Augusta Health
Registered Nurse
Professional Development Program

Roadmap Supporting Documentation Template

****One Category per Sheet****

- ☐ Transformational Leadership
- ☐ Structural Empowerment
- ☐ Exemplary Professional Practice
- ☐ **New Knowledge, Innovation, & Improvements**

Description/Details of Activity:

- **Education for Interventional Radiology Staff on PAT Computer Documentation**
- **SSP Unplanned Hypothermia**
- **Pain Scripting for Preoperative Cholecystectomy Patients**
- **Policy Review and Updates**
- **Antibiotic Chart Audits for OR**
- **Moderate Sedation Audit**

Dates of Meetings/Involvement:

- **See AH NPDP Supporting Documentation Log for evidence of dates**

Clinician Signature: Charlotte Naider Date 10/18/21

Supporting Signature: Emily Wyant, RN Date: 10/18/21

(Must be someone in leadership role or in attendance at the activity/event to verify your involvement)

Augusta Health
Registered Nurse
Professional Development Program

Supporting Documentation Log

****One Category per Sheet****

- ☐ Transformational Leaders
- ☐ Structural Empowerment
- ☐ Exemplary Professional Practice
- ☐ **New Knowledge, Innovation, & Improvements**

Date	***Time (Total Hours)***	***Activity or Event Name***	***Name of student / new team member***	***Activity description / Topics discussed***	***Validation Signature**** *(see pg. 2)*
May 11, 2021	6.5 hours	PAT documentation education for Interventional Radiology Staff		Computer documentation related to pre-procedural phone calls for staff making phone calls to IR patients before procedure	
September, 2021	1 CE credit hour	Unplanned Hypothermia SSP		Review for OPS/PACU staff of what hypothermia is, complications that can arise, etc.	
April, 2021		Pain Scripting for preoperative Cholecystectomy patients		PI project to determine if patients become more involved in their pain management if they are provided with pain education before surgery	
July, 2021		Policy Review and Updates		Review of OPS/PACU policies and updated as needed	
October, 2020-October, 2021		Antibiotic Chart Audits for OR		Review of 10 charts per month to determine if antibiotics are being given in a timely fashion	

October, 2020-current time		Moderate Sedation Audit			

Clinician Name: Charlotte Maiden Date: 10/22/21

Clinician Signature: Charlotte Maiden Date: 10/22/21

VALIDATION SIGNATURE PAGE

New Knowledge, Innovation, Improvements

**Validation signatures must be someone in leadership role or in attendance at the activity/event to verify your involvement in the stated hours on the Supporting Documentation Log*

Activity / Event Name: **PAT education for IR Staff** **Date: 5/11/21**

Validation Signature: Emily Wyant, RN Date: 10/18/21

Activity / Event Name: **Unplanned Hypothermia SSP** **Date: 9/21**

Validation Signature: BC Date: 10/22/21

Activity / Event Name: **Pain Scripting** **Date: 4/21**

Validation Signature: BC Date: 10/22/21

Activity / Event Name: **Policy Review/Updates** **Date: 7/21**

Validation Signature: BC Date: 10/22/21

Activity / Event Name: **OR Antibiotic Audit** **Date: 10/20-10/21**

Validation Signature: BC Date: 10/22/21

Activity / Event Name: **Moderate Sedation Audits** **Date: 10/20-10/21**

Validation Signature: BC Date: 10/22/21

Each activity from log on pg. 1 should have a corresponding signature for validation

Interventional Radiology Nursing Algorithm

PAT CALL

	Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
	Insert/Manage Urinary Device		D	OR	prn				
	Emergency/Chg Pt Condition/Status		D	OR	prn				
✔	IR: Pre-Admission Testing		D	OR	PAT				
	IR: Arrival		D	OR	Arrival				
	IR: Physical		D	OR	Arrival				
	IR: Teaching		D	OR	prn				
	IR: Transfer of Care		D	OR	prn				
	IR: Interdisciplinary Communication		D	OR	prn				
	IR: MD/Provider Communication		D	OR	prn				
	IR: Vital Signs/Pain/Rounds		D	OR	prn				
	IR: Pre-Procedure Checklist		D	OR	Arrival				
	IR: Intake and Output		D	OR	prn				
	COVID Screening		D	OR	Arrival				
	IV/Invasive Line Assessment IVSS		D	OR	09,21	2 days			
	IR: Discharge Instructions		D	OR					

PAT Call Intervention Contents:

Contact & Arrival section, Height & Pt Stated Weight section, Past Medical History section, Infection Disease History, COVID Vaccine Status, Anesthesia Evaluation, Home Meds/Allergies section, Procedure Instructions section, and COVID Testing Instructions section.

***Ensure that medication reconciliation completed in ORM**

DAY OF PROCEDURE

PRE-OP ASSESMENT CHECK- IN

	Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
	Insert/Manage Urinary Device		D	OR	prn				
	Emergency/Chg Pt Condition/Status		D	OR	prn				
	IR: Pre-Admission Testing		D	OR	PAT				
✔	IR: Arrival		D	OR	Arrival				
✔	IR: Physical		D	OR	Arrival				
	IR: Teaching		D	OR	prn				
	IR: Transfer of Care		D	OR	prn				
	IR: Interdisciplinary Communication		D	OR	prn				
	IR: MD/Provider Communication		D	OR	prn				
✔	IR: Vital Signs/Pain/Rounds		D	OR	prn				
✔	IR: Pre-Procedure Checklist		D	OR	Arrival				
	IR: Intake and Output		D	OR	prn				
✔	COVID Screening		D	OR	Arrival				
✔	IV/Invasive Line Assessment IVSS		D	OR	09,21	2 days			
✔	IR: Discharge Instructions		D	OR					

PRE-OP Assessment Check-In Intervention's Contents:

Arrival:
Weight section, Allergies section, Dietary section, Pregnancy Status section, Psychosocial section, General Information section, Infectious Disease section, and Family Notifications section.

Physical:
Physical Assessment section, Lung Assessment section, and Pulse section

Vital Signs

Pre-Procedure Checklist:
Pre-Operative Checklist section, and Personal Items/Info section

COVID Screening

IV/Invasive Line Assessment IVSS

Discharge Instructions:
Discharge Criteria & Disposition section, Follow Up Care section, Medication section, and Response to Instructions section

1) Patient Identification (patient states full name & DOB; RN verifies with armband & consent)
2) Consent (*full* procedure, laterality, signatures, dates, *and* times)
3) H&P within 30 days, or H&P Update within 24 hours
4) Allergies
5) Implants
6) Skin assessment
7) H&P assessment (complete heart & lung exam)
8) IV access (obtained during pre-op check-in)
9) Antibiotics (if applicable)
10) Complete *Pre-Sedation Assessment Checklist*

Heart Rhythm/Sound:
Resp Sounds:
Resp Sounds Location:

Teeth Intact	YES	NO
Mouth Opening at least 3 fingerbreadths	YES	NO
Cervical Spine (flexion and extension)	YES	NO
Thyromental Distance at least 3 fingerbreadths	YES	NO

