

PROTOCOL FOR: Respiratory Compromise Management in the Perioperative Phase

DESIRED PATIENT
OUTCOMES:

1. All patients will have baseline SpO₂ levels assessed preoperatively, during procedures that are done under moderate / light sedation or topical / local infiltration anesthesia, and postoperatively for all patients admitted to the PACU.
2. Patient will attain or maintain oxygenation levels within normal / prescribed limits, with goal of returning to baseline.

CLINICAL
ASSESSMENT
AND CARE:

PREOPERATIVE

1. Assess baseline vital signs and oxygenation status on admission for all patients.
2. Assess acute and chronic pain levels and evaluate impact on ability to oxygenate effectively
3. Administer any preprocedure breathing treatments, as ordered; obtain order for oxygen and / or other medications, as needed.
4. Include any pertinent information in hand-off / transfer communication.

INTRAOPERATIVE

1. Follow Moderate Sedation or Topical / Local Infiltration Anesthesia protocol, as appropriate, for frequency of monitoring vital signs and oxygenation status; administer oxygen per protocol / by order.
2. Include any pertinent information in hand-off / transfer communication, including need for ventilator or other respiratory support for anesthetized patients.

POSTOPERATIVE

1. Include in respiratory component of vital signs measurement, as appropriate: airway patency, respiratory status, breath sounds, type of artificial airway, mechanical ventilator settings, and oxygenation status; end-tidal CO₂ monitoring for ventilated patients.

PROTOCOL FOR: Respiratory Compromise Management in the Perioperative Phase

2. Frequency of vital signs will be according to perioperative structure standards. In the PACU, postoperative vital signs are documented at least q 15 min for the first hour, more frequently as patient condition warrants or per order. Patient condition that would warrant more frequent monitoring of vital signs may include:
 - a. vital signs not within 20% of baseline:
 - b. receiving medications to treat hypo- or hypertension
 - c. frequent need for pain medications
 - d. significant intraoperative events such as cardiac event or large blood loss
3. Assess for respiratory adequacy, as evidenced by:
 - a. airway patency
 - b. respiratory rate, excursion, symmetry, and use of accessory muscles
 - c. breathing quality and rhythm; breath sounds
 - d. oximetry values; ABG values, per order
 - e. color
 - f. breath sounds by auscultation
 - g. utilize chest x-ray results, if available
4. Assess need for oxygen by observing for signs and symptoms of hypoxia:
 - a. tachypnea
 - b. O₂ saturation below 90%
 - c. tachycardia or dysrhythmia such as PVC
 - d. change in level of consciousness / decreased cerebral oxygenation, as evidenced by irritability, confusion, lethargy, up to coma
 - e. cyanosis, peripheral or central
 - f. labored respirations
 - g. myocardial stress, as evidenced by increased heart rate and, if values available, stroke volume / cardiac output
 - h. dilated pupils
5. Stimulate breathing and deliver oxygen as needed. Position patient for airway protection and/or maximum respiratory excursion. Place patient in semi-Fowler's position, unless contraindicated, to increase lung compliance, facilitate airway clearance, and decrease work of breathing.
6. Suction oropharynx and trachea as necessary. Observe for changes in color and consistency of suctioned sputum that may indicate dehydration or infection.
7. Protect airway in event of vomiting.
8. Assist ventilatory effort with ambu/mechanical ventilator per order / *prn*.
9. Relieve pain; assess for hypoxia whenever patient becomes newly anxious, restless, or agitated prior to administering narcotics / sedatives.

PROTOCOL FOR: Respiratory Compromise Management in the Perioperative Phase

10. Review test results, as appropriate:
 - a. ABGs - for diagnosis and management of clinical oxygenation status and acid-base balance
 - b. chest x-ray - for treatment of pulmonary disease that affects oxygenation.

REPORTABLE
CONDITIONS

1. Respiratory distress
2. Persistent hypoxemia
3. Signs of laryngospasm or bronchospasm
4. Persistent ventilator alarms

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 11/85

REVISION DATES: 7/88, 2/90, 10/90, 12/90, 2/92, 3/93, 5/94, 5/97, 2/08, 10/09