Clinical objectives of the operating room nursing essay

The Pre-operative nurse has many duties to perform for their patients prior to surgery. Patients usually go through the Assessment Clinic prior to being transported to the Outpatient facilities. However, if patients do not go through the Assessment Clinic, it is the pre-operative nurse’s duty to gather this information. The information to be gathered prior to surgery is as follows; past medical history, last flu/pneumonia vaccination, prior surgeries, assessment of various pre-existing disorders/diseases processes (such as hypertension, migraines, diabetes, heart trouble, etc.), current medications (dosage, frequency, last dose taken), name and phone number of a family member, pain assessment, NPO status, assessment of any metal in or on the patient’s body (can it be removed), alcohol/tobacco/drug use, if the patient has any dentures, glasses, or contacts that need to be removed prior to surgery, and what procedure is being done and the location of the body the procedure is to be done on.

When all of the Administration Assessment is complete, the nurse then starts to “ prep” the patient for surgery according to her duties. The pre-operative nurses have many duties. The nurse is to start by checking the physician’s orders against the chart for the specific procedure being done. The nurse must also ensure any lab work ordered is with in “ normal” limits for that patient. If there is previous history of heart conditions, the patient must be cleared through radiology prior to surgery; the nurse is responsible for making sure all appropriate forms from radiology are present and signed accordingly. Prior to being administered any medications or having any invasive procedures (IV), the nurse explains the procedure to the patient and makes sure they have no questions. The nurse then ensures that all surgery

consent forms are present and signed by the patient. For any female patients that are not post-menopausal or has not had a hysterectomy, the nurse must get a urinalysis to rule out possible pregnancy prior to surgery. The nurse applies Sequential Compression Devices (SCD's) to the patient's calves to help prevent blood clots during surgery. The patient's respiratory status is confirmed through obtaining RR, HR and BP. The pre-operative nurse does not typically obtain these vitals as the OR aids are responsible for this; however, the nurse is responsible for making sure the vitals are within normal ranges for that patient and that the patient's vitals are charted.

The nurse then starts the patient's IV. Prior to injecting the Jelco, the nurse administers 0. 1 ml of lidocaine, intro-dermally to numb the area. This helps calm the patient's anxieties due to the thought of the " smaller" needle delivering a numbing agent before the " big" needle is inserted. If the physician has ordered a catheter prior to surgery, the nurse is responsible for carrying out these orders. This is a sterile procedure and can be performed by the pre-operative nurse.

After all of these duties have been performed, the nurse does another pain assessment on the patient. If it is deemed necessary for pain medication administration, the nurse will notify the physician by phone and the nurse takes a telephone medication order. It is the nurse's responsibility to make sure the physician comes back and signs the telephone medication order that was given over the phone as well as to carry out the orders as soon as she can so the patient is not in any pain. Antibiotics are almost always ordered prior to any surgery. If antibiotics are ordered, the nurse will administer through IV already established. All duties performed must be

charted prior to patient being transferred to the operating room. The nurse will continue to check in on the patient periodically until the patient is taken back into surgery.

Duties of the Intra-operative Nurse

Once the patient is ready for surgery, they are transferred to the intra-operative nurse. The intra-operative nurse does a “ pre-op” interview asking the patient of any allergies, any metals in or on the body, and if these metals can be removed. If the metal can be removed, it is the intra-operative nurse’s responsibility to remove it and secure it to either a family member or where ever determined appropriate by said nurse. The intra-operative nurse is responsible for the patient during surgery and until they are transferred to the Post-Anesthesia Care Unit (PACU). The intra-operative nurse must maintain a log of times for entering the OR, intubation, anesthesia administration, Foley catheter insertion, when surgery starts, and when surgery stops. The intra-operative nurse is the only personnel in the operating room that is not sterile and therefore can leave the operating room during surgery to obtain any supplies needed such as extra sutures, emergency supplies in case a patient codes, etc. For this reason the intra-operative nurse is called the “ Circulator”.

The intra-operative nurse assists the anesthesiologist with placements of the intubation tube and the naso-gastric tube. Blood pressure cuff, EKG (3 Lead), and Pulse Ox are all attached to the patient by the intra-operative nurse. The nurse applies a sticky Bovie pad to the patient’s outside, upper thigh. The Bovie sends probes of electricity through the patient’s body during surgery

which cauterizes the patient’s veins and helps minimize bleeding. This is the reason for removing any metal prior to surgery.

Once the patient is under anesthesia, the nurse is responsible for correctly positioning the patient on the operating table according to the procedure being performed and maintaining the patient’s safety during surgery. Once positioning is correct, the nurse begins to “ prep” the patient for surgery. This includes cleaning the surgical area, as well as, any areas nearby that could contaminate the surgical procedure or compromise the sterile field. The prep solution of choice for this facility is Betadine. The nurse cleans the surgical site and surrounding areas three times with the prep solution, using a fresh prep sponge each time and patted the area with sterile drape cloths in between each cleansing. The intra-operative nurse also hooks up the suction canisters and preps a bag of normal saline used for irrigation. The intra-operative nurse is also responsible for counting all instruments and sponges before surgery, before suturing, and after suturing. All of these duties are performed before the attending physician enters the operating room.

