Trust Standard Operating Procedure

Main Recovery Clinical Management

Issue Date	Review date	Version
November 2018	November 2021	V1.0

Purpose

- Guidance for the clinical management of patients within the Recovery department

Who should read this document?

- Recovery staff
- Theatre staff
- Trust site team
- Other users of the Recovery department i.e. Interventional Radiology

Key messages

- Clear process for patient transfer, handover and care in Main Recovery
- Key training and developmental requirements for staff

Accountabilities

Production	Katie Moore- Junior Sister and Catherine Martin- Senior ODP
Review and approval	Theatre and Anaesthetic Clinical Governance Committee
Ratification	Clinical Director Anaesthetics Theatre Central
Dissemination	Cindy McConnachie – Senior Matron Theatres and Anaesthetics
Compliance	Theatre Central Management Team

Links to other policies and procedures

- Recovery Practitioner Competencies document
- Recovery opioid competency pack
- Medical Device Training Policy
- Main Recovery Operational Management: Standard Operating Procedure
- Clinical handover of care and internal transfer of Adults (Excluding Maternity) Standard Operating Procedure

Version History

V0.0	Initial SOP	

PHNT is committed to creating a fully inclusive and accessible service.

Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff.

We will treat people with dignity and respect, actively promote equality and diversity, and eliminate all forms of discrimination regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/ maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\Document Library). Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

NHS
University Hospitals Plymouth
NHS Trust

Standard Operating Procedure (SOP)

Recovery Clinical Management

1 Purpose and Scope

- This SOP sets out clear guidance for the clinical management of patients within the Recovery department.
- It details a clear process for patient transfer, handover, care in Main Recovery and discharge to the allocated ward.
- It highlights the training and staffing needs in order to optimise safe, effective patient care.

2 Definitions

PACU	Post Anaesthetist Care Unit
PFC	Patient Flow Co-ordinator
CME	Continuous Medical Education
LMA	Laryngeal mask airway
I-GEL	Supra-glottic airway device
PCA	Patient Controlled Analgesia
AVPU	Alert, Verbal, Pain, Un-rousable
ICU	Intensive Care Unit
HDU	High Dependency Unit
SBAR	Situation, Background, Assessment, Recommendations (handover tool)
HCA	Health Care Assistant

3 Advisory Background

- The Association of Anaesthetists of Great Britain and Ireland (AAGBI)
- Nursing and Midwifery Council (NMC)
- The Royal College of Nursing (RCN)
- The Health and Care Professions Council (HPCC)

4 Roles and Responsibilities

- The Recovery department will be led on a day to day basis by a Recovery Co-ordinator who should be a senior member of staff.
- The Recovery Co-ordinator should not be expected to directly care for patients except in exceptional circumstances.
- The Recovery Co-ordinator is directly responsible to the Duty Senior Band 7 and must raise and highlight with them any issues that will directly impact on the performance of Recovery and Patient care.
- The Recovery Co-ordinator should participate in the Theatre Operational Meeting to discuss bed availability and capacity within the Recovery department.

- The Recovery Co-ordinator should attend the Site Operational Meetings, in the absence of the Recovery Team Leader to identify and communicate demand and capacity issues affecting Main Recovery.
- The Acute Care Team (ACT) are available for support with a deteriorating patient or advice on pain management. If a patient is discharged to a ward with complex on-going nursing needs or pain management, the ACT must be informed prior to patient discharge.

5 Standards

- All staff must have received appropriate training, as per the Recovery Practitioner Competencies.
    - These are in line with nationally recognised standards such as the UK National Core Competencies for Post-anaesthetic Care (AAGBI, 2013a).
- Training should be accessible and tailored to meet the individual needs of the Recovery staff.
    - Where possible CME times should be protected to ensure personal development, teaching and team training can take place, to ensure that the highest standards of care are met.
    - All Recovery Practitioners must have undertaking the local IV training and be assessed as competent to enable them to administer intravenous drugs, including opioids as prescribed.
        - Refer to Recovery opioids competency pack
- All staff should be encouraged to attain at least one Advanced Life Support qualification, but must have completed the annual mandatory resuscitation training for Adults and Paediatrics.

