



PACU Downtime Form

HM2578

Service Date: _____ PACU Department: _____
Procedure(s): _____

Staff

Surgeon(s):	Anesthetist:
OR circulator(s):	CRNA:
	Resident:

PACU Nurse's Name	RN Initials	Bed #	Date	In PACU	Discharge Criteria Met	Return to OR	Out of PACU	Procedural Care Complete

PACU Admission Checklist

Date & time taken			
RN initials			
Alarm limits checked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Alarms audible	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Doctor's orders checked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Equipment alarms on	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
ID band in place	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Warming blanket on	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Allergies: _____

DNR Status

Code Status: Full DNR Other _____



Patient Infection & Isolation Status

Infection: _____

Encounter level? Yes No Other: _____

Date added: _____ Last indicated by (print name): _____

Resolved date: _____ Resolved by (print name): _____

Reviewed date: _____ Onset date: _____

Isolation: Airborne Contact Droplet Enteric Other (comment): _____

Precautions

- | | | | | |
|---|---|--------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Hip | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Spinal |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Decubitus | <input type="checkbox"/> Latex | <input type="checkbox"/> Radiation | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Assault | <input type="checkbox"/> Elopement risk | <input type="checkbox"/> Neutropenia | <input type="checkbox"/> Reflux | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Bizarre | <input type="checkbox"/> Fall | <input type="checkbox"/> Pelvic | <input type="checkbox"/> Seizure | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Other (comment): _____ | | | | |

Sequential Compression Devices

SCD Type	Status	Laterality	Area
	<input type="checkbox"/> On <input type="checkbox"/> Off	<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Lower foot <input type="checkbox"/> Lower leg
	<input type="checkbox"/> On <input type="checkbox"/> Off	<input type="checkbox"/> Bilateral <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Lower foot <input type="checkbox"/> Lower leg

Interpreter

Interpreter used: <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter ID#:	Date:	Time:
Language:	Those present during interpretation:		
Interpreter used for: <input type="checkbox"/> Consent for surgery <input type="checkbox"/> Consent for procedure <input type="checkbox"/> Discharge instruction			
<input type="checkbox"/> Medication education <input type="checkbox"/> Other:			

Vitals Sign

Date					
Time					
RN Initials					
Charting type (1=admission, 2=shift, 3=reassess-no change, 4=reassess-changes noted)					
BP					
MAP (mmHg)					
Arterial line BP					
Arterial line MAP (mmHg)					
BP location (L-arm, R-leg, arterial)					
Orthostatic vitals? (Y/N)					
Patient position (lying, sitting)					
BP method (monitor, manual, doppler)					
Heart rate					
Heart rate source (monitor, apical)					
Respiratory rate					
SPO2					
Pulse oximeter location					
Temp					
Temp source (oral, skin, temporal)					
ETCO2 (mmHg)					
CVP (mmHg)					
Glucose					
Hematoma					
Groin hematoma present? (Y/N)					
Radial hematoma present? (Y/N)					

Pain Assessment

Date							
Time							
RN Initials							
Charting type (1=admission, 2=shift, 3=reassess-no change, 4=reassess-changes noted)							
Pain assessment (PIPP, FLACC, NIPS)							
Pain score (1 – 10)							
Wong-Baker FACES Pain Rating							
Patient's stated pain goal (1 –10)							
Pain type (acute, chronic, surgical)							
Pain location (hand, foot)							
Pain orientation (left, mid, proximal)							
Pain descriptors (aching, burning, numb, shooting, sore)							
Pain frequency (constant, rare, once per week, intermittent)							
Pain onset (awake, gradual, sudden, on-going, progressive, unable to tell)							
Clinical progression (no change, rapid improving, gradual worsening)							
Effect of pain on daily activities (1=worse to 5=better)							
Pain intervention(s) (meds, food, heat/cold applied, elevated)							
Response to interventions (effective, partial, ineffective)							
Multiple pain sites (Y/N)							
Pain on discharge (acceptable, chronic, Pt. going to ICU)							

