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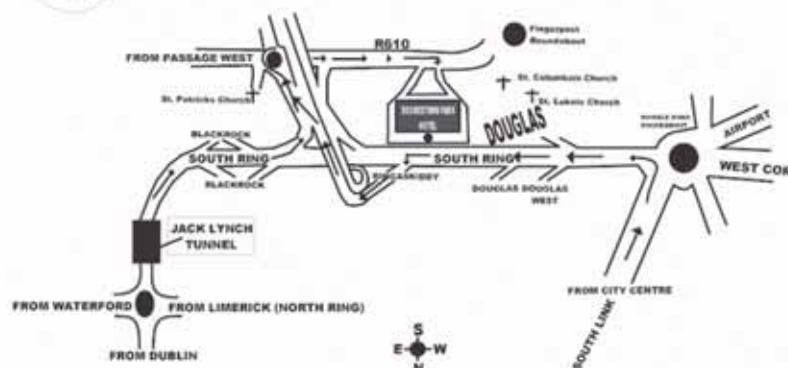
Venue for the
IARNA Conference 2006
 on
Saturday, October 21st 2006

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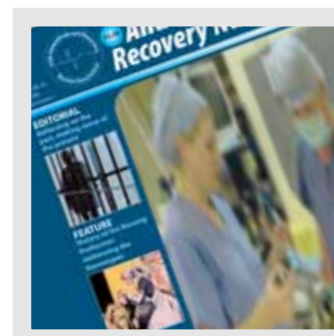


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Fionuala O'Gorman and Sheila Murphy attending the Multi-Disciplinary Conference on November 25th in Brookfield Health Sciences Complex, University College Cork, Ireland.

Chairperson's Letter



Fionuala O'Gorman

Chairperson

As we begin a New Year I would like to take this opportunity to wish our members a Happy New Year. I hope the forthcoming year will be productive and rewarding for everyone.

The Irish Anaesthetic and Recovery Nurses Association in 2001 was founded by Sheila Murphy. She had great vision and foresight to understand the need for such an organization, but more importantly, she had the *get up and go*, stamina and courage to actually go and do it.

From the outset, the organization has gone from strength to strength with the development of the journal, the website, the annual conferences and links to other international organizations. In order for this to take place there was a lot of hard work from many people with major contributions from members of the Cork, Dublin and the Galway committees for the organization of past conferences. The 2006 conference will be held in the **Rochestown Park Hotel** in Cork on Saturday October 21st 2006, which is a date for you to keep free in your diary

As the incoming Chairperson of IARNA, I firstly want to acknowledge all the work that has been done to date and hope to further consolidate the position of the organization in the arena of peri-operative nursing both nationally and internationally.

I wish to reach out to nurses and managers who are responsible for patients not only in the acute setting, but also in all settings where patients require anaesthesia and essential monitoring during their recovery period. These settings range across a broad spectrum of health care delivery and include areas such as the gastro-intestinal clinics, radiology, and dental surgeries.

All patients post anaesthesia require nursing care but patients truly benefit if this care is delivered by an experienced anaesthetic and recovery nurse, who is trained to anticipate a situation through early recognition and intervention. This is often referred to in peri-operative journals as the *"invisible knowledge"* of peri-operative nurses. Therefore it is essential we turn this invisible knowledge to a visible knowledge underscored by a need for experienced peri-operative nurses to care for patients in all settings. In order for our care to be visible we have to document it and work at it. This will ensure that our approach to patient care can never be negated to a chore or task that anyone can do.

Again I wish all our members a great 2006 and I look forward to your continued support and ideas to further the work of this organization.

Yours Sincerely,
Fionuala O'Gorman

About the Journal

Irish Journal of Anaesthetic & Recovery Nursing

JOURNAL DESCRIPTION

The Journal is published on a quarterly basis and provides articles, reviews, letters and discussion on key topics, which are pertinent to the perianaesthesia nurse. Topics include updates on clinical issues, perianaesthesia nursing care, research on perianaesthesia nursing care, legislation and the practice of the perianaesthesia nurse. Other features include updates on practical innovations, book reviews, conference reports and education supplements.

AUTHOR GUIDELINES

The Irish Journal of Anaesthetic & Recovery Nursing welcomes manuscripts pertaining to nursing practice in the areas of Anaesthesia and Recovery. The Journal endeavours to publish information on current trends in the provision of optimum health care. Manuscripts (which examine an area of clinical practice, details the author's research or discusses practical innovations), short-case studies, papers expressing professional opinions or letters are welcome from all members of the multidisciplinary team.

EDITORIAL AND PEER REVIEW POLICY

Manuscripts are evaluated by the Editor and two members of the IJARN Editorial Board while the Editor may modify the style of a contribution, major changes will be reviewed by the author prior to publication.

MANUSCRIPT PREPARATION

Submit three copies of the manuscript (on paper) and one copy on a disc (Microsoft Word document). Discs and paper copies of the manuscript will not be returned to the author. The manuscript must be double spaced, wide margin (3.17 cm left and right margins and 2.54 for top and bottom) and should be typed on one side of the paper only. The word count should be up to 2000 words (consult Sub Editor for specific advice). The top sheet should display: paper title, author's names, professional and academic qualifications, positions and place of work and address to which all correspondence should be sent. Figures, legends, tables, pictures (submitted on a separate page) should be referred to in the text and their appropriate position referred to in the margin. The main text should be preceded by a short summary (100-200 words).