6 Patient care

- The Anaesthetist will formally hand over care to the Registered Recovery Practitioner, who must be satisfied with the condition of the patient and a plan of care must be documented before the Anaesthetist leaves.
    - The handover must be performed in accordance with the recovery handover checklist (Appendix 1).
    - The Anaesthetic handover checklist should be completed at handover on the peri-operative integrated pathway.
- The Scrub Practitioner will handover to the Recovery Practitioner in accordance with the recovery handover checklist (Appendix 1).
    - The Scrub Practitioner remains responsible for the patient until the Recovery Practitioner has taken over. This involves maintaining on-going monitoring and ensuring all relevant documentation are commenced.
        - Training opportunities are made available on CME sessions to develop these skills, if individuals require.
- All patients must be observed on a one-to-one basis by a Registered Practitioner until they have regained control of their airway and are cardiovascular stable.

        - When a patient is brought into Recovery with an endo-tracheal tube in situ, the Anaesthetist must remain with the patient until they deem that it is appropriate to remove the tube, which they must do so themselves. After removal, the Anaesthetist must stay in Recovery until they and the Recovery Practitioner are satisfied that the patient will need no further airway intervention.
            - Throughout the time the patient has an endo-tracheal tube in situ the patient's CO_2 should be monitored along with all other standard monitoring.
        - It is common that patients will arrive in Recovery with their airway being maintained via an LMA/I-GEL. LMA/I-GEL's should be left in situ until they are no longer tolerated by the patient, at which time they should be removed. All trained Recovery Practitioners should receive the appropriate training (Recovery Core Competencies) to ensure that they are competent at airway management.
    - The anaesthetising Anaesthetist is responsible for the medical care of their patients whilst they remain in recovery.
    - Handover of clinical care must be given to the duty Anaesthetist of any patients in Recovery when the responsible Anaesthetist becomes unavailable i.e. off duty. The named person must be communicated to the Recovery Practitioner.
    - Patients must be kept under clinical observation at all times. The frequency and type of observations will depend on the stage of recovery, nature of surgery and clinical condition of the patient. The observations will be consistent with "Recommendations for Standards of Monitoring during Anaesthesia and Recovery" (AAGBI, 2015) and local policies such as 'Essential Adult Inpatient Observations, Reporting and Escalation Policy' and Infusion protocols.
    - For patients where ICU/HDU is anticipated, but who are unable to go direct, can be brought to the Recovery department. However, it is imperative that the Recovery department is informed prior to the transfer from Theatre or procedural room. The standards of care should be equal to that of ICU/ HDU. The Anaesthetising anaesthetist remains responsible for the care of that patient, until such a time that the care for the patient is formally handed over to Critical Care.
        - Regular reviews are essential at this stage.
    - If a patient's condition deteriorates whilst they are in recovery then the Anaesthetist responsible for them should be informed immediately so that the appropriate action can be taken. If the patient needs to be transferred to ICU it is the responsibility of the reviewing Anaesthetist to co-ordinate with the ICU clinicians to ensure that this happens both quickly and in a safe manner.
    - Patients must only return to the ward when the discharge criteria has been met (Appendix 2).

7 Post-Operative: Pain Management

- All staff must have completed the Trust's administration of medication competencies prior to administering any form of analgesia.

- Accurate pain assessment tools must be utilised and the pain score documented (Appendix 3).
- Patients should participate in the assessment process wherever possible, non-verbal and physiological signs forming part of the assessment.
    - The Abbey Pain Scale is available for pain assessment if a patient is unable to verbalise (Appendix 4).
- Paediatric pain assessment tool must be used with paediatric patients (Appendix 5).
- Appropriate analgesia, as per the pain ladder, must be given to alleviate any discomfort (Appendix 6).
- Pain score on discharge should be at a level tolerable to the patient.
- Patients experiencing pain must be afforded some privacy and dignity when receiving treatment.
- There should be a referral process to the Acute Pain Team where necessary (see section 4 for details).

