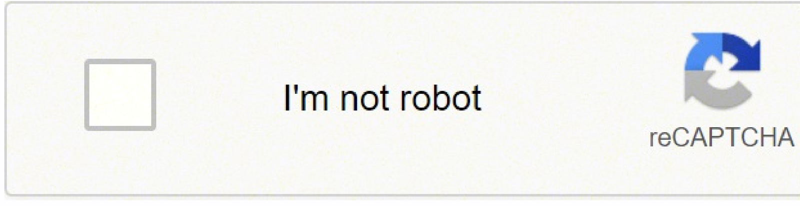

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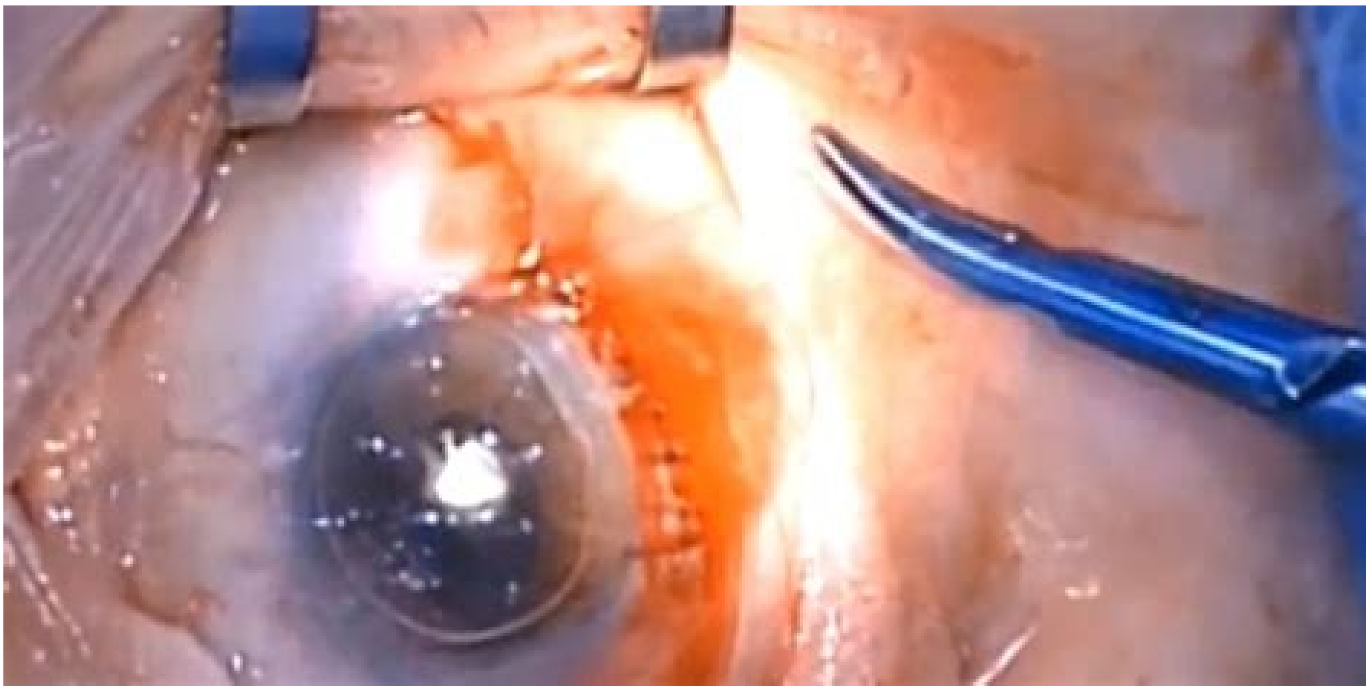
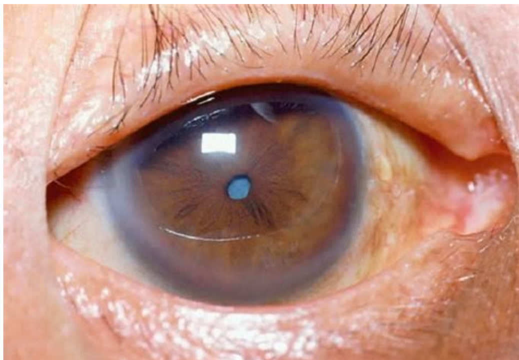
Cataract surgery fasting guidelines





How long should you fast before cataract surgery. How big does a cataract have to be before surgery. Should i fast before cataract surgery. Can i eat and drink before cataract surgery. Why fast before cataract surgery.

