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)
- Middleton PACU staff also provide post anaesthetic care to patients in the Oncology Treatment Centre (OTC) satellite area
- 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

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st June 2021	**Review Period**: 3 years
Team Leader:	Nurse Unit Manager	**Area/Dept**: MDSU CHW

Date of Publishing: 18 May 2021 8:03 AM Date of Printing: 18 May 2021

CHANGE SUMMARY

- Due for mandatory review. Tittle change. Previous title being *Post-operative Care & Discharge in the Middleton Day Surgery Unit - CHW*
- This document has been updated in accordance with Infection control standard and additional precautions for the Operating Suite – CHW, Perioperative Suite operating guidelines for COVID-19 response, Aseptic Non Touch Technique (ANTT) policy, Local escalation of care procedures, SurgiNet and PowerChart Perioperative documentation systems.
- The criteria for discharge from MDSU has been changed from a Post Anaesthetic Recovery Score to meeting the age appropriate Standard Paediatric Observation Chart discharge criteria.

READ ACKNOWLEDGEMENT

- All Registered Nurses who work in Middleton Day Surgery Unit 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.

TABLE OF CONTENTS

Summary

- Middleton Day Surgery Unit (MDSU) is the admission area for all planned surgical Day Only and Day of Surgery Admission (DOSA) patients. MDSU admits over 95% of all surgical patients for SCHN – Westmead campus.
- Middleton Day Surgery Unit (MDSU) encompasses a Pre-operative Admission area, Post Anaesthetic Care Unit (PACU 1) and a Discharge Lounge (PACU 2)
- MDSU can accept appropriate preoperative surgical patients from the Emergency Department, Outpatient clinics and Surgeon's rooms requiring General Anaesthesia.
- Middleton PACU has 11 monitored bays. A minimum of two nurses must be present at all times 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
- All unconscious patients admitted to the PACU must be nursed 1:1 until fully awake, clinically stable, and parent/carer is in attendance
- Patients with known infectious status must be managed and recovered as per the Infection prevention and control grid for Operating department. Infection control standard and additional precautions for the Operating Suite - CHW
- Patients with suspected, high risk or confirmed COVID-19 must be managed as per Perioperative suite operating guidelines for COVID-19 response CHW
- At the commencement of each day, the following checks must be performed:
    - Resuscitation trolleys and defibrillators as per Cardiopulmonary Resuscitation and Equipment Practice Guideline
    - S4d & S8 Drug count in safe as per Accountable Medications – Management Practice Guideline . Middleton order day is Tuesday. Ensure enough stock is ordered until the next order day. Requisition book to be sent to pharmacy as early as possible in the day (ideally by 11am). If any stock is needed urgently from pharmacy please call immediately.
    - Ensure an adequate supply of clean equipment is available in the MDSU including the recovery bays and trolleys
- The Tracheostomy trolley must be checked at the beginning of each month
- 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 the recovery area and should be used if the recovery nurses are unable to maintain the child's airway or if additional assistance is required. 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.

All emergency call buttons should be checked monthly and documented in monthly WH&S Audits

Preoperative Process

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

Any concerns regarding patient's wellness check should be escalated to NUM or TL and decision made, in consultation with admitting team/anaesthetist, whether patient is suitable to continue with their surgery.

Fasting and arrival calls are conducted the evening prior to patients' surgery and a final wellness check and COVID-19 Risk Assessment completed

NUM or senior staff member to 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, Day surgical and DOSA patients, with their Parent/Carer, must present to Middleton Reception where Clerical Support Admission (CSA) staff initiates the Admission process.

Emergency list patients being transferred to Middleton from the Outpatient Clinic, Emergency Department or Private Rooms must be accompanied by a staff member and a handover to Middleton RN must occur as per Clinical Handover Policy. Relevant paper work should be given to ward CSA so patient can be admitted onto the unit.

