

BADDIE RN

PACU Study Book

Phase I • Phase II • Orientation Workbook

STUDY GUIDANCE ONLY — Not patient-specific medical advice or a substitute for orientation. Use current provider orders, facility policy, approved protocols, pharmacy references and your scope of practice. Escalate deterioration and activate local emergency pathways.

Prepared for thoughtful study, safer communication and supervised practice.

How to use this book

Read one chapter at a time. Use the quick-reference points to organize—not replace—your unit's policy. Answer the knowledge check before viewing the rationale. Practice the checklist with a preceptor, then document competency only through your facility's approved process.

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Core PACU lens

Prepare → Assess → Anticipate → Escalate → Reassess → Communicate

Foundations, Bay Readiness & Handoff

KEY TAKEAWAY

Build a repeatable pre-arrival routine and receive the handoff without losing your own assessment.

QUICK REFERENCE

Verify oxygen, suction, monitors, emergency access, warming, lines and drains. On arrival, independently assess airway, breathing, circulation, neurologic baseline, site, pain, nausea and temperature.

SAFETY WARNING

A complete handoff never replaces a bedside assessment. Escalate any mismatch between report and presentation.

KNOWLEDGE CHECK

What should happen first when the handoff and bedside assessment disagree?

Answer and rationale: Stay with the patient, support immediate threats, clarify the discrepancy and escalate early. The current patient assessment drives action.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Phase I Assessment: Airway First

KEY TAKEAWAY

Use a consistent primary survey while trending the patient against baseline and the anesthetic course.

QUICK REFERENCE

Look, listen and feel for air movement; assess effort, rate, oxygenation, ventilation waveform when ordered, sedation and response. Reassess after every intervention.

SAFETY WARNING

A normal oxygen saturation on supplemental oxygen can coexist with hypoventilation. Assess ventilation directly.

KNOWLEDGE CHECK

Why is oxygen saturation alone insufficient after anesthesia?

Answer and rationale: Supplemental oxygen can mask hypoventilation; respiratory effort, air movement, sedation and capnography when indicated provide essential context.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Hemodynamics, Rhythms & Bleeding

KEY TAKEAWAY

Treat trends and perfusion—not one isolated number—and look for reversible causes.

QUICK REFERENCE

Verify readings, compare with baseline, inspect the site and drains, review losses and fluids, assess skin, mentation and urine output when relevant.

SAFETY WARNING

New hypotension, tachycardia, bleeding or poor perfusion requires bedside presence and prompt team escalation.

KNOWLEDGE CHECK

What is the safest first response to a sudden blood-pressure change?

Answer and rationale: Verify the reading while assessing the patient, then investigate perfusion, rhythm, pain, bleeding and recent medications while escalating as needed.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Medication Safety, Sedation & Reversal

KEY TAKEAWAY

Pair every medication with an indication, current order, monitoring plan and timed reassessment.

QUICK REFERENCE

Confirm allergies, concentration, route, compatibility and last doses. Use independent checks and pharmacy references where required.

SAFETY WARNING

Reversal does not end the risk. Re-sedation, pain, withdrawal or recurrent weakness may occur after the reversal agent wears off.

KNOWLEDGE CHECK

What belongs in a post-medication reassessment?

Answer and rationale: Effect, adverse effects, sedation, ventilation, hemodynamics and the next reassessment time, documented according to policy.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Pediatric Recovery

KEY TAKEAWAY

Use age-appropriate assessment, weight verification and family-supported recovery while anticipating rapid airway change.

QUICK REFERENCE

Confirm weight in kilograms and ordered calculations. Assess airway effort, hydration, pain behavior, emergence pattern and temperature.

SAFETY WARNING

Children may maintain oxygenation until reserve is exhausted. Rising effort, stridor, apnea or altered responsiveness requires immediate escalation.

KNOWLEDGE CHECK

Why must a pediatric weight be independently verified?

Answer and rationale: Most pediatric medication and fluid calculations depend on kilograms, so an incorrect weight can propagate serious dosing errors.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

ENT, Dental & Airway-Specialty Recovery

KEY TAKEAWAY

Expect shared-airway complications and know what was packed, removed or left in place.

QUICK REFERENCE

Clarify procedure details, airway course, blood loss, packing and surgeon instructions. Position and suction only within the ordered plan.

SAFETY WARNING

Frequent swallowing, hematemesis, increasing work of breathing, stridor or expanding neck swelling can signal deterioration.

KNOWLEDGE CHECK

What subtle observation can suggest bleeding after tonsillar surgery?

