Oxygen: Tube Mask Nasal cannula Aerosol Ventilator

On_______ On_______ On_______ On_______ On_______
Off Off Off Off Off

Airway (see key on back)

Graphic Key Time

V BP Cuff
190
180
170
Arterial Line
160
150
Pulse
140
Resp
130
120

Equipment
110

d Teds

100

SCD
90
80
Pulse Boots
70
60
Other:
50
40
30
20
10

O2 Saturation
EtCO2
Temperature [Route____]

(Circle one):
Warming Unit/Blanket
Cooling Unit/Ice/Elevate

Activity
Respiration
Circulation
Consciousness
Oxygen Saturation

Aldrete Score
Respiratory
Cardiac
Neurovascular
Spinal/Epidural
Neurological
G.I.
G.U.
Surgical Site #1
Surgical Site #2
Integumentary
Musculoskeletal
Fundus/Involuting Uterus
Blood Glucose

R.N. Initials
Report Given to: Discharged to: Time/Date:
RN Signatures: _____________________ _____________________ __________________________

Discharge Mode: Cart Bed Wheelchair Carry

Care delivered as per Protocols / Care Plans / Policies / Procedures / Standards
Documentation Guidelines, Keys and Pain Scales

<table>
<thead>
<tr>
<th>Pain Quality Key *</th>
<th>Pain Intervention Key</th>
<th>Medication Route Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>A = Achy</td>
<td>HA = Heat Application</td>
<td>PCA = PCA Continuous &amp; Demand</td>
</tr>
<tr>
<td>B = Burning</td>
<td>CA = Cold Application</td>
<td>PCA- = PCA Demand Only</td>
</tr>
<tr>
<td>C = Constant</td>
<td>RT = Relaxation Technique</td>
<td>D = Epidural Continuous &amp; Demand</td>
</tr>
<tr>
<td>CRA = Cramping</td>
<td>CS = Cutaneous Stimulation</td>
<td>EP = Epidural Demand Only</td>
</tr>
<tr>
<td>Cr = Crushing</td>
<td>ST = Stretching</td>
<td>EP-D = Orally</td>
</tr>
<tr>
<td>D = Dull</td>
<td>E = Elevation</td>
<td>PO = Intramuscular</td>
</tr>
<tr>
<td>I = Intermittent</td>
<td>RP = Repositioning</td>
<td>IM = Intravenous</td>
</tr>
<tr>
<td>P = Prickling</td>
<td>S = Splinting</td>
<td>IV = Intrathecal</td>
</tr>
<tr>
<td>R = Radiating</td>
<td>M = Medication</td>
<td>IT = If not listed (Specify)</td>
</tr>
<tr>
<td>S = Sharp</td>
<td>- If not listed (Specify)</td>
<td></td>
</tr>
<tr>
<td>T = Throbbing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U = Unable to describe</td>
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</tr>
</tbody>
</table>

* Pain: assess patient rating (scale 0-10 or verbal description), location (anatomical body part/area and side), quality (descriptor), and pasero scale if giving opioids.

Aldrete's Modified Phase 1 Post-anesthesia Recovery Score

<table>
<thead>
<tr>
<th>Activity</th>
<th>0</th>
<th>1</th>
<th>2</th>
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Equipment / Therapy - Place a "√" in the appropriate box to indicate the assessment was done.
Assessment Section - To be completed according to Standards of Care for Post-Anesthesia Phase I.

- Indicate the times assessments are done in the boxes at the top of the graphic section.
- Upon carrying out an assessment with significant findings, place a "√" in the appropriate box to indicate the assessment was done.
- Upon carrying out an assessment with significant findings, place an "×" in the appropriate box. If an "×" is placed in the box, document the significant findings in the narrative portion of the nurses notes.
- An arrow "→" can be used in a box if the significant findings are unchanged from the previous documentation. Any unused assessment rows may be left blank.

Guidelines for Assessments

Respiratory: Respirations quiet and regular with even depth without assistive devices. Breath sounds vesicular through both lung fields and bronchial over major airways. (For PACU: If airway adjuncts are utilized, (*) will be noted and appropriate airway will be indicated by check in box on flowsheet. No narrative documentation is required. Narrative documentation required if respirations or breath sounds are not WNL).

Cardiac: Regular apical pulse. (For PACU: Monitor shows NSR or patients preoperative rhythm if known.)

Neurovascular: No edema. (For PACU: No edema. Affected extremity is pink, warm and movable within patient’s prior ROM. Sensation intact without numbness or paresthesia. Peripheral pulses palpable. CRT < 3.)

Spinal/Epidural Level: (For PACU: Document Dermatome level.)

Neurological: Alert and oriented to person, place and time. Verbalization clear and understandable. Able to follow and understand directions. Memory intact. (For PACU: above parameters when recovered from anesthesia. In addition: swallowing without choking and coughing. Tongue midline. Facial movements symmetrical. Active ROM of all extremities with symmetry of strength of all nonsurgical joints. No numbness or paresthesia. [Includes Mental Status: Behavior appropriate to the situation. Thoughts are clear and reality-based.])

Gastrointestinal (GI): Tolerates prescribed diet without nausea or vomiting. Elimination within patient’s usual pattern. (May be by patient report). (For PACU: Abdomen soft without distention. No nausea or vomiting.)

Genitourinary (GU): Voiding without difficulty. (May be by patient report). (For PACU: Bladder not distended. If patient voids or Foley is present, urine is clear and yellow to amber. If Foley present, urine output > 30 ml / hr.)

Surgical Site: (For PACU: Dressing present: dry and intact. No dressing: No evidence of swelling, redness, or increased temperature in surrounding tissue. Sutures/steri-strips intact. No drainage present.)

Invasive Line(s) Site: Without redness, swelling or tenderness.

Integumentary: Skin intact. (For PACU: Excludes surgical sites.)

Musculoskeletal: Gait stable and independent. (For PACU: Active ROM in all non-surgical joints. No joint swelling, inflammation or cramping. Absence of joint deformity.)

SocioCultural: No barriers to discharge.

Fundus: (3) below umbilicus (2) at umbilicus (1) above umbilicus (0) displaced.

Involuting uterus: (2) firm (1) firm with massage (0) boggy.