



INFORMATIONAL ARTICLE

HISTORICAL CONTEXT OF THE ANESTHETIC RECOVERY

CONTEXTO HISTÓRICO DA RECUPERAÇÃO ANESTÉSICA

CONTEXTO HISTÓRICO DE LA RECUPERACIÓN ANESTÉSICA

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ABSTRACT

Objective: to describe the historical aspects of anesthesia recovery evidenced in the publications. **Method:** this is an exploratory and descriptive historical-social research, based on the publications and legislation about nursing practice in Brazil, representing the historical context of the anesthetic recovery for the recognition and valuation of perioperative nursing. **Results:** In this historical evolution, the nursing of the anesthetic recovery built a path permeated by the technical approach, need for individualized assistance and critical area, with a search of scientific knowledge and hospital accreditation processes for patient safety. In Brazil, initiated only in 1980, the anesthetic recovery of the 2000s has been based on systematized assistance, permeated by patient safety actions in search of better team training. **Conclusion:** there is a movement of the Brazilian nursing with the assistance of the anesthetic recovery and improvement of these actions over time. **Descriptors:** Post-Anesthesia Nursing, Anesthesia Recovery Period, History of Nursing, Perioperative Nursing.

RESUMO

Objetivo: descrever os aspectos históricos da recuperação anestésica evidenciados nas publicações. **Método:** investigação histórico-social, exploratória e descritiva, com base nas publicações e legislações pertinentes ao exercício da enfermagem no Brasil, representando, dessa forma, o contexto histórico da recuperação anestésica para o reconhecimento e valorização da enfermagem perioperatória. **Resultados:** nesta evolução histórica, a enfermagem da recuperação anestésica construiu um caminho permeado pelo enfoque técnico, necessidade de assistência individualizada e área crítica com busca de conhecimento científico e processos de acreditação hospitalar para segurança do paciente. No Brasil, iniciada apenas em 1980, a recuperação anestésica dos anos 2000 tem sido baseada na assistência sistematizada, permeada por ações de segurança do paciente em busca de melhor capacitação da equipe. **Conclusão:** há um movimento da enfermagem brasileira na assistência da recuperação anestésica e aprimoramento destas ações com o decorrer do tempo. **Descriptores:** Enfermagem em Pós-Anestésico; Período de Recuperação da Anestesia; História da Enfermagem; Enfermagem Perioperatória.

RESUMEN

Objetivo: describir los aspectos históricos de la recuperación anestésica evidenciados en las publicaciones. **Método:** investigación histórico-social, exploratoria y descriptiva, con base en las publicaciones y legislaciones pertinentes al ejercicio de la enfermería en Brasil, representando de esa forma el contexto histórico de la recuperación anestésica para el reconocimiento y valorización de enfermería peri-operatoria. **Resultados:** en esta evolución histórica, la enfermería de la recuperación anestésica construye un camino lleno de un enfoque técnico, necesidad de asistencia individualizada y área crítica, con busca de conocimiento científico y procesos de acreditación hospitalaria para seguridad del paciente. En Brasil, iniciada apenas en 1980, la recuperación anestésica de los años 2000 ha sido basada en la asistencia sistematizada, permeada por acciones de seguridad del paciente en busca de mejor capacitación del equipo. **Conclusión:** hay un movimiento de la enfermería brasileña en la asistencia de la recuperación anestésica, y mejoramiento de estas acciones con el curso del tiempo. **Descriptores:** Enfermería Pos anestésica, Período de Recuperación de la Anestesia, Historia de la Enfermería, Enfermería Peroperatoria.

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INTRODUCTION

Anesthetic Recovery (AR) is the area for patients undergoing any anesthetic-surgical procedure, the patient must remain until recovery of consciousness, normalization of reflexes and vital signs, under observation and constant care of the nursing team. The team should prevent intercurrences of the post-anesthetic period and/or, if they occur, give them assistance.¹⁻²

AR depends on the existence of systematic assistance, since it allows checking, over time, if the adopted behaviors are effective, considering the specificities of the patient and also of the anesthetic and surgical procedures, intermediated with teamwork.

Knowing the work of the nurse in the anesthetic recovery room throughout history enables to distinguish the stages of the evolution of the post-anesthetic period, to provide improvements in this assistance process, with the construction of new histories, and to provide support to undergraduate and post-nursing students about the historical context of this area that may be their area of activity.

