

# Abdominal hysterectomy surgery patient



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Around 40, 000 elective hysterectomies take place each year, mostly on women aged between forty and fifty years old (NHS 2010). Hysterectomy has a profound effect on a women's health because of the complex mix of biological, physical and social factors. This assignment will follow an integrated care pathway (ICP) of a female patient undergoing total abdominal hysterectomy (TAH) surgery and will consider the preoperative, perioperative and postoperative care the patient will receive. The assignment will critically discuss the area of patient controlled analgesia when managing a patient's pain postoperatively.

There are several different types of hysterectomy which involve the removal of the uterus and depending on the underlying condition sometimes involve the removal of the ovaries, fallopian tubes or cervix. TAH is the removal of both the uterus and cervix usually through a horizontal incision in the abdomen just above the pubic bone, on occasions where there is abdominal swelling or scar tissue a vertical cut may be necessary and should only be considered if less evasive procedures have been unsuccessful (Pudner 2010, NHS 2010).

An ICP gives health professionals a guideline based on evidence based best practice to giving care whilst assisting a patient through a clinical procedure, such as surgery (RCN 2009). Its aim is to reduce risk and ensure each patient receives high quality care by guiding the multidisciplinary team on the care required from the pre-operative assessment through to discharge (RCN 2010). Following major surgical procedures patients experience improved outcomes if they have received holistic care (Hilton 2004). Therefore an ICP should give guidance on the patient's psychological and social needs in

addition to physical needs (NHS 2010). The care pathway chosen is entitled: Major Abdominal Surgery – Gynaecology and appears in the first instance to meet this criteria (NHS 2010).

Prior to the operation the patient will attend a pre-operative assessment clinic which is often led by a Registered General Nurse (RGN) supported by other multi-disciplinary team (MDT) members involved in the surgical process such as surgeons, consultants, anaesthetists, pharmacists, therapists and social workers, providing an integrated approach to holistic care (Manley and Bellman 2000). The aim of the pre-assessment is to assess the patient's fitness for both surgery and anesthetic to minimise complications during and after surgery and to explain to her what is involved in the procedure. She will be encouraged to involve family in discussions so they can support her after hospital discharge (Pudner 2010).

Assuming the patient gives written consent, the MDT will carry out a medical review. Gaining valid consent is both a legal and ethical requirement which should always be obtained prior to giving treatment or physical examination (NMC 2008). In surgery consent is an ongoing process and the MDT should ensure its validity before giving any care or treatment at any point (Dimond 2008). Any medications including herbal remedies will be reviewed by pharmacy such as the introduction of Hormone Replacement Therapy, or some patients take regular aspirin which they should stop prior to surgery due their antiplatelet properties (Davey and Ince 2000). The patient's general medical background including obstetric and menstrual history, present illness, allergies and pre-operative tests will enable the anaesthetist to assess if the patient is fit enough to go ahead with surgery in conjunction

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with the American Society of Anesthesiologists recommendations (ASA 1991).

The RGN will carry out a nursing assessment, quickly establishing a rapport with the patient which is important to maintain through to discharge to thoroughly explore any anxieties or fears she may have. Patients are mostly afraid of anesthetic and pain but other fears associated with undergoing a hysterectomy may include altered body image, femininity, sexuality or inability to reproduce (Pudner 2010). Consistent, clear, evidence based advice and information should be given to the patient, which will include admission to hospital, pre-operative fasting, length of stay in hospital, the effects of surgery and anesthesia, control of pain, any possible complications and recovery (Dougherty and Lister 2008). Surgery can mean different things to different people; therefore provision should be made for specific cultural and spiritual requirements. For example a Buddhist patient may refuse certain drugs which alter mental awareness that are contained in the anesthetic (Hollis 2009). The patient should be made aware of the importance of being in optimum health pre-operatively and be advised on any weight loss and smoking cessation issues (Pudner 2010).

TAH is grade three major abdominal surgery (REFERENCE). The routine pre-operative tests according to the ICP include taking the patient's vital signs of temperature, pulse, respirations, oxygen saturations and urinalysis which will provide baseline to monitor changes or deterioration during and after surgery (Dougherty and Lister 2008). Height, weight, body mass index (BMI), blood glucose monitoring (BM) and Methicillin-resistant staphylococcus aureus (MRSA) screening will be required as will blood tests including U&E's

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and a full blood count for cross-match purposes in the event the patient needs a blood transfusion during surgery are required (NICE 2003, Pudner 2010). Further tests are not taken routinely, only if necessary after completion of a pre-operative questionnaire. This is to prevent all patients being subjected to unnecessary and sometimes painful procedures. Further tests may include an ECG for women of 60 to detect an underlying cardiac issues or electrophoresis to test for sickle cell and  $\hat{I}^2$  thalassaemia in Afro-Caribbean and Mediterranean women (NICE 2003).

