CARE OF PATIENTS IN MIDDLETON DAY SURGERY UNIT - CHW

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Middleton Day Surgery Unit (MDSU) encompasses a Pre-operative Admission area, Post Anaesthetic Care Unit (PACU 1) and a Discharge Lounge (PACU 2)
- MDSU PACU nurses also provide post anaesthetic care to patients in the Oncology Treatment Centre (OTC) satellite area, and Block K Children's PACU
- To be used in conjunction with ACORN standards for the PACU nurse, NSQHS standards, policies / practice guidelines as hyperlinked through document and organisational surgical procedure specific documents
- This practice guideline covers the following areas:
  - General principle of care in MDSU
  - Emergencies
  - Parental presence
  - Length of stay
  - Nurse Initiated Discharge
  - Admission and transfer to a Ward
  - Documentation

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st August 2025	**Review Period**: 3 years
Team Leader:	Nurse Unit Manager	**Area/Dept**: MDSU CHW

CHANGE SUMMARY

- Due for mandatory review.
- Block K Children's PACU, emergence delirium and postoperative nausea and vomiting added
- Updated links, ANZCA guidelines and bibliography

READ ACKNOWLEDGEMENT

- All Registered Nurses who work in MDSU are required to read and acknowledge they understand the contents of this document.
- Staff who work in MDSU on weekends are required to read and acknowledge they understand the contents of this document and are familiar with the Nursing Discharge Criteria.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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Summary

- Middleton Day Surgery Unit (MDSU) is the admission area for all planned surgical Day Stay and Day of Surgery Admission (DOSA) patients. MDSU admits 60% of all surgical patients for SCHN – Westmead campus.
- MDSU encompasses a Pre-operative Admission area, Post Anaesthetic Care Unit (PACU) 1 and a PACU 2 / discharge lounge.
- MDSU can also accept appropriate preoperative surgical patients from the Emergency Department, Outpatient clinics and Surgeon's rooms requiring General Anaesthesia alongside patients on the elective list.
- PACU 1 has 11 monitored bays. A minimum of two nurses must always be present when patients are in Recovery.
- The PACU nurse must practice within the Nursing Midwifery Board - Registered Nurse competency standards for practice, NSQHS standards and the ACORN standard for the PACU nurse
- Care of the patient in MDSU should be family cantered, ensuring parents/carers are informed of their child's condition and treatment and, where possible, involved in their care.
- Patients are discharged according to Nurse Initiated Discharge Criteria. If patients do not meet these criteria, patients may be discharged at the discretion of the treating anaesthetist and/or surgical team.
- Patients are cared for as per this document and additional applicable models of care
- All unconscious patients admitted to PACU 1 must be nursed 1:1 until fully awake, clinically stable, and parent/carer is in attendance
- The Anaesthetist who managed the patient should be notified if there are any concerns or there are changes in the patient's condition, regarding airway, vital signs and/or pulse oximetry.
- If any concerns or changes relating to surgical site or procedure, please notify relevant admitting Team registrar for patient review.
- A **RED** emergency button is located at each bed space in PACU 1, preoperative admission area and PACU 2, for urgent escalation of care. If assistance is required outside normal business hours (0730 – 1800), staff should press the **RED** emergency button to alert theatre staff **AND** call 2222 to alert staff outside theatre for assistance.

Preoperative Process

Parent/Carers of elective surgical patients (DOSA and Day Surgery) will receive a phone call 4 days prior to admission from Clerical Support Administrator (CSA) to complete a Wellness check and confirm patient details.

Any concerns regarding patient's wellness check should be escalated to Nurse Unit Manager (NUM) or Team Leader (TL) and in consultation with admitting team/anaesthetist, the decision will be made whether patient is suitable for surgery.

A final wellness check, COVID-19 Risk Assessment and fasting and arrival call is conducted the evening prior (or on Friday afternoon for Monday's list) to surgery, by a member of the MDSU nursing staff.