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References in the text should cite the author's names followed by the date of publication, in date order e.g. (Murphy 1990, McCarthy 1998 and Lennox 1999). Where there are three or more authors, the first author's name is followed by et al (O'Sullivan et al 1999), all author's names are included in the reference list. Text taken directly from another article i.e. a direct quote should be referenced with the page number (Ryan 2001 p.29). Detailed list of references should be included as a separate page which include author's surnames and initials, year of publication, title of paper, name of journal, volume number (and issue number where relevant) and first and last page numbers.

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Editorial

The Future of Anaesthetic and Recovery Nurses



Josephine
Hegarty

Editor

In recent years nursing in general has tried to keep pace with rapidly changing technology, the need to provide quality evidence based patient care in the presence of economic constraints (despite a national economic boom), changing patient demographics and population characteristics. The peri-operative nurse's role continues to evolve encompassing many and varied dimensions. Thus the peri-operative nurse needs a chance to voice their opinions regarding the future direction of peri-operative nursing in general.

Many have voiced the opinion that aspects of the peri-operative nurse's role would best be subsumed into the job description of other grades of workers within the theatre environment. Nurses need to become more active in determining their preferred direction. Peri-operative nurses are confined by the structural boundaries surrounding a theatre suite and the movement restrictions imposed for infection control reasons. These boundaries could artificially limit the scope of practice of the nurse in the theatre suite and diminish the perceived importance of the role of the peri-operative nurse, if we are not careful.

In my role as editor of the Irish Journal of Anaesthetic and Recovery Nursing, I feel it is imperative that the voice of the peri-operative nurse is heard. McGee (1991) reported that the theatre nurse became the first specialist nurse. Yet the appointment of clinical nurse specialists or advanced nurse practitioners in either the Anaesthetic or Recovery room nursing

specialities have received little attention and needs to be urgently addressed.

This journal will provide a forum for the exchange of ideas and the promotion of quality evidence based nursing practice. This depends on you the reader taking time out to read current literature and if possible writing for this or other journals. As nurses we are competent at documenting patient care on a daily basis. The leap to writing for a professional nursing journal may seem at first to be insurmountable. Yet it is still only writing so I would urge you to take that pen out or sit at the computer and resurrect the literature review you did for a recent course or the audit of clinical practice report completed as part the accreditation process or the script of the seminar you gave at work and reshape it, update it and submit it for publication. If you feel strongly about any nursing issues then let your voice be heard.

Josephine Hegarty

Josephine Hegarty

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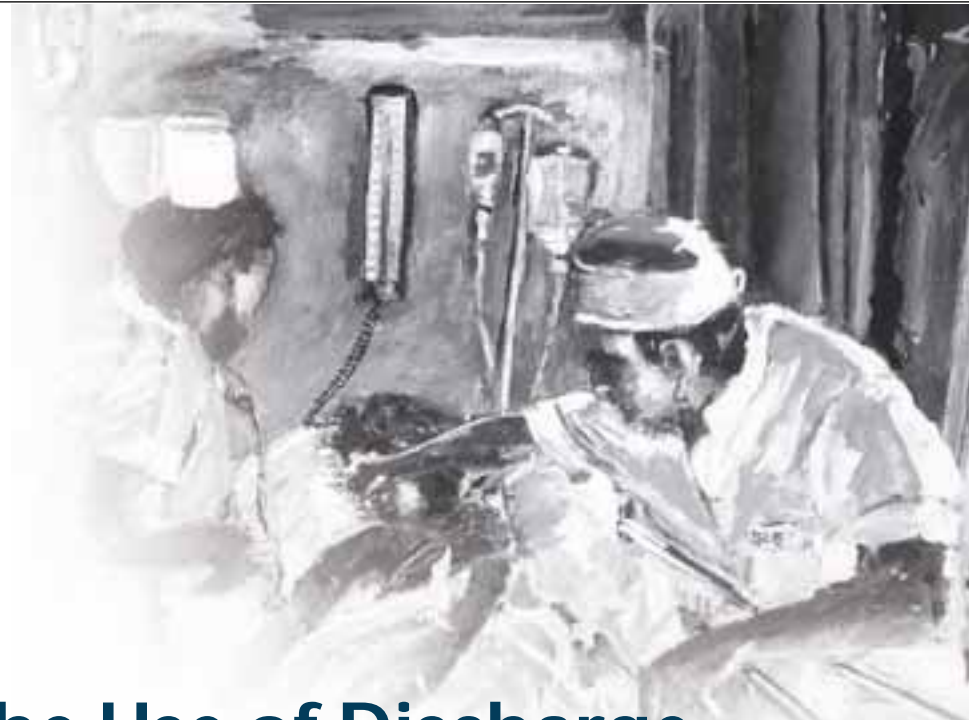
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The Use of Discharge Criteria in Irish Post Anaesthetic Care Units

As the volume and complexity of surgical procedures continue to grow and develop, nurses are being challenged to provide patients with an optimal peri-operative experience.

The post anesthetic care unit (PACU) or recovery room is the phase I clinical environment in which patients are cared for in the initial period post anesthesia and surgery (Muller-Smith, 1999). The care provided in the PACU aims to:

1. Support patients in the removal of the pharmacological effect of anesthesia;
2. Attain haemodynamic stabilization of patients;
3. Monitor for and treat potential complications;
4. Ensure patient's comfort;
5. Discharge patients who meet a certain minimum standard of fitness to appropriate environments (Leykin et al, 2001).

