University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR POST ANAESTHETIC CARE IN THE OPERATING DEPARTMENT (RECOVERY ROOM)

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Contact for Review	Nigel Roberts
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Policy Content

POST ANAESTHETIC CARE IN THE OPERATING DEPARTMENT

(RECOVERY ROOM)

1. Introduction

This document is a Policy for hospital staff working within the Recovery unit at Derby Teaching Hospitals NHS Foundation Trust.

The recovery room exists to provide a place of safety for patients recovering from general, regional and local anaesthetic.

With the anaesthetist and surgeon the recovery practitioner will plan the patient's immediate and continuing care needs, organising pain relief, physical and psychological support and assessment of all surgical and physiological considerations in the recovering patient.

2. Purpose and Outcomes

The purpose of this policy is to outline the care of patients who have undergone a surgical procedure under general, regional, local anaesthesia or sedation. All patients are at risk of compromise to airway, breathing and circulation. Once suitably recovered and having met the discharge criteria, patients can be safely discharged to a general ward in a stable condition.

All standards and recommendations described in this policy should be applied to all areas where patients recover from anaesthesia; these areas include Surgical, Orthopaedic, Gynaecology, Obstetric and Paediatric Theatres and DCUs.

3. Definitions Used

RECOVERY: The Recovery Room

DCU: Day Case Unit

Day Surgery: the patient must be admitted and discharged on the same day, with day surgery as the intended management

Recovery Practitioner: either Registered Nurse or Registered Operating Department Practitioner (ODP).

4. Key Responsibilities/Duties

All clinical staff that provide post-anaesthetic care within Royal Derby Hospital are responsible for ensuring that these guidelines are adhered to and are accountable for the decision making process involved. Those with

additional responsibilities are the Theatre Managers, Lead Practitioners, Senior Theatre Practitioners who co-ordinate to operational activity within theatres.

5. Policy

The patient will be admitted into the recovery room and received by a registered practitioner.

The recovery room will ideally have a warm, quiet and professional environment.

5.1 Admission into the recovery room

A comprehensive hand over will be provided to the recovery room practitioner receiving the patient.

Anaesthetist and Scrub/ responsible practitioner who is familiar with the patient must handover to the recovery staff with SBAR 1

An anaesthetist will handover the patient:

S – Situation

- Patient name
- Anaesthetic record, drug prescription and fluid record chart
- Communicate the anaesthetic technique, including the intraoperative analgesia, antiemetic and fluid management

B – Background

- Communicate a summary about the patient, including any drug allergies and provide relevant medical history, e.g. diabetic status
- Patient observations e.g. BP, temperature

A - Assessment

- Anaesthetic care including intra-operative problems
- Intra-operative input/output balance especially blood loss and its replacement

R - Recommendations

- Communicate post-operative instructions using the recovery handover chart on the back of the anaesthetic chart in conjunction with the recovery practitioner paying particular attention to:
    - Recovery plan:

- Immediate postoperative orders
- Potential problems/complications
- Analgesia, antiemetic, oxygen therapy, fluids prescribed and cannula care
- The need for ECG, blood sugar tests and/ or x-ray for example

The recovery chart must be signed by the anaesthetist and recovery practitioner confirming thorough handover.

The anaesthetists must not leave the theatre complex until the patient has a stable airway with no airway adjuncts and must not leave the hospital until the patient is fully stable and ready for discharge. Alternatively anaesthetic handover is provided to an on-call anaesthetist.

A Scrub/ Responsible Practitioner will handover and sign the Electronic Care Plan:

S – Situation

- Patient name
- Surgical team/ theatre
- Operation/ procedure details and variances
- Details of any local anaesthetics given by the surgeon
- Closure
- Packs
- Dressings/ casts
- Location and types of drains
- Provide catheter PU details

B – Background

- Allergies
- Issues in theatres/
- IR1s

A – Assessment

- Estimated blood loss
- Peri-operative progress e.g. position & total time of procedure, grafts

- Skin check result and/ or areas of concern
- Surgical specific care required from surgeon and concerns discussed at WHO ‘sign out’

R – Recommendations

- For on-going care

The scrub/ responsible practitioner and recovery practitioner must sign the peri-operative care pathway for validity and handover.

