

Good pre-operative care, helping patients to feel less anxious and making sure their individual needs are met, means they have a better experience and faster recovery

Preparing patients to undergo surgery

In this article...

- › How to prepare patients for surgery
- › The importance of providing psychological support
- › Checklists of key action points

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Pre-operative preparation is vital to patient safety and a key nursing role. Careful preparation can minimise anxiety, and therefore physical effects, and ensure patients arrive in the operating department ready for surgery. This involves a range of procedures, including ensuring patients understand the operation, and are able to give informed consent, unless this is not possible due to age or mental capacity.

For most people, an operation is a worrying event, regardless of the procedure or whether they have had surgery before. Good pre-operative care improves the patient experience by minimising anxiety and promoting recovery. Improving pre-operative care is one of three key elements of the Enhanced Recovery After Surgery initiative to improve outcomes and speed up recovery.

Patients should be fully informed about the procedure, recovery and discharge.

Anxiety

Many factors contribute to anxiety in patients about to undergo surgery, such as the anaesthetic, the procedure itself and the potential outcome of the surgery (Pritchard, 2009a). Patients may value detailed information and opportunities for discussion.

If they are to reduce anxiety, nurses should be able to recognise its signs; these may be physical, such as raised vital signs, sweating, nausea and heightened senses (Pritchard, 2009b), or psychological, such

as behaviour change, aggression, wanting constant attention, or becoming withdrawn or uncharacteristically emotional.

The most difficult time is waiting for the surgery. If possible, having someone to sit with patients before surgery – perhaps a relative – may help to reduce anxiety. Patients with learning disabilities or mental health problems can find new environments stressful, so it is preferable if the person with them is familiar. Children are usually accompanied by parents, and play therapists can also help to distract them.

Pre-admission assessment

Elective patients usually attend a pre-admission clinic, which is often nurse led. The appointment will involve a medical history, a nursing assessment, the provision of written or verbal information and tests based upon National Institute for Health and Clinical Excellence (2003) guidance.

For patients with a learning disability or mental health problems, it is advisable that a relative or carer is present so consent, capacity and reasonable adjustments can be discussed. A ward visit for these patients may make the ward less daunting on the day of surgery.

Admission to the clinical area

On admission to the clinical area, an identity band should be placed on the patient's dominant arm with printed information, in line with National Patient Safety Agency (2009) guidance. Any assessments not performed at the pre-assessment clinic will need to be undertaken and documented.

The following risk assessments should be included, in line with local policy:

- › Pressure ulcer;
- › Venous thromboembolism (VTE);

5 key points

1 Patients should be fully informed about the procedure, postoperative recovery and discharge home

2 Psychological and physiological care of pre-operative patients is important

3 The special needs of children and patients with a learning disability or mental health issues must be addressed

4 National and local guidelines, and policies and assessment tools must be adhered to

5 Patients' privacy, dignity and comfort must be maintained



Waiting to go in is a difficult time

- » Falls;
 - » Malnutrition screening.
- Baseline observations are required and should be recorded:
- » Blood pressure;
 - » Pulse;
 - » Respirations;
 - » Temperature;
 - » Oxygen saturations;
 - » Blood glucose (if appropriate).

Anxiety has physiological effects, which may result in hypertension, tachycardia and a rise in temperature (Pritchard, 2009b), so observations should be performed when the patient has settled in and has been resting. For accuracy, it is advised that recordings are performed manually, especially if a reading is abnormal; readings that remain abnormal should be reported to medical staff.

Preparing for postoperative care

A number of actions may be needed to prepare patients for postoperative care:

- » Postoperative physiotherapy referral;
- » Patient education on the importance of deep breathing and coughing, regular gentle leg exercises and early mobilisation to reduce the risk of complications such as chest infection, deep-vein thrombosis and pulmonary embolism;
- » VTE prophylaxis – measure patient for anti-embolism stockings, foot impulse device or intermittent pneumatic compression device (NICE, 2010);
- » Explain what patients can expect to have in situ after surgery, such as intravenous lines or drains, and that pumps might bleep;
- » Discuss analgesia;
- » Patients who are expected to be transferred to the intensive care or high dependency unit after surgery might like to visit the unit beforehand;
- » Warn patients their bed may be moved when they return to the ward so they can be observed more closely by nursing staff immediately after surgery.

Preparing the patient for theatre

Nutrition and hydration

The Royal College of Nursing (2005) recommends clear fluids up to two hours and food up to six hours before induction in healthy patients of all ages. Many clinical areas have set fasting times for patients.

Fasting can be difficult to manage when theatre lists can be changed and operations cancelled. Nurses need to be aware of patient comfort and hydration, and enable them to access food and drink for as long as is possible, in line with local policy.

All staff should know when patients are

nil by mouth (NBM), and this should be documented in patients' records.

Once patients are fasting, mouth care should be available or administered to those unable to perform it themselves.

When operations are cancelled, poor communication between operating departments and wards may mean patients' NBM status is prolonged (NPSA, 2011). This issue needs to be addressed by senior nursing and medical staff, and decisions passed to ward and operating department staff.

Other actions

- » Patients should wash or shower using soap and water the evening before surgery (NICE, 2008);
- » Prescribed medication should be reviewed pre-operatively and only essential medicines given – those taken orally should be swallowed with the smallest amount of water possible;
- » Medicines that will cause drowsiness should be administered once the patient has been prepared for theatre and the patient should be advised to stay on the bed with a call bell;
- » Hair around the incision site should be removed on the day of surgery if necessary, using electric clippers with a single-use disposable head;
- » Patients' comfort and dignity should be maintained when they are changing into their theatre gown;
- » Depending on the surgery, patients may wear pants, but women should be asked to remove bras before surgery;
- » Anti-embolism stockings should be measured and fitted on admission or immediately before transfer to theatre, depending on VTE risk;
- » Jewellery should be removed where possible, although local policy may allow tape to be applied around jewellery that is difficult to remove;
- » Dentures and hearing aids should be removed, and patients may prefer this to be done in the anaesthetic room – these items should be taken to the recovery area, and stored and labelled;
- » Loose teeth, caps or crowns should be identified as a safety precaution to prevent choking during anaesthesia;
- » Wristband details should be checked with patients and to ensure they match those on patient records, medicine records, X-rays and test results;
- » Vital signs should be recorded and abnormal readings reported;
- » Allergies should be documented;
- » The site of surgery should be marked on the ward or day unit before patients go to theatre or receive premeds (NPSA,

2005); this should be checked by the nurse on the ward or day unit who is completing the pre-operative checklist;

- » Consent should have been obtained in line with Department of Health (2009) guidance, and checked immediately before surgery. This involves ensuring patients understand the procedure and that they are happy to go ahead with it. How consent is gained and confirmed will depend on age and mental capacity.

Transfer to theatre

Before patients leave for theatre, a final pre-operative checklist should be completed.

Children are usually accompanied to the anaesthetic room by a parent. It may be appropriate for patients with a learning disability or mental health problems to be accompanied by someone familiar to them.

Preparing the postoperative bed

When patients are to be moved to a different bed after surgery, all their property must be labelled and moved safely.

Pressure ulcer risk may be higher post-operatively, so a pressure-relieving mattress may be required. Nurses should identify, obtain and prepare equipment required for postoperative nursing.

Conclusion

When patients are adequately prepared psychologically and physically, and policies and guidelines have been followed, the risk of postoperative complications should be low, leading to a quick recovery. **NT**

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