The NUM or a senior nurse will allocate appropriate fasting and arrival times for DOSA/Day Surgery patients with some exceptions from specialities where surgeons/anaesthetists prefer to allocate patient arrival times

On the day of surgery, patients, with their Parent/Carer, must present to MDSU Reception where the CSA will initiate the admission process.

Patients booked on the emergency list who are transferred to MDSU from the Outpatient Clinic, Emergency Department must be accompanied by a nurse and a handover to a MDSU RN must occur as per SCHN Clinical Handover Policy. Relevant paperwork must be given to ward CSA so patient can be admitted onto the unit. An emergency booking form must have been completed and the operating theatre floor manager notified by the surgical team.

Some patients may not be suitable for admission via MDSU this may include children with severe behavioural needs, metabolic conditions requiring overnight admission prior to surgery, trauma patients and infectious patients requiring airborne precautions.

Nursing Admission:

- All patients presenting to MDSU for surgery are required to have a Pre-Op Checklist, and a full set of vital signs
- Vital signs must be recorded on Between the Flags (BTF) Observation Chart – the Anaesthetist, treating team and TL must be notified if patient's observations are not BTF and care escalated as per Between The Flags – Clinical Emergency Response System – SCHN Procedure
- For COVID and Beta-hCG testing requirements, refer to 'Preparing a Patient for Surgery – CHW' practice guideline
- Patients who have airborne infections or test positive via RAT or PCR to COVID-19 are unable to remain in MDSU preoperatively and are also unable to be recovered in PACU1. The MDSU TL will need to liaise with the hospital Bed Manager and Operating Suite Floor Manager to organise a bed for the patient to be transferred to prior to their surgery time. Patients who have tested positive to COVID-19 will need to be recovered in a theatre and transferred directly back to the ward as there is no appropriate recovery bay in MDSU.

- DOSA and MDSU patients requiring contact and droplet precautions should wait in an isolated area in MDSU pre-operatively according to Infection Control: Standard and Additional Precautions for the Perioperative Service – CHW
- For patients with fractures to the limbs and extremities, neurovascular and pain assessments must be conducted hourly whilst waiting for surgery.
- Patients undergoing cardiac catheterisation and electrophysiological study (EPS) procedures require a set of upper and lower limb neurovascular observations preoperatively
- Consent must be obtained prior to surgery in accordance to policy Obtaining Consent Prior to Admission to the Operating Suite – CHW , 'Preparing a Patient for Surgery – CHW' practice guideline and NSW Health Consent to Medical and Healthcare treatment
- Refer to 'Preparing a Patient for Surgery – CHW' practice guideline for additional requirements
- Consider postoperative discharge medication requirements and discuss with treating team to prevent delays in receiving discharge medications postoperatively.
- An appropriate mode of transport home should be identified preoperatively.

Fasting Guidelines:

- All patient having surgery are required to fast. The TL in consultation with the anaesthetist and operating theatre floor manager may initiate the clear fluid protocol. Please refer to Fasting Guideline for Children Having General Anaesthesia – CHW Practice Guideline
- Patients with Type 1 Diabetes should be allocated first case on the theatre list in the morning where possible. If a morning list is unavailable, patients are to be allocated first of the afternoon list.
    - Blood Glucose Level (BGL) monitoring should commence from the time of fasting (i.e. time of the first missed meal) and continue hourly whilst fasting and until patient is eating and drinking post-operatively.
    - All BGL's must be performed using ward blood glucometer.
    - If the patient is expected to be able to eat and drink soon after their operation, their usual insulin management can be recommenced with oral intake.
    - If the surgery is expected to take more than 2 hours, an insulin infusion should be commenced in consultation with the endocrine team and anaesthetist.
    - Please refer to Fasting and Surgery – Type 1 diabetes Mellitus (T1DM) – CHW Practice Guideline for further information.
- Special attention must be given to infants under 6 months old. BGL must be monitored if fasted longer than expected and 5% oral glucose solution (order from CHW Formula room) should be readily available in MDSU.