Nursing care in the PACU needs to be planned in a manner that not only identifies reports and treats complications in their early stages but also reduces the risk of unpleasant complications that would delay the patients discharge from the PACU (Burden, 2003). The safe and expeditious discharge of patients from the PACU can be achieved if appropriate discharge criteria are utilized to assist the nurse or anesthetist in assessing the patient's fitness for discharge. Recovery following anesthesia takes time.

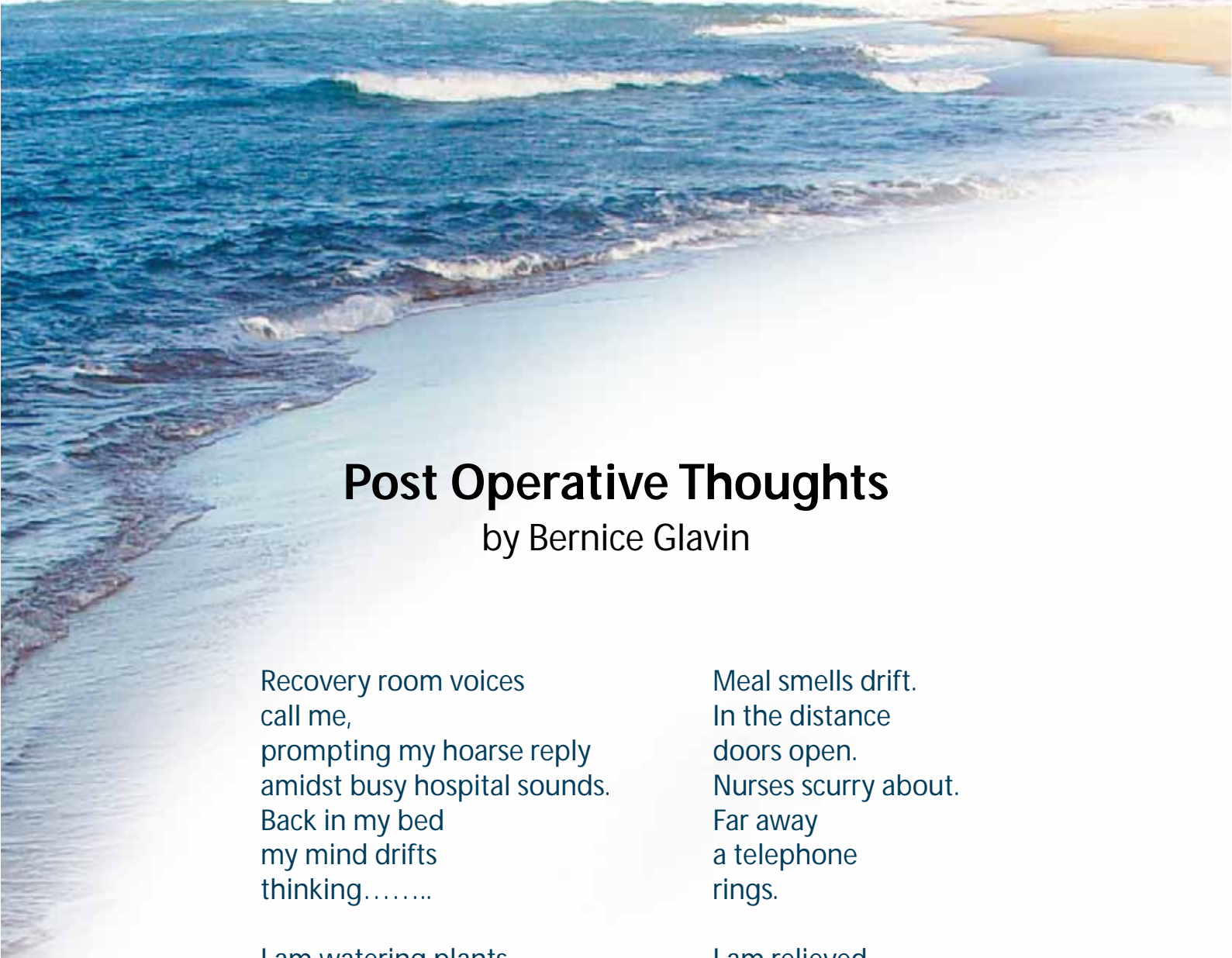
In the early recovery period, patients awaken and recover their vital reflexes; this is the phase that generally occurs in the PACU. No specific duration of stay in the PACU can be specified with certainty for patients undergoing specific procedures or types of anesthetic as a patient's condition may vary in response to the surgical

procedure, type of anesthetic, or medications given. Patients also leave the PACU for a number of destinations: some maybe discharged home; others go to day-case units, surgical inpatient units, high dependency units, or even intensive care units. The choice of destination will depend on the type of procedure the patient has had, the patient's physical status, the patient's needs, and the availability of appropriate resources to meet those needs.

Patients generally remain in the PACU until they meet a certain number of outcome indicators. The outcome indicators are usually based on the patient's level of consciousness, maintenance of airway, breathing and circulation, patient's comfort, and absence of complications. The variety of indicators assessed and appropriateness of the patient scores on these indicators varies depending on the ultimate destination of the patient when they leave the PACU and the policies and procedures adopted by the PACU staff. Discharge protocols developed by a multidisciplinary team should be in place in all PACUs (Swatton, 2004).

There are many and varied criteria used to discharge patients post general anesthetic (Table 1), however, evaluation of the validity and reliability of these criteria needs further work. The factors which influence the duration of time spent by patients in the PACU are varied and have been studied by a number of researchers citing the need to contain costs as a rationale for the need to study this topic.

