#33 - PROVIDING POSTOPERATIVE CARE (Partner Check-Off)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: ______________________________ **Date:** ____________________

Talk Through Skill. May look at Skill Sheet as needed while testing	P1	P2	P3	Comments
1. Checked PACU orders.				
2. Performed hand hygiene, and provided for the patient's privacy.				
3. Introduced self to the patient and family.				
4. Phase 2: Convalescent period: a. Made a final check of the equipment setup and supplies in the patient's room, including an emesis basin and waterproof pads. Made sure the bed was in the high position, level with the stretcher, and that the wheels were locked. b. On arriving at the patient's room, introduced self to the patient and assisted the PACU staff in using a three-person carry or slide board to transfer the patient to the bed. c. Once the patient had been transferred to the bed, immediately attached any oxygen tubing, hung IV fluids, checked the IV flow rate, checked NG tube placement and attached suction, and placed an indwelling catheter in the drainage position. d. Conducted a complete assessment of all vital signs. Compared findings with the vital signs in the recovery area and with the patient's baseline values. Continued monitoring the patient as ordered and as the patient's condition warranted. e. Checked the medical records to see if the patient received pain medication in the PACU. Asked the patient to rate the severity of his or her pain. f. Encouraged the patient to cough, deep breaths, and continue performing leg exercises every 1 to 2 hours. If the patient was unable or unwilling to do them, performed passive range-of-motion exercises with the patient. g. Made sure the patient's surgical dressing was intact, and noted the presence and character of the drainage. Reinforced the dressing as ordered. If no dressing was present, inspected the wound. h. Assessed the patient for bladder distention if the patient did not have an indwelling catheter. Offered the bedpan or urinal if the patient had an urge to void. i. Positioned the patient on his or her side if allowed. If the patient remained sleepy or lethargic, kept the patient's head extended to maintain a patent airway. j. Measured and recorded all sources of fluid I&O. k. Positioned the patient comfortably, maintained his or her airway and correct body alignment. Avoided positioning patient on the surgical wound site. l. When ordered, applied elastic stockings or pneumatic compression cuffs and attach them to the compressor. Explained that the				

compression cuffs would inflate and deflate intermittently.

m. Told the patient when observations were complete, and let the patient know they would ask his or her family members or significant other to come into the room. Placed the bed in the lowest position, placed the call light within reach, and raised the side rails as appropriate.
n. Explained the patient's general status to the family and/or significant other. Described the purpose of any equipment in the room, and explained the reason for frequent observations and procedures.
o. Gave the family simple tasks to perform, such as wiping the patient's face with a washcloth and coached the patient as he or she performed postoperative exercises.
p. Referred to the PACU record to determine if pain medication was administered. Asked the patient to rate the severity of his or her pain. Administered an analgesic if the patient's vital signs remained stable, or initiated PCA if ordered.
q. Provided oral hygiene, and repeated as needed.

5. As the patient stabilized, performed the following measures:

   a. Monitored bowel sounds per protocol, and asked the patient if he or she had passed flatus.
   b. Promoted a normal voiding pattern. Assessed the patient's bladder volume with a bladder scanner, if necessary.
   c. Had the patient participate in postoperative exercises.
   d. Encouraged the use of an incentive spirometer if ordered. Watched the patient use the spirometer the first few times to judge the efficacy of the patient's breathing pattern. Charted the level the patient achieves.
   e. Closely monitored the progress of the patient's wound healing, and changed the dressings as ordered.
   f. Monitored and maintained wound drainage devices, such as Jackson-Pratt, Hemovac, and Penrose drains:
      i. Emptied Jackson-Pratt or Hemovac drainage system when it was half full of drainage or air. Recharged or compressed it.
      ii. Monitored the color, consistency, and amount of drainage every 4 to 8 hours. Compared this amount to any previous assessment.
   g. Began activity orders. Assessed the patient's vital signs the first time the patient sat or stood.
   h. Began dietary orders slowly, according to the patient's tolerance. Medicated with an antiemetic when the patient was nauseated. Gave an analgesic with an antiemetic until the patient was eating well.
   i. Gradually increased the patient's involvement in decision-making, and increased explanations of the surgery and related implications.
   j. Taught the patient and family to be alert for signs of complications. Emphasized the need for nutrition for wound healing, and taught techniques of wound care if needed.
   k. Discussed discharge plans with the patient and family or significant other.
   l. Prepared to make a referral for home care or convalescent care as the patient's condition dictates. Obtained an order from the physician

6. Placed the call light and PCA button, if ordered, within easy reach, and made sure the patient knew how to use it to summon assistance.

7. Ensured the patient's safety and comfort.				
8. Removed and disposed of gloves, if used. Performed hand hygiene.				
9. Documented and reported the patient's response and expected or unexpected outcomes.				

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed *=Must Perform to Pass

By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.

Practice 1: Evaluator:_______________________________ Signature:_______________________________

Practice 2: Evaluator:_______________________________ Signature:_______________________________

FINAL Student Evaluator:______________________________ Signature:______________________________

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