University Hospitals of Derby and Burton NHS Foundation Trust

# TRUST POLICY FOR POST ANAESTHETIC CARE IN THE OPERATING DEPARTMENT (RECOVERY ROOM)

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<tr><td colspan="5">To be read in conjunction with: Theatre policy, ANTT, infection control policy, PONV clinical guideline, PONV clinical guideline- paediatrics, IV policy, obstetrics policy, adult pain, paediatric pain policies, NatSSIPs and LocSSIP handover and information transfer.</td></tr>
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| **Contact for Review** | Jane Minton |
| **Executive Lead Signature** | Garry Marsh, Executive Chief Nurse |

**Policy Content**

# POST ANAESTHETIC CARE IN THE OPERATING DEPARTMENT

# (RECOVERY ROOM)

## 1. Introduction

This document is a Policy for hospital staff working within the Recovery unit at UHDB The recovery room exists to provide a place of safety for patients recovering from general, regional and local anaesthetic.

With the anaesthetist and surgeon the recovery practitioner will plan the patient's immediate and continuing care needs, organising pain relief, physical and psychological support and assessment of all surgical and physiological considerations in the recovering patient.

## 2. Aim and Purpose

The purpose of this policy is to outline the care of patients who have undergone a surgical procedure under general, regional, local anaesthesia or sedation. All patients are at risk of compromise to airway, breathing and circulation. Once suitably recovered and having met the discharge criteria, patients can be safely discharged to a general ward in a stable condition.

All standards and recommendations described in this policy should be applied to all areas where patients recover from anaesthesia; these areas include Surgical, Orthopaedic, Gynaecology, Obstetric and Paediatric Theatres and DCUs.

## 3. Definitions Used

RECOVERY: The Recovery Room

DCU: Day Case Units

Day Surgery: the patient must be admitted and discharged on the same day, with day surgery as the intended management

Recovery Practitioner: either Registered Nurse or Registered Operating Department Practitioner (ODP).

## 4. Key Responsibilities/Duties

All clinical staff that provide post-anaesthetic care within UHDB are responsible for ensuring that these guidelines are adhered to and are accountable for the decision making process involved. Those with

additional responsibilities are the Theatre Managers, Lead Practitioners, Senior Theatre Practitioners who co-ordinate to operational activity within theatres.

## 5. Policy

The patient will be admitted into the recovery room and received by a registered practitioner.

The recovery room will ideally have a warm, quiet and professional environment.

### 5.1 Admission into the recovery room

**Transfer from theatre to recovery**

An anaesthetist will escort the patient from theatre to recovery with an effectively maintained airway (with or without adjunct) with a full O2 cylinder and facemask on the trolley. If the patient had a GA or sedation, they will receive O2 therapy.

A comprehensive hand over will be provided to the recovery room practitioner receiving the patient.

Unconscious patients staff ratio 1-1.

Anaesthetist and Scrub/ responsible practitioner who is familiar with the patient must handover to the recovery staff with SBAR.

**An anaesthetist will handover the patient:**

**S – Situation**

- Patient name
- Anaesthetic record, drug prescription and fluid record chart
- Communicate the anaesthetic technique, including the intraoperative analgesia, antiemetic and fluid management

**B – Background**

- Communicate a summary about the patient, including any drug allergies and provide relevant medical history, e.g. diabetic status
- Patient observations e.g. BP, temperature

**A - Assessment**

- Anaesthetic care including intra-operative problems
- Intra-operative input/output balance especially blood loss and

its replacement

**R - Recommendations**

• Communicate post-operative instructions using the recovery handover chart on the back of the anaesthetic chart in conjunction with the recovery practitioner paying particular attention to:

Recovery plan:

Immediate postoperative orders

- Potential problems/complications

- Analgesia, antiemetic, oxygen therapy, fluids prescribed and cannula care

- The need for ECG, blood sugar tests and/ or x-ray for example

The recovery chart must be signed by the anaesthetist and recovery practitioner confirming thorough handover.

The anaesthetists must not leave the theatre complex until the patient has a stable airway with no airway adjuncts and must not leave the hospital until the patient is fully stable and ready for discharge. Alternatively anaesthetic handover is provided to an on-call anaesthetist.