Post Operative Thoughts by Bernice Glavin



Recovery room voices
call me,
prompting my hoarse reply
amidst busy hospital sounds.
Back in my bed
my mind drifts
thinking.....

Meal smells drift.
In the distance
doors open.
Nurses scurry about.
Far away
a telephone
rings.

I am watering plants.
Then I am sitting on a bench
with an old man
unknown to me
in warm sunshine.
I feel calm
In his presence.

I am relieved
it is over
for now.
Whatever will follow
presently forgotten.
Recovery room memories
fading from my mind.

I am lying in bed
immobile,
wrapped in blankets,
numbed by injections
temporarily relaxed.
The monitor beeps.
The corridor is quiet.

My Morphine induced state
permits me to see
a staring giraffe
standing in the corner,
and a joyriding armchair,
along with a scampering mouse
that is not really there.

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Seago et al, (1998) sought to identify the factors, which lead to prolonged lengths of patient stay in the PACU for 1,067 patients using prospective observational analysis. Variations in prolonged length of stay (LOS) can be predicted by age, pain medication at the time of admission to the PACU and postoperative cardiovascular, pulmonary and pain symptoms. Interestingly it was noted that organizational factors might be a more important indicator of prolonged PACU stays (Seago et al, 1998). In an observational study by Waddle et al, (1998) of 340 PACU patients mean actual LOS was 95 +/- 43 minutes. LOS predictors were anesthetic time and technique and amount of intra-operative fluids (Waddle et al, 1998). Frequent causes of excessive LOS were cited as waiting for physician release or laboratory or radiographic results (Waddle et al, 1998).

Using prospective cohort analysis, Truong et al, (2004) demonstrated that a clinical scoring system based on Aldrete's scoring system was associated with a significantly reduced PACU-LOS post general anesthesia in comparison with time-based criteria. Anesthetic technique has been shown to influence the length of stay in the PACU (Marshall and Chung, 1997). However some PACUs delay discharge of patients post spinal anesthesia from recovery units until full or partial (sensory levels of Lumber spine 1 or less) return of sensation or until

a specific time has elapsed (Knoerl et al, 2001) citing the potential effect of the sympathetic blockade on the cardiovascular system as the rationale for this. Researchers using a prospective descriptive design and a convenience sample of 109 same day surgery patients demonstrated that orthostatic blood pressure testing as a discharge criterion is a safe and effective alternative to sensory/motor/time based criterion in assessing haemodynamic stability and reducing the amount of time patients spend in the PACU post spinal anaesthesia (Knoerl et al, 2001).

The post anesthesia patient trajectory (Prowse and Lynne, 2000) describes the journey of patients from a state of unconsciousness and potential cardiovascular instability to consciousness, cardiovascular stability, maintenance of airway and pain control. Indeed this trajectory is the basis on which discharge criteria have been developed. A large variety of criteria exist to assist nurses and anesthetists when discharging patients from the PACU. In the United Kingdom, a pilot study sought to describe the use of such criteria by nurses. The majority of respondents utilised a criteria, which encompassed the Airway, Breathing and Circulation algorithm (Oakley, 2004). From an Irish perspective this descriptive study sought to examine the use of discharge criteria within PACUs within all public hospitals in the Republic of

Discharge Criterion	Variables assessed within the criterion	Scoring Sytem	PACUs using this criteria (n)%
Time based discharge criteria (PACU specific protocols usually)	Specific time frame as decided by PACU policy	Based on a minimum specified period of time the patient is required to spend in recovery prior to discharge	n=8, 22.9%
Clinical Discharge Type Criteria (CDC) or clinical scoring systems or a criteria based solely on airway, breathing circulation		Varied clinical criteria, including some with unknown authors and others listed below.	n=15, 42.9%
1. Aldrete (1970) scoring system.	Activity, respiration, circulation, consciousness, color (Or Oxygen(O ²) saturation included in modified Aldrete (1995).	Numerical scoring system, maximum score of 10	n=4, 11.4%
2. Post-Anesthesia Discharge Scoring System (Chung, 1993), (PADSS).	Vital signs, activity/ambulation and mental status, pain, nausea and or vomiting, surgical bleeding and fluid intake and output.	Numerical scoring system, maximum score of 10	0
3. Modified post-anesthesia discharge scoring system (Chung, 1995) (modified PADSS).	Vital signs, ambulation/activity level, nausea and vomiting, pain, surgical, bleeding.	Numerical scoring system, maximum score of 10	0
4. Salim's coma score			n=1, 2.9%
White and Song discharge criteria (also used to fast-track patients from the operating room to Phase II area for recovery, Song, 1999)	Level of consciousness, physical activity, hemo-dynamic stability, respiratory stability, O ² saturation status, postoperative pain assessment, postoperative emetic symptoms	Numerical scoring system, maximum score 14	N=0
Association of Anaesthetists discharge criteria (2002).	Consciousness, respiration/oxygenation, cardiovascular system, pain, emesis, temperature, prescription of O ² and intravenous therapy		n=5, 14.3%
Other			n=6, 17.1%

Table I describes the discharge criteria, variable assessed and the number of PACUs, which utilize the discharge criterion.

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Ireland.

