6. THE POSTANAESTHESIA PERIOD

6.1 Care of patients recovering from anaesthesia

To be reviewed in 2026

- Recovery from anaesthesia must occur under appropriate supervision in an area designed for this purpose.
- This area should either be in the theatre itself or close to where anaesthesia was administered.
- The staff members who work in this area must be appropriately trained. When the need arises, staff must be able to contact the anaesthetist or designate promptly. See Section 2.4 Anaesthesia support personnel.
- It is desirable for patients to have regained consciousness and be stable before they are transported any distance.
- If patients must be transported within and from the operating suite when not fully recovered, they must be moved on a suitably designed trolley or bed capable of a head-down tilt. The bed or trolley should be provided with oxygen, a means of inflating the patient's lungs, equipment for suctioning and an appropriate monitor. The patient must be accompanied by qualified staff to deal with problems that may occur during transport.

6.2 Transfer from theatre to recovery room

To be reviewed in 2026

It must be noted that the safe transfer of the anaesthetised patient from the theatre to the RR is of the utmost importance.

1. A roller board should be used, if available, and the patient should be gently transferred from the theatre bed to trolley/bed.
2. An adequate number of staff should be available to transfer the patient from the theatre bed to the patient trolley/bed.
3. All lines and equipment should be handled with care.
4. The oxygen mask, filter and suction tip should accompany the patient to the RR.
5. An IV infusion stand should be available on all trolleys/beds.
6. The dignity and privacy of the patient should always be protected.
7. The bed should be tidy and clean.
8. All trolleys/beds should be fitted with safety straps or cot sides. These should be in working order.
9. The anaesthetic nurse/specifically appointed person should assist the anaesthetist with transferring the patient to the RR.

6.3 Guidelines for the handover of postoperative patients to the staff of the theatre recovery area

To be reviewed in 2026

- The responsibility of the anaesthetist does not end with the handover to the recovery staff. The anaesthetist or an appointed designate should be available in the theatre complex until it can be reasonably assumed that anaesthesia has worn off.
- The anaesthetist must formally hand over a patient's care to a RR nurse or other appropriately trained staff members.
- The patient should be breathing spontaneously, and oxygen saturation should be appropriate.
- The patient should have recovered from the neuromuscular blocker, as determined by the return of the train-of-four or by appropriate clinical signs of recovery, e.g., head lift or hand squeeze.
- The patient should be haemodynamically stable. If excessive blood loss has occurred, the anaesthetist should remain with the patient until adequate volume resuscitation has occurred and appropriate measures to test haemoglobin level and blood products have been ordered if necessary and the ordering of homologous blood has been carried out.
- The patient should have adequate control of pain and PONC.

Safe handover of postoperative adult patients to RR staff is easily remembered with the use of the STAMPED acronym.

S	T	A	M	P	E	D
Stable patients in all respects	**Tell** the recovery staff about preoperative and intraoperative condition/problems	**Airway** secured	**Muscle** relaxants adequately reversed	**Pain** and nausea under control	**Ensure** that fluids and haemoglobin are adequately replaced	**Discharge** the patient from recovery room

Airway patency remains the responsibility of the anaesthetist until patients can maintain their own airways. Patients should not be left unattended with an airway device in situ. The airway should remain the responsibility of the physician anaesthetist until such time that conscious control is taken back over by the patient or the responsibility is handed over to another responsible physician anaesthetist. SASA strongly recommends that endotracheal tubes and supraglottic devices should be removed by the attending anaesthetist.

The anaesthetist should authorise discharge from the recovery area to the ward. Patients should not be discharged until they have regained airway control, are haemodynamically stable, and can communicate adequately. If the modified Aldrete score is used to assess the patient before discharge, it is reasonable to expect that the patient must score ≥ 9/10 before discharge, unless there is a good reason for failure to meet these criteria.

Aldrete score

Should be 2/2 for each parameter depending on circumstances and at least 9/10 before discharge from the recovery area.

Activity	Able to move four extremities voluntarily or on command	= 2
	Able to move two extremities voluntarily or on command	= 1
	Unable to move extremities voluntarily or on command	= 0
Respiration	Able to deep breathe and cough freely	= 2
	Dyspnoea or limited breathing	= 1
	Apnoeic	= 0
Circulation	BP 20% of preanaesthetic level	= 2
	BP 20–50% of preanaesthetic level	= 1
	BP 50% of preanaesthetic level	= 0
Consciousness	Fully awake	= 2
	Arousable on calling	= 1
	Not responding	= 0
Colour	Pink (SaO_2 > 92% on room air)	= 2
	Pale, dusky blotchy (O_2 required for SaO_2 > 90%)	= 1
	Cyanotic (SaO_2 < 90% despite supplementary oxygen)	= 0
Total		

If the patient requires admission to an ICU or high care unit, the anaesthetist should remain in attendance until the transfer has taken place and handover to the appropriate personnel has occurred.

The time at which the responsibility of the anaesthetist for a particular patient end is not possible to determine precisely. It is reasonable to expect an anaesthetist to be in attendance, or at least available, until the patient has fully recovered from the anaesthetic and until the anaesthetist is satisfied that there are no sequelae from the delivery of the anaesthetic. In addition, if the patient is to be handed over to other medical personnel, it is the responsibility of the anaesthetist to ensure that the patient is stable, that the medical personnel are competent to take over the management of the patient, and that the handover is done clearly and concisely to ensure continuity of information.

6.4 Management and supervision

To be reviewed in 2026

Written protocols for safe management should be established.

A written daily routine for checking the equipment and drugs must be established.

Observations should be recorded at appropriate intervals and, at the very least, should include state of consciousness, colour, respiration, oxygen saturation, pulse, BP, and pain level. The record should form part of the patient's clinical notes.

All patients should remain in the RR until the anaesthesiologist considers it safe to discharge them from the RR according to validated criteria, which include return of protective airway reflexes, stable cardiovascular and respiratory function, full reversal of neuromuscular blockade, absence of nausea and vomiting, and absence of pain.

The anaesthesiologist is responsible for:

- Supervising the recovery period and authorising the patient's discharge.
- Accompanying the patient to the RR and adequately handing them over to the nursing staff, who will document the patient's condition on arrival and subsequent course in recovery.
- Providing appropriate written and verbal instructions and information to the RR staff for each case.
- Specifying the type of apparatus and the flow rate to be used in oxygen therapy.
- Remaining in the facility until the patient meets the criteria detailed above or delegating this responsibility to another anaesthetist or intensivist (after providing appropriate information to such a doctor).

The airway should remain the responsibility of the physician anaesthetist until such time that conscious control is taken back over by the patient or the responsibility is handed over to another responsible physician anaesthetist. SASA strongly recommends that endotracheal tubes and supraglottic devices should be removed by the attending anaesthetist.

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