Nurse Initiated Medication/Standing Orders:

- A once only loading dose of oral Paracetamol can be administered to eligible preoperative patient's by MDSU RN's who have completed the relevant education and assessment, as per Loading Dose Paracetamol (Middleton Ward Only – CHW.
- Lignocaine 4% (LMX4) cream can be administered to preoperative patient's where clinically indicated by MDSU RN's who have completed the relevant local learning package. These patients include, although not limited to, children having IV induction, infants undergoing tenotomy under local anaesthetic, children who have/ are suspected of having or at risk of malignant hyperthermia. Refer to Topical Anaesthesia - Lignocaine 4% Cream (LMX4)
- Standing order Dilating Eye Drops are administered to appropriate patients preoperatively for diagnostic and therapeutic procedures as per the following Standing Order Eye Drops Protocols. Please refer to:
    - Oxybuprocaine **Eye Drop**s - **Eye** Clinic & Middleton Ward CHW
    - Tetracaine **Eye Drop**s - **Eye** Clinic & Middleton Ward - CHW
    - Tropicamide **Eye Drop**s - **Eye** Clinic & Middleton Ward CHW
    - Cyclopentolate Hydrochloride **Eye Drop**s - **Eye** Clinic & Middleton Ward - CHW
    - Phenyleprine **Eye Drop**s - **Eye** Clinic & Middleton Ward CHW

Premedication and Transfer of Patient to Outlying Areas

- If the patient requires admission, bed allocation must be confirmed prior to administration of premedication.
- Surgical consent must be complete prior to premedication administration.
- Premedications are frequently administered within the MDSU for patients who are anxious, having cardiac or spine surgeries or have a history of requiring premedication.
- The anaesthetist is to chart the premedication and notify the MDSU nursing staff when the premedication is required.
- Two SCHN accredited nurses are to administer the premedication in PACU1 to be close to oxygen and airway equipment in case the child becomes unconscious.
- Once the premedication is administered one recovery trained registered nurse is to remain with the patient until they are taken into the operating suite. See Enteral Premedication Before Anaesthesia – Practice Guideline for more information.
- If the patient requires transfer to an outlying area following premedication administration, a recovery trained RN is to transfer patient on bed/cot with oxygen cylinder, suction, monitoring and airway equipment.

General Care Principles of PACU 1

Anaesthetic Handover

Patients are transferred from the operating room (OR) to PACU 1 by an anaesthetist and Operating Assistant (OA). The anaesthetist hands over relevant information to the recovery nursing staff, which should include:

- Patient identifiers
- Known allergies
- Type of procedure and why the procedure was required
- Type of Anaesthetic / Anaesthetic techniques e.g. airway management, use of muscle relaxant
- Analgesia and fluids given
- Significant intraoperative events
- Medical history
- Length of stay if varying from the usual
- Post anaesthetic instructions
- Infectious status

Communicate with Anaesthetist if you have concerns prior to them leaving PACU.

Airway Management and Breathing

- **AN UNCONSCIOUS PATIENT MUST NEVER BE LEFT UNATTENDED**.
- Complete assessment of airway and breathing on arrival to PACU 1
- Unless otherwise indicated, all children are to be given oxygen at 6 litres per minute via an appropriately sized mask and T-piece circuit. This will minimise re-breathing of CO_2 and avoid diffusion hypoxia.
- If the patient has been transferred to PACU 1 without a T-piece (e.g. Hudson mask), the anaesthetist is to bring an appropriately sized face mask with the patient to PACU 1
- If the patient has been transferred to PACU 1 with an endotracheal tube (ETT) or a Laryngeal mask airway (LMA), the anaesthetist must stay until it is removed.
- Children are routinely placed in the lateral position unless contraindicated, to facilitate drainage of secretions and/or vomitus.
- Chin lift / jaw thrust, and suctioning of excessive secretions and vomitus will assist in maintaining a patent airway. This may also apply to children who have an artificial airway *in situ*.
- The Guedel airway, if in situ, should be removed once the child is awakening.

