RECOVERY ROOM NURSING
STANDARDS AND PROCEDURES

苏醒室

护理手册

DEVELOPED AND EDITED BY:
MARY ANN BELL, R.N., M.Ed.
PROJECT HOPE/CHINA

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INTRODUCTION

This manual has been designed to establish nursing care standards and correct operating procedures for patient care in the Recovery Room setting. The purpose is to ensure that uniform, quality nursing care is delivered to all patients postoperatively.

This manual is also intended to be a learning tool for the nurses. It is to be used as part of the nursing orientation process. Each RR nurse should review the material in this manual and be able to perform all of the skills satisfactorily on the Performance Checklist in the presence of an experienced RR nurse. This process should be repeated each year in order to ensure that all nurses maintain a high level of competency in recovery room nursing.

引 言

编制本手册的目的，是建立苏醒室的护理标准和确立正确的操作程序，使护士能对所有术后病人提供质量一致的护理。

本手册可作为护士的学习工具，也可作为护理入门课程的一部分。苏醒室护士应复习本手册的内容，要能够在有足够资历的护士督导下完满地执行工作清单所列的项目。上述复习要每年进行一次，以保持高水平的苏醒室护理。

SECTION I PATIENT ASSESSMENT

ASSESSMENT GUIDELINES FOR THE RECOVERY ROOM PATIENT

These guidelines are to be used both in patient assessment and documentation in the patient record.

NEUROLOGICAL:

Level of Consciousness: Oriented, Confused, Inappropriate, Incomprehensible, Unresponsive

Movement of Extremities, Muscle Tone

Reflexes: Cough, Gag

CARDIOVASCULAR:

EKG Rhythm: Normal sinus rhythm or abnormal, Rate, Regularity

Perfusion: Skin temperature, Capillary refill

Edema: Presence or Absence

IV Fluids: Type, Additives, Rate, Site, Condition of site

RESPIRATORY:

Character of Respirations: Regular, Signs of Distress, Apnea, Retractions

Breath Sounds: Equal or Unequal, Rales, Rhonchi, Wheezes

Ventilatory Support: Type (ventilator, mask, nasal cannula), Ventilator Settings, Amount of Oxygen

Cough: Productive, Nonproductive

GASTROINTESTINAL:

Any G. I. Tubes: Suction, Gravity, Feedings

Bowel Sounds: Presence or Absence

Status of Abdomen: Soft, Distended, Hard

Stools: Frequency, Description

Feeding: Type and Tolerance to Feeding

GENITOURINARY:

Urine: Color, Character

Presence of Catheter

Any Problems Voiding Spontaneously

SKIN:

Skin Color

Skin Abnormalities: Open areas, Rash, Petechiae, Bruises, Burns

OTHER:

Drainage Tubes: Volume of drainage, Type, Color, Location of tubes, Suction

Dressings: Location, Type, Drainage

第一章　病人评估

苏醒室(RR)病人评估规则

下列规则适用于评估病人和病历记录。

神经系统：

知觉水平：定向、错乱、反应不当、无理解力、无反应
四肢运动、肌肉张力
反射：咳嗽反射、呕吐反射

心血管系统：

心电图节律：正常窦性心律或异常心律、心率、规律性
灌注：皮肤温度、毛细血管充盈
水肿：有或无
静注液：种类、内加药物、流速、静注点、静注部位状况

呼吸系统：

呼吸特点：规则、呼吸困难体征、呼吸停顿、三凹症
呼吸音：相等或不相等、湿罗音、干罗音、喘鸣
通气支持：种类(呼吸机、面罩、鼻导管)、呼吸机的调校、供氧量
咳嗽：有痰、无痰

胃肠系统：

有无胃肠插管：吸引、重力引流、喂食
肠鸣音：有或无
腹部状态：软、膨胀、硬
大便：次数、特点描述
喂食：食物种类、病人对喂食的忍受程度

泌尿生殖系统：

尿：颜色、特性
有无导尿管
自尿时伴随的问题

皮肤：

皮肤颜色
皮肤异常：破损区、疹子、瘀斑、挫伤、烧伤

其他：

引流管：引流量、种类、颜色、引流管的位置、吸引
敷料：位置、种类、引流物

PROCEDURE: PATIENT ADMISSION TO THE RECOVERY ROOM

Each patient admitted to the RR will receive the necessary nursing assessment and care. The following equipment should be available at the bedside so that the nurse can remain with the patient on his/her admission to the unit.

Equipment

Clean, prepared patient bed
EKG monitor with 3 electrodes
Oxygen humidifier and flow meter, mask or cannula
Blood pressure cuff
Suction source
Clean suction tubing and bottle
Sterile suction catheter with glove
Sterile bowl for normal saline
Sterile bottle of normal saline for suction
IV pole
Thermometer
Self-inflating bag (Ambu)
RR special nursing record

Nursing Action

1. Check to see that the patient has a patent airway and is breathing.
2. Put oxygen on the patient according to the doctor's orders. Count the respiratory rate.
3. Attach EKG electrodes to the patient and the EKG monitor, select lead, and check for a clear waveform. Set alarm limits and turn the alarm on.
4. Check blood pressure.
5. Count the apical pulse with stethoscope for one minute to check the accuracy of the monitor.
6. Check temperature.
7. Check IVs for function and accurate flow rate.
8. Perform nursing physical assessment including:
   a. Neurological: Level of consciousness, orientation, ability to follow commands, limb movement.
   b. Respiratory: Listen to breath sounds with stethoscope, assess quality of respirations.

