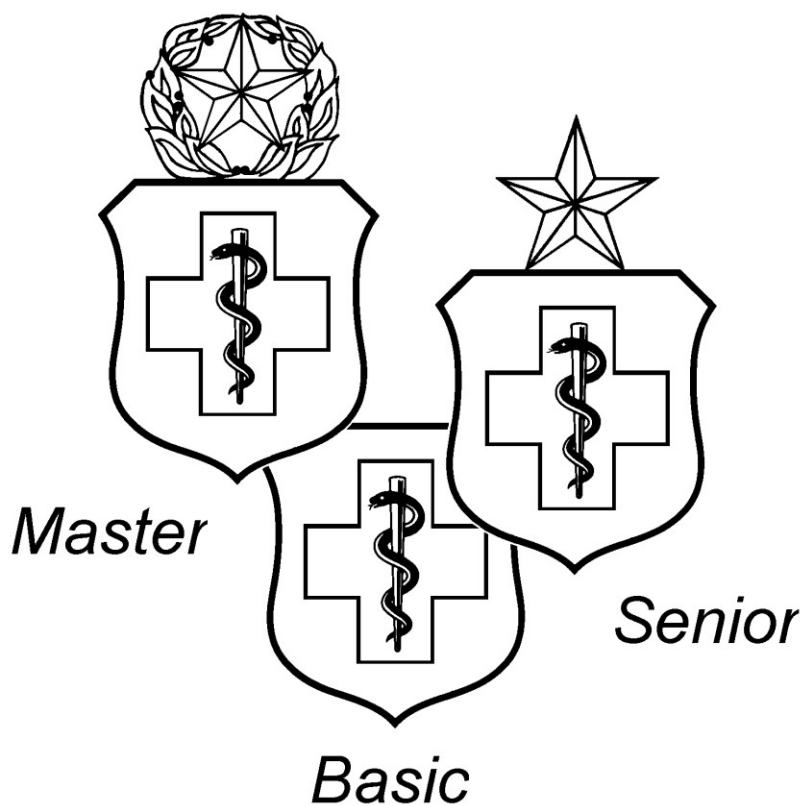


SURGICAL SERVICE SPECIALTY

Nursing Care of the Surgical Patient



ACCESSIBILITY: Publications and forms are available on the e-publishing website at www.e-publishing.af.mil for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

THIS PAGE INTENTIONALLY LEFT BLANK

QTP 4N1X1-06
SURGICAL SERVICE SPECIALTY
Volume 06: Nursing Care of the Surgical Patient

TABLE OF CONTENTS

Introduction		iii
Module 1.	Intravenous Infusion/Blood Administration	
	<i>Intravenous Infusion</i>	1
	<i>Blood Administration</i>	5
Module 2.	Vital Signs	
	<i>Take and Record Vital Signs Manually</i>	8
Module 3.	Basic Post-Anesthesia Nursing Care	
	<i>Oxygen Administration</i>	11
	<i>Management of Post-Operative Complications</i>	13

OPR: AF/SG1E
Certified by: SMSgt Judy Hickman (60 MSGS/CCC)
Supersedes: QTP4N1X1-06, 18 Dec 2009
Pages: 21

