One + all | we care

NHS
Royal Cornwall Hospitals
NHS Trust

Post Anaesthetic Practice Standards Clinical Guideline

V3.1

February 2021

Table of Contents

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

1. Aim/Purpose of this Guideline

1.1. Please note that this is one of 4 documents that make up the theatre standards, namely:

1.1.1. Generic Theatre Practice Standards Clinical Guideline

1.1.2. Scrub Practice Standards Clinical Guideline

1.1.3. Anaesthetic Services Practice Standards Clinical Guideline

1.1.4. Post Anaesthetic Practice Standards Clinical Guideline

1.2. All healthcare professionals have a duty to set a standard by which to practice. With a focus on clinical effectiveness and evidence-based care theatre staff must be able to demonstrate the ability to audit care and theatre practice. The care that is delivered and improvements in practice must be based on evidence and best practice guidance.

1.3. The aim of this policy is to outline the standards of care that must be delivered to each individual patient to ensure a high quality of care is provided to patients entering all Trust Operating Theatres.

1.4. Objectives

- To ensure that a standard of care is delivered to each individual that is equitable and fair.
- To identify the standards of care to be delivered to patients through all the areas within the operating theatres i.e. anaesthetic room, Operating Theatres and the Post Anaesthetic Care Unit.
- To enable auditing of theatre practice and patient care throughout all areas.
- To ensure all staff are aware of standards of care to be delivered to patients whilst in the Operating Department.
- To provide information to all staff of the departments expectation of the standards of care to be delivered to all patients.

1.5. These standards of care will apply to all Operating Theatres across Royal Cornwall Hospital Trust sites.

1.6. All new members of staff will receive an electronic copy of the standards applicable to the area they will work in. All staff will be able to access the care standards via desktops in operating departments

1.7. This version supersedes any previous versions of this document.

2. The Guidance

2.1. *PACU Standard No 1 - Transfer of patients from the operating theatre to the post anaesthetic care unit (PACU)*

2.1.1. Standard Statement

Staff will ensure the safety and dignity of the patient during the transfer from theatre to PACU post operatively, and ensure full handover takes place.

2.1.2. Method

2.1.2.1. Patient handover from theatre to the Post-Anaesthetic Care Unit/ Recovery area:

- Before transfer, the anaesthetist should be satisfied that the PACU/recovery area staff are competent and able to take responsibility for the patient.
- The patient should be physiologically stable on departure from the operating theatre, and the anaesthetist must decide on the extent of monitoring during transfer.
- Recovery practitioners must be competent in assessing the patient's condition including: vital signs, intermediate life support, intravenous medicines administration, assessment of homeostasis, patient-controlled analgesia, epidural anaesthesia, sedation and the effective management of pain.
- An appropriate qualified member of the perioperative team should escort the patient with the anaesthetist.
- The patients' anaesthetist should retain overall responsibility for the patient during the recovery period and should be readily available for consultation until the patient is able to maintain their own airway, has regained respiratory and cardiovascular stability, unless this care has been handed over to another named anaesthetist or intensivist.
- Theatre staff will assist in the application of the oxygen delivery system and full monitoring as required
- The anaesthetic assistant will handover any relevant information concerning the patient to the Designated PACU staff member

2.1.2.2. Anaesthetist Handover to PACU Staff

- Patient's name, date of birth, and theatre they are being transferred from.
- The ward the patient is scheduled to return to.
- Planned and actual procedure(s) performed, with site and side if relevant, and surgical course.
- The type of anaesthesia used, or combination of anaesthesia such as general anaesthetic, regional block, analgesia, anti-emetics.

- The duration of anaesthetic, if appropriate.
- Details of any local infiltration to the wound, including local anaesthetic agent, strength and dose administered.
- Release times for analgesic filtration devices.
- Release times for autologous blood collection devices (in particular where local anaesthetic infiltration has also occurred).
- Post-operative plan of care for rectus sheath catheter boluses.
- Site and type of local block, drug used and total amount used, time of administration and anticipated duration of action, inspection of the insertion site.
- Patency of intravenous access
- Intraoperative temperature and any warming devices used
- Postoperative oxygen requirements in percentage and litre values and mode of delivery and assigned cardiovascular parameters.
- Patient prescription documents (EPMA) - appropriate analgesia/ anti-emetics/ oxygen prescribed.
- Any allergies
- Intravenous fluid documents (if appropriate) and ongoing fluid management plan.
- Intravenous pain relief given.
- Whether there is a need for an interpreter, carer or parent to assist in patient care and the arrangements that are in place for contacting such individuals. Ideally this should be organised prior to the patient entering PACU.
- Whether the patient has any personal items such as dentures, spectacles or hearing aids that must accompany the patient on transfer.
- Any item of clothing that may have been removed, and details of whether the patient was told in advance that this would happen.
- Relevant medical history (e.g. the presence of a pacemaker).
- Any communication difficulties (e.g. hearing loss, or partially sighted).
- Care plans e.g. urinary catheter, cannula, CVP etc.
- Any other information that is specific to the patient.
- Any specific security needs, such as a patient who is serving a custodial sentence.
- Release times for analgesic filtration devices.

The formal checklist on the back of the anaesthetic chart should be appropriately utilised by the anaesthetist to document assigned observation parameters, and specific requests for patient destination such as extended stay/HDU care/ ward.

2.1.2.3. In addition, the scrub practitioner should handover:-

- Type of dressing, wound closure and drain (including the method used to secure and position).
- Blood loss
- Presence of stoma / urinary catheter.
- Skin condition and integrity or pressure areas.
- Position of diathermy plate, if relevant
- The scrub practitioner should handover any relevant information regarding the surgical procedure etc. to the PACU practitioner, any property to the patient should also be transferred to PACU
- All relevant documentation should accompany the patient and should be completed
- Other relevant patient care details such as pressure are problems, known skin breaches or adverse reactions must be recorded in the peri-operative document and handed over to PACU for communication to the ward staff
- The theatre staff will sign the perioperative document on completion of handover

AAGBI 2013, RCOA 2019

2.2. *PACU Standard No 2 - Post-Anaesthetic Recovery Care of the Adult Patient in the Post Anaesthetic Recovery Unit.*

2.2.1. Standard Statement

2.2.1.1. After general, epidural or spinal anaesthesia, all patients should be recovered in a specially designated area (PACU) that complies with the standards set out in the AAGBI 2013 'Immediate post-anaesthesia recovery' guidelines.

2.2.1.2. Staff will ensure the safety and dignity of the patient during the post anaesthetic care phase and ensure full handover to ward area takes place.

- The PACU is a specialist clinical area – therefore recovery practitioners must possess the competencies to provide safe and effective care without direct supervision. The practitioner must understand the implications of the surgery the patient has undergone and the complications which can be expected. When critically ill patients are managed in the recovery unit, the primary responsibility for the patient lies with the critical care team e.g. the anaesthetist for that patient, or ITU anaesthetist. The standard of nursing and medical care should be equal to that within the critical care unit.
- Recovery practitioners must be competent in advanced airway management and in managing a patient with a

laryngeal mask airway insitu. The removal of the endotracheal tube is the responsibility of the anaesthetist. The anaesthetist can delegate removal of an endotracheal tube to a non-medical recovery practitioner who has received validated training for the task and is deemed competent to perform the duty. Training and assessment of competence must be documented.

