Nurse / Location / Outreach Partner or Trainee
Date of Evaluation:
Evaluator:

Clinical Treatment: PACU Patient Assessment

Assessment Data: Physical Assessment (vital signs, respiratory system, oxygenation, neurological status); Fluid Balance; Pain Management; Intake & Output; Scoring System/Transfer to Ward

Level I / Basic	Level II / Intermediate	Level III / Competent	Level IV / Advanced	Level V / Expert
Able to perform vital signs	Recognizes abnormal vital signs	Recognizes trends and need to intervene	Recognizes and is able to intervene when significant vital sign trends/changes occur. Understands when and who to call	Acts autonomously in recognition and management of abnormal vital signs; Intuitively responds to patient situations and intervenes before patient condition deteriorates. Aware of environment and need to educate fellow nurses
Able to identify a normal respiratory pattern including: Examples:	Able to identify abnormal respiratory pattern including: Examples:	Is able to independently intervene and perform basic needed tasks to manage patient airway.	Is able to independently intervene and perform invasive interventions needed to manage	Acts autonomously in the management of airway emergencies and intuitively

• Rate • Depth • Identify adjunct airway • Color of patient	• Oxygen saturation level • Breath sounds • Patient color • Work of breathing Has an understanding of the needed interventions and is able to get the appropriate assistance to maintain patient stability	Is able to assess effectiveness of interventions and management of complications. <u>Examples</u>: • Patient positioning • Jaw thrust/chin lift • Placement of oxygen • Placement of pulse oximeter • Suctioning	patient airway. Is able to assess effectiveness of interventions and manages complications. Understands when and who to call for assistance. <u>Examples</u>: • Placement of OPA • Placement of NPA • Use of BVM	responds to patient situations Is aware of environment and need to educate fellow nurses.
Neurological Status Understands that there are different levels of consciousness	Recognizes the need for and is able to assess basic level of consciousness (LOC) <u>Examples</u>: • Assesses orientation to person, place, time • Able to assess a change in LOC • Performs a neuro assessment including ability to follow	Is able to independently intervene and perform needed tasks to assess and manage the patient's neuro status. Is able to assess effectiveness of interventions and manage complications.	Possesses the clinical thinking skills and understands the significance of a change in neuro status, intervenes appropriately and calls for assistance when needed. Recognizes Emergence Delirium as a postop complication versus a change in neuro status and intervenes appropriately.	Acts autonomously in the management of a patient's level of consciousness and intuitively responds to patient situations. The nurse is aware of the environment and need to educate fellow nurses.

	commands, response to stimulation, presence of protective reflexes and pupillary responses			
Discharge from PACU Understands there are standardized scoring systems used to determine patient stability and readiness for discharge	Recognizes the need for and uses a standardized scoring system to evaluate patient readiness for discharge	Uses a discharge scoring system to guide interventions of patient care	Understands there is variability in patient progression for discharge readiness and manages patient care appropriately	Acts autonomously in the utilization and management of a patient scoring system and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
Clinical Treatment: Fluid Balance **Assessment Data**: Intake; Urine output; Monitoring of fluid status				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
Understands need to monitor intake and output	Documents intake and output and recognizes what constitutes an imbalance Examples: • Assesses urine output since returning from surgery • Assesses IV fluid intake since surgery • Assesses oral fluid intake since surgery • Assess for any nausea /vomiting • Monitors any increased trend in heart rate	Understands nursing measures related to maintaining fluid balance. Examples: • Offering fluids slowly beginning with clear liquids • Monitoring output • Reporting imbalance	Possesses the clinical reasoning skills to independently intervene in managing patient's fluid balance.	Acts autonomously in the utilization and management of a patients fluid balance and intuitively responds to patient situations. The nurse is aware of the environment and the need to educate fellow nurses.

	and/or blood pressure			
Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
Clinical Treatment: Anesthetic Agents and Adjuncts **Assessment Data**: Use and Effects of: Inhalation Agents, IV Agents, Narcotics, Sedatives, Nerve Blocks				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
Understands anesthetic agents are used to induce, assist with and maintain anesthesia	Recognizes there are different types of anesthesia and adjunct drugs used for a variety of procedures Examples: • General • Conscious sedation • MAC • Nerve block • Spinal	Understands risks and complications of anesthesia and why patients are evaluated for their anesthetic prior to their surgery or procedure Can utilize a BVM and other types of airway adjuncts; knows when it is appropriate to use and remove Examples: • Can maintain airway by use of jaw thrust and suctioning • Can insert and remove OPA, NPA	Actively treats patients appropriately for the type of anesthetic/adjunct that has been administered Able to remove an ETT and LMA safely and at the appropriate time Understands the levels of anesthesia and what is normal and what is abnormal	Acts autonomously in the postop care of patients that have undergone an anesthetic and intuitively responds to patient situations The nurse is aware of the environment and the need to educate fellow nurses

