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:

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):

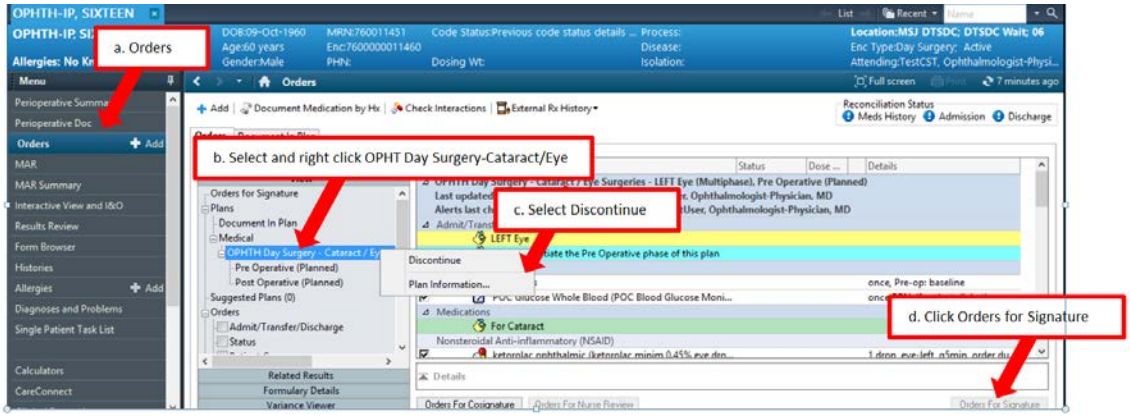
- Patient may be discharged home when the discharge criteria are met or has returned to baseline cognitive and functional status, absence of nausea, no evidence of bleeding, and absence of significant pain, and accompanied by a responsible adult See Appendix A