- No fewer than two PACU trained registered staff should be present in the recovery unit when there is a patient who does not fulfil the criteria for discharge,

(AAGBI 2013)

2.2.2. Preparation of the Recovery Unit

Everything must be checked, prepared and ready before the patient arrives in the unit. At the beginning of each shift check that:

- The adult and paediatric crash trolley, the defibrillator and line trolley has been checked
- Patient observation charts are availableto include NEWS, and neurological observation chart and any appropriate care plan.
- Sharps and rubbish containers are available
- All drug cupboards are restocked together with IV and irrigation fluids
- Emergency drugs checked and readily available
- Good supply of pillows, blankets and linen available together with warm touch heater and blankets, and a supply of incontinence pads
    - Ensure all ceiling lights are working
    - Ensure recovery unit has been cleaned and damp dusted
    - Check refrigerator and record temperature
    - Check anaesthetic machine (if applicable)
    - Ensure portable oxygen cylinders are available with adequate oxygen
    - Check patient transfer bag and portable suction
    - Check availability of PCA, epidural and IV pumps
    - Ensure controlled drugs are checked on a twice daily basis
    - BM boxes checked daily
    - Haemacue checked daily

2.2.3. Each recovery space should have:

- Waters circuit- working and with a mask available and a selection of face masks of various sizes available
- Cardiac monitors are working together with leads and appropriate blood pressure cuffs and probes- all within service date.
- Oxygen flow meters- checked, working and within service date.
- Suction is working, within service date and fitted with tubing and yanker – suction catheters available with gloves
- Disposable items are available including a selection of airways,

laryngeal connectors ('T' pieces), vomit bowls, cannula bungs, gauze, cotton wool, syringes and sticky tape

- Various sizes of unsterile rubber gloves are available
- Alarm bells are working and understood by all staff
    - Each bay restocked with appropriate hygiene materials such as tissues, patient wipes, incontinence sheets.

(AAGBI 2015, AAGBI 2013, BARNA 2012)

2.2.4. Monitoring the patient

- Patients must be kept under clinical observations at all times and vital signs recorded. The frequency of observations will depend on the stage of recovery, nature of surgery and clinical condition of the patient. The Association of Anaesthetists of Great Britain and Ireland (AAGBI, 2013) recommend the recording of:
    - Level of consciousness
    - Haemoglobin oxygen saturation and oxygen administration
    - Blood pressure
    - Respiratory rate
    - Heart rate and rhythm
    - Pain intensity at rest and on movement
    - Fluid balance
    - Medicines administered
    - Temperature, urinary output, central venous pressure, end tidal CO2, surgical drainage – depending on circumstance
- Each patient must be assessed on admission and re-assessed as necessary following ABC protocol **(See Appendix 3)**; assessment must include using pressure sore risk calculator and National Early Warning System (NEWS) score. Patients with lower limb fractures to follow specific pressure ulcer prevention policy (RCHT 2012).
- Naloxone injection to reverse over sedation and opioid-induced respiratory depression should be available in all locations where diamorphine and morphine are stored.
- Patients must not be returned to the ward until emesis and post-operative pain is optimally managed and the patient is comfortable. There should be a simple pain assessment tool incorporating a numerical (eg: 0-10) or descriptive (mild, moderate, severe) scale.

2.2.5. Post-anaesthetic care of the paediatric patient

Children have special needs reflecting fundamental psychological, anatomical and physiological differences from adults. These needs are best met by having a designated, separate paediatric recovery area that is child-friendly and staffed by nurses trained in the recovery of babies, children and young people.' (AAGBI, 2013)

- Children will be recovered in a segregated PACU/recovery area with provision for parents to join them in the unit when appropriate.
- There should be available a full range of face masks, breathing systems, airways, nasal sponges and tracheal tubes. Monitoring

equipment should include a full range of non-invasive blood pressure cuffs and small pulse oximeters.

- There should be access to the advice of a paediatric nurse.
- Paediatric postoperative pain should be managed effectively using pain assessment tools.
- Staff should be familiar with the relevant safeguarding procedures.

2.2.6. Additional care of the "unwell" patient in PACU

- When patients are unwell in recovery and the original operating list remains ongoing, the operating surgeon and anaesthetist must be informed. Where they are unable to send a deputy, the on call registrar should be called.
- The theatre coordinator should be informed at the earliest opportunity and should assess the current status of all lists to facilitate rapid return to theatre and appropriate deployment of staff and equipment if required.
- Where patients are unwell in recovery and the list has finished (inside or outside normal operating hours) the on call registrar should be contacted. They should prioritise the patients' needs alongside other emergencies and will be responsible for informing the consultant if required.
- The responsible consultant / operating surgeon should be informed but may not be able to attend.
- Out of hours the on call registrar for general surgery is the first point of contact for unwell vascular, GI, Colorectal, breast, gynaecological and urology patients.
- Liaise with the surgical scrub practitioner in charge who will be able to assist in contacting the on-call consultant appropriate for the patients requirements
- The nurse in charge of the recovery area should assist in co-ordinating the response to a patient requiring multidisciplinary team involvement.

2.3. *PACU Standard No 3 - Maintenance of airway in the unconscious / semiconscious / conscious patient.*

2.3.1. Standards Statement:

On admission each patient in PACU will have their airway, respiratory rate and oxygen saturation level monitored until the patient is able to safely maintain their own airway without intervention.

2.3.2. Method

- Head tilt, chin lift and jaw thrust
- Oropharyngeal airway (Guedal airway).
- Laryngeal mask airway. (LMA)
- Nasopharyngeal airway.

Compliance 100% Exceptions: None

2.3.3. Interventions

- Look for chest and abdominal movement. Listen and feel for air flow at the mouth and nose.
- Monitor saturation's. Monitor respiratory rate, depth and rhythm.
- Administer oxygen.
- Recognise airway obstruction- see appendix 3 (airway)
- If required suck out mouth and pharynx. Yanker sucker.
- Take care not to pull the LMA past the teeth, this may cause damage.
- Check to see no residual secretion remains in the oral cavity.
- Place the oxygen mask onto the patients face.

(Resuscitation Council UK 2020)

2.4. *PACU Standard No 4 - Monitor the breathing of the postoperative patient.*

2.4.1. Standard statement

On admission into PACU all patients will be monitored with a pulse oximeter and will have an O2 saturation reading of > 96% with or without oxygen, with a normal respiratory rate and pattern.

2.4.2. Method

- Place oximeter on patients finger on admission into PACU.
- Count respiratory rate on admission into PACU.
- Note the rhythm of patients respiration's on admission into PACU.
- Listen to the patient's breath sounds as soon as a problem is identified.

Compliance 100%
Exceptions: Known underlying disease process.

