

PROTOCOL FOR: Day of Procedure Care, Perioperative Care

- POLICY:**
1. All patients will undergo a nursing assessment prior to invasive or operative procedures. Patient assessment will be individualized to the patient and family and to the proposed invasive and anesthetic procedures, including but not limited to age-specific concerns, language proficiency acute and chronic pain management, falls risk, skin assessment, cultural care issues, physical impairments, and correct site surgery.
 2. Each chart for elective patients will be prepared using an individualized Face Sheet to track document availability and completion, DOS orders, etc., with the exception of Cardiac Catheterization Lab patients whose charts are prepared entirely by staff from that unit.
 3. Dep't. of Anesthesiology/Hartford Anesthesia Associates criteria (appendix A) will be followed for preoperative testing for patients undergoing anesthetic procedures. Additional testing will be done per MD/PA/APRN order and individual patient assessment only. At a minimum, requirements include an EKG for diabetics 40+ and all others 50+, unless the patient is younger than criteria and has a positive cardiopulmonary history. Testing for other patient groups will be done per protocol or by specific order.
 4. Sources of information for chart preparation may include but are not limited to:
 - a. patient and family interview
 - b. history & physical examination
 - c. LCR system, procedure requisition or alternative sources of data
 - d. Perioperative scheduling system/OR schedule/surgical booking sheet
 - e. other care givers
 5. Information required for the chart (e.g. missing consent or H&P) or orders to be completed (e.g. preoperative antibiotic administration or lab testing/results) will be clearly marked on the Face Sheet prior to transferring the patient from the Holding Area to help assure proper follow through.
 6. Staff will collaborate with the patient and family regarding plans for care, whenever possible. Choices within the scope of care will be allowed.
 7. Patient teaching will be individualized to the patient and family and to the proposed nursing, invasive, and anesthetic procedures.
 8. Patients will be encouraged, whenever possible, to participate in safe practices. This may include encouraging them to:
 - a. confirm they are receiving the correct patient ID band;
 - b. be aware of safe medication practices that include RNs and MDs confirming they are the "right patient" by checking their ID bands and orally confirming identity with them, and re/confirming any allergies prior to administering medication.
 - c. participate in site marking, as appropriatePatients will be encouraged to question anything they do not understand or that does not seem right.
 - d. questioning staff about handwashing

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9. The privacy of confidential patient information will be safeguarded judiciously.

**DESIRED PATIENT
OUTCOMES:**

1. All patients will be assessed prior to invasive procedures according to established standards.
2. An individualized plan of care will be developed for all patients prior to invasive procedures.

**CLINICAL
ASSESSMENT AND**

CARE:

Surgical Patients

1. Review chart and preoperative checklist / Face Sheet, for completeness; confirm any DOS testing needed and complete; ensure completion of missing paperwork, lab results, x-rays, etc. as identified in Preadmissions.
2. Obtain blood pressure, pulse, respirations, and temperature to establish baseline levels; obtain pulse oximetry reading on all patients. Perform ongoing monitoring, as appropriate.
3. Confirm signed procedure consent on all charts. Confirm availability of signed Transfusion Consent form on all Admit Day of Surgery patients and inpatients. Draw confirmatory ABO testing samples as needed.
4. Establish IV access for JDH patients with a 20g catheter in ambulatory patients, an 18g catheter for admit day of surgery patients who have higher potential need for blood replacement; for FSC patients not undergoing regional blockade anesthesia with 20g saline lock and for those undergoing a block with 20g catheter. Insertion site should be on non-operative side when upper extremity or lateral torso is the operative site.
5. Use Lactated ringers for IV solution unless the patient is in renal failure, for whom 0.9% NaCl solution is indicated. If patient is diabetic and fingerstick glucose reading is outside reference range, anticipate using IV solution with dextrose and obtain order.
6. Administer medications as ordered, except for antibiotics. At JDH location, prepare antibiotics for administration by anesthesia care provider and document same, but do not begin infusion unless Vancomycin.
7. Assess for need for surgical prep; delegate or complete preoperative shave prep.
8. Assess acute and chronic pain and psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
9. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special needs, discharge planning concerns, etc.
10. Assist patient and surgeon in marking correct surgical site, *prn*, per protocol.