THIS PAGE INTENTIONALLY LEFT BLANK

INTRODUCTION

1. This qualification training package (QTP) was developed to make available a training aid which will assist Surgical Service Technicians to develop technical skills essential to performing specialized tasks. The tasks are broken down into teachable elements, which help the trainer guide the trainee into becoming proficient with the tasks. The QTP will also aid the task certifier when evaluating trainees for task certification.
2. As a trainer, go through each module (lesson) and identify which QTP tasks are appropriate for the trainee's duty position (items identified in the CFETP as core tasks are mandatory), then determine the order in which you want the trainee to learn about each subject area. Direct the trainee to review the training references to better understand the objective of each module. Go through the steps in the task performance with the trainee and allow for enough time to learn each step; some objectives may take more time than others. Remember, the objective of the QTP is to ensure the trainee can perform each task thoroughly. When the trainee receives enough training and is ready to be evaluated on an objective, follow the evaluation instructions. Use the performance checklist as you evaluate each objective. If the trainee successfully accomplishes the objective, document appropriately in the individual's training record. If the trainee does not accomplish the objective, review the areas needing more training until the objective is met. Conduct a feedback with the trainee on each module. After the trainer has ensured and documented that the trainee is qualified to perform the task, the trainee should be evaluated by a certifier.
3. The goal of the developers of this QTP is to publish a useful document for trainers and trainees that will meet Air Force needs under the concepts outlined in the Career Field Education and Training Plan (CFETP). We value your expertise in meeting this goal. If you find discrepancies in this QTP, or have suggestions for its improvement, or if you have suggestions for other areas that may benefit from a QTP, please let us know about them by contacting the below individual.

***SMSgt Judy Hickman
60MSG/CCE
Travis AFB, CA 94535
DSN: 799-2385
E-mail: judy.hickman@us.af.mil***

NURSING CARE OF THE SURGICAL PATIENT

Intravenous Infusion/Blood Administration

SUBJECT AREA:	Duties of Circulating Personnel
TASK(s):	Intravenous Infusion
CFETP/STS REFERENCE(s):	7.6. Commonly used intravenous (IV) solutions 7.6.1. Electrolyte solutions 7.6.2. Blood volume expanders 7.7. Commonly used IV supplies 7.7.1. Needles/catheters 7.7.2. Tubing 7.7.8. Initiate IV infusion 7.9. Monitor intravenous fluid 7.10. Monitor infusion pumps 7.11. Change intravenous fluid 7.12. Discontinue intravenous fluid
TRAINING REFERENCE(s):	CDC 4N151A, Surgical Service Journeyman, Part I Volume 3, Preoperative and Postoperative Patient Care; Anesthesia, Unit 2 Volume 5, Surgical Pharmacology, Surgical Wound Management, Unit 1 Surgical Technology for the Surgical Technologist; A Positive Care Approach Standards, Recommended Practices and Guidelines
EQUIPMENT REQUIRED:	Gloves, tourniquet, antiseptic, alcohol pads, 2x2 and 4x4 gauze pads, transparent adhesive dressing (Op-site), tape, IV solution, IV tubing, extension set, IV catheters, infusion pressure bag, arm board, rolled gauze, IV pump/controller with appropriate administration set
OBJECTIVE:	The trainee will, without error, properly and safely perform all required tasks associated with intravenous infusion
REMARKS/NOTES:	Before evaluating the trainee on the performance aspects of this QTP, the trainer/evaluator should ensure trainee has basic knowledge about common IV solutions and their uses. Since this task involves direct hands-on patient care, ensure the trainee understands the process, knows inherent risk factors, and is closely supervised during the evaluation. If patient is awake, explain procedure and purpose of evaluation. The evaluator will STOP the procedure immediately and correct the trainee if performance may compromise safety. Ensure the trainee dons all personal protective equipment (PPE) required by current standards/precautions.
EVALUATION INSTRUCTIONS:	1. This QTP should be evaluated during actual performance of the tasks.

2. After the trainee has received instructions, allow sufficient practice on each part of the task. The trainee must satisfactorily perform all parts of the task *without assistance*.
3. Use the appropriate checklist when evaluating the task to ensure all steps of the task are accomplished.
4. Document competency upon satisfactory completion of the evaluation. Initial evaluation should be documented in the Specialty Training Standard (STS). All recurring evaluation should be documented using AF Form 1098, *Special Task Certification and Recurring Training*, or using an approved substitute record.