Vascular Access

Date					
Time					
RN Initials					
Charting type (1=admission, 2=shift, 3=reassess-no change, 4=reassess-changes noted)					
Type (arterial, central, etc.)	<i>Peripheral IV</i>				
Details					
Placement date & time					
Size (20G, 22G, 24G, etc.)					
Catheter size					
Orientation (left, right, etc.)					
Location (arm, neck, foot, etc.)					
Site prep (alcohol, CHG, etc.)					
Local anesthetic (inject, topical)					
Technique (ultrasound, anatomical landmarks, etc.)					
Inserted by					
Inserted attempt (1-5+)					
Securement type					
Dressing					
Patient tolerance (well, poor)					
Removal date & time					
Removal reason					
Site assessment					
Dressing type (gauze, antimicrobial, transparent)					
Dressing status (clean, dry, intact, removed)					
Dressing intervention (new, changed, removed)					
IV tubing changes? (Y/N)					
IV change due date					
Site assessment (swelling)					
Dressing type (gauze, tape)					
Line status (linking, positional)					
Dressing status (clean, dry)					
Dressing intervention					
IV tubing changed (Y/N)					
IV change due date					

Arterial Sheath

Date			
Time			
RN Initials			
Charting type (1=admission, 2=shift, 3=reassess-no change, 4=reassess-changes noted)			
Present on admission?			
Placement date & time			
Inserted/placed by			
Sheath size (Fr.)			
Line orientation (left, right)			
Sheath insertion site			
Sutured (Y/N)			
Local anesthetic (topical, injectable)			
Site prep (alc., betadine, CHX)			
Free flowing blood return (Y/N)			
Insertion attempt (1-5+)			
Removal date & time			
Removal Reason			
Removed by			
Method of sheath removal			
Arterial closure device			
Time to hemostasis (min.)			
Hours of bedrest			
Initiated post removal site assessment			
Distal pulses (weak, moderate, strong, bounding, doppler, absent)			
Site assessment			
Line status			
Dressing			
Dressing status (dry, clean, intact)			
Dressing intervention			
Securement type (suture, taped)			
Color/movement/sensation			
ACT result			
Post interventions (x-ray, labs)			
Daily review of necessity			
Homeostasis Device			
C-CLAMP (External Compression Device)			
TR band (radial band)			
Tracelet (radial band)			

Line, Drain, Airway

Document any additional detail assessment on PACU Nurse's Notes.

Date					
Time					
RN Initials					
LDA type:					
Present on admission?					
Placement date:					
Placement time:					
Reason for insertion:					
Inserted/placed by:					
Insertion attempts:					
Size (indicate gauge, Fr, mm, cm, etc.):					
Number of lumens/ports:					
Device:					
Local anesthetic:					
Orientation:					
Location/laterality:					
Destination:					
Catheter type:					
Catheter balloon size:					
Tube size (Fr.)					
CVC type (tunneled, non-tunneled)					
Total length upon insertion (cm):					
Reason subclavian not selected:					
Technique:					
Initial exposed catheter (cm):					
Securement type (suture, taped):					
Catheter tip cultured (Y/N)					
Urine output (ml)					
Drain tube type:					
Tube number (1 thru 10):					
Chest tube drainage system					
Reservoir tube type:					
Drain reservoir size (mL):					
Colostomy type (ascend, loop, sigmoid)					
Ileostomy type:					
Urostomy type:					
Stoma size (mm):					
Duration (temporary, permanent)					

Line, Drain, Airway Continued

Date					
Time					
RN Initials					
Patient tolerance:					
Placement verification:					
Pump agreement signed and in chart?					
Urine returned? (Y/N)					
Urine Output (mL):					
LDA to remain in place discharge?					
Removal date:					
Removal time:					
Removal catheter length (cm):					
Removal reason:					

Use additional pages as needed. Page _____ of _____

Incision & Wound Assessment

Document any additional detail assessment on PACU Nurse's Notes.

