

Cardiac Intervention Patient Peri-Procedural Care Following Anesthesia

Site Applicability

- VGH Cardiac Catheterization Lab (CCL): High Acuity Unit (HAU) & Cardiac Investigation Unit (CIU)
- VGH Cardiac Care Unit (CCU)

Practice Level

RN's with the following training/experience:

- **Critical Care training and/or experience** – RN's must have completed the BCIT Critical Care Course (or equivalent) or have 2 years critical care or Emergency experience.
- **Post Anesthetic Care Competency** – RN's must have completed Cardiac Cath Lab specific post anesthetic care training or have Post Anesthetic Care Unit (PACU) or Cardiac Surgery Intensive Care Unit (CSICU) experience.

Policy Statements

- All cardiac cath lab post anesthetic patients admitted to the recovery area will have airway patency, respirations, SpO₂, pulse, blood pressure, ECG, depth of consciousness, sedation score, pain level, muscle tone, temperature, procedural access site(s), peripheral perfusion, bladder, comfort and safety assessed at given intervals as outlined in this document. RN's caring for these patients will intervene appropriately to changes in patient's condition.
- As transition criteria are met by the patient, monitoring and assessment parameters will change until patient meets criteria to be safely discharged home. A physician will need to determine if the patient can be discharged home or be admitted to an appropriate in-patient acute care ward should the patient not meet the discharge home criteria.
- Circumstances may arise such that the acuity of the patient will allow for 1:2 nurse-patient ratio ([Appendix D Perianesthesia Nursing Standards, Practice Recommendations](#))

Need to Know

Some interventional procedures performed in the CCL may require the patient to be sedated – ranging from procedural sedation to general anesthetic. Such procedures are (but not limited to): electrophysiology (EP) studies and ablation, transesophageal echo (TEE), cardioversion, device implants (internal cardioverter-defibrillator [ICD])

and/or cardiac resynchronization therapy [CRT]), transcatheter aortic valve implants (TAVI) and left atrial appendage (LAA) occlusions. Device implants will require assessment of the implant site incision (usually left upper chest). EP studies, TAVI and LAA procedures will require assessment of the right

and/or left femoral access puncture sites (venous plus/minus arterial). Some EP procedural patients may have their left subclavian vein accessed, the puncture site of which will require ongoing assessment.

The majority of patients admitted for EP and device implant are discharged home on the same day. The majority of patients coming for TAVI or LAA will be admitted overnight and discharged home in one to two days.¹

Patients who receive anesthetic care are at risk for various post-procedural physiologic disorders including (but not limited to) upper airway obstruction, hypoxemia, pulmonary edema, hemodynamic instability, delirium, renal dysfunction, body temperature changes/shivering, postoperative nausea and vomiting and delayed awakening. A well versed understanding of procedures performed, anesthetic agents used, and post-procedural complications, as well as interventions required to treat these complications, are needed by the RN to competently care for these patients.

Criteria for each stage of recovery post anesthesia are defined to ensure patients are safely transitioned from Phase I to Phase II and/or Extended Observation. Prior to being discharged home, the patient must achieve 16/16 on the Discharge Scoring System ([Appendix C](#)).

Patients who do not achieve discharge criteria require either a discharge order from an anesthesiologist and/or the most responsible physician (MRP).

Patients who have received general anesthesia or conscious sedation must have a responsible adult escort them home. Patients who have had a GA must have a responsible adult stay with him/her overnight, to provide care that is required.

Note: The Extended Observation Phase occurs immediately following Post Anesthesia Phase II and includes patients who require ongoing nursing care/observation or intervention. This may include patients awaiting transfer to an in-patient bed or awaiting transport home.

Refer to additional practice resources for more information:

- <http://shop.healthcarebc.ca/vch/layouts/15/DocIdRedir.aspx?ID=SHOP-1332384252-507>
- [Transfemoral, Transcatheter Aortic Valve Implantation, Post Procedure Care](#)
- [CPD-400: Procedural Sedation and Analgesia \(PSA\) – General](#)

¹ EP patients are usually cared for in the Cardiac Cath Lab HAU and/or CIU post procedure. TAVI and LAA patients are usually cared for in the CCU post procedure.