Working off the field? Information on our remote access options Volume 74, Section 6 p. 778-792 This is a consensus document produced by expert members of a working group established by the United Kingdom and Ireland Anaesthetists Association and the British Daily Surgery Association (BADS). It was seen and approved by the Board of Directors of the Association of Anesthetists and the Board of BADS. It was approved by the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI) and the Royal College of Anaesthetists (RCoA). You can reply to this article at The guidelines are presented for the organisational and clinical management of anaesthesia for daily surgery in adults and children. The advice submitted shall be based on previously published recommendations, clinical studies and expert opinions. Previous guide was published by the Association of Anaesthetists in 2011 1. The orientation of daily surgery has also been published by RCoA 2. Since the previous guidelines have been published, there have been a number of changes in daytime surgery, including an increase in the range of surgery performed and the patient's casemix. With the development of enhanced recovery programs, the short stay section of the previous guidelines has been excluded from this document. The previous guide of the Association of Anaesthetists has been updated and the entrance received by BADS, which includes surgeons and lay people, as well as the APAGBI. Pre-anaesthetic and pre-anaesthetic evaluation and preparation, guided by anaesthesia, as well as © discharge of the protocol, are essential for a safe and effective daytime surgery fitness for a procedure should concern the functional status of the patient rather than the physical state ASA is possible to perform most of the In adults and children as cases of the day All surgical units of the day should have a clinical lead whose responsibilities include the development of local policies, guidelines and clinical clinics All anesthetists must be familiar with the techniques that allow the patient to undergo a procedure with minimal stress and maximum comfort in order to allow early release, including regional nervous blocks and neural blockage, such as spinal anesthesia All members of the multidisciplinary team must be trained in day surgery practice, high-quality advisory brochures, age-appropriate surgical modules The definition of day surgery in Britain and Ireland is free; the patient is admitted and resigned on the same day, with day surgery as expected management. The term "23-h stay" must be avoided; This is used in the US health system, but in the UK it is considered as hospital care and should not be confused with day surgery. As the previous guideline was published in 2011 1, the complexity of procedures continues to increase, with a wider range of patients now considered suitable for day surgery. Despite these progress, the overall rates of day surgery remain variable throughout the UK. The objective that 75% of elective surgery should be performed as daytime cases remain on place 3, but minimally invasive surgery is now well established, allowing more procedures to perform as day surgery and even higher rates should be possible 4. There has been a great effort to promote day surgery at the beginning of the millennium 5 and recent impulses to reduce the duration of stay and improve the quality of thepost-operative have ensured that the principles of day surgery are fundamental for modern care of patients. a short stay in the hospital and a first mobilization also reduce the risk of infections acquired in hospital and venous thromboembolism 6. the nhs modernization agency has developed an operational guide that illustrated in detail in detailFacilities available in, and management of surgery day 7. This was refined in the document â € ~ten High Impact Changesâ € ™ in which the principle of treating daytime surgery such as the default option for elective surgery It has been established 5. The NHS Institute for Innovation and Improvement produced a document that focuses on laparoscopic colectomy 8. Although this document is specific to a procedure, many aspects of the patient's ideal path is equally applicable To a wide range of daily surgery procedures. Effective pre-anaxetic evaluation and preparation with discharge led by nurse protocol are fundamental to a safe and effective surgery of the day. Several publications provide useful tips for creating and executing a service 9-13. The British Association of Day Surgery produced a directory of procedures that provides targets for daytime surgery rates covering many different procedures 14. These specific objectives of the procedure serve as a focus for doctors and managers in the planning and supply of elective surgery of the day and illustrate the high quality of the service reachable in appropriate circumstances. In 2016, the Accademia dei Medical Royal Colleges produced a series of recommendations for doctors and patients entitled 'Choosing wisely' 15. The top recommendation for doctors was that day surgery should be considered the default for the greatest Part of surgical procedures. The change in the use of daily surgery for specific operations is measured and this information made available to all interested parties. For patients it was given the following recommendation â € œIt is having a surgical procedure, the surgery of the day must be considered and is suitable in many cases. The day surgery allows a rapid