POSTANESTHESIA OBSERVATION ROOM

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The postanesthesia observation room at St. Mary’s Hospital, Rochester, Minn., was established on March 17, 1942. The name was soon contracted to P.A.R., by which it will be called throughout this article. Since the problem of postanesthesia care is of great concern to the anesthetist, the room was arranged and is supervised by the staff of the Section on Anesthesiology of the Mayo Clinic.

The purposes of the postanesthesia observation room are: (1) to improve the care of the patient during the immediate postoperative period; (2) to make the special skill of the anesthesia staff available to the patient; (3) to concentrate the nursing care and thus lessen the duties of the floor nurses. Some of the many values of the system have become more apparent as it continues to be used. The patient, before leaving the operating room, is seen by a senior staff anesthetist. At that time the general condition of the patient, the depth of anesthesia, and the condition of the teeth and eyes and of the airway, as well as the presence or absence of any foreign body in the mouth, are checked. The patient receives better care in the P.A.R. than he would if he were in his own room. Other patients on the floors benefit from the arrangement because nurses are able to continue the care of those patients without being confined to the full-time care of the unconscious patient. The surgeon’s assistant is relieved of the immediate care of his patient. When he has accompanied the patient to the P.A.R., he may quickly return to the operating room and be confident that his orders will be carried out and that any emergency will be handled by the anesthetists. Every patient has the benefit of having readily available any of the special equipment that may be needed during his recovery. It would be impossible to equip every room in the hospital with all of the devices for emergency use, such as laryngoscopes, intratracheal tubes, airways, suction apparatus, and resuscitators. Drugs, fluids, and equipment for their administration are kept ready for immediate use (fig. 1).

The P.A.R. is situated near the operating rooms. It has been estimated that there should be one bed in the room for each operating room. At St. Mary’s Hospital, there are 12 operating rooms, and in the P.A.R. there are 15 beds. Each of the beds should be arranged so that it can be seen from any part of the room. Male and female patients
Fig. 1.—Table showing equipment kept ready for use in P. A. R.
are placed in the same room. Since the patients are returned to their own rooms before they are fully aware of their surroundings, there is no necessity for having separate wards for men and women.

The P.A.R. is opened at 8:00 A.M. and is closed at 5:00 P.M. Two graduate nurses and an orderly are in attendance. The room has two telephones to insure easy communication with the anesthesia room on the operating room floor. Physician anesthetists respond to calls for any special care the patient may require. Because of their familiarity with the problems of the unconscious patient, the nurse anesthetists who are not busy in

Fig. 2.—View of one end of P. A. R. showing arrangement of beds and equipment.

the operating room may be useful in the P.A.R.

Some of the problems of the P.A.R. have been solved. The patient is placed with his head toward the foot of the bed (fig. 2). This saves many unneces-

sary steps as the nurse walks from one patient to another. Sideboards are placed on each bed to prevent the patient from falling out of bed. Relatives of the patients are not permitted in the P.A.R. When a patient is sent there, the nurses on the floors are instructed to inform the relatives who may be waiting for him as to his whereabouts.

It has been estimated that the time which a patient spends in the P.A.R. is roughly equivalent
to the time he spent in the operating room. During his stay in the P.A.R., he receives fluids or any other medication or treatment which may have been ordered for him. When he has regained consciousness and his condition is satisfactory, he is taken to his room. A résumé of the treatment he has received is

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The increasing use of curare in combination with anesthetic gases has decreased the number of patients who are sent to the P.A.R. When a patient recovering from a general anesthetic has low blood pressure or respiratory depression, or requires special attention for any other reason, he is sent to the P.A.R.

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Lundy—Post Anesthesia Observation Room Record—1942

Fig. 3.—Record used in P. A. R.

sent to the floor with him. Special carts, which extend to the level of the bed instead of higher, as do carts used in the operating room, make the moving from and to the beds easier for the patient and for the P.A.R. personnel.

Not all patients who are operated upon are sent to the P.A.R. For instance, during one year more than 15,000 persons were operated on at St. Mary’s Hospital, and only 4,329, approximately 29 per cent, were sent to the P.A.R. The decision to send the patient to the P.A.R. is made by a senior member of the anesthesia staff. When a patient is awake after general anesthesia and when his condition is satisfactory, he is sent to his own room.