Discharge planning begins at the pre-assessment stage of the ICP. The patient will need to know what to expect once they get home such as what they can lift and when, absence of period's, hormone replacement therapy, when to resume sexual activity and post-operative breathing and leg exercises. Referrals to other members of the MDT will be necessary following discharge which may include a visit to remove staples/sutures from the district RGN or additional support from social services for such as an older woman who lives alone (Pudner 2010). Information give during the pre-assessment should be supported in leaflet form so the patient can take it home to remind them of the information discussed.

The pre-assessment and all nursing activities throughout the surgical process should be clearly documented including patients present condition, potential problems and evidence of care (NMC 2008).

When the patient is admitted to hospital a RGN will welcome her and orientate her to the ward, explaining the layout, facilities and routines. She will update the patient's nursing assessment and attach an identity bracelet

to the patient. Whilst in hospital a RGN will act as the patient's advocate and ensure she is informed and supported at all times to help her understand the surgical procedures and what to expect which will hopefully reduce any anxiety and ensure consent if valid (NMC 2008).

On the day of the operation the MDT will review the test results from the pre-assessment, carry out an anesthetic assessment so the patient can be given the most suitable anesthetic and marked the operation site to avoid any mistakes in theatre (Linton 2007). The anaesthetist will obtain the patient's final written consent for surgery to take place (Amos and Waugh 2007).. The patient should be fasted pre-operatively to avoid possible aspiration and inhalation of gastric contents during and immediately after anesthesia, which can cause serious complications (Dean and Fawcett 2002). Current recommended fasting periods are 6 hours prior to surgery for food and 2 hours for clear fluids. If there is a delay longer than 2 hours then clear fluids may be given with authorisation from the anesthetist or surgeon to prevent extreme thirst or dehydration (RCN 2010). A set of vital signs should be taken to highlight any potential complications and the patient weighed to enable the anesthetist to calculate the correct dose of anesthetic. The RGN will complete a pre-operative check list to ensure all steps have been taken to fully prepare the patient for theatre. The RGN will remove any hair from the operation site if required. The patient will then be offered the opportunity to shower before changing into a theatre gown with hair tied back and jewellery, nail varnish, contact lenses, prosthesis removed and clean linen provided for the patient's safety and to reduce the possibility of wound infection and cross-contamination (Dougherty and Lister 2008). Glasses,

dentures and hearing aids can remain with the patient until entering theatre to maintain the dignity and respect of the patient and aid communication. The theatre staff should also be informed of any crowns, caps or metal in the patient's body (McLatchie and Leaper 2006).

The RGN will administer any prescribed medications such as a 'premed' like Diazepam if required to relax the patient and reduce anxiety and an anticoagulant (find name) to thin the patient's blood. An intravenous (IV) line will be placed in the patient's arm for administration of medications and fluids during surgery (Dougherty and Lister 2008).

The RGN will escort the patient to theatre where she will transfer to the care of the peri-operative team. Upon return to the ward she will prepare the patient's bed area for their return including making available oxygen and suction should it be required (Pudner 2010).

The patient will be at her most vulnerable in theatre particularly while she is unconscious, and it is the RGN's primary role to act as advocate for the patient and ensure care is delivered safely and effectively whilst maintaining the patient's dignity and respect at all times (NMC 2008, Pudner 2010).

Anticipating the patient's arrival the circulating RGN will have made advance preparations to ensure the theatre is set up correctly and the right equipment is available and in working order to avoid injury (Dougherty and Lister 2008). The circulating RGN also has responsibility for maintaining patient records and patient positioning.

When the patient arrives she will be greeted by the RGN who will ensure the patient understands the procedure and consent is valid. The RGN will check the patient's identity against her wristband and notes, any test results are available and confirm the details provided on the pre-operative check list are correct. The RGN will note any additional information such as allergies, underlying medical conditions and any other special instructions which may affect the intraoperative care including cultural and religious considerations (Dougherty and Lister 2008). For example it is more difficult to diagnose cyanosis in dark coloured skins (Hollis 2009). The RGN will maintain a quiet and calm environment whilst communicating the procedure to the patient to reduce anxiety and encourage anesthesia take up (Dougherty and Lister 2008). If the patient is elderly, confused or frightened the RGN may need to repeat information, use therapeutic touch or hold the patients hand (Spouse, Cook and Cox 2008).

