CLINICAL PRACTICE GUIDELINE
Guideline coverage includes NICU KEMH, NICU PCH and NETS WA

Post-Operative Handover

This document should be read in conjunction with the Disclaimer

Post-operative Handover of Surgical Patients

Well before leaving theatre, the Anaesthetist or Anaesthetic Registrar should call the NICU Registrar (Vocera: '3B Registrar') to notify of patient's return with details of:

- procedure carried out
- any major complications or instability of the patient
- respiratory support and
- any infusions running.

The Registrar must notify the bedside nurse and 3B Duty Coordinator of the patient's expected return. The patient's bed space should be set up with appropriate monitoring, drug infusions and ventilator settings.

In hours:

The NICU Registrar should notify the NICU Senior Registrar and the Duty Neonatal Consultant.

After hours:

If the patient is **stable** without significant concerns, the NICU Registrar should initially take handover as outlined below and then update the Duty Senior Registrar or Neonatal Consultant.

If the patient is **unstable** or there are anaesthetic concerns, the NICU Registrar should immediately notify the Duty Consultant so that the Consultant has plenty of time to be present when the patient returns to the NICU.

If infant unstable, consultant anaesthetist (or delegate) should attempt to make contact with consultant neonatologist directly at least 20mins prior to end of procedure in order for them to be able to be on the unit at time of re-admission.

Handover

Handover from the consultant anaesthetist should always be to the most senior doctor available.

Personnel to be present:

- Anaesthetic Consultant/ Registrar
- NICU Consultant (all patients in-hours and unstable patients after-hours)
- NICU Registrar/ SR
- 3B shift co-ordinator (for unstable babies)
- Bedside nurse
- Theatre nurse
- +/- member surgical team
  (if not present for handover should present to NICU within 30 mins of patients return to NICU)
    - Await all necessary personnel to be present before commencing handover.

- The patient remains the primary responsibility of the anaesthetist until handover is complete.
- On arrival back, NICU staff should assist anaesthetist with transferring patient onto NICU ventilator +/- chest drains to suction.
- No other monitoring/ infusions should be switched until after handover.
- All non-essential staff should move away from immediate patient area.
- Everyone remains quiet and listens to anaesthetic handover until complete.
- At the end of handover, NICU medical team confirms shared understanding and agrees plan.

Following handover

Patient is transferred onto NICU monitoring and pumps.
NICU staff fully examine patient and record handover in patients notes.
Plans for bloods/ XRs agreed between medical and nursing staff.
Commence prescribed analgesia.
Encourage parents to see patient as early as possible, once stable.

Documentation

NICU Medical staff receiving handover needs to document in the inpatient progress notes

- Procedure preformed
- Any complications / blood loss
- IV Fluids and blood products given in theatre
- Medications given in theatre
- ETT type, length, cuff pressure used
- Ventilation settings on return to the ward
- Lines, catheters and/or drains insitu
- Examination on return to ward
- Ongoing plan of care

Resources

NSQHS Standards: 6. Communicating for Safety

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