professional agreement and exists in formal programmes of care for easy replication [21–23]. The lack of explicit pre-operative psychological programmes of care is evident in a number of recent nursing texts concerning day surgery [24–26]. These texts deal briefly with the nurses' role in anxiety management although put forward little practical advice. Traditionally, pre-

operative psychological nursing care has been solely associated with the provision of information and this continues to be the case today. Information is deemed to be the essential ingredient in helping a patient understand what is to happen and what is required of them. The implicit message being

Information provision = reduced anxiety.

Furthermore, mere information provision is frequently given the nonsensical label of 'reassurance' [27]. No one can fully gauge whether information alone has truly helped to reduce anxiety in the short time periods associated with day surgery [16]. Anxiety may begin many days or hours before the actual day of surgery yet only be adequately addressed a matter of hours or minutes prior to surgery [28–31].

Change is required as many studies have evaluated present pre-operative psychological management within modern surgery as outdated and unsatisfactory i.e. limited contact with hospital personal, rapid patient throughput, brief hospital stay [32–36]. A considerable number of studies have suggested a way forward would be to provide differing levels of information to match the patients preferred coping style i.e. vigilant and avoidant coping [4,36–46].

A vigilant coping style is distinguished by an approach to and an intensified processing of, threatening information. Its purpose is to help gain control over the main threat-related aspects of a situation thereby protecting the individual from the perception of unexpected dangers i.e. nothing surprises them as they are already aware of all the pertinent issues [47]. Mogg et al. [48] stated anxiety-prone individuals in acutely stressful situations may very easily activate their perception of threat relevant cues e.g. vigilant copers go into 'cognitive overdrive' in a stressful situation, extracting information from their environment and processing it constantly as negative or threatening (Table 3).

Cognitive avoidance is a withdrawal from threat-relevant information. Its purpose is to reduce the anxiety caused by the confrontation with a potentially frightening event [47]. Hock et al. [49] stated cognitive avoiders process far less threatening information than vigilant copers. This was viewed as advantageous in a dental surgery study by Baume et al. [50] as the patient was assessed as being less anxious during the actual procedure. Other studies have postulated avoidant behaviour to be a disadvantage in the long term as all too frequently healthcare matters requiring continued attention may be ignored [51–53]. Fluctuating copers are people who generally fall between these two extremes and commonly require a small amount of information although in some areas more detailed information e.g. more information regarding general anaesthesia as this has repeatedly been demonstrated as the most anxiety

Table 1
Main themes of anxiety management [17]

Intervention	Rationale
Provision of differing levels of information	Too little information for the patient who desires a great deal can increase anxiety. Conversely, too much information for the patient who desires very little can also increase anxiety
Promoting cognitive coping strategies	Constantly dwelling on the negative aspects of proposed anaesthesia and/or surgical treatment can give a false impression of safety
Therapeutic use of self	The close physical presence of the nurse is one of the most effective methods of anxiety management
Providing a semblance of control	Some patients desire more control over events than others. Therefore in a healthcare situation where the opportunity for such personal inclusion is often minimal, direct action is necessary
Promoting positive self-efficacy appraisals	Some patients feel less able to cope with a surgical event than others. Encouragement in self belief is therefore necessary especially when much recovery occurs at home
Persuasive environmental appraisals	Positive implicit and explicit environmental appraisals can have an advantageous effect upon the patients' perception of safety

Table 2
Types of pre-operative information [103]

Pre-operative information provision

Procedural information

The sequential order of events on the day of surgery i.e. what will happen next and in what order they will happen

Behavioural information

The behaviour[s] or action[s] the patient is required to undertake either before, during or after the surgical procedure i.e. adopting a certain position for the surgical procedure, deep breathing exercises, no lifting for 6 weeks, keeping the limb elevated, gentle movements only, etc.

Sensory information

The bodily sensations the patient is likely to experience either before, during or after the surgical procedure i.e. the likely sensations of the drugs entering the body during the initial stages of anaesthesia, degree and duration of pain, etc.

Cognitive coping strategies

The positive thoughts a patient can draw upon in order to gain assurance they will be safe, awake from their operation, be unharmed and gain a full recovery i.e. being told of the highly trained staff, effective drugs, modern well maintained equipment, many safe operations performed, etc.

Relaxation

Individual strategies of relaxation or a planned programme of relaxation techniques, music therapy, hypnosis, other simple methods of distraction, etc.

Modelling

Directly by actively copying the required or desired behaviour or by indirectly copying i.e. quietly watching and copying the required or desired behaviour. This could be via a real-life event, a relative or friend, the media or a video/audio-tape programme or leaflet produced by the hospital, etc.

provoking aspect of surgery [54–57]. All that is required to determine an individuals' coping style is the availability of choice i.e. offering an information package of full, partial or minimal disclosure [35,36].