Equipment and Supplies

- Post-procedural orders
- Documentation system/documentation records (unit specific)
- Basic Cardiac Life Support (BCLS) or Advanced Cardiac Life Support (ACLS) crash cart in recovery area including an external defibrillator Resuscitation Equipment including:
 - Oxygen, suction, pulse oximeter, Bag-Valve-Mask, appropriate sized airway, ECG monitor, BP equipment, end-tidal CO₂ monitor (as required)
 - Accessible nearby – crash cart
- Post anesthetic care drugs including reversal agents, analgesics, antiemetics and diuretics • Temporal thermometer

Practice Guideline

After receiving anesthetic care, all cardiac intervention patients will have adequate airway patency, respirations, SP02, pulse, blood pressure, depth of consciousness, sedation score, pain score, procedural access site(s), peripheral perfusion, comfort and safety, muscle tone and temperature assessed as per Phase 1: Care of the Immediate Post-Anesthetic Patient assessment table (see below). Monitoring and assessment frequency changes as the patient demonstrates criteria indicating their increased stability and then their readiness for discharge home or transfer to an inpatient unit.

RN's are responsible for monitoring and documenting parameters at specified intervals and for increasing the frequency and scope of assessments as required by changes in the patient's condition. These parameters must be consistent with the patient's procedure, anesthesia, and their pre-procedural status. As well, RN's are responsible for intervening appropriately to any post-procedural complications.

Phase 1: Care of the immediate post anesthetic patient ²

After their procedure, the patient will be monitored and assessed as follows:

² For Electrophysiology cases, the post anesthetic patient in phase 1 should be recovered in the Cath Lab HAU during Procedure Room operating hours; Phase 1 recovery in CIU is at the discretion of the anesthesiologist.

Vital signs/Parameters	Frequency
Airway patency	*Phase 1: care of the immediate post anesthetic patient: <ul style="list-style-type: none"> On admission, then Q5 minutes if unconscious/reacting or actively treating an unstable parameter Q15 minutes x 4 if responding/conscious and stable
Respirations	
SpO ₂	
Pulse/Heart Rate	
Blood Pressure <ul style="list-style-type: none"> Avoid using arm with AV fistula or arm on the same side of mastectomy 	
ECG	
Depth of Consciousness	
Sedation Score: <ul style="list-style-type: none"> begin when patient is conscious 	
Procedural access site(s)	
Peripheral perfusion	
Neurological Vital Signs (NVS)	As ordered and PRN
Comfort and safety <ul style="list-style-type: none"> Pain Score Post-Operative Nausea & Vomiting (PONV) Bladder 	<ul style="list-style-type: none"> On admission Q 15 minutes x 4
Temperature	<ul style="list-style-type: none"> Within 30 minutes of admission then Q1h until discharge Q30 minutes when actively warming the patient Q30 minutes when actively warming the patient
Sleep Apnea Protocol <ul style="list-style-type: none"> for those patients with diagnosed Obstructive Sleep Apnea (OSA) 	<ul style="list-style-type: none"> Continuous SpO₂ & ECG monitoring Respiratory parameters, BP & HR Q1 hour until discharged
Muscle Tone	Document if abnormal and assess Q1 hour until return to pre-procedure status

Assessment Parameters:

On transfer to the post-anesthetic care area from procedure lab:

1. Assess for symptoms of upper and/or lower airway obstruction by tracheal and lung auscultation and observation:
 - Absent or decreased breath sounds
 - Adventitious sounds, e.g., gurgling, snoring, stridor, wheezing, crackles
 - Dyspnea, e.g. nasal flaring, tracheal tug, indrawing, restlessness, increased abdominal movement
 - persistent coughing or gagging

****Immediately intervene if Airway Obstruction is present!!!!****

2. Assess for presence, site, position and patency of artificial airways.
3. Assess baseline respiratory status including:
 - Rate, depth, ease & regularity of respirations SpO₂
 - Symmetry of chest expansion
 - System & amount of supplemental oxygen Peripheral & central skin colour
4. Assess pulse
5. Assess blood pressure, avoiding arm with AV fistula in situ or arm on same side of mastectomy
6. Initiate ECG monitoring and assess rate, rhythm and for evidence of ischemia
7. Assess depth of consciousness and sedation, rating the patient as follows:

