**MEDICAL AND DENTAL PRACTITIONERS COUNCIL OF ZIMBABWE**

# POLICY ON RECOVERY ROOM STAFF

## Background

The standards for minimum anaesthetic and post anaesthetic care are fully pronounced in the Zimbabwe Anaesthetic Association publication on Minimum Monitoring Standards. A Committee of the Zimbabwe Anaesthetic Association (ZAA) is responsible for periodic review of these standards and align them with international best practice.

Emergence and recovery from anaesthesia is a time dependent process where a patient who has received anaesthesia recovers from the effects of those drugs. The patient is usually nursed in the recovery room by nursing staff who are trained to look out for peculiarities of recovering from anaesthesia. Most anaesthetic drugs have no therapeutic value and are indeed very toxic themselves. Their role is to facilitate therapeutic (surgical) treatment to be done in comfort, free from pain, fear and anxiety, and ease the performance of the procedure by the surgeon amongst other things muscle relaxation. The effects of anaesthetic drugs must therefore completely be reversed after surgery except for pain relief medication, if required.

## Introduction

Section 30(1)(i) of the Health Professions Act (Chapter 27:19) mandates the Medical and Dental Practitioners Council of Zimbabwe herein referred as Council to define ethical practice and enforce discipline among the registered practitioners. In this Policy document on recovery room staffing it has been found difficult to isolate the environment of care which includes the location where the care is delivered, equipment (not limited to monitors) and the crucial manual conduct of how to handle a patient from arrival till discharge. The recovery room is indeed a dynamic place. It may be empty at the beginning of day, a hive of activity as patients operations are completed and patients moved to the recovery room, and unexpectedly busy should a patient's condition suddenly deteriorate and resuscitation commence. There may be

logistical delays in sending patients to their various post operative wards after operations further crowding the recovery room. Further, recovery rooms are huge cost build- up centres, and customarily billed by the minute. Long stays in the recovery room are generally questioned by financiers of healthcare.

**Purpose of the Policy**

The purpose of this Policy is to provide minimum requirements on steps to follow from admission until discharge from the recovery room as well requirements on the staffing responsibilities in the recovery room.

**1) Staffing**

- Anaesthetic and post anaesthetic care is administered in specifically designated, equipped, and staffed registered hospital/ institutions by appropriately qualified and registered personnel or trainees under supervision of registered clinicians.

- The anaesthetist leads a team of medical and nursing practitioners that are charged with the responsibility of ensuring complete recovery from the now undesired effects of anaesthetic drugs. Pain control and stabilization of vital functions is also an important consideration for this team especially in the first 24 hours

- Staff qualifications, staffing levels, use of standardized minimum equipment, clinical techniques and clinical competence to decide the next therapeutic maneuvers (such as discharge or call anaesthetist for advice etc) is critically important for successful outcomes.

- There is no absolute numbers of staffing levels, but state of occupancy and condition of patients dictate how best to deal with staffing levels. This should be determined at the point of providing anaesthetic service.

- The key is that the recovery room charge Nurse should be able to vary staff levels very quickly and almost instantly, and call out for help if needed in a matter of an instant.

- As patient emerges from unconsciousness, and condition improves and begins to cooperate, one nurse could look after two patients on adjacent stations.

- Should patient condition deteriorates suddenly and unexpectedly, the Nurse immediately calls the Doctor and resuscitation team for help which should be accorded in a matter of seconds. In this circumstance one patient may be attended to by a team of medical professionals as is assessed to be appropriate in a rapidly changing situation e.g. cardio pulmonary resuscitation(CPR)

## 2) Recovery Room

- Following anaesthesia, a patient is placed in a recovery area, under intense monitoring in order to satisfy or assure that the patient has gained basic minimum vital functions before discharge to further areas of post operative care ( Ward HDU /ICU)

- In transporting a postoperative patient to recovery room the anaesthetist, the scrub nurse and a porter shall transport a stable patient lying in a hospital bed, appropriately monitored.

