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Interview

Your Local Anaesthetic/Recovery Unit: What Makes it Special?

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1. Describe the type of service you provide in your anaesthetic/recovery room?

The Post Anaesthetic Care Unit team here in York cares for patients following surgery in two locations within the same hospital. The Main theatre suite comprises of 12 theatres and the Day Theatre suite has 6. We also provide a monthly service to the MRI unit in recovering paediatrics following anaesthesia for scans, as children are unable to keep still for the period it takes to scan. Surgery includes many specialities including vascular, colorectal, urology, gynaecological, orthopaedic, Max Fax, ENT, general surgery (including bariatric), liver surgery and acute surgery.

The PACU staff care for patients waking up from routine surgery, regional anaesthetics and critically ill postoperative patients, both adult and children. In addition, for patients identified at pre-assessment as medium to high risk on cardio-pulmonary exercise testing, a programmed level of high dependency care is booked, staying in PACU for up to 6 h. For the majority of patients, this will be sufficient to ensure they are haemodynamically stable, oxygenated and comfortable prior to discharge to the Nurse Enhanced Unit, in most cases bypassing the need for admission to the High Dependency Unit. Also, carotid endarterectomy patients are monitored in PACU for a minimum of 2 h. Again, this has in most cases avoided the need for an overnight stay in the High Dependency Unit.

2. How is your unit set up?

Main theatres cater for the critically ill, postoperative patient requiring more involved care, invasive monitoring and prolonged stay. In the main theatre suite, the PACU is central (Picture 1), with the theatres situated down two sides. It has 16 patient bays. On the left side we have a 3 bay area for HDU patients and on the right side we have 2 paediatric bays decorated with murals of dolphins and fish to make an acute clinical area more 'paediatric friendly' (Picture 2).

The nurse's station (Picture 3) is very small and comprises of a bench with 2 computers, telephones, the communication diary and information boards for rotas and theatre lists. The Acute Pain team works closely with us and follow-up patients with PCAs' and epidural pumps set up and commenced by PACU staff. They require access to some relevant information from the documentation in PACU, therefore they too have a white board above the station. We also hold resources such as books, journals and articles, protocols and guidelines relevant for students and nursing staff in this area.

The Day Unit PACU is a recent purpose-built L-shaped unit, therefore more spacious and modern. It has 11 patient bays again split into adult (Picture 4) and paediatric areas (Picture 5). More surgery is being performed on an up to 23 h 59 min stay basis including types of surgery traditionally associated with longer in-patient hospitalisation, i.e. cholecystectomies, tonsillectomies and mastectomies. Patients with minor past medical histories having smaller surgery, e.g. minor urological, gynaecological or hernia procedures, are now performed as day cases. These patients stay for a shorter period of time in PACU and return to the Day ward bays, where they are discharged at the end of each session, once the discharge criteria is met. The nurses' station here is an even smaller area with room only for the computer, printer, communication diary and small area for storage of stationary and resource files.

3. Introduce us to your team.

The PACU team is made up of 22 nurses, 2 of which are on permanent night shift but who alternate onto day shifts for a short period each year to undertake any training or development plans.

