NICE News Inservice and Continuing Education Little Booklet

May 2011

INGHAM REGIONAL MEDICAL CENTER
A McLAREN HEALTH SERVICE

Pre-Procedure Protocol in Action

This NICE booklet will review the steps to prepare a patient for a procedure, as outlined in the new protocol, "Preparation of the Surgical/Pre-Procedure Patient, 200-133" and documented on the revised "Pre-Op, Pre-Procedure Flowsheet", now a permanent part of the medical record. Examples will be given to guide your practice in preparing a patient to enter a sterile/aseptic environment.

This module is required for all Registered Nurses. The booklet content is on the intranet/internet. Please complete the reading, print the post-test and turn in the completed post-test by Friday, June 17, 2011 to your manager. Email questions about this booklet to phyllis.mclellan@irmc.org

Definitions:

Asepsis/Aseptic – The process for keeping away disease-producing microorganisms.

DNR – Patient with 'Do Not Resuscitate' or 'Partial Do Not Resuscitate' status.

Electrocautery/Electrosurgery – The cutting and coagulation of body tissue with high frequency current (AORN, 2011).

ICD – The Implantable Cardioverter Defibrillator (ICD) - is an electronic device that senses lethal dysrhythmias (ventricular tachycardia, ventricular fibrillation) and shocks the heart, thereby interrupting the dysrhythmia (Phippen, Ulmer and Wells, 2009).

NPO – Nothing per os/oral. Time of NPO is when patient ceases intake of cigarettes, gum, lozenges, food and/or fluids. This does not include time of taking a pill with sips of water.

Sterile – The absence of all living microorganisms.

Surgical/Surgery – Terms may be interchanged with ‘Procedure’.

Content:

Patients scheduled for same day surgery (outpatient or planned admission following the procedure) are requested to arrive 2-3 hours prior to their scheduled procedure. Why??? There are many facets to preparing a patient to enter a sterile or procedural environment. Lab work, paperwork and physical preparation takes time and can cause major delays when time is critical in the procedure/surgical suite. Therefore, preparation for an inpatient must start as soon as the procedure is boarded.

The Registered Nurse preparing a patient for a surgical or invasive procedure must take steps to prepare them physically, psychologically and emotionally. Nurses should anticipate some level of anxiety from the patient and/or family. In fact, the patient may experience a sense of grief over the removal of an organ (e.g. unplanned hysterectomy) or functional loss (Phippen, Ulmer, Wells, 2009). Interventions aimed at helping the patient explore and cope with anxiety or anticipatory grieving should be implemented and documented.

Preparation incurs paperwork, phone calls and physical assessment of the patient. There should be preoperative orders, such as NPO, consent and any physical preparation (bowel prep, skin prep) required above the standard preparation. An anesthesia order set also includes labs and a cardiac risk assessment. Orders for consents and labs must be a priority; incomplete paperwork and orders cause delays in the procedure area.

Chart Preparation:
There are two consent forms **required**, one for the physician performing the procedure and one for anesthesia services during the procedure. They are legal documents and must be free of misspellings, abbreviations, write over and cross-offs (see back page of pre-procedure flow sheet for correct spellings of commonly misspelled procedures). Please do not use white-out on the form either! Additions or changes cannot be made after the consents have been signed. Phone the receiving department with questions about consents, spellings, etc.

It is important that each physician has given informed consent prior to the patient signing their specific consent form. The only exception is when a patient cannot

sign his/her consent forms and has a Medical Durable Power of Attorney (DPOA)/responsible adult and he/she will not be present at the time of the procedure.

If the DPOA will not be present at the time of surgery, significant delays often occur when consents and checklist items are not completed. Verbal phone consent is allowed in these situations, with two licensed providers confirming consent by phone with the responsible DPOA or designee. If questions arise and further explanation is needed from either person performing the procedure or anesthesia, contact the appropriate physician or designee to telephone that person.

For any patient, a family member or DPOA should be physically present at the time of the procedure to make decisions when the patient is unable (under anesthesia care or incapacitated). Please refer to the full policy, “Informed Consent/Authorization for Treatment of Adult & Minor – 200-086” for situations involving emancipated minors, minors, and incapacitated adults.

Additional questions about the procedure or anesthesia plan of care should be directed to the appropriate physician or his/her designee. There is always a resident on call for Anesthesia services (name and pager are located on the on-call schedule, via IRMC Operator, Nursing Supervisor, or Surgery Front desk).

