THE
ANAESTHESIA TEAM

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SECTION 1 - RECOMMENDATIONS

The development of an anaesthesia team which provides comprehensive peri-operative care offers many advantages for the provision of high quality anaesthesia services.

The introduction of a team-based approach to providing professional support for anaesthetists across the range of peri-operative activities which they carry out demands careful organisation and management on the part of the team leaders, the anaesthetists.

Although the non-medically qualified personnel involved may come from a range of backgrounds, they must be trained to nationally recognised standards.

These teams can be developed utilising the skills of existing grades of non-medically qualified staff.

Pre-admission screening is a vital early component of pre-anaesthetic assessment. It reduces cancellations and promotes efficient bed usage. It does not replace the need for the anaesthetist's pre-operative visit.

Anaesthetists must have dedicated skilled assistance wherever anaesthesia is administered, whether in the operating department, the obstetric unit or any other site.

Recovery areas must have trained staff available throughout all operating hours and until the last patient meets all the criteria for discharge.

All acute hospitals providing inpatient surgical services must have an acute pain team led by a consultant anaesthetist.

The Association of Anaesthetists supports the concept of common training schemes for operating department staff which share objectives and lead to the development of common working practices, pay, conditions and career opportunities.
SECTION 2 - INTRODUCTION

In 1988, the Association of Anaesthetists of Great Britain and Ireland made recommendations on assistance for the anaesthetist [1]. The objective was to demonstrate that anaesthetists could only provide a safe and efficient service if they had skilled assistance at all times.

In the light of experience with the development of day stay surgery and anaesthesia, attention has increasingly focused on the concept of the 'Anaesthesia Team'. Models have evolved in which appropriately trained, non-medically qualified personnel, working to carefully designed protocols, have been able to provide support for anaesthetists over a wide range of peri-operative activities. This system has permitted later admission of patients while still allowing the anaesthetist to deliver high quality anaesthesia.

The development of postbasic training programmes to train high quality nurse specialists, together with the evolution of the operating department practitioner grade, with its adoption of national vocational training, has encouraged the development of this concept.

Two recent reports [2] [3] initiated debate on the functions of non-medical personnel in the provision of anaesthesia services within the United Kingdom. The Association published its views on this matter in 1996 [4] but has carefully reconsidered the arguments both for and against the concept of anaesthesia being monitored and managed by non-medical personnel. We remain firmly of the opinion that to provide a first class anaesthesia service [5], with high levels of patient safety, anaesthesia in Great Britain and Ireland should continue as a physician delivered speciality. Evidence of increased cost effectiveness of alternative systems of delivering anaesthesia services is lacking.

Accordingly, this report revises previous recommendations on the provision of skilled assistance and develops the concept of expanding the role of nurses and ODPs in a team approach to peri-operative care. It considers pre-operative screening, anaesthesia assessment, the operating theatre, recovery and postoperative pain management. It urges innovative managers to support this initiative.
While we recognise that support for the anaesthetist in the intensive care unit and in chronic pain therapy is crucial, this was considered to be outside the remit of this document.
Ensuring that properly trained supporting staff and anaesthetists are available in the right place at the right time requires considerable effort, knowledge and expertise to organise and manage.

Each acute trust should have a designated head of anaesthesia services who will be responsible for all activities in which the department of anaesthesia is engaged. This individual will usually be the clinical director and will have managerial and budgetary control of the service. If, however, the department of anaesthesia is part of another directorate, it is necessary to have an identified anaesthetist to take responsibility for all aspects of the anaesthesia service. For the sake of simplicity we refer to this individual as the clinical director.

Whatever the wider directorate structure, the anaesthesia department's budget should include all expenditure that is within anaesthetists’ control.

