Admission of a High Risk Patient to PAR

Site Applicability

VGH, UBCH

DIRECTIVE / POLICY / STANDARD:

1. Roles and responsibilities of RN #1 (primary RN) include:
    - Ensuring set up and function of all equipment required for admission and continuing care prior to the patient's arrival in PAR.
    - Assuming primary role during admission.
    - Providing continuing care for the patient.
2. Roles and responsibilities of RN #2 include:
    - Assist with admission of patient to PAR.
    - Assist as required with continuing care and/or crisis events.

PROCEDURE / RECOMMENDATIONS / ASSESSMENT:

On admission of the high risk post-anaesthetic patient to PAR:

RN #1:

1. Verifies patient airway, obtains baseline VS and establishes oxygen therapy or mechanical ventilation as indicated:
    a. RN #1 may delegate these aspects of care depending on the patient stability, complexity of patient needs and in consultation with RN #2
2. Receives report from anaesthesiologist and OR nurse in attendance.
3. Ensures completion of and documents initial routine (A-B-C) PAR admission assessment.
4. Implements any urgent medical or nursing interventions required to ensure patient stability
    a. RN #1 may delegate these aspects of care depending on the patient stability, complexity of patient needs and in consultation with RN #2.
5. Completes and documents a systems assessment as soon as possible following admission when patient is stable.
6. Ensures documentation of all required information related to patient care & management.

RN #2:

1. Completes initial A-B-C assessment (airway, VS) if delegated by RN #1.
2. Establishes cardiac and hemodynamic monitoring including:
    - Obtaining rhythm and waveform strips
    - Setting alarms

- Attaching pressure cables/lines
- Leveling and calibrating transducers

3. Checks IV solutions and flow rates and communicates information to RN #1.
4. Establishes suction as required (for example, NG tube to low suction, chest tubes/UWSD to suction).
5. Reviews anaesthesia/surgical orders and implements STAT items, ensuring documentation of STAT medications.
6. Empties drainage bags (for example, urinary) and measures amounts, and communicates information to RN #1.
7. Obtains and sends appropriate blood samples.

Related Documents

- Care of the Post Anesthetic Patient in Phase I [D-00-07-30267]

References

American Society of PeriAnaesthesia Nurses. (2004). Standards of perianaesthesia nursing practice. ASPAN: Thorofare, New Jersey.

UNIT(s) OF ORIGIN: PAR (VGH), July 2005

Alternate Search Terms

Post Anesthetic Recovery

admissions

admitting

high risk pt