NURSING CARE OF THE SURGICAL PATIENT

PERFORMANCE CHECKLIST

Intravenous Infusion (If Applicable)	SAT	UNSAT
<i>Preparatory Phase</i>		
1. Verify physician's order		
a. Note type of IV, gauge, and special notes		
b. Note IV solution type.		
c. Note ordered flow/drip rate		
2. Gather supplies/equipment and prepare/prime the infusion set		
3. Identify patient/explain procedure		
4. Don appropriate personal protective equipment (PPE)		
5. Position patient as comfortably as possible, arm on firm padded surface		
6. Select insertion site		
7. Wash hands		
<i>Initiate Infusion</i>		
NOTE: This checklist covers infusion using needle-catheter only; specialty infusion (i.e. butterfly) is not covered in this QTP.		
1. Don gloves		
2. Apply tourniquet		
3. Clean and prep site (may require shave if excessively hairy)		
4. If local policy requires, inject intradermal local anesthetic		
5. Aseptically open IV catheter package, save ID wrapper		
6. Insert needle/catheter at a 45 degree angle, bevel up if vein larger than catheter, bevel down if vein smaller than catheter		
7. When blood "backflows," decrease catheter angle to 15-20 degrees		
8. Advance catheter into vein while holding needle in place; after catheter advanced, withdraw needle while holding catheter hub		
9. Attach previously primed infusion set tubing/extension set		
10. Release tourniquet		
11. Open clamp and ensure flow is unobstructed, reduce flow if OK		
12. Secure catheter hub with sterile transparent dressing (Op-site) or with gauze/tape per local policy		
13. Secure tubing at site in a loop to prevent accidental pulling		
14. Tape catheter package to tubing close to site (or use tape labeled with catheter type and size) on package (tape), write initials of person inserting, date, & time of insertion		
15. Apply arm-board using rolled gauze and tape (if ordered)		
<i>Regulate/Monitor Infusion</i>		
NOTE: This checklist covers regulating flow/drip using roller clamp only; mechanical regulating (i.e. IV pump/controller) is not covered in this QTP; follow manufacturer instructions/local policy		

Intravenous Infusion (If Applicable)	SAT	UNSAT
1. Regulate infusion flow rate		
a. Re-check anesthesia provider/physician's order for flow/drip rate		
b. Calculate drip rate		
c. Adjust flow by loosening/tightening clamp		
d. Time-tape IV bag if necessary		
2. Monitor insertion site for swelling/discoloration; correct per local policy if infiltration occurs		
3. Monitor tubing for blood backflow/blockage; correct per local policy		
<i>Change Intravenous Solution Bag/Bottle</i>		
1. Re-check physician's order for solution type and flow/drip rate		
2. Obtain new solution bag/bottle; check type and expiration		
3. Close tubing clamp		
4. Lower empty bag/bottle		
5. Remove spike without contaminating		
6. Spike new bag/bottle		
7. Hang and raise new bag/bottle on IV pole		
8. Ensure no air is in line		
9. Initiate IV fluid flow and adjust to proper flow rate		
10. Document procedure		
<i>Maintain/Monitor Infusion Pump/Controller or Pressure Bag</i>		
1. Infusion pump/controller		
a. Assemble appropriate solution/infusion set and attach to pump/controller per manufacturer instructions		
b. Connect infusion set to 3-way stopcock		
c. Switch IV from initial IV infusion line to pump/controller line		
d. Ensure settings/alarms on pump/controller are properly set		
2. Infusion pressure bag		
a. Change to fresh IV bag		
b. Set-up tubing and fill drip chamber completely		
c. Place IV bag inside pressure bag		
d. Remove excess air from bag by turning upside down and using needle and syringe in injection port		
e. Ensure no air is in line		
f. Initiate flow at pressure ordered by anesthesia provider/physician		
g. Monitor patient closely; insertion site for swelling/discoloration, tubing for blood backflow/blockage; correct per local policy		
<i>Discontinue Infusion</i>		
1. Verify the order; check for special patient requirements		
2. Gather supplies (gauze, tape)		
3. Wash hands and don gloves		
4. Clamp/shut off infusion		
5. Carefully remove securing tape/dressing from tubing and catheter		
6. Place sterile 2x2 or 4x4 over site, gently apply pressure, then quickly and smoothly remove catheter (ensure catheter is intact)		
7. Elevate insertion site above patients heart while applying firm but gentle pressure to site for 30 seconds (or until bleeding stops)		
8. Dress site and document procedure IAW local policy		

Intravenous Infusion (<i>If Applicable</i>)	SAT	UNSAT
FINAL RESULTS/NOTES:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc.