7a Post-Operative: Infusions

- These include: Patient Controlled Analgesia (PCA) / Epidural Infusion (PCEA/CEA), Peripheral Nerve Infusion, Spinal Anaesthetic, Ketamine and Local Anaesthetic IV infusion.
- All Registered Practitioners involved in the care of patients with any of the above infusion devices must be competent in the use and care of the medical devices.
- A stock check must be maintained in the Controlled Drug Register when withdrawing CD medication. A record of ward, patient hospital number and pump number must be kept for the ACT to track and monitor the patients on the ward.
- The infusion site must be checked for patency regularly and documented. Any reaction must be reported to an Anaesthetist and appropriate treatment undertaken to manage the patient's clinical condition. Accurate documentation must be maintained and this must be included during handover to the ward staff.
    - See guidelines on the relevant information sheet for managing adverse reactions.
- All records must be complete and recorded on the relevant observation chart, within the patient notes.
- Protocols for all infusion devices, describing overall management, troubleshooting guidelines and instructions for changing infusions must be available within the department. These protocols must be adhered to at all stages of the infusion.
- The specified emergency drugs must be readily available.

8 Post-Operative Nausea and Vomiting (PONV)

- PONV score must be recorded on the observation chart and appropriate action taken.

    - Drug therapy should be administered if required and as prescribed.
- Fluid loss must be recorded on the appropriate charts.
- Privacy and dignity must be maintained for patients experiencing PONV.

9 Record Keeping and Observations

- Speciality specific observation and documentation must be maintained. A concise description of this can be found on the 'Procedure specific observation and documentation chart- Main Recovery' document (Appendix 7).
- Conscious level (AVPU), pain and nausea scores must be recorded with all vital sign recording. Temperature must be measured on arrival and discharge.
- All appropriate patient records should be complete before the patient is discharged from recovery.
- A record of recovery times and name of Recovery Practitioner must be documented on the data capture forms.

10 Standard of care for delayed discharge to ward

- When a patient has met the discharge criteria and is clinically fit for transfer, however, the ward bed is not yet available; considerations regarding the level of nursing care should be reviewed. When appropriate, handover of care should be given to a Band 3 HCA until the ward bed becomes available.
- Alternatively, it may be appropriate for a Recovery Practitioner to receive a second post-operative patient, whilst maintaining safe care of all patients.
    - This requires appropriate patient allocation, considering the patient acuity and demand on the service.
    - In Main Recovery, this could be phrased as 'doubling up patients'.
- Ward based paperwork should be commenced at this time.

11 Discharge and Handover

- Patients must meet the discharge criteria (Appendix 2) prior to leaving Recovery. In certain circumstances where exceptions are made, the rationale must be documented in the patient's notes.
- Patients should be transferred to the ward accompanied by at least 2 members of staff one of whom should be suitably trained (see table below).

Healthcare Professional	**Level of care on discharge**			
	Level 0	Level 1	Level 2	Level3
HCA level 3	√ (no IV infusions)			

AP	√			
RN/ODP	√	√	√	
Anaesthetist				√

- Refer to the 'Clinical handover of care and internal transfer of Adults (Excluding Maternity) Standard Operating Procedure' for the level of care classification.
- The Recovery Practitioner must ensure that all of the relevant details and documentation is relayed to the ward staff, using an SBAR approach, with reference to the peri-operative integrated pathway.

12 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.
This document will be approved by the Theatre Policy and Procedures Committee and ratified by the Theatre and Anaesthetics Governance Committee.