**A Scrub/ Responsible Practitioner will handover and sign the Electronic Care Plan:**

**S – Situation**

- Patient name
- Surgical team/ theatre
- Operation/ procedure details and variances
- Details of any local anaesthetics given by the surgeon
- Closure
- Packs
- Dressings/ casts
- Location and types of drains
- Provide catheter PU details

**B – Background**

- Allergies
- Issues in theatres
- Datix

**A – Assessment**

- Estimated blood loss
- Peri-operative progress e.g. position & total time of procedure, grafts.
- Skin check result and/ or areas of concern
- Surgical specific care required from surgeon and concerns discussed at WHO ‘sign out’

**R – Recommendations**

- For on-going care

The scrub/ responsible practitioner and recovery practitioner must sign the peri-operative care pathway for validity and handover.

Post op note from Surgeon must be seen by the recovery practitioner

Delivery of patient care during the recovery phase of anaesthesia is managed and achieved by:

Practitioners who are trained and proficient in the recovery of patients following anaesthesia.

- The safe use of equipment, checked daily.
- Adequate supply of equipment for airway management, breathing and circulation compromise, including resuscitation equipment.
- Sufficient staffing levels to allow each unconscious patient to have one-one care.
- Staff able to recognise complications during recovery and be competent to take the appropriate action. This may involve consultation or assistance from anaesthetist or surgeon.
- Clear documentation of airway, breathing, cardiovascular and fluid balance observations.
- An anaesthetist must be available at all times when patients are in Recovery Room.
- A member of the surgical operating team should be contactable while the patient is in recovery room.
- Adequate supplies of respiratory stimulants, opiate antagonists and neuromuscular reversal agents.

Following handover the recovery practitioner will perform a full A-E assessment this includes;

- Airway
- Breathing
- Circulation
- Disability

- Exposure
- The patient's privacy and dignity is respected by all staff at all times.

### 5.2 Airway and Breathing

- Assessment of the patient's airway including patency and respiratory rate is performed immediately following admission into the recovery room

- Where necessary basic and advance manoeuvres will be used to ensure that patients health is not harmed by airway or respiratory compromise. This may involve consultation or assistance from an anaesthetist (or occasionally a surgeon).

- Oxygen therapy, pulse oximetry available for all patients in the recovery room. Capnography is used for all unconscious and or intubated patients.

- The recovery practitioner will ensure the patient achieves adequate airway protection, adequate oxygenation and adequate ventilation prior to discharge from recovery room.

- There will be adequate supplies of opiate antagonists, neuromuscular reversal agents and respiratory stimulants.

### 5.3 Guidelines for the Administration of Oxygen in recovery room

- LMA – oxygen administered via a T-piece at 6L/min with capnography. Oxygen administered as per prescription of the anaesthetist following removal of LMA.

- Post ETT removal in theatre, oxygen will routinely be administered.

- Extended administration of oxygen into the postoperative period after discharge from recovery room must prescribed by anaesthetist.

<u>For example</u>

  - long acting or on-going planned opiate administration post-operatively
  - epidural analgesia post-operatively
  - co-morbidities requiring oxygen administration into the postoperative period

It must be prescribed on lorenzo (RDH) or V6 meditec MAR (QHB) and nasal speculae should be preferentially used.

- Facemasks for oxygen administration will be available for use in recovery room if specifically requested by the anaesthetist.

### 5.4 Circulation

- Cardiovascular status is assessed after arrival in recovery room, once airway patency, safety and adequate breathing is confirmed
- Equipment to enable non-invasive blood pressure, heart rate, continuous ECG and invasive pressure monitoring.
- Blood pressure and heart rate is measured at a minimum of 5 minute intervals until the patient has suitable met the discharge criteria.
- Where appropriate, monitoring of peripheral vascular condition may be required (e.g. Peripheral pulses, capillary return and distal temperature for patients following vascular surgery and for orthopaedic patients following application of casts or fracture surgery).
- In some cases more advanced cardiovascular monitoring such as invasive measurement of arterial and central venous pressures may be required.
- Only appropriately trained practitioners will attend these patients. Patients requiring this monitoring may require more than one practitioner to look after them.
- Abnormalities in cardiovascular status, hydration, urine output or surgical drainage will be referred through the appropriate anaesthetic or surgical channels. This will be addressed before the patient leaves recovery room.
- The patient must have a stable cardiovascular system (within their normal values) before discharge from recovery room.
- Fluid replacement and drugs to treat cardiovascular compromise are available in recovery room.
- Resuscitation equipment including a Defibrillator are available for the use on either a Paediatric or an Adult patient. Availability of emergency drugs, and all resuscitation management is sourced from the ‘Resuscitation trolley’ both the adult and Paediatric trolleys are located in the Recovery Room.