3. Construction of information booklets

3.1. *Ethos*

In a comprehensive review of the literature by Webber [58] on patient education three main barriers to effective communication were identified (i) lack of co-ordination of the educators i.e. who's role, where and when; (ii) education of hospital personnel in the formation and distribution of educational material; and (iii) the low priority given to education by administrators. Webber [58] questioned the fundamental motive of patient education i.e. to empower the patient or to gain compliance. Following an in-depth interview of 30 surgical patients Meredith [59] suggested information should be provided in such a way as to help 'prime' patients to be able to ask for the information they required. For example, Pollock and Trendholm [13] reported 33% of patients would have preferred to meet their anaesthetist prior to surgery but did not.

Law [60] following a telephone survey of 45 ophthalmic day-surgery patients concluded more emphasis should be placed upon consumer choice and the Audit Commission [61] recommended patients should receive good written information about each stage of their treatment. Redman [62] in a review of 25 years of

patient education stated 'Informed consent should be seen as a minimum requirement. The real goal is discovery of what fits best the unique experienced needs and aspirations of a particular person, working through shared decision making'. (p. 728). Following an examination of 184 information leaflets from 97 hospitals concerning hysterectomy it was stated patient educational material should be both informative and empowering [63]. This theme of empowerment is also echoed by Malin and Teasdale [64] who state 'Empowerment implies that the nurse must maximise patients' independence and minimise their dependence' (p. 658). As the majority of recovery from day surgery occurs at home this may need to become an implicit part of all day surgery information.

Kaufmann [65] in an American literature review on informed consent and patient decision making between 1960 and 1980 concluded patients were able to make decisions when the information was understandable. Mumford [66] examined 24 leaflets from differing specialties and also recommended the use of simple language. Following a survey of day surgery patients De Jesus et al. [67] stated '...the single most common suggestion from surveyed patients on how to improve same day surgery services is to cater for possible complications through provision of clear and specific information' (p. 171). The well-known day surgery guidelines by the Royal College of Surgeons [68] also suggests information should be written in local language and translated for ethnic groups. In a survey of 317 patients undergoing a variety of day surgery procedures 19% felt they were given conflicting advice [69].

The N.H.S. Management Executive [70] stated all information must be consistent. Otte [71] reiterated this when highlighting the difficulties caused when contradictory advice was given.

In a review of information provision the readability of leaflets was identified as a problematic area [72]. The study recommended a reading age of 12 years to be most appropriate for all leaflets. Furthermore, educational material should try to lead with a question i.e. 'What do I have to do?' etc. This simple 'questions answered' theme by Kent [72] will be utilised here together with the logical sequence of leaflet construction outlined by the Audit Commission (1990 p. 43–44) [61] i.e. Phase I, before admission; Phase II, on admission and Phase III, on discharge, in order to establish a framework for future day surgery booklet construction (Table 4). However, any blueprint for an information booklet design will require rigorous patient and multi-disciplinary evaluation prior to its use. Additionally, local variations in practice may necessitate slight adaptation.

3.2. Phase I, before admission

During the pre-assessment visit, following medical suitability issues, the patient can choose the most appropriate level of information with the nurse i.e. a package of information containing full, partial or minimal disclosure. This provides the opportunity for questions and the chance for the nurse to reiterate some crucial points. For example, in a study by Zvara et al. [73] it was discovered approximately 50% of patients did not know when to stop eating and drinking prior to admission. Hawkshaw [74] suggested emphasising some helpful aspects e.g. the need for loose fitting trousers on the day of surgery when undergoing knee arthroscopy. Some patients may also like to look around the surgical unit to familiarise themselves with their future surroundings [75]. Yount and Schoessler [76] suggest skills teaching should take place at this point prior to surgery i.e. post-operative exercises, ways of dealing with pain, possible sensations following surgery/anaesthesia. Psycho-social support would then largely be the focus of care on the day of admission i.e.

Pre-assessment clinic

1. Main emphasis 'informing' i.e. procedural (order of events), behavioural (skills teaching), sensory information (likely sensations), etc.
2. To a lesser extent 'supporting'.

Admission day

1. Main emphasis 'supporting' i.e. psychological care (formal programme) social support (relatives), etc.
2. To a lesser extent 'informing'.

