Surgical Technology **Patient Care Skills**
8-Jul-09 **Preop Routine**

Objectives:

1) Discuss why preop preparation of the patient is important
   a) Preparing the patient decreases impact and potential risks of the surgery
      i) Physical
         (1) Smoother recovery
         (2) Fewer complications
      ii) Emotional
         (1) Psychosocial
            (a) Alleviate fears
         (2) spiritual
   b) Establishes a baseline to compare during and after surgery
   c) Teaching to reduce postoperative complications
      i) Deep breathing exercises
      ii) Coughing
      iii) Leg exercises / Early ambulation
   d) DRG's changed preoperative time to outpatient
      i) AM admits
      ii) Stable patient conditions preoperatively
2) Discuss the patient's preop physical preparation
   a) Helps the patients overcome stresses of
      i) Anesthesia
      ii) Pain
      iii) Fluid and blood loss
      iv) Immobilization
      v) Tissue trauma
   b) Aim is to have the patient be in the best physical condition possible at the time of surgery
      i) Specialty consults might be necessary
         (1) I.e. Cardiology, etc.
3) List and discuss preadmission procedures
   a) Surgeon's / physician's office
      i) History and physical exam
      ii) Lab tests based on patient's need or hospital policy – may have time limitations
         (1) Hemoglobin – normal
         (2) Hematocrit / CBC– normal
         (3) BUN or Creatinine for kidney function
         (4) Glucose
         (5) Electrolytes
         (6) UA
         (7) CXR
         (8) EKG
      iii) Diagnostic studies
         (1) Doppler
         (2) Biopsy
      iv) Blood type and crossmatch
         (1) May choose to give their own blood ahead of time
      v) Written instructions – may be reviewed later
         (1) NPO status before surgery
         (2) Taking medications before surgery
         (3) Any special skin cleansing
         (4) Not wearing nail polish / acrylic nails – at least one finger

(5) Jewelry / valuables left at home
(6) Someone to take them home after the procedure

vi) Informed consent
(1) Explanation of procedure
(2) Potential risks
(3) Alternatives to surgery
(4) Signed by patient or parent / guardian

b) Anesthesia assessment
i) History
(1) From surgeon
(2) From patient
(a) Previous anesthesia experiences
(b) Allergies
(c) Adverse reactions to drugs
(d) Drug use – legal and not
(e) Alcohol use
(f) Smoking
(g) Previous transfusion experiences
(h) Re teeth – and possible damage to teeth

ii) Physical
(1) Heart
(2) Lungs
(3) Emotional status
(a) Mental status
(b) Anxiety
(4) Weight

iii) Assess
(1) Degree of risk
(a) Complex medical history
(b) High anxiety

iv) Explains anesthesia choice/s and expectations / risks
v) Explains NPO status reasons
vi) Explains sedation before surgery
vii) May sign anesthesia consent form
viii) Answers questions to allay fears
ix) Assigns ASA classification – p374

c) Surgical nurse assessment
i) Physiologic, to include height and weight
ii) Psychosocial
iii) Assessment includes
(1) Assessment data
(2) Nursing diagnoses
(3) Expected outcomes
(4) Plan of care specific to this patient

iv) Reviews instructions and consent
v) Provides emotional support
vi) Teaches post op care plan

d) At home
i) Skin preparation / cleansing / shaving
ii) Bowel preparation
(1) Cleaning out bowel

4) Discuss day of surgery procedures
a) After arrival at the hospital / surgery center
i) Patient is identified by

(1) Identification armband
(2) Allergy armband and note on chart
(3) Surgeon
(4) Type of surgical procedure

ii) Ask about NPO status

iii) Removes clothing and dons patient gown

iv) Jewelry removed or wedding ring taped with bandaid over any stone
(1) Prevents loss
(2) Prevents alternate site for ESU
(3) May permit religious article to be taken to OR
(a) May be removed in OR
(4) *May* keep glasses / hearing aid
(5)

v) Prostheses removed
(1) Contact lenses
(2) Glasses
(3) Dentures / bridges removed
(a) Prevents loss - aspiration
(b) Prevents damage during intubation

vi) Hair confined under head cover

vii) Wig / hairpins removed

viii) Antiembolic stockings may be ordered - SCD
(1) Abdominal or pelvic procedures where stasis may occur
(2) Geriatric
(3) Long procedures

ix) Empty bladder to prevent over distention
(1) Catheter may be inserted to
(a) Keep bladder out of the way during surgery
(b) During long procedures
(c) To keep track of
(i) urinary out put
(ii) possible trauma / blood in urine