NURSING CARE OF THE SURGICAL PATIENT

Intravenous Infusion/Blood Administration

SUBJECT AREA:	Duties of Circulating Personnel
TASK(s):	Blood Administration
CFETP/STS REFERENCE(s):	7.6. Commonly used intravenous (IV) solutions 7.6.1. Electrolyte solutions 7.6.2. Blood volume expanders 7.7. Commonly used IV supplies 7.7.1. Needles/catheters 7.7.2. Tubing 7.8. Initiate peripheral IV infusion 7.9. Monitor intravenous fluid 7.10. Monitor infusion pumps 7.11. Change intravenous fluid 7.12. Discontinue intravenous fluid 7.13. Assist with blood administration 7.13.1. Prepare blood warmer
TRAINING REFERENCE(s):	CDC 4N151A, Surgical Service Journeyman, Part I Volume 3, Preoperative and Postoperative Patient Care; Anesthesia, Unit 2 Volume 5, Surgical Pharmacology, Surgical Wound Management, Unit 1 Surgical Technology for the Surgical Technologist; A Positive Care Approach Standards, Recommended Practices and Guidelines
EQUIPMENT REQUIRED:	Gloves, blood or blood component, IV bag (0.9% saline) blood warmer or pump, administration set If patient not being monitored electronically, also need: Blood pressure cuff Stethoscope, Electronic thermometer (or other temperature monitor) Watch/clock with second hand
OBJECTIVE:	The trainee will, without error, properly and safely perform all required tasks associated with blood and blood component administration
REMARKS/NOTES:	Before evaluating the trainee on the performance aspects of this QTP, the trainer/evaluator ensure trainee has basic knowledge about blood and various blood components and their care and uses. Since this task involves direct hands-on patient care, ensure the trainee understands the process, knows inherent risk factors, and is closely supervised during the evaluation. If patient is awake, explain procedure and purpose of evaluation. The evaluator will STOP the procedure immediately and correct the trainee if performance may compromise safety. Ensure the trainee dons all personal

protective equipment (PPE) required by current standards/precautions.

EVALUATION INSTRUCTIONS:

1. This QTP should be evaluated during actual performance of the tasks.
2. After the trainee has received instructions, allow sufficient practice on each part of the task. The trainee must satisfactorily perform all parts of the task *without assistance*.
3. Use the appropriate checklist when evaluating the task to ensure all steps of the task are accomplished.
4. Document competency upon satisfactory completion of the evaluation. Initial evaluation should be documented in the Specialty Training Standard (STS). All recurring evaluation should be documented using AF Form 1098, *Special Task Certification and Recurring Training*, or using an approved substitute record.

NURSING CARE OF THE SURGICAL PATIENT

PERFORMANCE CHECKLIST

Blood Administration	SAT	UNSAT
<i>Preparatory Phase</i>		
1. Verify physician's order		
2. Verify completed AF Form 1225, Blood Transfusion Informed Consent, is in patient's record		
a. Ensure professional staff member has completed Section I of SF 518, Blood and Blood Component Transfusion, for each unit of blood/blood product ordered		
3. Gather supplies/equipment		
4. Obtain blood/blood component from laboratory:		
a. Present card/label (local policy) stamped with patient hospital identification to blood bank personnel		
b. Verify identification data with blood bank personnel by checking stamped card against label on blood product and SF 518		
c. Confirm type and cross-match has been completed		
d. Sign log and transport blood product to operating room/patient location immediately		
5. Identify patient/explain procedure (if patient awake)		
6. Set-up blood warmer (if used) per local policy and manufacturer instructions:		
a. Turn on warmer per manufacturer's instructions		
b. Open door and insert tubing into tubing channels		
c. Close door and set/verify temperature settings		
7. Set up pressure infusion device (if used) per local policy and manufacturer instructions		
<i>Transfusion Administration Phase</i>		
1. Verify physician's order		
2. Verify completed AF Form 1225, Blood Transfusion Informed Consent, is in patient's record		
3. Verify proper patient/blood product on unit:		
a. Verify with professional staff member that blood product identification matches		