- If the child has a Tracheostomy or Nasopharyngeal airway in situ, ensure the suction outlet is always functioning and available and that an adequate supply of appropriately sized size of suction catheters available
- Care of the patient with a Tracheostomy should be in accordance with SCHN Tracheostomy Care Practice Guideline.
- Oxygen should be administered when saturations fall below 95% in room air, unless otherwise specified. Oxygen delivered via a Hudson Mask must be administered at no less than 4 litres per minute; delivery via Nasal Prongs should not exceed 2 litres per minute.

Vital Signs/Observations

- Document observations on PowerChart, on the PACU band in Interactive View
- Patients are to remain on continuous monitoring whilst in PACU 1.
- ECG should be monitored on infants, cardiac patients, the critically ill patient, in the presence of any arrhythmia, and when indicated in the postoperative anaesthetic or surgical orders.
- A full set of observations are to be documented on admission as to PACU 1 and then 10 minutely for the first 30 minutes or while the child is unconscious, and thereafter 30 minutely until child meets criteria to transfer to PACU 2. Clinical judgement must be applied, and vital sign frequency increased if the patient's condition dictates more frequent observation.
- Initial PACU observations include, but not limed to:
    - Respiratory Rate
    - Respiratory Distress
    - Oxygen Saturations (SpO2)
    - Heart Rate
    - Capillary Refill
    - Temperature
    - Level of Consciousness
    - Pain Score
    - Skin Integrity
    - Modified Aldrete Score
- Blood pressure must be measured following airway procedures, tonsillectomy, adenoidectomy, cardiac catheterisation, angiogram, renal and liver biopsy or when indicated by the anaesthetist.
- Pulse oximetry must be monitored continuously until the child is fully conscious or as clinically indicated until transfer to PACU 2.

- Neurovascular observations are routinely commenced following cardiac catheterisation, angiography, application of a plaster or where a tourniquet has been applied during surgery e.g. orthopaedic surgery or hand surgery.
- Patients will be transferred to PACU 2 when fully awake and observations are stable and within age-appropriate range as per BTF.
- No child is to be transferred or discharged from PACU if their observations are not within the appropriate age range on BTF.
- Observations outside of BTF age appropriate range must be escalated as per Between The Flags (BTF) : Clinical Emergency Response System (CERS)
- Altered calling criteria if required, must be attended by the Anaesthetist or Surgeon and documented in BTF and patient clinical notes. This includes patients whose criteria is altered to accommodate their normal physiological parameters, e.g. congenital heart disease. Orders varying the minimum frequency of observations should be re-evaluated based on changes in clinical condition and on clinical judgement.

Analgesia

- Check that appropriate postoperative analgesia has been ordered. If not, consult with the Anaesthetist to chart analgesia.
- Use age-appropriate pain assessment tools and administer analgesia as ordered / required.
- Intravenous opioid infusions may be commenced in PACU1, for patients waiting to be transferred to a ward bed. Infusions are to be checked and prepared by two registered nurses who have completed their Intravenous Opioid CSA.
- Intravenous opioid bolus analgesia must be independently double checked and administered by two accredited Registered Nurses as ordered on the electronic medication record (eMR) by the Anaesthetist in accordance with the Pain Protocol – Bolus Intravenous Opioid Administration in PACU – CHW practice guideline and SCHN Medication Administration Guideline
- If pain remains unresolved following administration of analgesia, the anaesthetist should be notified to assess the patient.
- All children given intravenous opioid must remain in PACU 1 for a minimum of thirty minutes post administration for close observations, continuous monitoring and 1:1 nurse:patient ratio before transfer to the PACU 2.

Emergence Delirium

- Emergence delirium can occur in paediatric patients following general anaesthesia.
- Emergence delirium is a state of altered consciousness and disturbance of awareness on emergence from anaesthesia.

