

# DT Procedure Rooms MSJ-Ophthalmology Surgery Postoperative Care and Discharge

## Site Applicability

MSJ- DT Procedure Rooms

## Practice Level

Basic: RN and LPN

## Need to Know

The OR nurse and physician will transfer the patient to post op area. The OR nurse will give a verbal hand over to the post op nurse receiving care of the patient. Hand over report includes but is not limited to:

- Patient name
- Allergy status
- Procedure, site and side
- If patient received PSA, indicate last medications given and time
- Other patient related concerns

The application of discharge criteria is used routinely as part of the nursing assessment for post-op patient and to determine if the patient is ready to discharge home. See [Appendix A](#).

Patient that has received sedations MUST be assessed, monitored and an adequate period of post-op observation until the patient meets discharge criteria and has returned to baseline cognitive and functional status.

If a patient requires further period of post op observation, inform the DT PR charge nurse and/or surgeon right away for further directives. **After hours**, notify the Clinical Site Coordinator at **604-499- 6935** to arrange for possible inpatient bed as needed.

## Guidelines and Protocol

The post op nurse will:

1. Complete the post-op observation, discharge criteria assessment and documentation.
2. Review physician's post orders and initiate action on any orders to be carried prior to patient's discharge home.
3. Discharge the patient as below:

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### Patient who received topical eye drops medication only:

- Patients who only received topical eye drops with stable vital signs before and during the procedure, will need a very short recovery period and do not require vital signs taken after the procedure.
- Patient may be discharged home when the discharge criteria are met or has returned to baseline cognitive and functional status, absence of nausea, no evidence of bleeding, and absence of significant pain, and accompanied by a responsible adult See [Appendix A](#)

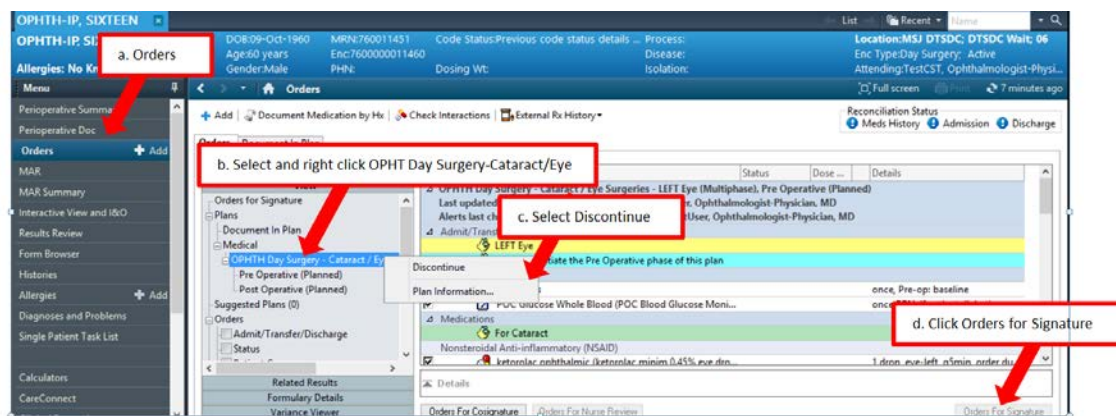
### Patients who received Anxiolytics medication (e.g. Ativan S/L):

- Patient may be discharged home when the discharge criteria are met or has returned to baseline cognitive and functional status, absence of nausea, no evidence of bleeding, and absence of significant pain, and accompanied by a responsible adult See [Appendix A](#)