Some patients who may not suitable for admission via MDSU –

- The Quiet pathway: This has been developed for patients with autism, developmental delay and/or behavioural disturbances who require individual plans and flexibility. Guidelines are being developed but there is a **Peri-operative care for children with severe behavioural disturbance** report that was developed for the hospital Accreditation Committee 2019.
- Metabolic patients.
- Trauma patients requiring close observation.
- Infectious patients requiring single room isolation

Nursing Admission:

- Neurovascular assessment must be done hourly for all fractures waiting for surgery and monitoring of pain must be documented.
- Patients undergoing cardiac catheterisation procedures require a set of lower limb neurovascular observations preoperatively
- Vital signs must be recorded on Between the Flags (BTF) Observation Chart – Anaesthetist, treating team and team leader must be notified if patient's observations are not BTF and care escalated as per Between The Flags – Clinical Emergency Response System – SCHN Procedure
- Consent must be obtained prior to surgery in accordance to policy Obtaining Consent Prior to Admission to the Operating Suite – CHW

Fasting Guideline:

- 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 where possible. BSL checks to be attended on admission and each hour thereafter whilst patient fasting and until patient eating and drinking again. If the patient is expected to be able to eat and drink soon after their operation, then once this occurs their usual insulin management can be recommenced as per Fasting and Surgery – Type 1 diabetes Mellitus (T1DM) – CHW Practice Guideline
- Special attention must be given to infants under 6 months old that are fasting for surgery – BSL must be monitored if extended fasting and 5% glucose water should be readily available in Middleton.

Nurse Initiated Medication/Standing Orders:

- A loading dose of 30mg/kg of oral Paracetamol can be administered to eligible preoperative patients' by Middleton RN's who have completed the relevant competency: Please refer to Loading Dose Paracetamol (Middleton Ward Only) - CHW
- Lignocaine 4% (LMX4) cream can be administered to eligible preoperative patients' by Middleton RN's who have completed the relevant competency. These patients include, although not limited to, children having IV induction, infants undergoing tenotomy under local anaesthetic, children who have/suspected of having, malignant hyperthermia. Please refer to Topical Anaesthesia – Lignocaine 4% Cream (LMX)
- Standing order Dilating Eye Drops are administered to appropriate patients preoperatively for diagnostic and therapeutic procedures.

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

Criteria for the Neonate/infant regarding Day Surgery Discharge:

Age in weeks at birth	PMA on day of surgery to which apnoea risk is <1%	Corrected age on Day of surgery which apnoea risk is <1%
< 32weeks	>60 weeks	> 28 weeks (these patients need to be carefully considered if they are appropriate for day surgery)
32-35weeks	56 weeks	16 -24 weeks
35-37weeks	54 weeks	17-19 weeks
>37weeks	46 weeks	>6 weeks

https://www.anzca.edu.au/resources/professional-documents/guidelines/ps29-guideline-for-the-provision-of-anaesthesia-ca

1. Term baby's >46 weeks should be monitored for a minimum of 4 hours or at the discretion of both the anaesthetist and surgeon. During this time they should not have any apnoea or hypoxic episodes, otherwise they should be admitted overnight for observations.
2. Children <46 weeks corrected age should be monitored for a minimum of 12 hours for apnoea's and hypoxia. Therefore currently they will need to be admitted overnight.
3. Children > 46 weeks should be monitored for 12 hours for apnoea/hypoxia if there is a history of apnoea, chromic pulmonary disease, and anaemia or other risk factors including gestational age, birth weight at the time of operation, history of oxygen therapy, metabolic or cardiac abnormalities.
4. Healthy preterm infants who have reached a PMA of 60 weeks can be sent home on standard discharge criteria if anaesthetist and surgeon agree.
5. For term infants between 46-60 weeks PMA there is currently no consensus as to whether or not these infants need overnight apnoea monitoring. It is at the discretion of the anaesthetist, in discussion with the surgeon whether an infant 46-60 weeks PMA warrants admission or extended stay for post –operative apnoea monitoring.
6. Minimum length of stay post for children >46 weeks PMA for term or preterm babies >56 weeks who are well and satisfy day surgery criteria should be 4 hours with

appropriate apnoea and hypoxia monitoring. If during this period they have not had any desaturations or apnoea of 15 seconds or more they may be discharged home.

Isolation of patients in MDSU.

