HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: IV-113 DOCUMENTATION OF NURSING ASSESSMENT AND VARIANCES	**POLICY #**: 1194 **VERSION:** 1
APPROVED BY: ASC Approvers	
DATE APPROVED: 06/28/2016	

PURPOSE: To establish guidelines for peri-operative nursing assessment documentation

POLICY: A licensed nurse will document peri-operative nursing assessment

PROCEDURE:

A. PRE-OPERATIVE CLINIC

1. The pre-operative clinic nurse initiates the initial pre-operative assessment of patients. Areas of focus during the assessment include but are not limited to:
   - vital signs
   - allergies
   - general health
   - significant medical history
   - age, sex
   - current diagnosis
   - scheduled surgical procedure
   - level of patient-education required
   - current medications being taken at home
   - pain management

2. During the pre-operative interview and assessment, the licensed nurse observes the patient and reviews the medical record to determine if any variations occurred in patient's status since last medical visit. These observations and findings are recorded in the appropriate section of the medical record.

3. Documentation of variations observed during pre-operative nursing assessment includes:
   - Blood pressure, Pulse and Respiration
   - Laboratory, X-ray, EKG results
   - Acute medical condition
   - Psychological readiness
   - Other significant diagnostic findings
   - Pain management

4. The licensed nurse reports observations and findings to the surgeon and anesthesiologist for evaluation and follow up.

5. Nursing entry in the medical record includes a description of the variance found, the course of action taken by the nurse and any prescribed medical intervention.

6. When appropriate, notification of variation in patient's status is made to the registered nurse in the Peri-operative Holding Area (POHA) and the ASC Nursing Director or designee to ensure continued monitoring and evaluation throughout the peri-operative process.

B. PERI-OPERATIVE HOLDING AREA (POHA)

1. Upon admission to POHA the patient will have a pre-operative assessment done. This will include a review of the chart, verification of surgical site, pain, determination of physical, spiritual and psychosocial well-being. Vital signs will be taken, including 02 Sat. Confirmation of diagnostic test completion and reinforcement of any previous teaching received.

2. Assessment will be recorded on the Nursing Admission Assessment sheet. Upon completion of the pre-operative assessment, any variation from normal lab/Xray/EKG values psychosocial or physiological status will be reported to the anesthesiologist, the surgeon, and the peri-operative nursing supervisor or designee. The peri-operative nurse will complete prescribed interventions. The nurse, if patient remains in the POHA, will initiate medical/nursing intervention, observe patient's response and document patient's response to intervention on medical record.

3. Upon return to POHA from the PACU or OR, an assessment is completed and documented in the medical record. The nurse will implement all prescribed interventions and record these with outcomes in the medical record. Any variances from expected norms will be conveyed to the surgeon and/or Anesthesiologist as needed with documentation in the medical record.

C. INTRA-OPERATIVE AREA (OPERATING ROOM)

1. Upon entry to the Operating Room the patient will have an assessment done. This will include a review of the chart, verification of surgical site, pain and surgical consent. Confirmation of diagnostic test and reinforcement of any previous teaching received. Any variance will be reported to Anesthesia and the Surgeons.

2. The patient's record will reflect the assessment performed by the Operating Room Circulating Nurse, who collects data about the patient's status assessment, and is ongoing in accordance with the AORN Standards of Intra-Operative Care.

3. The RN circulator will implement all prescribed interventions and record these along with the patient's outcomes in the medical record.

D. POST -OPERATIVE (POST ANESTHESIA CARE UNIT) (PACU)

1. The patient's record will reflect the assessment performed by the post anesthesia care nurse, who collects data about the patient's status assessment, and is ongoing in accordance with the ASP AN Standards of Phase I recovery.

2. The patient record will reflect nursing interventions. Documentation of nursing interventions promotes continuity of care and improves communications among personnel.

3. The patient's record will reflect continual evaluation of the post anesthesia nursing care and the patient's response to nursing interventions.

4. Post anesthesia documentation will include:
    a) Identification of person(s) responsible for providing care: Name, title and signature.
    b) Vital signs done every five minutes (BP, P, RR, Sp02)

c) Neurovascular: peripheral pulses and sensation of extremity (ies) as indicated

d) Condition of dressings, including amount and type of drainage, if any

e) Muscular response and strength as indicated

f) Fluid therapy, location of lines, condition of IV site and amount of solution infusing

g) Numerical score every 15 minutes, using Aldrete scoring system.

h) Documentation of pain assessment every 15 minutes or as necessary using appropriate pain tool for age

i) Time of discharge, disposition of patient, method of transfer and patient status

REFERENCE:

ANA; AORN Standards, 2008; ASP AN Standards, 2007

Ambulatory Surgery Principles and Practices, 2002

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