

POSTANESTHESIA UNIT IN THE PRIVATE HOSPITAL *

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ONE of the recent advances in the care of the surgical patient has been the introduction of the postanesthesia unit. This unit is practical, and relatively economical. Its tantamount value lies in the added safety for the patient who is undergoing a surgical procedure.

The advantages of such a unit extend in many directions. The patient is assured of a safer and more satisfactory recovery from anesthesia. Nurses, especially trained to recognize early signs and symptoms of undesirable complications of anesthesia and surgery, maintain continuous observation of the patients. Apparatus and supplies are concentrated in one location to meet any emergencies. The airway is properly controlled until the patient's reflexes return. Oxygen therapy is available to combat hypoxia. Incipient shock states are recognized early and actively treated. Gross postoperative bleeding can be recognized early. In transurethral surgery, for example, the immediate institution of irrigations, made possible by this unit, has been of great value in controlling clot formations which had been an annoying postoperative complication. For the most part the patient's postoperative requirements for fluid therapy are met before he leaves the unit. These, then, are the advantages to the patient.

The anesthesiologist and the surgeon are relieved of the worry regarding the safety of their patient during the early postanesthetic period. A member of the Department of Anesthesiology is always available in case of emergency and for routine checking of patients in the unit.

The advantages to the hospital are many—nurses and supplies to care for postoperative patients are not duplicated all over the hospital. The various nursing floors are relieved of the burden of caring for these patients, allowing routine nursing care to be carried on more efficiently. The continuing shortage of nurses warrants a system such as this, which allows the floor nurses to carry on their regular duties undisturbed. Out-patients who require minor surgical procedures under general anesthesia need not occupy hospital beds. They can be cared for in the unit at a nominal charge.

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Relatives of the patient and other patients in wards are relieved of the distressing sights and sounds associated with recovery of the patients from anesthesia. Likewise, since the postanesthesia unit is located adjacent to the operating rooms, such scenes of the patient recovering from anesthesia are not observed in the halls and elevators of the hospital, while returning from surgery to their rooms.

In all hospitals today the primary difficulty in organizing a postanesthesia unit is finding a suitable location not already in use. At Presbyterian Hospital this was met by taking a small suite of rooms adjacent to the operating rooms, consisting of two, two-bed wards with intervening bathroom. To help offset this loss of four surgical hospital beds, private rooms elsewhere in the hospital were converted into two-bed wards. The space now provided for the postanesthesia recovery unit accommodates a total of seven beds. The bathroom was set up as a supply and storage room.

The administration of the postanesthesia unit is under the Department of Anesthesiology. However, this is considered as a cooperative venture of the Department of Surgery and the Department of Anesthesiology in that the final word in the care of the patient is subject to the desires of the individual surgeon. This policy has, in no small way, been a factor in the successful operation of our unit.

The types of patients sent to the postanesthesia unit include all those who have received general anesthesia and any patient, regardless of type of anesthesia, whose condition warrants close observation for a number of hours during the early postoperative period. Patients who have had certain types of surgical procedures are not sent to the unit, notably, spinal fusions and cataracts, since it is preferable to move these patients as little as possible. Also, children are returned directly to pediatrics because the inclusion of these patients would overtax our facilities at the moment. The pediatric service carries a higher complement of nurses who can care for these patients.

The unit is open from 8:30 a.m. to 9 p.m. and is staffed by two graduate nurses and one orderly. In addition, student nurses (on the basis of one student nurse per week) rotate through the unit for training in the postanesthetic care of patients. The optimal daily turn-over of patients is about 2 patients per bed or, in the terms of our unit, about 14 patients per day. If necessary, however, about 18 patients can be accommodated daily, although this tends to strain our facilities.

From an economic point of view the postanesthesia unit will operate on a deficit basis in the hospital. A charge is made to the patient who receives the services of the unit and this charge is based on the type of accommodation the patient occupies in the hospital. The expenses of operating the unit are partially defrayed by these charges. The hospital administration and the medical staff are in complete agreement that the deficit created by the operation of this unit is minimal compared to the safety afforded the surgical patient. The patient

need no longer employ a private nurse for the first eight hours on the day of operation, and part of this saving pays the charge for the service in the postanesthesia unit. Besides, on the operative day, the private nurse's time is wasted to a great extent during the many hours while the patient is in surgery. This waste of private nurses' time is eliminated when patients can pass through a postanesthesia unit.

In our experience there have been two disadvantages to the operation of a postanesthesia unit. Relatives of the patient continue to express anxiety, even though they have been warned that the patient will be detained for some number of hours following operation. This is essentially a minor objection and we are attempting to relieve it by maintaining close liaison between the unit and the patient's nursing station so that information of the patient's recovery may be relayed to the relatives. A second disadvantage is the cost to the hospital of operating such a unit. The advantages to the patient are so great, however, that this objection loses its importance. The advantages of the postanesthesia unit are so many and varied that they greatly outweigh any disadvantages that we have noted so far.

In conclusion, we believe that the formation of the postanesthesia unit has been the greatest advance made for the care of surgical patients in this hospital in many years. The hospital administration, the medical staff, and the nursing division are in thorough agreement that it should remain as a permanent part of this institution.