Table 1: Depth of Consciousness & Sedation Score

Depth of consciousness:
<ul style="list-style-type: none"> ■ Unconscious: no response to stimulation ■ Reacting: non-purposeful movement to stimulation ■ Responding: obeys simple commands ■ Conscious: oriented to person, place & time
Assess Sedation Score (Appendix C) when patient is conscious using the Passero Opioid Induced Sedation Score (POSS)

8. Assess procedural access site(s) for hemostasis:
 - Dressing(s) dry and intact
 - No hematoma(s)
9. Assess peripheral perfusion:
 - Pedal pulses palpable bilaterally
 - +/- edema
 - Colour, Warmth, Sensation, Movement (CWSM) assessed

10. Assess muscle tone, e.g., ability to sustain head lift, extremity strength and movement
11. Assess temperature
12. Assess for risk to comfort and safety:
 - Pain level (refer to [D-00-07-30302](#) for more information)
 - Positioning/body alignment
 - Disorientation/agitation
 - Nausea & vomiting
 - Shivering
 - Bladder distention
13. Assess information obtained from anesthesiologist and patient record regarding:
 - Past medical history including record of substance abuse or aggressive behaviour
 - Pre-procedure baseline
 - Pre-procedure medications
 - Intra-procedure course
 - Anesthetic drugs and reversal agents
 - Fluid balance
 - Post procedure orders
14. Assess patient to ensure he/she has met the Phase I criteria ([Appendix B](#)) to transition to Phase II.

Interventions

1. **Notify Anesthesiologist** if:
 - Airway obstruction or dyspnea is present
 - Significant desaturation (SpO₂ is less than 90%) or hypoventilation
 - Significant arrhythmias present
 - Systolic BP is greater or less than 20% pre-procedure baseline and/or patient is symptomatic, e.g. symptoms of ischemia, alterations in LOC
 - Symptoms of local anesthetic toxicity (e.g. confusion, agitation, tinnitus) are present
 - Uncontrolled nausea/vomiting or pain
 - Unexpected hypothermia or hyperthermia
 - Abnormal lab results
2. **Notify Most Responsible Physician (MRP)** if new arrhythmia occurs or a change in hemodynamic status.
3. **Ensure airway patency:**
 - If evidence of airway obstruction, reposition patient flat and on side.

- Ensure anterior mandibular displacement via chin lift/head tilt or jaw thrust as required.
 - Insert oral or nasal airway as needed.
 - Suction as needed
 - Assist patient to deep breathe and cough as required
 - Ensure appropriate emergency cart is close by.
4. Initiate and maintain oxygen therapy as per physician orders.
 - Apply oxygen for shivering or temperature less than 36°C
 5. **Progressively elevate HOB as tolerated by blood pressure to stir-up patient** Q10-15 minutes and encourage
 - 2 to 3 deep breaths
 - Coughing if secretions present
 - Flex/extend extremities
 - Progressively elevate HOB as tolerated by blood pressure and hemostasis of vascular access site(s)
 - Assess for and relieve pain
 6. If patient is unable to turn self, turn patient Q2H and as needed.
 7. Implement measure(s) to manage pain.
 8. Administer antiemetics as ordered.
 9. Implement comfort and safety measures:
 - Cover with warm blankets and/or the bear hugger warming blanket
 - Remove wet or soiled linen
 - Ensure side rails are up and brakes locked
 10. Implement orders regarding diet, activity, monitoring, diagnostics, sheath care, IV's and medications.

Phase II: Care and discharge of the ambulatory patient and Extended Observation Phase

Assessment Parameters and Frequency

Vital signs/Parameters	Frequency
<ul style="list-style-type: none"> • Level of Consciousness/Sedation • Circulation (BP & Pulse) • Respirations • Oxygen saturation • Activity • Post op Nausea & Vomiting 	<p>Using the scoring system (Appendix C):</p> <ul style="list-style-type: none"> • On admission (unless done within 10 minutes of transfer) then • Minimum q30 min x 1, then • Minimum q60 min and PRN