Non-significant amendments to this document may be made, under delegated authority from the Anaesthetics Clinical Director or by the nominated author. These must be ratified by the Anaesthetic Clinical Director and should be reported, retrospectively, to the Theatre and Anaesthetic Clinical Governance Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed change

13 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Perioperative Matron and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

14 Monitoring and Assurance

What are we monitoring?	Safe care Fundaments of care Quality of patient care
How is it monitored?	Audits Daily review Saving lives Fundaments of care
Lead	Catherine Martin- Senior ODP
Validation	
Frequency	As per audit schedule
Reporting Arrangements	
Sharing the Learning	

15 Reference material

AAGBI (2013a) UK National Core Competencies for Post-anaesthesia Care 2013 https://www.aagbi.org/sites/default/files/corecompetencies2013.pdf

AAGBI (2013b) Immediate Post-anaesthesia Recovery 2013. *Anaesthesia* 2013; 68: 288-97.

AAGBI (2015) Recommendations for standards of monitoring during anaesthesia and recovery https://www.aagbi.org/sites/default/files/Standards_of_monitoring_2015_0.pdf

NICE (2016) Hypothermia: prevention and management in adults having surgery https://www.nice.org.uk/Guidance/CG65

Recovery Handover Checklist

Before Handover: **SILENCE**	**Handover**	
	Anaesthetic	**Surgical**
Apply brakes on bed/trolley Attach oxygen to wall flowmeter Place monitor on stand Quick patient assessment • **A** Airway patent • **B** Adequate breathing pattern • **C** Adequate blood pressure and • heart rate	Patient details inc. PMH, pre-op clinical status, allergies and seizures Type of anaesthetic Anaesthetic complications/ events Current Patient acuity Intra-operative Drugs Intra-operative blood loss/ IV fluids given (turn on fluids if applicable) • Post-operative plan • Expected complications • Monitoring parameters • Analgesia plan • IV fluids/transfusion trigger • PACU investigations • DVT prophylaxis • Medication review (drug chart) • Oxygen prescription • Antibiotics • Venous/arterial access • Infection control status	Procedure Surgical complications/ events Sutures and dressings Drains Local anaesthetic infiltration Operation note complete Post-operative plan Tissue viability Patients property Sick note (if applicable) Post Recovery destination Relatives (next of kin)

Main Recovery Discharge Criteria | Appendix 2

Although the following criteria should be met prior to discharge from recovery, patients can discharged from recovery if their parameters are at a variance to the documented limits, at the discretion of the Anaesthetist, who should ensure that their reasons are documented and it is safe to do so.

- The patient must be rousable to voice, able to maintain a clear airway and has protective airway reflexes
- Breathing and oxygenation must be satisfactory. Oxygen therapy must be prescribed as appropriate.
- The cardiovascular system remains stable, with no unexplained cardiac irregularity or persistent bleeding. The specific values of pulse and blood pressure must approximate to normal pre-operative values or be at an acceptable level, ideally within parameters set by the anaesthetist.
    - Peripheral perfusion must be adequate
- Pain and postoperative nausea and vomiting must be adequately controlled and suitable analgesic and anti-emetic regimens prescribed.
    - No patient will be discharged from recovery for at least 20 minutes after the last dose of IV opiates.
- Temperature must be equal to or greater than 36°c (NICE, 2016).
    - Patients must not be returned to the ward if significantly hypothermic.
- Intravenous cannulae must be patent and flushed to ensure removal of any residual anaesthetic drugs. Needle-free closed system devices must be in place unless the patient is a daycase.
- Intravenous fluids must be prescribed as appropriate
- All surgical drains, drain sites, wounds and catheters should be checked and their state documented.
- The position of all central lines (excluding femoral lines) must be confirmed by X-ray prior to the patient being discharged from recovery and the results of the X-ray appropriately documented.
    - 3-way taps must be removed and needle-free closed system devices attached to all lumens prior to discharge, except for patients going to ICU/HDU.
- Arterial lines should be removed prior to discharge unless the patient is being transferred to ICU/HDU then they should be left in situ.
- Appropriate DVT prophylaxis must be documented.
- All health records must be complete and medical notes present.

