**Freeman Hospital**

 **Post Anaesthetic Care Unit (PACU)**

**Standard Operating Procedure 2018**

PACU offers care equivalent to level 2 critical care for patients who have undergone a procedure in the central operating theatres. The care is delivered in the theatre recovery area. It is solely intended for patients with a planned duration of required escalated care of less than 24hours.

* Case selection: Patients due to undergo surgery are assessed in the pre-assessment clinic (PAC), and a recommendation for post-operative destination made.

This may include a bed in Intensive Care (level 3), High dependency (level 2), Post-operative Care Unit (PACU), ward, or day case discharge.

* This recommendation is not a mandated action, and is based on a combination of population based, and individual patient information.
* On admission, and during the course of surgery, this recommendation may be altered by an assessment of the individual patient’s clinical course & condition.
* An updated decision made on the day by the intensive care, anaesthetic and surgical multi-disciplinary teams may result in either upgrading or downgrading of the actual post-operative destination compared with the PAC recommendation.
* After their planned surgical procedure the patient is taken to recovery as per routine theatre cases.
* The anaesthetist responsible for the case will continue responsibility until the end of their list as per routine patients in recovery.
* The on call anaesthetic and surgical teams will be responsible for patients in PACU out of hours or in case of emergency.
* A critical care admission document should be completed by the theatre anaesthetist for all patients admitted to PACU. In the event of an unplanned admission to PACU the on-call team will complete an admission form.
* Handover from the list anaesthetist to the on-call team should be to one person minimum and preferably 1st call +/- anaesthetic consultant. It is then incumbent on the person who received the handover to update the others on the team.
* It is expected that the anaesthetic on-call team will review the PACU patients Monday –Friday between 1700-2000 hrs, enabling comprehensive handover to the night team.
* The on-call surgical specialty registrar must be aware of any patient in PACU and will provide appropriate surgical advice/ review and assist with patient management if the anaesthetic junior staff are otherwise busy.
* Additional cover will be available from the Consultant surgeon on call for the relevant specialty.
* The *hospital at night* (H@N) team will not usually be involved in the care of these patients whilst they are in PACU.
* Ultimate responsibility for patients in PACU (along with admission and discharge rights) will belong to the on call consultant anaesthetist.
* Admission / discharge timing: It is not mandatory (unless otherwise stated by the responsible anaesthetist) for patients electively admitted to PACU during the day to stay overnight. If reviewed by the appropriate anaesthetic staff and deemed fit for discharge to the ward then after the necessary documentation the patient may be discharged on the day of surgery before 22.00hrs. Between the hours of 22.00hrs and 07.00hrs it is recommend that patients are not discharged to the ward from Critical care areas (PACU included) unless circumstances are extreme and that it would constitute a critical incident if discharge occurred. In these circumstances an appropriate form would need to be completed and the patient reviewed the following morning by the Outreach team on the ward. Planned discharge time for overnight stays on PACU is between 07.30 and 08.00am.
* Physiological scoring for PACU patients as per the NEWS system should be performed a minimum of 3 times for patients staying overnight. This includes a mandatory record at around 6am prior to 2nd call review.
* Between 06.30 and 07.00 am the anaesthetic second call or if necessary the first call should review any patient in PACU. They should do a physical assessment and chart review, record it on the medical record and state whether the patient is fit for discharge to the ward.
* The morning review for discharge can be the first call but the patient cannot be discharged before either the 2nd call or consultant has reviewed/signed off the review.
* Patient needs to be handed over to a medical team, not just a nurse, in the morning.
* If the second call does not think the patient fit for ward discharge then they must inform the nurse in charge of ITU of a potential need for an HDU bed. They must then also pass this information to the anaesthetist coming on to start in emergency theatre that day.
* Any patients not discharged by 8am will be reviewed by the consultant on call for emergency theatre at 08:00 – 08:15. If the patient is not likely to be fit for discharge within 30 mins then the emergency theatre consultant should contact the Critical Care Consultant immediately so they are aware of the need for this patients’ HDU admission before giving the go ahead to that days’ elective surgery patients.
* Emergency surgical patients or elective surgical patients with an unanticipated need for PACU overnight may be admitted to the PACU beds if capacity is available and they meet the standard PACU criteria in particular the suitability for discharge by 8am. (Temporary admission to an available PACU bed or the emergency bed until ICCU bed availability is urgently arranged may be considered for patients needing higher or more prolonged level of care).
* No more than 4 patients can be cared for on PACU at any one time. If a non-electively-booked-PACU-suitable patient needs prolonged post-op close observation during the evening or overnight and all the PACU beds are occupied then they can be cared for in the “Emergency Recovery” bed as the fifth patient in recovery. However that precludes recovery staff from taking any further patients. As such any patients having emergency surgery overnight will have to be recovered by the emergency theatre staff as occurred prior to the 24 hour recovery system being introduced. This fifth patient should be treated as a Recovery patient and would be eligible for discharge to the ward during the night if they meet discharge criteria.
* In the case of a patient requiring barrier nursing the patient has to be considered level 3 and will need a dedicated nurse. This will effectively cut the number of patients that can be admitted to PACU. This should not routinely happen and must only take place after discussion between the critical care consultant and the infection control team.
* When the lack of a ward bed prevents a patient returning to the ward at 8am the patient will be monitored to the same standard as a ward patient. The responsibility for the patient will remain with the anaesthetic on-call team until they leave the recovery area.