<ul style="list-style-type: none"> Pain <p>Note: ability to sustain head lift is a good indication of muscle strength/airway protection</p>	<ul style="list-style-type: none"> Monitoring must be appropriate to the patient condition. Should the patient's condition revert to Phase I status, consult with PCC/charge RN <p>Once Phase II discharge criteria are met, and patient is awaiting discharge or require further observation/intervention consistent with Extended Observation Phase:</p> <ul style="list-style-type: none"> Q1H x 2 hours then <p>Q4H until discharge</p>
Procedural Access site(s)	<ul style="list-style-type: none"> As ordered and PRN
Neurovascular (CWMS) <ul style="list-style-type: none"> Peripheral perfusion (i.e. DP/PT pulse checks) 	<ul style="list-style-type: none"> As ordered
Temperature	<ul style="list-style-type: none"> Q1H x 2 hours, then Q4H until discharge
Sleep Apnea Protocol <ul style="list-style-type: none"> for those patients with diagnosed Obstructive Sleep Apnea (OSA) 	<ul style="list-style-type: none"> Continuous SpO₂ & ECG monitoring Respiratory parameters, BP & HR Q1 hour until discharged

Transfer to Unit:

If a patient is to be admitted overnight, ensure the following have been organized:

1. Ensure Physician has arranged the admission.
2. Inform the patient's ride of change in plans
3. Ensure post-procedure orders are done and chart is complete and in order.
4. Ensure patient's belongings and chart goes with patient to unit/ward.
5. Determine if RN is required to escort patient to unit (see following section on "Determining RN accompaniment during transfer")
6. Arrange for transport.
7. Relay report to unit (see following: determining RN accompaniment during transfer).

Determining RN Accomplishment during Transfer:

If a patient is to be transferred to an inpatient unit, determine if an RN must accompany the patient during transfer. If an RN is to accompany the patient during transfer, the RN will notify the receiving inpatient unit of the estimated transfer time and then give a verbal report upon arrival to unit.

Circumstances where an RN must accompany the patient include:

1. Airway Management:
 - Intubated airway
 - Anesthesia will determine whether an Anesthesiologist or an RT/AA (anesthesia assist) will accompany the patient with an ETT in situ in addition to RN
 - Intubated patients can only be received by CCU, CSICU, Intensive Care Unit (ICU) and PACU (as arranged by physician)
 - Assistance/support required to maintain patent airway (e.g., C-spine precautions, new tracheostomies, quadriplegics, decrease LOC, frequent suctioning required)
 - Patients requiring continuous CPAP or BiPAP.
2. Respiratory:
 - FiO₂ at or greater than 50%
 - Consult AA or RT to verify oxygen set up for transport if patient requires greater than 50% O₂
 - NOTE: AA or RT must accompany patient if FiO₂ at or greater than 70%
3. Monitoring:
 - Continuous ECG is needed
 - Continuous SpO₂ is needed
 - Invasive hemodynamic monitoring (only CCU, CSICU, ICU and PACU can receive these patients)
4. Infusions:
 - Vasoactive, inotrope and/or antiarrhythmic drugs
 - Blood/Blood products currently infusing or within 1 hour post-transfusion
5. Other:
 - Patients being transferred to nursing units where continuous nursing observations will be provided (CCU, CSICU, ICU, PACU)
 - Femoral sheath insitu
 - Seizure precautions with seizure within past 24 hours
 - Elopement risk or threat to self/others
 - NOTE: Consider age, developmental level, psychiatric history, history of aggressive behavior
 - NOTE: Security must accompany patients in locked restraints

A phone report will be given to all other nursing units when RN accompaniment is not required.

Discharge Home Checklist

Once a patient has met the discharge home readiness criteria or the Physician has written an order permitting patient discharge, the RN will ensure the following:

1. Verify:
 - Patient achieves a discharge score of 16/16 or
 - Written order confirming that the patient may be discharged home
2. Assist patient to dress at bedside.
3. Contact the responsible adult designated to accompany the patient home. Provide the information re:
 - Specific time to arrive at hospital
 - Where to park
 - Directions to unit

Patients who receive general anesthesia or sedation must be discharged in the company of a responsible adult and patients who have had a GA must have a responsible adult stay overnight with the patient.

4. Complete patient education with the responsible adult.
5. Complete documentation as per unit policy.
6. When patient leaves the unit, discharge through PCIS.

Expected Patient Outcomes

The patient will be able to safely care for him/herself at home.