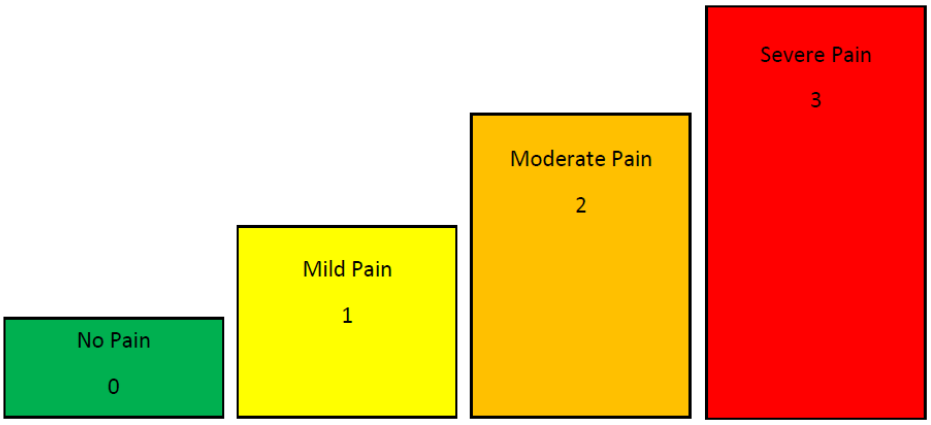
(AAGBI, 2013b)

Trust Pain Assessment Tool | Appendix 3

Plymouth Hospitals NHS
NHS Trust

Acute Pain Assessment Tool for Adult Patients
Pain is the 5th Vital Sign

- Assess pain and document on the observation chart whenever vital sign observations are taken
- Use the verbal rating scale below or the Abbey Scale (available on Staffnet under pain management) for non-verbal adults
- Assess pain on movement / deep breathing
- Treat moderate or severe pain
- If no response to intervention after 30 minutes, contact the ACT on 0195 or 89048
- Verbal rating scale may also be recorded as 0, 1, 2, 3



Alternate pain scales commonly used include a 0-10 verbal rating scale, bounded by "no pain" and "the worst pain imaginable". This is usually restricted to research applications. 10cm visual analogue scales are also utilized in research but not in routine clinical practice.

Abbey Pain Scale | Appendix 4

Plymouth Hospitals NHS
NHS Trust

Mark Rockett Review February 2019

The Abbey Pain Scale

For the measurement of pain in patients who cannot verbalise

Use of the Abbey Pain Scale

The Abbey Pain Scale is best used as part of an overall pain management plan.

Objective

The Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs.

Ongoing assessment

The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

The Abbey pain scale should be completed based on observations of the patients during activity or movement i.e. being rolled in bed, washed etc

Complete the scale immediately following the procedure and record the results on the observation chart. Record the action (if any) taken in response to results of the assessment in the patient's notes, eg pain medication or other therapies.

A second evaluation should be conducted one hour after any intervention taken in response to the first assessment, to determine the effectiveness of any pain-relieving intervention.

If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the pain scale hourly, until the patient appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken.

If pain/distress persists despite use of prescribed medications please ask your ward doctor to review the patient and either suggest alternative analgesia or management or if required advice from acute care team (pager 0195), palliative care or more senior doctors.

Adapted from Imperial College Healthcare NHS Trust Document

The Abbey Pain Scale

For measurement of pain in patients who cannot verbalise

While observing the patient, Complete the following 6 questions,

Total the score, take action, then record severity on the observation chart and action in patient notes (see above).