Answer and rationale: Frequent swallowing may reflect blood draining posteriorly and should prompt assessment and escalation.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

GI, Orthopedic, Regional & Neuraxial Care

KEY TAKEAWAY

Connect the procedure and anesthetic technique to expected motor, sensory, circulation, bleeding and mobility findings.

QUICK REFERENCE

Trend block level and regression, distal neurovascular status, dressing/drain output, nausea, pain and mobility readiness. Protect insensate limbs.

SAFETY WARNING

Do not ambulate or discharge based on elapsed time. Follow ordered block precautions and complete facility criteria.

KNOWLEDGE CHECK

What teaching matters while a limb remains numb?

Answer and rationale: Protect it from heat, pressure, injury and unsupported weight-bearing, and follow the ordered mobility and fall precautions.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

MH, LAST & Anaphylaxis Recognition

KEY TAKEAWAY

Recognize patterns early, name the emergency and activate the local response before the picture is complete.

QUICK REFERENCE

Know emergency carts, call pathways and roles. Use closed-loop communication, record events and prepare protocol-directed treatment.

SAFETY WARNING

Emergency dosing and sequencing must follow current approved protocols, orders and team leadership—not memory from a study guide.

KNOWLEDGE CHECK

What is the shared first principle across these emergencies?

Answer and rationale: Stay bedside, call for help, stop suspected triggers/exposure when directed, support ABCs and activate the facility-specific emergency pathway.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Hemorrhage, Unstable Rhythms & Neurologic Change

KEY TAKEAWAY

Detect time-sensitive deterioration through trends, focused assessment and early escalation.

QUICK REFERENCE

Verify monitors without delaying care. Assess perfusion, bleeding, neurologic baseline and airway protection; prepare ordered diagnostics and treatment.

SAFETY WARNING

Do not normalize new deficits, unstable rhythms or concealed bleeding because the patient is recently anesthetized.

KNOWLEDGE CHECK

What communication style best supports an emergency call?

Answer and rationale: A concise SBAR with current trend, assessment, interventions, response and a clear request supports faster team action.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

SBAR, Provider Calls & Escalation

KEY TAKEAWAY

Communicate the change, its significance and what you need using read-back and closed-loop language.

QUICK REFERENCE

Gather recent vitals, baseline, medications, relevant output, focused findings and actions already taken. Document the response and follow-up plan.

SAFETY WARNING

If the patient is worsening, call first and complete nonessential data gathering afterward. Use the chain of command when response is delayed.

KNOWLEDGE CHECK

What makes a provider call actionable?

Answer and rationale: State the concern and trend, provide focused evidence, say what has been tried and make a clear request.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Phase II, Documentation & Discharge Teaching

KEY TAKEAWAY

Turn recovery into a safe home plan through complete criteria, teach-back and a verified escort.

QUICK REFERENCE

Review restrictions, medications, wound/drain care, diet, mobility, follow-up and emergency contacts. Verify understanding in the patient's words.

SAFETY WARNING

A readiness score never independently authorizes discharge. Provider orders, facility policy and complete clinical criteria govern.

KNOWLEDGE CHECK

Why is teach-back stronger than asking "Do you understand?"

Answer and rationale: It demonstrates what the patient and caregiver can actually explain and reveals misunderstandings before discharge.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Cases, Reflection & Orientation Sign-off

KEY TAKEAWAY

Use cases to practice prioritization, communication, reassessment and recognition of limits.

QUICK REFERENCE

After each case, identify the first safety priority, data needed, escalation path, ordered options and documentation. Debrief with a preceptor.

SAFETY WARNING

Workbook completion is not certification or independent competency validation. Skills require supervised demonstration and facility sign-off.

KNOWLEDGE CHECK

What is the best response when a case exceeds your preparation or scope?

Answer and rationale: Stay with the patient, call qualified help early, follow approved pathways and ask for direct supervision.

PRACTICE NOTES

Assessment cues	
Priority and escalation	
Reassessment and documentation	

Final review

Use this self-check before a supervised case review or preceptor conversation.

- I can receive a handoff while independently checking airway, breathing, circulation, neurologic baseline, site, lines, drains, pain, nausea and temperature.
- I can recognize deterioration, stay bedside, call for help early and use closed-loop communication.
- I verify every medication against current orders, concentration, allergies, policy and pharmacy references.
- I can explain Phase I versus Phase II priorities and why a score never replaces full discharge criteria.
- I know my unit's emergency equipment, escalation chain, approved protocols and documentation expectations.
- I can name the limits of my knowledge and ask for supervision before acting outside my training or scope.

Preceptor review

Strengths observed: _____

Next practice priority: _____

Learner / date: _____ Preceptor / date: _____

Completion of this book does not confer certification, accreditation, privileges, independent authorization or a guarantee of clinical outcomes.