If your patient is currently a DNR, the patient must receive options from the anesthesiologist about cardiac interventions in the surgical suite. This relates to a patient’s right to self-determination (free choice). For example, a DNR patient in end-stage lung cancer needs a Pleurx catheter inserted for palliative symptom relief of pleural effusion. This patient may opt to not have certain cardiac interventions if an emergent crisis occurs during the procedure. The interventions the patient can choose (after an informed discussion with Anesthesiology) are cardiac defibrillation, compressions, pacemaker and cardiac massage. A Perioperative DNR Clarification consent form needs to be completed by the anesthesiologist and patient, and can then be witnessed by any Registered Nurse provider. The DNR clarification consent is only valid during the intra-operative and immediate post-operative period (while under Anesthesia provider care). Upon post-operative transport to the inpatient unit, the DNR order needs to be re-written along with the other orders.

The History and Physical (H&P) can assist with a systems review and is also **required** to be on the chart before a procedure is performed that requires informed consent. The original H&P must be less than 30 calendar days old. An

update is required less than 24 hours before surgery (update by physician can be an entry in the Progress Note).

Other key items to send in the front of the chart include the Medication Administration Sheets (current day and day before), Facesheets, Patient Labels, House wide Report Sheet and the Ticket to Travel. Fax the report sheet, pre-procedure flow sheet and consents to the receiving department. If the patient has a known LATEX allergy, call the receiving department to ensure preparation of instruments and equipment will provide a latex free environment.

Does the patient have an ICD? (e.g. AICD)? These devices require postoperative interrogation to validate their functioning status due to the intra-operative use of electrocautery. The representative must be called as soon as possible to notify their required presence the day of surgery and be available if questions or interventions are needed pre-procedure. The patient should carry their ICD card with the company name. The phone number to call for the company representative is on the back of the new pre-procedure flow sheet if it is not on the ICD card.

Does your patient have a language barrier? If so, when you call for interpreter services, ensure that the interpreter also knows the patient is going for a procedure. Delays occur when there is no-one available to interpret and communicate with the patient. Remember that a family member is not the best choice to interpret.

Does your female patient meet criteria for required pregnancy testing? You do not need a physician order. Write“Nurse Discretion for urine pregnancy test” on the order sheet, enter in computer and (unless trained in point of care pregnancy testing), send a non-sterile urine specimen to lab for any female except for these few exceptions: history of hysterectomy, immediate post-partum, post-menopausal (natural absence of period for 12 consecutive months) or is having surgery for fetal demise/missed AB. If unable to obtain urine, order lab for Qualitative BHCG (yes/no results) and have blood drawn stat. The pregnancy test is considered ‘good’ for 7 days.

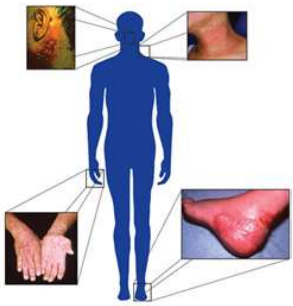
Remember to include female pediatric patients in testing if menstruating and/or developed. There is no need to ask if the patient is sexually active, has had sex recently or if they think they are pregnant. It doesn’t matter if they ‘think so or not’, because believe it or not, they have been wrong before! A positive test can delay the procedure or even identify if the procedure needs to be canceled (and be sure not to give the patient the test results if positive; that’s news you definitely want the physician to give)! If the patient is pregnant, risks and benefits

of the patient and fetus are assessed to determine if surgeon/anesthesia provider will proceed with procedure or not.

Physical Assessment Preparation:

Pre-procedure review of systems, vital signs and lab work is critical to make sure the patient is safe to proceed to the surgical/procedure area. New abnormal findings in cardiac or respiratory assessment, vital signs or labs should be reported to the attending physician performing the procedure (or designee) to initiate a further assessment of patient's stability/risk.

Documentation should also include time of NPO, accurate/current weight and vital signs written on the pre-procedure flow sheet. Check that all appropriate armbands are on the patient and if on telemetry, the telemetry box must remain on the patient to transport and will be returned by volunteer or staff if the patient is transferred to a different department post-procedure.



Skin assessment should include an overall assessment and the intended surgical/procedure site. Elective procedures have been canceled in the past due to rashes or inflammatory conditions (unrelated to the need for the procedure) at the surgical site. Contact the person performing the procedure or designee to have the skin assessed further. Initiate a Skin/Wound Flowsheet to document any abnormal skin assessment findings.

Double check any pre-procedure orders for Type/Screen and/or units of blood for 'standby'. A type and screen is limited in time, so call Blood Bank to make sure it is still active or that ordered units are available. Delays occur when a type and screen is drawn right before surgery as it takes a minimum of forty-five minutes to an hour to run this test.

The number one item requested by a surgical/procedure department (Same Day Surgery, Surgery, Endoscopy, Special Studies, and Radiology) and the anesthesia staff is a functioning peripheral intravenous line! Almost every procedure in these areas begins with infusion of either relaxant or intubation medications – it is the first thing the surgical team needs to access. Unless there is a triple-lumen central line, the surgical team needs at least a 20 G running intravenous line.