2.4.3. Interventions

- Administer oxygen as required by the patient's condition.
- Use suction catheter if required to remove excess secretions.
- Watch airway and chest movement.
- Look for signs of cyanosis and hypoxia.
- Listen to the patient's chest.
- Record respiratory rate and rhythm.
- Encourage your patient to cough and expectorate.
- Position your patient in an upright position to help their breathing.
- Call for help if needed. Consider whether related to neuromuscular blockades or opiates.
- Administer medications as per prescription (EPMA) chart.

(Resuscitation Council UK 2020)

2.5. *PACU Standard No 5 - Cardiovascular System.*

2.5.1. Standard statement

2.5.1.1. All patients will be monitored according to their individual requirement. They will have their cardiovascular status maintained by appropriate measures.

2.5.1.2. Patients should have an adequate stock of cross matched blood and blood products according to their individual needs prior to being admitted for surgery.

2.5.1.3. Patients will be cardiovascularly stable when discharged to the ward.

2.5.2. Method

- All staff will have training in the equipment currently used.
- Staff will have an increasing understanding of the patients post-operative conditions.
- Staff able to recognise any abnormality in patient's condition.
- Depending on procedure performed check that there are cross matched units of blood for the patient available if required.
- Vital signs are measured according to the patients individual need and as their condition dictates.
- Ensure the correct blood pressure cuff size is used. The bladder size should be 40 – 50% of the upper arm circumference. The bladder length should encircle 80% of the arm.
- If arrhythmias are detected the doctor should be informed and the patient treated accordingly.
- 12 lead electrocardiograph should be taken in the event of chest pain or arrhythmias to detect serious ECG changes.
- Aseptic technique used at all times when changing or removing intravenous lines.
- Hypotension (systolic BP <90 OR mean arterial BP <60) needs to be recognized and treated promptly to avoid organ dysfunction, and organ failure.
- Monitor for evidence of functioning organs (e.g. urine output >0.5ml/kg/hr)
- Heart rate is within acceptable range

Oxford Handbook of Critical Care Nursing 2nd Ed 2016

2.6. *PACU Standard No 6 – Invasive monitoring*

2.6.1. Standard statement

2.6.1.1. Those patients who require continuous monitoring will have their vital signs invasively monitored until they are discharged to the Intensive Therapy Unit to continue their High Dependency Care

or until they are fully recovered and able to return to a ward. Staff monitoring HDU patients will work within agreed criteria set out by the anaesthetist. Whilst a high dependency patient is cared for in recovery, ultimate responsibility of care should fall under the hospital critical care team (AAGBI 2013) The patient will suffer no ill effects from being invasively monitored.

2.6.1.2. The use of transduced arterial monitoring is essential for:

- Unstable patients
- Patients on vasoactive infusions
- Patients who require frequent arterial blood sampling
- Patients for whom therapeutic decisions require an accurate blood pressure measurement

2.6.1.3. However, individual patients monitoring requirements will be at the discretion of the anaesthetist.

2.6.2. Method

- All staff will have training and competency assessment in the use of invasive monitoring.
- An awareness of the possible complications of being invasively monitored will be understood by all staff.
- Equipment is regularly checked and maintained.

Compliance 100%
Exceptions None

2.6.3. Interventions

- Prepare the patient for the insertion or removal of the monitoring equipment.
- Ensure that the arterial line is secure and correctly zeroed.
- If requested or clinically indicated the Central Venous Catheter is x-rayed if new, and that the x-ray is checked prior to use.
- Keep arm with arterial line visible to ensure continuous observation.

(Oxford Handbook of Critical Care Nursing 2nd Ed 2016, AAGBI 2015, AAGBI 2013)

2.7. *PACU Standard No 7 - Fluid Balance*

2.7.1. Standard statement

The patient in PACU will have an accurate record of their fluid balance and adequate fluids prescribed for their discharge to the ward. The patient should be neither dehydrated nor overloaded with fluid. Urine output should in the average adult be a minimum of 0.5 ml/kg/h. The patient will not experience any deterioration of their kidney function.

2.7.2. Method

- All IV fluids will be recorded when set up on the fluid balance sheet.
- Oral intake will be monitored and recorded.
- NG output will be monitored and recorded.
- Urine output will be measured either hourly or four hourly as the patient's condition dictates.
- Staff will have training to ensure they understand the signs and symptoms of fluid overload and dehydration.
- All output from indwelling drains will be measured and monitored.
- The fluid balance sheet must be maintained to show a running total of fluid balance for the patient.

Compliance 100%
Exceptions None

2.7.3. Interventions

- Check urinary catheter is draining and not blocked.
- Label any drains for ease of reference. Ensure they are not clamped.
- Follow procedure for cell trans drain and document appropriately.
- Check patency of all IV cannula on a regular basis and record on care plan
- Remove IV cannula if it is not patent or looks infected.
- Check all IV infusion lines are patent and intact.
- Label all IV infusion lines. Fluid being infused and date.
- Follow hospital policy for the infusion of blood and blood products.
- Adhere to an aseptic technique at all times.

(RCHT Fluid Balance for Adult In-patients Clinical Guideline)

2.8. *PACU Standard No 8 - Pain Control*

2.8.1. Standard statement

The patient will have effective pain relief which will be continuously monitored and evaluated in the recovery area .A patient should experience no more than moderate pain and no ill effects of analgesia can be observed.

2.8.2. Method

- Pain assessment and documentation should be regarded as the fifth vital sign.
- The RCHT pain assessment tools and guidance should be used:
  - Guidelines for the assessment and documentation of pain (adults)
  - Guidance on the assessment and documentation of pain in children
  - Guidance for the assessment and management of pain in dementia
- Pain intensity must be assessed and recorded on the patient's care

plan on admission, and on discharge from recovery. Pain intensity on discharge must be at a level acceptable to the patient

- Patients should participate in the assessment process wherever possible.
- Non-verbal clues (facial expression, upper limb movements, and tolerance of intubation); physiological signs (blood pressure, heart rate) should also form part of the assessment.
- The recovery practitioner must be aware of the cultural differences in pain behaviours while remaining sensitive to the individual needs of the patient and their family.
- The recovery practitioner must act as the patients advocate if they feel the patient needs that support.
- Staff must be competent in undertaking therapeutic analgesic interventions by a number of routes including intravenous, rectal and subcutaneous. All PACU staff should be specifically trained in the management of patients with PCA's epidurals, spinal, peripheral nerve blockade and rectus sheath catheter top up administration.
- Diversional therapy should be employed to assist in pain management where the recovery practitioner thinks necessary (i.e. change of position or tactile reassurance). Guided imagery and music can be useful to reduce pain intensity.
- Patients experiencing pain must be afforded some privacy and dignity when receiving treatment.
- There must be a referral process to the pain team for follow-up if appropriate.
- At hand-over of care, pain assessment and the effectiveness of interventions must be a principal point in the process.

  (Nursing Times 2015)

- All documentation must be complete in accordance with the perioperative documentation policy, with a signed hand-over to the receiving nurse indicating a complete transfer of care. This includes the 'Pain Team' documentation if appropriate.
- Infusion devices for epidural infusion must be easily distinguishable from those used for intravenous (PCA use) and other therapies.
- Pharmacy prepared infusions should be used to minimise variations in prescribing practice and reduce the risk of confusion.
- Pain management related infusion-giving sets and epidural catheters should be clearly identified.