In a review of the psychological factors affecting recovery from surgery it was reported the need for information pre-operatively was to help reduce anxiety and reassure patients [77]. Reid [78] questioned 15 members of staff in day surgery about the information they provided and again the main purpose of information was to reduce anxiety and increase patient appraisals of control. Lancaster [79] suggested patient education was one of the primary roles of the peri-operative nurse and as the amount of day surgery expands and patient requirements grow several studies have also recommended day surgery patients should receive an increased level of information [11,80–83].

The information provided prior to surgery must cover the whole range of procedural, behavioural and sensory information plus cognitive coping strategies and relaxation advice where applicable [17] (Table 1). An explanation of the planned surgery and anaesthesia must be discussed to the requested level of disclosure and the relevant written information provided.

3.3. Phase II, on admission

As previously stated in a study by Yount and Schoessler [76] 116 patients admitted on the morning of surgery were surveyed and it was concluded psycho-social support should be the main emphasis on the day of surgery. Menon [14] reported the long waiting period on the day to be a main source of complaint. Buttery et al. [84] recommended the possible reasons for any delay on the day of surgery should be included in all information leaflets. Procedural, behavioural and sensory information should be provided briefly although the main focus at this point should involve the repetition and reinforcement of available cognitive coping strategies. As stated earlier, information provision should be part

Table 3
Innate coping styles [8]

Vigilant coper	Patients with this coping style should receive copious amounts of information as too little makes them more anxious. Full disclosure of information therefore recommended.
Fluctuating coper	Patients with this coping style should generally receive a small amount of information as too much may make them anxious. However, in certain areas they will desire greater detail i.e. proposed surgery. Minimal plus selected areas of disclosure therefore recommended.
Avoidant coper	Patients with this coping style should receive a small amount of information as too much makes them more anxious. Minimal disclosure of information therefore recommended.

Table 4
Framework for information booklet construction (examples not exhaustive)

Booklet construction framework

Phase I

What is day surgery?

Example – Modern surgical and anaesthetic practice, minimal access surgery, intermediate surgery, reduced waiting list time, one morning or afternoon in hospital, recovery at home, safe, etc.

What do I need to know about the day surgery unit?

Example—Location, parking, telephone number, arrival and approximate discharge times, where to go on arrival, arrangements for relative/friend, identification of staff, brief definition of staff roles in the day surgery unit, etc.

What operation will I have?

Example—Vigilant copes a full account of procedural, behavioural and sensory information with diagrams, a chance to visit the unit, full written information, take-home video, etc. Fluctuating copes a partial account of procedural, behavioural and sensory information, written information with requested additional elements e.g. fear of surgery or its potential outcome. Avoidant copes a simplified account, written information, emphasis on relaxation, etc.

What type of anaesthetic will I have?

Example—Vigilant copes a full account of procedural, behavioural and sensory information with diagrams, etc. Fluctuating copes a partial account with requested additional elements e.g. fear of anaesthesia. Avoidant copes a simplified account, emphasis on relaxation, etc.

What are the benefits of having this surgical procedure?

Example—Avoidance of future complications, improved health status, patient request, specific issues, etc.

Why is a pre-assessment visit required?

Example—Medical suitability, social circumstances, information provision, recovery advice, anxiety management, etc.

What arrangements should I make before the day of surgery?

Example—Transport to and from the unit, relative/carer to accompany, 24 h post-operative care by adult, plan adequate convalescence period, social and employment arrangements, pain management provision, wound management advice, specific issues, etc.

What do I need to do before I arrive at the hospital on the day of surgery?

Example—Nil-by-mouth, suitable clothing, what to bring and what not to bring, medication, relative/carer, arrival and approximate discharge time, special instructions, etc.

Phase II

What will happen to me once I arrive at the hospital on the day of surgery?

Example—Briefly reiterate procedural, behavioural and sensory information although concentrating mainly on psycho-social aspects of care i.e. cognitive coping strategies, carer information/advice, social arrangements, etc.

If I am anxious how will I be helped?

Example—Full implementation of anxiety management care plan [17]

Who are the people caring for me and when will I meet them to discuss my care?

Table 4 (*Continued*)

Booklet construction framework

Example—Introduce self, other staff, surgeons and anaesthetist, time for brief discussions, etc.

How will my carer be kept informed of my progress and eventual discharge?

Example—Carer to remain with patient, telephone contact, pre-arranged telephone call, special arrangements, etc.

What will happen after my operation before my discharge home?

Example—Recovery room, ward recovery, warning of possible use of medical equipment (intravenous infusion, cannula, etc.), analgesia, anti-emetics, medications, wound management advice, medical certificate, specific instructions, etc. Recovery room, ward recovery, warning of possible use of medical equipment (intravenous infusion, cannula, etc.), analgesia, anti-emetics, medications, wound management advice, medical certificate, specific instructions, etc.