The surgeon will lead the surgery with assistance from the MDT. The scrub RGN has responsibility for maintaining the sterile fields, ensuring aseptic techniques are used to reduce the risk of infection and is accountable for the provision and counting of swabs, sutures and instruments (Pudner 2010).

The anethetist will be responsible for all aspects of anesthesia with assistance from an anesthetic RGN who will ensure safety of the patient whilst unconscious (Pudner 2010).

Patient positioning will be supine for a TAH to enable the surgeon to access the operation site and prevent injury to nerves or tissues (Pudner 2010).

During anesthesia the RGN will remain with the patient throughout the surgery, monitor her vital signs, fluid status and organ functions to ensure

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her well-being (Brooker and Waugh 2007). The patient should be covered by a blanket, her eyes should be closed and secured to prevent damage, her airway protected, patent and safe to minimise breathing complications and her temperature maintained to avoid hypothermia (Dougherty and Lister 2008).

Handover to the Post Anesthetic Care Unit (PACU) will include details of the surgery which will include information wound drains, skin closures, catheters, complications encountered and any special requirements. PACU is the short-term intensive 1: 1 nursing care given to the patient until they are fully conscious, stable and able to maintain their own airway. Stability will include good oxygenation, respiratory function and urinary function, no unexplained cardiac irregularities or excessive bleeding. The RVN should ensure the patient's pain is adequate control by antiemetics and analgesia and maintenance of body temperature at least 36OC. (Dougherty and Lister 2008). Continual assessment of vital sign and observation of wound drainage will be required whilst the reversing stages of anaesthetic take place. The RGN will deal with adverse changes to the patient's condition quickly and efficiently, which may include respiratory and circulatory problems or nausea and vomiting (Pudner 2010). Patient's are individuals and such will exhibit different physical and emotional responses when recovering from anesthetic (Dougherty and Lister 2008). The patient can return to the ward once she becomes stable.

Once the patient returns to the ward she will be transferred into a bed and positioned either lateral or semi-prone for comfort, to minimise any pain and reduce the risk of aspiration should she vomit (Walker 2003). Clinical

monitoring and visual observations are essential to build up a picture of the patient's condition and monitor for any signs of potential complications arising from the operation and anesthetic and to enable immediate interventions to reduce harm to the patient(Walker 2003).

Initially vital signs should be taken 4 hourly, reducing to daily once they return to normal levels. Patients returning from surgery are at risk of electrolyte imbalance and therefore a strict fluid balance chart will be required. She will have intravenous fluid in place until she is able to tolerate fluids and then a light diet will introduced. The RGN should encourage her to drink up to 2 litres of fluid to prevent dehydration and promote soft stool formation (Roper Logan and Tierney. )She will also have a catheter to empty her bladder which should be checked frequently as oliguria is one of the first signs of patient deterioration. Any drain in situ will require monitoring for blood loss and exudate.

The RGN should inspect the wound site, disturbing the wound as little as possible for signs of heavy exudate, swelling, redness, heat, malodour and pain which may indicate a hemorrhage or infection. If all is well the dressing should be taken off day 2 post operatively (Dougherty and Lister 2008, Baxter 2003)

The RGN should make general observations to include any circulation, hemorrhage, fluid and pain which might indicate problems such as deep vein thrombosis, shock, infection, bowel obstruction, constipation, compromised respiration or circulation and anxiety which are common complications resulting from surgery (Dougherty and Lister 2008).

The patient will require strong analgesics for the first 24 hours which may be given by intramuscular injection or patient controlled analgesia. Pain is said to have a detrimental effect on the wound healing process, immune function and rehabilitation (Curtiss 2001, Dougherty and Lister 2008). As RGN's are the clinicians who spend the most amount of time with patients they should ensure a thorough pain assessment is carried out to enable postoperative pain to be managed effectively avoiding unnecessary discomfort for the patient (NMC 2008, Pudner 2010). Patients are individuals and will experience different levels of pain which is subjective and said to be whatever the patient says it is (McCaffery and Beeb 2000). Inadequate pain relief can have a negative effect on both the physiological and psychological outcomes of patients (Hanks-Bell, Halvey and Paice 2004).