Methodology

The study was conducted between December 2004 and May 2005 and aimed to describe current practices regarding the discharge of patients from the PACU. The study objectives were to:

- Find out if documented discharge criteria were used to assess patient fitness for discharge from the PACU
- Describe the types of written criteria been used to discharge patients within PACUs
- Ascertain the means by which discharge criteria were developed within PACUs
- Identify the health care professional who most frequently makes the decision to discharge a patient from the PACU.

The method used was a descriptive survey design of all the public PACUs in the Republic of Ireland. We designed a self-report questionnaire to collect information about discharge criteria used in PACUs.

A literature review assisted in identifying possible criteria used to discharge patients. The questionnaire consisted of 9 questions, which could be answered by ticking the most appropriate options listed. The questionnaire was piloted with a clinical nurse manager of a PACU and a lecturer in nursing with expert knowledge in the area. The choice of responses provided for most questions were taken from the findings of the literature review. Each question had an "other" option to allow for any responses that had not been anticipated. A likert scale was used to ascertain the identity of the health care professionals who made the decision to discharge the patient from the PACU.

Sample

The sample hospitals were selected based on a computer search of the Health Service Executive, Ireland (management structure for health care provision in Ireland) Website (www.hse.ie), which listed the public hospitals with operating theatre departments. The final questionnaire was then mailed to all PACUs of public hospitals (n=45) in the Republic of Ireland marked for the attention of the Clinical Nurse Manager in charge of the unit. One reminder was sent seven weeks later. The final response rate was 77.8% (n=35).

Ethical considerations

An information letter accompanied the questionnaire, which assured respondents that participation in the study was optional, respondents would remain anonymous and publications resulting from this study would not identify any individual PACUs. Completion and return of the anonymous questionnaire was taken as inferred consent.

Data analysis

A statistical expert was consulted regarding the appropriateness of the questionnaire and the

statistical tests used. Responses to the questionnaire were entered into a database and analyzed using Statistical Package for Social Sciences. Descriptive and inferential statistics (percentages, Chi² test, and t-tests) were carried out.

Results

Completed questionnaires were received from 35 PACUs. 27.3% of the respondents were from acute band 1 hospitals (activity levels greater than 20,000 patients per annum), 39.4% were from acute band 2 (activity levels above 10,000 patients per annum), 18.2% were from acute band 3 (activity levels of 1,000 inpatient admissions per annum), 12.1% were from maternity hospitals, and 3% were from other types of hospital. The average number of recovery bays (patient care spaces in the PACU) was 5.14 (S.D. = 3.46) and the range was from 1 to 15 recovery bays. The average patient throughput in the PACU on a normal weekday was 24.81 (S.D. = 23.68) and the range was from 3 to 115 patients per day. A total of 77% of the respondents utilize discharge criterion in their units.

PACU specialties included: General (74.3%), Vascular (42.9%), Plastics (28.6%), Gynaecology (71.4%), Renal (14.3%), Cardiac (8.6%), Urology (45.7%), Neurosurgery (8.6%), Ophthalmology (5.7%), Ear, Nose and Throat (40%), Orthopedic (51.4%), Obstetrics (42.9%), and Others (31.4%). Discharge criteria documentation methods utilized in respondents' units included: tick boxes (n=5, 14.2%), numerical scoring (n=4, 11.4%) and comment boxes (n=9, 25.7%).

The Discharge criteria used in particular units was developed utilizing PACU's staff clinical experience (n=18, 51.4%), sourced from colleagues in other hospitals (n=7, 20%), from the literature (n=8, 22.9%), in conjunction with anesthetic colleagues (n=24, 68.6%) and through practice development initiatives (n= 4, 11.4%). The decision to discharge patients from the PACU was made by the: nurse (almost always n= 23, 65.7%), nurse and anesthetist (almost always n=9, 25.7%) and the anesthetist alone (almost always n=2, 5.7%).

A Chi² test was conducted in order to investigate the possible relationship between the type/size of hospital and the utilization of discharge criteria. There was not a significant relationship between the variables (Chi²=1.72, p=N.S.). A T-test was conducted in order to compare the number of recovery bays and the average patient throughput for PACUs that utilized discharge criteria and PACUs that did not. There was no significant difference (t(33) = 0.098, p=N.S.) in the number of recovery bays for PACUs that utilized discharge criteria and PACUs that did not. There was no significant difference (t(30)= -1.272, p=N.S.) in the average patient throughput for PACUs that utilized discharge criteria and PACUs that did not.

Informed consent for the perioperative nurse includes another dimension that needs to be considered when preparing and caring for surgical patients from ethnically diverse backgrounds. The continuous contact with the patient prior to surgery might be perceived as a continuum ranging from common everyday contact, on the one hand, to specific procedures in preparation for surgery that fall outside this category and which are not easily separated from routine work-ups in preparation for surgery. This is not a significant problem if communication is effective between nurse and client. Care continuums highlight the area of implied consent but the problem this poses is that implied consent is given different interpretations by different nurses and even if its interpretation is consistent with acceptable legal and ethical definitions, the concept of implied consent is difficult to apply in the clinical setting (Aveyard, 2002). For instance, if communication barriers exist between the nurse and client, the

multicultural world need to be built into the principles of informed consent (De Costa, 2004). The notions that certain ethical principles are applicable across cultures need to be reconsidered.

The position of the perioperative nurse in educating and obtaining consent from ethnic minorities within the health care system is therefore difficult. Communication difficulties and lack of cultural awareness questions the framework suggested by Beauchamp and Childress (1989) underpinning consent as it does not address the needs of all health care recipients in multicultural Ireland today.

