Notes For Staff re Binder

- Binder includes: Master Signature List, Staff Communication, Inventory Checklist, Equipment Checklist/Tests, Emergency Drugs & Pharmacy Communication, Restocking Of Operatory and Recovery Rooms, Nursing Orientation Package, Shipping Reports, Medication (Propofol/Fentanyl) Log. Please ensure you review the binder each shift and sign off where indicated. Please utilize the staff communication section to keep each other updated, as to what occurred/what needs attention.

Reminders

- Please call in to the office 1-2 days before your shift to ensure you're aware of the start and chair times, whether there have been any scheduling changes, and any additional information or list details. This is particularly important when attending a new clinic or an office you have not previously serviced.
- This is a good time to also inquire about any pertinent medical history of patients. For example, if there is a patient with a medical history of diabetes, ensure the patient has been informed about bringing diabetic supplies. If there is a history of asthma, ensure the patient is aware they need to bring puffers on day of surgery.
- As an additional precaution, please also connect with the anesthesiologist assigned to the list to confirm the start and chair time. If you do not have the contact information for either of the clinic or anesthesiologist, please reach out to our operations manager.
- At the start of your shift, please verify that two adults are available to accompany a child home upon discharge.
- Patient recovery may begin in the operatory before the patient is transferred to the recovery room. Please ensure you begin recording vitals every 5 minutes for a minimum of 20 minutes if the patient is cooperative. This is a requirement under the RCDSO guidelines. Beyond good practice, proper documentation is a requirement and patient charts are thoroughly examined during College inspections. All patient charts must be well documented and signed. A follow up phone call should be made and also be documented.
- Please review all documentation prior to handing to staff at the end of day. Verify all relevant sections are completed and signed for.

SURGISERVICES

Daily Operations, Information & Communication Log

CONTENTS

- Master Signature List
- Staff Communication
- Inventory Checklist
- Equipment Checklists & Tests
- Emergency Drugs & Pharmacy Communication
- Restocking of Operatory & Recovery Room
- Nursing Orientation Package
- Shipping Reports

MASTER SIGNATURE LIST

NAME (PRINT)	SIGNATURE	INITALS

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Please use this document to communicate amongst each other. Use this log to indicate when supplies have been ordered through Marijana, ideas/thoughts/reminders (ie items currently on backorder) and any other relevant information.

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For all orders, please contact Marijana at (416) 567-0795.

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Hepa Filters										
Tubing										
IV Extension Set										
Propofol Tubing										
Syringes										
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20 cc										
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EQUIPMENT CHECKS/TESTS

DATE	AED CHECK /TEST	SUCTION & BACK UP SUCTION	OXYGEN & OXYGEN TANK	AMBU BAGS Adult & Pediatric	VITAL SIGNS MACHINE/ SUPPLIES	INITALS

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NOTE: Please check date, initial and keep a copy of the current updated inventory in this binder and in the emergency cart. Quantity implies not expired. Contact pharmacy if expiry is < 1 month. If quantities below recommended/required amounts, place order with pharmacy and document in Staff Communications section of this binder. Please discard all expired drugs once adequate replacement has been secured.

***Ensure narcotics and benzodiazepine are locked up. Insulin and succinylcholine must be refrigerated.**

EMERGENCY DRUGS

MEDICATION	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial	Date & Initial
Amiodarone 50mg/ml							
ASA 80mg chewable							
Atropine 0.6/1cc							
Atrovent							
Calcium Chloride 1mg/ 10ml							
Dantrolene 20mg							
Dextrose 50%, 25/50ml							
Diphenhydramine 50mg/1cc							
Dopamine 400mg							
Ephedrine 50mg/1cc							
Epinephrine 1:1000, 1mg/ 1ml							

