SUBJECT: **PREOPERATIVE PREPARATION OF PATIENTS IN OUTPATIENT SURGERY**

Purpose of Procedure: Outline nursing responsibilities for preoperative care in Outpatient Surgery (OPS) that ensure patients are properly prepared for surgical procedures.

Performed by: RN

Policies:

1. Same day surgery patients are to report to OPS on the day of their surgery. In-patients will be called from their units according to O.R. schedule. Same day surgery patients who come early are asked to wait in surgery waiting area.
   KEY POINT: Reinforce patients to remain NPO, to include no chewing gum/ice, smoking or hard candies.

   a. Upon arrival to OPS, same day surgery patients are:
      1) identified with name, birth date and Rancho number
      2) oriented to preop area
      3) assisted to a gurney
      4) instructed to remove all clothing, jewelry, nail polish, hair accessories, dentures, contact lenses, hearing aids, and any other prosthetic devices. (See Hospital Administrative Policy #B516 – Patient Valuables)
         KEY POINT: Patient clothing and valuables are handled according to department policy. Lockers are provided for patients being discharged the same day.

   b. For in-patients, upon arrival to OPS, the nurse will:
      1) Verify patient's identity by reconciling name on arm band with the name stated by patient, Rancho number and birthdate.
         KEY POINT: If patient is unable to state name, then reconciled arm band, Medical Record Number and birthdate with identity in medical record.
      2) transfer to OPS gurneys. If patient comes in on a wheelchair make sure all clothing, jewelry, contact lenses, partials and dentures, hearing aids and other prostheses devices have been removed
      3) send any personal items back to unit or have unit staff pick up

Procedural Steps:

I. Preoperative preparation

   1. Determine the following and document on the Preop Nursing Notes.
      a. NPO status
      b. If any AM *PO* medications taken, and with how much water.
         KEY POINT: Determine if any narcotic meds given within the last three hours.
      c. If any allergies to medication, tapes, betadine soap, or latex.
      d. If patient or family gave informed consent, verify surgical consent has been completed according to hospital policy and accurately states proposed surgical procedure and correct site if applicable.

e. Have patient or family state in their own words the surgical site and the proposed surgery, type of anesthesia.
f. Verify that Blood Transfusion Consent form is signed, and the patient gave informed consent (as applicable).
KEY POINT: Call or confirm with blood bank that the directed or autologous blood is available. Send clot and appropriate requisitions as needed.
g. Determine if patient has any metal or hardware, IE plates, pins, screws or prosthesis from previous surgery or has a pacemaker.
KEY POINT: To prevent patient injury or pacemaker malfunction the patient return electrode dispersive pad must not be placed directly over sites where metal or hardware is located.
h. If patient has any loose or broken teeth document and notify the anesthesia staff in charge of the patient.
KEY POINT: In the event that a tooth is very loose, a stat dental consult may be ordered.
i. Patients means of transportation upon discharge.
KEY POINT: All patients being discharged the same day and who receive sedation/anesthesia are required to have a responsible adult drive them home.

2. Take vital signs and pain level.

3. If patient is a diabetic, obtain finger stick blood sugar level. Report abnormal results to anesthesiologist and MD.

4. Review most recent preop labs, EKG, and chest x-ray results. Report abnormal results to anesthesiologist and MD.

5. Document IV lines, catheters, G tubes, tracheostomy type and size. Change all external bags as needed.

6. Check chart for preop antibiotics to be given ON CALL to OR, or OPS.

7. Check chart for required medical/surgical documentation. Hold pre-op narcotic medications if any of the following are not completed:
a. Informed consents: Surgical, Anesthesia, Blood Transfusion (if applicable) and General Consent are obtained.
b. Site is marked by Attending Surgeon.
c. Signed History and physical (completed within 30 days for outpatients)
e. Cardiac and Respiratory assessment within 24 hours.

8. Assess skin integrity of operative site(s). Notify attending surgeon if there is any break in skin integrity at operative site. Document any pressure ulcers, rashes, or wounds on the body. Notify circulating nurse.

9. Shave and prep operative site according to physician preference.

10. Document neurovascular assessment of proposed surgical extremity.

11. If surgical extremity has cast, make sure cast has been bi-valved prior to going into OR.

12. Apply TED HOSE or ACE WRAP as appliciable.

13. Administer all pre-op and/or on-call to OR medications as ordered by anesthesia and/or surgical MD.

KEY POINT: HOLD PREMEDICATION if there are any problems with unstable vital signs, surgical consents, site mark, lab values, or patient requests to speak with surgeon regarding risks, benefits or alternatives to proposed surgery.

14. Maintain a quiet, comfortable environment.
KEY POINT: Visitors/family are limited to 1 per pediatric patient, or 1 person to assist with translation when applicable. Visitors are requested to wait in surgery waiting area. Assure family they will have an opportunity to see surgical patients before O.R. calls for them.

15. Continue to monitor patient after premedication for abnormal level of consciousness, comprised respiratory status, or allergic reactions. Document accordingly.

16. Place patient on oximeter monitoring. Cardiac monitoring and BP as needed.

III. Transferring patient to O.R.

1. Patients are transferred to O.R. on a gurney. Air Pal will be placed on gurney as applicable
2. Patients family will be called to see patient before going to OR.
KEY POINT: Information as to surgery and recovery time, planned patient disposition after surgery, will be given to family.

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References: Lippincott Manual of Nursing Practice, 10th Ed. Philadelphia
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