recovery with less inconvenience for you and Your family life and also reduces the risk of infections acquired by the hospital. The tests suggest that if the day surgery has been performed for 20 common procedures, an additional 186,000 patients could be treated each year without without expenditure". This view was also supported by the King's Fund: "The increasing proportion of operations carried out as daytime cases in recent decades has been good for patients and much more efficient use of NHS resources" 16. Patients may be reported for day surgery by outpatient clinics, emergency departments or primary care. Progress in surgical and anesthetic techniques, as well as published evidence of successful results in patients with more comorbidity, have changed emphasis on the selection of the day surgery patient. It is now accepted that most patients are appropriate for day surgery unless there is a valid reason why an overnight stay would be beneficial. If it is considered that outpatient surgery is important to question if any strategies could be used to allow the patient to be treated as a case of day. It is recommended that a multidisciplinary approach, with agreed protocols for patient evaluation, including inclusion criteria and exclusion for day surgery, should be agreed locally between surgeons and anesthetic department. The patient's evaluation for surgery of the day falls into three main categories: social, medical and surgical. The patient must understand the procedure and post-operative assistance and give informed consent to daily surgery. Traditional criteria for day surgery included the presence of a carer for 24 hours after surgery. This is now being reassessed 17 and it is recognized that for some minor procedures 24 hours postperative treatment may be an excessive requirement, while for complex surgery may be insufficient. For example, a patient who has undergone hysterectomy as a daytime case is likely to require care to support theof daily life for more time than someone who has undergone hysteroscopy. It is essential that, following the procedures of general or regional anesthesia, a responsible adult will accompany the patient's home; However, it may not always be essential that a worker remainsThe full period of 24 hours. Various models were evaluated 18, 19, including a virtual department system in which patients are unloaded without home care during the night, but followed by phone for the first 24 hours, putting carers in patient homes during the Night or downloading selected groups of patients at home without night assistance. Fitness for a procedure should relate to the functional state of the patient as determined as pre-anesthetic evaluation, and not as a physical ASA, etÃ or body mass index 20-22. Patients with a chronic stable disease like diabetes are often best managed as cases of day because there is a minimum interruption to their daily routine 23. The only routine patients not included in the day surgery are those with unstable medical conditions . In these circumstances, the application should be placed in relation to the fact that it is possible to proceed with the procedure or if it should be delayed until the patient's condition is optimized. Once optimized, it may be appropriate to proceed as a case by day. If surgery is required before the patient's condition can be optimized due to urgency (such as malignity), then they can request inpathy admission. The obesity itself is not a contraindication to daytime surgery, since obese patients can be managed safely by experts, provided that adequate resources are available. This includes additional factoring for anesthesia and surgery, as well as the presence of assistants and qualified equipment. The incidence of complications during the operation or early recovery phase is greater in patients with increased body mass index. However, these problems would still be present with inpathy care and usually solved or have been successfully treated since a day patient was downloaded. In addition, obese patients benefit from short-term anaesthetic techniques and early mobilisation associated with 24-day, 25-day surgery. Prophylaxis of long-vein thrombosis should be considered 26. Obstructive sleep apnoea is not an absolute contraindication for daily surgery. Adults with OSA anamnesis or those identified at risk using â~ punteggio, the score is to be identified in the pre-anesthesia assessment. It is recommended to avoid post-operative opioids in these patients. The optimal technique, if possible, is regional anesthesia. The Society for Outpatient Anesthesia has issued a statement of consent on the pre-operative selection of adult patients with OSA scheduled for outpatient surgery: di'patients with a supposed diagnosis of OSA, based on screening tools such as the STOP-Bang questionnaire and with optimized comorbie conditions can be taken into account for outpatient surgery, if postoperative pain can be handled predominantly with non-ophoids,226; 128; b. 27. Patients using nasal CPAP (continuous positive respiratory tract pressure) at home should be encouraged to bring their devices to the hospital with them and an individual decision on whether it is appropriate for them to be discharged the same day. The procedure should not entail a significant risk of serious postoperative complications requiring immediate medical care, such as hemorrhages or cardiovascular instability. Placeperator symptoms (such as pain and nausea) must