DOSA and Middleton patients requiring contact and droplet precautions should wait in an isolated area in Middleton recovery pre-operatively according to Operating Suite Guideline: Infection Control: Standard and Additional Precautions for the Operating Suite - CHW

http://webapps.schn.health.nsw.gov.au/epolicy/policy/3915

Premedication and Transfer of Patient to Outlying Areas.

Appropriate RN to transfer patient post administration of premedication to outlying areas according to policy with patient on bed/cot: oxygen cylinder/suction, monitoring and airway equipment e.g. T-piece/mask

http://webapps.schn.health.nsw.gov.au/epolicy/policy/4543/download

General Care Principles of PACU 1

Anaesthetic Handover

Patients are transferred from the operating room (OR) to Middleton PACU 1 by an anaesthetist and porter. The anaesthetist hands over relevant information to the recovery nursing staff, which includes:

- Name of patient
- Known drug 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

Please communicate with Anaesthetist if you are not happy for him/her to leave.

Airway Management

- 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.
- Children are routinely placed in the lateral position unless contraindicated, to facilitate drainage of secretions and/or vomitus.
- Children who are showing signs of airway obstruction may need airway support.
- Lifting the jaw bilaterally and suctioning of excessive secretions and vomitus will assist in maintaining a patient airway. This may apply also to children who have an artificial airway *in situ*.
- The Guedel airway, if in situ, should be removed once the child is awakening.
- AN UNCONSCIOUS PATIENT i.e. a child who has not responded adequately to stimuli or and/or who has an artificial airway in situ, MUST NEVER BE LEFT UNATTENDED.
- If the child has a Tracheostomy or Nasopharyngeal airway in situ, ensure the suction outlet is functioning and available at all times 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.

Observations

- Document observations on the age appropriate Standard Paediatric Observation Chart (SPOC). If the patient is deteriorating, escalate to the appropriate person/s as per the Clinical Emergency Response System (CERS) escalation flowchart.
- A full set of observations are to be documented on admission as to PARU and then 10 minutely for the first 30 minutes, and thereafter 30 minutely until child meets discharge criteria, unless the patient's condition dictates more frequent observation.
- Blood pressure is required on admission to the ward and as clinically indicated, including when any single observation enters the yellow or red zone on the SPOC as this may be a sign that the patient is deteriorating.
- Temperature must be recorded on admission and more frequently post GA. Close observation should be occur with hyperthermic patients, as these children may be at risk of malignant hyperthermia.
- Pulse oximetry must be monitored continuously until the child is fully conscious or otherwise specified.
- 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.

- Blood pressure must be measured following tonsillectomy and adenoidectomy, cardiac catheterisation, angiogram, and renal and liver biopsy, at the commencement of an epidural infusion or when indicated by the anaesthetist.
- Patients will be transferred to the Discharge Lounge when fully awake and observations are stable and within the normal range as per the SPOC.
- No child is to be transferred or discharged from PARU if their observations are not within the appropriate age range on the SPOC.
- Where a patients abnormal observations are in fact normal for that individual and do not reflect an acute deterioration in clinical condition, it may be appropriate to alter calling criteria. For example:
  - An infant with cyanotic congenital heart disease whose normal status is to have oxygen saturations lower than healthy infants.
  - A young, fit adolescent with a resting heart rate that is normally low for them.
- Orders varying the minimum frequency of observations should be re-evaluated if there is a change in clinical condition and at all times clinicians should use their clinical judgement regarding the frequency and timing of observations. Unstable patients may need frequent or continual assessment of observations until they are reviewed and stabilised.

Hydration

- Intravenous lines are to be inserted and secured as per SCHN Intravenous Cannulation Procedure. http://www.schn.health.nsw.gov.au/_policies/pdf/2013- &client=internal-
- Ensure the Anaesthetist has ordered adequate intravenous fluid orders for the patient if required.
- Intravenous fluid orders are to be checked and signed for by two registered nurses and the infusion commenced as charted. Fluid balance documentation should be completed. Refer to Intravenous Fluid Management Practice Guideline for more information. http://chw.schn.health.nsw.gov.au/o/documents/policies/guidelines/2009-8070.pdf
- The use of infusion pumps on all patients should be consistent with the Intravenous Fluid Management Practice Guideline. A micro drip set with burette should be used on all children not utilising an infusion pump.
- In some cases oral fluids may be contraindicated for a period of time e.g. after topicalisation 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 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.

