POST OPERATIVE CARE IN TODMAN POST ANAESTHETIC CARE UNIT (PACU) - CHW

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Todman Post Anaesthetic Care Unit (PACU) is responsible for the postoperative care of all hospital in-patients, patients admitted day of surgery (DOSA), and Electrophysiology Studies (EPS) / Cardiac Catheterisation (CC) patients deemed suitable for day of procedure discharge Model of Care (MoC).
- Todman PACU also provides postoperative care to patients in a variety of satellite areas following general anaesthesia.
- To be used in conjunction with Australian College of Perioperative Nursing (ACORN) standards for the PACU nurse, NSQHS standards, policies / practice guidelines as hyperlinked through document and organisational surgical procedure specific documents.
- This practice guideline addresses the following areas:
  - Risk management for infectious patients
  - General principles of care in the PACU
  - Escalation of care and emergency situations
  - Parental presence in the PACU
  - PACU length of stay
  - Documentation
  - Transfer of patients
  - Discharge to ward

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1 July 2024	**Review Period**: 3 years
Team Leader:	Clinical Nurse Educator	**Area/Dept**: Anaestheitcs and Recovery

CHANGE SUMMARY

- New EPS and CC Day of procedure discharge through Todman Recovery MoC.
- New General surgery and Ear, Nose and Throat (ENT) surgery extended stay in Todman Recovery MoC.
- New K Block PACU and EPS stage 1 (Westmead Hospital PACU 1) added to 'outlying/satellite' areas.
- Updated related links.

READ ACKNOWLEDGEMENT

- All Registered Nurses who work in Todman PACU are required to read and acknowledge they understand the contents of this document.

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Introduction

- The PACU nurse must practice within the NMBA Registered Nurse competency standards for practice, NSQHS standards and the ACORN standard for the PACU nurse.
- Todman PACU Registered Nurses are responsible for the post anaesthetic care of all CHW inpatients, Day of Surgery Admissions (DOSA), patients deemed suitable for day of procedure discharge and extended recovery MoC.
- Todman PACU also provides postoperative care to patients in a variety of satellite areas following general anaesthesia.
- A minimum of two nurses (or one nurse and one anaesthetist) are required whenever a patient is present in the PACU.
- Priorities of patient care reflect the DETECT Junior A-G algorithm.
- All patients admitted to the PACU must be nursed at minimum 1:1 until they meet discharge criteria, with exception only for patients under the EPS and CC MoC.
- Patients with known infectious status must be recovered as per the Infection prevention and control grid for Operating Suite see Infection control standard and additional precautions for the Operating Suite - CHW.

At the commencement of each day, the following checks must be performed:

- The resuscitation trolleys and defibrillators as per Cardiopulmonary Resuscitation and Equipment Practice Guidelines.
- Suction and oxygen outlets, in each bay are operational.
- Anaesthetic Difficult Airway Trolley.
- S4 & S8 medications see Medication Administration Practice Guideline and NSW Medication Handling.
- Adequate supply of equipment in the PACU including, but not limited to, fluid/PCA/Epidural pumps, monitoring equipment, Hi-Flow set up, intravenous fluid, sterile bottles, and splints.

Admission to the PACU

Patient Transfer from Operating Room to the PACU

- Patients are to be transferred from the Operating Room to PACU by an anaesthetist and an Operating Assistant. If an Operating Assistant is unavailable, another staff member must accompany the anaesthetist on transfer.
- The patient should be transferred on their bed, with the side rails up and have oxygen and a T-piece or Hudson Mask.

Patient Transfer from Outlying Areas to the PACU

- Patients being transferred to the PACU from outlying areas must be accompanied by an anaesthetist and an Operating Assistant.
- The patient must be transported in their bed with the side rails up and have oxygen and a T-piece available.
- The anaesthetic tray, with an endotracheal tube and laryngoscope, should accompany the patient on transfer.