Date			
Time			
RN Initials			
Charting type (1=admission, 2=shift, 3=reassess-no change, 4=reassess-changes noted)			
Present on admission (Y/N)			
First assessment date:			
First assessment time:			
Current dressing status (dry, clean, intact, absent)			
Primary wound type (ulcer, burn, incision, surgical, abscess)			
Wound approximate age at first assessment (weeks)			
Wound drainage (small, copious, scant, none)			
Wound size			
Orientation (left, anterior, inner, distal, lateral, upper)			
Location (abd, ankle, chest, head, sclera, tibial)			
Description (4x4, ace, abd webril, wound vac)			
Dressing placed in OR:			
Dressing securement (gauze roll, tape, stockinette)			
Wound cleanse (irrigation, periwound care, wash, CHX)			
Primary dressing changed (new, changed, reinforced)			
Primary dressing (vac assist closure, dry, adhesive)			
Burn type (abrasion, electric, chemical, smoke, thermal)			
Degree of burn (1st, 2nd, 3rd):			
Final assessment date			
Final assessment time:			
Wound status at discharge:			
Wound outcome (healed, palliative, no longer present)			

Wound assessment comments: _____

RASS Scoring

Date						Scoring Guide	
Time						+4=combative	-1=drowsy
RN Initials						+3=very agitated	-2=light sedation
Richard Agitation Sedation Scale (RASS)						+2=agitated	-3=moderate sedation
						+1=restless	-4=deep sedation
						0=alert & calm	-5=unarousable

Glasgow Coma Scale

Date						Scoring Guide	
Time							
RN Initials							
Eye opening						4=spontaneous 3=to speech	2=to pain 1=none
Best verbal response						5=oriented 4=confused 3=inappropriate words	2=incomprehensive speech 1=none
Best motor response						6=obeys commands 5=localizes pain 4=withdraws from pain	3=flexion to pain 2=extension to pain 1=None
Glasgow Coma Scale Score						Total score	

Reflexes

Date					
Time					
RN Initials					
Gag (absent, present, weak, UTA)					
Cough					
R Corneal (intact, impaired, absent, UTA)					
L Corneal					
R Babinski (absent, present)					
L Babinski					

Cardiac

Date					
Time					
RN Initials					
Cardiac rhythm (NSR, SB, ST, A-fib)					
Cardiac (WDL, X)					
Cardiac regularity					
Heart sounds (s3, s4, murmur, gallop)					
Jugular venous distention (yes, UTA)					
Cardiac symptoms (rest, chest pain, exertion, fatigue, palpitations)					
Life vest (on/off)					
Heart block					
Telemetry (Y/N)					
Pacemaker					
Pacemaker type (permanent, transcutaneous)					
Pacemaker mode (Off, AOOB, VOO, etc.)					
Pacemaker sensing (capture, sensing)					
Pacemaker rhythm (100%, 75%, etc.)					
Temporary wires					
Wire status					
Temp pacemaker pads					
Atrial rate (beats/min)					
Atrial output (milliamps)					
Ventricular rate (beats/min)					
Ventricular output (milliamps)					
Pacemaker set rate (beats/min)					
Atrial sensitivity (mV)					
Ventricular sensitivity (mV)					
Battery changed (done, other)					
Pacemaker vendor					

Respiratory

Document any additional detail assessment on PACU Nurse's Notes.

Date					
Time					
RN Initials					
Charting type (1= <i>admission</i> , 2= <i>shift</i> , 3= <i>reassess-no change</i> , 4= <i>reassess-changes noted</i>)					
Respiratory (WDL, X):					
Chest assessment					
Bilateral Breath Sounds (clear, rhonchi, wheeze, crackles, diminished)					
R breath sounds					
L breath sounds					
Non-Surgical Airway					
Present on admission?					
Placement date					
Placement time					
Airway device (combitube, king tube, nasal, oral)					
Size (mm)					
Insertion attempts (1-5+)					
Placed by					
Removed by					
Removal date					
Removal time					
Airway Suctioning/Secretions					
Suction type (nasal, oral)					
Suction device (bulb, catheter, nasal aspirator, Neo-sucker, yankauer)					
Secretion amount (small, large)					
Secretion color (clear, green)					
Secretion consistency					
Suction tolerance (well, fair, poor)					
Suctioning adverse effects					