Temperature Control

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

Pain Relief

- If analgesia has been given **intra-operatively** this should be documented within Surginet /EMR
- Check that appropriate postoperative analgesia has been ordered. If not, discuss with the Anaesthetist.
- Intravenous opioid infusions, may be commenced in Middleton PACU1, for patients waiting to be transferred to the ward bed. Infusions are to be checked and primed by two registered nurses who have completed their 20 medication checks, Opiate Infusion competency and employed within SCHN for greater than three months.
- The checking and administration of intravenous analgesia as per Post-Operative Care in the Todman Recovery Unit Practice Guideline and Pain Management Practice Guidelines.
- Intravenous opioid bolus analgesia may be checked and given by two accredited Registered Nurses as ordered on the electronic medication record (eMR) by the Anaesthetist in accordance with the CHW PACU pain protocol
- If pain remains unresolved following administration of analgesia, the anaesthetist should be notified to assess the patient.
- All children given intravenous, intramuscular or subcutaneous narcotics must remain in PACU1 for a minimum of thirty minutes post administration for close observations before transfer to the discharge lounge.
- If any child remains unsettled after analgesia has been administered, the anaesthetist should be notified to review the child.

Wound and Drain Assessment

- All wound and puncture sites should be assessed on arrival to the PACU and at regular intervals to observe for bleeding, haematoma and swelling. The surgical registrar 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 AMO.

Emergence Delirium

- Emergence delirium can occur in paediatric patients following general anaesthesia
- 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.
- A patient with emergence delirium may require a review by the anaesthetist if the PACU nurse is unable to settle the child or maintain their safety during this time.

Special Considerations

- All cardiac patients must have ECG monitoring.
- Child should be reunited with their parents once awake and stable.
- Only two parents/ carers are permitted into PACU 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.
- Exceptions may be made after hours, or at the NUM or Team Leaders discretion.
- If a patient's observations are documented in either the Blue, Yellow or Red zone on the SPOC, care must be escalated as per the Clinical Emergency Response System (CERS) protocol. Escalate to the appropriate person/s as per Clinical Emergency Response System.
- Any adverse patient incidents must be entered into the EMR, Surginet Clinical Indicators and in the electronic Incident Monitoring Management System (IMMS) Safety at Kids Icon on the Novell Screen.

Quiet pathway patients in PACU1

- Due to the complexity of the patient it is recommended that the same RN that takes handover to PACU remain with patient till discharge.

Emergency Situations

- When further medical assistance is urgently required in the MDSU, an emergency call should be activated by pressing the **RED** emergency button; these are located in the Admission area, at each bed space in PARU and on the wall in the Discharge Lounge

- Outside normal hours (0800 – 1730hrs), or when the availability of anaesthetists is reduced, staff should press the emergency button and also call 2222 to alert appropriate staff for assistance as per CPR Practice Guidelines.
- Any adverse patient incidents must be documented in the EMR, Clinical Indicators and in Incident Management System plus (IMS+).

Recovery Area Length of Stay

- The length of stay of a patient in the PACU 1 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
- Patients will be transferred to the Discharge Lounge when fully awake and observations are stable and within the normal age appropriate range on the SPOC (Between the Flags Procedure)
- Where a patients' abnormal observations are in fact normal for that individual and do not reflect an acute deterioration in clinical condition, it may be appropriate to alter the calling criteria. Refer to the Between the Flags – Clinical Emergency Response System Procedure

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

1. Procedures involving the airway, e.g. Laryngoscopy, Bronchoscopy, Oesphagoscopy
2. Adenoidectomy
3. Tonsillectomy
4. Closed reduction of hips
5. Trans Iliac Bone Biopsies require a **4 hour stay** in a bed
6. Renal Biopsy
7. Cardiac Catheterisation patients.

If the patient observations are outside age appropriate limits, they should remain in PACU until medical review and plan for care put in place or observations return to the normal range.