Post op note from Surgeon must be seen by the recovery practitioner

Delivery of patient care during the recovery phase of anaesthesia is managed and achieved by:

Practitioners who are trained and proficient in the recovery of patients following anaesthesia.

- The safe use of equipment, checked daily.
- Adequate supply of equipment for airway management, breathing and circulation compromise, including resuscitation equipment.
- Sufficient staffing levels to allow each unconscious patient to have one-one care.
- Staff able to recognise complications during recovery and be competent to take the appropriate action. This may involve consultation or assistance from anaesthetist or surgeon.
- Clear documentation of airway, breathing, cardiovascular and fluid balance observations.
- An anaesthetist must be available at all times when patients are in Recovery Room.
- A member of the surgical operating team should be contactable while the patient is in recovery room.
- Adequate supplies of respiratory stimulants, opiate antagonists and neuromuscular reversal agents.

Following handover the recovery practitioner will perform a full A-E assessment this includes;

- Airway
- Breathing
- Circulation
- Disability

- Exposure

5.2 Airway and Breathing

- Assessment of the patient's airway including patency and respiratory rate is performed immediately following admission into the recovery room

- Where necessary basic and advance manoeuvres will be used to ensure that patients health is not harmed by airway or respiratory compromise. This may involve consultation or assistance from an anaesthetist (or occasionally a surgeon).

- Oxygen therapy, pulse oximetry available for all patients in the recovery room. Capnography is used for all unconscious and or intubated patients.

- The recovery practitioner will ensure the patient achieves adequate airway protection, adequate oxygenation and adequate ventilation prior to discharge from recovery room.

- There will be adequate supplies of opiate antagonists, neuromuscular reversal agents and respiratory stimulants.

5.3 Guidelines for the Administration of Oxygen in recovery room

- LMA – oxygen administered via a T-piece at 6L/min with capnography. Oxygen administered as per prescription of the anaesthetist following removal of LMA.

- Post ETT removal in theatre, oxygen will routinely be administered.

- Extended administration of oxygen into the postoperative period after discharge from recovery room must prescribed by anaesthetist.

<u>For example</u>

  - long acting or on-going planned opiate administration post-operatively
  - epidural analgesia post-operatively
  - co-morbidities requiring oxygen administration into the postoperative period

It must be prescribed on EPMA (Protocol section) and nasal speculae should be preferentially used.

- Facemasks for oxygen administration will be available for use in recovery room if specifically requested by the anaesthetist.

5.4 Circulation

- Cardiovascular status is assessed after arrival in recovery room, once airway patency, safety and adequate breathing is confirmed.

- Equipment to enable non-invasive blood pressure, heart rate, continuous ECG and invasive pressure monitoring.

- Blood pressure and heart rate is measured at a minimum of 5 minute intervals until the patient has suitable met the discharge criteria.

- Where appropriate, monitoring of peripheral vascular condition may be required (e.g. Peripheral pulses, capillary return and distal temperature for patients following vascular surgery and for orthopaedic patients following application of casts or fracture surgery).

- In some cases more advanced cardiovascular monitoring such as invasive measurement of arterial and central venous pressures may be required.

- Only appropriately trained practitioners will attend these patients. Patients requiring this monitoring may require more than one practitioner to look after them.

- Abnormalities in cardiovascular status, hydration, urine output or surgical drainage will be referred through the appropriate anaesthetic or surgical channels. This will be addressed before the patient leaves recovery room.

- The patient must have a stable cardiovascular system (within their normal values) before discharge from recovery room.

- Fluid replacement and drugs to treat cardiovascular compromise are available in recovery room.

- Resuscitation equipment including a Defibrillator are available for the use on either a Paediatric or an Adult patient. Availability of emergency drugs, and all resuscitation management is sourced from the 'Resuscitation trolley' both the adult and Paediatric trolleys are located in the Recovery Room.

- All practitioners must be adequately trained to assist in resuscitation if required.