Does the patient use O2 or CPAP at home? [ ] Yes [ ] No
Has the patient had any previous reaction to a sedative or anesthetic? [ ] Yes [ ] No
Pupil dilating sponge removed? [ ] Yes [ ] No [ ] N/A

Comment: _____

Sedation RN: _____ Date: _____ Time: _____

Mallampati Class
Class I [ ]
Class II [ ]
Class III [ ]
Class IV [ ]

Physician Signature: _____ Date: _____ Time: _____

*If patient is a Mallampati Class III or IV, anesthesia must be consulted prior to surgery start
*Adult patients classified as an *unstable* ASA 3 or greater require sedation to be evaluated or delivered by an anesthesia provider

INTRAOPERATIVE

Procedural Safety Checklist Part 1

(To be completed immediately upon patient arrival to procedural room)

1 Before induction of anesthesia or sedation

- ☐ **Patient has confirmed:**
  - Identity
  - Site
  - Procedure
  - Consent
- ☐ **Site marked/not applicable**
- ☐ **Anesthesia safety check completed**
- ☐ **Pulse ox on patient and functional**

Does patient have a

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway/aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500 ML blood loss (7ML/KG in children)?
- ☐ No
- ☐ Yes, and adequate IV access and fluids planned

*Staff introductions performed
*Patient transferred to procedure table, positioned appropriately, and offered warm blankets
*Monitoring equipment applied (B/P set to q5 minutes, critical alarms on, pulse waveform audible)
*Monitoring RN to remain at patients head, vital signs within view, for remainder of procedure
*Monitoring RN to administer sedation medications, titrated to desired level of sedation

Procedural Safety Checklist Part 2

(To be completed immediately prior to incision)

2 Just prior to procedure starting in the procedure room

- ☐ **Confirm all team members are silent and participating in the timeout.**
  Any team member should stop the procedure to ensure the proper time-out is conducted.

Surgeon, anesthesiologist, and nurse verbally confirm:
- ☐ Consent signed and dated
- ☐ Correct patient
- ☐ Correct site
- ☐ Correct procedure
- ☐ Agreement on procedure to be done
- ☐ Availability of special equipment, implants, or special requirements to complete the procedure (if applicable)
- ☐ Correct position (if applicable)

Anticipated Critical Events
- ☐ **Surgeon reviews:** What are the critical steps, operative duration, anticipated blood loss?
- ☐ **Anesthesia team reviews:** Are there any patient-specific concerns?
- ☐ **Surgical team reviews:** Has sterility (including indicator results) been confirmed? Are there equipment issues or any concerns?

Has antibiotic prophylaxis been given in the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

*Provider initiated
*SPEAK UP FOR SAFETY! If all staff are not in agreeance, hard stop until concerns are resolved
*Monitoring RN to assess patient's status throughout procedure entirety, titrating medications to desired level of sedation

Procedural Safety Checklist Part 3

(To be completed immediately upon procedure completion)

3 Before patient leaves the procedure room

Nurse verbally confirms with the team:
- ☐ The name of the procedure recorded
- ☐ That instrument, sponge, and needle counts are correct (or not applicable)
- ☐ How the specimen is labeled (including patient name)
- ☐ Whether there are any equipment problems to be addressed

- ☐ **Surgeon, anesthesiologist, and nurse review the key concerns for recovery and management of this patient**

*Monitoring RN to remain with patient for the entirety of designated recovery period
*If transfer to a recovery unit available, monitoring RN will transfer patient to unit, and provide handoff report to RN

Interventional Radiology Observations/Recommendations

- After shadowing during a procedure, it was clear that there are a number of process issues that can be improved on
- I was given a copy of all of the paperwork, which after reviewing, is exactly the same as it was when I floated to IR about 10 years ago—***need an updated computerized documenting process***
- More complicated procedures have to be approved by Dr. Hidlay before scheduling—***what does that mean***?
- Pre-procedure process is to obtain a consent, labs, office note, orders, and phone assessment. ***Similar to PAT, but does not feel as comprehensive***
- Prior to phone assessment, the nurse I shadowed acknowledged that she looks a patient up in our system to get background health information. ***I asked if they had access to Athena, EPIC?***
- Lab results have to be within 30 days? All patients getting a biopsy have to have a PT, INR. ***Should this time frame be less than 30 days?***
- COVID testing is done for procedures involving Lung and GI tract and then they are not tested again. All patients have to be 4 weeks post vaccine for all vaccines. ***Prior to any surgical procedure our policy is that a patient will not be retested if their negative test is within 4 days or 7 days is inpatient.***
- Often get phone calls to schedule COVID testing, but patients are not preregistered as surgical patients are so this is not an option. ***Should that change?***
- Nothing is documented in the computer—everything is on paper—***needs to across the board accessible to post operative areas to ensure optimal patient care if given***
- ***How far in advance are patients called? Is there a list of medications to discontinue or hold?***
- ***Do they require a pregnancy test day of procedure***?

1. The procedure I was to observe was a liver biopsy. The room was already set up when I arrived

2. Staff was in the room with the patient when I arrived. Only conversation that I observed was between the tech and the patient. The nurse was not involved as far as I could tell

3. Dr. Hidlay came in and was very thorough with his explanation and obtained consent

4. IV started and patient was placed on monitor and initial vital signs obtained. Oxygen placed/CO2 monitoring tubing applied

5. IV sedation given and continuous monitoring in place. ***Medication did not seem to be titrated to individual patient—are they giving what is ordered automatically? Do the rooms all have suction? Where is emergency equipment kept?***

- ***Need order sets in the computer for pre and post procedure care*—this will carry forward when and if a patient is recovered either in OPS or if sent back to the inpatient unit. How is a patient recovered if inpatient?**

- ***Need assessment/check lists in computer*—Need a checklist similar to what is used in preoperative area to make sure all necessary information is already in place, such as H&P, consent, etc.**

- ***Does the H&P have to be within 30 days as with surgical patients? Is there a H&P update needed? Is an immediate post procedure note needed?***

- How are medication dosages decided on? Is it the same for all patients? MD has never met the patient most often. ***Meds should be scanned and documented in computer.***

- Nurses need to be more involved once in the room with patients. It seems that their only job is to document and give sedation doses. The tech appears to do most all of the conversing with patient.

- After looking at the existing pre-procedural assessment form I would recommend that it be expanded to include more information and be in the computer to include a pre-procedure instruction sheet to include NPO status, medications to hold, where to come to, arrival time, etc. ***Nurse shadowed also indicated that she would explain procedure and answer questions if it was something she was familiar with as she only worked a couple of days a week. Patients***

need thorough explanation of process, procedure and what to expect after the procedure.

- They are using a "older" version of a "hospital form" for when to stop blood thinners. "Dr. Hidlay is responsible for the time frame"—***where did it come from and when was it updated?—it should be standardized across the board for all patients no matter what procedure they are having and not rely on Dr Hidlay to determine time frame.***
- What are red flags for postponing or cancelling procedures?
- Are all protocols the responsibility of Dr. Hidlay?
- Are the nurses required to have conscious sedation education?