Phase III

On discharge home from the hospital what should I do?

Example—Go home immediately, rest, take recommended medications i.e. analgesia, antibiotics, etc., allow time for convalescence, manage wound as advised, specific instruction, etc.

If I experience any pain how will I reduce it?

Example—Some pain and discomfort is expected, rest completely for the first 24–48 h, avoid sudden or excessive movement for the first 24–48 h, take recommended analgesia exactly as advised for at least the first 24–48 h, etc.

What side-effects may occur at home and how can I recognise them?

Example—Excessive pain, tiredness, nausea, wound problems, sore throat, fatigue, specific issues, etc.

What support will I have at home?

Example—Adult carer main support for a minimum of 24 h, helpline telephone number, 24 nurse initiated telephone call, general practitioner, district nurse, 6 week hospital appointment, specific issues, etc.

How will the operation affect my normal lifestyle?

Example—Brief advice on returning to normal i.e. sleeping, eating and drinking, bathing, mobility level, returning to work, stretching, advice on sexual matters, bowel and bladder function, housework, lifting, driving, exercise and sport, weight loss/gain, specific issues, etc.

Who can I contact for more advice or the early results of my surgery?

Example—Day surgery telephone number, general practitioner, district nurse, early hospital appointment, special arrangements, etc.

Where can I obtain more information about my surgery?

Example—Day surgery unit, consultant, general practitioner, district nurse, bads website, etc.

What are the possible complications of this type of surgery?

Example—Degree, duration and possible sites of pain, nausea, wound infection or poor healing, usual and unusual events plus how to recognise them as such, possible sensations, specific events, etc.

NB: This section should be brief for minimal disclosure leaflet (avoidant copes) as it may result in more anxiety if read. Indeed, it is extremely unlikely this section will be read pre-operatively by a patient with an avoidant coping style. However, they may utilise some of this information in the post-operative period.

of a formal anxiety management plan and all aspects of the plan must be fully utilised at this most stressful stage [16–18,27,54,56,57], (Table 1).

A number of studies have identified the lack of knowledge regarding the role and qualifications of the anaesthetist [57,85,86]. Meeting the anaesthetist has been seen to help aid anxiety management and provide the opportunity to gain answers to frequently asked questions e.g. does induction of anaesthesia involve a mask or needle and how long will the anaesthetic last [36,87].

In an audit of the carers' views the main complaints were stated as lack of parking space, quality of written information and information regarding medications [88]. A number of studies have also recommend a relative/friend should be present prior to discharge during the giving of information [20,89,90]. Pollock and Trendholm [13] stated 40% of patients left hospital with no feedback concerning the outcome of their surgery although this may be due, in part, to the patient forgetting the information [91].

3.4. Phase III, on discharge

Bostrom et al. [92] reported the first two weeks following discharge were viewed as the most important as patients were often striving to regain autonomy in their health care. Indeed, this aspect of 'returning to normal' is the largest theme within the literature on recovery at home following day surgery together with pain management, sleep disturbance and nausea [93] (Table 2). Many studies uncovered the patients' desire to be informed of possible complications in the post-operative period and also how such complications can be recognised [67,86,91,92,94]. Donoghue et al. [95] interviewed 31 days surgery patients and 'Many of the participants reported that there were experiences they had not anticipated, surprises that they did not welcome and things that they would have liked to have known before the operation' (p. 173). The provision of information in this area may help to prevent issues of 'trial and error' recovery [96].

The Royal College of Surgeons of England and East Anglia Regional Health Authority [11] sent a postal questionnaire to 550 days surgery patients to enquire about their experiences. The main problems were sleep disturbance, asking for help, wound care, mobility, returning to work and nausea. In one day surgery study the most common problem at home was pain (42%), sleep (15%) and nausea (11%) [97]. Some patients wanted information regarding the safe time to resume activities, warning of the possible problems and what to regard as 'normal or unusual' in the post-operative period [97]. Bradshaw et al. [98] examined the whole issue of information provision and recommended improved leaflet evaluation. A guide to the main patient

requirements was also developed and included post-operative pain management, common wound problems, aspects of bathing, stretching and heavy exercise, return to work, driving and advice on sexual matters.

Bostrom et al. [91] interviewed 1400 patients in a telephone follow-up after day surgery and over 90% of patients had questions about self-care and recovery at home. The interviews also revealed written information provided by the nurses prior to discharge had either been forgotten or mis-understood. The main questions asked by the patients related to when to eat, when the hospital follow-up appointment would be and who would see them, possible complications and their recognition, return of normal bowel function, pain management and how to rest. In an Australian survey 40 patients were asked on the eve of surgery to rank 13 categories of information into the most preferred order [86]. When they were able to eat following surgery, when they were able to get out of bed and the common complications were all rated as most desirable.