Respiratory Continued

Date					
Time					
RN Initials					
ETT Airways					
Present on admission?					
Placement date					
Placement time					
Tube size (mm)					
Type (cuffed, inflated)					
Location (oral, left nare, stoma)					
Mask ventilation					
Technique					
Blade size (00, 0, 1, 2, etc.)					
Grade view (1 - 4)					
Insertion attempts					
Placed by					
Placement verification (auscultation, chest x-ray, cuff palpitation, end tidal CO ₂ , etc.)					
Comments (use nurse's notes)					
Removed by					
Removal date					
Removal time					
Secured at (cm)					
Measured from (gums, lips, nare)					
Secured location (left, right, center)					
Secured by (tube holder, tape)					
Cuffed status (MOV, MLT, audible leak, uncuffed, suction above cuff)					
Skin integrity (intact, breakdown)					

Ventilator Settings

Date					
Time					
RN Initials					
Vent mode (CPAP, Bi-PAP, SIMV, Bilevel/MMV, PRVC, timed, etc.)					
Set resp. rate					
PEEP/CPAP (cm H2O)					
Vt (Set, mL)					

Oxygen Therapy

Date					
Time					
RN Initials					
O2 delivery method					
Humidified? (Y/N)					
FiO2 %					
O2 flow rate (L/min)					
SpO2					
Heater temperature					
Heliox mixture (80/20 or 70/30)					
Heliox delivery device					
Heliox flow rate (L/min)					

Comfort & Safety

Date								
Time								
RN Initials								
Comfort (HOB elevated, pillow, placed in gown, reposition, warm blanket, sock, etc.)								
Precautions taken (Standard, seizure, fall, aspiration, neutropenic, chemo, radiation, etc.)								
Safety (ID band on/verified, rails up x2, wheels locked, call light within reach, alarms on & audible, yellow armband, padded side rails, allergy band, pink limb alert)								
Neuro cognitive interventions (Room darkened, oriented patient)								
Positioning (Turned every 2hrs, L/R side, supine, Fowler's, prone, extremities elevated)								

Neuro

Date			
Time			
RN Initials			
Neuro (WDL, X):			
Level of consciousness (alert, confusion, dozing, drowsy – easily aroused, sedated, sleepy)			
Orientation level (person, place, time, situation)			
Cognition (confuse, unable to follow commands)			
Speech (clear, slurred, incomprehensible)			
Facial Symmetry (left/right drooping)			
Pupil Assessment			
R pupil size (mm)			
R pupil shape (round, irregular, oval)			
R pupil reaction (brisk, fixed, dilated, pinpoint, sluggish, non-reactive)			
R pupil accommodation (absent)			
R neurological pupil index (NPI) value			
L pupil size (mm)			
L pupil shape			
L pupil reaction			
L pupil accommodation			
L neurological pupil index (NPI) value			

Neuro – continued

Date				
Time				
RN Initials				
Motor Function Assessment				
R hand grip (absent, weak, moderate, strong)				
L hand grip				
R foot dorsiflexion				
L foot dorsiflexion				
R foot plantar flexion				
L foot plantar flexion				
RUE motor response (tremors, flaccid)				
RUE motor strength (cannot overcome gravity/resistance, muscle flicker, none)				
LUE motor response				
LUE motor strength				
RLE motor response				
RLE motor strength				
LLE motor response (tremors, decerebrate, decorticate, non-purposeful movement)				
LLE motor strength				
RUE Neurovascular Assessment				
RUE capillary refill (> 3 seconds, absent)				
RUE temp/moisture (hot, warm, cold, dry, clammy, diaphoretic)				
RUE color				
RUE sensation (numb, tingle, pain)				
LUE Neurovascular Assessment				
LUE capillary refill				
LUE temp/moisture				
LUE color				
LUE sensation				