The clinical director's role
The clinical director must ensure that the relevant senior manager understands and accepts the recommended national standards of staffing required to provide a high quality anaesthesia service throughout the peri-operative period. Sufficient resources must be committed to recruiting and training staff and to encouraging continued professional development. The clinical director must be provided with management assistance, usually in the form of a business manager and clinical service manager, as well as having sufficient contracted time to undertake his other duties. In addition to management responsibilities, the clinical director must offer support, guidance and encouragement to all members of the staff of the department.

The role of other consultants
Some operational aspects of the anaesthesia team will usually be delegated by the clinical director. It is often helpful to have a lead consultant to provide medical supervision in specialist areas such as day surgery, obstetric pain relief and postoperative pain control.

The manager's role
The practical running of the non-medical component of the anaesthesia team will largely be the responsibility of the clinical service manager or a senior ODP, via
appropriate line managers in each functional area. As with medical staff, some functions will need to be delegated or managed in co-operation with managers in other departments:

- pre-operative screening requires careful co-ordination and communication with individual surgeons, the medical records and outpatient clinics; the individual responsible for overseeing the adequacy of these processes needs to be defined;

- maintaining adequate staffing with anaesthesia assistants in the operating department must be the day-to-day responsibility of a senior manager;

- the recovery area must be appropriately supervised;

- there are advantages in rotating trained staff with common skills between theatres, recovery areas, high dependency and intensive care. This requires co-ordination by managers in several departments;

- the postoperative pain service will require independent supervision but should be integrated into the overall anaesthesia service;

- all components of the anaesthesia service require regular auditing not only for the efficient use of resources but also for clinical quality.

There is therefore a need for close communication with all users of the service. A multidisciplinary theatre users' committee is often a useful instrument for engendering common goals, co-operation and motivation across specialities.
SECTION 4 - PRE-OPERATIVE ASSESSMENT

Assessment prior to anaesthesia is the sole responsibility of the anaesthetist. However, pre-anaesthesia screening prior to assessment achieves several desirable objectives. It ensures that patients are *prima facie* fit for anaesthesia and surgery and that all likely investigations will be completed and available at the time of the pre-operative assessment. It thus minimises the disruption caused by late cancellation or postponement and their adverse effects on theatre utilisation and bed occupancy, not to mention the inconvenience to patients and their relatives or carers. It enhances efficiency and ensures a higher level of overall patient care. *All patients scheduled for elective anaesthesia should pass through a pre-anaesthesia screening routine.*

Screening starts in the general practitioner's surgery or outpatient department when indications for surgery present. Nowadays, 'fast-track' arrangements are being developed whereby the surgeon or the GP may book a patient directly onto an operating list by computer link. Same day admission, even for quite major surgery, is increasingly common.

Pre-admission screening clinics employing nurses and ODPs who have received special training, organised by surgical teams or by anaesthesia departments, are already established in many hospitals. The patient can be seen on the same day as the initial surgical out-patient appointment if waiting lists are short but more often this will take place at a later date, ideally within two weeks of the planned surgery. If the initial screening is delayed until the patient is admitted for surgery it may be difficult to ensure that all results are available, that no further investigations are required and that the patient's health is optimal. There must be time to deal with any problems encountered.

It is very important for everyone to be clear about the boundaries between the remit of the pre-anaesthesia screening team and the responsibilities of the anaesthetist which are discussed below. *It is inappropriate for a non-anaesthetist to promise a particular type of premedication, anaesthesia technique or postoperative pain management.* Good liaison between those involved will minimise problems.
Aims of pre-anaesthesia screening

- to provide the anaesthetist with basic information on the patient's health status which will enable a meaningful assessment of fitness for anaesthesia to be made;

- to identify and instigate relevant investigations, according to pre-determined protocols;

- to increase the patient's understanding of the pre-operative, intra-operative and postoperative care being planned;

- in patients scheduled for day surgery, to assess the home situation, social circumstances and the availability of support [6].