Augusta HEALTH

EDUCATIONAL PROGRAM ATTENDANCE ROSTER

Course Title: Interventional Radiology (IR) Process Flow / ORM Review

Date: 5/11/21 **Length:** 6.5 hrs **Time:** 0930 - 1400 **No. Sessions:** 1 of 1

Location: Mannix Conference Room **Presenter and Department:** Emily Wyant or Charlotte maiden

Employee ID #	Printed Name (Write Clearly)	Signature	Title	Department	Other (Specify)
18663	Makenna Eppard	Makenna Eppard	RN	IR	
5296	Heather Carter	Heather Carter	RN	IR	
324	Cindy Higgs	Cindy Higgs	RN	IR	
19020	Paul Smith	Paul Smith	RT(R)	IR	
18951	Lauren St. Mary	Lauren St. Mary	RTR VI	IR	
01764	Jennifer Critzer	Jennifer Critzer	RTR	IR	
08965	Faith Huff	Faith Huff	RN	IR	
15738	Alison Simmons	Alison Simmons	RN	IR	
00745	Dale Booth	Britta Dale Booth	RTR	IR	
12555	Lori Nelson	Lori Nelson	RTR	IR	
05539	Catherine Elder	Catherine Elder	RN	IR	
17668	Dawn Wilcox	D. Wilcox	RN	IR	
3963	Karen Best	Karen Best	RN	IR	

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Employee ID #	Printed Name (Write Clearly)	Signature	Title	Department	Other (Specify)
00584	MATTHEW PAINTER		NP	IR	

Unplanned Hypothermia

Charlotte Maiden, MSN, RN, CPAN, CAPA,
Clinician 4

Surgical Services

September, 2021

Synopsis of Unplanned Hypothermia SSP:

- Core body temperature less than 36 degrees Celsius.
- One of most common complications of surgery.
- Even mild cases increase incidence of SSI and adverse cardiac events.
- For every 2 degree drop in temperature blood loss increases by 500 ml.
- Anesthesia depresses the thermoregulatory center/unable to compensate for temperature changes
- Influenced by cold surgical environments, removal of clothes, draping, evaporation of skin preps, open cavity surgery.
- Prevention, early detection, treatment are high priorities.
- Management is through all phases of perioperative experience/simple measures started early can help prevent this complication
- Identify risk factors, assess temperature, active skin warming, keep patient covered, prevent wet surgical drapes, warm fluids.
- 4 physical processes of heat exchange—conduction, convection, radiation, evaporation
- Radiation and convection result in 85% of heat loss during perioperative period.
- Levels of hypothermia range from light to profound. Light is body temperature 32-37 degrees Celsius, Moderate, 26-32 degrees, Deep, 20-26 degrees, Profound, 20 degrees.
- Any level of hypothermia can cause serious problems.
- Increased blood loss, longer post anesthetic recovery, shivering, increased risk of infection, longer hospital stays.
- Shivering initiated by hypothermia increases oxygen consumption by 400-500%, increases overall myocardial work, increases incisional pain.
- Can cause prolonged elimination of muscle relaxants.
- May alter normal clotting mechanisms.
- Hyperventilation is the initial response to hypothermia, then hypoventilation, irregular breathing patterns leading to hypoxia and lactic acidosis.

Pediatric Risks:

- Increased risk of hypothermia due to ratio of body surface to body mass.
- Can occur quickly in children 2 years or younger due to lack of insulating subcutaneous fat and larger body surface compared to muscle mass.
- Infants less than 6 months have not developed involuntary shivering mechanisms that helps restore body temperature.

Geriatric Risks:

- Typically have a lower core temperature.
- Predisposed to hypothermia due to decreased muscle mass and subcutaneous fat layer.
- Arthritis, diabetic neuropathies, cardiac disorders, arteriosclerosis inhibit thermoregulation increases risk of unplanned hypothermia.

Potential Complications:

- Liver and kidney function are susceptible.
- Slowed blood flow interferes with liver and pancreas activities increasing risk for drug accumulation.

Cardiac Problems:

- Hypertension, bradycardia, PVC's
- Unstable angina, increased chance of MI.
- Cardiac arrest.
- 30 degrees Celsius a 30% decrease in cardiac output occurs.
- Below 30 degrees produces atrial fib/flutter.
- Below 20 degrees produces V Tach and V fib.
- Below 15 degrees produces Asystole.

Nursing Management:

- Develop a plan of care preoperatively to minimize risk of unplanned hypothermia.

Nursing Interventions:

- In the preoperative phase monitor baseline temperature, assess risk factors, and begin warming measures.
- In the intraoperative phase institute/continue warming measures, monitor core temperature, and humidify and warm anesthetic gases.
- In the postoperative phase initiate oxygen on admission, monitor temperature, remove wet garments and apply warm, dry gowns and blankets, watch for signs of hypothermia such as shivering or delayed recovery time, continue to utilize warming methods, and do not discharge until temperature is within normal range.

Warming:

- Consider pre-warming for a minimum of 15 minutes immediately prior to induction for patients at risk.
- Prior to induction and/or regional anesthesia warm the skin and peripheral tissues which prevents redistribution hypothermia.
- 15 minutes of pre-warming and intraoperative forced-air warming results in a higher core body temperature when compared to the use of warm cotton blankets.

Summary:

- Many methods to prevent and treat hypothermia—all have advantages and disadvantages.
- Passive methods: warm cotton blankets, thermal blankets, or head/extremity covering.
- Active warming methods: forced air warming, circulating water garments, energy transfer pads, and overhead heaters.

This information was obtained from Health Stream.

Charlotte Maiden, MSN, RN, CAPA, CPAN, Clinician IV

September, 2021

Surgical Services

Maiden, Charlotte

From: DeMonico, Christine
Sent: Sunday, October 3, 2021 2:13 AM
To: Maiden, Charlotte
Subject: RE: presentation for clinical ladder

All done!

From: Maiden, Charlotte
Sent: Monday, September 27, 2021 9:55 AM
To: OPS/PACU
Subject: presentation for clinical ladder

Please read this and acknowledge when you have completed it. This is for clinical ladder and I had planned on presenting at the staff meeting, but it is being moved. Thank you in advance.

Charlotte D. Maiden, MSN, RN,
CPAN, CAPA, Clinician 4
OPS/PACU/PAT

Augusta Health

Office: 540-245-7873 | Mobile: 540-649-2462

augustahealth.com

Maiden, Charlotte

From: Jones, Sue
Sent: Thursday, September 30, 2021 7:29 AM
To: Maiden, Charlotte
Subject: RE: presentation for clinical ladder

Completed.....thanks

From: Maiden, Charlotte
Sent: Monday, September 27, 2021 9:55 AM
To: OPS/PACU
Subject: presentation for clinical ladder

Please read this and acknowledge when you have completed it. This is for clinical ladder and I had planned on presenting at the staff meeting, but it is being moved. Thank you in advance.