Blood Administration	SAT	UNSAT
SF 518		
b. Check patient identification band and ask patient to state name (if patient is awake)		
c. Check expiration date and time on blood product		
d. Complete information of SF 518 in Section III, Pre-Transfusion Data		
4. Explain procedure to patient (if awake)		
5. Ensure IV of .09% normal saline has been initiated, or initiate one		
6. Take and record baseline vital signs		
7. Wash hands and don gloves		
8. Assemble necessary blood administration equipment:		
a. "Y"-type blood administration set (or locally approved set)		
b. Blood warmer (if ordered)		
c. Pressure device (if ordered)		
9. <i>Professional staff member will hang blood and perform actual transfusion; assist as needed</i>		
10. Monitor patient per local policy; as a minimum:		
a. Instruct patient to report any unusual signs or symptoms (if patient is awake)		
b. Monitor patient closely during first 15 minutes of transfusion		
c. Measure and record vital signs after 15 minutes		
d. Continue to monitor patient and measure and record vital signs every 30 minutes until transfusion is complete		
11. If adverse signs/symptoms are noted, immediately stop transfusion and notify nurse or physician		
Post-Transfusion Phase		
1. Measure and record post-transfusion vital signs		
2. Properly dispose of contaminated tubing		
3. Return empty blood component bag to laboratory (if local policy) along with 2nd and 3rd copies of SF 518		
4. Continue to monitor patient for adverse reactions		
FINAL RESULTS/NOTES:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc.

NURSING CARE OF THE SURGICAL PATIENT

Vital Signs

SUBJECT AREA:	Nursing Care of the Surgical Patient
TASK(s):	Take and Record Vital Signs Manually
CFETP/STS REFERENCE(s):	8.8. Measure/document patient vital signs 8.8.1. Blood pressure 8.8.1.1. Manual 8.8.1.2. Electronic 8.8.2. Pulse 8.8.2.1. Manual 8.8.2.2. Electronic 8.8.3. Respirations
TRAINING REFERENCE(s):	CDC 4N151A, Surgical Service Journeyman, Part I Volume 3, Preoperative and Postoperative Patient Care; Anesthesia, Unit 3 Surgical Technology for the Surgical Technologist; A Positive Care Approach Standards, Recommended Practices and Guidelines
EQUIPMENT REQUIRED:	Electronic thermometer or other temperature monitoring device Watch/clock with seconds counter Blood pressure cuff Stethoscope
OBJECTIVE:	The trainee will, without error, manually take and record patient vital signs
REMARKS/NOTES:	Since this task involves direct hands-on patient care, ensure the trainee understands the process, knows inherent risk factors, and is closely supervised during the evaluation. If patient is conscious, explain purpose of evaluation before starting procedure. The evaluator will STOP the procedure immediately and correct the trainee if performance compromises safety. Ensure the trainee dons all personal protective equipment (PPE) required by current standards or precautions.
EVALUATION INSTRUCTIONS:	<ol style="list-style-type: none"> 1. This QTP should be evaluated during actual performance of the tasks. 2. After the trainee has received instructions, allow sufficient practice on each part of the task. The trainee must satisfactorily perform all parts of the task <i>without assistance</i>. Ensure the trainee can state or otherwise demonstrates knowledge of facts relating to selection of appropriate vital sign monitoring devices (rectal vs. oral thermometer, infant vs. child vs. adult BP cuff, etc.) and can properly identify and report abnormal vital signs. 3. Use the appropriate checklist when evaluating the task to ensure all steps of the task are accomplished.