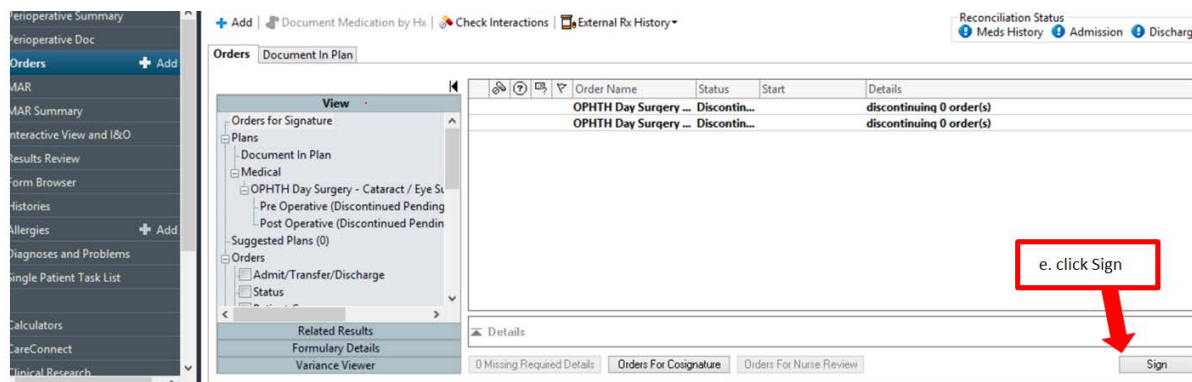
### Patients who received PSA and/or blocks

- Patient may be discharged home when the discharge criteria are met or has returned to baseline cognitive and functional status, absence of nausea, no evidence of bleeding, and absence of significant pain, and accompanied by a responsible adult. See [Appendix A](#)
4. Provide patient surgeon's specific post-op instructions and follow up visit.
  5. Complete patient discharge on Powerchart.
    - a. Discontinue orders, select **"Orders"** on Menu
    - b. Select and right click **OPHTH Day Surgery**
    - c. Select **Discontinue**. Orders are pre-selected (checked off).
    - d. Click **"Orders for Signature"**
    - e. Then Click **"Sign"**

**NOTE: DO NOT discontinue any of the LAB orders e.g. microbiology.**



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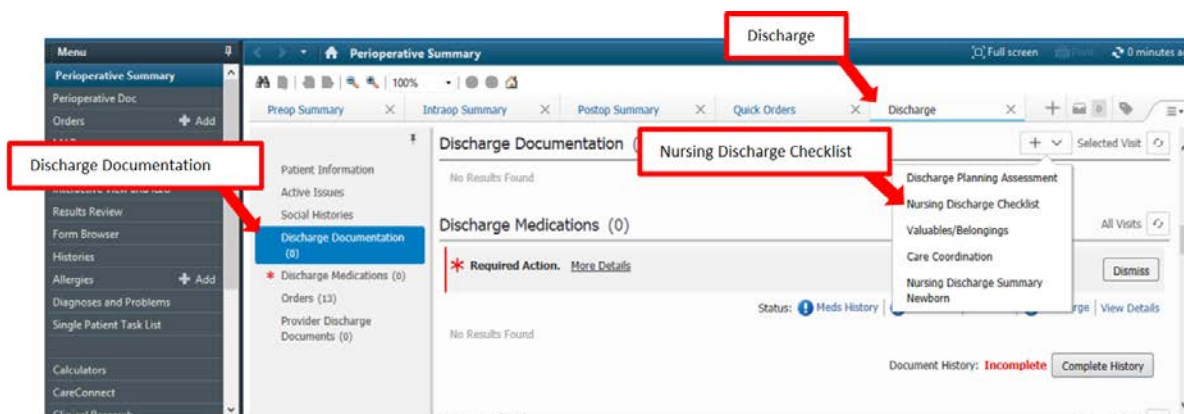
Reconciliation Status: Meds History Admission Discharge

Order Name	Status	Start	Details
OPHTH Day Surgery ...	Discontin...		discontinuing 0 order(s)
OPHTH Day Surgery ...	Discontin...		discontinuing 0 order(s)

Details: 0 Missing Required Details Orders For Cosignature Orders For Nurse Review

Sign

6. Complete and finalize the **Nursing discharge checklist**, under Perioperative Summary “Discharge” tab.



Menu: Perioperative Summary Perioperative Doc Orders + Add Results Review Form Browser Histories Allergies + Add Diagnoses and Problems Single Patient Task List Calculators CareConnect Clinical Research

Discharge Documentation (0)