Charlotte D. Maiden, MSN, RN,
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OPS/PACU/PAT

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Maiden, Charlotte

From: Shenk, Sharon
Sent: Wednesday, September 29, 2021 2:40 PM
To: Maiden, Charlotte
Subject: RE: presentation for clinical ladder

Thanks Charlotte. I completed this today.

From: Maiden, Charlotte
Sent: Monday, September 27, 2021 9:55 AM
To: OPS/PACU
Subject: presentation for clinical ladder

Please read this and acknowledge when you have completed it. This is for clinical ladder and I had planned on presenting at the staff meeting, but it is being moved. Thank you in advance.

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Maiden, Charlotte

From: Taetzsch, Shannon
Sent: Wednesday, September 29, 2021 9:51 AM
To: Maiden, Charlotte
Subject: RE: presentation for clinical ladder

Done

From: Maiden, Charlotte
Sent: Monday, September 27, 2021 9:55 AM
To: OPS/PACU
Subject: presentation for clinical ladder

Please read this and acknowledge when you have completed it. This is for clinical ladder and I had planned on presenting at the staff meeting, but it is being moved. Thank you in advance.

Charlotte D. Maiden, MSN, RN,
CPAN, CAPA, Clinician 4
OPS/PACU/PAT

Augusta Health

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NPDP Project Submission Form

- ☐ Quality or Performance Improvement (PI)
- ☐ **Evidence Based Practice (EBP)**
- ☐ Care Delivery Innovation

NPDP projects requires initial meeting with Unit Director to discuss project that adds value to the unit or hospital.
Unit based projects are approved by Director, Hospital based projects are approved by the CNO.
Project must be completed and presented to staff in person before NPDP submission date.

Title:	**Pain Scripting for the Preoperative Cholecystectomy Patient**
Submitted By/Clinician Level:	**Charlotte Maiden, MSN, RN, CAPA,CPAN, Clinician 4**
Team Members:	Members of the OPS/PACU Unit Council and Brooke Campbell were involved in reviewing and approving final product.
Purpose and Rationale:	EBP supports the need for patients to better understand that pain is a part of the surgical experience and by teaching them about it they may develop more realistic expectations. Research has shown that a patient will be more involved in their pain management if they are provided with education prior to surgery. We want to have a mutual agreement with the patient to establish a goal for controlling pain at a tolerable level.
Practice Change Anticipated:	Education process starts in the preoperative period. Questions will be presented to the patient to include history of chronic pain, pain medication on a regular basis and what, what is considered a tolerable level of pain based on AH pain scale, education from surgeon about what to expect, are they anticipating having pain and what their expectations are of the amount of pain they will have. Staff in Phase 2 will round on these patients after surgery to determine if the patient felt the education received was of value to them.
Implementation Strategies:	Will start process once unit is more settled from COVID surge. Staff has been educated/re-education will take place prior to roll out.
Evaluation:	Rounding forms will be collected by myself and evaluated. Results presented to Unit Council/Brooke Campbell If successful plan is to add another type of surgical patient using this approach
If you've already done a literature review please attach this information. Include project timeline.	

Clinician Signature Charlotte Maiden Date 10/22/21

Director Approval/Signature BC Date 10/22/21

Revised 3/5/2021

PAIN SCRIPTING

Charlotte Maiden, MSN, RN, CPAN, CAPA
cmaiden@augustahealth.com

PICOT Question:

In the adult patient does the use of scripting with a purpose of educating about comfort goals compared to individualized educational teaching styles provide a patient with realistic perceptions of pain control during perioperative and recovery time?

Introduction/Evidence

Pain control has historically presented challenges for health care. Pain perception is different for each individual and needs to be addressed to meet that perception. A pointed, scripted education of the purpose of comfort goal should provide the patient with a realistic perception of pain control.

Evidence Based Change

- Best, Musgrave, et al showed that pain education is helpful in managing postoperative pain at a significant (P=0.03) level and structuring education improved patient knowledge. Education needs to fit patient needs, be presented consistently and include approaches to pain management.

Mavridou, Manataki, et al found 94.2% of patients wanting to know about about postoperative pain and 77.8% believing they would feel calmer if they had this education before surgery. Pain scales, as a measure of pain control and increasing patient involvement in control of their pain has led to evidence-based use of comfort goals. With scripted education about the purpose of comfort goals should provide a realistic perception of pain control.

Results/Recommendations:

1. Look at presenting this education initially to cholecystectomy patients preoperatively.
2. Overcome challenges to using scripting versus existing individual teaching styles and methods by providing education to staff.
3. Ensure that surveys are completed prior to discharge to be able to measure the impact of the education on the patient.
4. Determine using surveys if a patient's expectations of pain were realistic.

Conclusion/Future Directions:

Scripted education that includes pain management interventions can alter a patient's perception of pain control. Education preoperatively has been shown to have a positive impact on postoperative knowledge levels, ability to take a more active role in their own care, and overall satisfaction with their surgical experience.

References:

Best,J., Musgrave, B., Pratt, K., Hill,R., et al. (2018,August). The impact of scripted pain education on patient satisfaction in outpatient abdominal surgery patients. Journal of Perianesthesia Nursing, 33 (4), 453-460. https://doi.org/10.1016/j.jopan.2016.02.014.

Mavridou,P., Manataki, A., Arnaoutoglou, E., Damigos, D. (2017, October). A survey of patients' preoperative need for information about postoperative pain—Effect of previous surgery experience. Journal of Perianesthesia Nursing, 32 (5), 438-444. https://doi.org/10.1016/j.jopan.2015.06.008.

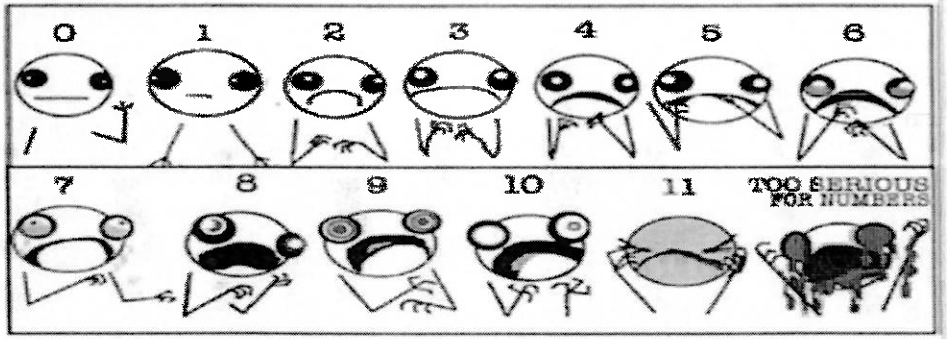
McLean, V. (2018, April 11). Implementation of a scripted education on comfort goals to improve patient perception of pain control. https://digitalcommons.liberty.edu/nurse grad proj schol/17.