Q1. Vocalisation eg whimpering, groaning, crying			
Absent 0	Mild 1	Moderate 2	Severe 3
Q2. Facial expression eg looking tense, frowning, grimacing, looking frightened			
Absent 0	Mild 1	Moderate 2	Severe 3
Q3. Change in body language eg fidgeting, rocking, guarding part of body, withdrawn			
Absent 0	Mild 1	Moderate 2	Severe 3
Q4. Behavioural change eg increased confusion, refusing to eat, alteration in usual patterns			
Absent 0	Mild 1	Moderate 2	Severe 3
Q5. Physiological change eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor			
Absent 0	Mild 1	Moderate 2	Severe 3
Q6. Physical changes eg skin tears, pressure areas, arthritis, contractures, previous injuries			
Absent 0	Mild 1	Moderate 2	Severe 3

Total Scores

0-2 none **3-7 mild** **8-13 moderate** **14+ severe**

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.

Paediatric Pain Assessment

Pain is the 5th vital sign

- Please use one of the assessment tools below
- Self Reporting Scores are more reliable than Behavioural Scores
- Use the most appropriate for the child's age or development
- Please act if moderate or severe pain. Reassess 30 min later

0	=	none	pain
1 - 3	=	mild	pain
4 - 7	=	moderate	pain
8 - 10	=	severe	pain

AGE GROUP: 2 months to 7 years — **Behavioural**

FLACC Score

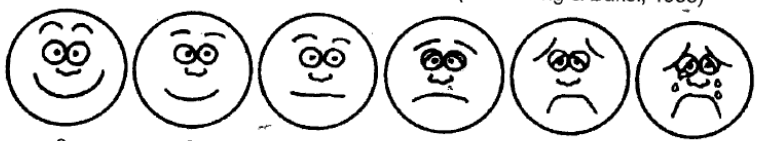
	Scoring 0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Leg	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

Score each category from 0-2: **(F)** Face; **(L)** Legs; **(A)** Activity; **(C)** Cry; **(C)** Consolability; giving a total out of 10
FLACC is also effective where the child is sedated or has learning difficulties.

AGE GROUP: 4 years and over — **Self-report**

Wong & Baker

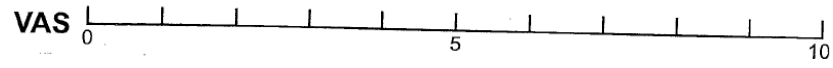
Point to each face using the words to describe the pain intensity. Ask the child to choose a face that best describes their own pain and record the appropriate number (from Wong & Baker, 1988)



0	2	4	6	8	10
No Hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst

VAS (Visual Analogue Score)

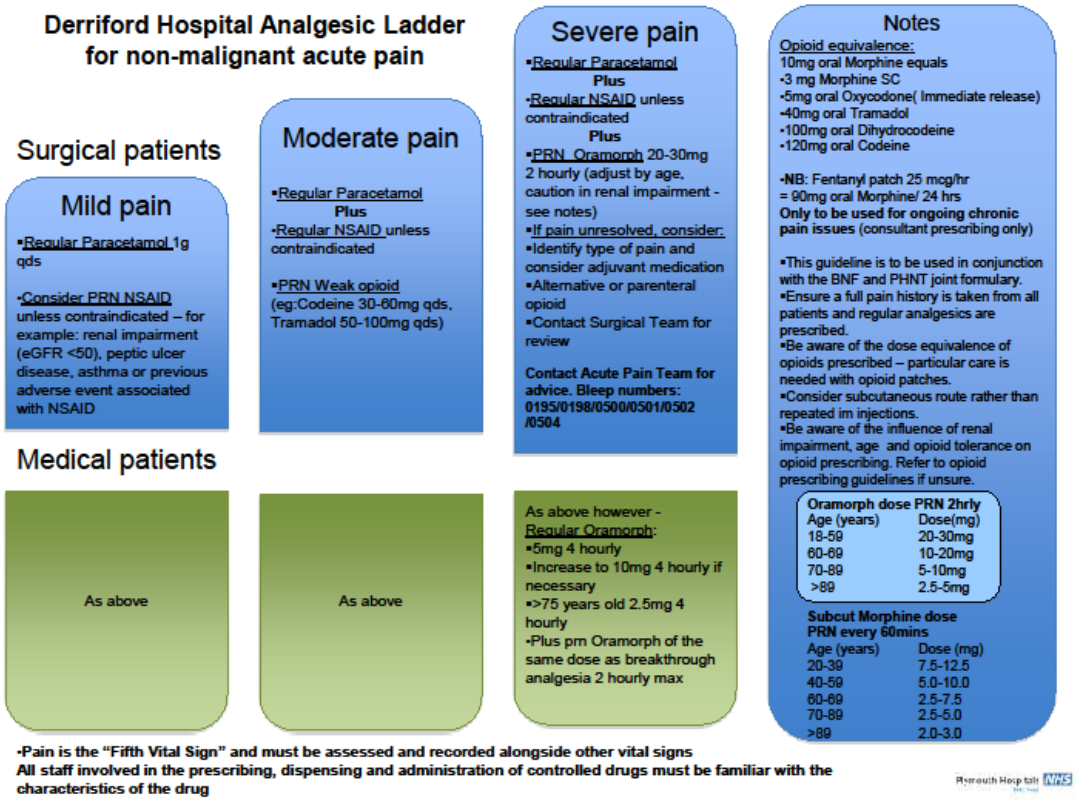
Ask the child to indicate on the line the severity of their pain.