  All practitioners must be adequately trained to assist in resuscitation if required.

## 5.5 Temperature Maintenance

- The environmental temperature will be maintained at a comfortable level for the patients.
- Patients' temperature is measured using an appropriate thermometer site and thermometer.
- Hypothermic patients will be warmed passively or with external warming (e.g. force air warmer).
- Intravenous fluids will be warmed using a fluid warmer.

- Hyperthermic patients who require treatment will be identified. These patients will be given antipyretics (paracetamol) and passive or active external cooling applied.
- Management of hypothermic and hyperthermic patients may involve consultation with an anaesthetist or surgeon.
- The patients' normal body temperature should be maintained, or kept within acceptable safe/comfort levels prior to discharge from the recovery room.
- Equipment will be available to allow fluid warming and active external warming.
- Practitioners are trained in use of all equipment.
- Post-operative temperature must be recorded on the recovery chart every 15 minutes.

## 5.6 Minimum Observations

All patients' to have continual pulse, SPO2, BP and ECG every 5 mins until meets discharge criteria.

Once ready for discharge monitor and record as per Patientrack protocol.

## 5.7 Pain Relief

- Pain is a routine observation for post- surgical patients and will be identified and treated promptly.
- All recovery practitioners are trained and able to assess and treat acute pain.
- Staff are educated in the methods used to minimize other physical discomforts which may exacerbate pain.

- The pain assessment tools and information regarding the prescription and pain management of Paediatrics and Adult Post–operative patients are available within the Trust clinical guidelines.

- Practitioners will aim to administer analgesia appropriate to the patient's requirements and general condition.

- Prescriptions are accessed using the computer online prescription chart. (lorenzo for UHBD and V6 for QHB)

- The effects of analgesic interventions will be monitored to detect effectiveness of pain relief and complication of pain relief.

- Efficacy of pain relief is recorded. Adverse effects will be recorded and reported to the anaesthetist.

- The aim is for the patient to be able to cough, take a deep breath or change position in the bed with a pain level which is bearable by the patient.

- Failure to achieve expected or adequate pain relief may require consultation with and assistance from an anaesthetist or surgeon.

- The patient may be discharged from the recovery room no less than 20 minutes after administration of an intravenous opiate bolus. This allows 15 minutes for the peak effect of the opiate to have elapsed, which will ensure appropriate time to assess efficacy and side effects of the drug administration.

- Medication will be administered in accordance with the prescribing of drugs/treatment and administration of drugs policies.

- Analgesia required including advanced techniques (such as the use of epidural opiates) will be handed over to the ward nurse when the patient is discharged. Epidural infusion should be connected by the anaesthetist.

- Training will be given to staff in management of pain, intravenous administration of drugs and specialised equipment for the relief of pain, e.g. PCA or Epidural administered as per trust policy (CG-PM/2011/013).

## 5.8 Post-Operative Nausea and Vomiting (PONV)

- Nausea and vomiting after surgery and anaesthesia (PONV) can be frequent and multifactorial.

- It is a routine observation for post-surgical patients and is identified, recorded and treated promptly.

- Practitioners are educated in the methods used to minimise other physical discomforts which may exacerbate PONV.

- Practitioners will aim to administer anti emetics appropriate to the patient's requirements, general condition and surgery. The effects of antiemetic interventions are monitored to detect effectiveness and complications.

- Failure to achieve expected or adequate anti-emesis may require consultation with an anaesthetist.

- The aim is to prevent or reduce nausea and vomiting post operatively.

- Infection control policy should be followed when handling body fluids and disposing of them.

- Regular oral hygiene should be given.

- The patient should not be discharged from the recovery room until PONV is effectively controlled.

## 5.9 Preventing Infection

- Appropriate PPE must be worn when handling all body fluids and removing IV cannulas.

- Staff will be aware of the trust infection control policy and adhere to its recommended practice.

- Patient trolleys, equipment, shelves and cupboards will be cleaned regularly between patients, daily and weekly according to the department cleaning schedule and documented for audit purpose.

- Items designed for single use will be used once and disposed of.