Anaesethetic Handover

Patients are transferred from the operating room (OR) to PACU by an anaesthetist and operating assistant. A pause period is required upon the patient's arrival in PACU and while the patient is being connected to monitoring equipment. This pause allows the PACU nurse to complete a brief initial assessment before receiving a verbal handover (Webber et al., 2023). The anaesthetist hands-over relevant information to the PACU nursing staff, which includes:

- Patient identifiers
- Known allergies
- Medical history
- 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
- Intravenous (IV) access
- Any altered criteria
- Infectious status
- Length of stay if varying from the usual
- Post anaesthetic instructions

General Principles of Care in the PACU

Airway

- Unless otherwise indicated, all children are to be given oxygen at 6 litres per minute via a T-piece circuit or Hudson Mask until fully awake. This will minimise rebreathing of CO2 and avoid diffusion hypoxia.

- Children are routinely placed in the lateral position unless contraindicated, to facilitate drainage of secretions and/or vomitus.
- Suctioning equipment should be available for all PACU patients.
- An unconscious patient must never be left unattended.
- Chin lift / jaw thrust and suctioning of excessive secretions and vomitus will assist in maintaining a patent airway. This may apply also to children who have an artificial airway in situ.
- Airway obstruction and laryngospasm are managed initially with airway manoeuvres and CPAP via a T-piece.
- A variety of devices to support the patient's airway are available in the PACU e.g. Guedel/ Oropharyngeal airway; Nasopharyngeal Airway (NPA). An anaesthetist should be called if further assistance is required, or the emergency bell should be pressed if urgent assistance is required.
- The Guedel/Oropharyngeal airway, if in situ, should be removed once the child is awakening.
- If the child has a Tracheostomy or Nasopharyngeal airway in situ, ensure suction is functioning and available at all times, and that an adequate supply of appropriately sized suction catheters are available.
- Care of the patient with a Tracheostomy should be in accordance with the 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 liters per minute; delivery via Nasal Prongs should not exceed 2 litres per minute.
- Humidified high flow nasal prong oxygen may be required in PACU for patients with increased work of breathing, see Humidified High Flow Nasal Cannula Therapy Practice Guideline.

Vital Sign Observations

- Observations are to be recorded in PowerChart, on the PACU Band in 'Interactive View', and can be reviewed in the BTF chart.
- An initial set of observations are to be taken on arrival to the PACU and 10-15 minutely there-after, unless the patient's condition indicates more frequently.
- For extended recovery patients, observations and nursing ratios will reduce if clinically appropriate during their stay in PACU.
- Initial PACU observations include, but not limed to:
    - Respiratory Rate
    - Respiratory Distress
    - Oxygen Saturations (SpO2)

- Heart Rate
- Capillary Refill
- Blood Pressure
- Level of Consciousness
- Pain Score
- Temperature
- Blood Glucose Level (BGL) if appropriate
- Skin integrity
- Modified Aldrete score

- Unless specified in the post-operative surgical or anaesthetic orders, temperature, and blood pressure recordings do not need to be repeated at each observation interval unless the initial recording is outside the normal ranges within the age-appropriate Standard Paediatric Observation Chart (SPOC), or as clinically indicated. These observations should, however, be repeated prior to discharge to the ward.
    - Clinical indications for continuous blood pressure monitoring include patients who have:
        - a cardiac or renal history
        - an increased risk of post-operative bleeding
        - had a liver or renal biopsy
        - an epidural or regional infusion
        - has a cardiac procedure
        - blood pressure outside the age-appropriate range

- 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.
- SpO2 must be monitored continuously in PACU until discharge.
- Additional observations should be recorded when indicated in the postoperative orders, for example, neurovascular observations and neurological observations.
- Neurovascular observations are routinely commenced following CC, EPS, angiography, application of traction, application of a plaster or where a tourniquet has been applied during surgery e.g. orthopaedic surgery or hand surgery.
- BGLs should be measured routinely on all infants less than three months old, patients with diabetes or other endocrine issues, and those indicated by the anaesthetist. The BGLs should be checked on any lethargic or unwell infant or child, even in the absence of specific symptoms of hypo and hyperglycemia. If the level is outside normal limits, the anaesthetist or appropriate medical team should be notified.
- Observations that meet the Yellow or Red zone criteria on PowerChart BTF, will trigger a Yellow or Red zone pop-up alert.

