Saint Francis Memorial Hospital
A Dignity Health Member

POST ANESTHESIA CARE UNIT

ASSESSMENT/MANAGEMENT/DOCUMENTATION

02/2014

Patient Care Policy

POLICY:

Perianesthesia registered Nurses (RN) at Saint Francis Memorial Hospital perform a systemic Standard Post Anesthesia assessment, ongoing assessment and management, and discharge assessment; assure all collected data documented while the patient is in the Phase I Post Anesthesia Care Unit (PACU). (See Standards of Perianesthesia Nursing Practice, American Society of PeriAnesthesia Nurses (ASPAN))

PURPOSE:

To ensure a systematic method of assisting the patient in transitioning to a safe physiological level (Phase II) by utilizing the collected assessment data to develop an individualized plan of care.

PROCESS:

A. Initial assessment and documentation include, but not limited to:

1. Integrate the data received at transfer of care.
   a. Relevant preoperative status.
   b. Anesthesia/sedation technique and agents
   c. Length of time anesthesia/sedation administered, time reversal agents given.
   d. Pain and comfort management interventions and plan.
   e. Medications administered.
   f. Type of procedure.
   g. Estimated fluid/blood loss and replacement.
   h. Complications occurring during anesthesia course, treatment initiated response.
   i. Emotional status on arrival to the operating or procedure room.
2. Vital signs
   a. Assessments of vital signs and pulse oximeter oxygen saturations are checked immediately on arrival to the PACU. Report the vital signs and 0_2 saturation to the anesthesiologist on admission.
   b. Use audible, palpable, or oscillation method to monitor Blood Pressure.
   c. Pulses: apical or radial and pedal.
   d. Assess immediately quality and rate of respirations,
   e. Monitor the patients with a cardiac monitor. Insert a strip in the progress notes. Assess rate - normal, bradycardia, and tachycardia; Rhythm - regular, irregular, extrasystole, bigeminy, or any other rhythm
   f. Temperatures – temporal artery, oral, or axillary
   g. Hemodynamic pressure readings: central venous, pulmonary artery and wedge, arterial, intracranial pressure if indicated
   h. Pain and acceptable pain level with each vital signs
3. Airway/Respirations

Start oxygen at 3 liters nasal cannula unless chronic pulmonary disease or otherwise ordered by the anesthesiologist. Assess patency and type of airway present, the ability of the patient to maintain an airway, adequacy, muscle retraction (suprasternal, substernal, intercostal), nasal flare, dyspnea, shallow abdominal breathing, Kussmal, Cheyne-Stokes, paradoxical, grunting, apnea, and mechanical ventilator settings as appropriate. Breath Sounds are checked on all patients. Note occurrence of sounds on inspiration or expiration and, if clear, wheezing diminished, absent, moist, rales, or rhonchi.

4. Pain
   Include type, location, quality, frequency, sedation level, physical appearance, functional level and ability to relax, and intensity using self-report numerical scale, facial expression, or nonverbal pain scale. Pediatric patients should use Wong-Baker face scale if >3 year-old, FLACC scale if 2months – 7 year-old.
5. Level of psychological/emotional comfort
6. Neurological function including level of Consciousness
   Check consciousness, examine response to verbal stimuli, and do not painfully stimulate unless absolutely necessary. Note if awake, alert, drowsy or state of orientation. Check pupillary response as indicated.
7. Sensory and motor function as appropriate.
8. Condition and color of the skin
   Observe immediately on arrival in the PACU: pink, pale, dusky, cyanotic, erythema. Areas observed - lips, nail beds, earlobes, and conjunctiva. Note difference between limbs vs. trunk.
9. Position: Chart the position of the patient on arrival to PACU and record any position changes- supine, prone, semi-prone, right or left lateral, Trendelerburg, fowler's, semi-fowler's, use of traction or cervical towel rolls, elevation of extremities.
10. Patient safety needs.
11. Neurovascular: Assess and document peripheral pulses and sensation of extremities as applicable. In cardiovascular surgery, check dorsalis pedis, posterior tibial, popliteal, and femoral pulses.
12. Dressings and visible incisions. Describe type, location, and dry or stained. Check dressing frequently.
13. Drainage tubes, catheters, and receptacles: include type, patency, securement, location, amount and type of drainage, and use of suction.
14. Intravenous (IV) and Central Venous Pressure (CVP) Line: Note the location of lines and describe the site. Chart the type of solution infusing and if medications in the solution by scanning the bar code. Record the amount of solution infused on Intake and Output flow sheet.
15. Arterial Line - is to be stabilized. Insertion area is to be kept visible, and pulse, color, warmth of extremity noted. Note and describe the site. Optimize accuracy of pressures, monitor the waveform, insert a strip in the progress notes, and chart on PACU flow sheet.
16. CVP and Pulmonary Artery Line - Note and describe the site. Optimize accuracy of pressures, monitor the waveform, insert a strip in the progress notes, and chart on PACU flow sheet.
17. Anesthesia: If regional anesthesia has been used, assess the level of sensation (Dermatome level) and degree of movement (Bromage score for epidural).
18. Medication management: scan 3 D bar code on the patient's identification band and medication bar code.
19. Nausea/Vomiting: Document the Medication given as ordered per anesthesiologist. Notify the anesthesiologist if the nausea is not relieved by the ordered medication.
20. Procedure specific assessment (i.e., firmness of abdomen).
21. Postanesthesia scoring system- Aldrete score.