If the patient's observations fall within the yellow or red zone on the SPOC, care must be escalated as per Clinical Emergency Response System (CERS) protocol must be assessed by the attending anaesthetist and have a plan of care documented

Parental Presence

- Parents may attend once the child is conscious.
- Dependant on patient needs one or two family members can be with patient at any one time in MDSU unless negotiated with nursing staff.
- Siblings or visitors under 13 years of age are not permitted in the MDSU unless discussed with team leader and NUM.

Nurse Initiated Discharge from Middleton Unit

In order 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.

Patients must not be transferred between clinical units, to home or other care facility when their observations are not stable and within the normal range on the SPOC. If following activation of a Clinical Review or Rapid Response patient transfer is required, this should occur in consultation with the Attending Medical Officer, Patient Flow Manager and/or Nurse or Midwife in Charge (Refer to policy: Recognition and Management of a Patient who is Clinically Deteriorating)

As well as following a Medical Officer's discharge orders as documented in Surginet

Post-operative instructions the Registered Nurse must ensure the following criteria have been met prior to discharge:

Discharge Criteria:

- The patient is conscious and responding appropriately.
- Standard observations must be attended on discharge. (Patients must not be transferred or discharged when their observations indicate the need for a Clinical Review unless as part of the escalation of care process).
- Mode of transport home should be identified preoperatively and be appropriate
- Adequate oral intake has been tolerated or the patient has received adequate intravenous hydration.
- The patient should have minimal nausea and no vomiting for at least one hour.
- The patient should be able to mobilise in an age appropriate manner, taking into consideration the type of procedure involved.
- The patient **may be** required to pass urine prior to discharge if requested by surgeon or anaesthetist.
- The wound site has nil or minimal ooze. Patients should not be discharged if there is active bleeding and surgical review should be organised.

The following information is a general guide only as some patients may achieve discharge criteria before the stated times below. Not all surgery can be listed. The minimum length of stay should be 2 hours, with exceptions only at medical officer's discretion

Length of Stay	Duration	Procedure Types
Routine Stay	**Minimum 2 hours**	• Insertion and or removal of ventilation tubes into the ears – Myringotomies +/- insertion • Examination Under Anaesthetic of eyes – check with anaesthetist for length of stay for babies under 8 weeks • Probe and Syringe of Nasolacrimal Ducts • Release of Tongue Tie • Removal of Sutures • Examination Under Anaesthetic (EUA) • Anal Dilation • Minor Emergency procedures for Plastic and Orthopaedic specialties • < 2hours only at Medical Officers discretion and must be documented in clinical progress notes.
Extended Stay	Greater than 2 hours	• Tonsillectomy – RMO review of patient in Middleton within 1 hour of discharge to assess if patient ready for discharge. • Procedures involving a biopsy e.g Endoscopy/Colonoscopy – 2-3 hours as per surgeon's instructions • Caudal anaesthesia - as per anaesthetist. Generally 4 hours from insertion of caudal block. (Check with anaesthetist and document if the child is required to void prior to discharge) • 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. • General surgery as per discharge orders

		• Ophthalmic Surgery • Full Term Babies over 4 weeks may require > 4 hour stay as documented by Anaesthetist /Surgeon.
Procedures needing Medical review prior to Discharge		• Renal Biopsy • Cardiac Cath • Mastoidectomy / Myringoplasty • Adenoidectomy ' • Tonsillectomy • Inferior Turbinectomy • BAHA implantation device • Cerebral Angiogram

For more information: refer to the "Surgical Procedures: Day Only and Day of Surgery Admissions"

Exceptions / Variations

- Delayed discharge for patients following IV/IMI medication. The surgeon or anaesthetist may specifically request the patient stay longer.
- If discharge outside the guidelines required, a note of permitted discharge time **must** be made by the surgeon or anaesthetist in the patient's medical record.
- If any uncertainty exists regarding the patient's suitability for discharge, a Medical Officer should be consulted.

Discharge following administration of Oral / IMI / IV medication

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.

1. After administration of the following medications, patients must be observed in the PACU for a **further one (1) hour**. The medications are:
   - Ondansetron
   - Metoclopramide
   - Fentanyl
   - Oxycodone
2. After administration of the following medications IMI/IV, patients must be observed for a further two (2) hours. These medications are:
   - Droperidol

- Pethidine
- Morphine

If **discharge outside these guidelines is required**, the patient is to be assessed by the individual surgeon/anaesthetist and the assessment documented.

