PERIOPERATIVE NURSING

INTRODUCTION
What is Perioperative Nursing

- Describe five domains of the Perioperative Nurse
- Differentiate the roles and responsibilities of the Perioperative Nurse
Perioperative Professional Practice

- Care Provider
- Educator
- Manager
- Professional

Perioperative Nurse
Nursing Process

**PREOPERATIVE PHASE**
- Collect Data
- Identify needs
- Develop Plan of care
- Communicate needs

**INTRAOPERATIVE PHASE**
- Implement plan of Care
- Coordinate Activities of care

**POSTOPERATIVE PHASE**
- Evaluate Care
- Communicate Information

- Assessment
- Nursing Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation
Nursing Diagnosis

- Perioperative Nursing Data Set, PNDS examples
  - Risk for positioning injury
  - Risk for infection
  - Risk for altered body temperature
  - Risk for injury from mechanical/thermal sources
The patient is free from signs and symptoms of injury caused by extraneous objects.

The patient is free of symptoms of injury related to positioning.

The patient is free of symptoms of infection.

The patient’s fluid, electrolyte, and acid–base balances are consistent with or improved from baseline levels established preoperatively.
Intraoperative Phase
Post Operative Phase

- Evaluate your care
- Did you meet the outcomes
- Communicate important information to the other health care providers
Role of Researcher

- Quality Assurance
- Read Research
- Problem Solver
- Integrate research into practice
Role of Educator

- Orientation for new staff
- Inservice training & continuing education
- Perioperative Consortium
“In order to be accountable, nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth and self determination of the patient. Nurses are accountable for judgments made and actions taken in the course of nursing practice, irrespective of health care organizations’ policies or providers’ directives.”

ANA Code of Ethics
Role of Professional

- Ethics
- Role Model
- AORN membership
- Certification
Attributes Expected in a Perioperative Caregiver

- Conscientiousness
- Efficiency
- Sensitivity
- Open minded
- Flexible/Adaptable
- Supportive
- Communicative
- Listens/Even tempered
- Versatile
- Analytic
- Creative
- Sense of Humor
- Manual Dexterity
- Stamina
- Hygiene
- Ethics
WHAT IS GOING ON BEHIND THIS DOOR?

OPERATING ROOM MYTHS REVEALED AND TRUTHS DISCOVERED!!
Surgical Conscience

*Remember, “Do unto the patient as you would have others do unto you”

*Treat the patient as if they were a member of your own family

*Mary Louise Kohn—“the patient is the reason for our existence”

**the awareness that develops from a knowledge base of the importance of strict adherence to principles of aseptic and sterile techniques
Surgical Attire—Why we look like this

In OR area:
- Scrub top/bottom/warm up jacket
- Surgical hat
- Shoes w/ booties
- No jewelry, watches
- No artificial nails, nail polish
- No clothing laundered outside of facility
- No perfume

In OR w/ open sterile supplies or Surgery started:
- Same as above
- Mask
- Eye protection
Getting ready for the day

**RN duties**
- Morning report
- Goes to room and starts getting 1st case ready
- Look at schedule and plan for the day
- Retrieve medications
- Ensure any special order items/equipment are located at start of day
- Discuss w/Surgeon any requests/potential complications for the day

**Scrub tech duties**
- Morning report
- Looks at preference cards and pulls all instruments for the day and ensures they have everything needed for their cases
- Assist with opening 1st case supplies
What happens before the Patient comes into the OR?

The room is prepared for the patient
- OR table is prepared for proper positioning and equipment is placed on the table and in the room
- Supplies and instruments are opened
- Medications are retrieved to add to the surgical field
- Items and supplies needed to prep patient are organized
- Scrub tech sets up sterile field and counts items as indicated
Outpatient Surgery

- Patients are “prepped” for surgery in this area
- Pts come in 1 ½ hours before scheduled surgery time
- Change into patient gown
- All paperwork and chart is reviewed
  - IV started
- Seen by Anesthesia/CRNA
- Pre-op medications given if ordered
  - Labs/tests completed
- Given a nerve block if indicated by surgery, Surgeon and Anesthesia MD
- Seen by Surgeon, correct site marked if indicated
  - H&P updated if needed
- Meet the RN circulator in this area
- Each team member that meets the pt will identify the pt. with 2 identifiers
- Patients will and do, start to get aggravated and irritated with having to repeat all of the same questions
- We tell them that it is for their safety
What we do...

1. Patient is identified using 2 identifiers
2. Pt is asked to state what surgery they are having and what Dr. is performing it
3. Pt is asked to show where the Dr. has marked them if indicated
4. Pt is asked many questions related to NPO status, contact lenses, glasses, jewelry, piercings, false, loose or capped teeth, metal implants in their body, any prosthesis, any problems with their mobility, etc.
5. RN explains what is going to happen to the pt in the room

Why we do it...

1. *to ensure we have the correct pt for the correct surgery
2. *to ensure pt has given informed consent
3. *to prevent wrong site surgery
4. *pt is at risk for aspiration, corneal damage, burns from cautery, risk for damage to teeth, risk for infection if jewelry, nail polish left on, risk for damage to fingers if rings left on, risk of nerve damage or injury if not positioned properly, if existing injury isn’t taken into consideration prior to positioning them
5. Surgery produces anxiety, it’s an unfamiliar environment, explanation of what to expect helps to relieve some anxiety
Once the Patient is in the OR room

What we do...