- Appropriate high standard care will be given to all patients in order to reduce the risk of infection.

- Appropriate observations are carried out to detect signs of local and/or generalised infection.

- Strict aseptic care of catheters, tubes, drains, venous lines and wounds will be maintained.

- Existing infection will be treated where this is required and management will minimise the risk of acquiring any preventable infection as a result of being in hospital.

- All staff must adhere to hospital and unit infection control guidelines.

- Follow infection control protocol for identified infected patients admitted into Recovery Room.

- In the event of an existing patient infection, clinical judgement should be used and collaboration with infection control to determine whether it would put other service users at risk to bring out the patient to recovery.

Wherever possible a single recovery practitioner should be allocated the patient to recover. Good hand hygiene practices should be adhered to.

Recovery staff should be aware of signs of sepsis and follow the guidelines in a timely manner if sepsis is suspected.

## 5.10 Wound Management

- The aim is to promote uncomplicated healing. This will include a clean, dry wound with no obvious signs of complication. Stomas should be well perfused.

- Aseptic technique will be used for wound dressings.

- When dealing with body fluids nursing staff will adhere to Infection Control Policy.

- Wound and drain inspection will be undertaken to detect complications. If detected; these will be reported to the appropriate person.

- Medication or dressings will be given or applied as prescribed and in accordance with the hospital policy.

### 5.11 Elimination

- The aim is for the patient to have no deterioration in bladder or bowel function in line with post-operative expectations.

- Observations of bladder, bowel/stoma function will be made and recorded. Any identified or suspected malfunction or concerns will be referred appropriately.

- Management of elimination should ensure privacy and dignity at all times.

- Toileting devices should be readily available.

- Strict aseptic technique will be used during bladder catheterisation.

- Hourly urine measurements will be made for appropriate patients.

### 5.12 Hygiene

- The aim is for the patient to be clean and comfortable with no effects because of lack of hygiene facilities.

- Eyes and mouth care should be carried out according to policy.

- The patients care should be planned to meet their individual needs and privacy and dignity must be maintained.

### 5.13 Pressure area care

- The aim is for the patient to be comfortable with healthy intact skin.

- The patient's skin condition will be observed for signs of redness or broken areas. These will be recorded and actively managed where necessary.

- Patients with spinal blocks are at increased risk of pressure sores and should be monitored particularly carefully.

- Patient mobilisation and turning will be used as appropriate.

- The recovery staff will ensure pressure areas are checked regularly.. Pressure area care should be recorded within the patient's theatre care pathway and any concerns communicated on handover.

### 5.14 Moving and handling

- The correct and most appropriate bed for the patient should be chosen before admission into the recovery room.

- All beds where possible, should be a profile bed with remote controls to ease positioning of the patient.

- At the time of admission into the recovery room, if the patients' bed from the ward is not available; the site coordinator should be informed to ensure an alternative bed is available to prevent unnecessary prolonged care on a theatre trolley.

- Particular care should be given to those patients following regional anaesthesia. Attention should be made to the positioning of the patients limbs to ensure adequate space is available at the end of the bed or trolley. The patient's arms should be protected from pumps or drip stands.

- If required any wet linen must be removed and clean linen replaced. Movement of any patient should be carried out in accordance with the hospitals safe moving and handling policy.

- Cot side bumpers are available and should be used for any patient who is restless during the post-operative phase of care.

### 5.15 Discharge Criteria

Record and document final observations on patientrack when patient is ready for discharge.

If Mews Score 5 or above Patient to be reviewed by anaesthetist prior to discharge and a plan of on-going care documented.

Minimum criteria for discharge of patients from the post-anaesthetic care unit include:

- The patient is fully conscious, able to maintain a clear airway and has protective airway reflexes

- SpO2 is greater than 94%, dependant on pre existing conditions, such as COPD.

- Oxygen therapy is prescribed as appropriate

- The patient's rate and depth of respiration and their oxygen saturation must be within the parameters set by the anaesthetist for each individual patient

- The patient is alert and orientated when awake

- The patient is haemodynamically stable. If any observations are outside of the patients normal pre-operative range then the anaesthetist must be informed and any appropriate measures to address the problem must be taken, i.e. prescription of IV fluids

- If catheterised, the patients urine output is 1ml/kg over 2 hours

- Pain and post-operative nausea and vomiting are adequately controlled and continuing treatment must be prescribed.