The following guidelines can guide the practitioner in pain management of simple and complex patients:

- Guidelines for Peri and post-operative Pain Control for Complex Patients
- Clinical Guidelines for use of Ketamine as an adjunct analgesic for use by anaesthetist only
- Intravenous Opioids for adults in Recovery Areas –"The Recovery Protocol"

- Clinical Guidelines For Drug Doses In Obesity
- Analgesic Advice for Ward Doctors

2.8.3. Patient Controlled Analgesia (PCA)

The following RCHT guidelines can be accessed in the document library and should be used as reference for patient controlled analgesia (Adult/ Child).

- RCHT Acute Post-operative Patient Controlled analgesia guideline
- RCHT Patient Controlled Analgesia [PCA] Adult Clinical Guideline
- RCHT Patient Controlled Analgesia/ Intravenous Opiate infusion in Child Health Clinical Guideline
- RCHT Paediatric Analgesia Guideline
- The checking and administration procedure for Patient Controlled Analgesia must be undertaken by a registered and competent recovery practitioner. The second recovery practitioner provides an independent check to confirm the identity of the drug(s), strength, dose to be administered, the expiry dates and the patient identity and allergies / sensitivities.
- A record must be kept of the identity of the infusion device and patient details. The infusion devices must be checked before each use. Faulty devices must be reported to the medical physics department. The identity number of the faulty device must be recorded, and the device decontaminated, labelled as faulty and taken out of use.
- The infusion devices must be cleaned after each use.
- Naloxone injection to reverse over sedation and opioid induced respiratory depression must be available be available in all locations where and diamorphine and morphine are stored.
- All records must be contemporaneous and complete (PCA chart, vital signs chart, prescription sheet, fluid balance, pain team sheet and care documentation).

2.8.4. Epidural Administration: management of equipment and assessment of patients

The following guidance can be found in RCHT document library and should be used for reference when caring for patients with epidural infusions.

- RCHT Epidural Insertion Guidelines
- RCHT Clinical Guideline for the Care of Epidural Infusions (adult)
- RCHT Clinical Guideline for Acute Postoperative Adult Analgesic-Neuroaxial Blockade
- RCHT Clinical Guideline for Management of Leg Weakness with Epidural Analgesia
- Staff caring for patients receiving epidural analgesia must have

received specific education and training and be deemed competent. Staff must attend update sessions at least once every three years.

- A record must be kept of the identity of the infusion device and patient details. This must be placed on the PACU documentation and electronically e.g. EPMA
- The infusion devices must be checked before each use. Faulty devices must be reported to the medical physics department. The identity number of the faulty device must be recorded and the device decontaminated, labelled as faulty and taken out of use.
- The infusion devices must be cleaned after each use and a green “I am clean” label applied.
- Preparation of the pump and the prescribed analgesia regime must be undertaken by a registered and competent practitioner.
- All observations must be performed regularly and recorded on the observation chart, according to local policy. Pressure areas, especially heels, must be observed in all patients receiving epidural analgesia.
- Patients with fractures below the waist must follow the appropriate care pathway. Monitoring of the level of sensory and motor block is essential.
- An increasing degree of motor weakness requires immediate review by an anaesthetist. Observations must be continued and recorded for at least 24 hours after attempted epidural insertion or epidural catheter removal to aid early detection of epidural haematoma formation.
- The infusion rate, volume delivered and route of administration must be checked regularly and recorded, as well as being checked against the prescription.
- Emergency drugs must be readily available including Naloxone and Ephedrine.
- Trouble shooting guidelines are available in the local epidural policy.
- Any change in the patient’s condition must be recorded contemporaneously and reported where necessary.
- The Pain Team audit form must be filled in as this acts as a referral for next day review by the Pain team.

2.8.5. Continuous peripheral nerve blockade: Management of equipment and assessment of patients

Staff caring for patients receiving peripheral regional analgesia must have received education and training and be deemed competent.

- Ensure staff order and maintain sufficient supplies of analgesic drugs, and also keep accurate records of administration.
- Staff aware of the details on protocols sheet.
- Pain and sedation scoring of patients having sophisticated pain control techniques.
- Systems for regular maintenance and repair of syringe driver pumps.

- Training for new staff in the use of epidural and intra-venous opiates infusions.
- Staff trained to assess, monitor and evaluate the effects of pain relief.
- Regular updating of staff and encouragement to participate in pain relief research.
- Staff trained to recognise side effects when administering specialised pain control and able to take appropriate action.

Compliance 100%
Exceptions None **Interventions**

(RCHT Continuous Local Anaesthetic Infusions for Post-Operative Pain Relief)

2.9. *PACU Standard No 9 - Administration of medications to patients in PACU.*

2.9.1. Standard statement:

2.9.1.1. On admission into PACU all patients will have a current medication chart, (EPMA) with appropriate medications to better control their post-operative symptoms.

2.9.1.2. The correct administration of medications will be carried out by the practitioner in charge of their care, a designated nurse/ODP or a nurse/ODP in further training under direct supervision of the practitioner in charge of that patients care.

2.9.1.3. The administration of symptom controlling medication will take place in a timely manner.

2.9.2. Method

- Give medication according to the symptom and medication chart (EPMA).
- Check name bands, medication chart, anaesthetic chart, prescription, route and drug dose.

Compliance 100%
Exceptions Drug incompatibilities, known patient allergies and if the drug was previously administered to the patient.

The following guidance is available on RCHT document library:
RCHT Injectable Medicine Policy
RCHT Medicines Policy
RCHT Intravenous Opioids for adults in Recovery Areas –"The Recovery Protocol"

2.9.3. Interventions

- Assess the patients pain score, and if the patient is suffering from nausea.
- Critical medications should be administered in a timely manner, and delays or omissions should be considered serious and avoided where possible. For full list of 'critical medicines' see the RCHT Delayed and Omitted Doses of Medicines Procedure
- Follow the recovery protocol for intravenous opioids when managing analgesia
- Choose from the medication chart (EPMA) an appropriate drug and route to control the patients symptom/s.
- Controlled drugs are administered in line with relevant legislation and organisational policies
- Look at the anaesthetic chart for any premedication already given.
- Check for patient allergies and always monitor for drug related reactions.
- Note drug incompatibilities, whenever possible, administer drugs separately.
- Sign the chart when the drug has been given, not before.
- Explain to the patient what you intend to give and why.
- Assess the patients respiration rate and blood pressure, before, during and after the administration of opiate drugs.
- If you are unsure during any stage of the procedure, seek advice.

(Royal Pharmaceutical Society 2019)

2.10. *PACU Standard No 10 – Communication*

2.10.1. Standard statement

Patients and their relatives / carers will receive clear, accurate and relevant information whilst in PACU. They should feel free to seek advice and express their needs and feelings.