Plymouth Hospitals NHS
NHS Trust

Paediatric Pain Team
Dec 2005

Version 3.2 Nov 2013


Derriford Hospital Analgesic Ladder for non-malignant acute pain
Surgical patients
Mild pain
▪Regular Paracetamol 1g qds
▪Consider PRN NSAID unless contraindicated – for example: renal impairment (eGFR <50), peptic ulcer disease, asthma or previous adverse event associated with NSAID
Moderate pain
▪Regular Paracetamol
Plus
▪Regular NSAID unless contraindicated
▪PRN Weak opioid (eg:Codeine 30-60mg qds, Tramadol 50-100mg qds)
Severe pain
▪Regular Paracetamol
Plus
▪Regular NSAID unless contraindicated
Plus
▪PRN Oramorph 20-30mg 2 hourly (adjust by age, caution in renal impairment - see notes)
▪If pain unresolved, consider:
▪Identify type of pain and consider adjuvant medication
▪Alternative or parenteral opioid
▪Contact Surgical Team for review
Contact Acute Pain Team for advice. Bleep numbers: 0195/0198/0500/0501/0502 /0504
Notes
Opioid equivalence:
10mg oral Morphine equals
▪3 mg Morphine SC
▪5mg oral Oxycodone(Immediate release)
▪40mg oral Tramadol
▪100mg oral Dihydrocodeine
▪120mg oral Codeine
▪NB: Fentanyl patch 25 mcg/hr = 90mg oral Morphine/ 24 hrs
Only to be used for ongoing chronic pain issues (consultant prescribing only)
▪This guideline is to be used in conjunction with the BNF and PHNT joint formulary.
▪Ensure a full pain history is taken from all patients and regular analgesics are prescribed.
▪Be aware of the dose equivalence of opioids prescribed – particular care is needed with opioid patches.
▪Consider subcutaneous route rather than repeated im injections.
▪Be aware of the influence of renal impairment, age and opioid tolerance on opioid prescribing. Refer to opioid prescribing guidelines if unsure.
Oramorph dose PRN 2hrly
Age (years) Dose(mg)
18-59 20-30mg
60-69 10-20mg
70-89 5-10mg
>89 2.5-5mg
Subcut Morphine dose PRN every 60mins
Age (years) Dose (mg)
20-39 7.5-12.5
40-59 5.0-10.0
60-69 2.5-7.5
70-89 2.5-5.0
>89 2.0-3.0
Medical patients
As above
As above
As above however - Regular Oramorph:
▪5mg 4 hourly
▪Increase to 10mg 4 hourly if necessary
▪>75 years old 2.5mg 4 hourly
▪Plus prn Oramorph of the same dose as breakthrough analgesia 2 hourly max
▪Pain is the "Fifth Vital Sign" and must be assessed and recorded alongside other vital signs
All staff involved in the prescribing, dispensing and administration of controlled drugs must be familiar with the characteristics of the drug
Plymouth Hospitals NHS