- The patient's temperature is within acceptable limits (above 36.0 degrees Celsius)

- IV fluids, anti-emetics and analgesia are prescribed as appropriate

- Any required DVT treatment is prescribed and/or flowtrons boots or TED stockings applied appropriately.

- There is no excessive blood / fluid loss from wounds or drains

- Patients receiving intra operative cell salvaged blood from theatre, must be transfused prior to discharge

- All documentation must be completed in full before discharging the patient to the ward area. These documents include, Theatre Care Pathway,Pain management documentation, IV fluid prescription chart, and Blood Transfusion chart and patientrack, in those areas using it.

Patients, who do not meet these criteria but have received an anaesthetic review deeming them suitable for discharge, must have this annotated in the patients' notes and/or anaesthetic chart. This should include a suitable second stage recovery plan.

When transferring patients from recovery to ward or other second stage recovery area, ensure staff have an appropriately filled transfer bag inc.ambu bag, guerdal airways, o2 face mask and tubing, hand held suction, vomit bowls, gloves etc.

Only recovery trained practitioners and appropriately qualified ward staff are able to both escort back to the ward and receive hand over.

**5.16 Useful guidance for duration of stay in recovery room**

All patients must fulfil criteria for discharge, times based on full patient assessment and clinical judgement:

- Local Anaesthetic (may return to the ward from theatre)
    - 1 set of observations and return to ward.

Should the patient:

- Receive a first dose of antibiotics or commence a transfusion of a blood product
    - Discharge should be delayed for at least 15 minutes

Should the patient:

- Receive a dose of IV opiate pain relief, other than a self-administered PCA
- Receive a bolus dose via an epidural catheter
- Discharge should be delayed for a minimum of 20 minutes

### 5.17 Handover to the Ward

- The patient should be informed of their transfer to the ward.

- A suitably trained practitioner should either escort to the ward or collect from recovery.

- Any delays expected from the ward should be made clear by the nurse in charge during the conversation.

- Escalation practices following delays longer than an hour and/or if there are unresolved issues regarding discharge.

- The patient's documentation should be ready to be handed to the escorting practitioner.

- The ward practitioner will be given a full handover of the patient's condition and any appropriate post-operative instructions.

- Time data and the recovery record should be completed on ormis (RDH) or V6 meditech MAR (QHB)

- Recovery staff must be certain that the ward practitioner understands the patient's condition and is willing and competent to accept responsibility for the patients care. The recovery practitioner must ensure that full clinical details are relayed to the ward practitioner with the emphasis on complications, medical devices and infusion checklist.

- The ward practitioner must sign for the handover on the anaesthetic/ recovery chart

## 5.18 Ventilated and Critically ill Patients

Patients requiring assisted ventilation should wherever possible be transferred to ITU.

•NOTE: In exceptional circumstances when ITU bed is not available, it may be necessary to use the recovery room as an overflow to ITU or for the stabilisation of patients prior to transfer. The anaesthetic consultant in charge to liaise with ITU to provide medical and nursing cover. Only in an emergency situation should a patient be ventilated in the recovery room. ITU patient in recovery will have immediate anaesthetic input with ITU overarching decision making. This is a temporary solution and plans to free capacity in ITU must be addressed as a matter of urgency.

•When a patient is receiving prolonged HDU or ITU care in recovery room this may require reduction or cessation of operating in some or all Theatres.

•When a patient is receiving ITU care in recovery room an appropriately senior anaesthetist must be immediately contactable.

•Should a patient require ITU/HDU unexpectedly, then theatre/recovery staff should inform ITU and the Bed Manager immediately. Critical care outreach team can be contacted for additional assistance if necessary.

•Recovery staff may be required to monitor and care for patients receiving IV inotropes via medical devices.

## 5.19 Paediatric Patients

In accordance with local policies, a child's needs are met in the recovery room by understanding their fundamental differences in psychology, anatomy and physiology to adults. This is supported by a warm, decorated bay with sufficient room for visiting relatives.

Paediatric patients should be cared for on a strictly 1-1 basis and another member of staff must be present at all times

The bay is equipped with a paediatric airway management trolley including;

- Range of paediatric face masks
- Breathing circuits
- Range of airway adjuncts

Patient monitor has set parameters for paediatric patients. Essential monitoring includes a full range of;

- Non-invasive blood pressure cuffs
- Small sized pulse oximeter probes
- ECG
- Capnography

A paediatric trolley fully equipped for the management of paediatric anaesthesia and patient stabilisation is within close proximity of the paediatric recovery bay.