2.10.2. Method

- All staff will be proficient in communication skills and receive training as appropriate.
- Escalation of care should be communicated in a SBARD method as per trust policy
- All staff will ensure they are friendly and approachable at all times.
- Communication with all patients will commence on admission into PACU, regardless of conscious level.
- Orientate patient to time and place
- Be sensitive and adept to reading non-verbal communication.
- PACU staff will gather information from theatre handover and patient documentation to ascertain the patients preferred name, communication abilities and needs (e.g. Sight, hearing, comprehension, verbal abilities, special needs etc.)
- All bed areas will have an accessible, working emergency call bell.
- Lights will be dimmed at night and noise kept to a minimum at night.
- Ensure main carer is known to all staff and where appropriate, involved with decisions affecting patients' care.

- Patients understanding of new information will be verified
- All staff to be aware of patient's need for privacy for communication where possible.
- All documentation should be clear, accurate and complete, whether hand – written (in black pen) or computerised and signed by the appropriate staff.

Compliance 100%
Exceptions None

2.10.3. Interventions

- Ensure up to date liaison between all health care staff.
- All relatives and carer's will be prepared for entering the recovery environment, both psychologically and with regard to their and others safety.
- Patient will have anxieties dealt with by reassurance, information, with access to relatives or specialist staff as needed.
- Nurses may give specific counselling as they feel able or ensure patients are referred to the appropriate services.
- Specific communication needs will be addressed quickly by appropriate means (e.g. Hearing aid, spectacles, carer's involvement etc.)

(Nursing Times 2017, ACT Academy 2018)

2.11. PACU Standard No 11 - Privacy and Dignity.

2.11.1. Standard statement

2.11.1.1. All patients when admitted into PACU will have their privacy maintained, they will be treated with dignity by all staff members at all times regardless of their race, gender or medical condition.

2.11.1.2. The patient will know who their nurse is as soon as they are conscious and able to understand where they are.

2.11.2. Method

- Introduce yourself to the patient when the appropriate time arises.
- Ensure that all medical notes are kept with the patient in a folder.
- Receive patient handover from other members of the MDT.
- Always consider the patients feelings when interventions of a personal nature are required.
- Try to announce your arrival to a private bed space.

Compliance 100% Exceptions None

2.11.3. Interventions

- Introduce yourself, tell the patient where they are and reassure them.
- Speak to the patient in a clear voice with respect and understanding.
- Be sympathetic of the patients medical condition and how it affects them.

- Staff must respect a person's personal preferences, lifestyle and care choices
- Reasonable efforts should be made to ensure discussions about care are not overheard
- Always explain any procedure to the patient before you act.
- Never expose the patient unnecessarily.
- Always answer any questions honestly.
- Keep the patient informed of your intentions.

(Roper.N., Logan.W. and Tierney.A).
(CQC *Health and Social Care Act 2008)*

2.12. PACU Standard No 12 – Elimination

2.12.1. Standard statement

All patients in PACU will have their toilet needs met with prompt and appropriate methods of elimination. They will be treated with dignity and be given privacy to conduct their toilet needs. They will be offered the appropriate assistance in order to achieve a satisfactory outcome without deterioration or complications post operatively.

2.12.2. Method

- Ask the patient if they need to use the toilet.
- Adequate toileting devices are available.

Compliance 100%
Exceptions None

2.12.3. Interventions

- Observation of bladder, bowel / stoma function.
- Obtain consent for all interventions
- Ensure privacy and dignity for the patient at all times.
- Ensure toilet devices are available.
- Ensure the infection control policy is adhered to when dealing with waste products.
- Note any abnormalities in appearance of urine or stool, report to doctor if concerned.
- Note volume and quantity. Record appropriately on fluid chart.
- Ensure an aseptic technique is used when catheterising or dealing with an indwelling catheter.
- Hourly urine measurements if appropriate.

(The Royal Marsden NHS Trust Manual of clinical Nursing Procedures 9th edition)

2.13. PACU Standard No 13 - Post operative nausea and vomiting.

2.13.1. Standard statement

To prevent or reduce post-operative nausea and vomiting. For patients in PACU to remain comfortable and free from post-operative nausea and vomiting. For patients to remain safe from the effects of nausea and vomiting

2.13.2. Method

- Patients should be managed by the pre-op fasting policy- RCHT Fasting for Adults (including Young Adults 16+ years) who require Anaesthesia or Intravenous Sedation Clinical Guideline V5.0
- There should not be excessive starvation time.
- Patients at risk of PONV should be identified in the preoperative period
- Patients at high risk of PONV should receive anti-emetic prophylactic
- Patients suffering nausea and vomiting should be afforded privacy and dignity.
- Tissues, and face wash should be provided for the patients suffering PONV.
- Drug therapy should be administered for persistent or symptomatic PONV).
- A fan can be provided to agitate air for a cooling breeze.
- Mouthwash can be provided for hygiene and comfort (AfPP 2011).
- Any vomiting must be recorded on the fluid balance chart.
- If a nasogastric tube is in situ, any aspirate from this must be recorded. Aspiration via suction can be performed where necessary.
- Reassurance should be given to the patient.
- Patients must not be returned to the ward until emesis and post-operative pain is optimally managed and the patient is comfortable.

Compliance 100%
Exceptions None

2.13.3. Interventions

- Continued education for all staff in the management of post-operative nausea and vomiting.
- Staff will use gloves and aprons when dealing with body fluids.
- All staff will be able to pass a NG tube safely and demonstrate its patency.
- Follow the RCHT ‘Post-Operative Nausea and Vomiting Clinical Guideline’ for algorithm to manage with anti-emetic medications.
- The patient will if allowed sit up to avoid aspiration and to promote orientation.
- Strict fluid balance will be adhered to, ensuring dehydration does not occur.
- Inform the anaesthetist if unable to manage post-operative nausea and vomiting with standard methods.

2.14. PACU Standard No 14 – Hygiene

2.14.1. Standard statement

Patients in PACU will have their hygiene needs met promptly when identified, or at a time which is clinically convenient. For patients to feel clean and comfortable.

2.14.2. Method

- Wash patients' skin with warm water and soap in the order of face, neck, arms, chest, stomach, legs, feet and intimate areas.
- Avoid wetting any drains, dressing or intravenous devices and perform catheter care if necessary.
- Provide clean linen and allow the patient to choose what clothing they would like, providing a clean gown if necessary.
- Offer mouth care to patients and assist male patients with shaving if required.
- Give eye care wherever appropriate.
- Assist patient into desired position either in the bed or chair if available.

Compliance 100%
Exceptions None

2.14.3. Interventions

- Be aware of the patient's medical condition.
- Be aware of the patient's temperature.
- Assess individual patient risk for PPE equipment and undertake appropriate hand hygiene.
- Gain consent and ensure that the patient understands the intervention.
- Provide privacy and dignity throughout.
- Encourage the patient be as independent as possible.
- Ensure the safe disposal of soiled laundry; keep the linen skip near the bed throughout.
- During intervention assess patients skin throughout for evidence of damage.
- Offer the patient appropriate analgesia if required, and observe for any signs of pain during procedure such as grimacing.