5.5 Temperature Maintenance

- The environmental temperature will be maintained at a comfortable level for the patients.

- Patients' temperature is measured using an appropriate thermometer site and thermometer.

- Hypothermic patients will be warmed passively or with external warming (e.g. force air warmer).

- Intravenous fluids will be warmed using a fluid warmer.

- Hyperthermic patients who require treatment will be identified. These patients will be given antipyretics (paracetamol) and passive or active external cooling applied.

- Management of hypothermic and hyperthermic patients may involve consultation with an anaesthetist or surgeon.

- The patients' normal body temperature should be maintained, or kept within acceptable safe/comfort levels prior to discharge from the recovery room.

- Equipment will be available to allow fluid warming and active external warming.

- Practitioners are trained in use of all equipment.

- Post-operative temperature must be recorded the recovery chart.

5.6 Minimum Observations

All patients' to have continual pulse, SPO2, BP and ECG every 5 mins until meets discharge criteria.

Once ready for discharge monitor and record as per Patientrack protocol.

5.7 Pain Relief

- Pain is a routine observation for post- surgical patients and will be identified and treated promptly.

- All 'Core' recovery practitioners are trained and able to assess and treat acute pain.

- Staffs are educated in the methods used to minimize other physical discomforts which may exacerbate pain.

- The pain assessment tools and information regarding the prescription and pain management of Paediatrics and Adult Post–operative patients are available within the Trust clinical guidelines.

- Practitioners will aim to administer analgesia appropriate to the patient's requirements and general condition.

- Prescriptions are accessed using the computer EPMA online prescription chart.

- The effects of analgesic interventions will be monitored to detect effectiveness of pain relief and complication of pain relief.

- Efficacy of pain relief is recorded. Adverse effects will be recorded and reported to the anaesthetist.

- The aim is for the patient to experience no more than mild / bearable pain

- Failure to achieve expected or adequate pain relief may require consultation with and assistance from an anaesthetist or surgeon.

- The patient may be discharged from the recovery room no less than 20 minutes after administration of an intravenous opiate bolus. This allows 15 minutes for the peak effect of the opiate to have elapsed, which will ensure appropriate time to assess efficacy and side effects of the drug administration.

- Medication will be administered in accordance with the prescribing of drugs/treatment and administration of drugs policies.

- Analgesia required including advanced techniques (such as the use of epidural opiates) will be handed over to the ward nurse when the patient is discharged. Epidural infusion should be connected by the anaesthetist.

- Training will be given to staff in management of pain, intravenous administration of drugs and specialised equipment for the relief of pain, e.g. PCA or Epidural administered as per trust policy (CG-PM/2011/013).

5.8 Post-Operative Nausea and Vomiting (PONV)

- Nausea and vomiting after surgery and anaesthesia (PONV) can be frequent and multifactorial.

- It is a routine observation for post-surgical patients and is identified, recorded and treated promptly.

- Practitioners are trained to assess and treat PONV.

- Practitioners are educated in the methods used to minimise other physical discomforts which may exacerbate PONV.

- Practitioners will aim to administer anti emetics appropriate to the patient's requirements, general condition and surgery as per trust PONV policy (CG-T/2014/095)

- The effects of antiemetic interventions are monitored to detect effectiveness and complications.

- Effects of anti-emetics are monitored. Adverse effects are recorded and reported to the anaesthetist.

- Failure to achieve expected or adequate anti-emesis may require consultation with an anaesthetist.

- The aim is to prevent or reduce nausea and vomiting post operatively.

- Infection control policy should be followed when handling body fluids and disposing of them.

- Regular oral hygiene should be given.

- The patient should not be discharged from the recovery room until PONV is effectively controlled.

5.9 Preventing Infection

- Gloves are worn when handling all body fluids and removing IV cannulas.

- Staff will be aware of the trust infection control policy and adhere to its recommended practice.

- Patient trolleys, equipment, shelves and cupboards will be cleaned regularly between patients, daily and weekly according to the department cleaning schedule and documented for audit purpose.

- Items designed for single use will be used once and disposed of.

