Guidelines for Less Than 24-hour Aftercare Recovery Units

"Managing Your OR" focuses on various aspects of aesthetic surgery in the ambulatory surgical setting.

In the past few years, there has been extensive media coverage of serious complications and fatal outcomes that have occurred in unregulated office-based surgical facilities. This heightened awareness has triggered an in-depth review of office-based surgical facilities by a number of states seeking regulation of facilities through licensure, mandated standards, or accreditation by national agencies, such as the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).

With the development of generally accepted national standards, such as those of AAAASF, it became apparent that the continued health, safety, and welfare of patients treated in these units and then transferred less than to 24-hour aftercare recovery units should also be reviewed. These recovery units play a significant role in the overall management of the surgical patient, but they have the potential to cause postsurgical problems. California has requested the input and expertise of the AAAASF to address this issue. To develop facility guidelines, the Standards Committee has implemented a task force that includes surgeons and anesthesiologists who receive input from recovery room nurses and home health nursing services. These minimal requirements are applicable to the single-surgeon, office-based surgical facility as well as to multispecialty ambulatory surgical centers, and they are intended as an added service for patients' safety and general comfort, not as a replacement for medically indicated hospitalization.

The existence of such aftercare facilities must be allowable under state law, and the facility must be licensed (if this is required by the individual state). For standardization purposes, the accepted overnight stay period begins with the time of the patient's arrival in the postanesthetic care unit and may extend to a maximum of 23 hours and 59 minutes. The patient may be discharged at any time before the end of this maximum time, but under no circumstances may the period be extended. If additional recovery time is required, the patient must be hospitalized or transferred to an extended-care unit.

James A. Yates, MD, Camp Hill, PA, *is a board-certified plastic surgeon and an ASAPS member.*

Robert Singer, MD, La Jolla, CA, *is a board-certified plastic surgeon and an ASAPS member.*

There are 2 levels of overnight aftercare services to be considered, depending on the needs and requirements of the individual postsurgical patient. In level I, the patient may need intravenous fluids or require intramuscular or intravenous medications. Monitoring of vital signs—including blood pressure, pulse, and O_2 saturation levels—and recording of these parameters may be required along with wound evaluation. It should be emphasized again that this care does not replace indicated hospital admission or transfer. Staffing requirements for level I aftercare services are as follows: at least one registered nurse, and at least one other trained medical professional to assist the registered nurse with medications, equipment, food service, or calls for emergency help. One of the members of the staff present in the level I unit should have advanced cardiac life-support training with evidence of current certification.

Level II aftercare service is for observation purposes only. At this level of care, patients receive no intravenous fluids or intravenous or intramuscular medications and may be capable of taking their own medications. This type of care is custodial only; the patient has already achieved the level of recovery suitable for discharge. The only vital signs required for level II care are blood pressure, pulse, and respiratory rates. A Licensed Practical Nurse or Licensed Vocational Nurse is sufficient to meet staffing requirements.

Several general requirements are necessary for level I and

Table 1. Necessary medications

1. Intravenous fluids
2. Epinephrine
3. Lidocaine (plain)
4. Vasopressors other than epinephrine
5. Narcotic antagonist (Narcan)
6. A minimum of fifteen 50-mL vials (or equivalent) of preservative-free H_2O diluent for Dantrolene
7. A minimum of four 50-mL ampules of $NaHCO_3$
8. A minimum of 12 vials of Dantrolene
9. The facility must be within close proximity to an available source that can and will provide the remaining dose of 24 vials of Dantrolene with sufficient diluent on a STAT basis in the event of an emergency, or the remaining vials and diluent must be stored in the facility.
10. Seizure-arresting medications (Valium, barbiturates, dilantin)
11. Bronchospasm-arresting medications (aminophylline)
12. Intravenous corticosteroids (to treat anaphylaxis)
13. Antihistamines (to treat anaphylaxis)
14. Antihypertensives (to decrease blood pressure)
15. Atropine
16. Neuromuscular blocking agents
17. Benzodiazepine reversing agent (Mazicon, Flumazenil)

Table 2. Resuscitative equipment

1. EKG monitor with pulse readout
2. Pulse oximeter
3. Blood pressure monitoring equipment
4. Defibrillator
5. Oral airways
6. Nasopharyngeal airways
7. Laryngoscope
8. Endotracheal tubes
9. Endotracheal stylet
10. Positive pressure ventilation device (Ambu bag)
11. Source of O_2
12. Source of suction

level II status. A physician should be present in the unit or immediately accessible by phone or pager. The patient may only be admitted to and discharged from the recovery unit with a written or verbal order from the physician responsible for the patient's care. An existing postanesthetic care unit or other room designated for this specific purpose may serve as the recovery unit. This area should be immediately accessible to all other areas of the surgical facility and must conform to all applicable state and local codes for occupancy and fire safety. There must be sufficient illumination for patient evaluation, with battery-operated lighting available in the event of a power outage, and an emergency backup power unit to provide at least 90 minutes of power to all life-safety devices and resuscitative equipment. The building that houses the facility must be accessible after normal operating hours by elevator and/or properly functioning doors. Each patient's bed should be equipped with a nurse call button or alert signaling device. If there is more than one bed in the unit, all of them must be visible from a central nursing station. Appropriate patient and staff restrooms are necessary, and telephones should be available for patient use. If more than one patient is in the recovery unit at any time, the registered nurses and trained personnel should be available in sufficient numbers to meet the patients' needs. Food should be purchased, stored, and prepared in compliance with local Health Department regulations, and all personnel providing food services must meet local health regulation requirements. The written record for overnight care should include all treatment orders and nursing notes, along with patient follow-up instructions.

In each recovery unit, all necessary medications should be available (Table 1) and resuscitative equipment (Table 2) should be in proper working order. Equipment and medication supplies must be available in a sufficient quantity to meet the needs of all patients in the unit. A policy should be developed for the immediate transfer of any patient in case of an emergency, and the physician who arranges the transfer must have current privileges at the receiving hospital. Finally, level I and level II patients may share the same overnight or aftercare facility. At the conclusion of the maximum stay period, the patient must be either discharged home or sent to another aftercare facility or hospital.

Although these considerations for aftercare recovery units may be revisited in the future, as presently described they provide basic guidelines for safe and effective patient recovery in the office-based setting. ■

Dr. Yates is Chairman of the Standards Committee of the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).
Dr. Singer is President of the AAAASF.

Reprint orders: Mosby, Inc, 11830 Westline Industrial Drive, St Louis, MO 63146-3318; phone (314) 453-4350; reprint no. 70/1/104906