		• Uses a BVM effectively for respiratory support Understands complications of types of agents <u>Examples</u>: • Postop N/V with inhalation agents and narcotics • Airway compromise with anesthesia		
Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
<u>Clinical Treatment</u>: Post Op Pain Management **<u>Assessment Data</u>**: Pain Type, Assessment Scales, Analgesics and their Side Effects, Non-drug Interventions, Effectiveness of Treatment				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
Able to identify causes of pain and understand definition of pain. <u>Examples</u>: • Incisional	Able to assess patient's pain using different methods, scales <u>Examples</u>: • Numerical (0-	Has knowledge and understands indication of the medications used for pain management <u>Examples</u>:	Able to independently intervene in managing patient's pain. <u>Examples</u>: • Pharmacologic vs	Acts autonomously in the utilization and management of patient's pain and intuitively responds to patient situations.

• Deep tissue • Positional • Respiratory • IV site Patient's pain is subjective and personal	10) • Wong-Baker (Faces pain scale) • Physiologic signs • Behavioral indicators	• NSAIDS • Opioids • Antiemetics • Benzodiazepines • Reversal agents	non-pharmacologic • Repositioning • Cold/heat • Medications • Family • Distraction (music, etc)	The nurse is aware of the environment and the need to educate fellow nurses
Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
<u>Clinical Treatment</u>: Narcotic Safety **<u>Assessment Data</u>**: Five Rights, Drug Nursing Care and Safety, Narcotic Side Effects, Drug Interactions/Contraindications				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
Understands the importance of safety around the administration and use of narcotics	Understands safety measures used in administration of narcotics <u>Examples</u>: • Double checking dosing with another licensed care provider	Knows the side effects of narcotics and the treatment for them. <u>Examples</u>: • Decreased respiratory rate • Decreased LOC • Loss of airway Uses airway adjuncts for	Recognizes and actively intervenes when appropriate with his/her patient and helps with other patients in the unit when needed Is a resource to other novice nurses in the unit in regards to narcotic safety	Acts autonomously in regards to patients that are being treated with narcotics Intuitively responds to patient situations

	• Knows the 5 rights of drug administration: Right patient, right drug, right dose, right route, right time	treatment when appropriate. <u>Examples</u>: • Stimulation • Positioning • BVM • OPA • NPA • Use of reversal agent (Narcan) for narcotic toxicity Recognizes and calls for help when needed Upon patient discharge, educates patient/family going home on narcotics the importance, side effects of medication dosing		

Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
<u>Clinical Treatment</u>: Temperature Management **<u>Assessment Data</u>**: Hypothermia; Hyperthermia				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
<u>Hypothermia</u> Understands that patient temperature is an important aspect of patient care Includes temperature monitoring with vital signs	Understands there are levels/degrees of hypothermia: Mild (32°-36°C) Moderate (32°-28°C) Severe (<28°C) Recognizes the signs/symptoms of hypothermia: • Shivering • Delayed wake up • Decreased oxygen saturation • Patient color • Delayed capillary refill	Understands the causes that can contribute to hypothermia: • Type and length of procedure • Type of drugs used for procedure • Surgical environment • Age of patient Initiates appropriate treatment actions: • Need for warm environment • Provides blankets, head cover; parents holding child • Monitoring vital signs for any change/trends • Providing oxygen as needed	Independently recognizes the potential for hypothermia, intervenes and provides treatment as needed Is a resource to other nurses	Acts autonomously in the recognition and treatment of hypothermia and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

		• Calls for help as needed		
<u>Hyperthermia:</u> Understands that patient temperature is an important aspect of patient care Includes temperature monitoring with vital signs	Understands that a patient temperature >39˚C is considered hyperthermia Recognizes the signs and symptoms of hyperthermia: • Elevated temperature • Skin flushing • Tachycardia • Increased respiratory rate	Understands the causes that can contribute to hyperthermia: • OR environment • Malignant Hyperthermia • Aspiration Initiates appropriate treatment actions: • Cools patient down • Monitors vital signs • Calls for help as needed	Independently recognizes the potential for hyperthermia and initiates treatment as needed Recognizes and acts immediately in the treatment of Malignant Hyperthermia including the use of Dantrolene Is a resource to other nurses	Acts autonomously in the recognition and treatment of hyperthermia, Malignant Hyperthermia and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

Nurse / Location / Outreach Partner or Trainee **Date of Evaluation:** **Evaluator:**				
Clinical Treatment: Post Op Emergencies **Assessment Data**: Airway Emergencies (obstruction, laryngospasm, bronchospasm), Bleeding, Nausea/Vomiting				
Level I / Basic	**Level II / Intermediate**	**Level III / Competent**	**Level IV / Advanced**	**Level V / Expert**
Obstruction: Understands the importance of maintaining a patent airway	Recognizes that there is a potential for airway obstruction in a postoperative patient Recognizes signs and symptoms for airway obstruction: • Snoring • Increased work of breathing • Color/tone • Desaturation	Understands some potential causes of airway obstruction: • Positioning • Tongue • Residual anesthetic agents/sedation • Retained throat pack Initiates appropriate treatment actions: • Stimulation • Positioning • Oxygen • Jaw thrust • OPA/NPA • BVM Recognizes need to call for help	Independently recognizes the potential for airway obstruction and initiates treatment as needed Recognizes and acts immediately to maintain patient airway Is a resource to other nurses	Acts autonomously in the recognition and treatment of airway obstruction and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