x) Give antibiotic prophylaxis

xi) Give preanesthesia drugs as ordered by anesthesia
(1) Side rails up during this time
(2) Call bell available if nurses aren't readily available

xii) Emotional wellbeing
(1) Allow family to stay with patient as long as possible
(2) May request to see chaplain / cleric

xiii) Check off all items on official hospital checklist

b) Preop surgical or preop nurse visit
i) Assess physical and emotional status
(1) To alleviate anxiety and fears
(2) To express feelings

ii) Give information

iii) Clarify misunderstanding / misinformation

iv) Develop care plan if not already done

v) Increase patient cooperation

5) Discuss Preop holding area procedures
a) Identify the patient
(a) Name and birthday (or other identifier) given orally
(b) Armband – should match patient's information and chart and schedule
(c) Surgery, site, side as appropriate
(d) surgeon

b) Review chart for necessary items / hospital policy
    i) History and physical
    ii) Lab / diagnostic data
c) Check for consent form
d) Asks about NPO status
e) Measures vital signs
f) Checks for allergies
g) Checks skin integrity
h) Check mobility / limitations
i) Checks emotional status
j) Checks head cover
k) May do the following:
    i) do skin prep - remove hair
    ii) start IV if not done previously
    iii) insert invasive monitoring devices
    iv) insert Foley now or after anesthesia
    v) administer preanesthetic drugs
        (1) antibiotics
        (2) sedatives
    vi) give regional anesthesia blocks
l) provide comfort to patient when necessary
    i) warm touch
    ii) music

6) List procedure to transfer patient to the OR
a) Introduce yourself
b) Greet and Identify the patient
    i) Name
        (1) Ask name
        (2) Check armband for
            (a) Name
            (b) number
        (3) Check surgery schedule and compare
    ii) Procedure and site if appropriate
    iii) Surgeon
c) Ask about allergies
d) Ask about NPO status
e) Check for anything applied to or into patient – tubes, wires, etc.
f) Observe for anxiety level
g) Check list as per hospital policy
    i) H&P
    ii) Labs
    iii) Diagnostic tests
    iv) Etc. above
h) Review care plan for this patient's needs
i) Move patient to OR table
    i) Follow same rules as for transfer to stretcher
    ii) Exchange covers for new, warm bath blanket
    iii) Secure patient with safety strap
    iv) Make patient comfortable
j) Assist anesthesia provider with monitor attachment and induction of anesthesia
k) SMILE

7) Transfer to the OR
a) Transfer occurs with a stretcher
    i) Positioning patient on stretcher

(1) Identify patient as above
(a) Name and birthday (or other identifier) given orally
(b) Armband – should match patient's information and chart and schedule
(c) Surgery, site, side as appropriate
(d) surgeon
(2) Lock wheels before moving patient to stretcher
(3) Care with any tubes connected to patient
(4) Far side rail up if patient is getting on stretcher by themselves
(a) If they are moving from a bed to stretcher
(i) Another person on far side
(ii) Or
(iii) Stretcher locked up against bed
(iv) You on near side to receive patient
(5) Hold stretcher to prevent it's slipping
(6) Secure near side rail
(7) Cover patient
(8) Apply safety strap
ii) Push from head end, feet first
iii) Head slightly elevated may be more comfortable
iv) Hands / feet inside rails
v) IV's should hang at the foot end to prevent injury to patient if it falls
vi) If patient is ambulatory / depending upon the procedure
(1) May walk to OR if not medicated
(2) May be taken with wheel chair

b) Patient comfort
i) Warm enough
ii) Covered for privacy / dignity
iii) Don't bump walls, go fast, etc.

c) Chart goes with patient
i) Check chart for necessary items / hospital policy
(1) History and physical
(2) Lab / diagnostic data
(3) DNR
ii) Check for consent form
iii) Check dates on time sensitive lab tests
iv) Check for allergies

8) Post-op Procedure to move the patient who cannot move themselves from the OR table to the stretcher
a) Lock stretcher next to OR table
b) Ask anesthesia provider if it is OK to move patient
c) Remove safety strap
d) Place warm bath blanket on patient (and gown if necessary)
e) Lift the "lift sheet" to roll the patient toward yourself next to the OR table
f) Place Davis roller under lift sheet / patient's trunk
g) Hand off "lift sheet" to staff on stretcher side
h) Anesthesia holds head / staff feet and each side
i) Lift/pull "lift sheet" toward stretcher
j) Lift "lift sheet" on OR table side to remove Davis roller
k) Center patient on stretcher
l) Make sure they are warm and covered
m) Unlock stretcher and move patient to recovery with anesthesia provider