病人进入苏醒室(RR)的操作程序

每名新进入苏醒室的病人都要接受必要的护理评估和护理。病人进入苏醒室时，护士须与病人在一起，所以病床边应备有下列各项器材。

器材

整理好的清洁病床
心电图监测器与三枚电极
氧气湿化器和流量表、面罩或鼻导管
血压袖
吸引器
清洁的吸引管和瓶子
消毒吸引管和手套
消毒碗，用于盛生理盐水
吸引时用的消毒生理盐水
静注架
体温计
自动充气囊(Ambu)
苏醒室专用的护理记录单

护理操作

1.检查病人气道是否畅通，有无呼吸。
2.按医嘱给氧。数呼吸率。
3.替病人接上心电图电极，贴好心电图电极，接心电图监测器，选择导联，检查波形是否清晰。调好警报值，让警报开着。
4.测量血压。
5.用听诊器听心率一分钟，以检查监测器是否准确。
6.测量体温。
7.检查静注系统，注意滴注正常、流率准确。
8.进行下列各项护理体检评估：
a.神经系统：知觉程度、定向、能否遵从命令、四肢运动。
b.呼吸系统：用听诊器听呼吸音、评估呼吸性质。

c. Cardiovascular: Note EKG rhythm, check peripheral pulses.

d. Gastrointestinal: Palpate abdomen, listen for bowel sounds.

e. Renal: If patient has catheter, assess urine color and amount.

9. Check all drainage tubes to see that they are draining properly and note amount and kind of drainage.

10. Check all dressings for drainage and intactness.

11. Record all vital signs and observations on the nursing flow sheet.

c.心血管系统：注意心电图节律、检查周围脉搏振动。

d.胃肠系统：触诊腹部、听肠音。

e.肾：如病人有导尿管，评估尿的颜色和量。

9.检查所有引流管，注意引流是否畅通，记录引流量与类别。

10.检查所有敷料，注意有无引流物和是否完整。

11.在护理记录单上记录所有生命体征和一切观察结果。

VITAL SIGNS

Vital signs are the most convenient and reliable indicators of a patient's condition.

Definition

Vital signs in the RR-ICU include apical pulse, respiratory rate, blood pressure and temperature.

Necessity

Vital signs allow the doctor and nurse to recognize changes in a patient's condition and possibly prevent a life threatening situation.

The nurse needs to be aware of a patient's pre-operative vital signs to serve as a basis for interpreting vital signs during the post-operative period.

It is also important to record the vital signs on the RR special record. We do this in order that both the doctors and nurses can follow the patient's progress post operatively.

Pulse

An apical pulse is taken because it is the most accurate. Every heart beat may not be going through the circulatory system. In this case, it would not be felt in the peripheral pulses.

The normal pulse rate is 60-100 beats per minute. The pulse should be measured for one full minute because there may be irregular beats.

When the patient's pulse increases, there is an increased stress placed on the heart.

Respirations

It is important to measure the respiratory rate for one full minute. The nurse should note the quality of respirations also, i.e., shallow, irregular.

The normal respiratory rate is 16~22 times per minute.

Blood Pressure

The systolic blood pressure is an indication of the highest pressure exerted on the arterial walls during the cardiac cycle.

The diastolic blood pressure is the lowest level of pressure in the arteries during the cardiac cycle, which is right after the heart contracts.

Normal blood pressure is: systolic 100-140
diastolic 70-90

生 命 体 征

生命体征是观察病人病情变化的最简单而可靠的标志：

一、定义

在苏醒监护室里，生命体征包括心率、呼吸、血压及体温。

二、必要性

生命体征可使医生和护士了解病人的病情变化，并可防止威胁生命的情况发生。

护士必须知道病人手术前的生命体征，并以此为基础解释术后阶段生命体征的变化。

为方便医生和护士及时了解病人术后的病情进展，在苏醒室的特殊记录单上作好生命体征的记录也很重要。

三、心率

测量心率因为它是最准确的。并不是每次心跳都经过循环系统，在这种情况下，周围脉搏摸不到。

正常心率是每分钟60-100次。测量心率应以一分钟为准，因为可能出现不规则心跳。

当病人的心率增加，说明心脏负担加重。

四、呼吸

测量呼吸频率也应以一分钟为准。护士还应注意呼吸的特点，诸如深浅度及规则与否。

正常呼吸率为每分钟16—22次。

五、血压

收缩压是指心脏收缩时，作用于血管壁的最高压力。

舒张压是紧接着心脏收缩后，动脉内的最低压力。

正常血压是：收缩压100—140

舒张压70—90

Temperature

All temperatures taken in the RR-ICU should be rectal. The rectal temperature is more reliable because it is not as easily affected by external temperature changes.

It is necessary to check the temperature at least every 4 hours during the post-operative period because an increase in temperature is one of the first signs of infection.

When the patient's temperature increases, there is increased stress on the body which causes the heart to work harder.

Special Notes

If there is a change in the patient's condition, vital signs must be checked every 30-60 minutes. Always record vital signs on the RR-ICU special record with the time and date.

六、体温

在监护病房每次测量体温都必须通过肛门测温。肛门测量不易受外界温度变化的影响，故比较准确可信。

对术后病人须至少每 4 小时测一次体温，因体温上升是术后感染的第一信号

病人体温上升时，机体代谢增加使心脏负担加重。

七、特别注意

如果病情发生变化，必须每30—60分钟检查生命体征，并作为苏醒监护室的特别记录，包括时间及日期。