- If a pop-up alert appears for a patient in the PACU following transfer from the Operating Room, select ONLY 'immediately' for re-alert.

> **NB**: If a child has any one (1) blue zone criterion present you must increase the frequency of observations as clinically appropriate.
> If a child has any one (1) or more yellow zone clinical review criteria present, you must escalate care as per local guideline.
> If a child has any one (1) red zone criterion present, escalate care as per local guideline.

- Observations must be checked on BTF prior to discharge to ensure they are age appropriate, and the patient will require review if not BTF or trending outside of flags.
- Altered calling criteria if required, must be attended by the Anaesthetist or Surgeon and documented in BTF and patient clinical notes.

Analgesia

- All patients must have a pain management plan in place prior to transfer to the ward.
- If analgesia has been given intra-operatively, this must be verbally handed over to the receiving ward nurse and recorded in the Anesthetic Record on electronic Medical Record (eMR).
- Analgesia given in the PACU, must be recorded in the Medication Administration Record (MAR), noted within the PACU nurses' report, and verbally handed over to the receiving ward nurse.
- IV opioid infusions, epidural and regional infusions are to be independently double checked and commenced by two registered nurses who have completed the Administration of an IV Opioid Clinical Skills Assessment (CSA) and Administration of epidural / regional analgesia CSA.
- IV opioid bolus analgesia must be independently double checked and given by two accredited Registered Nurses as ordered on the MAR by the Anaesthetist in accordance with the CHW PACU Pain Protocol.
- After receiving IV opioid patients must be monitored in PACU for a minimum of 30 mins before being transferred to the ward and 1 hour prior to being discharged home.
- Prior to discharge from PACU the effect of an opioid bolus must be assessed, patient observations and Aldrete score assessed and discharge criteria met.
- If pain remains unresolved following administration of analgesia, the anaesthetist should be notified to assess the patient.
- The checking and administration of analgesia should be as per Pain Management CHW Practice Guideline and Medication Administration Practice Guideline

Temperature Control

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

Wound and Drain Assessment

- All wound and puncture sites should be assessed on arrival to the PACU and at regular intervals and prior to discharge to observe for bleeding, haematoma and swelling.
- Any wounds with excessive ooze/bleeding should have their dressing reinforced and if appropriate, pressure applied, and the surgical team notified.
- Drains should be assessed for patency and positioned appropriately on the bed.
- 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

- IV lines are to be secured by applying either an arm splint, tape and/or Tubigrip to prevent accidental removal of the intravenous cannula- checking of pressure areas is required.
- IV fluid should be charted on the MAR by the anaesthetist & commenced as ordered before transfer to the ward.
- On commencement of IV fluids, orders are to be independently double checked and signed for by two accredited registered nurses on the MAR.
- IV lines must be labelled as per National standard for user-applied labelling of injectable medicines, fluids and lines.
- All IV fluids given should be recorded on the Fluid Balance Chart within 'Interactive view' on PowerChart.
- Infusion pumps and burettes are used on all patients requiring IV fluids.

- If a patient is to remain nil by mouth (NBM) postoperatively, this must be documented in the postoperative surgical orders and documented by the PACU nurse in the handover report.
- Unless otherwise indicated in the postoperative orders, clear fluids (lemonade, water, apple juice, and ice blocks) may be offered to the child once fully awake.
- Breast fed babies may recommence feeding and bottle-fed babies may be offered formula if verified by the anaesthetist or surgeon. For formula preparation see Infant Feeding: 0-12 Months Formula Feeding and Introduction of Solids Practice Guideline.
- All IV fluids and any input or output in PACU should be documented in the Fluid Balance Chart in the '*Interactive view and I&O'* see Intravenous Fluid and Electrolyte Therapy Practice Guideline.

Management of Post-Operative 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 (The Royal Children's Hospital Melbourne, 2023).
- 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 (The Royal Children's Hospital Melbourne, 2023)
- Management of PONV is per Pain Management Guideline (section 11.2.3).

Administration of Medication

- Administration of all medications must be in accordance with Medication Management and Handling – CHW policy and Aseptic Non-Touch Technique policy.