Pre-anaesthesia screening inevitably provides an occasion for patients to ask questions. Information leaflets describing the process of anaesthesia are available from the Association [7]. *In case of doubt, the person performing the screening should seek advice from the anaesthesia department.*

Screening routine and investigations

Screening often makes use of a questionnaire completed by the patient, followed by a checklist completed by a nurse or ODP who has the relevant training and experience for this role. An example of a questionnaire is in appendix 1 of the Association’s publication on day surgery [6]. Checklist and reference protocols, together with the questionnaire, should be developed in conjunction with the anaesthesia department. Local guidelines should also be established to identify patients requiring admission prior to the day of planned surgery.

A brief medical history should be taken with particular reference to current medication, drug allergies and adverse reactions to anaesthesia experienced by the patient and close relatives.

The data to be recorded at screening is a matter for local agreement but should normally include the patient's height, weight, pulse rate and blood pressure. Urinalysis should also be carried out. Other physical examination is not usually performed at this time but will be undertaken by the surgeon and the anaesthetist on admission.
Arrangements for investigations should follow agreed protocols. It is worth drawing attention to the fact that many investigations previously regarded as routine are now considered to be of little value in asymptomatic patients in determining clinical management or predicting postoperative outcomes [8].

When screening identifies a patient whose medical condition does not meet agreed criteria, there must be clear guidance in place on the lines of communication which enable the screening staff to take appropriate further action. This should include informing the anaesthetist who will initiate subsequent management and discuss the problem with the surgeon. It is essential that a plan of action be identified and discussed with the patient.

**The anaesthetist's assessment visit**

Previous screening does not reduce the need for the anaesthetist to visit the patient before transfer to the operating department. The Association strongly recommends that, other than in exceptional circumstances, patients should be assessed prior to their arrival in the anaesthetic room. In such circumstances, the patient will be apprehensive and less receptive to explanation. At this late stage, pressure may be put on the anaesthetist to proceed even though the patient is in a suboptimal condition or has been inadequately prepared or investigated.

During the visit, the anaesthetist will introduce him/herself to the patient, check the information recorded at screening, including the results of investigations, and carry out the appropriate physical examination. The anaesthetist should ensure that the patient has received sufficient information concerning the anaesthesia and immediate postoperative care [7]; it is good practice to reassure the patient that the anaesthetist will be present at all times during anaesthesia. There should also be an explanation of where and when the patient will awake and recover from surgery.

Choices between local and regional techniques should be discussed and the patient informed of the possibility that numbness and/or weakness may be experienced in the first few postoperative hours if a local or regional technique is selected. Explanation and consent concerning the use of analgesic suppositories should also be obtained. Consent for all such procedures should then be formally confirmed and documented [9].
In summary, the responsibilities of the anaesthetist include:

- the decision that the patient is optimally prepared;
- the choice and prescription of premedication;
- the choice of anaesthetic technique;
- the method of administering postoperative pain relief;
- the obtaining and recording of consent.

If the assessment has been made by an anaesthetist other than the patient's own, good communication between them is essential. *The decision to proceed cannot be delegated.*
SECTION 5 - THE OPERATING DEPARTMENT

Assistance for the anaesthetist
The safe administration of anaesthesia cannot be carried out single-handedly. Competent and exclusive assistance is necessary at all times. However, there are still places in the United Kingdom and Ireland where anaesthetists continue to practise without appropriate assistance, despite the fact that this recommendation has been in force for more than a decade.

The clinical director must insist on adequate resources to employ and train sufficient numbers of assistants to ensure a safe anaesthesia service.

If appropriate basic resources are not available, the clinical director should limit clinical practice so that safe, quality based patient care is ensured.

Management
The operating department must have a manager who is responsible for ensuring an efficient and effective service. This individual will be responsible for ensuring the provision of adequately trained staff and ongoing audit of activity, whatever the local directorate structure. Proper use of resources and optimum throughput of patients depends on maintaining good communication between anaesthetists, surgeons and operating department staff.

