POST OPERATIVE CARE DAY SURGERY UNIT (DSU)

POST OPERATIVE CARE IN DSU FOLLOWING A GENERAL ANAESTHETIC

KEY WORDS
DSU, general anaesthetic, airway, vital signs, discharge

AIM
The appropriate nursing / midwifery care of a woman in DSU following a general anaesthetic.

KEY POINTS

1. Observations should be performed as often as indicated by the woman’s clinical condition.
2. All deviations from normal shall be referred to a medical officer. Documentation of the referral shall be made in the patient’s progress notes.
3. Patients are not to leave the unit unaccompanied. If a patient refuses to wait in the unit, they must sign a “Discharge Against Medical Advice” form.
4. Patients shall only be discharged when they have fulfilled the discharge criteria on the Day Surgery Unit Care Record MR 335.

PROCEDURE

1. Collect the woman from recovery, noting any post operative orders.
2. Escort the woman to the DSU. Ensure she has a patent airway at all times.
3. On arrival in DSU perform and document a full set of vital signs - respiratory rate, oxygen saturations, heart rate, blood pressure, temperature and consciousness (If necessary, wake the patient before scoring). Record the observations on the Adult Observation and Response Chart (MR 285.02).
4. Check and document any wounds and vaginal loss. Laparoscopy patients should have the umbilical dressing changed if it is blood stained.
5. Observations are repeated in one hour, and then 4 hourly, unless the clinical condition of the woman dictates that they should be performed more frequently.
6. Check and regulate any intravenous infusions. Document the time an IDC was removed in theatre and / or DSU.
7. Ensure the woman is warm and comfortable.
8. Collect all documentation, note any discharge medications and send the medication chart to pharmacy if required.

9. Keep the following at the woman’s bedside
   • Day Surgery Unit Care Record MR 335.
   • Medication chart MR 810.05 and / or 810.06
   • Staff Initial / signature identification chart MR 810.12
   • Anaesthetic chart MR 300
   • Post operative Nausea and Vomiting Protocol chart MR 810.02
   • Appropriate post operative instruction sheet
   • Adult observation and Response chart MR 285.02
   • Fluid balance chart MR740
   • Diabetic record MR 265(when appropriate)

10. Give the notes to the ward clerk to complete the filing. Once done, the notes are returned to the notes trolley.

11. Provide analgesia and / or anti emetics as required.

12. When the woman is awake (generally after 1 hour), progressively sit her up in the bed. Offer fluids and sandwiches.

13. Collect the woman’s clothes from her locker and return them to her.

14. Disconnect the IV line, leaving the cannula in situ.

15. The woman should be asked to change into her own clothes by the bed.

16. Escort the woman to the lounge area when appropriate.

17. Encourage the woman to void. When she has voided the IV cannula may be removed.

18. Women who have undergone laparoscopic surgery must void a minimum of 100mL prior to discharge. It is recommended that they are transported to the bathroom by wheelchair when they initially get out of bed.

19. Provide the woman with a discharge information sheet, discuss any post operative instructions and complete the discharge criteria.

20. The woman may be discharged when she has achieved the discharge criteria. NB Patients are not to leave the unit unaccompanied.