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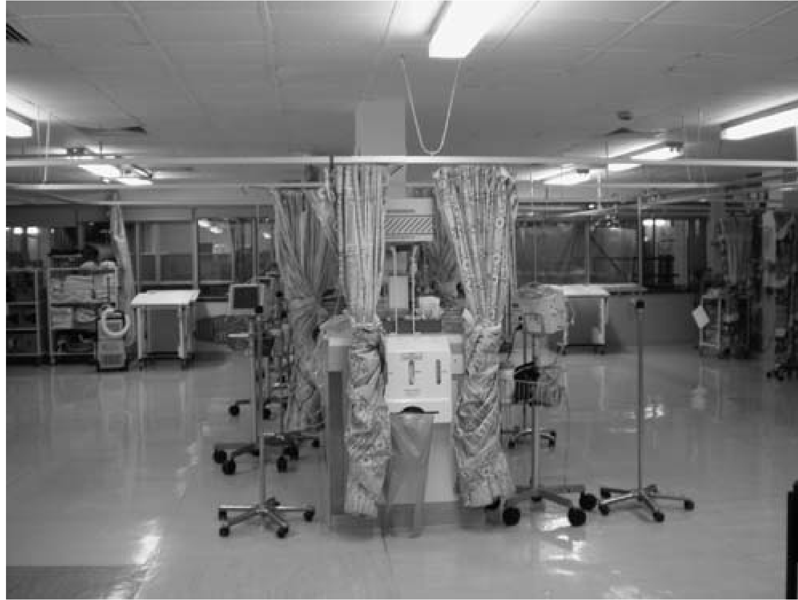
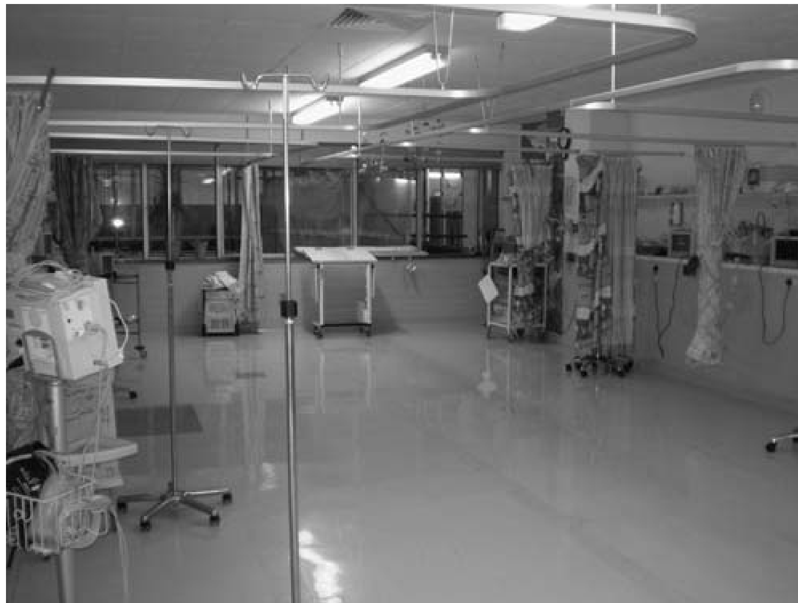


Picture 1.



Picture 2.

We have 1 Team Leader, 2 Deputy Team Leaders and the remaining are all staff nurses. Three porters are allocated to cover main theatres and PACU and in the Day Unit, 2 porters. PACU is devoid of a resident anaesthetist therefore medical assistance is sought from the acute anaesthetist if the anaesthetist from the list is no longer present or from the on-call consultant anaesthetist or intensivist, if the acute anaesthetist is unable to attend due to theatre working.

Each Monday to Friday we aim to cover the busiest part of the day (10.00–18.00 h) with up to 8 staff in the main theatre suite and 2 to 5 nurses on the Day Theatre suite depending on the number of lists running, workload and skill mix. Evenings are often busy times; therefore we maintain staff

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Picture 3.

Picture 4.

numbers at 4 or 5 between 19.00 and 21.00 h. To reduce lone working, we roster one nurse to work till 24.00 h alongside the night nurse in the main theatre suite.

Weekend working is generally covered by 2 staff per shift, to reduce lone working and meet the needs of the theatre acuity. Main theatres run an acute and trauma theatre until 13.00 h on Saturday. One acute theatre will run for the remainder of the weekend. Day Theatres finish at 18.00 h on Friday.

4. What are the daily clinical or managerial challenges you cope with in your unit?

The nature of the workload in the PACU is difficult to plan and co-ordinate effectively as it depends on

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Picture 5.

the length and nature of the surgery. It is difficult to predict the staffing levels required at peak times and admissions sometimes have to be halted to maintain patient safety. The ratio varies depending on theatre activity, staff skills, experience and patient care requirements during the 24-h period.

Effective communication is vital in order to use resources effectively and ensure that the patients' journey is managed safely and professionally ensuring they experience no further stress to what is likely to be their most traumatic journey.

ICU capacity has diminished without cessation of surgical procedures during the building of a new unit and as Aps (2002a, b) suggests, acute surgical patients often prioritise poorly against other urgent or medical admissions. The availability of trained personnel, resources and space with the ability to maximise patient safety places pressure on PACU staff to manage ICU overflow patients. This appears to be happening nationally as it is recognised by many authors (Radford, 2003; Lindsay, 1999; Richardson, 2002; Ryan and Tobin, 2003). Admissions frequently occur during the night and may give rise to bed blocking the following day for surgical patients as well as staffing issues.