Augusta HEALTH

Pain Scripting

Charlotte Maiden, MSN, RN, CAPA, CPAN
Clinician IV

A BETTER PAIN CHART



0: Hi. I am not experiencing any pain at all. I don't even know why I'm here.

1: I am completely unsure whether I am experiencing pain or itching, or maybe I just have a bad taste in my mouth.

2: I probably just need a Band Aid.

3: This is distressing. I don't want this to be happening to me at all.

4: My pain is not f_cking around.

5: Why is this happening to me??

6: Ow. Okay, my pain is super legit now.

7: I see Jesus coming for me and I'm scared.

8: I am experiencing a disturbing amount of pain. I might actually be dying. Please help.

9: I am almost definitely dying.

10: I am actively being mauled by a bear.

11: Blood is going to explode out of my face at any moment.

Too Serious For Numbers: You probably have ebola. It appears that you may also be suffering from Stigmata and/or pinkeye.

- The management of pain is an important part of the care that we provide our patients.
- By managing pain after surgery we can increase patient satisfaction and help to provide an optimal postoperative outcome.

Pain Scripting

- We know that pain is a part of every surgery.
- We can offer our surgical patients the education needed to help them realize that no matter how big or small, every surgery comes with a degree of pain.
- This education helps us to set expectations.

Pain Scripting

After introducing ourselves start by asking questions to establish:

- Do they have existing chronic pain?
- Do they take medication for their pain on a regular basis?
- If yes, what do they usually take?
- What do they consider to be a tolerable level of pain based on the pain scale used here at Augusta Health?

Pain Scripting

After introducing ourselves start by asking questions to establish:

- Did your surgeon talk about what to expect after surgery?
- Are they anticipating that they will have pain after surgery?
- What are their expectations of the amount of pain they might have based on pain scale

Pain Scripting

Review the pain scale:

- 0 is not pain at all
- 1-3 is mild pain
- 4-6 is moderate pain
- 7-10 is severe

Pain Scripting

- Ensure that we mutually agree and establish a goal for controlling pain at a tolerable level after surgery.

Pain Scripting

- Talk with them about what to expect after their cholecystectomy and why it occurs.
- Expect to experience pain in shoulder and chest.
- This occurs due to the gas used during surgery which pushes up against the diaphragm causing symptoms.
- Gas will absorb over next few days.

Pain Scripting

M/F	Age	DOS	Surgery	Pre-Op Education Yes/No	If yes, rate on 1-10 scale for value of education	What could have made it better?

Pain Scripting—Rounding Form

Policy/Procedure Title: Pre-Post OP Care when OPS is Closed		Hardcopy Manual Location:
Issued (Date): Revised (Date): 11/97, 10/03, 04/08, 8/11, 7/14, 8/7/17 Reviewed (Date): 10/00, 6/06, 12/10, 7/26/17		
Department (Name of Department): Surgical Services-PACU		
Department Director Approval (Name): Brooke Campbell	Date:	
Infection Control Coordinator/Pharmacy Approval (Name or N/A): N/A	Date:	
Administrative Director Approval (Name): Vickie Taylor	Date:	
Medical Director Approval (Name or N/A): N/A	Date:	
Chief Nursing Officer Approval (Name): Marvella Rea	Date:	

Policy:

Purpose of guideline is to provide direction for decision making in assigning the area to care for a post-op outpatient. Rationale for inclusion of all parties in decision:

1. Anesthesia - knows what level of anesthesia to be used. Can evaluate estimated recovery time necessary before discharge.

2. Surgeon - knows what level of surgery to be done. Can evaluate estimated recovery time necessary for pain control, follow-up care needed before discharge.

Procedure:

PRE-OPERATIVE:

- **Out Patients:**

  If patient is arriving from outside hospital, the PACU nurses on call will be called in to care for the patient pre-operatively. This process should be initiated by the OR charge nurse so that she can assign a PACU nurse to meet the patient at the OPS registration area. PACU nurses will notify bed center for them to register the patient. The PACU nurse(s) will prep the patient for OR. PACU recovers the patient phase 1 & phase 2, discharging the patient when criteria is met.

Post-Operatively:

- Out patients will be cared for by the PACU nurses on call for up to 4 hours post-op and/or post-PACU (phase 2 status)
- Patients requiring more than 4 hours of post-op and/or post-PACU care will be cared for on the Surgical Unit or unit assigned by the house supervisor.
- Anesthesia, surgeon and Operating Room charge nurse need to start decision process early as the need to call in PACU nurses in some cases exists and cannot be made appropriately during last few minutes of surgery.

Pre-Postoperative Care when Outpatient Surgery is Closed

Revision Date: 10/14/2021
PACU

1. Purpose

To provide guidelines to assist the perianesthesia nurse in understanding their role in providing care to a surgical patient both preoperatively and postoperatively when the outpatient department is closed.

2. Scope

PACU nurses

3. Definitions

4. Policy

To provide guidance for the perianesthesia nurse for the management of a patient arriving from outside of the facility when the preoperative and Phase 2 postoperative phases are not available, i.e. evenings and weekends.

5. Procedure: Preoperative

1. Care of any patient arriving from another facility or home will be responsibility of the on call PACU nurses on the weekend.
2. After being notified and arriving, the nurses will accept the care of the patient if they have arrived from home, from the ED, or another facility.
3. The bed center will be notified to get the patient registered as same day surgery if arriving from outside of Augusta Health.
4. Check in of a patient may also include patients from the ED and/or the floor if the OR staff is busy.
5. The patient will be prepared for the OR, i.e., start an IV as needed, obtain vital signs, determine if there is a surgical consent and that it has been completed correctly. Also determine if there is a history and physical that has been completed by the surgeon.

6. Procedure: Postoperative

1. Following a surgical procedure the patient will return to the PACU where they will be recovered after which time their status will be changed to Phase 2 recovery.
2. These patients will be recovered up to 4 hours as a Phase 1 and/or Phase 2 recovery patient and ultimately discharged home.
3. Nurses should notify the surgeon for patients requiring more than 4 hours of postoperative care, despite the level of care, so they can be admitted to the hospital for continued care.

7. References

- List references here

8. Revision Notes

Notes
[Date]: 10/14/2021

Policy/Procedure Title: Discharge Instruction Procedure		Hardcopy Manual Location:
Issued (Date): 6/13 Revised (Date): 11/16 Reviewed (Date):		
Department (Name of Department): Surgical Services - OPS		
Department Director Approval (Name): Brooke Campbell	Date:	
Infection Control Coordinator/Pharmacy Approval (Name or N/A): N/A	Date:	
Executive Director Approval (Name): Vickie Taylor	Date:	
Medical Director Approval (Name or N/A): N/A	Date:	
Department Vice President Approval (Name): Marvella Rea	Date:	

Policy

To establish a protocol for the RN to create patient specific discharge instructions for the patient upon discharge from out patient surgery.