NIH Stroke Scale

Date	Time	RN Initials	Scoring Guide
Interval:			Baseline, 24hr follow up, change in condition, shift change, transfer unit, discharge
Level of consciousness:			0=alert, 1=not alert but arousable minor stimulation, 2=not alert requires repeated stimulation, 3=responds only w/ reflex motor, flaccid
LOC questions:			0=performs 2 tasks correctly 1=perform 1 task correctly, 3=performs neither correctly
LOC commands:			
Best gaze:			0=normal, 2=partial gaze palsy, 3=forced deviation
Visual:			0=no visual loss, 1=partial, 2=complete, 3=bilateral hemianopia (include cortical blindness)
Facial palsy:			0=normal symmetrical movements, 1=minor paralysis, 2=partial paralysis, 3=complete paralysis of 1 or both sides
Motor – L arm			0=no drift, 1=drift, 2=some effort against gravity, 3=no effort against gravity, 4=no movement. Amputation/joint fusion
Motor – R arm			
Motor – L leg			
Motor – R leg			
Limb ataxia:			0=absent, 1=present in 1 limb, 2=present in 2 limbs. Amputation/joint fusion
Sensory:			0=normal, no sensory loss, 1=mild to moderate, 2=severe to total sensory loss, pt. not aware touch on the face, arm, leg.
Best language:			0=no aphasia, 1=mild to moderate, 2=severe, 3=mute
Dysarthria:			0=normal, 1=mild to moderate, 2=severe. Intubated/other physical barrier
Extinction & Inattention:			0=no abnormality, 1=visual, tactile, auditory, spatial, 2=profound hemi-inattention/extinction > 1 modality
NIH Total:			Total score

HEENT

Date			
Time			
RN Initials			
HEENT (WDL, X):			
L eye (impaired, blind, blurred, conjunctiva red, double vision, drainage, edema)			
R eye			
L ear (deaf, battle sign, drainage, foreign object, laceration, impaired hearing)			
R ear			
Nose (drainage, foreign object)			
Throat/palate (difficulty swallowing)			
Other:			

Musculoskeletal

Date			
Time			
RN Initials			
Musculoskeletal (WDL, X):			
RUE (mildly/moderate/severely impaired, amputation, swelling)			
LUE			
RLE			
LLE			
Weight-Bearing Status (non-weight bearing, toe-touch, touch down, partial, tolerated, LUE, RUE, LLE, RLE)			
Other assessment:			

PACU Interventions

Date				
Time				
RN Initials				
Miscellaneous Devices (abductor pillow, abdominal binder, immobilizer, sling, splint)				
Comfort/environment interventions (cold therapy, warming blanket)				
Head of bed elevated (flat, HOB: >20, 30, 45, 60, 90)				
Heel/feet (elevated off bed, foot of bed elevated, protector, boots)				
Anti-embolism devices				
Other PACU interventions (ice chips, mouth care, perineal care, sheet change)				
Post-Op x-ray done? (Y/N)				
Other PACU Interventions				

Integumentary/Skin

Date				
Time				
RN Initials				
Integumentary (WDL, X):				
Skin color (pale, ruddy, jaundice, ecchymosis, cyanotic, mottled, dusky, ashen)				
Skin condition/Temp (clammy, cool, dry, hot, diaphoretic, flaky)				
Skin integrity (blister, burn, rash, incision, wound/see LDA)				
Skin Turgor				

Gastrointestinal

Please document any additional detail assessment on PACU Nurse's Notes.

Date					
Time					
RN Initials					
Gastrointestinal					
Gastrointestinal (WDL, X)					
Last BM date					
Abdomen inspection (soft, taut, rounded)					
Bowel sounds (all quadrants)					
Retired tenderness					
Passing flatus (Y/N)					
GI symptoms (nausea, pain, cramping, fecal incontinence)					
Liver/spleen palpation (hepatomegaly, splenomegaly, tender liver/spleen)					
Abdominal girth (cm)					
Tolerating PO fluids (Y/N)					
Enema Type					
Amount instilled					
Preparation					
Result					
How tolerated?					
Stool Assessment					
Stool appearance					
Stool color					
Unmeasured stool amount					

Postoperative Nausea & Vomiting (PONV)