- Appropriate high standard care will be given to all patients in order to reduce the risk of infection.

- Appropriate observations are carried out to detect signs of local and/or generalised infection.

- Strict aseptic care of catheters, tubes, drains, venous lines and wounds will be maintained.

- Existing infection will be treated where this is required and management will minimise the risk of acquiring any preventable infection as a result of being in hospital.

- Necessary steps will be taken to avoid or minimize risk of cross-infection between patients.

- All staff must adhere to hospital and unit infection control guidelines.

- Follow infection control protocol for identified infected patients admitted into Recovery Room.

All the above patients may be recovered in recovery, with the exception of those with open pulmonary tuberculosis, or influenza, these must be recovered in theatre.

Wherever possible a single recovery practitioner should be allocated the patient to recover. Good hand hygiene practices should be adhered to.

5.10 Wound Management

- The aim is to promote uncomplicated healing. This will include a clean, dry wound with no obvious signs of complication. Stomas should be well perfused.

- Aseptic technique will be used for wound dressings.

- When dealing with body fluids nursing staff will adhere to Infection Control Policy.

- Wound and drain inspection will be undertaken to detect complications. If detected; these will be reported to the appropriate person.

- Medication or dressings will be given or applied as prescribed and in accordance with the hospital policy.

5.11 Elimination

- The aim is for the patient to have no deterioration in bladder or bowel function in line with post-operative expectations.

- Observations of bladder, bowel/stoma function will be made and recorded. Any identified or suspected malfunction or concerns will be referred appropriately.

- Management of elimination should ensure privacy and dignity at all times.

- Toileting devices should be readily available.

- Strict aseptic technique will be used during bladder catheterisation.

- Hourly urine measurements will be made for appropriate patients.

5.12 Hygiene

- The aim is for the patient to be clean and comfortable and who has no effects because of lack of hygiene facilities.

- Eyes and mouth care should be carried out according to policy.

- The patients care should be planned to meet their individual needs and privacy and dignity must be maintained.

5.13 Pressure area care

- The aim is for the patient to be comfortable with healthy intact skin.

- Every patient admitted to recovery room will have their pressure sore risk assessed and a plan of action formulated on admission.

- The patient's skin condition will be observed for signs of redness or broken areas. These will be recorded and actively managed where necessary. This may require consultation with or assistance from a surgeon.

- Patients with nerve blocks are at increased risk of pressure sores and should be monitored particularly carefully.

- Patient mobilisation and turning will be used as appropriate.

- Pressure area care and any sores present will be managed in an aseptic manner using research proven techniques.

- The nursing staff will ensure pressure areas are checked regularly and use assistive devices as necessary. Pressure area care should be recorded within the patient's theatre care pathway and any concerns provided on handover.

5.14 Moving and handling

- The correct and most appropriate bed for the patient should be chosen by the theatre team before admission into the recovery room.

- All beds were possible, should be a profile bed with remote controls to ease positioning of the patient.

- At the time of admission into the recovery room the patients' bed from the ward is not available; the site coordinator should be informed to ensure an alternative bed is available to prevent unnecessary prolonged care on a theatre trolley.

- Particular care should be given to those patients following regional anaesthesia. Attention should be made to the positioning of the patients limbs to ensure adequate space is available at the end of the bed or trolley. The patient's arms should be protected from pumps or drip stands.

- If required any wet linen must be removed and clean linen replaced. Movement of any patient should be carried out in accordance with the hospitals safe moving and handling policy.

- Cot side bumpers are available and should be used for any patient who is restless during the post-operative phase of care.

5.15 Discharge Criteria

Record and document NEWS score when patient ready for discharge.

If Score 5 or above Patient to be reviewed by anaesthetist prior to discharge and a plan of on-going care documented.

