

# How safe are level 3 patients when cared for in Post Anaesthetic Care Units?

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# Overview

- Standards of care
- Potential barriers and effectors to high standards
- The anecdotal background & literature
- Responses to our request for information
- Next steps

# Standards of care

- Those who experience critical care services and their relatives should be confident that they have received the best possible care. Staff should be able to work with enthusiasm knowing that they are being enabled to give their best for their patients

– Paraphrased from Department of Health (2000)  
*Comprehensive Critical Care*

# Standards of care

- The characteristics of the service should be:
- Integration
  - A hospital wide approach to critical care with services extend beyond the physical boundaries of intensive care and high dependency units
- Networks
  - Service provided in the context of integrated networks involving several Trusts working to common standards and protocols

# Standards of care

- Workforce development
  - A planned approach to human resources, workforce planning, recruitment and retention issues, education & training
- A data collection culture promoting an evidence base
  - A service underpinned by good information that will ensure the delivery of an effective service in terms of outcomes for patients
  - Paraphrased from Department of Health (2000)  
*Comprehensive Critical Care*

# Standards of care

- Although a lower level of care will usually require a lower nurse to patient ratio or reduced critical care support, this may not apply in all circumstances and the aim should be to be flexible in the provision of staff resources to meet the needs of the patient...*the location of patients does not determine their level of care*

– Paraphrased from Intensive Care Society (2009)  
*Levels of Critical Care*

# Barriers & effectors

- Nationally agreed competences & development frameworks
  - Outreach (in press)
  - Acutely ill patient (published)
  - Advanced and assistant practitioner for critical care (published)
- Services run on the lowest possible staffing establishments
  - AFC means high salaries for those with high level clinical skills; higher salaries mean fewer employees

# Barriers & effectors

- Bed management
  - Intra-network transfers & intra-site bed management
- Rotation of nursing staff between critical care and
- Communication & reciprocally favourable relationships between
  - Critical care ward staff
  - Operating department staff
  - Anaesthetic & PACU staff
  - Surgical departments

# Anecdote & literature

- The question of support for nurses working with this problem came up at a perioperative nurses' conference (December 2007)
- The RCN Perioperative and Critical Care forums held a joint open meeting and gave a voice to others in similar situations (May 2008)
  - Rotation is good but not every one wants to do it
  - Outreach support varies from site to site
  - Swapping staff between units works well

# Anecdote & literature

- There are no national standards and practices vary widely; of 14 respondents, 4 offered no training to PACU nurses in this aspect of care  
– (Hodge 2006)
- PACU nurses who don't have appropriate skills (and their patients) are vulnerable to errors  
– (Aps 2004)
- These pressures often arise “out of hours”
- PACUs are neither designed nor equipped for full-blown critical care  
– (Ziser et al 2002)