For example:

- How does the nurse ensure or evaluate the appropriateness of pre-consent information to



nurse may mime what s/he wants the patient to do. Consent can then be implied by the action of the client as demonstrated, for example, by the client placing their arm in the correct position to have blood pressure measured. If patients are placed in a vulnerable position because of lack of communication, fear, or inability to understand, they can adopt an unquestioning attitude toward those in authority and may comply with requests or sign a consent form without fully understanding the procedure / surgery they are to undergo. Surgical nurses need to be aware that implied consent is not a substitute for obtaining informed consent prior to nursing care procedures. Aveyard (2002) reminds nurses that it is important to understand the ethical and legal rationale underpinning informed consent as patient autonomy may be infringed by some, but not necessarily all, nursing care procedures. However, Aveyard now needs to consider that norms and values differ within ethnic groups that present a challenge to the application of Western ethical principles of informed consent which require all adults to be primary decision makers about their own participation. Given the growth of ethnic diversity within the Irish setting, the relevance and applicability of Western principles of autonomy may need to be reviewed. Value differences relevant to science and health in a

ensure the patient makes an appropriate decision?

- How does the nurse establish the patient's pre-consent understanding even if she/he is a competent or autonomous person?
- How does the nurse manage implied consent / continuing permission if decisions are made collectively since the patient is eligible to withdraw consent at any point in the treatment process?

Recommendations

To obtain informed consent from patients whose first language is not English, do not share similar concepts of disease or treatment, and who identify themselves as members of their families or communities rather than as autonomous individuals is a very challenging responsibility. In order to facilitate meaningful decision-making prior to any procedure, the patient requires clear communication and the nurse requires an understanding of the patient's ethnic background to fully appreciate and respect decisions made. Through education, Irish health care practitioners' knowledge and skills for assessing patients' needs and understanding can be enhanced. Such knowledge needs to be developed in a reflective way in order to challenge rather than increase depersonalising or stereotyping practice.

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The Changing Cultural Environment

Today there are 160 different nationalities living in Ireland (National Anti-Racism Awareness Programme, 2002). This is a relatively new concept for Ireland which less than a decade ago, was largely monocultural apart from the established ethnic minority groups such as Travellers and the Jewish community. To deliver appropriate care to this increasingly ethnically diverse population, all nurses need to be aware of cultural patterns and how they are influenced by social factors (race, gender and social divisions), political factors (power and power relationships between individuals), and economic factors (distribution of wealth). All of these factors are interwoven and have significance for delivering culturally sensitive care (Cortis, 2004).

Peri-operative nurses need to understand how the different ethnic minority groups perceive the informed consent process thus preventing undue anxiety or mistrust in our patients. The question is; are peri-operative nurses prepared to undertake this challenge and are they sufficiently prepared or aware of cultural diversity and its significance in dealing with patients whose ethnic and cultural origins are different from their own? Individuals from ethnic minority groups are taught the nuances of how to behave when ill or suffering, or when healthy, by previous generations. If the health professional is not a member of the minority ethnic group, he or she may not understand the patient's actions or reactions. Informed consent is compromised when language or cultural barriers are present (Joffe et al, 2001). To combat this situation, the consent process needs to recognise the impact of ethnicity and the circumstances under which decisions are made; otherwise, understanding of the process and response to the process may not be understandable to the patient or the nurse (Habib et al, 2004). Depending on the ethnic background, beliefs about personhood, individual autonomy, and decision capacity can be embedded within the social and cultural patterns of family ties and community obligations. It has often been suggested that the concept of an individual, and, in particular, a female, making a personal decision independent of the family or community is not common in cultures of the developing world. In these communities, personhood is often defined as one's family, village or social group and therefore, decisions about consent are likely to be made at the level of the extended family, community or village. Cortis (2000) suggests that nurses may presume that a person from another ethnic background will understand and accept nursing care as prescribed to them. This presumption can lead to a situation where care delivery in the Irish setting offers a view of health and illness that may prove inappropriate to the patients' understanding of their healthcare needs. As Irish nurses, our values and ethics are predominantly determined by a Western system that may not be congruent with expectations of non-Western communities in an

ethnically diverse society and may contribute further to a cultural divide or uncertain situation. Improving understanding requires respect and recognition of differences (Gerrish, 1996) that may not be available as textbook information, but comes rather from being open to understanding cultural uniqueness and showing respect for individuals in the clinical setting.

Being registered with An Bord Altranais and guided by the code of conduct gives nurses rights and privileges in practice. However, in return, we must meet the standards of competence, care and conduct set out by the nursing governing body. Effective communication is highlighted continuously by An Bord Altranais as a major part of the nurse's role to ensure the patient understands what is happening, or going to happen, to them, for legal as well as ethical reasons. However, in a study undertaken by Boyle (1999), Irish nurses identified communication difficulties and lack of knowledge as key areas of concern for delivering culturally competent care. Collins (2001), in a report commissioned by Partnership Tralee, identified the main barriers to working with ethnic minorities as language barriers, cultural differences and lack of knowledge. This situation still poses challenges for nurses today (O'Connor, 2005) and needs to be addressed through education in order to facilitate culturally sensitive care for minority ethnic communities within the perioperative setting and society in general. Perhaps the concept of effective communication and the theory surrounding this important element of nursing now needs to be revisited to incorporate the many ongoing changes in Irish society.