After the use of local or spinal anesthesia, the patient does not require special care unless, of course, shock or other complicating factors alter the picture. When a patient has engaged a special nurse, he may be sent to his own room although he is unconscious. When additional care may be necessary, he is sent to the P.A.R., and his special nurse attends him there until such time as the need for extra care has passed. When a respirator or other elaborate apparatus is necessary in the postanesthesia period, the patient is sent to his own room, although he may be unconscious. The services of the anesthesia staff, when they are needed, are available to him there.
Records are kept for each patient who comes to the P.A.R. (fig. 3). On the reverse side of the record sheet, which does not contain any printing, details of the pulse rate, blood pressure, and respiration are recorded. In addition to this record, detailed daily records are kept of the hours, numbers of patients, treatments, and so forth. From these records information has been obtained which will give some idea of the amount of work which was concentrated in the P.A.R. during the first five years of its existence.

During the period from March 17, 1942, to March 17, 1947, 18,593 patients were cared for in the P.A.R. at St. Mary's Hospital. Each year the room was in use for an average of 295 days. More than 30 patients were cared for in a single day on several occasions. Each patient spent an average of 1 hour and 32 minutes in the P.A.R.; the time varied from a few minutes to 21 hours. In the latter instance, a special nurse stayed with the patient in the P.A.R. Although the actual hours on duty for the P.A.R. staff varied from day to day, over the five year period the average was seven hours a day, six days a week. The room is not open at night, on Sunday, or on holidays.

Records of all treatments have been kept for the five year period. During that time, fluids, other than blood, were administered intravenously more than 9,500 times. In addition to cases in which the intravenous administration of fluids was started in the P.A.R., there were 1,930 instances in which the administration was started in the operating room and continued in the P.A.R. Blood transfusions were started in the P.A.R. 488 times; 427 transfusions were completed in the P.A.R. after having been started in the operating room. These figures do not include the transfusions which were started and completed in the operating room. Some of the drugs which were given were insulin, hydornone, morphine, epinephrine, synkamine, and cortin. Carbon dioxide and oxygen as well as oxygen alone were administered a total of 85 hours during the five year period. Hypodermoclysis was started 7,695 times.

The P.A.R. may be used for other purposes than actual post-anesthesia observation. Patients who have undergone encephalography, for instance, may be kept in the P.A.R. while the encephalograms are being examined. Out-patients who may require observation or rest for a few hours before leaving the hospital may be sent to the P.A.R.

To evaluate the usefulness of the P.A.R. it would be necessary to transpose the statistics into actual performances. Not only the number of hours needed to attend the unconscious patients but also the time and number of persons required to bring equipment, to prepare hypodermic or intravenous apparatus, and to procure and set up suction apparatus would have to be taken into account. In addition to nursing duties, the time required and the distances covered to accomplish the many duties of the physicians in caring for the patients when they are allowed to recover in their own rooms, widely sep-

(Continued on page 57)
sions can be drawn from the circumstances of their occurrence in the reported cases. However, the opinions of two groups of workers deserve mention. Mousel states: "There is a great deal of controversy in regard to the etiology of convulsions which occur during general anesthesia. Impurities in the ether, impurities in the oxygen, hypoglycemia, an overdose of atropine, cerebral anemia, alkalosis, hyperventilation, idiosyncrasy, disturbance of calcium metabolism, anoxemia, deficiency in carbon dioxide, overoxygenation and many other factors have been suggested as possible causes for this condition." With regard to convulsions occurring during ether anesthesia, Rosenow and Tovell suggested that "ether convulsions are attributable to a neurotoxin produced by some strains of streptococci in amounts insufficient to cause spasms in the absence of anesthesia but which in the course of general anesthesia suffice to incite the muscular spasms characteristic of this condition."

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P. A. R.

(Continued from page 24)

arated over the hospital, must be considered.

An idea of how indispensable the P.A.R. has become is illustrated by a statement taken from the report on its use in 1944.1 "In 1944 the room was closed for the entire month of April when it was moved from one building to another and the superintendent of the hospital wished to see what the result would be if the room were closed. The response from the nurses and others was immediate and one supervisor said she would rather resign than carry on without this facility. The superintendent considers the P.A.R. an excellent arrangement." At the present, when nursing service is limited by the shortage of nurses, the P.A.R. has solved one of the problems by arranging for the care of patients during the critical post-anesthesia period in such a manner that one nurse does the work which usually requires the services of three nurses.

BIBLIOGRAPHY