Procedure

A. Ensure that criteria for discharge has been met. See Discharge Parameters Policy.

B. Using the CPOE or written orders, the RN will create discharge instructions using the electronic version in PCS and provide the patient with physician specific patient discharge instructions

C. The RN will print electronic discharge instructions

1. General discharge instructions will be chosen from the following list of instructions based on the type of anesthesia administered or the surgical procedure performed:

i. regarding diet :

a. advance slowly

b. return to normal soft foods

c. clear liquids

d. no alcohol today

e. no alcohol with pain meds

f. drink plenty of fluids

g. call for persistent nausea/vomiting

ii. regarding activity:

a. do not operate machinery or equipment

b. no rough play

c. no riding toys
d. no heavy lifting
e. no pushing, pulling

iii. regarding driving:
a. no driving today
b. no driving while taking pain meds

iv. regarding decision making:
a. no signing legal documents
b. no major decisions

v. for regional anesthesia:
a. provide peripheral nerve block specific instructions to provide information in the care and protection of extremities until sensation returns

2. Wound care will be transcribed from the surgeons post-op orders referring to the surgery specific instructions if applicable and will include instructions on when the patient may remove/change the dressing and when the patient may shower.
3. The nurse will be able to instruct the patient to call the surgeon for following abnormal post-op findings or changes to the operative site after discharge:
a. chills
b. fever >100.5
c. excessive bleeding
d. grossly bloody urine
e. nausea and vomiting for over 8 hours
f. severe pain
g. abnormal skil color
h. extreme coolness
i. large amout of swelling
j. new onset numbness
k. new onset tingling
l. pus-like drainage
m. redness

4. The RN will also provide the patient with the date, time and provider for the post-op appointment at the surgeons office.
5. The RN will document on the instruction sheet if prescriptions were given to the patient and the time of the last medication given in OPS so that the patient can time subsequent doses at home.

Discharge Parameters/Instruction Procedure

Revision Date: 10/14/2021
OPS/PACU

1. Purpose

To establish parameters for discharge criteria that the postoperative patient must exhibit prior to being considered ready for discharge home.

To establish protocols used by the perianesthesia nurse to create specific discharge instructions to be presented to postoperative patients prior to discharge.

2. Scope

Phase 1 and Phase 2 perianesthesia nurses.

3. Definitions

- List any definitions here. This section is intended for clarifying terms that may have multiple interpretations; not spelling out abbreviations.

4. Policy

Parameters and protocols established will be used by the perianesthesia nurse to ensure that every postoperative patient is safely discharged from OPS and have received appropriate instructions for use at home following surgery.

5. Procedure

1. Ensure that respiratory function, vital signs, level of consciousness, muscle strength at preoperative baseline. Blood pressure with 20 mm Hg, effective cough, grips, moving all extremities, alert and oriented, or as on admission.
2. Patient must be able to ambulate consistent with age, surgical procedure or at their preoperative baseline.
3. Patient demonstrates ability to swallow/retain oral fluids.
4. Adequate pain control is documented by pain scale or return to preoperative baseline.
5. Surgical/procedural site and/or dressing dry and intact.
6. Skin color/condition warm and dry or as on admission.
7. Neurovascular status of operative extremity appropriate with capillary refill less than 3 seconds.
8. Patient and/or responsible party will be presented with a hard copy of verbal discharge instructions and be able to verbalize understanding said instructions.
9. All patients receiving analgesia and/or sedation must have safe transportation home.
10. Patients that have received spinal anesthesia are required to meet criteria for discharge to include motor, sensation, and strength in lower extremities.

11. Voiding prior to discharge are dependent on parameters established in the "voiding upon discharge policy" and/or surgeon discretion.
12. Colonoscopy/EGD patients must meet general discharge criteria. Colonoscopy patients should present with soft abdomens, minimal pain, and passing flatus freely.
13. Patient will be given additional resources to contact as needed.
14. Using CPOE and/or written orders, physician specific instructions will be created using electronic version in PCS. Patient and/or responsible party will be presented with a hard copy of verbal discharge instructions and be able to verbalize understanding of said instructions.
15. General discharge instructions will include diet, activity, driving, and decision making. If a patient has received a regional anesthesia they will be presented with specific peripheral nerve block instructions regarding care and protections of extremities.
16. Wound care will be per physician specific instructions, i.e., changing/removing dressing, showering, etc.
17. The patient will receive specific instructions on when to call the surgeon based on abnormal postoperative findings and/or changes to the operative site.
18. The patient will be provided with follow-up appointment date and time. If patient arrives after the surgeon's office is closed, patients will be instructed to call the next day the office reopens to schedule appointment.
19. Prescriptions given will be documented in the instructions as well as the time of last medication given prior to discharge home.

6. Related Policies and Documents

- List Related Document or Policies here

7. References

- List references here

8. Revision Notes

Notes
[Date]: 10/14/2021

Policy/Procedure Title: Use of IvNow Fluid Warmer		Hardcopy Manual Location:
Issued (Date): 7/15 Revised (Date): 8/12/18 Reviewed (Date):		
Department (Name of Department): Surgical Services-OPS		
Department Director Approval (Name): Brooke Campbell	Date:	
Assistant CNO Approval (Name): Vickie Taylor	Date:	
Vice President & CNO Approval (Name): Crystal Farmer	Date:	

Purpose

Use of the IvNow Fluid Warmer to provide fluids with consistent temperatures to the surgical patient.

Policy:

ASPAN Evidence-Based Clinical Practice guideline for the promotion of perioperative normothermia.

Rationale: To ensure that Perianesthesia nursing staff recognizes and understands the benefits of the use of warm fluid in the surgical patient. To establish guidelines for the use of the IvNow Fluid Warmer in the promotion of normothermia.

Persons/Departments Covered by this Policy:

Perioperative, Phase 2 (Postoperative), and Phase 1 PACU Nursing Staff.

Procedures:

In the preoperative phase, patients requiring surgery or special procedures will receive warm IV fluids when PIV is started day of surgery.

Preoperative nursing staff will pull warm fluid from the IvNow Fluid Warmer system and charge the patient in Omnicell.

Nursing staff will understand that the IvNow Fluid warmer will consistently warm fluids to 39 degrees.

The majority of the fluid being warmed is Lactated Ringers with one Normal Saline warmed for those patients that would require a different fluid.

As Lactated Ringers and/or Normal Saline are pulled from the warmer, nursing staff from any Perianesthesia phase will replace that liter of fluid from stock.

Fluids are pulled from the bin closest to the warmer first for restocking and then moving to the bins to the right in preoperative and Phase 2 areas

Fluids used in PACU will be pulled from area closest to Omnicell first and replace with fluids from storeroom as needed.

All Lactated Ringers and Normal Saline solutions that are stocked by MM will have an out of date sticker in place.

Each bag of fluid once put in the warmer expires in 14 days so nursing staff will need to make sure that they verify at the time of use that the bag is in date.

If any error code is displayed, refer to trouble shooting guide located on the wall to the right of the warmer. Call BioMed immediately to assess the machine for error codes.

Use of IvNow Fluid Warmer

Revision Date: 10/14/2021
OPS/PACU

1. Purpose

The use of the IvNow Fluid Warmer allows the perianesthesia nursing staff to provide surgical patients with consistently warm IV fluids.