Procedure specific observation and documentation chart- Main Recovery

Appendix 7

Surgical Procedure	Cardiac Observation	Neurovascular Observation	Neurological observation	Eye observations	PV Check	Fluid Chart	PCA Chart	LAI Form	Spinal Chart	Epidural Chart	Sensation Chart	CVC Form	ERAS Protocol	NG Tube	Catheter Care Plan	Chest Drain
Arthroscopic Orthopaedic	✓	✓														
Total hip/knee replacement	✓	✓				✓	✓/-	✓/-	✓/-	✓/-					✓	
Partial hip/knee replacement	✓	✓				✓	✓/-	✓/-	✓/-	✓/-					✓	
Open shoulder	✓	✓				✓	✓/-									
Laparoscopic gynaecological surgery	✓				✓											
Total abdominal hysterectomy	✓				✓	✓	✓/-	✓/-	✓/-	✓/-					✓	
Laparoscopic gynaecological surgery	✓				✓	✓										
Laparoscopic/vaginal hysterectomy	✓				✓	✓	✓/-									
Open gynaecological surgery	✓				✓	✓	✓/-	✓/-	✓/-	✓/-					✓	
Lower Caesarean section	✓				✓	✓	✓/-		✓						✓	
Assisted delivery	✓				✓				✓							
Laparascopic cholecystectomy	✓					✓										
Open cholecystectomy	✓					✓	✓			✓/-					✓	
Laparascopic appendicectomy	✓															
Open appendicectomy	✓					✓	✓								✓	
Laparascopic hernia repair	✓															
Open hernia repair	✓					✓	✓	✓/-						✓/-	✓	
Small bowel resection	✓					✓	✓	✓/-				✓/-	✓	✓/-	✓	
Pancreaticoduodectomy (Whipples procedure)	✓					✓	✓	✓/-		✓/-		✓	✓	✓	✓	
Large bowel resection	✓					✓	✓	✓		✓/-		✓	✓	✓	✓	
Liver resection	✓					✓	✓	✓				✓	✓	✓	✓	
Laparascopic bowel resection	✓					✓	✓	✓					✓		✓	
Oesophagogastrectomy (Ivor Lewis procedure)	✓					✓	✓	✓/-				✓	✓	✓	✓	✓
Renal transplant	✓					✓	✓	✓		✓/-		✓			✓	
Formation of fistula	✓	✓				✓										
Endovascular aneurysm repair	✓	✓				✓						✓/-				
Femoral-popliteal bypass graft	✓	✓				✓	✓								✓	
Abdominal aortic aneurysm repair	✓	✓				✓	✓					✓			✓	
Carotid endarterectomy	✓		✓			✓	✓					✓				
Mastectomy	✓					✓	✓/-									
Wide local excision	✓		✓													
Transphenoidal hypophysectomy	✓		✓	✓		✓	✓								✓/-	
Microdiscectomy	✓		✓			✓	✓/-				✓				✓/-	
Lumbar decompression	✓		✓			✓	✓				✓				✓/-	
Lower spinal fusion	✓		✓			✓	✓				✓				✓/-	
Burr holes	✓		✓			✓										
Insertion of shunt	✓		✓			✓										
Anterior cervical discectomy and fusion	✓		✓			✓	✓				✓				✓	
Craniotomy	✓		✓			✓	✓					✓/-			✓	

Authors BM/KM

NB. All patients who are in recovery for over 4 hours must have an intentional care record commenced. A NEWS observation chart must be commenced for all Adult In-patients. A MEWS observation chart must be commenced for all Obstetric Adult In-patients.

Leading with excellence, caring with compassion