Reception
Written guidelines are required to cover the sending for patients and their handover at reception to a designated member of the operating department by the ward nurse [10] [11]. Local protocols should determine the grade and experience of the nurse accompanying the patient to the operating department. Factors such as medication and level of consciousness should be taken into account. The handover must include clear communication of the patient's name, clinical details and medical records. Portering services must be readily available to transport patients to and from wards, preferably using porters who are responsible to the operating department manager.

Anaesthetic room
There should be a minimum of two members of staff present in the anaesthetic room at induction, the anaesthetist and a trained anaesthesia assistant. In some departments, additional personnel will be present to assist in transferring and positioning patients or
for nursing procedures such as urinary catheterisation. Depending on circumstances and local policy, a ward nurse and parent/carer may also be present at induction of anaesthesia.

As soon as the patient is transferred to the care of the anaesthetist, it is essential that the anaesthesia assistant provides exclusive support for the anaesthetist.

*The Association recommends that the anaesthetist should not proceed to induce anaesthesia, except in extreme emergency circumstances, if a trained anaesthesia assistant is not present.*

**The role of the anaesthesia assistant**

The current trend is towards multiskilling where most professionals in the operating department are able to perform many tasks including assisting the anaesthetist, assisting the surgeon, working in the recovery area and undertaking administrative duties. However, patterns of work must ensure that skills are maintained. In many hospitals the more junior members of the team perform a wide range of tasks within the operating department, while senior personnel specialise in a particular area.

*Assistance for the anaesthetist must be exclusive for any particular operating or investigational setting where anaesthesia is being administered.*

**Training**

Assistance for the anaesthetist may be provided by ODPs or nurses. In England and Wales, this assistance is more commonly provided by ODPs. In some trusts, particularly in Scotland and Ireland, nurses provide the majority of assistance. Whatever the background, the training for all anaesthesia assistants must comply fully with national standards. Employment of staff without an appropriate national qualification is not acceptable. Learners are accepted for formal training as anaesthesia assistants but they must be supernumerary and supervised at all times by a fully trained person. It is usual for an individual senior ODP or nurse to be responsible for rostering the anaesthesia assistants and for their ongoing training.

**ODPs**

Currently, the appropriate qualification for ODPs is the NVQ Level 3 in Operating Department Practice (SVQ in Scotland). Previously, the qualification was the City & Guilds of London Institute Certificate 752 or a formal Certificate of Assimilation.
issued prior to 1979. At present, there are 23 ODP training schools in England and Wales, some hospital based but many attached to colleges of higher education or universities. NVQ/SVQ training is flexible. Candidates must hold a trainee ODP post in a hospital which can provide the necessary on-the-job training and supervision.

The anaesthesia assistant who has undergone such training will be appropriately skilled and adequately trained but competence must be constantly updated and each trust should provide facilities for further professional development.

At present, ODPs do not have statutory registration. Without this, career development of ODPs is limited and the handling of controlled drugs, some non-controlled drugs and fluids is restricted in some places. Local arrangements can improve flexibility but the situation would be markedly improved by the introduction of statutory registration and amendment of the Misuse of Drugs Act. In the absence of such provision, the Association of Operating Department Practitioners (AODP, formerly BAODA) maintains a voluntary register and the Association of Anaesthetists recommends that trusts ensure that applicants for employment are registered with this scheme.

**Nurses**

Following the introduction of Project 2000, student nurses receive less exposure to specialist areas such as the operating department and intensive care. As a consequence, recruitment to both these areas has become more difficult. Despite this, a significant number of anaesthesia assistants are derived from a nursing background in many hospitals and nurses remain a potential pool of expertise for recruitment into the anaesthesia team.

Qualified nurses are already registered professionals but require additional training before taking on the duties of anaesthesia assistant. In England, the recognised national qualification of competency for nurses as anaesthesia assistants is the English National Board qualification. A list of current operating department ENB courses is detailed in the Appendix. Despite the availability of such training and qualifications, many nurses working with anaesthetists have at best undergone an abbreviated local training scheme with no national accreditation and at worst are seconded without any specific training. This practice is unacceptable.