be controllable using a combination of oral drugs and local anesthetic techniques. The procedure should not prohibit the patient from taking oral intake within a few hours of the end of the procedure. Patients must be able to mobilize before the discharge, for example, walking with a chalk arm, but if complete mobilization is not possible, a suitable venous tromboembol prophylactic must be established and maintained. Pre-operative preparation has three essential components: educate patients and assistants about pathwaysdaytime to transmit information about programmed procedures and post-operative care to help patients make informed decisions; important information must be provided in writing to identifyRisk factors, health promotion and optimal preparation of the patient's condition can be carried out in various contexts. In order to achieve the three objectives, the best practice is that the personnel involved in the evaluation of day-to-day surgery by experts are engaged in an autonomous structure of day-to-day surgery. This allows patients and their relatives to familiarize themselves with the environment and to meet the staff who will provide their peri-surgical care and who are well positioned to educate the patient about the way of daily intervention 28. However, other settings such as primary care or safety (general rule on data protection) may be appropriate for some patients. Whatever the approach used, the process must be carried out by a member of the multidisciplinary team trained in the pre-anaesthesia assessment for daytime surgery. The process should follow a clear protocol, in agreement with the team providing anaesthesia, surgery and nursing care. It should identify problems requiring management or optimisation before surgery and follow national or locally agreed guidelines. The clinics managed by consultants and nurses have proved very effective. The monobloc clinics, where pre-anaesthetic preparation takes place on the same day as the surgical decision, offer significant benefits for both patients (avoiding an additional visit to the hospital) and for the hospital, ensuring that patients are prepared for surgery as soon as possible in the course of treatment, thus allowing maximum optimisation time, if necessary. Screening questionnaires, together with agreed protocols, may provide guidance on appropriate preliminary investigations. Although the National Institute for Health and Care (NICE) is widely used Guide on pre-operative investigations, a study showed no difference in patient results with day surgery when all pre-operative investigations were omitted 30. However, screening for hypertension 31, anemia 32 and an initial riskFor venous thromboembolism 26 should be carried out to guide the management according to local protocols. Most patients can be evaluated and prepared for surgery in pre-anesthetic nursing clinics. Consultant The pre-operational pre-operational consultant clinics improve efficiency by allowing the advance revision of the notes only in complex cases, guaranteeing the appropriate investigations and that patients refer to a specialist opinion, if necessary. Patients who have acute conditions that require urgent surgery can be treated efficiently and effectively as cases of day through a semi-elective path 33. After the initial evaluation, many patients can be downloaded home and return for an intervention Surgery in an appropriate time, both in one case of day list or as a patient programmed on an operating list, while others can be transferred immediately to the surgery of the day. This reduces the probability of repeated postponement of surgery due to the prioritization of other cases. A robust day surgery process is the key to the success of this service. Some of the successfully managed procedures in this way are shown in Table 1 34-36. Table 1. Types of Urgent Surgery Suitable for the Day Cashier Day Procedures General Surgery Gynecology Trauma Maxillofacial Engraving And Drainage Drawing Evacuancing Products Keeping Tendon Conception Mua Fractured Nose Laparoscopic Colecystectomy Laparoscopica Pregnancy Pregnancy Mua Fracture Repair Repair Fractible laparoscopic mandible appendectomy fracture plating MUA of bone temporal artery biopsy, manipulation under anesthesia. The essential components of an emergency surgery path are: identification of the appropriate procedures identification of a list theatres that can reliably host the procedure (e.g. a dedicated day surgery list or a list of flexible emergency theatres) Ensure clear routes are in place decisive if the condition is safe to be left untreated for a maximum of 24 hours and manageable at home with oral analgesiaclear pre-operative information of the patient, ideally in writing Patients should be provided with general information as well as specific procedures. This should be given prior admission to allow the patient time to absorb the information before their day-home surgery. The verbal comments should be reinforced with written material. General information should include practical details about participation in the day-to-day surgical unit, while the specific information of the procedure should include clinical information on the condition of the patient and the proposed surgical procedure. The anaesthetic information leaflets developed jointly between the Association of Anaesthetists and RCoA are a useful resource 37. Detailed documentation is important within the surgical environment of the