2. Scope

Perioperative nurses, Phase 1 and Phase 2 postoperative Nursing Staff. **(Can we add anesthesia to this list?)**

3. Definitions

- List any definitions here. This section is intended for clarifying terms that may have multiple interpretations; not spelling out abbreviations.

4. Policy

A. ASPAN Evidence-Based Clinical Practice guidelines for the promotion of perioperative normothermia.

1. To ensure that Perianesthesia nursing staff recognizes and understands the benefits of using warm IV fluid for the surgical patient. To establish guidelines for the use of the IvNow Fluid Warmer in the promotion of normothermia.

    a. Level 3

5. Procedure

A. On the day of surgery/procedure patients will receive warm IV fluids when their PIV is started.

1. In the preoperative phase nursing staff will charge the patient's IV fluids in Omnicell before pulling warm fluid from the IvNow Warmer.
2. Nursing staff understands that IV fluids taken from the IvNow Fluid Warmer are consistently warmed to 39 degrees.
3. The majority of IV fluid being warmed is Lactated Ringers with one slot kept for Normal Saline if ordered.
4. As the Lactated Ringers and Normal Saline are pulled from the warmer, nursing staff will replace it with a liter bag from stock.
5. When pulling fluid to use for restocking start with the bin closest to the warmer and then move to the bins to the right.
6. Fluids used in PACU are pulled from the area closest to the Omnicell and replaced with fluids from the storeroom as needed.
7. Lactated Ringers and Normal Saline are stocked by materials management and will have an out of date label in place.

8. Once put on the warmer, each bag of fluid will expire in 14 days so nursing staff must verify the fluid is within date before using it.
9. If an error code is displayed, refer to the trouble shooting guide located on the wall to the right of the warmer. Call BioMed immediately to assess the machine.
    i. Level 4

6. Related Policies and Documents

- List Related Document or Policies here

7. References

- List references here

8. Revision Notes

Notes
[Date]: 10/14/2021

Policy/Procedure Title: Perianesthesia Staff Orientation and Competency		Hardcopy Manual Location:
Issued (Date): 09/94 Revised (Date): 04/00, 10/00, 07/03, 04-08; 8/11 Reviewed (Date): 04/00, 10/00, 01/06; 6/14; 6/30/17		
Department (Name of Department): Surgical Services - PACU		
Department Director Approval (Name): Brooke Campbell	Date:	
Infection Control Coordinator/Pharmacy Approval (Name or N/A): N/A	Date:	
Administrative Director Approval (Name): Vickie Taylor	Date:	
Medical Director Approval (Name or N/A): N/A	Date:	
Chief Nursing Officer Approval (Name): Marvella Rea	Date:	

ASPAN Standard III- Staffing and Personnel Management

Policy:

An appropriate number of professional nursing staff with demonstrated competence is available to meet the individualized needs of patients and families in each level of peri-anesthesia care based on patient acuity, census, and physical facility.

Purpose:

To assure that all Perianesthesia staff are qualified, sufficiently oriented and competent to deliver care in the Perianesthesia area to which they are assigned.

Procedure:

1. The knowledge, skills and training required for the Perianesthesia Nurse is defined by job descriptions for each specific Perianesthesia area.
2. All new employees will attend the hospital orientation and selected portions (or all) of the nursing orientation.
3. Each new employee will be assigned a preceptor who will be responsible for following an orientation program for that employee.
4. Periodic meetings will be held with the new employee and the preceptor to assess the orientation and competency process.
5. Each new employee will be expected to complete orientation within six months of hire date and attain the expected competencies.
6. ACLS certification is required for all Perianesthesia nurses. PALS certification is recommended for all Perianesthesia nurses.

7. ACLS and PALS certification is required for Post anesthesia Phase I nurses (PACU).
8. BLS will be maintained by all Perianesthesia nurses.
9. All Perianestheisia nurses will be expected to complete all yearly educational requirements. Competence will be evaluated by the clinical leader and other clinical designees.
10. Competencies are measured by return demonstration or cognitive methods (verbal, written or return demonstration).

Perianesthesia Staff Orientation and Competency

Revision Date: 10/14/2021
OPS/PACU

1. Purpose

To assure that all perianesthesia staff are qualified, sufficiently oriented and competent to deliver care in the perianesthesia area to which they are assigned.

2. Scope

Staff from Phase 1, Phase 2, Preoperative, and Preadmission perianesthesia areas.

3. Definitions

- List any definitions here. This section is intended for clarifying terms that may have multiple interpretations; not spelling out abbreviations.

4. Policy

An appropriate number of professional nursing staff with demonstrated competence is available to meet the individualized needs of patients and families in each level of perianesthesia care based on patient acuity, census, and physical facility.

5. Procedure

1. The knowledge, skills and training required for the perianesthesia nurse is defined by job descriptions for each specific perianesthesia area.
2. All new employees will attend the hospital orientations and selected portions and/or all of the nursing orientation.
3. Each new employee will be assigned a preceptor who will be responsible for following an orientation program for that employee.
4. Periodic meetings will be held with the new employee and the preceptor to assess the orientation and competency process.
5. Each new employee will be expected to complete orientation within six months of hire date and attain the expected competencies.
6. ACLS and PALS certification is required for all PACU nurses. ACLS certification is required for all other perianesthesia nurses with PALS certification being recommended.
7. BLS will be maintained by all perianesthesia nurses.
8. All perianesthesia nurses will be expected to complete all yearly educational requirements. Competence will be evaluated by the clinical leader and other clinical designees.
9. Competencies are measured by return demonstration, verbal or written methods and/or cognitive methods.

6. Related Policies and Documents

- List Related Document or Policies here

7. References

- List references here

8. Revision Notes

Notes
[Date]: October 14, 2021

Patient Name	MR #	Account Number	DOS	Inpatient/ Outpatient	Procedure Name	Name of Antibiotic Ordered	Scheduled Antibotics	Antibiotic Start Time/Date
			4/3/2021		Hip Trochanger	Ancef		1145 4/3/21
			4/3/2021		Cysto	Cipro		
			4/3/2021		SBO	Ancef		2300
			4/5/2021		Nissen	Ancef		1412
			4/5/2021		Cysto	Levoquin		918
			4/5/2021		Lap Chole	Ancef		742
			4/5/2021		Lami	Vanc		1144
			4/5/2021		Shoulder	Ancef		949
			4/5/2021		TKR	Ancef		730
			4/5/2021		C-section	Clinda		1214
			4/5/2021		Cysto	Cipro		1205
			4/12/2021		TKR	Vanc		800
			4/12/2021		THR	Ancef		1030
			4/12/2021		Exp Lap	Cefoxitin		1041
			4/19/2021		Port	Clinda		1055
			4/12/2021		Colon Resect.	Zosyn		1307
			4/12/2021		C-section	Ancef		702
			4/17/2021		C-section	Ancef		2147
			4/19/2021		Ankle ORIF	Ancef		1515
			4/19/2021		Tibial Rod	Ancef		1559
			4/19/2021		C-section	Azithromycin		2240
			4/24/2021		C-section	Ancef		111
			4/24/2021		Hip Troch	Ancef		831
			4/24/2021		Lap Chole	Cefotetan		1545 ED
			4/26/2021		Thoracoscopy	Ancef		752
			4/26/2021		Ing Hernia	Clinda		1259
			4/26/2021		Cervical Disc	Ancef		1121
			4/24/2021		Lap Appy	Meropenum		1500