In Scotland, until 1997, professional studies modular courses which included assistance for the anaesthetist were run by colleges of nursing and validated by the National Board for Scotland. These have now been suspended and replaced by a
university course leading to a BSc for specialist practitioners. There is an urgent need for the introduction of an intermediate level of nurse training. Such courses have also been proposed in Wales and Ireland but local encouragement and resources are required for their development.

It is possible for nurses to utilise the training schemes set up at ODP training schools and to take a 'fast track' to NVQ/SVQ Level 3. Their previous nursing training is taken into account and, as a result, the training time is shortened. Registered nurses clearly come to this training with an established knowledge and skill base but there is a core curriculum for nurses and ODPs who wish to become members of the anaesthesia team.

**Recruitment**

There is currently a shortage of anaesthesia assistants throughout the United Kingdom and Ireland and an urgent need for further recruitment and training. It would be to the advantage of anaesthetists and patients if motivated, trained assistants were recruited from as wide a professional spectrum as possible. Other entry routes to a common training scheme for anaesthesia assistants should be explored.

To this end, ODP training schemes should be expanded and those achieving the necessary qualification should receive national professional recognition. More nationally accredited nursing courses relating to anaesthesia assistance should also be developed in the United Kingdom and Ireland. There is much to be said for developing common training schemes and establishing common goals, working practices, pay and conditions and career opportunities. The clinical director must insist that adequate resources are provided by trusts to employ and train sufficient numbers of assistants to ensure a safe anaesthesia service. *The Association encourages its members to take an active interest in such developments in their own areas.*

**Agency employed staff**

Many trusts rely heavily on agencies to fill staff vacancies. If trusts were to ensure that proper pay and conditions were in place, the need for agency staff would diminish. This may be found, in the long run, to be the cheaper option. The recent report published by the Audit Commission has drawn attention to the high costs of employing agency staff [3]. Agencies should be discouraged from employing ODPs with less than 12 months' experience after qualification. As with all support staff, it is the theatre manager's responsibility to ensure that appropriately trained and experienced ODPs are employed. If it is necessary to recruit staff from agencies, it is
essential that an induction period is undertaken. Advice on the employment of ODPs from agencies may be obtained from the Secretary, AODP, 4 Walnut Tree Park, Walnut Tree Close, Guildford, Surrey GU1 4TR.

Equally, it is unacceptable for trusts to recruit nurses as anaesthesia assistants who do not possess a nationally recognised qualification for work in this specialised area of practice.
SECTION 6 - RECOVERY

The Association of Anaesthetists published guidance on the required facilities for the safe recovery from anaesthesia in 1993 [12]. The concepts and recommendations presented in that document hold true today. There is, however, a need to re-emphasise the principles outlined in that report and to update the recommendations on staffing and training.

The responsibility of anaesthetists for the care of their patients extends into the postoperative period and includes the management of postoperative pain. Emergence from anaesthesia is potentially hazardous and patients require close observation until recovery is complete. If the anaesthetist is unable to remain with the patient during this period, care must be transferred to staff who have been specially trained in recovery procedures.

While patients remain in the recovery area there must always be a suitably trained anaesthetist (and surgeon) immediately available within the hospital. The anaesthetist must be readily contactable and able to return promptly to the recovery area.

Close collaboration between the anaesthetist and the surgeon is particularly important at this time so that clear instructions are given to recovery staff.

Transfer to recovery area

The anaesthetist should be satisfied that the recovery staff are competent to take responsibility for the patient before care is transferred. If this level of staffing cannot be assured, the anaesthetist should stay with the patient until satisfied that the patient is fit to return to the ward.

Recommendations on the transfer of the patient from the operating theatre to the recovery area are outlined in an earlier Association of Anaesthetists' publication [13].