<u>Laryngospasm</u>: Has an understanding of what a laryngospasm is and that immediate action is required	Recognizes signs/symptoms for laryngospasm: • Dyspnea • Rapid desaturation • Partial closure will produce high-pitched crowing sound; sternal retractions on inspiration; decreased chest excursion and abnormal chest expansion • Complete closure – no audible sounds; may have paradoxical rocking motion of chest	Understands physiology of laryngospasm (upper airway): • Reflex closure of glottis (vocal cords) • What produces partial or complete breath sounds • Due to stimulation of pharyngeal tissues/vocal cords by secretions or foreign bodies Identifies causes of laryngospasm: • Difficult/repeated intubation • Secretions from procedure/bleeding • Anesthetic agents may act as airway irritants • Stimulation of patient on emergence from anesthesia Initiates appropriate treatment: • Call for immediate help	Independently recognizes the potential for laryngospasm and initiates prevention / treatment as needed: Examples: • Minimize head and neck movement during induction/emergence • Inhalation of humidified oxygen in PACU • Side lying position • Call for immediate help • 100% oxygen with positive pressure • Use of succinylcholine (complete closure) • Use of racemic epinephrine via nebulizer (partial closure) Recognizes and acts immediately to maintain	Acts autonomously in the recognition and treatment of laryngospasm and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

		• 100% oxygen with positive pressure • Use of succinylcholine (complete closure) • Use of racemic epinephrine via nebulizer (partial closure)	patient airway Is a resource to other nurses	
<u>Bronchospasm</u>: Has an understanding of what a bronchospasm is and that immediate action is required	Recognizes signs/symptoms for bronchospasm: • Audible wheezing • Tachypnea • Use of accessory muscles • Shortness of breath • Chest tightness • Diaphoresis • Mild cyanosis	Understands physiology of bronchospasm (lower airway): • Spasmodic contraction or exaggerated tone of smooth muscle layers of bronchi • Increase in airway resistance • Decreased airflow to the lungs Identifies causes of bronchospasm: • Restrictive airway disease, COPD • Inflammatory response (airborne irritant, ET placement, suctioning) • Hypersensitivity and	Independently recognizes the potential for bronchospasm and initiates treatment as needed Recognizes and acts immediately to maintain patient airway Is a resource to other nurses	Acts autonomously in the recognition and treatment of bronchospasm and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

		histamine release (anaphylactic response) • Infectious process Initiates appropriate treatment: • Calls for help • Humidified oxygen with high flow delivery • Patient position – head elevated • Aerosolized inhaled medication (Albuterol)		
<u>Bleeding</u>: Understands the importance of and need for monitoring postoperative blood loss	Identifies specific surgical procedures that might produce greater blood loss <u>Examples</u>: • Cleft palate • Burn cases	Able to identify and recognize signs /symptoms of increasing blood loss <u>Examples</u>: • Obvious active bleeding • Elevated HR • Decreased capillary refill • Swelling at surgical site • Cool, clammy skin • Decreased BP • Decreased hgb/hct	Independently understands and recognizes the potential for postoperative bleeding and initiates treatment as needed Recognizes and acts immediately to maintain patient airway Is a resource to other nurses	Acts autonomously in the recognition and treatment of postoperative bleeding and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

		Initiates appropriate treatment: • Stop active bleeding • Contact anesthesia / surgeon • Support circulation, fluids • Monitor VS frequently - (O2 Sat, HR, BP) • Surgery specific actions • Comfort measures • Pain control • May require return to OR		
<u>Nausea / Vomiting</u> Understands the potential for nausea and vomiting in postoperative patients	Identifies specific surgical procedures, patient types, and medications that may put patient at risk for postoperative nausea/vomiting <u>Examples</u>: • Oral surgical procedures (palates, tonsils) • Teenage girls • Inhalation anesthetic	Identifies specific treatment for patient with postoperative nausea/vomiting: <u>Examples</u>: • Importance of prevention • Preoperative hydration • Pre-emptive medication (ondansetron, decadron) • Delay oral intake	Independently understands and recognizes the potential for postoperative nausea and vomiting and initiates treatment as needed Recognizes and acts immediately to maintain patient airway Is a resource to other nurses	Acts autonomously in the recognition and treatment of postoperative nausea and vomiting and intuitively responds to patient situations The nurse is aware of the environment and need to educate fellow nurses

	agents	• Start with clear liquids • Alternative therapies (aromatherapy, relaxation)		