- It can be common in paediatric patients depending on the anaesthetic agents used, and manifests as disorientation, hyperactivity, and hypersensitivity.
- It is important to ensure the patient's safety by keeping the bed/cot side rails up. Support and reassurance should be provided to the parents/carers by the PACU nurse who shall remain at the bedside until delirium is resolved.
- A patient with emergence delirium may require a review by the anaesthetist if the PACU nurse is unable to maintain their safety during this time.

Exposure

- Temperature is measured in the PACU 1 using an axillary thermometer, or an infrared digital thermometer, if unable to obtain axillary temperature.
- Patients must not be discharged from PACU 1 with a temperature less than 35.5 degrees Celsius, except for patients under 3 months of age, who must have a temperature of 36 degrees Celsius or above
- Patients must not be discharged from PACU 1 with a temperature ≥ 38.5 or ≥ 38 for patients receiving oncology treatment, without clinical review, see Oncology Patient-Fever-Low Risk Management practice guideline.
- Warming devices (e.g. heated warming blanket) should be utilised where appropriate within PACU1 to increase the patient's temperature.

Wound and Drain Assessment

- All wound and puncture sites should be assessed on arrival to PACU 1 and at regular intervals to observe for bleeding, haematoma and swelling. The surgical team needs to be notified if there are any concerns about excessive changes in condition of wound site.
- Any dressing with excessive ooze or bloodstain should be reinforced or changed prior to discharge to the ward in consultation with surgical team.
- Drains should be assessed for patency and positioned appropriately.
- Wound drainage should be recorded on the Fluid Balance Chart within the PowerChart 'Interactive View and I&O'
- The presence of a wound, condition of the wound and any changes should be documented in the PACU Band and PACU nurses' report.

Fluid and Glucose Management

- If not contraindicated, clear fluid (lemonade, water, apple juice and ice blocks) may be offered to the child once fully awake. Babies may commence normal feeds.
- In some cases, oral fluids may be contraindicated for a period of time e.g. after topicalization of the airway with local anaesthetic. If so the surgeons or the anaesthetist's instructions for oral intake must be documented and verbally verified
- If required, intravenous fluid orders are to be checked and signed for by two registered nurses and the infusion commenced as charted using an inline burette and infusion pump as per the SCHN Intravenous Fluid and Electrolyte Therapy practice guideline.
- Fluid balance documentation should be completed.

Management of Postoperative Nausea and Vomiting (PONV)

- Nausea and vomiting are unpleasant experiences which are rated by patients to be as distressing as pain. PONV is a common recognised complication of general anaesthetic/surgery and the perioperative use of opioid.
- PONV is multifactorial in children due to the patient's history of previous motion sickness or PONV, the surgery type, the anaesthetic type, and agents used, length of surgery, length of fasting time, analgesic and antiemetic medications and techniques employed, the presence of pain, as well as psychological distress.
- Management of PONV is per Pain Management – CHW practice guideline (section 11.2.3).

Additional considerations

Parent/Carer Presence in PACU 1

- Child should be reunited with their parents once awake and stable.
- Only two parents/ carers are permitted into PACU 1 at the same time.
- Change -over of family members into and out of this area is discouraged due to patient privacy and acuity of other patients in the unit. It is not appropriate for siblings and/ or younger children to be within the unit. As it is an acute area, and it may be distressing for children other than patients to be present.
- Siblings are not permitted to visit within the PACU due to the high acuity of the area, with the exemption of breastfed babies and at the discretion of the PACU nurses after hours.

Discharge planning

- Consider postoperative discharge medication requirements and discuss with treating team to expedite filling of scripts
- Contact Physiotherapist or Occupational Therapist as required via referral through eMR or page.