4. Document competency upon satisfactory completion of the evaluation. Initial evaluation should be documented in the Specialty Training Standard (STS). All recurring evaluation should be documented using AF Form 1098, *Special Task Certification and Recurring Training*, or using an approved substitute record.

NURSING CARE OF THE SURGICAL PATIENT

PERFORMANCE CHECKLIST

Take and Record Vital Signs Manually	SAT	UNSAT
Temperature		
1. Place a disposable cover over the probe or temperature sensor		
a. Oral probes are usually blue		
b. Rectal and axillary are red		
c. Ear canal sensors look similar to otoscope		
2. Place the covered probe under the patient's tongue, in the axilla, in the rectum, or in the ear canal, as appropriate		
3. Activate the thermometer		
4. Wait until the thermometer indicates reading is complete		
5. Document results		
6. Remove and discard probe cover		
Radial Pulse		
1. Place tips of first three fingers on center of palm side of patient's wrist, about 2 inches from the base of the hand		
2. Slide fingertips toward thumb side of wrist		
3. Lightly press inward until the pulse of the radial artery is palpated		
4. Determine rate by one of these methods: NOTE: If the pulse is irregular, you must use the full minute method		
a. Counting the beats for 15 seconds and multiplying by 4		
b. Counting for 30 seconds and multiplying by 2		
c. Counting for a full minute		
5. Document results		
Carotid Pulse (Note: Emergency Use ONLY)		
1. Place index and middle fingers on the patient's Adam's apple		
2. Gently slide fingertips laterally into the groove between the trachea and the sternocleidomastoid muscle		
3. Lightly press inward until pulse of carotid artery is palpated		
4. Determine rate by one of these methods: NOTE: If the pulse is irregular, you must use the full minute method		
a. Counting the beats for 15 seconds and multiplying by 4		
b. Counting for 30 seconds and multiplying by 2		
c. Counting for a full minute		
5. Document results		
Apical Pulse		
1. Place stethoscope diaphragm on left side of chest, slightly below the breast		
2. Move diaphragm until "lub-dub" of heartbeat heard		
3. Count each "lub-dub" as one beat; count for 1 full minute		
4. Document results		
Respiration		
NOTE: Assess respiration immediately before or after assessing pulse, keeping fingers/stethoscope in position used to palpate pulse. If patient thinks pulse is being assessed, they generally do not alter breathing		
1. Do <i>not</i> tell the patient you are assessing respiration		

Take and Record Vital Signs Manually	SAT	UNSAT
2. Begin count on inhale (chest rises); count each rise and fall of the chest as one respiration.		
3. Observe for regularity, symmetry, depth, and pain or difficulty		
4. Count respiration for 1 full minute		
5. Report any abnormalities to professional staff		
6. Document results		
Blood Pressure		
1. Select the appropriate BP cuff.		
2. Ensure patient is as comfortable as possible, sitting or lying, forearm supported about heart-level, palm up		
3. Locate brachial pulse by palpating		
4. Wrap cuff snugly around upper arm, lower edge 1 to 2 inches above elbow, cuff range or diaphragm centered over brachial artery		
5. Place ear pieces of stethoscope in your ears, hold inflating bulb in palm of hand, and close pressure release valve		
6. Palpate brachial pulse or radial pulse using fingertips of free hand		
7. Continue to palpate pulse as you inflate cuff; inflate cuff 30 mm Hg higher than point where pulse palpation disappears		
8. Place stethoscope diaphragm (if no internal cuff diaphragm) over brachial artery; ensure stethoscope head does not touch cuff/clothing		
9. Listen closely and open valve slightly; gradually deflate cuff 2-3 mm Hg per second. Watch manometer; when two consecutive heartbeats are heard, record reading as systolic pressure		
10. Continue deflating cuff slowly and evenly. The reading when the pulse is no longer heard or is muffled is the diastolic pressure		
11. Continue to monitor, slowly releasing cuff pressure another 30 mm Hg, then release all pressure by fully opening valve		
12. Document results		
FINAL RESULTS/NOTES:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc.