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 (Lerman, 2022).
- It can be common in paediatric patients depending on the anaesthetic agents used, and manifests as disorientation, hyperactivity, and hypersensitivity (Lerman, 2022).
- 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.

Escalation of Care and Emergency Situations

Escalation of care as per Between the Flags (BTF)-clinical emergency response system-SCHN and in accordance with local escalation procedures below:

- Escalation of care in hours (0800-1730):
  - Consultation with team leader
  - Contact the patient's treating Anesthetist 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 ext.: 52831 (or K Block Team Leader on: 0498 568 987) for assistance and extra staff.
  - Dial 2222 for the arrest team as per Cardiopulmonary Resuscitation and Equipment Practice Guidelines.
  - Any adverse patient incidents, escalation of care or altered calling criteria must be documented in the patient's notes on eMR, in SurgiNet clinical indicators, and if required the electronic Incident Management System (IMS).
  - Where possible a scribe sheet should be filled out during an emergency in any PACU area, to be kept with the patient's notes.

Parental Presence in the PACU

- Once awake and stable, a child should be reunited with their parents/carers as soon as possible.
- Only two parents/carers are permitted in the PACU at one time. The number of parents/carers may be restricted if the clinical situation or other conditions require this for safety or other reasons.
- Care of the patient in the PACU should be family centered, ensuring parents/carers are informed of their child's condition and treatment and, where possible, involved in their care.
- Interchanging of family members in the PACU is discouraged due to patient privacy and the acuity of other patients within the unit.
- Children under the age of 10 are not permitted to visit within the PACU due to the high acuity of the area. An exemption may be made after hours at the PACU nurses' discretion.

PACU Length of Stay

- The length of stay of a patient in the PACU is determined by the patient's condition and procedure.
- For discharge from PACU, patients require:
    - a modified Aldrete score of 8
    - effective analgesia
    - 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.
- Procedures requiring a minimum stay of one hour include but are not limited to:
    - Procedures involving the airway (example: Tonsillectomy, LaryngoscopyBronchoscopy, Oesophagoscopy)
    - CC and
    - Angiograms Liver Biopsy

Electro-Physiology Studies (EPS) and Cardiac Catheterisation (CC) Discharge from PACU

- Patients who meet specific criteria set by their Cardiologist and Anaesthetist, can be discharged home from Todman Recovery the day of their EPS or CC procedure.
- Patients undergoing MoC will have regular 1:1 recovery for 1 hour stay, with their observations and nursing ratios reducing (if clinically appropriate) during their duration in recovery.
- These patients require a medical review prior to discharge. All patients being discharged home from any PACU area must meet discharge criteria, and nurses must follow regular discharge home procedures as per Care of the Patient in Middleton Day Surgery- CHW Practice Guideline.

Refer to: Appendix 1 'EPS and CC Day of surgery discharge' for specific discharge instructions and criteria.

Ear, Nose and Throat (ENT) extended stay in PACU

- Patients who meet a specific criteria, set by their Surgical team and Anaesthetist, can be cared for in Todman Recovery for an extended period of time, prior to transfer to a general ward- in lieu of admission to Close Observation Unit or Intensive Care Unit.
- The period the patient should stay must be indicated by either the patients treating Surgical or Anaesthetic team.
- 1:1 nursing should be provided throughout the entirety of the patients' stay in PACU.
- Patients must meet criteria for ward transfer or have an altered calling criteria prior to being discharged to the ward.
- Patients must be reviewed by the medical team prior to discharge to the ward, unless otherwise states by Anaesthetics.

Documentation

- All observations are to be recorded on the PACU Band in 'Interactive View' on PowerChart.
- Observations recorded in PACU Band will auto record in BTF.
- A Perioperative Record – Recovery Nurses' Report must also be completed for each patient in eMR.