Discharge Medications (0)

\* Required Action. More Details

Status: Meds History

Document History: Incomplete Complete History

Discharge Planning Assessment

Nursing Discharge Checklist

Valuables/Belongings

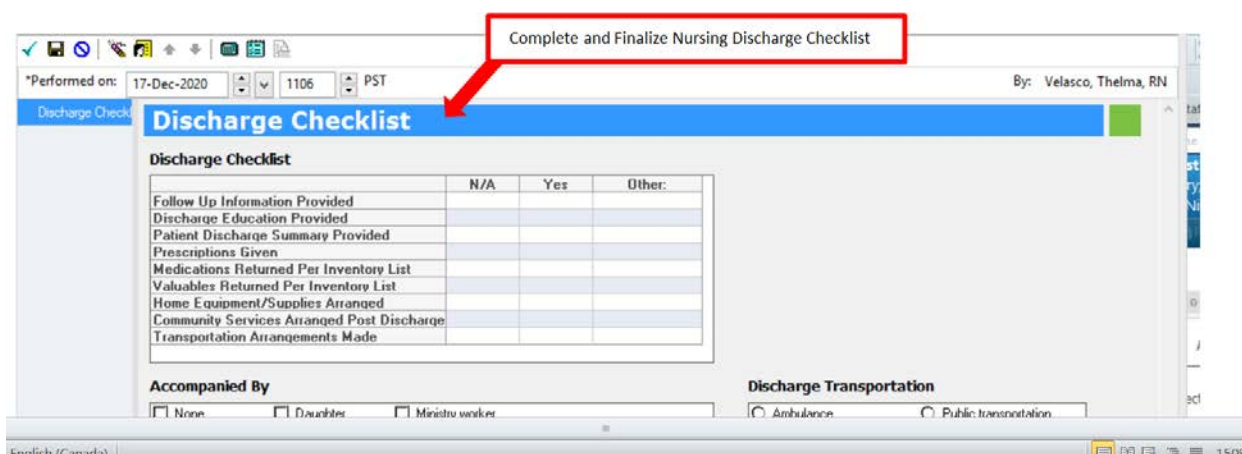
Care Coordination

Nursing Discharge Summary

Newborn

Dismiss

View Details



Performed on: 17-Dec-2020 1106 PST By: Velasco, Thelma, RN

Discharge Checklist

	N/A	Yes	Other:
Follow Up Information Provided			
Discharge Education Provided			
Patient Discharge Summary Provided			
Prescriptions Given			
Medications Returned Per Inventory List			
Valuables Returned Per Inventory List			
Home Equipment/Supplies Arranged			
Community Services Arranged Post Discharge			
Transportation Arrangements Made			

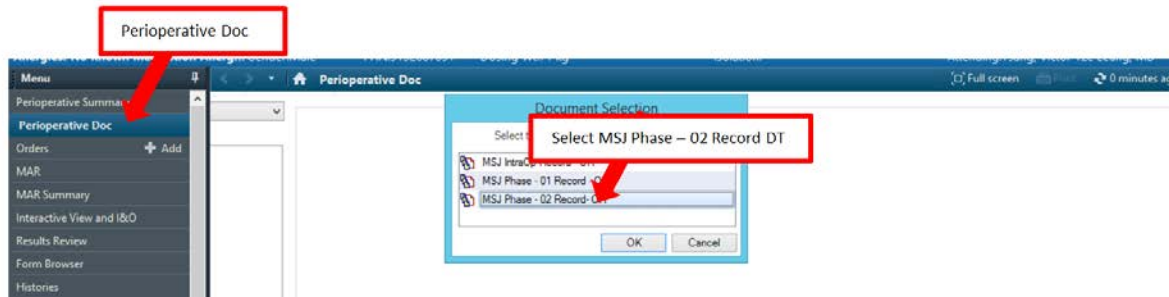
Accompanied By: ☐ None ☐ Doula/Midwife ☐ Ministry worker

