RECEIVING A PATIENT FROM RECOVERY POST SURGERY

1. PURPOSE
The safe transfer of care from the recovery room to the ward.

2. PROCEDURE

IN RECOVERY

1. Confirm the patient’s identity.

2. Assess the patient for the following in the recovery room
   - Airway maintenance
   - Respiration rate is > 10 breaths per minute.
   - Oxygen saturations > 95% on oxygen.
   - Pulse is regular and within normal parameters.
   - Systolic blood pressure as per the Adult Observation and Response chart MR 285.02
   - Peripheries are well perfused.
   - The patient is able to respond to commands.
   - The epidural block is at / below T4 (if in situ).

3. Check the operation notes.

4. Check the ongoing orders for analgesia, intravenous hydration, indwelling catheter etc.

5. Check the Epidural/opiate infusion pump program is ordered and check the rate infusing and the rate prescribed are correct.

6. Check all IV/Arterial/epidural/Naso-gastric lines are labelled appropriately.

7. Clarify any concerns before leaving the area.

8. The patient is transported to the ward area on their bed. Bedrails should be used during transportation. Ensure any prosthetic items are with the patient e.g. glasses, false teeth, hearing aid.

9. The patient must meet the Recovery Room discharge criteria. See clinical guideline Recovery Room Discharge Criteria

10. Following clinical handover the recovery nurse/midwife and the ward nurse / midwife must sign the handover section of the MR 325.
IN THE WARD AREA

1. Check the oxygen and suction is working correctly and that all equipment is present before collecting the patient.

2. Make the bed linen into a pack and place in the patients room.

3. Ensure an IV stand and infusion pump are available.

4. Place the additional following equipment in the patients room
   - Continence sheet
   - Pillow
   - Emesis container
   - Water jug, glass and straw
   - Drainage holders as necessary
   - Tape for drains
   - Perineal pads
   - IV labels

PROCEDURE | ADDITIONAL INFORMATION
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1. Return the patient to the room, position appropriately and ensure brakes are on. Hang the IV, IDC and drains as required. Remove any under sheets and check vaginal loss. Check the epidural site and all dependant pressure areas. Complete the Braden Scale MR 260.0 | Ensures the patient’s temperature is maintained. Identifies an occult vaginal bleeding. Enables inspection of the skin and epidural site.

2. Perform baseline observations and complete the Falls Risk Management Tool MR 810 Check all dressings, drains, intravenous therapy and vital sign measurements before leaving recovery room. | Note type and volume of loss. Ensures adequate orders available to continue management.

3. Ensure all documentation is complete. Complete a nursing care plan. Check the medication chart for analgesia and Post op nausea and vomiting (PONV MR327A). | Enables patient to have analgesic and anti-emetic if required.

4. Check the Epidural/opiate infusion pump program is ordered and check the rate infusing and the rate prescribed are correct.

5. Check the Anaesthetic chart (MR300) to see if analgesic or anti emetic has been given. This enables medication to be given on return to the ward if required, by checking the last time it was given and prevents administration error.
6. Ensure dentures, medical records and x-rays are returned to the ward with the patient.

7. Read the operation notes for post-op orders.

8. Position the patient according to the surgical procedure performed. Recheck all sites/dressings/drains.
   Perform and record vital signs as per clinical guidelines Care following Minor Surgery and Care following Major Surgery

9. Position the patient according to the surgical procedure performed. Recheck all sites/dressings/drains.

10. Empty IDC/SPC and observe drainage on drainage bottles. Mark drainage at 2400 hours. Nurse will be able to ascertain amount of loss during her shift and report abnormal drainage.

REFERENCES (STANDARDS)

National Standards – 1.8 Care provided by the clinical workforce is guided by current best practice
Legislation - Nil

Related Policies – P: Recovery Room Discharge Criteria
   Recognising and Responding to Clinical Deterioration
   WNHS Policy W 160 Patient Identification
   WHNS Policy Clinical Handover W073
   Labelling of Injectable Medicines and Fluids

Other related documents – Nil

RESPONSIBILITY

Policy Sponsor  Nursing & Midwifery Director OGCCU
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Access the current version from the WNHS website