Summary

The postanesthesia care unit (PACU) is designed and staffed to monitor and care for patients who are recovering from the immediate physiologic effects of anesthesia and surgery. PACU care spans the transition from one-on-one monitoring in the operating room to the less acute monitoring on the hospital ward or, in some cases, independent function of the patient at home. To serve this unique transition period, the PACU is equipped to resuscitate unstable patients while providing a tranquil environment for the "recovery" and comfort of stable patients. Its location in close proximity to the operating rooms facilitates rapid access to physician consultation and assistance.

Emergence from anaesthesia, although usually uneventful, can be associated with major morbidity. The unconscious patient may develop upper airway obstruction with subsequent hypoxaemia and hypercapnia and is at increased risk of aspiration due to the absence of the protective airway reflexes. The hazards are compounded in the immediate post operative phase as the patient may be haemodynamically unstable requiring ongoing resuscitation.

The importance of observation and early intervention during this period has been recognised for many years. Adequate post operative recovery facilities along with fully trained staff should be provided in all hospitals, and ideally, at all times.

The patient should be placed in the left lateral position on a tipping trolley, supplemental oxygen should be administered and care should be taken to avoid injury to eyes, dentition and peripheral nerves. The anaesthetist must accompany the patient during transfer and hand

over information about any medical condition, the anaesthetic technique, intra-operative problems and post operative management to the recovery staff. Oxygen saturation must be monitored during transfer.

Continuous observation must be made on a one-to-one basis by a nurse trained in recovery procedures until the patient is able to maintain their own airway. Respiratory and cardiovascular parameters, pain severity and conscious level should be documented at appropriate intervals.

All patients should have oxygen saturation measured in the recovery room until discharge. Non invasive blood pressure and electrocardiogram (ECG) monitoring should be used where clinically indicated and the means for invasive monitoring should be available.

Set criteria must be met before a patient is discharged to the ward. The patient being transferred to the high dependency or intensive care unit is an obvious exception to this.