day because © The patient's experience is often condensed in a few hours. All aspects of treatment and care must be accurately recorded to ensure that each patient follows an effective and safe path. The documentation should be a continuum from pre-operational preparation to discharge and subsequent follow-up. Individual care plans and electronic patient records that reflect a multidisciplinary approach are favoured in many units. Variations should be available for specific groups, including children and patients undergoing local anaesthetic procedures. The specific treatment plans of procedure that reflect the integrated treatment pathways can be used for more complex and challenging cases 38. The treatment plans are also useful for quality assurance and evaluation of results. All surgical units of the day should have a clinical advantage with a specific interest in daytime surgery whose responsibilities include the development of local policies, guidelines and clinic. An expert analyst with management experience is ideal for such a role, and work plans should reflect this responsibility 4. Daytime surgery should ideally be represented at Council level 5 and the issues that arise should be scaled up to senior senior senior if

necessary. Clinical lead should be supported by a responsible day-to-day surgical unit that is responsible for the day-to-day operation of the service. The manager will often have a nursing background and should have the knowledge and skills to make informed decisions and bring on all aspects of the development of daytime surgery. Nurses, anaesthetic assistants and other auxiliary staff will depend on the design of the structure, the mix of cases, the workload, the local preferences and the ability of the individual unit to comply with national guidelines. Staff must be specifically trained in day care. Many units favour multiskilled personnel who have the knowledge and ability to work within different areas of the intervention unit. The efficient use of resources is better achieved by a well-trained, flexible and multi-skilled 39-workforce. Extended roles facilitate job satisfaction and encourage personal development and staff retention. Many health care workers in the surgical unit of the day are now, under supervision, able to carry out tasks traditionally only undertaken by qualified nurses 40, 41. Individual units should develop a staff structure that takes local needs into account. Each unit should have a multidisciplinary operational group that supervises the daily execution of the unit, agrees policies and schedules, examines operational issues and organizes quality assurance strategies. Daytime surgery works better when it is supplied in a self-contained unit that is functional and structurally separated from impassive corridors and theatres. It should have its own reception, consulting rooms, department, theatres and recovery area, along with administrative facilities. The typical opening hours of the unit of I am 07: 00-20: 00 h Monday to Friday, but with the growing complexity of surgery many units now open until 22:00 h. Some units provide a service of 6 or 7 days. The operating theater and the recovery areas of the first stage should be equipped and made available to the same as a shelter, except for the use of trolleys rather than beds. Several patients a day can occupy the same space as trolleys, providing a lean rotation time. The unit is of day surgery should not have the ability to accept night admissions. Clear arrangements should be made to ensure that it is not used for emergency hospital care. The units are that have introduced beds at night in their day unit have discovered that they are regularly occupied by emergency patients, with consequent interruption of the activity of the following day, reduction of the standards of care and demoralization of personnel 42. The introduction of short-term beds for elective surgery in a unit is daytime surgery can also put at risk the results for daytime surgery patients making it relatively easy for a patient to be admitted to one of these beds during the night, so the push to facilitate the same day leave can be compromised. Near the unit there should be a parking or a short stay and withdrawal. An alternative to a unit is specially constructed is the use of a day department, with patients transferred to the main operating room. This model can allow for a simpler change during the transition from day to night stay for complex procedures, as there is little impact on theatrical equipment or staff. However, the day homes scattered in many departments do not achieve the same efficiency, nor © provide the targeted service that is necessary to get good results. Many hospitals provide assistance to patients in day surgery who need anaesthesia in specialised units, such as ophthalmology or dentistry. It cannot be possible or appropriate to centralise such services; However, all these patients should receive the same high standards of preparation, perioperative care, discharge and follow-up of those who attend the dedicated day surgery facilities. Services should ensure the maintenance of the privacy and dignity of a patient at any time. The side rooms are particularly useful whenFor patients who require a greater level of sensitivity, such as those with special needs. Patients must be admitted to the day surgery unit as close as possible at the time of their surgery. The stunning full of patient admission times can