Date				
Time				
RN Initials				
Potential for nausea and vomiting – interventions				
Nausea or vomiting (Y/N)				
Emesis color/appearance				
Nausea precipitating factors (dizziness, movement, smell)				
Nausea interventions (antiemetic, cool air/fan, NPO, aromatherapy, IV fluid, rest, pain control, vomiting, self-resolving)				
Nausea reassessment after intervention (improving, unchanged, worsening, resolved)				

Pelvis

Date				
Time				
RN Initials				
Genitourinary Assessment				
Genitourinary (WDL, X)				
Genitourinary symptoms (urgency, anuria, bladder pressure, bladder spasm, due to void, CBI, urethral catheter, external catheter, suprapubic catheter, stents, PD, HD)				
Implanted urinary devices				
GU LDAs (refer to LDA section)				
Urine Assessment				
Urine color/appearance				
Urine odor				
Bladder scan volume (mL)				
Intermittent/straight Cath (mL)				
Post void Cath residual (mL)				

Psychosocial

Date				
Time				
RN Initials				
Psychosocial (WDL, X):				
Patient behavior/mood (anxiety, confusion, agitation, combative, depressed, hallucination, irritable, tearful restless)				
Family behaviors				
Name & relationship of family present				
Visitor behaviors				
Name of visitor present				
Rest/sleep for patient				
Rest/sleep for family				

Input Output (I/O)

Date						
Time						
RN Initials						
Voided Urine Output/Assessment						
Voided urine (mL)						
Diaper used						
Unmeasured urine occurrence						
Unmeasured urine amount (small, large)						
Urine color						
Urine appearance (cloudy, sediment, clots)						
Urine odor						
Stool Output/Assessment						
Last BM date						
Stool (mL)						
Bowel Incontinence? (Y/N)						
Unmeasured stool occurrence						
Unmeasured stool amount						
Stool appearance						
Stool color						
Emesis Output/Assessment						
Emesis						
Unmeasured Emesis occurrence						
Unmeasured Emesis amount						
Emesis appearance/color						
Blood Output						
Est. blood loss (mL)						

Blood & Transfusion

Date					
Time					
RN Initials					

Transfusion Documentation

Informed consent obtained? (Y/N)					
History of previous transfusion reaction? (yes, no, unknown)					
Pre-Meds given? (yes, no – or none ordered)					
Vital signs within one hour prior to admin? (Y/N)					
Vital signs 15 minutes from start time? (Y/N)					
Vital signs taken hourly thereafter? (Y/N)					
Obtained/record vital signs (completion)? (Y/N)					
Blood transfusion total time (0-1 hr, 1-1.5 hrs., 1.5-2 hrs., etc.)					

Transfuse

Transfuse type (RBC, FFP, Platelet)					
Status (start, completed, stop)					
Route					
Site					
Rate (mL/hr)					
Volume infused					
Blood warmer?					

Use additional pages as needed. Page _____ of _____

Blood & Transfusion - Continued

Date					
Time					
RN Initials					
Suspected Transfusion Reaction					
Blood bank notified? (Y/N)					
Lab sent? (Y/N)					
Patient identity reverified at bedside? (Y/N)					
Blood identification reverified at bedside? (Y/N)					
Physician notified? (Y/N)					
Provider name					
Reaction Symptoms (chills, fever, hives, chest pain, ache)					
Reaction Interventions (transfusion stopped, IV inserted, meds, labs drawn, return blood product)					
Bilateral breath sounds (transfusion reaction - clear, crackles, diminished, rhonchi, absent, stridor, expiratory/inspiratory wheezes)					
R breath sounds (transfusion reaction)					
L breath sounds (transfusion reaction)					

Point of Care Testing (POCT)

POCT type: Glucose Urine, specify gravity Other _____

Specimen	Providers
Type:	Billing (provider name):
Collected by:	Resulting:
Collection date & time:	Resulting Lab
<input type="checkbox"/> No collection information available	Lab name:
Components detail:	Technician:
	Result
	Result date & time:
	<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal
	Status: <input type="checkbox"/> In progress <input type="checkbox"/> Preliminary <input type="checkbox"/> Final result