Interventional Radiology and Radiology with Sedation Patients

1. Review chart and preoperative checklist / Face Sheet, for

completeness; confirm any DOS testing needed and complete; ensure completion of missing paperwork, lab results, x-rays, etc. as identified prior to admission.

2. Obtain blood pressure, pulse, respirations, and temperature to establish baseline levels; obtain pulse oximetry reading on all patients.
3. Review chart for signed procedure consent; document pending consent on Face Sheet.
4. Establish IV access with a 22g catheter for all patients except those undergoing cerebral aneurysm coiling and carotid stent placement, into whom a 20g catheter is inserted. Insert bilateral upper extremity IVs for cerebral aneurysm coiling and carotid stent placement patients; notify MD if alternative sites needed or in event of access problems.
5. Per order, start IV solution or establish saline lock access; no access to be established in absence of order. If patient is diabetic, obtain fingerstick glucose; if reading is outside reference range, notify MD.
6. Administer medications as ordered.
7. Assess acute and chronic pain and psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
8. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special needs, discharge planning concerns, etc.

Non-interventional Cardiology Patients

1. Review chart and preoperative checklist / Face Sheet, for completeness; confirm any DOS testing needed and complete; ensure completion of missing paperwork, lab results, x-rays, etc.
2. Obtain blood pressure, pulse, respirations, and temperature to establish baseline levels; obtain pulse oximetry reading on all patients.
3. Review chart for signed procedure consent; document pending consent on Face Sheet.
4. Per order, start IV solution or establish saline lock access; no access to be established in absence of order. If patient is diabetic, obtain fingerstick; if reading is outside reference range, notify MD.
5. Administer medications as ordered.
6. Assess acute and chronic pain and psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
7. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special needs, discharge planning concerns, etc.

Interventional Cardiology Patients

1. Review chart and preoperative checklist / Face Sheet, for completeness; confirm any DOS testing needed and complete; ensure completion of missing paperwork, lab results, x-rays, etc.
2. Obtain blood pressure, pulse, respirations, and temperature to establish baseline levels; obtain pulse oximetry reading on all patients.
3. Review chart for signed procedure consent; document pending consent on Face Sheet.
4. Establish IV access with a 20g catheter into left upper extremity. If unsuccessful, attempt insertion on right side, either hand or antecubital placement and not wrist area; notify MD in event of access problems.
5. Per order, start IV solution or establish saline lock access; no access to be established in absence of order. If patient is diabetic, obtain fingerstick glucose; if reading is outside reference range, notify MD.
6. Administer medications as ordered.
7. Assess acute and chronic pain and psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
8. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special needs, discharge planning concerns, etc.

GI Endoscopy Patients and Bronchoscopy Patients

1. Review chart and preoperative checklist / Face Sheet, for completeness; confirm any DOS testing needed and complete; ensure completion of missing paperwork, lab results, x-rays, etc. as identified in Preadmissions.
2. Obtain blood pressure, pulse, respirations, and temperature to establish baseline levels; obtain pulse oximetry reading on all patients.
3. Review chart for signed procedure consent; document pending consent on Face Sheet.
4. Establish IV access with a 22g catheter into right upper extremity. If unsuccessful, insert on left side; notify MD in event of access problems.
5. Per order, start lactated Ringer's IV solution. If patient is diabetic, obtain fingerstick glucose; if reading is outside reference range, notify MD.
6. Administer medications as ordered.
7. Assess acute and chronic pain and psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
8. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special

needs, discharge planning concerns, etc.

Preoperative Circulating Nurse Assessment

1. Review chart and preoperative checklist for completeness, including but not limited to informed consent, allergies, and pertinent lab data.
2. Confirm surgical schedule, picklist, and informed consent match; resolve discrepancies as needed.
3. Assess psychological response of patient to perioperative plan of care; provide instruction and emotional support *prn*.
4. Collaborate with staff, as appropriate, regarding physiological and psychological health data, response to procedures, special needs, discharge planning concerns, etc.
5. Assist patient and surgeon in marking correct surgical site, *prn*.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 9/97

REVISION DATES: 6/00, 6/03, 9/06, 1/08, 11/08, 4/09, 5/09

REVIEWED DATES: 1/09