PATIENT / CLIENT / RESIDENT EDUCATION:

Initiate appropriate patient education as follows and reinforce with appropriate written discharge instructions:

After receiving general anesthesia or sedation:	Do not operate a motor vehicle or machinery or enter into legal contracts for 24 hours. Caution about the additive effects of alcoholic beverages and/or other drugs
Pamphlets:	<ul style="list-style-type: none"> • General Anesthesia/ Local Anesthesia/ Procedural Sedation (ED.925.G286) • Electrophysiology Discharge Instructions • See TAVI CPD
After local anesthetic affecting function of a limb:	Do not operate a motor vehicle or machinery for 24 hours. Protect the limb from injury and over-bending until sensation and movement have returned to normal and access site has healed overnight. Also patient should not lift heavy objects greater than 10 lbs for 3 days.
Any additional post-procedural instructions	Write any additional instructions on pamphlet(s).

Documentation

Complete written or electronic documentation as per unit policy.

Related Documents

- [Femoral Arterial Sheath/Line: Removal and Groin Clamp \[D-00-12-30363\]](#)
- [Care of the Post Anesthetic Patient in Phase I \[D-00-07-30260\]](#)
- [Discharge of the Post Anesthetic Patient – Phase I \[D-00-07-30267\]](#)
- [Care & Discharge of the Ambulatory Surgical Patient in Phase II and Extended Observation Phase \[D-00-07-30268\]](#)
- [Pain Assessment and Documentation \[D-00-07-30302\]](#)

References

Adapted from CPD C-155, PCG D-112 & PCG D-113 developed by Joanne Beetstra, VGH PACU RN clinician.

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Alternate Search Terms

cardiac electrophysiology EP
CRT ICD Cath Lab Anesthesia

Appendix B:

The patient must demonstrate stability in the following criteria. Stability is defined as: vital signs and other related parameters within acceptable limits for 3 consecutive 15 minute assessments in the half hour prior to discharge.

Phase 1 Discharge Criteria	
System	Criteria
NEURO OSA – sedation score 1	LOC – conscious, oriented x 3 or equal to pre-op baseline; obeys POSS Sedation ≤ 2 Muscle Tone – head lift sustained x 5 seconds; hand grips (pre-procedure equivalent) Motor/Sensory to extremities unchanged from preop
RESP *OSA – baseline SpO ₂ 90% on room air	RR – spontaneous, regular at 8-24/minute assuming sedation score ≤ 2 ; Airway – intact reflexes; artificial airways removed *SpO₂ – as ordered or $> 94\%$ on room air O₂ – d/c'd or no O ₂ changes and stable in 15 min prior to d/c
CVS	BP/P – within normal limits ($\pm 20\%$ pre-procedure) ECG – stable and equal to preop Extremities – warm & perfused; peripheral pulses are palpable bilaterally IV – patent Temp – independently maintains $> 36^{\circ}\text{C}$; consult anesthesia if $T > 38.5$
GU	Bladder – non-distended and/or scanned volume < 400 mL and/or no c/o bladder discomfort
Procedure Parameters	Dressings – dry and intact, no active bleeding
Comfort & Safety	Nausea – minimal Pain – at level acceptable to patient and/or pain score $< 5/10$ unless otherwise ordered Positioning – for comfort, if unable to turn, position on side unless contraindicated
Medication	IV bolus or infusion – 30 min after injection or infusion if 1 st dose or 15 min for subsequent dose(s) Subcutaneous – 30 min
Documentation	Criteria met/not met; D/C time; name of unit RN report given to

Appendix C:

Discharge of Phase II / Extended Observation Phase Ambulatory Patients SCORE KEY

PACU SEDATION SCORE (derived from Passero Opioid Induced Sedation Score – POSS)	
SCORE	DEFINITION
S	Sleep, easy to rouse
1	Awake and alert
2	Slightly drowsy, easily roused
3	Frequently drowsy but rousable, drifts off to sleep during conversation
4	Somnolent, minimal or no response to verbal & physical stimulation (use trapezius muscle squeeze for physical stimulation – DO NOT use sternal rub)

