Bradford Teaching Hospitals NHS
NHS Foundation Trust

Post Anaesthetic Recovery

Authors: Lesley Hawthorne - Elaine Appleby

Approved by: CGCG 23.8.11
Minor changes only 5.3.13 - 3.6.14 – 12.5.16

Review date: 12.5.18
25/06/2018 reviewed by Debbie Horner - currently safe.
Extended for 6 months. Under review

Version: 10

Introduction

The Association of Anaesthetists of Great Britain and Ireland (September 2002) & The Obstetric Anaesthetists Association (May 2005) published recommendations regarding the standard care during the immediate post anaesthetic recovery period.

This guideline is based upon these recommendations

Guidelines are for all post-operative women on Labour ward (DS) who have had a general or regional anaesthetic. Life threatening complications can occur during this period, a regional anaesthetic should not cause complacency in the level of monitoring or care.

Equipment available

Post anaesthetic care units (PACU) are equipped with monitoring equipment for the measurement of non-invasive blood pressure and access to resuscitation equipment. Patient controlled analgesia equipment and infusion devices for post-operative pain relief are also available.

All rooms including PACU have;

- oxygen,
- suction,
- entonox equipment.

Additional equipment is available for;

- monitoring ECG,
- oxygen saturation, non-invasive BP monitor (electronic)
- invasive haemodynamic monitoring if required.

Pulse oximeter
Tympanic thermometer
pH machine
Crash trolley
Forced air warming device
Fluid warmer
Nerve stimulator
Capnography can be performed in PACU and Room 5 (high dependency). The monitoring lines are stored in Room 5.
Labour Ward rooms and PACU have active scavenging of inhalational analgesics to comply with COSHH guidelines on anaesthetic pollution.

This is monitored through COSHH risk assessments.

Criteria for Transfer to PACU

Before transfer, the anaesthetist should be satisfied that the recovery staff are competent and able to take responsibility for the patient. If this cannot be assured, the anaesthetist should stay with the woman, until she is fit to return to the ward.

All women after general, epidural or spinal anaesthetic remain in the theatre under direct supervision of the anaesthetist and operating department practitioner (ODP) until the woman has airway control, cardiorespiratory stability and can communicate. Women with a High spinal must have muscular power and a good grip in their hands.

Women are then transferred to a specially designated area PACU immediately adjacent to the theatre. Following a GA, women should be transferred to PACU on a bed with side rails

The anaesthetist verbally hands over the care of the woman to the appropriately trained member of staff with all the relevant information/documentation i.e. type of surgery, type of anaesthetic any intra-operative complications, prescription sheet, clinical notes. IV fluid chart

Observation of Women in PACU

- All women must be observed on a one to one basis, by an appropriately trained member of staff.
- All women should be kept under direct clinical observation for at least thirty minutes after any anaesthetic.
- Observations are recorded on the perioperative care plan/perioperative record every 5 minutes for 30 minutes followed by two episodes of ¼ hourly observations. Record MEWS on admission to PACU then record ½ hourly for two hours. Women can be transferred to the ward before completing 2hrs of MEWS as long as they have met the discharge criteria below. If they remain on labour ward after 2hrs, record MEWS hourly until transfer to the ward
- . Observations include
- Conscious level
- Saturated peripheral oxygen
- Oxygen administration
- Respiratory rate
- Blood pressure
- Pain score
- Heart rate

Temperature should also be recorded on admission to PACU then 1/2hrly. Ward transfer should not take place until the woman's temperature is 36.5^{0}C or above**.** If the temperature falls below 36.0^{o}C they should be warmed using a forced air warming device.

- Accurate record keeping of the woman's progress is essential. The perioperative care plan should have clear concise information recorded and must be signed by the recovery midwife / nurse responsible for that woman.
- Type and volume of intravenous fluids should be recorded and urine output measured if appropriate.
- Lochia, fundal height, wound dressing should be observed.
- Pain should be assessed () if analgesia is inadequate it should be dealt with promptly. Refer to anaesthetist if any concerns.

Criteria for discharge from PACU

The woman's transfer is dependent on their condition and varies with each individual.

Assessment is made by the appropriately trained recovery midwife / nurse. If the criteria are not achieved the patient should remain in the recovery room and the anaesthetist informed.

The midwife/nurse should report to the labour ward coordinator if she has any concerns regarding the woman's recovery.

All midwives have direct access to a consultant if they have concerns about the woman's condition.

1. The woman should be conscious, orientated and with normal protective reflexes.
2. The basic observations of temperature pulse and blood pressure should be within acceptable parameters with respiratory function providing good oxygenation.
3. It should be ensured that the wound site and drains are not bleeding persistently or excessively and that lochia is not excessive.
4. Pain and emesis should be controlled and suitable analgesic and anti-emetic regimes prescribed.
5. Oxygen and intravenous therapy, if appropriate should be prescribed on the drug chart.
6. Skin will have been observed for any sensitivity / reactions.

When the woman has met the above criteria, the MEWS Score is 1 or less, they may return to the ward environment. MEWS is continued on the ward 4 hourly for 24hrs then frequency according to MEWS guideline. Any special equipment required such as bariatric equipment, intravenous pumps etc. must be in place before transfer takes place.

Handing over to ward staff

- Women should be transferred to the ward by a suitably trained member of staff and porter.
- The full clinical details should be relayed to the ward midwife highlighting any problems / complications that have occurred.
- The verbal handover and allergy box on the perioperative care plan/perioperative record must be completed and signed.
- All women who have received regional analgesia, anaesthesia, or general anaesthetic are reviewed following delivery – a continual anaesthetic audit is in place.

Care of mother in first 24 hours after delivery

- Initial postoperative care should take place in PACU (see above)
- Record Mews every four hours Please refer to postnatal care guidelines
- Women who are feeling well and have no complications can eat and drink as soon as they wish.
- Remove wound dressing after 24hours. Keep wound clean and dry
- The patient should be seen and checked by a doctor prior to discharge home and discussion should take place re the indication for the caesarean section and the implications of her delivery for future pregnancies. There are very few indications for repeat LSCS in women who have had 1 LSCS. Where there is any doubt about this please liaise with her consultant or (in their absence) the Labour ward consultant.
- Bladder Care. The urethral catheter is usually removed l 12 hours after delivery. 6 hours if enhanced recovery. See post-operative instructions .Please follow **see bladder care after delivery guideline**

See MEWS algorithm / Outreach Service
Outreach service available Mon to Fri 0:800 to 17:30
Mobile #6775

All midwives/ staff nurse working on Labour ward attend Skills Days on a yearly basis training will include
Basic airway management/respiratory depression/ airway obstruction

- Mews training
- Basic life support
- Obstetric haemorrhage

An anaesthetist is always available on the Labour ward who can be called at any time for advice or if complications arise

See High dependency guideline

See Transfer guideline.

Author
Appleby / Hawthorne (2009)

References:

1. Recommendations for standards of monitoring during anaesthesia and recovery 4th ed. (March 2007). AAGBI
2. OAA / AAGBI Guidelines for obstetric anaesthetic services Rev. Ed 2005.
3. Caesarean section: Summary of effects and procedural aspects (April 2004). NICE
4. Immediate post anaesthetic recovery (Sept 2002). AAGBI
5. Confidential enquiry into maternal and child health. (2004). The sixth report of confidential enquiries into maternal deaths in the UK
6. The inadvertent perioperative hypothermia (IPH) guideline. April 2008). NICE / R