Once the surgeon enters the room, the intra-operative nurse assists him/her with donning sterile gloves, gown, and mask and a “ Time Out” is performed. The Time out procedure consists of specific verbal reports between the intra-operative nurse, the anesthesiologist, and the surgeon. Patient ID is established through chart, arm band, and stating aloud by the intra-operative nurse. The procedure is read aloud from the informed consent. Any imaging required prior to surgery is confirmed labeled and stated to be present. Pre-procedure antibiotics, dosage, and route are stated aloud by the

intra-operative nurse. Any safety precautions such as history of drug allergies, medication uses, etc. are stated aloud by the intra-operative nurse. Once all of this information has been stated aloud, the intra-operative nurse says, “ Does everyone agree?” at which time all personnel must say aloud, “ Agreed”.

Once surgery has begun, the nurse calls a friend or family member to inform them surgery has begun. The nurse is to call the family every hour that the patient is in the operating room. During surgery, the nurse is responsible for answering the phone, turning lights off and on, adjusting the heating or air conditioning, positioning any unsterile equipment, removing and reapplying any sterile garments, keeping track and charting what supplies were used for that patient’s procedure, and any extra equipment needed by surgical personnel during surgery for billing purposes.

Also during surgery, the intra-operative nurse is to chart all times logged, any specimens (body parts) removed, sutures used, anyone present in the operating room, amount of any fluids collected through suctioning, and who performed what procedures. If any specimens were removed, the intra-operative nurse is responsible for labeling and delivering to the lab. Once all supplies are accounted for and the patient is released from the operating room, the patient is transferred to the PACU.

duties of the PACU nurse

I was not able to observe a nurse performing duties in the PACU, however, one of the nurses was kind enough to sit with me and explain some of their duties. Once a patient is transferred to the PACU, the PACU nurse applies a

face mask delivering oxygen and vitals are obtained every ten minutes. The vitals obtained include blood pressure, pulse ox and EKG readings. The PACU nurse must monitor the patient's temperature, as well as patient's hemodynamics for any rhythm changes according to the patient's medical history.

Patients are set up with a Patient controlled analgesic unit (PCA unit) to deliver pain medication PRN as deemed by the patient at the push of a button. The PCA unit is designed to only deliver a specific amount of pain medication regardless of how often the patient " pushes the button" therefore the patient is not at risk of overdosing and doesn't have to wait on the nurse to administer pain medication.

If a Foley catheter hasn't been inserted yet, the PACU nurse will perform this duty as the patient will not have bathroom privileges until they are Post-op. PACU nurses cannot intubate, however, they can ex-tubate. The PACU nurse is also responsible for discontinuing arterial lines, inserting nerve blocks for pain management, and filling out all proper forms and charting. PACU nurses can only care for a maximum of two patients at a time. However, if the patient is less than eight years of age or an Intensive Care Unit patient, then that will be the PACU nurse's only patient until they are transferred to post-op. Once the patient is awake and determined to be " stable", they are transferred back to Outpatient where they were prepped Pre-op.

DUTIES OF THE PRE-OPERATIVE NURSE

Once patients are transferred back to Outpatient area, a Pre-operative nurse assumes responsibility for the patient until discharge, but performs post-op

duties. Vitals are obtained every thirty minutes by the outpatient aids, but are charted and monitored by the post-operative nurse. The nurse assesses the surgical site for bleeding or excess swelling if the site is visible. The patient’s pain is assessed and the PCA button is placed well within reach for the patient. The post-operative nurse checks physician’s orders for discharge pain medications and calls the order into the patient’s personal pharmacy of choice. The nurse discontinues the patient’s IV, catheter, and SCD’s. The family or whoever is providing transportation home for the patient is notified and allowed to return to the Outpatient prep area until patient is discharged. The post-operative nurse also gathers any discharge instructions as ordered by the physician and sets the post-op follow-up appointment prior to discharge. The physician will specify the criteria in which the patient must fulfill before the patient is discharged. For example, if kidney stones were “ zapped”, the patient must void freely at least once before discharge. The post -operative nurse is responsible for ensuring that all required information in regards to forms being signed and paperwork required in medical record is present, and all charting required is complete for that patient.

ONE ASPECT OF PATIENT TEACHING

One aspect of patient teaching that I identified was during post-op and prior to discharge. The example I observed was when the post-operative nurse specified to the patient what she should expect in the days to come, specifically how to “ wipe” after going to the bathroom, as well as specific warning signs of complications that would need immediate attention.

WHAT WERE MY STRENGTHS & WEAKNESSES

I believe my strengths were first and foremost my previous, in-class instruction. I felt very informed and knew what supplies were needed and how to start an IV. Secondly, I believe my willingness to learn whatever the staff wanted to teach me without reserve is another one of my strengths.

My weakness was my not understanding the jargon used by everyone. I had to repeatedly ask what all of the acronyms used stood for. It seemed that they had an acronym for everything. I believe the more clinical hours I am able to participate in, the more jargon I will learn. I also believe that taking a medical terminology class would be a tremendous asset to my education investment.