1. Pt is introduced to the team and asked to tell them what they are having done
2. Pt is assisted to the OR table, gown is untied, safety strap placed across thighs, given warm blankets
3. Anesthesia places monitors on pt with assistance (or not) from RN
4. Pt will be given O2 via mask, medication to induce anesthesia given via IV
5. RN assists anesthesia and does not leave until pt. intubated, ET secure and their help is no longer needed
6. Pt is then positioned depending on surgery. Surgeon is in room at this point. All team members check position of pt
7. RN preps surgical site according to Surgeon preference and product indication
8. extensive “TIME OUT” completed before surgery starts
9. During surgery, RN is vigilant about sterile technique and observing sterile team members and protecting the pt from harm

Why we do it...

1. *to prevent potential wrong site surgery
2. *Assistance given, table is narrow, pt could fall, safety strap applied
3. *knots in gown not untied could cause pressure areas
4. *OR room is cold, anesthesia causes decrease in body temp
5. *monitors tell anesthesia pt vital signs and how pt is reacting to surgery
6. *induction of anesthesia stops pt breathing and O2 sats rapidly decrease
7. *RN is needed to assist (cricoid pressure, pass the tube)
8. *Pt can be hurt during positioning, surgery, and transferring. All team members are conscious and aware of proper techniques and safety considerations
9. *at least 4 team members needed to move a pt
10. *RN aware of prepping principles and what prep is OK to use on the body (iodine can burn, ETOH based preps need to dry), jewelry removed, name band not on operative limb
11. *TIME OUT process is to prevent wrong site surgery, make sure all team members are ready for the case
12. *RN is in charge of the room, sets the tone.
   *has a 3rd ear listening to what is going on at the field
   *anticipates the needs of the team
   *checks position of pt after OR table is moved
After the surgery is over

What we do...

- 1. RN secures dressing, drains, tubes
- 2. Scrub tech wipes prep/blood off pt
- 3. Team members move pt back to supine if needed
- 4. Pt redressed, covered up, warm blankets given
- 5. Pt transferred to stretcher/bed
- 6. RN stays at head of bed to assist anesthesia with extubation

Why we do it...

- 1. *to prevent the dressing, drain, tube falling off/out
- 2. *prep left on pt can be irritating, burn, body fluids can be disturbing to pt
- 3. *pt needs to be put back in supine position, legs lowered together and slowly if in lithotomy
- 4. *hypothermia is a result from anesthesia, can delay healing
- 5. 4 team members needed to safely move pt. goes to PACU on stretcher/bed
- 6. *pt emerging from anesthesia can be restless, unpredictable, harm themselves, have airway issues
PACU—Post Anesthesia Care Unit

- Pts come to PACU after General/Spinal anesthesia
- If local w/ sedation can go directly to Stage 2
- Pts usually spend 1–2 hours in PACU
- RN from OR/Anesthesia provider gives report
- Pt is placed on monitors and observed
- Pain/nausea medications given
- Anesthesia provides the orders for the pt while they are in PACU
- RN completes OR record
- RN reports back to room to assist with next set up OR carries on to OPS to pick up next patient
EQUIPMENT AND ROOM SET UPS

- Positioning devices—equipment to hold heads, arms, legs, knees, place patients prone, lateral, lithotomy
- Not just 1 kind but many, mcconnell headrest, mayfield headrest, stryker knee holder, blue knee holder, mcconnel arm holder, peg board, bean bag, etc…….
- Special OR tables—able to X ray through
- Video towers—laparoscopic surgery, take pictures/video/hi def
- Special cautery machines—urology/gyne
- Ultrasounds
- Lasers—holmium, CO2, KTP/YAG, green light, etc…….
- Consoles for power sources—Stryker command, styker TPS
- The equipment that you use in the OR is dependant on what Surgical service it is, the surgery you are doing and the surgeon’s preferences
Perioperative Team Members

- **Circulator–RN**
- **Scrub tech–Certified or on the job trained, RN**
- **Anesthesiologist–MD, working on their own or supervising CRNAs**
- **CRNA–certified registered nurse anesthetist, operates under the direction of Anesthesia MD, RN with specialized training**
- **Surgeon–MD/DO with special training, General, Gyne, Plastics, ENT, Vascular, Urology, Orthopedics, Podiatry, Dental, Opthomology**

- **Assistant–another surgeon, Physician Assistant (PA), Nurse Practitioner, Medical student, another OR team member**
- **Unit Assistants/OR aide–team member, assists with turnovers, picks up patients, assists with stocking rooms of supplies**
- **Manager/Director–oversees administrative duties**
- **OPS staff–prep the patients**
- **PACU staff–recover the patients**
- **SPD staff–sterile processing department, decontaminate, wash, sterilize OR and hospital items**
MYTHS and TRUTHS

Myths.....

- We sit /stand all day
- Surgeons yell and get mad
- You never get to do anything interesting or scrub in for cases
- You use one set of instruments for all of the surgeries
- There are no 12 hours shifts
- The staff in the OR are “clicky”
- OR nurses are mean and they yell at you
- You never get breaks
- You have no patient contact
- You are nothing but a “gopher” (go for this, go for that)

Truths....

- You are only sitting when you are charting, everything is going smoothly
- Surgeons respect you and appreciate what you do, if they are upset, it’s usually not directed at you...
- Our work is interesting and we do train RNs to scrub...
- There are over 100 different instrument sets that we use, in addition to separate instruments, supplies and equipment
- We have 8, 10 and 12 hour shifts
- We have to work together as a team, we don’t get out of our dept. much...
- OR nurses are “watchdogs”, so if they observe a break in sterility, they will tell you
- Our work is physical, fast paced, no floats to our area, breaks are important
- You have a short time to establish a relationship, then you become the pt. advocate
- If you prepared for your cases, then you should not have to do any running, if you do need to “go for” an item, you do it urgently
Various views in the OR
Summary