(Lawson S, Shepard E 2019)
(The Royal Marsden NHS Foundation Trust 2020)
(Royal College of Nursing 2018)

2.15. PACU Standard No 15 - Infection Control

2.15.1. Standard statement

All patients who are admitted into PACU will be protected from hospital acquired infection.

2.15.2. Method

- All PACU staff will have yearly infection prevention and control mandatory training including hand hygiene.
- PACU nurses will be fully aware of the local policies and guidelines in conjunction with infection control.
- PACU staff will carry out effective infection control procedures to minimize risk to patients when required.

Compliance 100%
Exceptions None

2.15.3. Interventions

- Effective hand hygiene, using the WHO 5 moments of hand hygiene.
- Select correct PPE equipment using a risk assessment, and be able to correctly put on and remove PPE.
- Use appropriate isolation precautions when patients have a known or suspected infection
- Use sharps safely and dispose of them correctly
- Separate waste and linen as per the appropriate policy.
- Clean, disinfect or sterilize equipment, instruments and surfaces.

(WHO 2009)
(Royal Cornwall Hospital Trust (2018) Standard Infection Prevention and Control Precautions Policy)
(Dougherty. L & Lister, S. 2015)

2.16. PACU Standard No 16 - Prevention of Pressure Sores

2.16.1. Standard statement

Patients will have their pressure area needs assessed on admission into PACU. Patients will have their pressure areas inspected and assessed by a PACU practitioner within 15 minutes of becoming conscious or as soon as they are able to tolerate being moved to promote healthy intact skin.

2.16.2. Method

- Assess risk of pressure ulcer development using the registered nurse's clinical judgement
- Complete skin assessment based on the assessment of the most vulnerable areas for each patient.
- Use the SSKIN bundle tool to assess patient's risk and implement the appropriate level of skin assessments.
- Assess and implement the correct equipment for the patients' specific needs.
- All healthcare professionals are required to attend educational days on pressure ulcer prevention and training on the use of correct equipment.

Compliance 100%
Exceptions None

2.16.3. Interventions

- Roll patient on admission and assess skin condition.
- Document skin condition using appropriate care plans, implement pressure ulcer relieving care and plan for their time in the PACU.
- If incontinent wash and dry to prevent skin breakdown and apply barrier product to vulnerable areas.
- Position patient for optimum pressure area care using pressure relieving equipment if necessary.
- Support vulnerable areas adequately and treat any existing pressure sores, using research-based practice
- Avoid shearing and friction by using correct equipment such as slide sheets when moving patients.
- Provide information and education on pressure ulcer prevention to high risk patients and encouragement movement if patient is able.

Royal Cornwall Hospital Trust (2019) Prevention of Pressure Ulcer Policy.

The Royal Marsden NHS Foundation Trust (2020), Pressure ulcers – Evidence based approaches, accessed 8 April 2020, http://www.rmmonline.co.uk

2.17. PACU Standard No 17 - Wound Management

2.17.1. Standard statement

2.17.1.1. Wounds will be inspected promptly following patient transfer to the PACU. The wound will be assessed for signs of infection and blood loss.

2.17.1.2. Measurements from drains will be recorded at this time and further assessment of wound and drains will follow at regular intervals.

2.17.2. Method

- Gain consent if able, check and observe wounds, dressings, drains or newly formed stoma throughout PACU stay
- Aseptic technique will be adhered to at all times by all staff.
- Stoma will be assessed for perfusion.
- PACU staff will be trained to recognise any complications and act accordingly.

Compliance 100%
Exceptions None

2.17.3. Interventions

- Demonstration of ANTT by staff.
- Maintain privacy and dignity.
- Infection control protocol adhered to.
- Assessment of wounds and drains alongside observations.
- Check any analgesia requirement if intervention is required.

- Demonstrate ability to manage drains.
- Ability to change a stoma bag.

(The Royal Marsden NHS Foundation Trust 2020)
(Royal Cornwall Hospital Trust (2019) Wound Care Clinical Guideline)

2.18. PACU Standard No 18 - Patient Discharge from the Post-anaesthetic care unit/recovery

2.18.1. Standard statement

Patients will be safely discharged from the PACU area

2.18.2. Criteria for discharge

- The patient is conscious and able to maintain their own airway. Their protective reflexes should be present.
- The patient's rate of respiration and their oxygen saturation must be within the parameters set by the anaesthetist for each individual patient
- The patient's cardiovascular system must be stable with no unexplained irregularity or persistent bleeding. Consecutive readings of pulse and blood pressure should approximate to normal preoperative values or be at an acceptable level within the parameter set by the anaesthetist. Peripheral perfusion should be adequate.
- Pain and nausea should be adequately treated and continuing treatment must be prescribed.
- Temperature should be within acceptable limits and there should be no evidence that hypothermia or malignant hyperthermia are developing.
- Oxygen and intravenous fluids should be prescribed.
- Intravenous cannulas should be patent and flushed, to ensure any residual anaesthetic drugs are removed. Intravenous fluids should be prescribed if necessary.
- Surgical drains and catheters should be checked and within satisfactory parameters.
- All health records completed and medical notes present.
- A bed must be available and sufficient staffing on the unit in which the patient is to be received.

(The Royal Marsden NHS Foundation Trust 2020)
(Whitaker DK, Booth H, Clyburn P, et al. 2013)

2.19. Guidance for duration of stay in the Recovery Unit (Adult Patients)

2.19.1. All patients must fulfil criteria for discharge

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 (20 minutes or less)	**Once the patient is fully conscious and maintaining their own airway; a minimum stay of 15 minutes.**
Medium duration operations (20 minutes to 2 hours)	**Once the patient is fully conscious and maintaining their own airway; a minimum stay of 30 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 60 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 at least 30 minutes**

2.19.2. Handover information

2.19.2.1. Handovers should be both verbal and written and should be documented.

2.19.2.2. Surgeons/operators must participate in handovers in which the patient's pathway has deviated from that planned and when patients are handed over to critical care teams after procedures.

2.19.2.3. Participation of the patient and / or representative (parent, guardian, carer or birth partner) should be encouraged when feasible.

2.19.2.4. During handovers only one person should speak at a time, and the conversation during the handover should relate only to the patient. Non-handover activities should cease during the handover. Each team member should be given the opportunity to ask questions and clarify information.