Epinephrine 1mg/10ml							
Flumazenil 0.1mg/ml							
Insulin regular 1000U/10ml							
Labetolol 5mg/ cc							
Magnesium Sulfate 500mg							
Midazolam 5mg/ml							
Morphine 10mg/ml							
Naloxone 0.4mg/ml							
Nitroglycerine Spray 0.4mg							
Phenylephrine 10mg/1cc							
Salbutamol							
Sodium Bicarbonate, 8.4%							
Solucortef 100mg							
Sterile Water, 1L Bag							
Succinylcholin e 20ml/ml							
Verapamil 5mg/2ml							

Otrivin Nasal Spray							
Sevoflurane (**check to ensure adequate supply) MIN. 2 bottles**							

RedBox Rx 905-451-4888

redboxrx@gmail.com

COMMUNICATION WITH PHARMACY

DATE	NOTES	INITALS

COMMUNICATION WITH PHARMACY

DATE	NOTES	INITALS

COMMUNICATION WITH PHARMACY

DATE	NOTES	INITALS

COMMUNICATION WITH PHARMACY

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DATE	NOTES	INITALS

RESTOCKING OF OPERATORY AND RECOVERY ROOM

Please sign and date once operatory and recovery rooms have been restocked at end of shift.

DATE	SIGNATURE

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Nursing Orientation Package

Marijana Milkovich R.N. BScN

Dr. Robert Milkovich M.D.

TABLE OF CONTENTS

INTRODUCTION

QUALIFICATIONS AND JOB DESCRIPTION 2

1. START OF SHIFT & CHECKLIST 4

2. INTERVIEW “ON DECK” PATIENT 7

3. ASSIST WITH INDUCTION 10

4. RECOVERY OF PATIENTS 13

5. END OF SHIFT CHECKLIST 18

REFERENCES 21

1.Introduction

This manual is not intended to be a comprehensive guide or course for the complex role of a recovery room nurse. It does however describe what is involved and expected in this role for Surgiservices and this must always be within the context of the Code of Conduct and best practices as described and expected by the College of Nurses of Ontario (CNO).

Surgiservices is an organization that specializes in providing anesthesia care in the out of hospital environment. This includes both adult and pediatric patients. It is important to recognize that working in an out of hospital premises poses certain challenges not faced in a hospital environment. Resources are sometimes limited as is additional manpower. It is for this reason that a high level of diligence, proficiency, and efficiency are mandatory to avoid risk to our patients.

Please refer to our website for further information and to familiarize yourself to our documentation.
www.surgiservices.com

Qualifications

Minimum Qualifications are as follows:

- Registered Nurse Designation
- Member in good standing with CNO
- Professional Liability Coverage as offered by RNAO
- ACLS Certification
- PALS Certification
- BLS Certification

It is **preferred** that you have recent recovery room experience in a hospital or clinic providing post anesthesia care after general anesthesia or sedation. ICU/Emergency Department work experience is also welcomed. If this is not the case then a period of shadowing is required prior to taking on any assignments

Job Description

The role of RN as expected by Surgiservices includes but is not limited to the following:

1. *Preparation for the beginning of the day.*
2. *Interview and Screen Patients "On Deck"*
3. *Assist induction of first case.*
4. *Recover Patients fully and completely prior to discharge (principal role)*
5. *Assist setup for next case.*
6. *Assist induction of subsequent cases (if possible)*
7. *Call patients once settled in at home (courtesy call) and field any calls from discharged patients or families while still at the office.*
8. *Help dismantle the setup.*
9. *Communicate any deficiencies of supplies or equipment.*

These are expanded upon in the subsequent sections.

1. Preparation for Day

It is expected that you will be given access to the premises at least 30 minutes prior to the expected time that the first case is to commence induction. In that time the expectation is to help the anesthetist setup up the room, ensure that the emergency equipment is present and operational, and finally the first patient is interviewed by you**.**

Different premises are in different states of initial setup. This may range from everything being already setup and available in the operating room to all equipment in a storage area waiting to be transferred and setup by you and the anesthetist. Please ask the office representative if you cannot find something. It is the anesthetist's responsibility to ensure that the anesthetic machine and equipment is checked and functional for the day. If something is not functional they are to notify the office.