Minimum criteria for discharge of patients from the post-anaesthetic care unit include:

- The patient is fully conscious, able to maintain a clear airway and has protective airway reflexes

- SpO2 is greater than 94%

- Oxygen therapy is prescribed as appropriate

- The patient's rate and depth of respiration and their oxygen saturation must be within the parameters set by the anaesthetist for each individual patient

- The patient is alert and orientated when awake

- The patient is haemodynamically stable. If any observations are outside of the patients normal pre-operative range then the anaesthetist must be informed and any appropriate measures to address the problem must be taken, i.e. prescription of IV fluids

- If catheterised, the patients urine output is 1ml/kg over 2 hours

- Pain and post-operative nausea and vomiting are adequately controlled and continuing treatment must be prescribed.

- The patient's temperature is within acceptable limits (above 36.0 degrees Celsius)

- IV fluids, anti-emetics and analgesia are prescribed as appropriate

- There is no excessive blood / fluid loss from wounds or drains

- Patients receiving intra operative cell salvaged blood from theatre, must be transfused prior to discharge

- All documentation must be completed in full before discharging the patient to the ward area. These documents include, Theatre Care Pathway, N.E.W.S chart, CSM chart, Pain management documentation, IV fluid prescription chart, and Blood Transfusion chart.

Patients, who do not meet these criteria but have received an anaesthetic review deeming them suitable for discharge, must have this annotated in the patients' notes. This should include a suitable second stage recovery plan.

5.16 Useful guidance for duration of stay in recovery room

All patients must fulfil criteria for discharge, times based on full patient assessment and clinical judgement:

- Local Anaesthetic (may return to the ward from theatre)
  - 1 set of observations and return to ward.

- Simple short operations under sedation.
  - Once the patient is fully conscious; a minimum stay of 15 minutes.

- Simple short operations under general anaesthesia (30 minutes or less)
  - Once the patient is fully conscious and maintaining their own airway; a minimum stay of 20 minutes.

- Medium duration operations (30 minutes to 2 hours)
  - Once the patient is fully conscious and maintaining their own airway; a minimum stay of 40 minutes.

- Operations exceeding 2 hours

- This must be confirmed by the individual anaesthetist as this may vary.
- Once the patient is fully conscious and maintaining their own airway; a minimum stay of 50 minutes

Should the patient:

- Receive a first dose of antibiotics Commence a transfusion of a blood product
  - Discharge should be delayed for at least 15 minutes

Should the patient:

- Receive a dose of IV pain relief, other than a self-administered PCA
- Receive a bolus dose via an epidural catheter
  - Discharge should be delayed for a minimum of 20 minutes

Should the patient:

- Be Type IV or I Latex allergy
  - Anaphylactic reactions to latex occur 20-60 minutes after exposure. Therefore, patients should remain in the recovery area for a minimum of 1 hour

5.17 Handover to the Ward and SBAR2

• The patient should be informed of their transfer to the ward.

• The ward nurse in charge should be telephoned to request a suitably qualified practitioner to collect the patient.

• The ward practitioner should collect the patient within 20 minutes of the telephone call.

• Any delays expected from the ward should be made clear by the nurse in charge during the conversation.

• Escalation policy followed delays longer than an hour and/or if there are unresolved issues regarding discharge.

• The patient's documentation should be ready to be handed to the escorting practitioner.

• The ward practitioner will be given a full handover of the patient's condition and any appropriate post-operative instructions.

• To facilitate handover between the recovery practitioners and ward practitioner the SBAR2 should be used.

• Time data and the recovery record should be completed on the electronic care record.

• Recovery staff must be certain that the ward practitioner understands the patient's condition and is willing and competent to accept responsibility for the patients care. The recovery practitioner must ensure that full clinical details are relayed to the ward practitioner with the emphasis on complications, medical devices and infusion checklist.

The ward practitioner must sign for the handover on the anaesthetic/ recovery chart

SBAR2 face to face handover to ward/ ITU staff

S- Situation

- Patient identity
- Medical History
- Allergies
- Procedure performed- time on table (pressure areas)

B- Background

- Type of anaesthesia
- Anaesthesia complications
- Intra-op medications
- IV fluids administration
- Dressings, drains, packs, etc. including visual inspection
- Local Anaesthetic
- Catheter (output/ irrigation)
- Complications and interventions
- POP/ splint check
- CSM observations
- Elevation
- Positioning/ limb support

A- Assessment

- O2 requirement
- Review of haemodynamic stability
- Pain/ PONV
- Medications administered

- Temperature
- Medical devices
- Skin check
- NEWS completed

R- Recommendations

- Post-operative instruction
- Monitoring/ range for physiological variables
- Analgesia plan
- Plan for IV fluids, antibiotics, medication, DVT prophylaxis etc.