lead to inefficient processes due to the need for medical personnel examine pre-operational patients, but by grouping patients in two days and twice afternoon admission, such as 07:00 h, 10: 00 H, 12:00 HE 15:00 H Allows theatrical lists to function smoothly, minimizing delays and interruptions for patients. Ideally a second anesthetist should be provided in order to support two or three lists and allow the anesthetetic assigned to each list to see patients as they are admitted. Fasting times must be kept at a minimum. The recent European driving lines on peri-operational fasting (assumed by the Association of Ana-Aeeks) 43 state that adults should be encouraged to drink clear fluids up to 2 h before elective surgery and all except a member of the group of guidelines considered That tea or coffee with added milk (up to about a fifth of the total volume) are still considered clear fluids. Solid food must be prohibited for 6 h before an elective surgery in adults and children, although surgery does not necessarily have to be canceled or delayed only because they are chewing gum, suck a dessert boiled or smoking immediately before induction of anesthesia. Pre-operatively, patients should be allowed to remain in their "street vestimenti" for the longest possible to maintain dignity, heat and comfort. At a suitable moment, they should change in theater clothes and wait in a single sex area. They should walk to the theater and ideally move to the operating trolley in the anesthetic room. Stay on this cart during their day surgery path until ready for transfer to a chair in the postoperative department. The day surgical anesthesia should be a service led by consultants. However, as day surgery becomes becomes Election surgery standard, consideration should be given to the training of trainees recommended by the RCOA. This requires adequate training and senior coverage, especially in stand-alone units. Specialized anesthesiologists of rank and associates of staff who have an interest in day surgery should be encouraged to develop this as a specialist interest and take an important role in the management of the unit. National guidelines for patient monitoring and anaesthetist assistance should be followed 44, 45. Anaesthetic techniques should ensure minimum stress and maximum comfort for the patient and take into account the risks and benefits of the individual technique. The analgesia is fundamental and must be long acting, but as the morbidity such as nausea and vomiting must be reduced to a minimum, indiscriminate use of opioids is discouraged (especially morphine). Oral prophylactic analgesia with long-term non-steroidal anti-inflammatory drugs (NSAIDs) should be administered to all patients unless contraindicated. For certain procedures (E.G. laparoscopic cholecystectomy), there is evidence that standardised anaesthetic protocols or techniques improve the result 8. Anaesthetists should adhere to such clinical guidelines as they exist. Although early mobilisation is beneficial, extending the range and complexity of the day's surgical procedures may increase the risk of venous thromboembolism. National guidelines for the risk assessment of venous thromboembolism and prophylaxis should be followed. There should be policies for managing post-operative nausea and vomiting (Ponv) and discharge analgesia. Prophylactic anti-emetics are recommended in patients with a history of PONV, motion sickness and those who suffer from as laparoscopic sterilisation/ cholecystectomy or tonsillectomy. The routine use of intravenous fluids (I V) and maintenance of body temperature may improve the patient's feeling of well-being and further reduce PONV 46. Local area And nerve blocks can provide excellent anesthesia and pain relief after the day. Patients can be safely discharged at home with residual motor or sensory block, provided that the limb is protected and the appropriate support is available for the patient at home. The expected duration of the block should be explained and written instructions should be given to the patient regarding their conduct until normal return of power and sensation. Local anaesthetic infusions can also play a role 47, 48. The use of ultrasound guidance continues to expand the role of regional anaesthesia in day surgery, allowing a more accurate local anaesthetic positioning, reducing the total dose administered and supporting the development of regional anaesthetic function Elenchi. The use of a room block improves efficiency and allows the confirmation of an adequate nerve block before starting surgery. Spinal anaesthesia has been accepted for use in a day surgery with the introduction of local low dose anaesthetic techniques and more recent local anaesthetic shorter acting as Prilocaine hyperbaric 2% and 2-chloroprotein 49. Appropriate spinal anaesthetic targeted at the surgical site, e.g. lateral for a unilateral knee arthroscopy or sitting for perianal procedures, may minimise side effects such as hypotension and prolonged engine block. By limiting I.V. fluids to no more than 500 ml should reduce the incidence of urinary retention. Patients should be encouraged to drink after surgery to allow their body to correct the fluid balance. Concerns about post-dural drilling head scarring previously limited the use of spinal anaesthesia in surgical day patients, but the use of smaller caliber (25 g) and pencil needles reduced the incidence to

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