2.19.3. The following information must be included in the hand over from recovery:

- Patient's name and date of birth checked against identity band.
- Planned and actual procedure(s) that was carried out with site and side if relevant, and surgical course including surgical complications and interventions to correct these.
- The type of anaesthesia used, or combination of anaesthesia such as general anaesthetic and regional block (including attempted epidural insertion and the need to continue observation of sensation and movement for a minimum of 24 hours).
- The duration of anaesthetic and any complications, if appropriate and interventions to correct these.
- Details of any local infiltration to the wound, including local anaesthetic agent, strength and dose administered. Also the patient's pain score.
- Patient prescription documents.
- Intravenous fluid documents, including blood products given with estimated losses, if appropriate.
- Type of dressing, drain and wound closure used including any further information or instructions in relation to drains e.g. suction or not.
- Amount of exudates in the drain and, if this is excessive, what action has been taken such as informing the surgeon.
- Reinfusion times for autologous blood products
- Commencement times for local infiltration devices (pain busters)
- 'Top-up' intervals for rectus sheath devices and personnel charged with this task
- Oxygen therapy requirement for patient and completed drug prescription
- VTE therapy documented
- Invasive device care plans supplied
- Additional to: Skin condition and integrity – Lower Limb pathway followed where appropriate. Waterlow score completed and documented.
- Presence of stoma / urinary catheter and state of fluid balance/output.
- Any intentionally retained objects and plans for removal, if relevant.
- Confirmation that any throat pack has been removed.
- Oxygen requirements, percentage and duration.
- NEWS score
- Any allergies or sensitivities.
- Whether there is a need for an interpreter, carer or parent to assist in patient care and the arrangements that are in place for contacting such individuals if they are not accompanying the patient back to the ward.
- Whether the patient has any personal items such as dentures, spectacles or hearing aids that must accompany the patient on transfer, or if these items have been returned to the patient.
- Relevant medical history (e.g. the presence of a pacemaker).
- Skin condition, integrity and Waterlow score.
- Any changes at the site of the diathermy plate, if appropriate.

- Any other information that is specific to the patient, post-operative surgical and anaesthetic instructions. Including any patient safety incidents.

2.19.4. Transfer to the ward

- During the transfer from recovery to the ward, the patient should be escorted by a competent registered practitioner.
- Suitable equipment such as oxygen and suction must also be available.

2.19.5. When transferring a patient to ITU/HDU:

- Check and ensure all transfer equipment (e.g. portable sucker, portable O2, monitor) is available.
- If the patient is ventilated, an anaesthetist will escort and the PACU staff must make sure that they are available.
- A minimum of three personnel must accompany the patient.
- The receiving area must be warned in advance and agreement must be obtained before transfer.
- A crash box must accompany the ventilated patient.
- The anaesthetist will decide if there are any other drugs that should accompany patient.
- If transfer requires the use of lifts, then the portering staff must be informed and arrange for the lifts to be held on the appropriate floors.

2.19.6. Palliative / End of life care

- Occasionally, a patient who is expected to die imminently will be taken to PACU. The patient should be managed according to an end of life care pathway in isolation from others who should not ideally be aware of the situation. Relatives must be able to be present and a dedicated nurse should be available.
- Theatre staff must liaise with the nurse in charge of recovery prior to bringing patient out of theatre, to ensure staff and appropriate area is available.

3. Monitoring compliance and effectiveness

Element to be monitored	Practice compliance against all practice standards will be monitored
Lead	Recovery Services Manager / Deputy Managers
Tool	The revised theatre safety audit tool will be used to monitor compliance monthly. Each senior auditor will assess practice observed at each audit.
Frequency	Each member of the theatre senior team will audit 10 observations of practice each month. The observations will be submitted to the Governance Lead for Anaesthetics, Critical Care and Theatres by the 2nd of the following month for collation and reporting at the Care Group Huddle. Compliance with the WHO SSC standard 16 will be reported monthly to the management team.
Reporting arrangements	Care Group Huddle monthly, PRG monthly. Responses and actions agreed will be recorded in meeting minutes
Acting on recommendations and Lead(s)	It will be the responsibility of the Head of Nursing to action any recommendations from the report and report back to General Manager, Care Group Huddle on outcomes
Change in practice and lessons to be shared	This document consolidates and defines current practice; no changes to current practice are required. The documentation implementation will be led by the theatre managers in each area. All staff will have discussions on the local practice standards at yearly IPR. Any shortfalls by individuals identified will be dealt with by the appropriate manager in line with trust policy. Lessons learned will be shared with all stakeholders at theatre safety briefings and theatre managers meeting.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Post Anaesthetic Practice Standards Clinical Guideline V3.1			
This document replaces (exact title of previous version):	Theatre Practice Standards – Post Anaesthetics Care Clinical Guideline V3.0			
Date Issued/Approved:	February 2021			
Date Valid From:	February 2021			
Date Valid To:	July 2023			
Directorate / Department responsible (author/owner):	Myra Martin, Recovery Services Manager			
Contact details:	01872 25 3080			
Brief summary of contents	Defined clinical practice standards relevant to post anaesthetic care			
Suggested Keywords:	Post anaesthetic care Recovery Practice standards			
Target Audience	RCHT	CFT	KCCG	
	✓			
Executive Director responsible for Policy:	Medical Director			
Approval route for consultation and ratification:	Care Group Governance			
General Manager confirming approval processes	Doug Riley			
Name of Governance Lead confirming approval by specialty and care group management meetings	Matthew Body			
Links to key external standards	Not required			
Related Documents:	Included at Appendix 4			
Training Need Identified?	No – this document supersedes other practice policies and does not implement new practice			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Theatres			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job*
24 Feb 14	V1.0	Initial Issue	Sue Preston, Senior Matron, Theatres
May 2017	V2.0	Compliance with Natsips	Cathy Edwards
May 2020	V3.0	Updated references and minor content updates	Myra Martin, Recovery Services Manager
February 2021	V3.1	Title update, first paragraph updated to reflect that there are four documents that make up theatre standards	Matthew Body, Interim Theatre Service Manager

Appendix 2. Equality Impact Assessment

<table>
<tr><th colspan="6">Section 1: Equality Impact Assessment Form</th></tr>
<tr><td colspan="6">Name of the strategy / policy /proposal / service function to be assessed
Theatre Practice Standards – Post Anaesthetics Care Clinical Guideline V3.1</td></tr>
<tr><td colspan="3">Directorate and service area:
Theatres, Anaesthetics, Critical Care and Theatres</td><td colspan="3">Is this a new or existing Policy?
Existing</td></tr>
<tr><td colspan="3">Name of individual/group completing EIA
Matthew Body, Governance Lead</td><td colspan="3">Contact details:
01872 252645</td></tr>
<tr><td>1. Policy Aim
Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">The aim of this policy is to outline the standards of care that must be delivered to each individual patient to ensure a high quality of care is provided to patients entering all Trust Operating Theatres.</td></tr>
<tr><td>2. Policy Objectives</td><td colspan="5">To standardise care and practice within theatres</td></tr>
<tr><td>3. Policy Intended Outcomes</td><td colspan="5">Standardisation of care and practice</td></tr>
<tr><td>4. How will you measure the outcome?</td><td colspan="5">Continuous Audit</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Patients and staff</td></tr>
<tr><td rowspan="3">6a). Who did you consult with?

b). Please list any groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Please record specific names of groups:

Theatre Senior Team</td></tr>
<tr><td>c). What was the outcome of the consultation?</td><td colspan="5">Acceptance</td></tr>
</table>

7. The Impact
Please complete the following table. If you are unsure/don't know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy **could** have a positive/negative impact on:

Protected Characteristic	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		X		
Sex (male, female non-binary, asexual etc.)		X		
Gender reassignment		X		
Race/ethnic communities /groups		X		
Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)		X		
Religion/ other beliefs		X		
Marriage and civil partnership		X		
Pregnancy and maternity		X		
Sexual orientation (bisexual, gay, heterosexual, lesbian)		X		

If all characteristics are ticked 'no', and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:	Matthew Body, Governance Lead

If you have ticked 'yes' to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net

Appendix 3. ABC Assessment Protocol

On admission to the recovery unit immediately check the following in order:

A = Airway

- Check for airway obstruction- paradoxical chest and abdominal movements/ use of accessory muscles of respiration.
- Use airway opening manoeuvres/ adjuncts if required
- Use suction if required
- Administer oxygen via a face mask or laryngeal airway.
- Begin with 10 litres and titrate with pulse oximetry
- If still not satisfied with airway patency- call for help immediately.