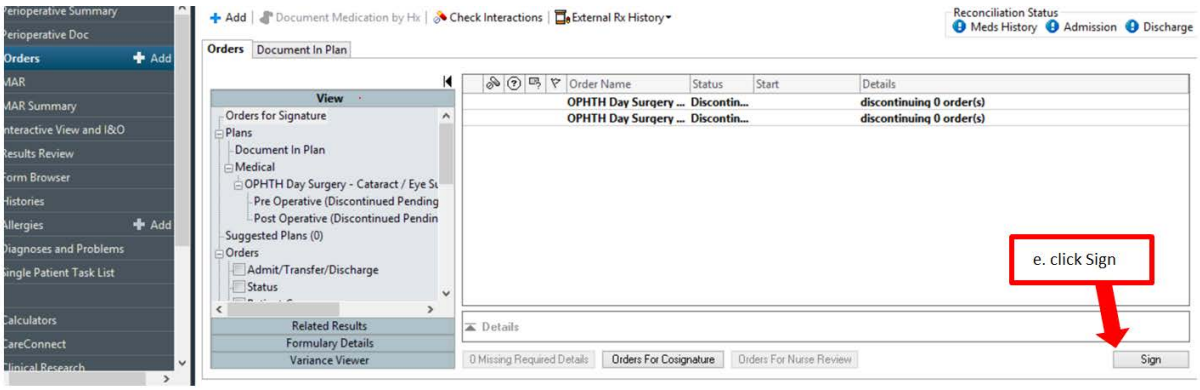
Patients who received PSA and/or blocks

- 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

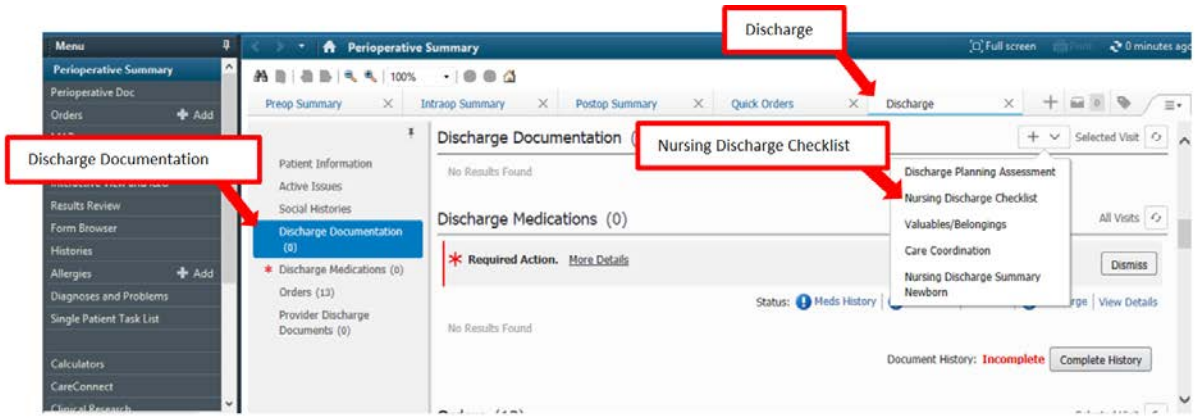
4. Provide patient surgeon's specific post-op instructions and follow up visit.
5. Complete patient discharge on Powerchart.
   a. Discontinue orders, select **"Orders"** on Menu
   b. Select and right click **OPHTH Day Surgery**
   c. Select **Discontinue.** Orders are pre-selected (checked off).
   d. Click "**Orders for Signature**"
   e. Then Click **"Sign"**

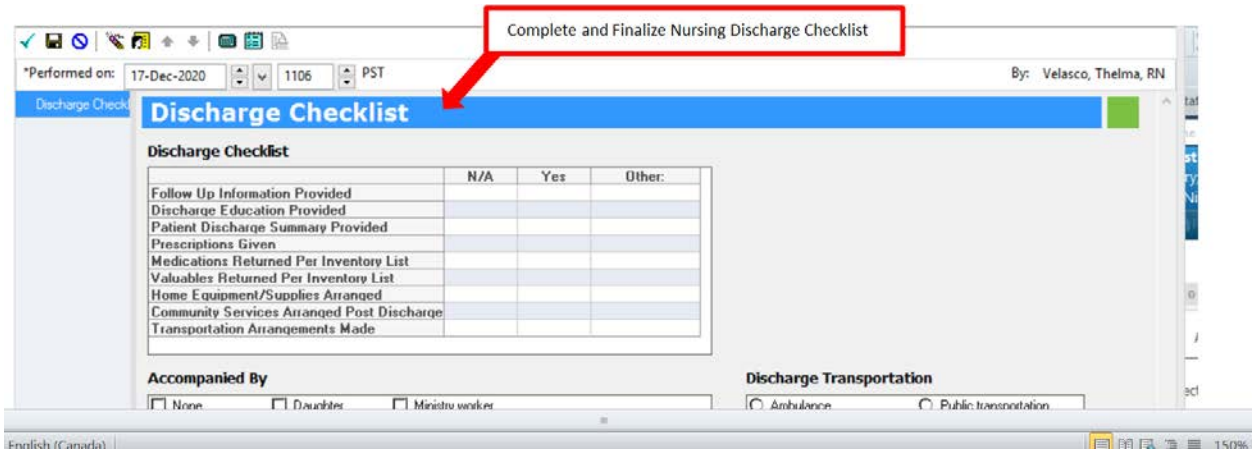
NOTE: *DO NOT discontinue any of the LAB orders e.g. microbiology*.



