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UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO  
CLINICAL CARE GUIDELINES

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**Subject:** PACU Patient Care Assessments: MAJOR SURGICAL PROCEDURES

**OBJECTIVE**

To provide a safe environment for the surgical patient by providing safe and adequate post anesthesia care.

This goal will be achieved by:

- Developing a guideline to standardize care in the Post Anesthesia Care Unit (PACU).
- Developing and then expanding a staff orientation to Perioperative Care.
- Developing a standard set of annual competencies to assess and maintain staff knowledge and skill level.

**POSITION STATEMENTS**

1. We at the University of Illinois Medical Center at Chicago believe that safe patient care is integral to the mission of the Medical Center.
2. We are committed to optimizing patient care outcomes through individualized, exceptional care based on evidence and congruent with standards developed by nationally recognized healthcare organizations (eg ASPAN, JCAHO).
3. We are committed to maximizing the number of positive patient outcomes for our post anesthesia patients.

**DEFINITIONS**

**Major Surgical Procedure:** Major surgical procedure surgical procedures provided in the Labor & Delivery Operating Suites include cesarean section, bladder repair, and hysterectomy.

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**PROCEDURE**

All surgical patients will be assessed, and reevaluated during postoperative care.

Assessment factors include but not limited to:

1. Relevant preoperative status including: Electrocardiogram, vital signs, radiology findings, laboratory values, oxygen saturation, allergies, disabilities, substance abuse, physical or mental impairments mobility limitations, and need for prostheses (including hearing aids).
2. Anesthesia technique (general, regional, local) effect preoperative medication.
3. Anesthesia agents, muscle relaxant, narcotics and reversal agents given.
4. Length of time anesthesia administered, time reversal agents used.
5. Type of surgical procedure.
6. Estimated fluid/blood loss and replacement.
7. Complications occurring during anesthesia course, treatment initiated, response and emotional status on arrival to the operating or procedure room.

A. Initial Assessment to include documentation of:

1. Vital signs
  - a. Monitor airway patency, respiratory rate and competency, breath sounds, type of artificial airway (if present), mechanical ventilator settings (if present) and oxygen saturation (following general anesthesia).
  - b. Blood pressure: cuff or arterial line.
  - c. Pulse: apical, peripheral.
  - d. Temperature: oral, rectal, auxiliary, digital through dermal sensor, temporal, or tympanic.

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**PROCEDURE**

4. Assess level of consciousness: Note changes in neurological status.
5. Record central venous, arterial blood, pulmonary and artery wedge pressure if indicated.
6. Position of patient
7. Condition and color of skin.
8. Patient safety needs (i.e. side rails and other protective devices).
9. Neurovascular: peripheral pulses and sensation of extremities as applicable.
10. Condition of dressing - dry and intact.
11. Condition of suture line, when dressing is absent.
12. Type, patency and area of placement of drainage tubes, catheters and receptacle.
13. Amount and type of drainage.
14. Muscular response and strength.
15. Pupillary response as indicated.
16. Fluid therapy, location of lines, condition of IV site, and amount of solution infusing (including blood).
17. Level of physical and emotional support.
18. ALDRETE numerical score.

B. Ongoing assessment should include, but not limited to the following:

1. Monitor, maintain and/or improve respiratory function and circulatory function by taking vitals q 15 min. and until reaching 10% variance of pre-operative assessment.
2. Promote and maintain physical and emotional comfort.
3. Monitor surgical site.
4. Interpret and document data obtained during assessment.
5. Document nursing action and/or intervention with outcome.
6. Notify patient care unit of any needed equipment
7. Include parent/legal guardian in care of patient as indicated.
8. Notify patient care unit when patient is ready for discharge from PACU.
9. Provide report of operation and PACU course including any unusual patient occurrences.

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**PROCEDURE**

C. Data collected and recorded to evaluate the patient's status for discharge:

1. Airway patent, respiratory function and oxygen saturation is charted.
2. Stability of vital signs, including temperature.
3. Level of consciousness and muscular strength.
4. Mobility of extremities.
5. Patency of tubes, catheters, drains, intravenous lines.
6. Skin color and condition.
7. Condition of dressing and/or surgical site.
8. Intake and output
9. Comfort level.
10. Anxiety level, if present, to what extent
11. Newborn-parent/significant others interactions

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