Quiet Pathway and Neurodiverse patients in MDSU

- Due to the complexity of the patient, it is recommended that the same RN that takes handover to PACU remain with patient till discharge.
- Recovered in allocated quiet area
- Parents/carers to be present in recovery earlier when recovery nurse deems appropriate (patient maintain own airway).
- Continuous monitoring whilst asleep.
- Discharge criteria may differ for Quiet pathway patients and will be tailored to the patient by the anaesthetist and communicated to the recovery nurse.
- *Anaesthetic quiet pathway practice guideline is due for release in May 2025*

Escalation of Care and Emergency Situations

- Any adverse patient incidents must be documented in the patient's eMR and in Incident Management Plus System (IMS+).
- Escalation of care as per the SCHN Between the Flags (BTF) clinical emergency response system and in accordance with local escalation procedures below:
    - Escalation of care in hours (0800-1730): - Consultation with team leader
        - Contact the patient's treating Anaesthetist and/or Surgeon to review patient via paging, voice paging, contacting the appropriate theatre or via switch.
        - Red emergency call bell located behind each bed space if urgent assistance is required.
        - Review by PICU outreach team if deemed necessary by PACU nurse, Anaesthetist or Surgical team.
    - Escalation of care out of hours (and when availability of Anaesthetists is reduced):
        - Contact treating Anaesthetist and/or Surgeon to review patient via paging, contact theatre, or via switch.
        - If the treating Anaesthetist is unavailable, page the on-call Anaesthetic registrar #6008 or the Duty Anaesthetist #6777.
        - Red emergency call bell located behind each bed space if urgent assistance is required.

    - Dial 2222 for the arrest team as per Cardiopulmonary Resuscitation and Equipment Practice Guidelines.
    - Review by PICU outreach team if deemed necessary by PACU nurse, Anaesthetist or Surgical team.
- Outlying areas: MRI, CT, CC, Neurovascular lab, Oncology Treatment Centre (OTC), EPS stage 1 PACU (Westmead Hospital PACU) and Block K kids PACU.
    - Treating Anaesthetist and/or surgical team may be present in department for consultation and review of patient deteriorating.
    - If the treating Anaesthetist is unavailable, page the on-call Anaesthetic registrar #6008 or the Duty Anaesthetist #6777.
    - Red emergency call bell if urgent assistance require (will only alert immediate area).
    - Contact operating suite floor manager (or K Block Team Leader for assistance and extra staff.
    - Dial 2222 for the arrest team as per Cardiopulmonary Resuscitation and Equipment Practice Guidelines.

Where possible a scribe sheet should be filled out during an emergency in any PACU area, to be kept with the patient's notes.

PACU 1 Length of Stay

- The length of stay of a patient in the PACU 1 is determined by the patient's condition. Relevant factors include airway management, sedation, vital signs, analgesic requirements and type of surgical procedure undertaken.
- Always refer to surgeon's post-operative orders and discharge instructions
- For discharge from PACU 1 to PACU 2, patients require:
    - a modified Aldrete score of 8 (only acceptable if pain score >3 and analgesia administered)
    - effective analgesia
    - If patients have received IV opioids in PACU 1, refer to Pain Protocol Guideline for length of stay
    - effective management of nausea and vomiting
    - minimal wound ooze/bleeding
    - observations must be BTF prior to transfer or the patient must have been clinically reviewed with altered calling criteria and a management plan in place.

The following procedures require a minimum one hour stay in PACU 1:

- Procedures involving the airway, e.g. Laryngoscopy, Bronchoscopy, Oesphagoscopy
- Adenoidectomy
- Tonsillectomy
- Closed reduction of hips
- Trans Iliac Bone Biopsies
- Renal Biopsy
- Cardiac Catheterisation patients.

Nurse Initiated Discharge from MDSU

To minimise the likelihood of post-operative complications, it is important to ensure that sufficient time has elapsed for the child to be fully recovered from anaesthesia and surgery. The length of the post-operative stay can vary between 2 to 10 hours.

