RECOVERY
CLINICAL GUIDELINE

ADMISSION GUIDELINES FOR PATIENTS TO THE RECOVERY HIGH DEPENDENCY UNIT

Staff this document applies to:

Medical and nursing staff caring for patients in the Austin Hospital RHDU.

Related Austin policies, procedures and guidelines:

Intensive Care minimum nursing care standards
Intravenous medications requiring intensive monitoring
Escalation of Clinical Issues - ICU
Patient Transfers - Clinical Responsibilities for Communication, Patient Preparation, Clinical Handover and Clinical Escort
Recovery Minimum Nursing Care Standards

Overview:

- RHDU is a 2-bed area within the Austin campus Recovery department.
- RHDU is a 24-hour Monday-Friday service only, with no capacity on weekends, public holidays, and designated holiday periods e.g., Christmas, Easter.
- Post anaesthesia care is provided to complex surgical patients who require longer than the standard post anaesthesia care and critical care monitoring after surgery.
- Care is managed by trained recovery RHDU nurses.
- Medical care is provided by the intensive care medical team after an appropriate handover by the anaesthetist.

Purpose:

- To ensure appropriate patients are admitted into the RHDU, these patients may be identified before, during, or after surgery.
- To ensure patients who no longer require RHDU are discharged to the ward, or for those who require a higher level of care are transferred to ICU in a timely manner.
- To ensure the nursing staff of Recovery are aware of the responsibilities and expectations when managing the care of RHDU patients.
- To ensure the medical staff are aware of the responsibilities and expectations when managing the care of RHDU patients.

Patient Admission Criteria:

- Patients have a ward bed allocated and available to facilitate timely discharge.
- Patients should be a surgical admission from either the AOS or TSC recovery
- Patients should be suitable to be nursed at a nurse-to-patient ration of 1:2.

OPPIC Document ID: [Document ID] **Date of last major update:** [Last Published Date] **Review Date:** [Review Date]

- Patients with minimally invasive monitoring. Including, but not limited to, an arterial line or central venous access device.
- Patients with epidural catheters or complex analgesia infusions post-surgery.
- Patients requiring postoperative, temporary, non-invasive respiratory support e.g., CPAP or BiPAP.
- Patients requiring inotropic or vasoactive medication. Accepted infusions include:
    - Noradrenaline (norepinephrine) ≤ 5 microg/min
    - Metaraminol ≤ 50 microg/min
    - Glyceryl trinitrate (GTN) ≤ 50 microg/min
    - Adrenaline (epinephrine) ≤ 5 microg/min
        - If patient requires higher doses, more than one infusion, or there is a rapid increase in dosage, the patient must be urgently reviewed by covering ICU doctor.
- Patients requiring intravenous heparin, or amiodarone infusions.
- In the event ICU reaches capacity an appropriate HDU surgical ICU patient may be transferred to RHDU after consultation with the recovery ANUM/NUM.
- The expectation is that the RHDU patient will be well enough for transfer to the ward before 0600hrs the day following surgery. A transfer plan, discharge plan, or plan of care is to be arranged before 0600hrs.

Patients NOT suitable for RHDU:

- Patients are not accepted as a direct admission post MET/EMR call.
- A patient will not be accepted into RHDU post MER **unless** the patient requires surgery in the imminent future.
- Patients with an endotracheal tube in situ.
- Patients requiring post-operative mechanical ventilation.
- Patients with intracranial monitor devices in situ e.g., jugular venous bulb catheters or intracranial pressure catheters for intracranial pressure monitoring.
- Patients with CSF catheters for CSF drainage and spinal cord monitoring.
- Patients with pulmonary artery catheters, femoral catheters, or RICC lines.
- Patients requiring vasopressor drugs in doses greater than those outlined above.
- Patients with external pacing wires.
- Patients requiring heamofiltration.
- Patients requiring more than one overnight stay in RHDU.
- Patients requiring greater than 50% oxygen.
- Patients post laryngectomy surgery.
- Patients post sternotomy surgery

Medical Review:

- At four hourly intervals and PRN as issues arise.
- By intensive care unit HMO from 0800-2000.
- By intensive care unit Pod D/E registrar.
- If Pod D/E registrar is unavailable, contact ICU fellow.
- Final line of contact is ICU consultant via switchboard.

OPPIC Document ID: [Document ID] **Date of last major update:** [Last Published Date] **Review Date:** [Review Date]

- The morning medical review should be completed **before 0530** to facilitate **discharge by 0600 for all patients**. If patients are to remain in RHDU past this time, a transfer plan or plan of care is to be arranged before 0600.
- Blood specimens for pathology are to be collected at 0300 for review.
- Interventions are to be documented and commenced prior to discharge to the ward.

Patient Discharge Criteria:

- For patients who received >200 microg of intrathecal morphine, the 16-hour post administration observations have been met.
- Patient's vital sign observations must meet hospital criteria OR altered calling criteria limits must be documented in Cerner by medical staff prior to discharge.
- Patients meet standard recovery discharge criteria as per Cerner Recovery Safety Departure checklist and WHO checklist.

Authors/Contributors:

Eva Vlachou, ANUM/CNS

Rhys Morgan, ANUM/CNS

Lynn Hampton, ANUM/CNS

In Consultation With:

Laurence Weinberg, BSc, MBBCh, MRCP, DipCritCareEcho, FANZCA, MD

Louise Ellard, MBBS, FANZCA, AdvPTEeXAM

Megan Postlethwaite, Recovery NUM

Renee Barbour, Recovery NUM

Stephen Warrilow, Director ICU

Drug & Therapeutic Committee

References:

The Australian College of Operating Room Nurses Ltd. (2014) *ACORN Standards for Perioperative Nursing, 2014-2015.* Adelaide, South Australia: The Australian College of Operating Room Nurses Ltd; 58-68 and 369-178.

Alan Tulloch, Chris How, Marjorie Brent, Rose Chapman, Brenden Burns & Su-Mei Pomery (2007) Admission and Discharge Practices: High Dependency Unit Audit Outcome, Contemporary Nurse, 24:1, 15-24.

Gillian Knight (2003) Nurse-led Discharge from High Dependency Unit, Nursing in Critical Care 8:2, 56-60.

Intensive Care: high dependency monitoring, observations, and reportable limits (2015)

Intravenous medications requiring intensive monitoring (2022)

Primary Person/Department Responsible for this document:

AOS Recovery NUM