Obtaining Consent from Ethnically Diverse Patients

Obtaining and checking understanding of informed consent for nurses wishing to fulfil their duties to patients of ethnic minorities can pose a problem if language barriers make it difficult to assess the patient's ability and preferences. Uncertainty continues to exist about what is the best way to bridge language and cultural barriers. Trained interpreters may not be readily available in all health care settings (Collins, 2001) leaving the options of untrained bilingual staff or family members to facilitate communication. More often, the reality of the situation is that nurses try their best to muddle through communication by using sign language, visual prompts, or by using small children, relatives and friends as interpreters. This is a situation that can severely limit the exchange of information and, therefore, the ability of the nurse to ensure that the patient is fully informed and that decisions by the patient are obtained voluntarily. The quality of interpretation may suffer if untrained interpreters are used, placing the patient at risk for medical mishap due to misunderstanding and the clinician at risk for medical malpractice suits.

Discharge Criteria post specific procedures or types of anaesthesia	PACUs using this criteria (n)%
Specific discharge criteria post intravenous sedation	n=11, 31.4%
Specific discharge criteria post local anaesthesia	n=8, 22.9%
Specific discharge criteria post nerve block(s)	n=5, 14.3%
Specific discharge criteria post epidural anaesthesia	n=15, 42.9%
Based on orthostatic blood pressure	n=7, 20%
Based on motor-sensory discharge criteria e.g. The Bromage scale	n=8, 22.9%
Based on a specific time spent in the recovery unit	n=10, 28.6%
Specific discharge criteria post neurosurgery e.g. Glasgow Coma Scale	n=2, 5.7%
Specific discharge criteria post ambulatory (day) surgery	n=3, 8.6%
Apgar score	n=3, 8.6%
Others	n=3, 8.6%

Table 2 describes the discharge criteria used after specific procedures or types of anaesthesia, and the number (%) of PACUs, which utilize the discharge criterion.

Discussion

Patient fitness for discharge from the PACU needs to be approached in a structured but simple and clear manner that meets international standards of appropriate nursing, medical, and anaesthesia patient care. 71.4% of the respondent PACU's confirmed that they utilized discharge criteria to evaluate patient's fitness for discharge from the PACU. Time based discharge criteria were used in n=8 PACU (22.9%), Aldrete scoring system (n=4, 11.4%), and PADSS (n=4, 11.4%) (Table 1). The effectiveness of these discharge criteria in terms of appropriate patient outcomes, time management as well as resource management needs to be researched in a global as well as an Irish context. The question of how long patients should remain in PACU following surgery and

anaesthesia is crucial as it has both safety, cost and resource implications. Therefore the most appropriate discharge criteria should be chosen carefully for each individual patient as well as each PACU, as the discharge criteria chosen will depend on the type of surgery/anaesthesia as well the ultimate discharge destination of the patient (see Table 1 & 2). The variables included in the discharge criteria used within the Republic of Ireland vary considerably (see Table 1). The majority of criteria include airway, breathing and circulation as the major indicators; other criteria include nausea and vomiting, pain and surgical bleeding. However the discharge criteria utilized do not seem to incorporate temperature as a major variable. Estimates of the incidence of inadvertent peri-operative hypothermia range from 60% to 90% of all surgical cases when this condition is defined as a body temperature below 36°C (degrees Celsius) / 97°F (degrees Fahrenheit) (Bernthal, 1999; Kenley, 1999). A study of clinical indicators and complications in the PACU (n=13266) found that the incidence of hypothermia (tympanic temperature < 35°C/95°F) equaled the incidence of respiratory complications in the PACU (Peskett, 1999). 22.9% of the surveyed PACUs in the Republic

of Ireland utilized a discharge criterion that was based on the time-frame spent in recovery, the unit having predetermined the minimum amount of time a patient should spend in recovery. Hatfield and Tronson (2004) in a textbook titled *The Complete Recovery Room Book* recommended that adult patients should spend a minimum of at least an hour after general anaesthesia and a half an hour after local anaesthesia. However this practice is not evidence based (Truong et al 2004). Evaluation of orthostatic blood pressure (BP) testing as a discharge criterion from PACU after spinal anaesthesia was used by 20% of PACUs. However, 22.9% of PACUs utilized motor-sensory discharge criteria, and 28.6% of PACUs used time-spent in recovery as a discharge criterion post spinal anaesthesia. This is interesting, as orthostatic BP criterion has been shown to be a safe and effective alternative to sensory/motor criteria in assessing haemodynamic stability and reducing the amount of time the patient spent in the PACU after spinal anaesthesia (Knoerl et al, 2001).

Different methods were used to develop the PACU discharge criteria chosen for each unit. 51.8% indicated that they utilized the clinical experience of their PACU staff to determine the most appropriate discharge criteria(s) for their individual PACUs. Thus PACU staff need to have the appropriate clinical experience to undertake this role. Retention of experienced PACU staff within recovery units, in Ireland in recent years has been a major issue for peri-operative nursing managers particularly in the large urban centers. 22.9% highlighted that they undertook an in-depth literature review in order to decide on a chosen PACU discharge criteria. Perceived barriers to the utilization of evidence-based practice in the PACU have been shown to include organizational factors such as lack of time and poor access to research literature (LaPierre et al, 2004). For well over half a century, educators and health policy leaders have written about and promoted interdisciplinary approaches as an ideal way to provide optimum care for patients (Huff and Garrola, 1995). Interdisciplinary care delivery is evident in the PACU as 68.6% of discharge criteria were developed by nurses in conjunction with their anaesthetic colleagues. This could however also be seen as an area where PACU nurses have chosen not to become leaders/expert in their own clinical area(s). The Commission on Nursing recognized the necessity for promotional opportunities for experienced nurses wishing to remain in clinical practice (Government of Ireland, 1998). Accordingly they recommended a clinical career pathway leading from registration to clinical specialization to advanced practice (Government of Ireland, 1998). The PACU is an area, which could benefit significantly from having advanced nurse practitioners. The core concepts of an advanced nurse practitioner include autonomy in practice, expert practice as well as professional and clinical leadership (National Council for the Professional Development of Nursing and Midwifery, 2004).