The following criteria must be met prior to discharge

- The patient:
  - Is conscious and responding appropriately.
  - has minimal nausea and no vomiting for at least one hour
  - can mobilise in an age-appropriate manner, taking into consideration the type of procedure involved
  - **may be** required to pass urine prior to discharge if requested by surgeon or anaesthetist. If patient has had a procedure in which they have received a caudal block and has no IDC/SPC please consult with the surgeon/anaesthetist as to whether patient needs to pass urine prior to discharge.
  - has tolerated a minimum of 80mls of oral/enteral fluid. If unable to tolerate or refusing oral intake the PACU2 nurse may discharge after consultation with treating anaesthetist
- A full set of vital signs must be attended on discharge and must be BTF.
- Assess patients' mobility and refer for allied health review if support required.
- The wound site has nil or minimal ooze. Patients must not be discharged if there is active bleeding, and a surgical review must be organised.
- Patients have met procedure specific minimum length of stay requirements
- Ensure mode of transport home is appropriate.
- If any uncertainty exists regarding the patient's suitability for discharge, the treating surgeon/anaesthetist should be consulted.
- Confirm that surgeons have spoken to family/carers post op.

The following table is a general guide only for duration of stay:

Length of Stay	Duration	Procedure Types
Routine Stay	**Minimum 2 hours**	• All procedures require a minimum 2 hour stay • *< 2hours only at discretion of the surgeon/anaesthetist and must be documented in clinical progress notes or Anaesthetic record chart.*
Extended Stay	**Greater than 2 hours**	• Day Stay Tonsillectomy – minimum 4 hour stay with surgical review of patient within 1 hour of discharge. (For intracapsular tonsillectomy, refer to Intracapsular Tonsillectomy - Day Surgery - CHW • Procedures involving a biopsy e.g. Endoscopy/Colonoscopy – 2-3 hours as per surgeon's instructions • Caudal anaesthesia - as per anaesthetist/surgeon. Generally, 4 hours from insertion of caudal block. • Laryngoscopy / Bronchoscopy- 3 hours • Adenoidectomy - 4 hours • Occurrence of an adverse reaction or patients requiring further pain management • Orthopaedic procedures where patient is required to remain in a bed/cot for care of plaster and/or comfort, or where GameReady is in use as per Day Surgery Orthopaedic Procedures - CHW • General surgery as per discharge orders • Ophthalmic Surgery • Full Term infants may require extended stay at the discretion of and as documented by Anaesthetist /Surgeon. • Trans Iliac Bone Biopsies require a **4 hour stay** in bed • Renal Biopsies (6 Hours)
Procedures needing medical review prior to discharge		• Renal Biopsy • Cardiac Cath, Cerebral Angiogram • Mastoidectomy / Myringoplasty • Adenoidectomy, Tonsillectomy • Inferior Turbinectomy • BAHA implantation device

Criteria for the Neonate/infant regarding Day Surgery Discharge:

The current ANZCA guidelines for care of neonates and infants during day surgery are as follows:

ANZCA PG29(A) Guideline for the provision of anaesthesia care to children 2020

> 10.1.6 Ex-preterm infants at risk of postoperative apnoea should not be considered for same day discharge unless they are medically fit and have reached a postmenstrual age of 54 weeks.
>
> 10.1.7 Term infants should not be considered for same day discharge unless they are medically fit and have reached a postmenstrual age of 46 weeks.

ANZCA PG29(A)BP Guideline for the provision of anaesthesia care to children Background Paper 2020

> 14.3 Most postoperative apnoea occurs within the first 2 hours. In healthy infants, after 12 apnoea free hours, apnoea risk approaches preoperative levels in healthy infants. Infants should be monitored for 12 apnoea free hours. High-risk infants or those with persistent apnoea's may need to be admitted for a longer period of monitoring.
>
> 14.4 Healthy ex-premature infants who have reached a PMA of 60 weeks can be sent home with standard discharge criteria. Ex-premature infants below 46 weeks should be admitted for apnoea monitoring after general anaesthesia or sedation. Between 46 weeks and 60 weeks PMA, there is currently no consensus as to whether infants need overnight monitoring.