POCT type: Glucose Urine, specify gravity Other _____

Specimen	Providers
Type:	Billing (provider name):
Collected by:	Resulting:
Collection date & time:	Resulting Lab
<input type="checkbox"/> No collection information available	Lab name:
Components detail:	Technician:
	Result
	Result date & time:
	<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal
	Status: <input type="checkbox"/> In progress <input type="checkbox"/> Preliminary <input type="checkbox"/> Final result

POCT type: Glucose Urine, specify gravity Other _____

Specimen	Providers
Type:	Billing (provider name):
Collected by:	Resulting:
Collection date & time:	Resulting Lab
<input type="checkbox"/> No collection information available	Lab name:
Components detail:	Technician:
	Result
	Result date & time:
	<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal
	Status: <input type="checkbox"/> In progress <input type="checkbox"/> Preliminary <input type="checkbox"/> Final result

Use additional pages as needed. Page _____ of _____

PCA / PCEA / PNB

Date							
Time							
RN Initials							
Pump cleared? (Y/N)							
Changed bag, syringe, or tubing (tubing - req'd if change concentration)							
Respiratory Quality/Sounds (agonal, apneic, dyspneic, labored, snoring, tachypneic, etc.)							
Level of consciousness (confusion, dozing, sedated, drowsy, sleepy, etc.)							
Orientation level (disorientated to person, place, time situation, UTA)							
Side effects (nausea, vomiting, itching, leg numbness, tingling, weakness, etc.)							
Site appearance (redness, swelling, tenderness, erythema)							

Restraints (NV)

Date			
Time			
RN Initials			
Restraint Order			
Order obtained (Y/N)			
Restraint type:			
Siderails x 4 (NV)			
Mitt (NV)			
Vest (NV)			
Less restrictive alternative			
Education			
Discontinuation criteria (compliance with prescribed activity)			
Discontinuation criteria explained? (Y/N)			
Patient's response			
Family notification (guardian, spouse, parent, etc.)			
Clinical Justification – Every 2 Hours			
Clinical justification (attempts to remove tubes/lines, attempts to interrupt treatment, other comment)			
Restraint Monitoring – Every 2 Hours			
Psychological status			
Skin integrity/circulation (no injury, abrasion, edema, redness, complains of pain, etc.)			
Range of motion (performed, pt. declined, pt. asleep)			
Fluids / Hydration (offered, pt. declined, asleep, NPO, IV fluids)			
Food/meal (snack, lunch, dinner, NPO, etc.)			
Elimination (offered, pt. declined, catheter, anuria, etc.)			
Prolonged Restraints Review			
Injury sustained due to restraint?			

Provider Notification

Notification time:	Method of notification:
Provider name/role:	
Notification reason:	
Response time:	
Response:	

Family Notification

Family update message:
Contact person relationship to patients:
Contact person phone number:
Communication method:
Delivery origin: <input type="checkbox"/> Surgeon <input type="checkbox"/> Surgeon liaison <input type="checkbox"/> Nurse <input type="checkbox"/> Other:
Message disposition:
Update given: <input type="checkbox"/> Yes <input type="checkbox"/> Other:

Sign-Off

PACU Nurse's Signature

Printed Name

Date/Time

Handoff

	Given By	Given To	Date	Time
1				
2				
3				
4				

Transport

Transfer

Taken by: _____ Date/Time: _____

Transfer delay reason:	
Transferred to:	<input type="checkbox"/> Nursing unit <input type="checkbox"/> ICU <input type="checkbox"/> IMU <input type="checkbox"/> PACU <input type="checkbox"/> Phase II <input type="checkbox"/> OBS unit <input type="checkbox"/> Home <input type="checkbox"/> Other:
Position:	<input type="checkbox"/> Head up <input type="checkbox"/> Head elevated <input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Lawn chair <input type="checkbox"/> Right leg elevated <input type="checkbox"/> Left leg elevated <input type="checkbox"/> Trendelenburg <input type="checkbox"/> Left lateral <input type="checkbox"/> Other:
Mobility at departure:	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Restrained <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stroller <input type="checkbox"/> Carried <input type="checkbox"/> Stretcher <input type="checkbox"/> Bed <input type="checkbox"/> Other:
Departure mode:	<input type="checkbox"/> By self <input type="checkbox"/> With spouse <input type="checkbox"/> With parents <input type="checkbox"/> With caregiver <input type="checkbox"/> In ambulance <input type="checkbox"/> In cab <input type="checkbox"/> In bus <input type="checkbox"/> In police custody <input type="checkbox"/> On stretcher (restraints) <input type="checkbox"/> In private custody <input type="checkbox"/> Other:
With cardiac monitor:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:

Oxygen Therapy

O2 device:	<input type="checkbox"/> None (room air) <input type="checkbox"/> Nasal cannula <input type="checkbox"/> Simple mask <input type="checkbox"/> Aerosol mask <input type="checkbox"/> Nasal cannula with reservoir <input type="checkbox"/> High flow nasal cannula <input type="checkbox"/> Face tent <input type="checkbox"/> Other:
Pulse oximetry type:	<input type="checkbox"/> Intermittent <input type="checkbox"/> Continuous <input type="checkbox"/> Other:

MAR

	Medication	Dose	Route	Rate	Volume	Frequency	Date/Time	RN Initials
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Use additional pages as needed. Page _____ of _____

Care Plan

Initiation date: _____ Time: _____ RN Initials: _____

Evaluation date: _____ Time: _____ RN Initials: _____

PACU Assessment/Nursing Diagnosis: Potential for Ineffective Airway Maintenance
Potential for Ineffective Airway Maintenance- Interventions <input type="checkbox"/> Assess lung sounds <input type="checkbox"/> Position/re-position airway <input type="checkbox"/> Insert nasal/oral airway <input type="checkbox"/> Suction nasal/oral Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Impaired Gas Exchange
Potential for Impaired Gas Exchange-Interventions <input type="checkbox"/> Assess lung sounds <input type="checkbox"/> Apply pulse oxi-meter, notify anesthesia SAO2 is < 90% <input type="checkbox"/> Encourage turn, cough and deep breath Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Hemorrhage
Potential for Hemorrhage-Interventions <input type="checkbox"/> Assess op-site/dressings and output/measure drainage <input type="checkbox"/> Notify anesthesia hypotension/tachycardia <input type="checkbox"/> Notify surgeon <input type="checkbox"/> Apply direct pressure if able Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Alteration in Comfort-Pain
Potential for Alteration in Comfort: Pain-Interventions <input type="checkbox"/> Assess level of comfort/pain <input type="checkbox"/> Re-position, support incision <input type="checkbox"/> Obtain analgesic order and evaluate patient response Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Nausea & Vomiting
Potential for Nausea & Vomiting- Interventions <input type="checkbox"/> Assess patient for complaints of nausea <input type="checkbox"/> Provide emesis basin/cloth <input type="checkbox"/> Notify physician, request antiemetic <input type="checkbox"/> Assess for relief of nausea and vomiting Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Thermoregulatory-Hypo/Hyper
Potential for Thermoregulatory-Hypo/Hyper- Interventions <input type="checkbox"/> Apply warm blankets/remove blankets <input type="checkbox"/> Apply thermal blanket and monitor temperature PRN <input type="checkbox"/> Obtain medication order Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Injury Related to Sedation or Emergence Excitement
Potential for Injury Related to Sedation or Emergence Excitement- Interventions <input type="checkbox"/> Side-rails up <input type="checkbox"/> Padded side-rails PRN <input type="checkbox"/> RN in constant bedside attendance Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:
PACU Assessment/Nursing Diagnosis: Potential for Knowledge Deficit Relative to Operative Procedure
Potential for Knowledge Deficit Relative to Operative Procedure- Interventions <input type="checkbox"/> Post-op teaching related to 0-10 pain scale <input type="checkbox"/> Post-op teaching related to IV/epidural PCA <input type="checkbox"/> Post-op teaching related to turning, coughing, and deep breathing <input type="checkbox"/> Teaching to be reinforced Evaluation of Goals Met <input type="checkbox"/> Goal met <input type="checkbox"/> Goal not met Comment:

Use additional pages as needed. Page _____ of _____