Nurses almost always (65.7%) made the decision to discharge patients from the PACU. This highlights the specialist knowledge and skill required by nurses working in the PACU. The Association of Anaesthetists, Great Britain and Ireland (2002) note that the decision to discharge patients from the PACU is the responsibility of the anaesthetist but the adoption of precise discharge criteria allows this decision to be delegated to a PACU nurse. To ensure a high standard care in decision-making, an investment in education and training of PACU nurses is essential. Post graduate courses in peri-operative nursing have been available in Ireland for over 20 years, encouraging nurses working in this area to seek specialist training. PACU nurses need to be facilitated to access appropriate continuing education in their specialist field. In addition The Irish Nurses Organization (Theatre Section) have been promoting peri-operative evidence based practice since its inception (www.ino.ie) and the recently formed Irish Anaesthetic and Recovery Nurses Association (IARNA) assists in advancing education by providing a forum for the dissemination of information on developments in the anaesthetic and recovery nursing arena (www.iarna.ie).

The majority of PACU nurses make the decision to discharge patients. This highlights that nurses working in this area are autonomous in their practice in the PACU and are free to make discretionary and binding decisions consistent within their scope of practice and using their personal clinical judgment. Woods (1999) noted that the nurses made the final decision to discharge patients from the PACU in 70% of cases. An Bord Altranais, (2000c), published a Code of Professional Conduct that provides guidance to the nursing profession. It states that all nurses are accountable for their own practice (An Bord Altranais, 2000c) for this to happen nurses need to have the autonomy to practice according to their professional judgment (An Bord Altranais, 2000c). Stephenson (1990) noted that the majority of nurses consider discharge criteria to be a minimum standard, and that most would be very cautious about discharging a patient if there was any doubt regarding the patients well being.

To conclude, this study provides information regarding the use of discharge criteria in Irish PACUs. Discharge criteria assist the peri-operative nurse who cares for the patient post anaesthesia and surgery to make the decision to discharge the patient from their care. However, further research needs to be undertaken to assess the reliability, validity and appropriateness of discharge protocols being used. Factors such as patient safety and resource management would need to be considered in such research. Discharge criteria provides nurses with guidance to assist their decision making thus ensuring patient safety when discharging patients from the PACU.

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Surgical Consent & the Changing Cultural Setting

The Irish healthcare system is failing to meet the needs of minority ethnic groups a factor that has been attributed to communication barriers and lack of cultural awareness between health care providers and recipients of care (O'Connor, 2005).

Moreover, with increasing diversity in Ireland, encounters between the health care professional and patient from ethnic minorities are becoming more common. Patients bring to the medical encounter different languages, explanatory models concerning treatment and illness, religious beliefs, and ways of understanding the experience of suffering. Thus the risk of misunderstanding and inability to complete appropriate assessments surrounding care and in particular the consent process is a growing concern.

Given that the concept of patient autonomy is a fundamental component of ethics and the law: respect for the patient giving permission to the health care professional to perform a clinical deed is of paramount importance and is designed to protect the rights of the patient. Therefore, informed consent is required prior to any treatment/procedure which, if undertaken without the patient's authorisation, would threaten their autonomy. To ensure patient autonomy, the principle of informed consent is enshrined in the Patient's Charter advising the patient of their right to any proposed treatment, including any risks involved in that treatment and any alternatives, clearly explained to them before they decide to consent for treatment (Department of Health, 1992). This charter has been incorporated into the Government's Health Strategy 2001, and, has not been superseded by another declaration of patient rights.

Beauchamp & Childress (1989) identify five fundamental elements encompassing consent: disclosure, understanding, voluntariness, competence, and consent. These elements serve as a useful framework when considering the consent process and should inform the health care professional.

In the surgical setting, the consent process protects the rights of the patient to self-determination and autonomy regarding the surgical intervention. It is the surgeon who is responsible for providing the patient with sufficient information to weigh the risks and benefits of the proposed surgery (disclosure). The role of the nurse in this process is one of patient advocate. To facilitate the process, the nurse should assess the patient's understanding of what is to occur during and after surgery and clarify any misconceptions. A signed consent form should not be mistaken for understanding; it merely provides evidence that the consent process has occurred and that the client is aware of the concept of informed consent. The ethical validity of consent hinges not on the written word, but on the quality of the interaction between the patient and clinician. Documenting the consent is just one part of the process (Worthington, 2002).

Kennedy and Grubb (2000) further support this viewpoint in stating that written consent is neither sufficient nor necessary for a valid consent:

'Consent is expressed when the patient explicitly agrees to what is proposed by the doctor. It need not have been set out in any specific form and it need not be in writing' (p.95)

However, the concept of informed written consent is fundamental to good surgical practice. To implement this concept appropriately today peri-operative staff need to be aware of the demographic changes in the population they serve. In Ireland, for instance, the population is becoming increasingly ethnically diverse.

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