Preioperative nursing

• Surgery is unique experience of planned physical alteration encompassing 3 phases:
  1. preoperative
  2. intraoperative
  3. postoperative

All of them referred to Preioperative
preoperative nursing

- **preoperative nursing**: started when the decision to have surgery is made and end when the client is transferred to the operating table.

- The nursing activity in this phase includes:
  - assessing the client
  - identify potential or actual problem
  - planning the care based on individual need
  - providing preoperative teaching and support
Intraoperative phase

• *Intraoperative phase*: begun when the client transferred to the operation table and ends when client admitted to the post anesthesia care unit (recovery).

• Nursing activity include variety of specialized procedure designed to create and maintain safe therapeutic environment for the client and health care professional.
**Postoperative**

- **Postoperative**: began with the admission of the client to the post anesthesia area and end when healing is completed.

- Nursing activates:
  - Physiologic and psychological response to the surgery
  - facilitate healing and prevent complication
  - teaching providing supporting the client planning for home care
• Ambulatory surgery center (ASC) or same day surgery centers that:
  • don’t required hospital admission
  • shortened preparative period
  • postoperative continuous at home
Type of surgery

- Type of surgery classified according to:
  A. purpose of surgery (table 35-1)
  B. degree of urgency
  C. degree of risk

- degree of urgency:
  - Emergency, immediately (life threatening)
  - Elective surgery: surgery is the preferred treatment.
• degree of risk:
  1- Major surgery: high degree of risk, for many reason:
    • Complicated or prolonged
    • large loss of blood may occur
    • vital organ may be involved
    • postoperative complication may be likely.
    - e.g. organ transplant, open heart surgery

  2- Minor surgery:
    • normally involve little risk
    • produce few complication
    • performed in day surgery
    - e.g. tonsils, biopsy
Degree of risk is affected by:

- clients age very young and elderly are greater risk than children).
- general health status (as infection).
- nutritional status (obesity, malnutrition).
- mental status (stress, dementia,).
- use of medication (anticoagulant).
Preoperative nurse

- Client must sign consent form

Assessment:
- Nursing history:
  - allergy, medication, previous symptom, mental status, coping, alcohol, etc...
- Physical examination.
- Screening test.
• **Diagnoses:**
  - Deficit knowledge
  - Fear
  - Disturbed sleeping pattern
  - Ineffective coping
  - Anticipatory grieving
• **Planning:** involve the client and family.
Implementation

• 1- Preoperative teaching:-
  - vital part to reduce anxiety.
  - Complete information including what well happened to the patient.
  - psychological support to reduce anxiety, active listing and providing accurate information.
  - skill training:
    • moving, deep breathing, coughing, splinting incision, using incentive Spiro meter
Implementation...continue...

2- Physical preparation:

- Elimination enema
- Hygiene
- Medication: anesthesia, preoperative medication, narcotic etc.
- Rest and sleep
- Valuable: jewelry
- Special order
- Skin preparation: shaving
- Prostheses (artificial body part, denture)
- Vital signs
- Antiembolic stocking
Intraoperative

• General anesthesia: loss of all sensation and Consciousness.
• Local anesthesia: nerve impulses transmission interrupted.

• **Goal**: maintain client safety
• **Evaluate**: whether the desired outcomes have been achieved poison for client.
Post operative
Immediate postanesthetic phase care:

- adequacy of air way
- oxygen saturation
- adequacy ventilation
  - respiratory rate, rhythm, depth
  - use of accessory muscle
  - breathing sound
- cardiovascular assessment:
  - heart rate
  - peripheral pulses
  - blood pressure
  - capillary filling
- level of consciousness
  - Not responding
  - Arousal with painful stimuli
  - Fully awake
  - Oriented to time person and place
Immediate postanesthetic phase care: continue.....

- Presence of protective reflexes as gag, coughing reflex.
- Activity ability
- Skin color
- Fluid status: intact and output, IV infusion, any dehydration.
- Condition of operative site
- Potency of drainage
- Discomfort (pain)
- Safety consideration e.g. side rails)
Implementation nursing intervention

- pain management.
- positioning spinal anesthesia lie flat on side 8-12 hours.
- deep berthing and coughing exercise to remove mucus.
- leg exercise to prevent thromboses.
- moving and ambulating: every 2 hour turning.
- Hydration( maintain IV infusion).
- diet : npo may several days then water then liquid.
- urinary elimination.
- Wound care: dressing. if excessive drain indicate hemorrhage or infection or open wound
Assessment for the wound include:

- Appearance
- Size
- Derange
- Swelling
- Pain
- Status of drain
Sing and symptom of healing

• absence of bleeding.
• inflammation (reddens and swelling at the wound edge 1-3 days).
• reduction in inflammation when the clot domination the wound bridge and closed 7-10 days.
• scar formulation.
• diminished scar size over period of the month or year.
Type of dressing

- surgical dressing: dressing remain in place until the suture is removed
- wound drain and suction
- closed wound derange contact with suction drain, reduce the possible of entry microorganism
- sutures: thread used to safe body tissue; plain in tempted each suture alone

Suture removed from 7-10 days