Woodhouse et al. [99] audited 268 patients who had undergone a variety of day surgery procedures to evaluate the level of community healthcare involvement. Common reasons for visiting their general practitioner were for medical certificates, discussion on return to work and wound care. The study recommended encouraging patients to use the day surgery telephone helpline, providing clear instructions on discharge regarding returning to work and the provision of medical certificates in order to combat any increased use of community healthcare facilities. MacAndie and Bingham [100] also examined the impact of day surgery on general practitioner workload and recommended improving information provision, analgesia provision and the distribution of sick leave certificates. In interviews of 252 carers of day surgery patients 90% were concerned with the patients' pain, wound care, sleep disturbance and nausea [101]. A leaflet especially constructed for carers was recommended.

4. Application to day surgery

The implementation of such a system, although ambitious, would result in major improvements to information provision within day surgery. A number of issues may present a challenge i.e. new nursing role, staff training, financial and legal implications. The implementation of a formal system of information can be provided within an explicit psychological programme of care, as reported elsewhere [17,18]. This will consist of a nursing role dedicated to the supervision and maintenance of day surgery information provision. While this new nursing role would involve the co-ordination of a formal pre-operative psychological programme of care it would need to be adopted and implemented by all

Table 5
Clinical negligence scheme for trusts – Standard No. 7 [103]

Information on the risks and benefits of proposed treatment or investigation	
7.1.1	There is patient information available showing the risks/benefits of 10 common elective treatments.
7.1.2	All consent forms used comply with N.H.S.E. Guidelines for design and use.
7.2.1	There is patient information available showing the risks/benefits of 20 common elective treatments.
7.2.2	There is a policy/guideline stating that consent for elective procedures is to be obtained by a person capable of performing the procedure.
7.3.1	There is a clear mechanism for patients to obtain additional information about their condition.

day surgery personnel. It would require a degree of staff training and gradual introduction i.e. one surgical procedure or surgical speciality at a time.

The financial implications may be somewhat prohibitive in the production of quality information encompassing all day surgery techniques especially concerning the production of full and minimal disclosure booklets. However, this may be less of a problem in the future if information resources can be centralised on the British Association of Day Surgery website (bads@bads.co.uk), the International Association for Ambulatory Surgery website www.iaas-med.org or other similar websites in America, Australia, Europe, etc. Day surgery units could be invited to produce (and periodically update) a full and minimal disclosure leaflet on a given surgical procedure within the 'Trolley of Procedures' [102]. The design outlined here could be employed for all procedures following its detailed patient and multi-disciplinary evaluation (Table 4). It may then be possible to make all surgical procedures within the Trolley of Procedures available on a website for use when and where applicable by downloading the required information or by merely viewing the desired information directly with the patient in the pre-assessment clinic. Local practices could be added or subtracted wherever deemed necessary. If the patient has access to an Internet facility he/she can be given the website address to go home and pursue the information for themselves. This centralisation of information may also have the added value of spreading best practice and ultimately be a source of reference for any day surgery patient, general practitioner or district nurse who requires information. It could also become a useful teaching aid for both medical and nursing students.

Legal implications dictate patients must receive some information regarding the possible risks and benefits of their planned surgery depending upon the level of legal cover required. In a review of the Clinical Negligence Scheme for Trusts one legal standard (No. 7) specifically relates to information provision [103] (Table 5).

This standard stipulates 'There is patient information available showing the risks/benefits of 20 common elective treatments' (p. 41). If all information was constructed and disseminated in the manner outlined here it would be legally acceptable as the risks and benefits of surgery would be available for the Trolley of Procedures i.e. approximately 250 surgical procedures.

5. Conclusion

A solution to the issues of information provision in day surgery must be pursued as a number of challenging aspects persist. The main problems relate to the level of information as some patients require more while others less. If a choice of information was to be made accessible, patients could decide which level was the most appropriate for them. Written information on two levels — full and minimal disclosure, could be made available centrally on the British Association of Day Surgery and the International Association for Ambulatory Surgery websites. A useful approach to the design of information is to provide a 'questions answered' format which encompasses all three phases of day surgery i.e. pre-operative, day of surgery and post-operative information. The required level of information could be downloaded with the nurse in the pre-assessment clinic or viewed on a personal basis. A central dissemination point may also help to spread best practice and provide a point of reference for any interested party. This method of information leaflet construction will, require full patient and multi-disciplinary evaluation prior to any implementation.

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