B = Breathing

- Look, listen, feel
- Look for any signs of cyanosis and ensure pulse oximetry is above 95%
- Check that the chest is moving, equally and bilaterally and air is moving in and out of the patients' mouth. Measure and record respiration's 5, 10 and 15 minutely – titrate as appropriate
- Listen to patients breath sounds- rattley/ stridor/ wheeze/ normal
- Feel for bilateral chest movements/ depth of breathing
- If breathing depth or rate felt to be inadequate, use bag-mask ventilation to supplement breaths and call for help.

C = Circulation

- Commence cardiac monitoring
- Measure and record blood pressure, pulse rate, 5, 10 and 15 minutely – titrate as appropriate
- Ensure invasive blood pressure monitoring is set up correctly
- Ensure adequate perfusion and peripheral return from limbs, monitor temperature
- Palpate peripheral or central pulses, assessing for rate, quality, regularity and equality.
- Measure central capillary refill time on acutely unwell patients.
- Check cannula in situ

- INPUT/OUTPUT Fluid balance - IV fluids + If urinary catheter insitu, check output

D = Disability

- AVPU
- Note drugs given in theatre, especially analgesics which may affect the patients breathing
- Check blood glucose if appropriate
- Check for patient allergies and what drugs will be required in recovery especially antibiotics and analgesics

E = Exposure

- To examine the patient properly, full exposure of the body may be necessary. Respect patients dignity and minimize heat loss.
- Plaster checks
- Check dressings/ drains
- Check pulses following arterial/ lower limb surgery
- Check circulation to graft sites
- Monitor analgesia

Resuscitation Council UK 2020,

Oxford Handbook of Critical Care Nursing 2nd Ed 2016

Appendix 4. References

AAGBI 2013, *Immediate post- anaesthesia recovery.* Date accessed 31st March 2020. https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_immediate_post_anaesthesia_recovery_2013_final.pdf?ver=2018-07-11-163754-287&ver=2018-07-11-163754-287

AAGBI 2015 *Recommendations for standards of monitoring during anaesthesia and recovery.* Date accessed 31st March 2020. https://anaesthetists.org/Portals/0/PDFs/Guidelines%20PDFs/Guideline_standards_of_monitoring_anaesthesia_recovery_2015_final.pdf?ver=2018-07-11-163757-223&ver=2018-07-11-163757-223

ACT Academy 2018- *Online library of Quality Service Improvement and Redesign tools: SBAR communication tool- situation, background, assessment, recommendation.* Date accessed 6 April 2020. https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf

BARNA 2012, *Standards of Practice.* Date accessed 4th April 2020. http://www.barna.co.uk/media/uploads/downloads/barna-standards-of-practice-2012.pdf

CQC 2020, *Health and Social Care Act 2008 Regulation 10: Dignity and respect,* https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-10-dignity-respect#guidance, Date accessed 7th April 2020

Lawson S, Shepard E (2019) The underlying principles and procedure for bed bathing patients. *Nursing Times* (online); 115: 5, 45-47

Nursing Times 2015 *Pain management 3: the importance of assessing pain in adults.* Date accessed 7th April 2020,https://www.nursingtimes.net/clinical-archive/pain-management/pain-management-3-the-importance-of-assessing-pain-in-adults-05-10-2

Nursing Times 2017, *Communication skills:1 benefits of effective communication for patients.* Date accessed 6th April 2020. https://www.nursingtimes.net/clinical-archive/assessment-skills/communication-skills-1-benefits-of-effective-communication-for-patients-20-11-2017

Nursing Times 2017, *Communication skills 2: overcoming the barriers to effective communication.* Date accessed 6th April 2020 https://www.nursingtimes.net/clinical-archive/assessment-skills/communication-skills-2-overcoming-the-barriers-to-effective-communication-18-12-2017/?storycode=7022518&hash=c628ff9baf295970d5423b162d52fe50

Oxford Handbook of Critical Care Nursing 2nd Ed 2016 *Cardiovascular assessment and monitoring.* Date accessed 4th April 2020. https://oxfordmedicine.com/view/10.1093/med/9780198701071.001.0001/med-9780198701071-chapter-6

Royal Pharmaceutical Society 2019. '*Professional Guidance on the Administration of Medicines in Healthcare Settings'*. Date accessed 7th April 2020. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Professional%20standards/SSHM%20and%20Admin/Admin%20of%20Meds%20prof%20guidance.pdf?ver=2019-01-23-145026-567

Royal College of Anaesthetists 2019. *Chapter 4: Guidelines for the Provision of Anaesthetic Services for Postoperative Care.* Date accessed 4th April 2020. https://www.rcoa.ac.uk/gpas/chapter-4

Resuscitation Council UK 2020, *Guidelines and guidance- The ABCDE approach.* Date accessed 3rd April 2020. https://www.resus.org.uk/resuscitation-guidelines/abcde-approach/

Roper.N., Logan.W. and Tierney.A. (1996) 4th edition The elements of nursing Churchill Livingstone

Royal College of Nursing (2018), *Tools of the Trade, Guidance for Health Care Staff on Glove Use and the Prevention of Contact Dermatitis,* accessed 7 April 2020, https://www.rcn.org.uk/professional-development/publications/pdf-006922

The Royal Marsden NHS Trust Manual of clinical Nursing Procedures 9th edition 2020 *Chapter 6: Elimination,* Date accessed 9th April 2020 https://www.rmmonline.co.uk/manual/c06-fea-0006

The Royal Marsden NHS Foundation Trust (2020), *Bed Bathing a Patient*, accessed 7 April 2020, http://www.rmmonline.co.uk

World Health Organization. (2009) *WHO Guidelines on Hand Hygiene in Health Care: First Global Patient*

Safety Challenge Clean Care is Safer Care. Accessed 7 April 2020, https://www.who.int/gpsc/5may/background/5moments/en/

The Royal Marsden NHS Foundation Trust (2020), *Pressure ulcers – Evidence based approaches*, accessed 8 April 2020, http://www.rmmonline.co.uk

The Royal Marsden NHS Foundation Trust (2020), *Post-anaesthetic care unit (PACU)*, accessed 8 April 2020, http://www.rmmonline.co.uk

Whitaker DK, Booth H, Clyburn P, et al. (2013) Immediate post-anaesthesia recovery. *Anaesthesia* 2013; ***68:*** 288–97