PACU nurses now require multiple skills to cover the diversity of the workload and staff often perceive themselves to be giving sub-optimal care in these situations, which causes low morale with an effect on retention and recruitment. Therefore maintenance of clinical competencies, having 'Standards of Practice' in place alongside identifying and securing resources for development, training and education is paramount and often challenging, particularly in these times of change and financial constraints.

When faced with adversity and change, displaying clear transformational leadership attributes can be challenging but rewarding; being honest, inspirational, enthusiastic, optimistic, and encouraging motivation and innovation.

5. What part of your working day do you find the most rewarding?

- Personally for me in my role, I enjoy the challenges each new day brings. I am passionate about effective leadership and team working and find it both beneficial and rewarding.
- Keeping patient care at the top of the agenda, maintaining and delivering safe and high-quality care for what is likely to be their most traumatic journey.
- Supporting staff through difficult decisions. I work in a very pro-active team, who not only identify problems but also work at finding a solution to the benefit of both patients and colleagues.
- Following particularly busy shifts or where staff perceive they have given sub-optimal care, it is most rewarding to encourage staff to reflect,

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review and discuss. This often happens the following morning when they have had time to reflect (or worry) at home. This stimulates personal and professional growth and may ultimately improve patient care.

- Being able to give feedback, reward team efforts and support innovation.
- Encourage team working both in work and socially to learn together and give colleagues support.
- Being able to meet staff hierarchical needs and improving moral by simple efforts like getting staff off-duty out on time, but being consistent and fair in all areas.
- Embracing change and new opportunities and encouraging others to do likewise.

6. How do you orientate learners in your unit and what provision do you have for on-going education?

- In PACU we take a large number of nursing students from their 2nd year of training. We also train ODP students and have junior medical staff, therefore we have a good number of mentors within the units. Each student will have 2 mentors assigned to them and will mainly work with them.
- For newly trained staff, we orientate them to the Trust through 2 study days and they too will be assigned a mentor in PACU to work through a competency package. The new starter will be supernumery for a period of 6–8 weeks. Periods will be organised for them to rotate through the various critical areas in order to learn new skills. Each year every member of the PACU team will have a Personal and Professional Development Review, following which action plans will be discussed and agreed to meet identified objectives. This may mean shadowing a specialist nurse, rotating to another area, undertaking Trust or University study days or modules or arranging updates.
- Staff are encouraged to take part in a monthly Journal club to promote practice and show evidence of a learning culture and identify needs and arrange training for a half day each month (Clinical Governance rolling day).
- Weekly meetings are high on our agenda. This improves communication; allows problems to be discussed, shared and dealt with; conflict to be kept to a minimum and all team members to be involved in decision making.
- Time for annual mandatory training is organised.
- Each nurse will volunteer to undertake a link nurse role and take responsibility for updating policies and protocols and training staff in the department, i.e. student, diabetic, paediatric, infection control, manual handling, blood transfusion, tissue viability and health and safety.
- For the past two years and hopefully to continue, we have, as a team organised a formal study day in this hospital, organising workshops and lectures which will encourage networking, development and enhancing the care of the postoperative patient. As I mentioned earlier obtaining resources for development, training and education is paramount and often challenging in these times of change and financial constraints.

7. What was the last audit/research your unit took part in and what were the outcomes?

- 'Should *parents be invited to recovery to be with their child on waking?*' Parents did want to come to PACU and this is encouraged as soon as the LMA or ET tube is removed.
- '*Lone working, is patient care compromised*'.
- '*Does hypothermia extend patient stay in PACU?*' This was very successful in showing patients could spend a couple of hours in PACU, simply to bring them to normothermia when all other discharge criteria was met. It gave us the opportunity to educate staff in the importance of this throughout all surgical areas. This may come to the fore again in the very near future with the NICE guidelines on normothermia for the surgical patient.
- '*Bringing beds to theatre to reduce manual handling*'. As a result of this audit, all major cases now come into PACU on a 'Profiling' bed instead of a theatre trolley. This has reduced manual handling for staff and benefits the comfort of the patient as it avoids having to transfer them several times following surgery.
- The latest audit undertaken and completed was for patients undergoing carotid endarterectomy with a local anaesthetic. By monitoring patients in PACU for a minimum of 2 h, it was shown to be effective in reducing the necessity for these patients to occupy a HDU or ICU bed immediately following surgery and the 1st postoperative night, as the patients are usually stable enough to return to a surgical ward. Further information may be sought from Dr. S. Forde, Consultant Anaesthetist at York Hospitals NHS Foundation Trust. Email: steven.forde@york.nhs.uk

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