Discharge Procedure

3. Remove intravenous cannula.
4. Standard observations must be on the SPOC Between the Flags.
5. Patients must not be transferred or discharged when their observations indicate the need for a Clinical Review.
6. Check the wound and ensure that the dressing is intact and the wound is not actively bleeding.
7. Ensure the post-operative instructions are discussed with and understood by the child's parents/guardians.
8. Give the parents written follow-up instructions with a hospital contact number.
9. Answer the parents' questions and give reassurance.
10. Obtain the parent's signature prior to discharge on the MR 4b-DS form.
11. Wheel chairs are provided to transfer patients to the car.
12. 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.

Overnight Admission to a Ward

Patients must not be transferred between clinical units, to home or other care facility when their observations indicate the need for a Clinical Review or Rapid Response (unless as part of the escalation of care process). If following activation of a Clinical Review or Rapid Response patient transfer is required, this should occur in consultation with the Attending Medical Officer, Patient Flow Manager and/or Nurse or Midwife in Charge (Refer to: Recognition and Management of a Patient who is Clinically Deteriorating)

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

- Intra-operatively it is the responsibility of the Surgeon and / or Anaesthetist to notify Floor Manager on 52381 if an inpatient bed is needed.
- Postoperatively if patient does not meet criteria for discharge the nursing staff must notify Surgeon and/or anaesthetist to review patient.
- If an inpatient bed is needed during normal working hours call the Floor Manger on 52381.
- After 5pm, page the Bed Manager on 6056 to arrange and inpatient bed.
- Clerical transfer on Patient Management System is the responsibility of the receiving ward

Procedure

1. Nursing staff to contact the allocated ward to arrange a transfer time.
2. Nursing staff should confirm that both the Surgical team and/or Anaesthetic team are aware of the transfer for continuity of team care

Handover to Ward Staff

- On arrival in the ward, the Middleton nurse should give a comprehensive handover to the ward nurse using the ISBAR guideline, including:
  - Summary of anaesthetic
  - Surgery or procedure performed
  - Any complications and treatment during recovery
  - Post-operative instructions
  - Vital signs and supplementary observations
  - Analgesia and other medications given
  - Intravenous fluid orders/intravenous access
  - Intake and output

The PACU nurse and ward receiving nurse must complete the handover checklist in the PACU band following handover

Related Information

- CHW Cardiopulmonary Resuscitation Practice Guidelines
- CHW Medication Management and Handling Practice Guideline
- CHW Tracheostomy Care Practice Guideline
- CERS escalation flowchart for the Deteriorating Patient
- CHW Intravenous Cannulation Procedure
- Intravenous Fluid Management Practice Guideline
- CHW Pain Management Practice Guidelines
- Surgical Procedures: Day Only and Day of Surgery Admissions

References

1. Australian College of Operating Room Nurses Ltd. (ACORN). Standards for Perioperative Nursing in Australia 15th ed. Adelaide, South Australia: ACORN; 2018
2. Chamber,M.A Jones,S.(2007) Surgical Nursing of Children .Butterworth Heinemann. Elsevier limited.
3. NSW Health Policy Directive (PD2010_026) Recognition and Management of a Patient who is Clinically Deteriorating: http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_026.pdf (accessed Nov 2011)
4. Festa. M, & Leaver J. (2012). DETECT Junior Manual The Paediatric Approach. Clinical Excellence Commission. NSW Health
5. Hamlin, L.,Richardson-Tench, M.& Davies, M. Perioperative Nursing: an introductory text. Mosby Elsevier: Sydney. 2009.
6. NSW Health. Detect Junior: The Paediatric Approach. NSW Health, Sydney. 2012.
7. NSW Ministry of Health. Transition to Perioperative Practice Program. NSW Government. 2018
8. https://www.anzca.edu.au/resources/professional-documents/guidelines/ps29-guideline-for-the-provision-of-anaesthesia-ca Accessed 3/3/2021