Patient controlled analgesia (PCA) is a common method of administering postoperative analgesia through a device which has a syringe, pump and timing mechanism. It works by delivering a small amount of analgesic, which is called a bolus dose into the patient's venous line on the push of a button from the patient to suit their individual pain level (Pudner 2010). The PCA system is an effective method of delivering analgesia and is known to reduce risk of serious post-operative complications (King and Walsh 2007). Rawal (1999) suggests it gives more pain control than conventional methods of oral, intramuscular (IM) and intravenous injections as it delivers a controlled and uninterrupted dose of analgesic. However Bandier (2004) suggests there is very little difference in pain experience during the first 24 hours by patients who have been given analgesics by IM injection and those who have PCAs. Conversely at 48 hours PCA's seem to be more beneficial. Bandier

(2004) believes this is because nursing care is more likely to be 1:1 during the first 24 hours, after this IM injections are less effective because of the delay in pain relief from when it is requested to when it is administered.

Studies suggest high patient satisfaction with PCA compared to IM forms of analgesia (King and Walsh 2007). The PCA device enables patients to be involved in their own care, saving nursing time and it has been suggested that patients require less analgesic when self-medicating (Peat 1995).

However maintenance of the device and patient observations can be more time consuming than giving IM injections (King and Walsh 2007). PCA systems do not suit all patients, some may experience difficulties with operating the device, others may be frightened they might become addicted to the drugs which may leave them with inadequate pain relief, confused and in pain (Carr 1990). In addition not all patients want autonomy and may not wish to have responsibility for their own pain control (Dougherty and Lister 2008). In this instance the RGN should review the pain assessment and organise alternative methods of analgesia.

Modern PCA's are generally reliable however machine maintenance, replacement of disposables, drug errors, overriding prompts, distraction and staff inexperience can cause problems (Hicks et al 2008). The cost of PCA devices are higher than IM methods because of equipment and disposables required, such as giving sets. However they are cheaper to use than epidural analgesia (Bartha 2006). Although the PCA system has a timing mechanism so the patient cannot overdose (Pudner 2010), the system does allow administration of analgesia 'by proxy' and overdoses have occurred when

the system has been overridden by the patients family or in RGN error (Viscusi and Schechter 2007).

The RGN should always communicate with the patient regarding what is happening as psychological care is important to promote recovery (Dougherty and Lister 2008).

The RGN can help to ease the patients anxiety by talking to her about the operation, reassuring her and keeping her informed and encouraging her to talk about her concerns and involving her in decisions regarding her own care (Pudner 2010).

The RGN will assist the patient with personal care, encouraging her to mobilise and become more independent on days two and three. The physiotherapist will engage her in some leg exercises and pelvic rocking to reduce the risk of DVT (Reference). The Roper Logan and Tierney Model of Health (2003) is often used on surgical wards although the Oram's model of self care might be more suitable for major abdominal surgery the model as the model supports independence and encourages patient's to take responsibility for their own health (Pudner 2010).

anticoagulant such as Herapin may be prescribed until the patient is able to mobilise (Sparks 1996).

Availability of and information on taking medication

Follow up appointments

Information on recovery, when and where to seek help and any counselling services available

Patients will be discharged three to five days after a TAH. The RGN will advise the patient and her family what she can and cannot do until she fully recovers which may take between six to eight weeks to return to normal activity and up to twelve weeks for a full recovery (Walsgrove 2001). The patient will be advised to mostly rest for the first two weeks and not lift anything heavy for at least four weeks and she should be encouraged to continue with exercise undertaken on the ward. Other advice will include vaginal bleeding, diet, work, driving and sexual activity (Pudner 2010).

To conclude the care pathway of a female patient undergoing a TAH has been followed discussing the physical, psychological and social care from the preassessment stage through to discharge to promote the patient's health and wellbeing. Throughout the process consent should be in writing and valid before any care or treatment is given and privacy, dignity and respect should be maintained at all times to comply with legal and ethical requirements.

The ICP is a checklist intended to guide, promote best practice and improve communications within the MDT. However the ICP was not totally inclusive of the whole TAH process as it did not incorporate the peri-operative phase. The ICP did cover the standard medical and nursing interventions required for the TAH surgery. However it is only as good as the clinicians giving the treatment and care. RGN's need to exercise sound clinical judgment supported by evidence based practice , tailored to the patients individual needs in order to provide optimum care during the surgical process.

The area of PCA was critically discussed which is the generally the patients preferred choice of analgesia and has proven to be no less effective or have more adverse effects than other methods of administration. However it is important to note that RGN's should carry out a thorough pain assessment for each patient as PCA is not suitable for everyone and review the assessment frequently for any potential problems. In addition the RGN should remember that although usually reliable machinery does require monitoring and regular maintenance. Staff should be given information, instruction and training on the use of PCA systems to minimise potential errors.