Postoperative Nausea and Vomiting (PONV)
Risk Assessment Nursing Tip Sheet

Why risk assess for PONV:
◊ PONV is an unpleasant, frequently occurring post-operative morbidity that can be avoided.
◊ It is a major patient dissatisfier and a leading cause of unanticipated hospital admission (in early discharged patients).
◊ The occurrence of PONV can delay discharge from post-anesthesia recovery, diverting precious nursing resources to the management of an issue that can be minimized or mostly avoided.
◊ Discomfort from PONV can delay the patient from engaging in activities to promote recovery.
◊ There are rare, but serious, complications associated with PONV: suture dehiscence, aspiration of gastric contents, and esophageal rupture, to name a few.

How to Combat PONV
◊ ASSESS
  When to assess:
  Pre Admission Testing (PAT): during the patient interview
  Preop: during preop assessment, review with the patient his/her risk for PONV from the PAT assessment and make any necessary modifications
  Post-Anesthesia Care Unit (PACU)/Recovery Room: immediately after recovery from anesthesia, and continue to reassess at regular intervals until discharge from PACU (may be done in tandem with pain assessment)
  Inpatient Unit: during the admission assessment and at regular intervals thereafter through 48h post-discharge from PACU (especially in patients with a PONV risk score of ‘moderate’ or ‘high’)
**Make sure to communicate PONV assessment status and interventions during hand-off communication between (staff/shift/unit) transfers of care**
  What to assess:
  1. Identify the PONV “triggers”: patient risk factors, anesthesia-related risk factors, and potential risk factors the patient may have (see NURSING PONV Risk Assessment pocket card).
  2. Tally the “triggers” and assign a score.
  3. Based on the range, assign risk (see NURSING PONV Risk Assessment pocket card).
  4. Document and communicate the risk to the anesthesiology team: anesthesiologist, MLP, nurses, and patient.

◊ INTERVENE
  Patient Education:
  1. Empowered awareness: provide personal risk score and education regarding PONV risk, goals, and intervention strategies. Patients should know what to expect so that they may participate in “reminders” to staff if/when necessary.
  2. Engage the patient in ERP’s team approach to care: emphasize the importance of patient self-advocacy in communicating PONV risk and associated needs to providers.

  Nursing Intervention:
  1. Continual assessment from PAT through 48h past PACU discharge *learn the PONV risk “triggers”, know each patient’s risk*
  2. Know what medications are available to the patient in advance
  3. Provide prophylactic and/or rescue medications for PONV
  4. Motion (ambulation) and opioid administration (morphine PCA) can precipitate PONV

RISK ALERT: de novo PONV
Patients who:
A. Have a PONV Risk Score of Moderate or High AND/OR
B. Received a rescue antiemetic in PACU
are at high risk for developing de novo (beginning again) PONV on the floor (unit)