Immediate recovery

Continuous individual observation of each patient is required on a one-to-one basis until the patient is able to maintain their own airway. The recovery staff, therefore, must not have any other duties at this time. Failure to provide adequate care for patients during this period of vulnerability, in which the possibility of serious complications is well recognised, may prove catastrophic for the patient and could result in serious medicolegal consequences for the hospital. In hospitals with an
emergency surgical service, fully staffed recovery facilities must be available throughout the 24 hours.

A postanaesthesia care plan should be implemented for each patient which includes monitoring to ensure satisfactory cardiorespiratory function, fluid and pain management and the administration of drugs to agreed protocols. These have been the subject of previous advice [13]. Careful records must be maintained and staff must be able to interpret the information and initiate appropriate action where necessary. Staff must also be able to assess the suitability of transfer of patients to the next level of care.

*All staff must be adept in basic and advanced resuscitation techniques.*

**Discharge**

The patient should remain in a suitably equipped recovery area until all the criteria for discharge have been met [12]. Discharge must be based on a carefully worded protocol or on the personal instructions of the anaesthetist.

Recommendations on the criteria for discharge from the recovery area have been published previously [6] [11].

**Management**

The optimal management structure for the recovery area should be within the overall responsibility of the anaesthesia directorate. There must be clear lines of communication with other relevant directorates and departments.

**Training and qualifications**

All staff who work in the recovery area should have received appropriate training and possess a nationally recognised qualification. To achieve this, nurses and ODPs must undertake postbasic training; the NVQ level 3 ODP qualification includes only basic training in recovery. An ENB A94 course or equivalent is recommended for both grades of staff.
Personnel who are in training may work in recovery areas but must be supervised by trained staff. Staffing levels should not be depleted to fill deficits in other areas of the hospital, although rotation between staff within the operating department should be encouraged to maintain skills. All staff must have access to further professional development and there should be appropriate, funded study leave.
SECTION 7 - POSTOPERATIVE PAIN MANAGEMENT

Background
This area of clinical practice is a useful model to illustrate the benefits of a team approach. From a standing start in the early 1990s, following the recommendations of a Joint Royal College of Surgeons of England and College of Anaesthetists Working Party, many hospitals developed an acute pain team [14]. From a survey of around 30 hospitals throughout England and Wales [2], it was apparent that the majority had some development of such a pain team. The structures were fairly consistent in having an anaesthetist in overall charge (the majority having a sessional commitment by a consultant to acute pain) and a senior nurse running the service on a day-to-day basis, following predefined protocols. There were variations in the extent of the role of the nurse in areas such as intravenous administration of drugs and recommending changes in clinical management. Another notable feature of this survey was that finance was quoted as a limiting factor in the development of this team. Hospitals across the full range, from a London teaching hospital to a small rural DGH, cited lack of money as the reason for not having yet developed an acute pain team.

More recently, the Audit Commission report [3] noted that 57% of the hospitals surveyed had formal acute pain teams but there was considerable variation in such provision between different regions. The report recommended more effective collaboration between the anaesthetist, surgeon, trainee surgeons and nurses.

A high quality postoperative pain management service should include identifying the patient's individual requirements on admission and then 'tracking' the patient from the surgical ward, through recovery, the HDU and back to the ward.

The team
Potential members of an acute pain team include:

- a consultant anaesthetist(s) with sessional commitments to the team;
- trainee anaesthetists, either part of the on-call team or part of modular training in pain management;
- a specialist nurse or nurse practitioner with specific training in the management of acute pain;
• nurses in training;
• a pharmacist;
• a physiotherapist;
• an ODP.

Consultant responsibility
It is important that postoperative pain be controlled immediately on recovery from anaesthesia. The pain team must therefore be involved from an early stage and the consultant responsible for the pain service has an obvious role in the recovery area and the HDU. This role will involve the design and implementation of pain management protocols and the education and training of staff.

A recent report on the provision of pain services [15] stated that every hospital undertaking major surgery should have an acute pain team. The minimal sessional commitment to supervise the service should be one consultant session but, if the service is responsible for the care of more than 1,000 individual patients per annum, this should be increased proportionally.

