Record-keeping for repair

Table 1 shows what information about repairs should be recorded in the central maintenance and repair record, and what useful information this can provide.

In addition to the practical benefits of a central maintenance and repair system, it also provides eye care unit administrators and the equipment maintenance team with valuable information and proof that they can use to ask for more resources.

Table 1. Record-keeping for repair

What should be recorded	This provides information about ...
The details of repair work done on each machine (including cause/suspected cause, and who carried out the repair)	• The history of each machine • Common problems
The spare parts and materials used	• The parts most frequently used • What needs to be re-ordered
The date equipment has broken down, and the date it is repaired.	• What still needs to be repaired (which allows you to prioritise the next week's tasks) • The duration equipment is not in use (down-time)
The causes of any delays	• What the most common causes of delays are (skill, labour, spare parts, transport, bureaucratic delays, money) and what additional resources may be needed to complete work on time

Budgeting for maintenance and repair

When we purchase a motor vehicle, we understand that we will have recurring costs for maintenance, theft and accident insurance, cleaning, parking, etc. The same is true for ophthalmic equipment since it costs money to operate and to maintain during its life cycle.

On average, the original purchase cost only makes up about twenty per cent of the entire life cycle cost of the equipment. As a general rule, you should budget anywhere from 3% to 6% of the equipment purchase cost per year for each device to cover consumables, parts, maintenance, and user training.

Plan for maintenance **when you purchase the equipment** and ensure that you buy the necessary accessories (including voltage stabilisers/surge protectors and uninterrupted power supply units) as well as enough spare parts (bulbs, fuses, and so on) to last for at least a year.

In conclusion, adopting practical and workable systems to manage eye care equipment, as suggested in this article, will help you to get the most use out of the equipment you have. With equipment, prevention is usually better than cure! It is also good practice to keep learning and to stay open to new ideas. Communicate with colleagues in other eye units, whether locally or through the internet, about the challenges you face and share with them the solutions you have found.

EXCHANGE

Multiple mobile operating tables for eye surgery

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High-volume eye surgery requires that patients be moved quickly in and out of the operating room (OR). Static operating tables in the OR make this difficult. Better patient flow can be achieved when using mobile tables, which can be expensive. We have developed an economical, wheeled operating table that can be constructed in a local engineering workshop.

Because this mobile operating table can transport the patient between the different areas before, during, and after an operation, the patient can stay on the table throughout and does not have to transfer beds. Four tables are in use at any one time: one for a patient being prepared for surgery, one for a patient being given local anaesthetic, one for a patient being operated on, and one for a patient being wheeled out of the OR and returned to the ward.

Jonathan Pons

One patient recovers after the operation while another is given local anaesthetic. SWAZILAND

Our finding is that multiple mobile operating tables minimise interruptions in the flow of work; surgeons can concentrate on surgery and may stay scrubbed for the entire day. The tables improve patient comfort through better head support and are also more comfortable for surgeons as they leave more room for surgeons' legs. Another advantage is that fewer staff are needed to manage the flow of patients. The results are dramatically improved time and cost savings: one surgeon can comfortably perform up to forty eye operations in a day.

The tables are designed to be manufactured in a local engineering workshop and the simplified design incorporates the following:

- A tubular steel welded frame
- A bed made of a shaped stainless steel sheet
- Adjustable bed height (using a simple hand-operated thread)
- A head end with non-castoring wheels for stability during surgery
- A foot end with lockable castoring wheels
- Bumpers on all wheel mountings, which prevent contact damage with door frames.

Each table costs approximately UK£300 to produce and drawings are available from the author.