- A patient arriving in the recovery room has a variable level of consciousness from a fully conscious (having been operated under local or regional) to a comatose patient sedated by drugs and perhaps an existing disease process such as head injury. Under the circumstances, the recovery room should receive the patient with a natural airway.

- Upon arrival, the anaesthetist attaches minimum monitors and fully evaluates the patient. These are pulse oxymetry, continuous electrocardiograph pulse, automated interval blood pressure monitor and temperature, amongst others.

- The anaesthetist physically hands over explained written down post-operative instructions for the care of the patient to a Nurse taking care of the patient in the recovery room, and ensures that there is complete understanding of the instructions. The Nurse examines the patient.

- The Nurse may point out areas they are concerned with or seek clarification.
  Some patients may be restless or agitated for various reasons post operatively (pain, fear, full bladder, child) and may require more than one staff member till they are settled. Self-injury is a risk if they are not settled or controlled. Upon accepting responsibility, the vital functions observations are documented.

- An accurate timed observation of respirations, pulse, blood pressure, pulse oxymetry amongst others is documented.

## 3) Minimum Staffing Levels

- Reception of patient: (the patient may be unconscious or emergent from that state) Staff ratio: 1:2 (one patient/two nurses) – to undertake handover/prioritise immediate care/set up monitoring). The skills of the first nurse must be appropriate for the acuity of case. The helper may be a novice nurse or member of the perioperative team.

- Stabilisation period: (self ventilating with no airway adjuncts or needing respiratory assistance; the patient's clinical condition stabilises through this period to full recovery but may regress back along the clinical continuum). Staff ratio: 2:1 (two patients/one nurse) skills of nurse must be appropriate to acuity of cases. If patient's condition deteriorates staff must be reallocated promptly.

- Fit for discharge: (has met all local discharge criteria – is stable and comfortable). Staff ratio: 3:1 (three-patients/1 nurse). The nurse looking after three patients must be experienced and may be assisted by novice nurse or member of the perioperative team.

- No fewer than two staff [of whom at least one must be a registered practitioner] should be present when there is a patient in the recovery room, who does not fulfill the criteria for discharge to the ward'.

- Until patients can maintain their airway, breathing and circulation they must be cared for on a one to-one basis to-one basis.

- At least two appropriately trained staff should be present in the recovery room while there is a patient who does not fulfill the criteria for discharge to the ward.

- It is difficult to give guidance on the exact numbers of staff required for any particularly recovery area. The staffing levels will depend on factors such as the case mix, numbers of patients and the number of operating lists per session.

- Staffing the recovery room is an ongoing intractable problem. All statements on staffing are based on minimal staff to patient ratios which are dependent on the clinical status of the patient. However, to adjust staff numbers to patient throughput accurately throughout the shift, matching patient acuity to staff expertise is very difficult. It remains doubtful that a 'magic formula' can be developed to fit this constantly changing, dynamic clinical area. Council would recommend auditing variables that affect staff – patient ratios [delayed discharge being one important factor]. Safe staffing the recovery room is still dependent on the expertise of the Charge Nurse who can adjust staffing if necessary on a day to day basis.

## 4) Discharge from Recovery

- The anaesthetist is responsible for the discharge of the patient to a suitable ward from the recovery room. In the alternative, the nurse attending the patient shall use agreed on preferably written down discharge criteria to send the patient to a prescribed place of further care.

- The Nurse will read out instructions of care to ward nurse upon hand over, verify that the patient is stable and in satisfactory condition and may point out any areas of care requiring closer attention.

- Often, fully recovered patients who should go to the wards are not collected by ward staff for various reasons. These remain the responsibility of recovery room nursing staff. One nurse can look after 4 such coherently communicating, comfortable patients. Again, patients must be in adjacent care stations, and help from a nurse aid afforded.

The general supervision of the patient condition is the responsibility of the anesthetist, who shall be easily accessible to the patient in an appropriate time to deal with complications as requested by the nursing staff?

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