A potential development of this team concept would be the introduction of a postoperative ward similar to the step-down wards used in the USA. Such a step-down unit would be staffed by nurses with recovery and acute pain training and with sessional input from consultant anaesthetists, with a trainee anaesthetist always available. This team should include a physiotherapist and a pharmacist, both with a specific remit for the ward. In the United Kingdom, HDUs are often used in this way in many hospitals to provide postoperative monitoring and pain control following major surgery.

Roles of non-medical personnel
A senior nurse is the appropriate person to be responsible for running the service on a day-to-day basis within the limits defined by protocols. In a similar manner to that described for the consultant role, it is important for there to be senior nursing input from HDU and recovery to the activities of the pain team. This pain nurse would be responsible for liaison between the wards, troubleshooting problems and referring problem patients to medical staff. They would also have an important role in education. Potential additional roles for this individual would be placing intravenous cannulae, administering appropriate drugs intravenously and topping up epidurals. The appropriateness of the delegation of any of these tasks would obviously be influenced
by the location in which they were used, with different roles being appropriate in the HDU, recovery and general ward.

The functions of the pain team can be enhanced by the introduction of a link nurse system in which a designated nurse in each clinical area is responsible for liaison with the acute pain team.

The pharmacy has a role in the provision of drugs for the acute pain team, including ready-prepared epidural and PCA packs. It should also be involved in maintaining the range of drugs required for the service, the evaluation of new drugs and education. This important role is enhanced by nominating a specific pharmacist to the team.

An important aim of postoperative analgesia is restoration of function and this can be assessed by the ward physiotherapist who should be involved with the acute pain team and may be a source of secondary referrals.

**Standards of practice**

The majority of pain services are delivered on the basis of protocols which have been drawn up by consultation between anaesthetists, surgeons and staff from recovery and general wards. Because there are local differences in both the role of the nurse and the extent of their remit, there will be variations in the protocols between hospitals. The pain team should be responsible for the implementation of a system to introduce, disseminate and review protocols for all grades of staff caring for postoperative patients and for continuing audit of the service.

There is a pressing need for national standards and recognition of training in pain management. This is a common problem in nursing practice where staff moving from one hospital or one region of the country to another may have to undergo a period of 're-training' for intravenous drug administration, for example, when they have previously demonstrated their competence over a considerable period of time and received local accreditation.

**Educational implications**

The educational implications are twofold: education of the team members and education by the team members.

Anaesthetists must play a major role in educating the members of the acute pain team, in collaboration with the senior nurse. Appropriate aspects of training should also be
addressed by other members of the team; pharmacists can advise on potential drug interactions and drug compatibilities and nursing staff will be able to contribute on aspects of patient counselling. The need for formal educational requirements for all team members should not be overlooked.

A primary role of the acute pain team is the education of trainee anaesthetists, surgeons, recovery staff, ward nursing staff, nurses and ODPs in training, pharmacists and physiotherapists. This educational process should be subject to quality assessment and review.
REFERENCES


APPENDIX

OPERATING DEPARTMENT RELATED ENB COURSES AVAILABLE TO REGISTERED NURSES (August 1998)

ENB 176  Operating Department Nursing
ENB 183  Operating Department and Anaesthetic Nursing
ENB 182  Anaesthetic Nursing
ENB R27  Anaesthetic Nursing for nurses who already hold a ENB 176 or 183
ENB 925  Principles of Operating Department Nursing
ENB N77  Nurse as First Assistant to the Surgeon
ENB A94  Post Anaesthetic Recovery
ENB R10  Post Operative Recovery (for nurses experienced in this field)
ENB A21  Perioperative and Day Care Nursing Practice
ENB N33  Perioperative and Day Care Nursing Practice (shortened courses for nurses experienced in this field)
ENB 998  Teaching and Assessing in Clinical Practice