# The request for information

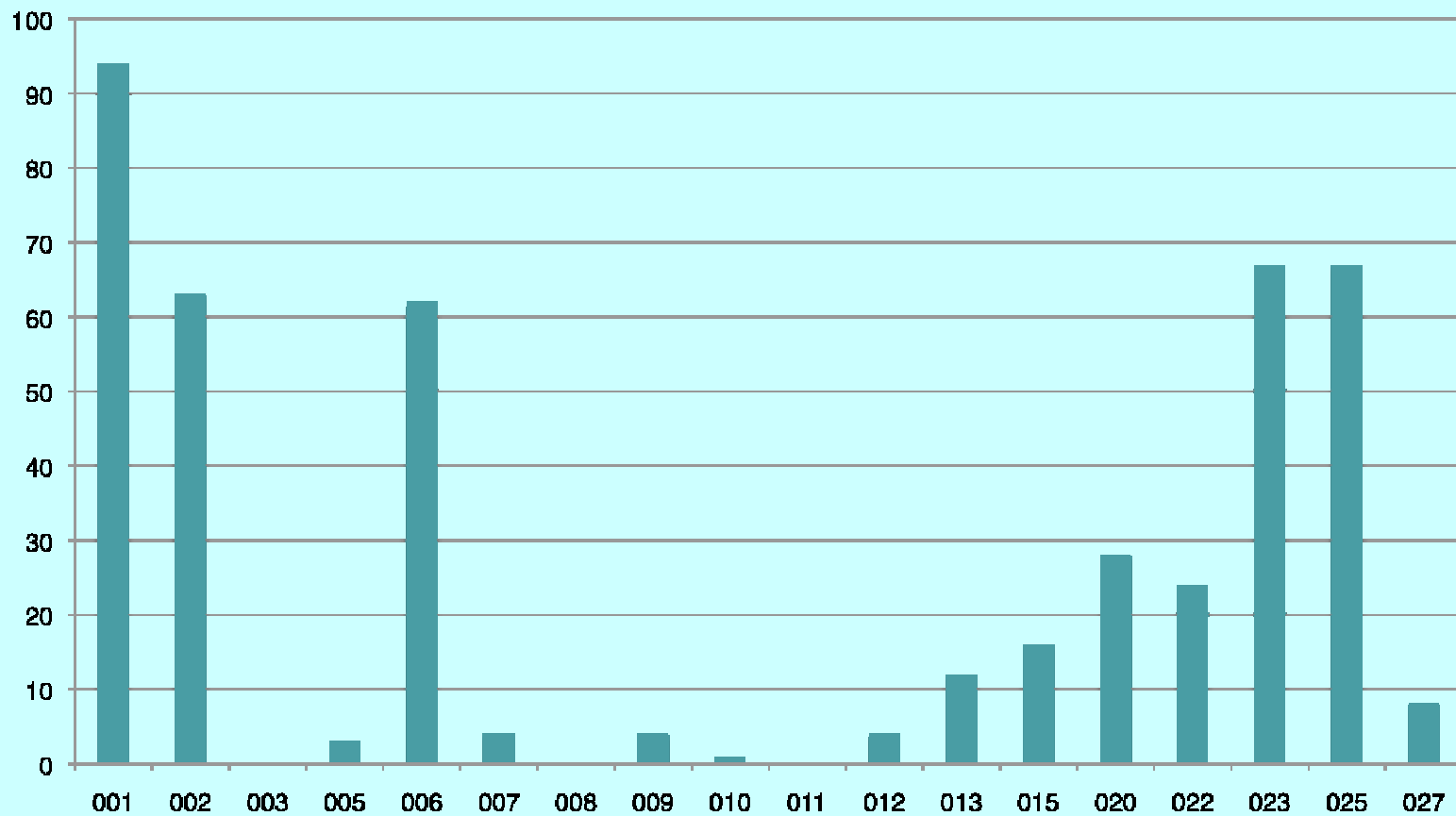
- In the period between 00:00 hours on 1st January 2008 and 23:59 hours on 31st December 2008, on how many occasions did the following phenomenon occur in the hospitals of your NHS Trust?
  - A person meeting the criteria of level 2 or level 3 critical illness by either Department of Health 2000 or Intensive Care Society 2009 definitions being cared for in a post-operative recovery room, post-anaesthetic care unit or other operating department recovery facility for longer than 3 hours and 59 minutes

# Responses to the request

- We do not collect/hold that information
  - 2 Trusts in England
  - 3 Scottish Boards (x hospitals)
  - 1 Welsh Trust (x hospitals)
- Retrieving the information would exceed the cost of compliance (£600.00p)
  - 1 Scottish Board (x hospitals)

# Responses to the request

<b>1</b>	<b>2</b>	<b>3</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>8</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>15</b>	<b>20</b>	<b>22</b>	<b>23</b>	<b>25</b>	<b>27</b>
94	63	0	3	62	4	0	4	1	0	4	12	16	28	24	67	67	8



# What we know now

- The phenomenon is not isolated
- Support services remain variable
- Nurses are nervous and feel vulnerable
  - This suggests that patient are therefore vulnerable
- Comments in the responses to the request for information suggest that some Trusts are aware of “something”
  - We cannot surmise what they are concerned about or what they plan to do about it

# What it does not tell us

- What management strategies are used to deal with the phenomenon
- Whether those strategies lead to safe, high quality care
- Whether the nurses delivering the care are competent to do so or not

# Next steps

- Write a position statement advising on immediate strategies
- Devise and disseminate a competence framework
- Investigate the qualitative elements of management strategies in sites where this occurs
- Exapant the scope of this work to include junior doctors, assistant practitioners and ODPs