The history of AR is full of controversies, since there are several interpretations of facts, from the initial use of anesthetics to the nursing performance in the care with the patient in the postoperative period.³ In this way, this study aims to describe historical aspects of anesthetic recovery evidenced in existing publications.

METHODS

It is an exploratory and descriptive historical-social research based on the publications and legislation about the practice of nursing in Brazil, representing the historical context of the anesthetic recovery for the recognition and valorization of perioperative nursing.

RESULTS AND DISCUSSION

• Historical context

The earliest documented evidence of these rooms originated in the early 1800s, more specifically in Newcastle, England reported in 1801, describing two rooms next to the operating room to treat patients with serious illness or patients submitted to major surgery. Each room had two beds, one would be occupied by the patient and the other would be occupied at night by the nurse.⁴⁻⁵

This report is dated before the discovery of modern anesthesia in 1846 with descriptions of the anesthetic effects of ether chloride by

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William T. G. Morton, who studied medicine and able to seal a tooth without the patient experiencing pain. Subsequently, Morton learned that sulfuric ether had similar properties and he hired surgeon John C. Warren and convinced him to undergo surgery under the effect of the new anesthetic. On October 16, 1846, at the Massachusetts General Hospital, Warren dissected a congenital vascular tumor of an unconscious patient in five minutes, which subsequently regained consciousness.⁴⁻⁵

In 1859, nurse Florence Nightingale had great influence in hospitals and nursing issues, when she established nursing as a highly trained specialty. She advocated the creation of small wards under separate administrations⁶. Years later, in 1863, she identified a small room in communication with the operating room where the patient remained until emerging from anesthesia and regained vital signs.^{4,7}

A few years later, in 1873, Charles Tomes, an English dentist surgeon, was invited to teach classes for dentistry students at Harvard University in the United States and to encourage them to use anesthesia. However, the new anesthetics had side effects such as nausea, vomiting and delirium, and it was necessary to observe the patient after surgery, so a recovery room is described for patient observation.⁴

Then, it began to spread to Europe and Asia. Reports cite the existence of recovery rooms in 1904 at the Boston City Hospital; in 1923 at Johns Hopkins Hospital; in 1932 at Cook Country Hospital, Chicago; in 1938 at New Britain General Hospital, Connecticut.⁴

With the outbreak of World War II, the number of post-anesthetic recovery rooms increased significantly as they realized that the number of nurses to care for the wounded people was scarce. To better serve them, they were placed in the area of anesthetic recovery after the surgical procedure, supervised by nurses, who deepened the knowledge and expertise in the area of anesthetic recovery.³⁻⁴

In 1942 at Washington Hospital, anesthesiologist Donald Stubbs trained nurses and determined an area to observe pediatric patients after surgery, as he would use Avertin as an anesthetic. From there, there was the genesis of the first post-anesthetic recovery room³. Afterwards, Dr. John Lundy, visiting Washington Hospital, was interested in the type of care provided to the patients after the surgeries, which motivated the implantation of these environments in the clinic of his city. Thus, he began to publish

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articles on the importance of these rooms and the need for new equipment, renaming them as the Post-anesthetic Recovery Room.^{3,6}

Recovery areas have also been documented as the place to save lives. In 1947, the Journal of the American Medical Association (JAMA) published a study with the advantages of these areas of recovery. This study evaluated patients who died within the first 24 hours after induction of anesthesia for a period of 11 years. Of the 306 deaths, 47% were classified as preventable, so with this result, there was a stimulus for the creation of more anesthesia recovery rooms in the United States. In 1949, the New York hospital declared the recovery room a necessity for any hospital to perform surgical procedures.^{3,4}

With the evolution of medicine, and the resources involved in this process, the surgical and anesthetic techniques were improved and allowed surgeries of greater complexity. As a consequence, the hospitals needed a recovery area after the surgeries, for the patient to restore the level of consciousness and to maintain stable vital signs.³

In Brazil, in the 1980s, a group of nurses from the Surgical Center of the Hospital das Clínicas, in São Paulo, improved the care provided to the patients after the experience at the Pitié-Salpêtrière University Center in Paris.³

