**Aim**
- The appropriate post-operative nursing / midwifery care of a patient in the Day Surgery Unit following spinal anaesthesia.

**Key points**
1. Observations should be performed as often as indicated by the patient’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 patients refuse 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 patient from recovery, noting any post-operative orders.
2. Escort the patient to the DSU.
3. On arrival in DSU perform and document a full set of vital signs - temperature, pulse, respirations, blood pressure and oxygen saturations.
4. The observations are to be recorded in the Adult Observation and Response Chart MR 285.02 and Epidural/Spinal Anaesthetic Chart MR 280.
5. Check and record dermatomes. See KEMH Clinical Guidelines, Anaesthetics: Testing of Dermatomes
6. Inspect and record the condition of the spinal insertion site.
7. Check and document any wounds and vaginal loss.
8. Check that the Indwelling Catheter (IDC) in situ is patent and draining well.
9. Observations are repeated in one hour, unless the clinical condition of the woman dictates that they should be performed more frequently.
10. Check and regulate any intravenous infusions.
11. Ensure the woman is warm and comfortable.
12. The woman may sit up providing she is not hypotensive, nauseous or has a headache.

13. Collect all documentation, note any discharge medications and send the medication chart to pharmacy if required.

14. Keep the following at the woman’s bedside:
   - Day Surgery Unit Care Record MR 335
   - Epidural/Spinal Anaesthetic Chart MR 280
   - Operation Report/Day Surgery Discharge Summary MR 207.01/MR 315
   - DSU Pre/post-operative Protocol for DSU Patient MR 810.06
   - Staff Initial/signature identification chart MR 810.12
   - Anaesthetic chart MR 300
   - Appropriate post-operative instruction sheet.
   - Adult Observation and Response Chart MR 285.02

15. Give the notes to the ward clerk to complete the filing. Once completed, the notes are to be returned to nursing staff.

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

17. Offer fluids and sandwiches.

18. Collect the patient’s clothes from her locker and return them to her.


20. Remove the IDC when patient achieves a motor function/block Bromage score of 1. (Bromage score of: 1=sustain straight leg raise). See guideline above for more details.

21. Measure the volume of urine passed and document in MR 335.


23. Encourage the patient to void. Perform bladder scan hourly. Re-insert IDC if bladder volume >= 350ml, the patient feels uncomfortable, or is unable to void within 4 hours. If IDC re-inserted, request review by the surgical team and notify duty anaesthetist. Disconnect the IV line, leaving the cannula in situ.

24. The patient should be asked to change into his/her own clothes by the bed.

25. Transport the patient to the lounge area in a wheelchair when appropriate.

26. Provide the patient with a discharge information sheet and ‘After your Epidural’ information sheet, discuss any post-operative instructions and complete the discharge criteria.

27. The patient may be discharged when he/she has achieved the discharge criteria. NB. Patients are not to leave the unit unaccompanied.
28. The IV cannula is removed just prior to discharge.
29. If the patient leaves before he/she has fulfilled the discharge criteria, complete a ‘Discharge against Medical Advice’ form and advise the anaesthetist before the patient leaves.