Beth Israel Deaconess Medical Center *Perioperative Services Manual*	
Title:	***Post Anesthesia Assessment***
Policy #	***PSM 300-3***
Purpose	To outline the ASPAN recommended elements for initial and ongoing assessment in the PACU.

Policy Statement:

Post Anesthesia nursing practice includes the systematic and continuous assessment of the patient's condition. The primary nurse assures that the data are collected, documented and communicated. The nurse continually analyzes the data to determine appropriate nursing interventions.

Guidelines for Implementation:

I. Initial Assessment

1. The PACU nurse receives a verbal handoff from the anesthesiologist detailing the patient's general health and intra-operative course. The patient's identification will be verified per policy during this transfer of care. Refer to **Periop Clinical Practice Protocol PSM # 100-102, *Admission, Discharge and Handoff of Care of Patients in Periop Services.***

2. The anesthesia provider will remain with the patient until the PACU nurse accepts responsibility for the patient's care.
3. The primary or associate nurse obtains, and documents an initial assessment of the patient which includes:
    a) Integration of data received at transfer of care.
    b) Alarm verification – monitor alarms on
    c) Temperature / route
    d) Respiratory status - airway patency: respiratory rate and competency; breath sounds; type of artificial airway and/or mechanical ventilator settings, if relevant; method of oxygen delivery; oxygen saturation; chest tubes if present.
    e) Cardiovascular status - heart rate and rhythm; blood pressure (cuff or arterial line); hemodynamic pressure readings, if relevant- CVP, pulmonary artery pressures, cardiac output; peripheral pulses on all vascular patients and those with sequential compression devices; skin color and temperature.
    f) Neurological status - level of consciousness; mental status; pupil size and response, as indicated; neuro signs, as indicated; ICP if indicated; sensation and motion in all limbs.
    g) Gastrointestinal - presence of nausea/ vomiting; nasogastric tube; abdominal assessment.
    h) Genitourinary - presence of an indwelling catheter; urine color, character, amount: DTV status.
    i) Integument - skin integrity; wound, dressings, suture lines, invasive line status (location, patency, drainage); type, patency and securement of drainage tubes, catheters and receptacles.
    j) Musculoskeletal - position of patient: muscular response and strength.
    k) Hydration status/fluid therapy, location of lines, condition of IV site, and amount of solution infusing.
    l) Patient safety needs.
    m) Pain Assessment
    n) Initial Post Anesthesia Recovery (PAR) Score

II. Ongoing PACU Assessments

1) The plan for nursing care is aimed at achieving optimum patient outcomes. These outcomes include but are not limited to where the patient:
    A. Returns to safe, stable level of physiological function.
    B. Experiences his/ her recovery in a safe, supportive environment where his/her individual needs are met.
    C. Achieves an optimal level of pain management.
    D. Achieves an adequate level of nausea and vomiting management.

2) Components of the plan of nursing care differ with individual patient needs; Physician orders may require different timing of patient assessments. The following guidelines outline the **minimum** standard of care in the PACU.

    A. **Inpatients:**
        a) Vital signs are assessed on admission and no less than every 15 minutes for the first 2 hours, every 30 minutes for two hours and hourly thereafter.
        b) Patient assessments are completed on admission no less than every 30 minutes for the first 90 minutes and hourly thereafter.

    B. **Outpatients:**
        a) Vital signs are assessed on admission and no less than every 15 minutes for the first hour (in Phase 1), and no less than every 30 minutes until the patient meets discharge criteria. Vital signs are assessed no less than every 2 hours in Phase 2 unless clinically indicated or until discharge.
        b) Patient assessments are completed on admission and no less than every 30 minutes in Phase 1 and no less than every 60 minutes if clinically indicated or until discharge.