The emergency equipment includes the following: "crash cart drugs", defibrillator, portable oxygen source and AMBU bag, suction. Please locate **all** of these and ensure that they are present and functioning prior to the beginning of the list. The emergency drugs are maintained by our pharmacist and are usually kept together in a case except for those drugs requiring refrigeration (insulin and succinylcholine) and controlled substances (midazolam and morphine) which are

locked away. There should be a master list (see attachment) with the most recent updated expiries of these drugs in the case please ensure that all drugs on the list are present and not expired prior to starting. If anything is missing or expired please notify the anesthetist and the pharmacist. Our pharmacist automatically replenishes expired drugs so first ask someone at the office if they have a delivery for us put away somewhere which may contain the replacement for the expired medications. Please ensure the same for the refrigerated and locked drugs as well. Turn on the defibrillator and allow it to run its self check. Make sure your portable oxygen source is full and is functioning. Locate the appropriate sized AMBU bag, LMA, and oral airways for your patients. Ensure that your suction is working and you have tips to use for the suction (saliva ejectors or yankauers). Also locate your portable back up suction and ensure its functional. Check your monitor for recovery and ensure the alarm volume and alarm parameters are set appropriately. Ensure you have capnography tubing. Have infection control tools readied for patient care and to clean the room between patients (ie gloves, alcohol hand sanitizer, steri wipes)

2. Interview “On Deck” Patient

When a patient is “on deck” it means they are waiting and next to be taken into the operating room. It is expected that when possible these patients will be adequately screened and interviewed by the RN and a brief report given to the anesthetist highlighting any concerns.

The purpose of this interview is to decide early if the patient is adequately prepared or appropriate for proceeding with their procedure. Things that may require further attention and possible rescheduling are things like active febrile illness, inadequate fasting as per our guidelines, family history of major anesthetic complications. For children it is also a good time to ensure that 2 adults are available for the drive home at this point. One to drive and the other to attend to the child in the back seat. If this is not the case then arrangements need to be made to make it so or risk cancelling the procedure. Ensure that both parents are consenting to the procedure. Also someone needs to be home with the patient after discharge for 24 hours. The offices are well versed at screening and preparing patients but a final review is prudent. If we identify that a patient should be cancelled or rescheduled it gives the front desk staff adequate time to respond and possibly move up our next patient in the interest of office efficiency.

This interview should consist of an abbreviated nursing assessment that includes pertinent anesthesia considerations. These include but are not limited to:

1. Patient height, weight, and calculated BMI
2. Baseline vital signs including pre-op temperature
3. NPO status
4. Past medical and surgical history
5. Past anesthetic history
6. Family history of anesthetic issues
7. Allergies
8. Medications
9. Airway evaluation including any loose teeth or false teeth as well as contact lenses

Febrile patients (temp greater than 37.5 C) are generally not appropriate for elective outpatient procedures. Also patients not adequately fasted may be cancelled altogether or the schedule may be altered to bring them into compliance. Our guidelines are:

2 hours for clear fluids
4 hours for breast milk
6 hours for a light meal
8 hours for a heavy meal

At this point the nurse may also offer a preoperative dose of ibuprofen if not contraindicated to supplement post procedure comfort.

This interview is always possible with the first case of the day however we recognize that subsequent cases may not be interviewed if you are busy recovering an active patient in phase 1 recovery. Constant vigilance is required during Phase 1 recovery and abandoning a patient in this phase is NEVER appropriate. Phases of recovery are defined later in this manual. It is preferred however that you discharge the recovering patient prior to interviewing the “on deck” patient and we recognize you may not get to the “on deck” patient at all.

3. Assist with Induction

It is recognized that high turnover lists may not allow you to assist in inducing any more than the very first case of the day as you are likely occupied with an actively recovering patient.