B. Ongoing Assessment and management include, but not limited to the following:

1. Vital signs and pulse oximeter oxygen saturations are checked every 15 minutes or more frequently if the condition of the patient warrants. Report the O2 Sat. readings below 92% with oxygen flow or if age and condition of the patient warrants a higher reading. Check temperature

prn on all patients whose skin feels warm or are chilling and promote normothermia. The patient should not be discharged from the PACU till a temperature of 36°C (96.8°F) or above has been obtained or returned to pre-op temperature. Exceptions: transfer to a critical care unit. Check and compare with the history of the patient and the anesthesia record.

2. Monitor, maintain, and or improve respiratory function. Keep artificial airways (oral, nasal, endotracheal, or laryngeal mask airway) clear of secretions with suctioning. Suction oral cases with extreme care. If the patient is unconscious, check frequently for possible airway obstruction and ability of patient to maintain airway. If no airway in place, maintain head/tilt, chin lift or jaw thrust position until the patient is able to maintain a patent airway. Insert oral or nasal airway if positioning fails to maintain clear airway. If intubated, secure the endotracheal tube, obtain x-ray for tube placement, and assess for the readiness of extubation (refer to the extubation of post anesthesia policy). If there is a chest tube connects to suction according to the order and provide the care according to SFMH policy.
3. Monitor, maintain, and or improve circulatory function. If hypotensive and consistent with the surgery performed, position the patient in Trendelenburg. If the patient is hypertensive and awakening, the head of the bed may be elevated, and the IV solution may be decreased if the patient is well hydrated. Obtain X-Ray for the CVP line placement. CVP readings are to be taken hourly and prn as the patient's condition warrants. While the patient's condition warrants, stabilize and keep the IV open. The Pediatric patients are to have microdrip tubing on their IV and only 500cc or less IV solution is to be added to the IV. The Pediatric patients are to have an IV control machine applied to their IV in the PACU before discharge to the nursing unit. Arterial line readings are taken and recorded every 15 minutes and prn as the patient's condition warrants, and the pressure bag should be checked frequently for adequate maintenance of pressure. PAP readings are to be taken every 15 minutes and charted while in the Post Anesthesia Care Unit. PAWP readings as ordered by the physician.
4. Monitor, maintain, and or improve neurological function to include level of consciousness. Orient the patient to the fact that the operation is completed; be constantly aware of their needs. Check pupils and be aware of their motor functions as appropriate.
5. Sensory and motor function as appropriate.
6. Promote and maintain effective pain and comfort management. Medicate as ordered per anesthesiologist. Evaluate effectiveness of the given pain medication within 5 minutes. Repeat as necessary to keep the patient comfortable. Notify the anesthesiologist if the pain is not relieved by the ordered medications
7. Promote and maintain emotional comfort. Introduce self to the patient. Reorient the patient to surroundings frequently. Continue to assess physical and psychological status with increasing level of consciousness. Explain treatments and activities.
8. Monitor surgical/procedural site and continue procedure specific care.
9. Arterial Puncture - Radial and Brachial - Follow Policy Procedure Manual: Note site of puncture. Chart pulses, color, temperature, and sensation of extremity. Apply pressure to the site for at least 5 minutes after the puncture or until the bleeding has stopped.
10. Individualized plan of care.
11. Document nursing action and/or intervention with outcome.
12. Physician Orders: initiate the Physician PACU Order plan for any timed or stat orders.
13. Notify patient care unit of any needed equipment as appropriate.
14. Include family/significant other in care of patient as indicated.
15. Notify patient care unit when patient is ready for discharge from PACU and provide report of all significant events in the operating room and PACU.
16. Postanesthesia scoring system - Aldrete score.

C. Discharge Assessment and documentation includes, but not limited to:

1. Airway patency, respiratory function, and oxygen saturation.
2. Cardiac and hemodynamic status.

3. Thermoregulation.
4. Level of consciousness.
5. Pain and comfort control.
6. Sedation level.
7. Sensory/motor function.
8. Patency of tubes, catheters, drains, intravenous lines.
9. Skin color and condition.
10. Condition of dressing and/or surgical site.
11. Intake and output.
12. Medication Management.
13. Emotional status.
14. Child-parent/significant others interactions.
15. Postanesthesia scoring system if used.
16. Review and discontinue PACU orders if patient transfer to acute floor or critical care unit, and complete activities (tasks) section in the electronic documentation.

Bibliography:

1. American Society of Perianesthesia Nurses. (2012). *2012-2014 Perianesthesia Nursing, Standards, Practice Recommendations and Interpretive Statements.* Cherry Hill, New Jersey: American Society of Perianesthesia Nurses.
2. Schick, L. , & Windle P. E. (Eds). (2010). *Perianesthesia Nursing Core Curriculum: Preprocedure, Phase I and Phase II PACU Nursing* (2nd ed.). St. Louis, Missouri: Saunders.

Sponsoring Department or Committee	Approval Date
Department of Surgery Operations	02/13/14
Other Approvals	**Approval Date**
Director of Perioperative Services	02/14/14
MEC	09/2010
Board of Trustees	10/2010
Past Approval	**Approval Date**
Surgical Management Committee	Reviewed: 09/1931 Revised: 12/1986, 12/1989, 01/1993, 02/1996, 02/1999, 05/2002, 05/2008, 07/2012

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