- The Recovery Nurses' Report should be a continuous account of the child's condition and any significant events, from the time of admission until discharge from the PACU.
- SurgiNet documentation as per Perioperative Nurses SurgiNet and Intraoperative documentation – CHW, for completion in the PACU includes:

  The following mandatory segments in SurgiNet must be completed;
  Case Times – PACU

- In PACU: Time patient enters PACU
- Discharge from PACU: Time patient is discharged from PACU

  PACU Location

- Select from Todman, Middleton, MRI recoveries or K Block PACU.
  Case Attendance-PACU

- Nurse/s directly delivering patient care
- Role performed (primary, secondary and relief nurse)

  Other fields include:

  - Ready for parent
  - Ready for discharge
    A delay reason and duration of delay in minutes shall be documented if a patient's discharge out of recovery is delayed. Delay reasons are to be selected from the drop-down list in SurgiNet (Segment – delays).
  - If a second stage discharge is required, PACU II shall be added (Segment – PACU II).
  - If patient care is to be handed over to another Registered Nurse, the Registered Nurse taking over must be recorded in 'case attendance' and the Primary nurse must enter their out time.

Discharge to the Ward

- The ward Team Leader should be notified when the patient is ready for discharge from the PACU and if there is any medical management plan that is in place.
- Any delays should be communicated to the PACU Team leader and as necessary the Operating Suite Floor Manager.
- The PACU nurse should ensure that the patient is clean and comfortable prior to discharge to the ward; for example, soiled clothing and bed linen are to be changed.
- The ward should be informed that the patient is ready to be discharged from PACU and a response from the ward must be communicated prior to the patient being transferred.

- Where possible if there is a delay in transferring a patient (for example due to clinical incidents) the ward should be informed.

Transfer from the PACU to the Ward

- Patients are to be escorted to the ward by the PACU Nurse and should be transferred in their bed/cot whenever possible, with the side rails up.
- When a young child is very distressed and refusing to lie down, it may be safer for the parent/carer to carry the child to the ward; this is at the discretion of the Recovery Nurse and parent/carer.
- The nurse should escort the patient from the head of the bed. This enables ongoing observations and access to the child, i.e. if the child vomits.
- An Operating Assistant should assist with the transfer to the ward. A nurse should not escort a child upon a bed without assistance of an Operating Assistant or another nurse.

Handover to Ward Staff

- On arrival in the ward, the PACU 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
    - Drains in situ and drainage
    - 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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Appendix 1: CC and EPS Day of procedure discharge

	Cardiac Cath		EPS
Observations	Normal PACU observations for 1 hour (include NV obs & continuous ECG monitoring) Half-hourly for 2 hours Hourly for 2 hours 2nd hourly thereafter		
Lying Flat	Venous access – 4 hours Arterial access - 6 hours Affected limb to be kept straight		
Dressing	Small safeguard holds 7mls (1ml/hour removed) Large safeguard holds 40mls (5-10ml/hour removed) Remove safeguard dressing and Sterri-strips Clean site with 0.1% chlorhexidine (blue) Apply new Sterri-strips in a crisscross shape *Note: air does not have to be completely removed to take off safeguard (if nil/scant bleeding)* Advise families to remove the Steristrips day 2 post procedure *Note: day of procedure is day 0 not day 1*		Leave existing dressing on and advise families to remove the Steristrips day 2 post procedure *Note: day of procedure is day 0 not day 1*
Recovery Length of Stay	Venous access – 4 hours Arterial access - 6 hours		
Standard pre-Discharge Tests	**Non-intervention/ diagnostic Cath** **Interventional Cath/ biopsy** **ASD + VSD device closure**	Nil required ECHO (technician 52145) ECHO (technician 52145) + 12 Lead ECG	12 Lead ECG (Before 5pm technician-52145) After 5pm recovery 12 lead ECG to be printed and reviewed by cardiology
Post procedure info for staff	See Cardiac Catheter report for specific post op recommendations		See EPS report for specific post op recommendations
Pre-Discharge Review	Patient must be reviewed by cardiologist/ cardiology Fellow or Registrar prior to discharge		
Discharge Medications	See post Cath report Aspirin may be prescribed Antibiotics may be prescribed for infective endocarditis prophylaxis Discharge script may be required		See post EPS report. Aspirin may be prescribed Occasionally, patient may be started (or re-started) on an anti-arrhythmic medication on discharge. Discharge script may be required.
Post-op appointment	Follow up appointments made prior to procedure – check with family to ensure follow up has been arranged (contact cardiology if not made)		