Assisting with induction means being present with the anesthetist while the patient is put to sleep. The anesthetist will take the lead here and please assist him or her as they instruct. This may vary greatly depending on the anesthetist as well as the patient. Different anesthetists approach this in different ways depending on their style. No way is standardized for this event.

Some anesthetists require little assistance and some require more. Please allow them to guide you until you learn their particular style.

In general monitors need to be placed on the patient. These include a blood pressure cuff, oxygen saturation probe, ECG leads, and a temperature probe is affixed to the body (often in the axilla). The anesthetist may ask you to assist with this.

An intravenous will be established. In adults this is often done before the patient is induced (induced means put to sleep). Please assist with this. Most anesthetists like to do

this themselves but if you wish to establish the intravenous please discuss with the anesthetist before hand. In children, special needs patients, and needle phobes when appropriate we offer mask inductions and the iv is established after the patient is asleep. You may be asked to assist with this as well. If you are proficient at iv access the anesthetist may ask you to do this while the anesthetist maintains the patient's airway. If the anesthetist wishes to start the iv they may ask you to maintain the airway. Either approach is acceptable.

After the patient is asleep and an iv is established please assist the anesthetist with the airway. This usually means assisting with an intubation. The anesthetist will guide you with what may be required. You should familiarize yourself with the notion of "BURP" as this is sometimes helpful to the anesthetist for intubation.

Once patient is intubated you are generally no longer required. At this point, you may take the time to update parents or reassure them and also prepare the recovery room for the patient (flattening the chair, finding blankets, organizing the recovery room monitor, supplemental oxygen, capnography, preparing your suction device, adequately preparing the site with infection control considerations, etc.). Also move on to interviewing the next "on deck" patient as described above.

4. Recovery of Patients

This is the most important role for Surgiservices RN's under the auspices of our care.

This cannot be emphasized enough. NOTHING should distract from this role. Phone calls, front desk questions, finding a blanket or other supplies, etc. are all pitfalls that distract from the hypervigilance needed to effectively care for post anesthesia patients.

Most patients in dental offices are recovered on flattened dental chairs and not stretchers. These chairs do not have siderails or belts so special attention needs to be had to prevent patients and especially children from flailing themselves onto the floor. Families cannot be tasked with this. This is the nurse's responsibility.

The most important consideration in phase 1 of recovery is maintenance of a patent airway. In this phase airways can become obstructed by secretions, regurgitated stomach contents, foreign material such as gauze at extraction sites, throat packs, dental materials, etc. Airways can also be lost secondary to apnea from over sedation or airway obstruction. Chest or abdominal movement does not mean that the patient is breathing. Looking for, listening for, and feeling for air exchange are helpful with the usage of capnography.

Pulse oximetry changes are a late indicator of an obstructed airway and if this occurs you have missed the boat and should have intervened earlier. ANY airway concern should immediately be brought to the attention of the anesthetist as this is a priority no matter what the anesthetist is doing. Calling for help early is paramount to keep the patient safe. Supplemental oxygen is encouraged along with the use of capnography in sedated patients.

A working iv is important and should not be discontinued until awake and in phase 2 recovery.

A FAQ regarding this role is attached and describes phase 1 and phase 2 under the context of recovery.

Patients must meet Aldrete score criteria prior to discharge from phase 1 to phase 2. These are clearly listed and described on the PACU record. This is a validated recovery room score used as compared to some sort of arbitrary time requirement for discharge as in the past.

When a patient is delivered to you by the anesthetist insist that a proper report is given summarizing and reviewing the pertinent health considerations as well as the surgical and anesthetic course that just occurred. Apply all appropriate monitors. ECG is not required but must be available for you just in case. A temperature on arrival should be

documented. Level of consciousness should be noted and if the patient is deemed too sedate, unarousable, etc. a capnograph must be used to ensure vigilance for early detection of apnea from airway obstruction or over sedation. If a patient is crying (child) or talking and rousable capnography is not required. A Ramsay Sedation Score of 4-6 mandates that capnography must be applied to the recovering patient according to the CAS guidelines.