Discharge Scoring System

PARAMETER	SCORE	CRITERIA
LEVEL OF CONSCIOUSNESS / SEDATION	2	Conscious, opens eyes, easy to arouse
	1	Frequently drowsy, easy to arouse
	0	Unresponsive or somnolent
CIRCULATION BP & P	2	Within 20% pre-procedure
	1	20% – 40% pre-procedure
	0	> 40 % of pre-procedure
RESPIRATION	2	Able to deep breathe
	1	Limited breathing (e.g. obstructed, shallow)
	0	Requires airway support
OXYGEN SATURATION	2	= or > 94% on room air *
	1	= or > 94% on oxygen
	0	< 94%
ACTIVITY	2	Steady gait *
	1	Moves some extremities, not ready to walk, able to turn to side
	0	No gross body movement
POST PROCEDURE NAUSEA & VOMITING	2	Controlled, acceptable to patient or maximal treatment given
	1	Further treatment required
	0	Uncontrolled after treatment
PAIN	2	Controlled, acceptable to patient or maximal treatment given
	1	Further treatment required
	0	Further treatment required
BLEEDING	2	No evidence of active or unexpected bleeding
	1	Operative site wet, bleeding/hematoma, no increasing
	0	Increasing bleeding/hematoma

* or pre-procedure status

Note: This is a **controlled** document for VCH internal use. Any documents appearing in paper form should always be checked against the electronic version prior to use. The electronic version is always the current version.

Appendix D: Perianesthesia Nursing Standards

PRACTICE RECOMMENDATION 1

Patient Classification/ Staffing Recommendations

Staffing is based on patient acuity, census, patient flow processes and physical facility. The perianesthesia registered nurse (RN) uses clinical judgment and critical thinking to determine nurse to patient ratios, patient mix and staffing mix that reflect patient acuity and nursing interventions.

POSTANESTHESIA PHASE

Phase I Level of Care^b

The perianesthesia registered nursing roles during this phase focus on providing postanesthesia nursing care to the patient in the immediate postanesthesia period and transitioning them to Phase II level of care, the inpatient setting, or to an intensive care setting for continued care.

TWO REGISTERED NURSES, ONE OF WHOM IS AN RN COMPETENT IN PHASE I POSTANESTHESIA NURSING, ARE IN THE SAME ROOM/UNIT WHERE THE PATIENT IS RECEIVING PHASE I LEVEL OF CARE.^c

- Staffing should reflect patient acuity. In general, a one:two nurse-patient ratio in Phase I allows for appropriate assessment, planning, implementing and evaluation for discharge as well as increased efficiency and flow of patients through the Phase I area
- This also allows for flexibility in assignments as patient acuity changes
- New admissions should be assigned so that the nurse can devote his/her attention to the care of that admission until critical elements^d are met
- Staffing patterns should be adjusted as needed based on changing acuity and nursing requirements and as discharge criteria are met

CLASS 1:2 ONE NURSE TO TWO PATIENTS

Examples may include, but are not limited to the following:

- a. Two conscious patients, stable and free of complications, but not yet meeting discharge criteria
- b. Two conscious patients, stable, eight years of age and under, with family or competent support staff present, but not yet meeting discharge criteria
- c. One unconscious patient, hemodynamically stable, with a stable airway, over the age of eight years and one conscious patient, stable and free of complications

CLASS 1:1 ONE NURSE TO ONE PATIENT

Examples may include, but are not limited to the following:

- a. At the time of admission, until the critical elements^d are met
- b. Airway and/or hemodynamic instability

- Examples of an unstable airway include, but are not limited to, the following:
- Requiring active interventions to maintain patency such as manual jaw lift or chin lift or an oral airway
 - Evidence of obstruction, active or probable, such as gasping, choking, crowing, wheezing, etc.

^bPhase I Level of Care: Laidlaw et al v. Lions Gate Hospital is a landmark case that refers to the Phase I PACU as "the most important room in the hospital," because it "poses the greatest potential dangers to the patient" so that there should be no relaxing of vigilance and there should be constant and total care provided by the nurse.¹

^cThe intent of this standard is that a nurse providing care to a Phase I patient is not left alone with the patient. The second nurse should be able to directly hear a call for assistance and be immediately available to assist.

^dCritical elements can be defined as:

- Report has been received from the anesthesia care provider, questions answered and the transfer of care has taken place
 - Patient has a stable/secure airway
 - Initial assessment is complete
 - Patient is hemodynamically stable
 - Patient is free from agitation, restlessness, combative behaviors