Day surgery discharge of any infant is at the discretion of the anaesthetist in line with the above guidelines.

Discharge following administration of specific medications

Sufficient time should have elapsed between the administration of medication and discharge to ensure the child is fully recovered and the likelihood of complications is minimised.

- After administration of the following medications, patients must be observed for a **further one (1) hour**:
  - Ondansetron and Metoclopramide – to ensure medication has had intended effect
  - Fentanyl/Oxycodone – as per Pain Protocol – Bolus Intravenous Opioid Administration In Post Anaesthesia Care Unit (PACU) CHW
  - Oral Oxycodone
- After administration of the following medications IV, patients must be observed for a further two (2) hours:
  - Droperidol
  - Cyclizine

Note: If the patient requires administration of IV opioids, Cyclizine or Droperidol in PACU 2, they must be transferred back to PACU 1 for continuous monitoring and a handover provided to the PACU 1 nurse. The patient must meet PACU 1 discharge criteria prior to transfer to PACU 2.

Discharge Procedure

1. Patients must have met discharge criteria
2. Remove intravenous cannula.
3. Ensure the post-operative instructions are discussed with and understood by the patient/parents/guardians.
4. Answer any questions and give reassurance.
5. Remind parents to collect any discharge medications from pharmacy and provide parents with original script to present to pharmacy
6. Obtain the parent's signature prior to discharge on the M1A form.
7. Wheelchairs are provided to transfer patients to the car if required.
8. Nursing staff must escort the child to the front of the hospital if there is only 1 parent in attendance and parent needs to bring the car to front entrance of hospital.

Ward admission from MDSU

Indications for admission to a ward

- Need for IV maintenance fluids overnight.
- Excessive vomiting not controlled adequately by anti-emetics.
- Need for respiratory monitoring or the presence of a compromised airway.
- Post-operative pain not controlled adequately by oral analgesia.
- Excessive wound drainage/bleeding.
- Surgery more invasive/complicated than originally anticipated.
- Need for further medications e.g. Intravenous antibiotics.
- Complex medical history that the RMO was unaware of when the Day Surgery booking completed.

Staff responsibility / procedure for admission

- Intra-operatively it is the responsibility of the Surgeon and / or Anaesthetist to notify the Operating Theatre Floor Manager (OTFM) if an inpatient bed is needed and communicate it to the team leader in MDSU.
- If an inpatient bed is needed during normal working hours the MDSU TL must call the OTFM.
- After 5pm, the MDSU TL contacts the Bed Manager to arrange inpatient bed.
- Clerical transfer on Patient Management System is the responsibility of the receiving ward
- Patients must not be transferred between clinical units when their observations indicate the need for a Clinical Review (CR) or Rapid Response (RR) unless as part of the escalation of care process.
- If following activation of a CR or RR patient transfer is required, this should occur in consultation with the Attending Medical Officer, Patient Flow Manager and/or Nurse in Charge (Refer to: Between the Flags (BTF): Clinical Emergency Response System (CERS))
- Nursing staff to contact the allocated ward to arrange a transfer time.
- Nursing staff should confirm that both the surgical team and/or anaesthetic team are aware of the transfer for continuity of care

Handover to Ward Staff

- On arrival in the ward, the MDSU nurse should give a comprehensive handover to the ward nurse using the ISBAR guideline, including:
  - Patient Identifiers
  - Medical history/background
  - Summary of anaesthetic
  - Surgery or procedure performed
  - Any complications and treatment during recovery
  - Post-operative instructions
  - Vital signs and supplementary observations
  - Dressings in situ
  - Analgesia and other medications given
  - IV fluid orders/IV access
  - Intake and output
- The PACU nurse and ward receiving nurse must complete the handover checklist in the PACU band following handover.

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11. SCHN practice guidelines and policy documents as linked in this document

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