Patient Name	MR #	Account Number	DOS	Inpatient/ Outpatient	Procedure Name	Name of Antibiotic Ordered	Scheduled Antibotics	Antibiotic Start Time/Date
			1-May		C-section	Azithro		1008
			5/1/2021		Foot part amp	Piperacillin		2:00 AM
			5/1/2021		Lap Chole	Zosyn		1515
			5/1/2021		Cysto	Ceftriaxone		2230
			5/1/2021		I&D groin	Zosyn		5/1 m/nite
			3-May		Nissen	Ancef		1200
			5/3/2021		Cysto	Levofloxacin		928
			5/3/2021		Colon Resect	Clinda		725
						Cipro		740
			5/3/2021		Hammertoe	Ancef		1400
			5/3/2021		Elbow	Ancef		1610
			5/3/2021		Vag Hyst	Ancef		1132
			5/3/2021		THR	Ancef		729
			5/8/2021		**I&D**	**Ancef**		**1530**
			5/8/2021		Dental Rest	Levofloxacin		1308 5/7/21
			5/8/2021		C-section	Azithro		1300
			5/8/2021		Exp Lap	Zosyn		1418
			5/10/2021		Port	Ancef		725
			5/10/2021		Ing hernia	Ancef		1249
			5/10/2021		Spinal Fusion	Ancef		810
			5/10/2021		Shoulder	Ancef		727
			5/15/2021		ORIF Forearm	Ancef		2218
			5/15/2021		Debridement	Zosyn 5/9		None found
			17-May			Ancef		1128
			5/17/2021		ORIF Ankle	Ancef		1316
			5/17/2021		Cysto	None		
			5/17/2021		Hydrocelect.	Clinda		1045
			5/17/2021		Lap Chole	Cipro		1048

Patient Name	MR #	Account Number	DOS	Inpatient/ Outpatient	Procedure Name	Name of Antibiotic Ordered	Scheduled Antibotics	Antibiotic Start Time/Date
			6/5/2021		Groin Exp.			
			6/5/2021		Lap Appy	Zosyn		6/5 0811
			6/5/2021		ERCP	Zosyn		513
			6/7/2021		ORIF Wrist	Ancef		1358
			6/7/2021		Cysto/Stent			
			6/7/2021		Lap Appy	Ancef		800
			6/7/2021		ORIF Ankle	Ancef		1234
			6/7/2021		TKR	Ancef		727
			6/7/2021		Lap Chole	Ancef		1340
			6/7/2021		Lap Colostomy	Cefotetan		733
			6/7/2021		Lobectomy			
			6/7/2021		Shoulder	Ancef		1030
			6/7/2021		VAAM	Ancef		953
			6/14/2021		Cysto	Cipro		?
			6/14/2021		Umb hernia	Clinda		900
			6/14/2021		Kypho	Ancef		1500
			6/14/2021		Rev. Shoulder	Ancef		736
			6/14/2021		Shoulder			
			6/14/2021		Acetabular	Ancef		741
			6/14/2021		Ing Hernia	Ancef		1216
			6/19/2021		Diag Lap	None		
			6/19/2021		Lap Appy	Cefotetan		30
			6/19/2021		C-Section	Ancef		1328
			6/21/2021		Nissan	Ancef		1240
			6/21/2021		Cysto/TURBT	Levoquin		844
			6/21/2021		Ing Hernia	Ancef		731
			6/21/2021		Lap Chole	None		
			6/21/2021		Osteotomy	Ancef		1451

Patient Name	MR #	Account Number	DOS	Inpatient/ Outpatient	Procedure Name	Name of Antibiotic Ordered	Scheduled Antibotics	Antibiotic Start Time/Date
			7/3/2021		Lap Appy	Rocephin		1852 ED
			7/3/2021		TFN	Ancef		920
			7/3/2021		Cysto	Rocephin		1827 1/2
			7/5/2021		Nissen	Ancef		740
			7/5/2021		Discectomy	Ancef		1155
			7/5/2021		Femoral Fx	Ancef		1535
			7/5/2021		Cysto	Rocephin		109
			7/5/2021		I&D Hip	Ancef		1137
			7/5/2021		Pilonidal	Ancef		1000
			7/10/2021			Ancef		1535
			7/10/2021		ORIF Wrist			
			7/10/2021		I&D Abscess	Vanc		409

Patient Name	MR #	Account Number	DOS	Inpatient/ Outpatient	Procedure Name	Name of Antibiotic Ordered	Scheduled Antibotics	Antibiotic Start Time/Date
			8/2/2021		Cysto/TURP	Levofloxacin		1241
			8/2/2021		Cerv. Disc	Ancef		1330
			8/2/2021		Hip	Ancef		1530
			8/2/2021		Ing Hernia	Cefozolin		742
			8/7/2021		Cysto	Ceftriaxone		914
			8/7/2021		Lap Chole	Zosyn		1209 am
			8/9/2021		Lap Chole	Ancef		931
			8/9/2021		Lami	Ancef		730
			8/9/2021			Ancef		1010
			8/9/2021		Total Joint	Ancef		1254

Augusta Health 2021

NAME: Charlotte Maides
DEPARTMENT: OPS | PACU

Quality Indicators	Jan	Feb	Mar	1st qtr	Apr	May	Jun	2nd qtr	Jul	Aug	Sep	3rd qtr	Oct	Nov	Dec	4th qtr	YTD
MODERATE SEDATION																	
Total # of sedation cases	10	10	10		10	10	10		10	10	10						
Total # of cases reviewed	10	10	10		10	10	10		10	10	10						
Total # with consent for moderate sedation anesthesia	10	10	10		10	10	10		10	9*	10						
Use of reversal drugs	Ø	Ø	Ø		Ø	Ø	Ø		Ø	Ø	Ø						
Oxygen sats consistently below 90%	Ø	Ø	Ø		Ø	Ø	Ø		Ø	8*	Ø						
Respiratory rates below 8/minute	Ø	Ø	Ø		Ø	Ø	Ø		Ø	Ø	Ø						
Assisted ventilation required	Ø	Ø	Ø		Ø	Ø	Ø		Ø	Ø	Ø						
Unplanned transfer to PACU, PCU, or ICU	Ø	Ø	Ø		Ø	Ø	Ø		Ø	Ø	Ø						
Vomiting/aspiration	Ø	Ø	Ø		Ø	Ø	Ø		Ø	Ø	Ø						

*1 Consent signature times do not match

* Sats 88% x 2
90% x 1

Sats 88%
91%