The emergency paediatric resuscitation trolley is situated within the recovery room.

Paediatric patients can be more restless and disorientated compared to adult patients. Continuous One to One supervision is required and cot bumpers are available for use to avoid child injury.

Paediatric patients in pain can be difficult to assess, especially if they are particularly young and unable to communicate. Protocols for pain management in children are available. If they are under 16 years, the anaesthetist will administer pain relief.

Before discharge from the recovery room all intravenous cannula must be flushed and documented by the anaesthetist.

Where possible both a ward nurse and relative should escort the child on return.

Paediatric PCA (CG-PM/2011/013) and Epidural infusions (PA EP 02) prescribed and connected by an anaesthetist as per protocol

## 5.20 Obstetric Patients

See Obstetric Anaesthesia- Recovery- Clinical Guideline (PN/12:23/R5)

If baby is present, a registered midwife must be present to care for baby while recovery will care for the mother.

### 5.22 End of life

Refer to Trust policy-Care of the Deceased patient in the Operating Department. If necessary, and staff are unable to return patient to ward, ensure patient is nursed in isolation, away from other patients and with a dedicated nurse.

### 5.23 Interpreters and Patient Carers

Staff may require access to interpreters to facilitate communication with non - English speaking patients or patients who use sign language to communicate.

A patient may request a relative to provide additional support and comfort during the post anaesthetic phase. The suitability of this request would be at the discretion of the recovery practitioner and Anaesthetist. Protection of other patient's confidentiality and dignity must always be considered.

### 5.24 Recovery Staff

Recovery staff are either registered general nurses (RGN), Operating Department Practitioners (ODP) and HCA's in RDH, who are trained and have undertaken competencies in post-anaesthetic care.

Qualified members of staff will be trained in ILS, PBLS and will have attended the IV study day.They will be appropriately trained in all relevant medical devices and recovery core skills such as ABCDE assessment.

Staff new to recovery will not work independently until they have been assessed by an experienced member of the Recovery team and will remain supervised until their training is complete and their competencies signed off.

## 6. Monitoring Compliance and Effectiveness

The key requirements will be monitored in a composite report presented on the Trusts Monitoring Report Template:

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| Monitoring Requirement : | Theatre Assurance |
| Monitoring Method: | Quarterly IPC audit |
| Report Prepared by: | Role title |
| Monitoring Report presented to: | Safer Surgery Meetings |
| Frequency of Report | Quarterly |

## 7. References

| Source of data | Date of publication/issue | Detail of requirement |
|---|---|---|

| | | |
|---|---|---|
| Guidelines for daycase surgery. | 2019 | |
| AAGBI Immediate Post-Anaesthesia | 2013 | |
| British Anaesthetic and Recovery Nurses Association [BARNA] Standards of Practice | 2012-revised 2021 | |
| Pain Management and Assessment-Paediatric | PAGI01/jan17/V004 | |
| ANTT Policy | POL-IC/12/10 aug 2022 | |
| Continuous Morphine Infusion - Clinical Guidelines | CG-PM/2011/006 | |
| Epidural: Post- Operative Use - Paediatric Full Clinical Guideline | PA EP 02-paediatrics | |
| Epidural - Obstetric - Clinical Guidelines | IP/07:23/E4 | |
| Epidural - Non- Obstetric - Clinical Guidelines | CG-PM/2012/009 Acute pain | |
| Obstetric Clinical Guidelines | PN/12:23/R5 | |
| Infection Control Policy | POL-IC/1869-061/05 | |
| Intravenous Sedation - Trust Policy | POL-CL/1870/15 | |
| Standard Operational Procedure for the Management of the Latex Sensitive Patient in Theatre | CG-surgen/2023/001/surgery | |
| Lidocaine Infusion - Clinical Guidelines | CG PAIN/2015/001 | |
| Local Safety Standards for Invasive Procedures (LocSSIPs) | POL-Clin/4234/23 | |
| Morphine Infusion: Post-operative Use - Paediatric Clinical Guideline | PA MO 01 | |
| | CG-PM/2023/014 | |
| | CG-PM/2024/004 | |

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