Discharge Transportation: ☐ Ambulance ☐ Public transportation

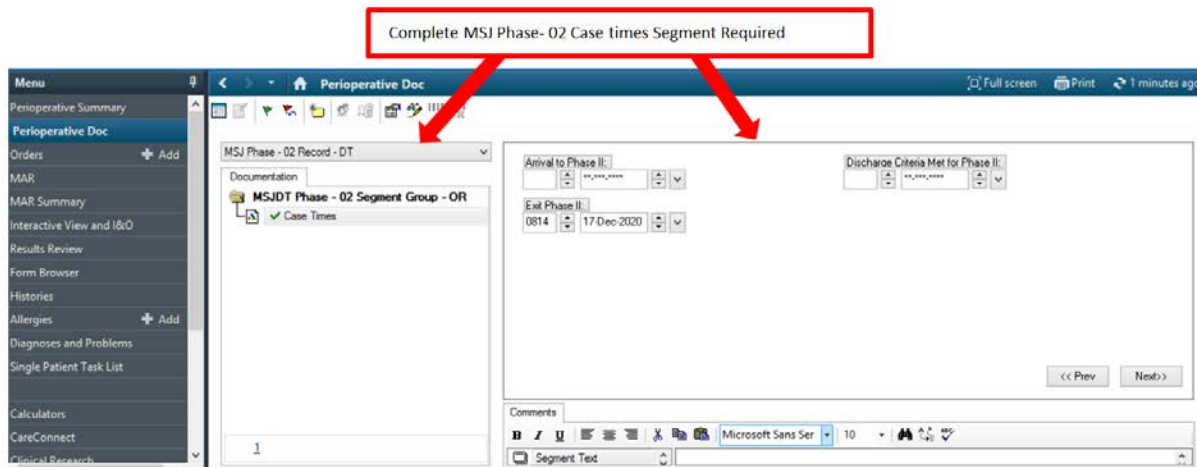
Complete and Finalize Nursing Discharge Checklist

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7. Go to **Perioperative Doc** select **MSJ Phase- 02 Record-DT**, click OK.



Complete **Phase- 02** Discharge Case times Segment.



8. **Discharge** the patient Encounter on **PM conversation**.

Complete the **Discharge Information** and click **Complete**.

Discharge Information			
*Discharge Disposition:	*Discharge Date:	*Discharge Time:	User ID: TRAIN.PERIONURSE9
			Discharge Username: Train, Nurse-Perioperative9
Deceased Details			
Deceased ID:	Deceased Date:	Deceased Time:	

9. The Encounter will **"Drop off the board"** on Periop Tracking Board. Patient is **DISCHARGED**.

**Documentation**

1. Powerchart- Perioperative doc, Patient discharge Phase- 02 Record.

**Patient and Family Education**

The post op nurse will give the patient the necessary surgeon's specific post-op instructions and follow up visit.

**Related Resources**

1. [B-00-13-10152](#) – DT Procedure Rooms MSJ: Procedural Sedation and Analgesia (PSA): Administration and Monitoring
2. [B-00-13-10151](#) – Peribulbar/Retrobulbar Block: Care of the Patient Receiving
3. [B-00-13-10108](#) - Local Anesthetic Systemic Toxicity: Care and Management of the Patient

**References**

1. AORN. (2018). Perioperative Standards and Recommended Practices.
2. ORNAC. (2019). Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (14<sup>th</sup> ed.).
3. Phillips, N. (2016). Berry & Kohn's Operating Room technique. (13<sup>th</sup> ed.).
4. Rothrock, J.C. (2018). Alexander's' care of the patient in surgery (16<sup>th</sup> ed.).

**Appendix A:****Monitoring Regional Nerve Blocks**  
(Peribulbular/Retrobulbular Blocks)**Pre- block:**

1. Assess and document **baseline vital signs**. Vitals signs include:
  - a. blood pressure
  - b. heart rate
  - c. respiratory rate
  - d. oxygen saturation
2. Assess and document level of consciousness (LOC), skin (colour/warmth) and level of pain status.