5.18 Ventilated and Critically ill Patients

Patients requiring assisted ventilation should wherever possible be transferred to ITU.

NOTE: In exceptional circumstances when ITU bed is not available, it may be necessary to use the recovery room as an overflow to ITU or for the stabilisation of patients prior to transfer. The anaesthetic consultant in charge to liaise with ITU to provide medical and nursing cover. Only in an emergency situation should a patient be ventilated in the recovery room. During this time it must be recognised that the primary responsibility for the patient lies with the consultant anaesthetist. This is a temporary solution and plans to free capacity in ITU must be addressed as a matter of urgency. These patients are recorded on the electronic care plans

• When a patient is receiving prolonged HDU or ITU care in recovery room this may require reduction or cessation of operating in some or all Theatres.

• When a patient is receiving ITU care in recovery room an appropriately senior anaesthetist must be immediately contactable.

• Should a patient require ITU/HDU unexpectedly, then theatre/recovery staff should inform ITU and the Bed Manager immediately. Critical care outreach team can be contacted for additional assistance if necessary.

5.19 Paediatric Patients (excluding paediatric theatre)

A child's needs are met in the recovery room by understanding their fundamental differences in psychology, anatomy and physiology to adults. This is supported by a warm, decorated bay with sufficient room for visiting relatives.

The bay is equipped with a paediatric airway management trolley including;

- Range of paediatric face masks
- Breathing circuits
- Range of airway adjuncts

Patient monitor has set parameters for paediatric patients. Essential monitoring includes a full range of;

- Non-invasive blood pressure cuffs
- Small sized pulse oximeter probes
- ECG
- Capnography

A paediatric trolley fully equipped for the management of paediatric anaesthesia and patient stabilisation is within close proximity of the paediatric recovery bay.

The emergency paediatric resuscitation trolley is situated within the recovery room if required.

Paediatric patients can be more restless and disorientated compared to adult patients. Continuous One to One supervision is required and cot bumpers are available for use to avoid child injury.

Paediatric patients in pain can be difficult to assess, especially if they are particularly young and unable to communicate. Protocols for pain management in children are available. If they are under 16 years, the anaesthetist will administer pain relief. All efforts should be made to comfort the child and contact the ward. If the patient is otherwise suitable for discharge, the family can be requested to visit the recovery room to comfort their relative whilst attempts are made to manage pain.

Before discharge from the recovery room all intravenous cannula must be flushed and documented. Where possible both a ward nurse and relative should escort the child on return.

Paediatric PCA (CG-PM/2011/013) and Epidural infusions (PA EP 02) prescribed and contacted by an anaesthetist as per protocol

5.20 Obstetric Patients

See Obstetric Anaesthesia- Recovery- Clinical Guideline (PN/11:15/R5)

5.21 Day Surgery Patients

Day surgery patients either undergo both surgery and recovery in the day surgery unit, or undergo surgery and stage 1 recovery in main theatres, followed by stage 2 recovery on the day surgery ward.

Stage 1 recovery for day surgery patients is equivalent to the recovery care inpatient surgical patients undergo in recovery room.

AMBULATORY RECOVERY ROOMS

- Within the ambulatory recovery rooms, there are a sub-section of skilled staff identified as 'core RECOVERY staff'. At least one of the core team will be present at all times in the recovery room. All core members of staff are trained and up to date in HLS and PHLS.

- All new staff who work in ambulatory recovery rooms should have completed the core recovery package.

Stage 1 Recovery for all ambulatory patients

- The care of day surgery patients in recovery rooms will be documented in the day surgery care pathway.