The intravenous site should also be free of redness/heat, infiltration or pain at insertion site. Do not send a patient with a non-functioning, possibly infected site. Patients report to procedure area staff, “I told the nurse this was hurting but she said you would take care of it down here”. Venipuncture sites should be changed every 96 hours unless patient is a difficult start and there are no signs of infection or infiltration (IV Therapy: Maintenance of Continuous and Intermittent, 40-4.267). After two unsuccessful attempts, call the Anesthesia provider/resident on-call to start the intravenous line in the patient room. This will prevent delays in starting the procedure. If attempts are made and no clinical expert is available to start the intravenous site for you, document on the flow sheet and send the patient to pre-procedure area.

Other interventions closer to procedure time include Accucheck (preferably within 2-3 hours of procedure time), assessing and sending antibiotics (unless cued by receiving department to start an antibiotic prior to transport of patient), preparing PAS stockings for transport (leave them on and running as long as possible to prevent circulatory compromise) and having the patient empty their bladder (better when awake than after they receive sedation in preoperative area).

Pre-operative Physical Preparation:

Physical preparation assists the surgical team to take over care of the patient, while maintaining the aseptic environment. Clothes need to be removed because personal items should not enter the surgical suite and the team may need access to areas other than the surgical site. For example, a patient needing carotid endarterectomy procedure must have his/her pants removed since the surgical team needs to insert a urinary catheter and/or may need to access the groin for an arterial line or unplanned intervention. At any time, an emergent situation can occur intra-operatively, initiating the need for quick interventions that require access to the any/all parts of the body. Personal items can contaminate the surgical/procedure suite, disrupting the sterile field and surrounding equipment.

Jewelry has always been a difficult topic. It's hard to ask the patient married for 55 years to remove his/her wedding band or insist that the 23 year-old patient remove his/her facial piercing when surgery is on the leg. Why is that necessary? In the majority of surgical procedures, electrocautery is used to cut tissue and/or coagulate tissue/bleeding. Even though the procedure site is not near the jewelry, the electric current still travels through the body. A special dispersive pad is used to direct the current away from the body and to the pad. AORN states "Metallic jewelry, including body piercing, presents a potential risk of burn from directed current, heat directed before an electrode cools, and leakage current. Eliminating metal near the activation site minimizes this. Jewelry that is left in place, particularly on the hands, has potential to cause swelling at the site during surgery or recovery" (AORN, 2011, pg. 106). Be sure to ask about all piercings (not visible) during preparation.

Other personal items must be addressed and removed, including wigs, hair pins/hair accessories, makeup, nail polish (for pulse oximetry), glasses, contacts, hearing aids and dentures. All items should be confined, labeled and kept either in the patient room, or if valuable, have Security come and gather, inventory and lock up in their department safe. Costs incurred by the facility to reimburse patients for personal items amount to thousands of dollars every year.

Transporting Patient to the Procedure Area:
A patient should be ready for transport 3 hours prior to the procedure. Why that long? Many times, for example, the surgery schedule changes (cancellations, running ahead of schedule) and if the surgeon is available, then there is a 'golden time' of opportunity to complete the procedure earlier than scheduled.

Surgery specific - Expect transport to pre-procedure area 1-1/2 hours prior to scheduled procedure time. Patients that are 'add-ons' to the surgery schedule are usually added to the end of the surgical day. The pre-procedure area (e.g. Same Day Surgery) will notify the unit of the anticipated time as soon as that time is known. This is a 'holding' area for the inpatient more than a preparation area.

On weekends and evenings the sending unit will be asked to transport the patient to the procedure area. This is because the procedure departments are closed on weekends and do not have the regular transport help as they do Monday through Friday during the day. Please do not bring the patient to the department in a wheelchair – the patient needs to be brought on a patient cart or the patient bed.

Summary:
Preparing an inpatient for a procedure takes organization and time management in addition to an already busy shift. Utilizing the Pre-Procedure Flow Sheet and the Preparation of the Surgical/Pre-Procedure Patient protocol will assist in completing the necessary elements and providing a smooth transition for the patient to enter the surgical/procedural environment.

Booklet References:
Protocol - Preparation of the Surgical/Pre-Procedure Patient, 200-133
Form - Pre-Op, Pre-Procedure Flowsheet Form 671-20

Phippen, M., Ulmer, B., and Wells, M. (2009) Preparation of the patient for the procedure, chapter 5. *Competency for Safe Patient Care During Operative and Invasive Procedures.* Denver, CO.

Perioperative Standards and Recommended Practices (2009). Association of peri-Operative Registered Nurses (AORN). Denver, CO.