**During and immediately after block:**

Patients receiving regional/nerve block must receive and meet appropriate vital signs, level of consciousness (LOC), skin (colour/warmth) and level of pain monitoring parameters prior to the surgical procedure.

1. Monitoring parameters:
  - a. Immediately after nerve block injection then
  - b. At 1 minute x 1, then
  - c. Every 5 minutes x 3

**Monitoring parameters for patients receiving PSA**

1. Monitor, assess and document vital signs with every sedation dose.
2. Vital signs include: BP, pulse rate, respiratory rate, O<sub>2</sub> saturation, level of consciousness, skin colour warmth and level of pain.
3. **Monitoring is:**
  - every 5 minutes x 3, then
  - every 15 minutes until the discharge criteria from one to one monitoring is met
4. Patients receiving PSA is transferred to the OR once discharge criteria from 1:1 monitoring is met. If the patient requires PSA top up while in the OR, the patient will be monitored and assessed for 1:1 monitoring until the discharge criteria from 1:1 monitoring is met.
5. Routine vital signs (BP, pulse rate, respiratory rate and O<sub>2</sub> saturation) will be assessed, monitored and documented in the OR.

## Discharge Criteria Using Modified Aldrete Scoring System

### Criteria for Discontinuing from One to One monitoring

- Modified Aldrete score for **Respirations** must be **2**; AND
- Modified Aldrete score for **Oxygen Saturation** must be **1 or greater**; AND
- **Total** Modified Aldrete score must be **8 or greater**.
- 30 minutes after the last dose of sedation or analgesia is given; AND
- 120 minutes after the last dose of IV reversal agent administered (if given).

### Criteria for Discharge or Transfer from Procedure Clinic / Area

- **Total** Modified Aldrete score for 1 to 5 must be **10**; AND
- A **TOTAL** score for criteria 1 to 8 must be **13 or greater**.
- There may be **NO score of 0 (zero) in any category**.
- Nausea and Vomiting must be acceptable to patient; AND
- Pain must be acceptable to patient
- Dressing/operative site is dry or requires extra padding but marked and not increasing; hematoma present but not growing. Indication of potential internal bleeding absent.
- 30 minutes after the last dose of sedation or analgesia is given; AND
- 120 minutes after the last dose of IV reversal agent administered (if given); AND

### Modified Aldrete Scoring System (NAPAN, 2014)

Category		Criteria	Point Value
1.	<b>Respirations</b>	Able to deep breath and cough freely	2
		Dyspnea or limited breathing	1
		Apneic	0
2.	<b>O<sub>2</sub> Saturation</b>	Able to maintain SpO <sub>2</sub> greater than 92% on room air	2
		Requires supplemental oxygen to maintain SpO <sub>2</sub> greater than 90%	1
		SpO <sub>2</sub> below 90% even with supplemental oxygen	0
3.	<b>Circulation</b>	Blood pressure +/- 20mmHg pre-procedure value	2
		Blood pressure +/- 20mmHg to 50mmHg pre-procedure value	1
		Blood pressure +/- greater than 50mmHg of pre-procedure value	0
4.	<b>Level of Consciousness</b>	Awake and oriented	2
		Wakens with stimulation	1
		Not responding	0
5.	<b>Movement</b>	Moves 4 limbs on own	2
		Moves 2 limbs on own	1
		Moves 0 limbs on own	0
6.	<b>Nausea and Vomiting</b>	No or mild nausea	2
		Transient nausea and vomiting, controlled with medication	1
		Persistent moderate to severe nausea and vomiting	0
7.	<b>Bleeding</b>	No evidence of internal or external bleeding	2
		Indications of potential for external or internal bleeding absent	1
		Symptoms of external or internal bleeding present	0
8.	<b>Pain</b>	No pain or mild pain (0 to 3 on pain scale)	2
		Moderate pain controlled with medication (4 to 5 on pain scale)	1
		Severe persistent pain (6 to 10 on pain scale)	0

#### SKIN LEGEND

**F** = flesh      **Cl** = cool      **Cy** = cyanotic      **Cd** = old      **P** = pale      **D** = diaphoretic      **W**=warm



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