Unexpected ward Admissions from Ambulatory Care

- If a patient deviates from the day surgery criteria and is deemed unfit for same-day discharge whilst in recovery room, the practitioner must ensure that:

    - The relevant surgical team are aware
    - The inpatient bed manager is aware and is allocating an inpatient bed
    - The patient has been informed of the reasons and arrangements have been made to contact the nominated carer
    - The reasons are documented clearly in the care pathway
    - The unplanned admission section of the care pathway recovery record is filled in
    - The Ambulatory ward staff are informed and will document in the ward admissions book

Arrangements should be made to divert the patient directly from recovery room to a bed on the inpatient ward however if a bed is not yet available then it may be necessary to temporarily continue to care for the patient in the Ambulatory ward area.

This decision should only be taken bearing in mind the level of care required for example the suitability of remaining on a DCU trolley.

5.22 End of life

Refer to Trust policy- Care of the Dying Patient and Bereavement Policy

5.23 Interpreters and Patient Carers

Staff may require access to interpreters to facilitate communication with non - English speaking patients or patients who use sign language to communicate.

A patient may request a relative to provide additional support and comfort during the post anaesthetic phase. The suitability of this request would be at the discretion of the recovery practitioner and Anaesthetist. Protection of other patient's confidentiality and dignity must always be considered.

5.24 Recovery Staff

Recovery staff are either registered general nurses (RGN) or Operating Department Practitioners (ODP) who are trained and have undertaken competencies in post-anaesthetic care.

Staff new to recovery will not work independently until they have been assessed by an experienced member of the Recovery team and will remain supervised until their training is complete and their competencies signed off.

6. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

Monitoring Requirement :	Theatre Assurance
Monitoring Method:	QuAD Audit
Report Prepared by:	Role title
Monitoring Report presented to:	Safer Surgery Meetings
Frequency of Report	Quarterly

7. References

Source of data	Date of publication/issue	Detail of requirement

AAGBI Day Case and Short Stay Surgery Guidelines	2011	
AAGBI Immediate Post-Anaesthesia	2013	
British Anaesthetic and Recovery Nurses Association [BARNA] Standards of Practice	2012	
DHFT Abbey Pain Scale – Chart	CG-PM/2011/013	
DHFT ANTT Policy	2016	
DHFT Continuous Morphine Infusion - Clinical Guidelines	CG-PM/2011/006	
DHFT Epidural: Post-Operative Use - Paediatric Full Clinical Guideline	IP/06:16E4	
DHFT Epidural - Obstetric - Clinical Guidelines	CG-PM/2012/009	
DHFT Epidural - Non-Obstetric - Clinical Guidelines	PA MO 01	
DHFT Hand Hygiene Policy	2016	
DHFT Infection Control Policy	2017	
DHFT Intravenous Sedation - Trust Policy	ANAES/2016/005	
DHFT Standard Operational Procedure for the Management of the Latex Sensitive Patient in Theatre	Pending	
DHFT Lidocaine Infusion - Clinical Guidelines	PAIN/2015/001	
DHFT Local Safety Standards for Invasive Procedures (LocSSIPs)	2017	
DHFT Morphine Infusion: Post-operative Use -	PAGI01/Jan17/v004	

Paediatric Clinical Guideline		
DGFT Morphine - Intravenous Bolus - Clinical Guideline	CG-PM/2014/014	
DHFT Morphine / Pethidine - Subcutaneous - Clinical Guideline	CG-PM/2011/004	
DHFT Pain - Assessment and management - Paediatric Clinical Guideline	PA PCA 01	
DHFT Patient Controlled Analgesia (PCA) - Paediatric Clinical Guidelines	CG-PM/2011/013	
DHFT Patient Controlled Analgesia (PCA)	CG-PM/2011/013	
DHFT Theatre Policy	2017	
NHS England National Safety Standards for Invasive Procedures (NatSSIPs)	2015	
Royal Marsden Post Anaesthetic Care in the Operating Department- PACU Policy from Harrogate and District NHS Foundation Trust	2015	
Royal Marsden Handover in PACU [online]	2016	
Royal Marsden Safe Management of patients in PACU [online]	2016	

8. Appendices

Appendix- Patient Journey through the operating theatre

Appendix

Patient Journey through the Operating Theatre