

Editorial

Post anaesthesia care unit length of stay: meeting the needs of today's ambulatory surgery patient

Bernard V. Wetchler

As modern surgery developed during the 20th century, no other aspect of healthcare in the United States has evolved and blossomed to maturity in as short a period of time as has ambulatory surgery, moving from less than 10% of surgical procedures performed in 1970 to 65% in 1995. With the experience gained has come significant liberalization of criteria for both patient and procedure selection. Post anaesthesia care unit (PACU) criteria for patient discharge have also changed, but at a much slower pace. There has been a move away from time-based recovery where the patient is required to stay for a minimum amount of time, unrelated to clinical activity level, and is being replaced by criteria-based recovery where patients who meet specific criteria are considered ready for discharge, regardless of time spent.

In their article, 'Discharge Following Ambulatory Surgery', Marshall and Chung conclude that patients can be discharged rapidly and safely if an ambulatory surgery patient specific scoring system is utilized. Early scoring systems developed by either Aldrete or Steward were non-specific for the day-surgery patient, whereas the modified Post Anaesthesia Discharge Scoring System (PADSS) developed by Chung and co-workers, in addition to vital signs, scores ambulation, nausea and vomiting, pain, and surgical bleeding.

By assigning numeric values to parameters indicating patient recovery, progress becomes more obvious than it would if vital signs were merely charted with accompanying notes, such as, 'patient reacting — appears able to go home'. In a discussion of a patient's postoperative condition, a numbered system is more easily understood, and it allows physicians and nurses to communicate with a common language. A scoring system is a way of providing uniform assessment for all patients and may have added medicolegal value when used in addition to the customary subjective means of assessing a patient's home readiness. For any scoring system to be useful, it must be a practical and simple method of evaluating the patient; it must also be easy to remember and be applicable to all post anaesthesia situations. A scoring system should not create busy work for the nursing staff

and take away from patient care.

Today, even though time-based recovery still exists in some facilities, the requirement for a PACU stay is being questioned by other facilities. Patients who have received short-acting anaesthetics, local anaesthesia with sedation, or regional blocks are being moved directly from the operating room to a secondary, less intensive recovery area if specific criteria are met. Rapid recovery of patients undergoing general anaesthesia in the day-surgery setting is now possible because of the pharmacokinetic and pharmacodynamic properties of the short-acting, fast emergence (S.A.F.E.) anaesthetic agents. The S.A.F.E. study, reported at both the 1996 American Society of Anesthesiologists Annual Meeting and the New York Post Graduate Assembly in Anesthesiology demonstrates that policies and procedures can be developed which will allow patients to safely bypass the labor-intensive first phase of post anaesthesia care. If a patient, at the conclusion of surgery and anaesthesia, meets all discharge criteria while still in the operating room, the anaesthesiologist would be permitted to bypass the phase I recovery area and transfer the patient directly to the phase II recovery unit. Preliminary data at five sites revealed that phase I recovery could be safely bypassed by 70–100% of patients receiving local anaesthesia with sedation, and anywhere from 13% to 40% of patients who received general anaesthesia. On average, the time spent in the less intensive phase II recovery unit was either the same or shorter than the duration of stay for patients who came from the phase I unit.

Recovery care is truly in a state of flux; on the one hand, as some facilities attempt to bypass the PACU, other day-surgery units are expanding their recovery care, providing 24–48 h of care for patients who have had more complicated procedures, in a continuing attempt to contain costs and to avoid use of hospital beds.

With the ever increasing number of ambulatory surgical procedures, each facility must perform its own outcome studies. Assessment of patient needs and time spent in the PACU is becoming an increasingly relevant issue, from both a clinical and cost standpoint.