At the same time, from the 1980s, nurses working in AR had to comply with the Nursing Practice Legislation, Law 7,498, of June 25, 1986, regarding the responsibility of the nurse professional. Thus, the article 11, Section I, paragraphs l and m, respectively, mention that nurses are legally entitled to "guide nursing care for serious life-threatening patients"; "Nursing care of greater technical complexity and requiring scientifically based knowledge and ability to make immediate decisions". Given the anesthetic-surgical act as a situation of greater risk to the patient, it is up to the nurse, according to the legislation, to evaluate and assist the severe patient in AR, and this professional can delegate the nursing care to the other team, when such delegation does not risks due to malpractice, negligence or professional recklessness.^{3,8}

In 1982, some nurses from the Brazilian Nursing Association (ABEn), São Paulo section, created the Study Group in Surgical Center and Material Center (GECC), with the purpose of promoting discussions about nursing practice in the Operative Block. In 1991, GECC became a society dedicated to the continuing education of nurses in this area, called the Brazilian Society of Surgical Center Nurses

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(SOBECC), with advanced studies for surgical center, anesthetic and material recovery practices.^{1,3}

However, only in 1994, under Administrative Rule MS-GM 1,884 of November 1, 1994, which revoked Administrative Rule MS 400/77, published in the Official Gazette of the Union of December 15, 1977, the existence of an AR was mandatory, to attend at least two patients simultaneously and safely.¹

Since 1999, with the publication of the report of the Institute of American Medicine (IOM) entitled "To Err Is Human", the interest in safety issues in patient care increased. Currently, patient safety is highlighted in the discussions of care and in the processes that involve it. Studies have sought best practices to ensure safety, as well as, institutions are constantly seeking improvement in their processes with accreditation certifications.⁹

The accreditation process in Brazil occurred in the 1990s when the Pan American Health Organization (PAHO) determined numerous measures to improve hospital parameters and services in Latin America and criteria for the hospital to be accredited. In 1999, the National Accreditation Organization (ONA) was created to manage the Brazilian accreditation model. In 2002, the National Health Surveillance Agency (ANVISA) made the Brazilian Accreditation System official through Resolution 921/02.¹⁰

In 1999, with a focus on international patient care, Brazil has its first private hospital accredited by the Joint Commission International (JCI). Over time, other hospital institutions sought this accreditation process. Hospital accreditation by the JCI methodology has the evaluation of the safety of care offered to patients as one of its main focuses.¹¹

In AR, the safety goals are seen through the identification of the patient with two identifiers; effective communication between team members, confirmation of the information received, transfer of information from the operating room to anesthesia recovery by the professional team, examinations collected or responses to medication treatments are promptly communicated to the anesthesiologist for immediate action; the safety of drug use, when high-vigilance administered after double-check, decimal solutions of analgesic medications prepared in syringes identified with patient's name and medication, and scorned using double-check and record the volume of scorn when not are fully used.

In the search for the reduction of the risk

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of infections associated with health care, recommendations and the commitment of guidelines of hand hygiene with lavatories with soap and water and use of alcohol gel at the bedside area highlighted, besides the nursing team's awareness.

The fall protection is performed by raising the stretcher bars that are maintained during the patient's stay. Patients with psychomotor agitation or presence of delirium require the presence of a staff member at the bedside until the picture is reversed.

This movement was expanded after 2010, with more institutions recognized by international practices. These actions aimed at patient safety and currently seen in hospital practice meet the safety goals published in the National Patient Safety Goals Effective.¹²

Regarding the current AR nursing, the movement of the exclusive AR nurse and no longer shared with the operating rooms, training in emergency care courses such as Advanced Cardiovascular Life Support (ACLS) and Pediatric Advanced Life Support (PALS) has followed a trend of hospital institutions, as well as the search for updating in national and international congresses and the encouragement of research and publications to contribute to perioperative nursing.

In another perspective, the effectiveness of education during undergraduate and postgraduate courses is required with the continuation of the surgical center curriculum for the minimum training of professionals in the operative area encouraging the search for specialization and providing professionals trained for perioperative assistance.¹³ The creation of the perioperative nursing curriculum as a guide for the definition of perioperative nursing skills and abilities as existing curricula in the United States and Europe is a path still to be explored for Brazilian perioperative nursing.

Regarding the management of anesthesia recovery, it is necessary to develop measurement indexes for personnel sizing specific to AR activities, the creation of protocols directed only to AR and construction of highly qualified teams.

CONCLUSION

It was observed a great improvement of the Brazilian nursing in the assistance of the anesthetic recovery and of these actions over time. It is indeed important for the perioperative nurse to know the historical context, its origin and to provide the construction of this history with improved

processes and patient-focused care.

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