Ramsay sedation scale

Score	Response
1	**Anxious or restless or both**
2	**Cooperative, orientated and tranquil**
3	**Responding to commands**
4	**Brisk response to stimulus**
5	**Sluggish response to stimulus**
6	**No response to stimulus**

BP, sat, HR, are to be continuously monitored and q15min vitals documented. Nausea, vomiting, pain, and bleeding should be assessed and addressed.

Once the hypervigilant stage of phase 1 has passed according to Aldrete score and your assessment then you may invite the escort (ie family members) in during phase 2 so that you can deliver any post-op instructions to them. Also ensure at this point that you have a reliable phone number to contact them after discharge home to touch base with them and see how they are doing (a courtesy call). They should also be given our card or the anesthetists number to contact us about any issues after hours. The sorts of things to contact us about are listed in our discharge package. Make sure the post-anesthesia discharge instructions are reviewed.

If the escort needs assistance please assist getting the patient to and into the car. Many offices have wheelchairs if so desired but most patients walk out on their own or are carried out if they are children. Our policy with children is that we require 2 adults for discharge home. One to drive and one to attend to the child in the back seat.

If the patient has been discharged and the next case is still on going this is a good time to screen/interview the “on deck” patient, or help set up the next case with the

anesthetist, prepare the recovery room for the next patient including infection control measures, call one of your prior discharges to see how they have settled in (courtesy call), or simply have a break.

5. End of the Day

After discharging your final patient please assist the anesthetist in tidying up after the day. This means trying to put back things where we found them so the next team does not have to route around at the beginning of their day next time. We try to keep most things in a consistent location from office to office as best as possible.

Do not let the anesthetist leave if there is anything you are not happy about in terms of discharge of the last patient. You have final call as to when you feel comfortable that the anesthetist leaves. The patient must be in phase 2 recovery.

In terms of sterilization of our equipment this is the responsibility of the office designate and not ours. This is in keeping with Public Health requirements as we are not trained on the specific autoclave the office may use and are not familiar with their sterilization protocols.
Infection control principles should however be adhered to. Make sure blankets are sent to be laundered, wipe things down with steri-wipes, etc.

We do not require that you call the last patient of the day (courtesy call) but do reinforce that they can call the anesthetist or office if they have concerns once at home.

This is because it is difficult to document this on the patient's chart once you have left the office.

Finally, during the day if any deficiencies of equipment or supplies are identified by you or the anesthetist please relay them to our management team to ensure it is replenished prior to the next list. Please look yourself and decide whether you think enough sundries are left at the end of the day for at least one more list. This includes endotracheal tubes, iv catheters, syringes, filters, tubing, iv fluid, etc. Please restock any drawers that are depleted.

We do not leave any anesthesia drugs or anesthesia adjunct drugs on site (except for sevoflurane). The anesthetist is instructed to carry these on their person and ensure they have enough for the day. They are also required to complete the drug log book for controlled substances left at the office in the format we have described to them.

References

CPSO OHPIP Program Standards

https://www.cpso.on.ca/CPSO/media/documents/CPSO%20Members/OHPIP/OHPIP-standards.pdf

RCDSO Standard of Practice Use of Sedation and General Anesthesia

https://az184419.vo.msecnd.net/rcdso/pdf/standards-of-practice/RCDSO_Standard_of_Practice__Use_of_Sedation_and_General_Anesthesia.pdf

PIDAC Infection Prevention and Control for Clinical Office Practice

https://www.publichealthontario.ca/-/media/documents/bp-clinical-office-practice.pdf?la=en

CAS Guidelines to the Practice of Anesthesia

https://www.cas.ca/English/Page/Files/97_2019_Guidelines_To_The_Practice_Of_Anest.pdf