3) The guidelines for implementation of care in the PACU are as follows:
    A. Alarms
        a) Document monitor alarms on.
    B. Respiratory (Inpatients and Phase 1 patients)
        a) Continuously monitor patency of the airway, respiratory rate and effort, and oxygen saturation. Document every 15 minutes for the first hour, every 30 minutes for the next 2 hours and hourly thereafter.
        b) Apply supplemental oxygen if the O2 saturation is less than 92% on room air (unless patient's baseline).
        c) Assess for apnea for those patients at high risk for or with a diagnosis of Obstructive Sleep Apnea (OSA). **Refer to BIDMC Policy CP-47, Guidelines for Perioperative Screening and Management of Patients with Obstructive Sleep Apnea.**
        d) Auscultate lung fields every 2 hours and more frequently if indicated.
        e) Encourage deep breathing and coughing exercises.
        f) Follow standard of care for intubated patients.
        g) Respiratory monitor alarms must be on at all times.
    C. Cardiovascular Assessment
        a) Monitor heart rate, rhythm and blood pressure.
        b) Transduce all invasive pressure lines.
        c) Alarms must be on at all times.
        d) Cardiac output and PCWP will be obtained as ordered, if relevant.
    D. Level of Consciousness

a) Neuro signs every hour, or as indicated.

E. Temperature
   a) Document temperature on admission every 1-2 hours until discharge.
   b) Implement rewarming techniques for temperatures <96.8 F/ 36.8C.
   c)

F. Positioning
   a) Position/reposition with HOB elevated as appropriate for surgical procedure and to provide for optimal breathing.
   b) Place patient on side if N/V are present, or if unable to sit up.
   c) Reposition every 1-2 hours as condition and patient comfort warrants.
   d) Observe skin integrity on admission and every 2 hours thereafter.

G. Gastrointestinal Status
   a) Nausea/vomiting
   b) Presence of nasogastric tube or gastrostomy tube
   c) Color and amount of drainage

H. Urinary Status
   a) Document output every hour on catheterized patients.
   b) Document catheter securement device
   c) Patients are DTV 8 hours after their last void, unless directed otherwise by surgeon.

I. Surgical Incision
   a) Document appearance of dressing at least every hour.
   b) Document tubes and drains as ordered noting patency and condition, amount and color of drainage.

J. Fluid Management
   a) Assess fluid volume status and requirements.
   b) Document location & condition of all IV sites.
   c) Administer IV fluid at rate ordered.

K. Pain
   a) Document pain score identified by patient (0-10) on admission and with every assessment.
   b) Reassess response to interventions within 15-30 minutes after every intervention and minimally every 30 minutes thereafter for 2 hours and then hourly thereafter. Additional pain reassessments will be documented in the comments section in eMAR when the frequency of bolus dosing occurs in a time period less than 15 minutes.
   c) Document location, intensity and character of pain.
   d) Implement anesthesia pain orders per protocol, epidural and PCA orders as patient condition warrants until optimal level of comfort is reached.
   e) Consult with anesthesia provider assigned to PACU for unrelieved, continued pain.

L. Motor response
   a) Assess and document block/sensation and motor activity at least as frequently as hourly for patients who have had a spinal anesthetic or who have an epidural catheter in place.
   b) Ambulation for outpatients may be attempted when normal perianal sensation (L5- S1), plantar foot flexion and great toe proprioception return.
   c) Ambulation & discharge for outpatients s/p femoral nerve block per protocol**. Refer to Periop Post Anesthesia Policies, PSM 300-109, Care of Patients with Femoral Nerve Block.**

M. Emotional Support

a) Frequently reassure patients of their progress/effectiveness of treatments.
b) Answer questions directly or provide appropriate personnel to do so.
c) Family/significant other will be included in care of patient, as indicated.

4) Patients remaining in the PACU due to medical center capacity issues may advance to less frequent vital signs and assessments following standard four hour protocols for Postoperative patients.

5) Patients in the PACU who are of critical care level will follow ICU protocols for vital signs and assessments.

6) Continued PAR / PADDS scoring system, as indicated.

References

American Society of PeriAnesthesia Nurses. *PeriAnesthesia Nursing Standards, Practice recommendations and Interpretive Statements, 2017-2018.* Cherry Hill, NJ: ASPAN; 2017.

Vice President Sponsor:	**Marsha Maurer, DNP, RN, VP, Patient Care Services and Chief Nurse Officer**
Author/Owner/Chair:	**Elena Canacari, BSN, RN, CNOR Associate Chief Nurse, Perioperative Services**
Approved By:	
OR Executive Committee/Date:	**Elliott Chaikof, MD, Chair, Department of Surgery Daniel Talmor, MD, MPH, Chair, Department of Anesthesia & Critical Care Elena Canacari, BSN, RN, CNOR Co-Chairs**
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