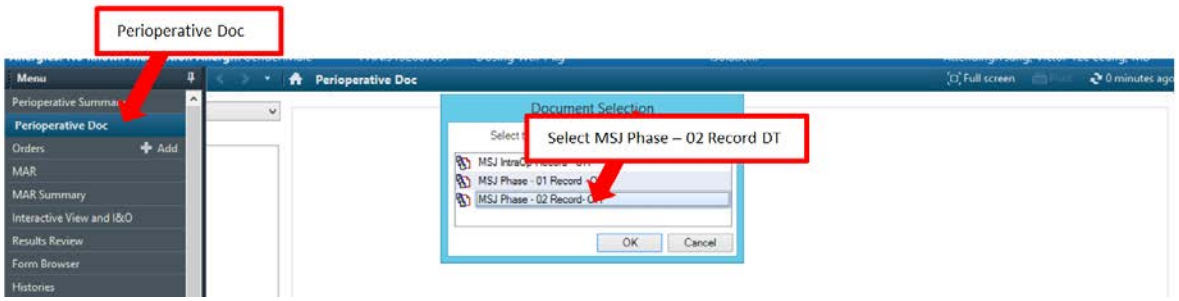


6. Complete and finalize the **Nursing discharge checklist**, under Perioperative Summary "**Discharge**" tab.

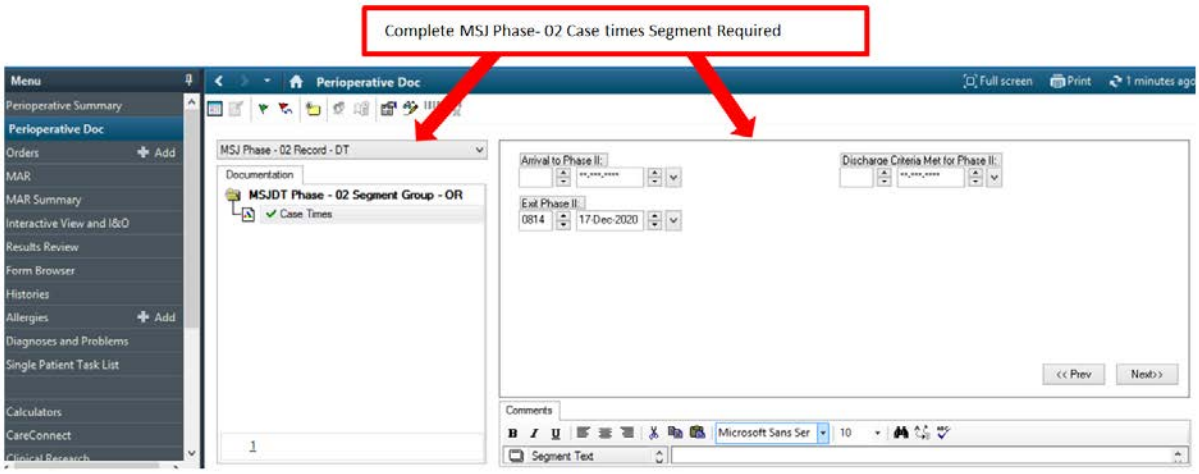




7. Go to **Perioperative Doc** select **MSJ Phase- 02 Record-DT**, click OK.

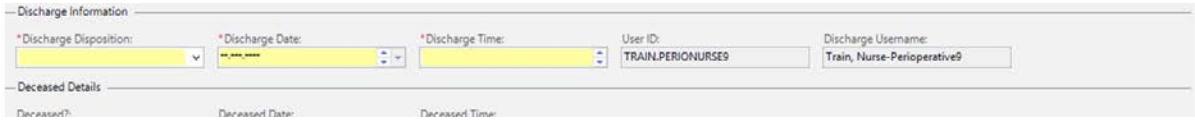


Complete **Phase- 02** Discharge Case times Segment.



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

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



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 (14th ed.).
3. Phillips, N. (2016). Berry & Kohn's Operating Room technique. (13th ed.).
4. Rothrock, J.C. (2018). Alexander's' care of the patient in surgery (16th 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_2 saturation, level of consciousness, skin colour warmth and level of pain.

3. **Monitorin**g 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_2 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.	**Respirations**	Able to deep breath and cough freely	2
		Dyspnea or limited breathing	1
		Apneic	0
2.	**O_2 Saturation**	Able to maintain SpO_2 greater than 92% on room air	2
		Requires supplemental oxygen to maintain SpO_2 greater than 90%	1
		SpO_2 below 90% even with supplemental oxygen	0
3.	**Circulation**	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.	**Level of Consciousness**	Awake and oriented	2
		Wakens with stimulation	1
		Not responding	0
5.	**Movement**	Moves 4 limbs on own	2
		Moves 2 limbs on own	1
		Moves 0 limbs on own	0
6.	**Nausea and Vomiting**	No or mild nausea	2
		Transient nausea and vomiting, controlled with medication	1
		Persistent moderate to severe nausea and vomiting	0
7.	**Bleeding**	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.	**Pain**	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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	Surgery MSJ