NURSING CARE OF THE SURGICAL PATIENT

Basic Post-Anesthesia Nursing Care

SUBJECT AREA:	Nursing Care of the Surgical Patient
TASK(s):	Oxygen Administration
CFETP/STS REFERENCE(s):	8.7. Assist with oxygen administration 8.7.1. Fixed 8.7.2. Portable
TRAINING REFERENCE(s):	CDC 4N151A, Surgical Service Journeyman, Part I Volume 3, Preoperative and Postoperative Patient Care; Anesthesia, Unit 3 Surgical Technology for the Surgical Technologist; A Positive Care Approach Standards, Recommended Practices and Guidelines
EQUIPMENT REQUIRED:	Oxygen source, flowmeter, humidifier, delivery device (nasal cannula, mask, tent), sterile water, warning signs required by current standards/local policy
OBJECTIVE:	The trainee will, without error, assist with administration of oxygen to a surgical patient
REMARKS/NOTES:	Since this task involves direct hands-on patient care, ensure the trainee understands the process, knows inherent risk factors, and is closely supervised during the evaluation. If patient is conscious, explain purpose of evaluation before starting procedure. The evaluator will STOP the procedure immediately and correct the trainee if performance compromises safety. Ensure the trainee dons all personal protective equipment (PPE) required by current standards or precautions.
EVALUATION INSTRUCTIONS:	<ol style="list-style-type: none"> 1. This QTP should be evaluated during actual performance of the tasks. 2. After the trainee has received instructions, allow sufficient practice on each part of the task. The trainee must satisfactorily perform all parts of the task <i>without assistance</i>. 3. Use the appropriate checklist when evaluating the task to ensure all steps of the task are accomplished. 4. Document competency upon satisfactory completion of the evaluation. Initial evaluation should be documented in the Specialty Training Standard (STS). All recurring evaluation should be documented using AF Form 1098, <i>Special Task Certification and Recurring Training</i>, or using an approved substitute record.

NURSING CARE OF THE SURGICAL PATIENT

PERFORMANCE CHECKLIST

Oxygen Administration	SAT	UNSAT
<i>Preparatory Phase</i>		
1. Verify and determine delivery method ordered		
2. Wash hands		
3. Explain procedure to patient (if awake)		
4. Assist patient to semi-sitting position		
5. Attach flowmeter to oxygen source		
6. Attach humidifier to flowmeter (fill with water if necessary)		
7. Attach connection end of delivery tubing to humidifier		
8. Set flow rate to ordered setting (i.e. liters/minute)		
9. Check for proper oxygen flow (bubbles in humidifier, output through delivery device)		
<i>Delivery- Nasal Cannula</i>		
1. Place cannula over face		
a. Prongs in nares		
b. Elastic around back of head; pad bony areas if necessary		
2. Adjust to stay in place		
<i>Delivery- Face Mask</i>		
1. Apply so mask covers nose first, then mouth		
2. Adjust mask to contour of face (sides, chin, nose clips)		
3. Place elastic around back of head; pad bony areas if necessary		
4. Place reservoir bag (if present) on chest, ensure unobstructed		
5. Adjust mask to fit snugly over nose and mouth		
<i>Delivery- Face Tent</i>		
1. Place tent over face, applying from chin upward		
2. Adjust elastic or ties around head; pad bony areas if necessary		
<i>Follow-up/Monitor Phase</i>		
1. Check patient for skin/pressure irritation from delivery device		
2. Monitor water level and liter flow; change humidifier, water, and/or delivery device per local policy		
3. Assess patient condition per local policy		
4. Document procedure		
FINAL RESULTS/NOTES:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc.

NURSING CARE OF THE SURGICAL PATIENT

Basic Post-Anesthesia Nursing Care

SUBJECT AREA:	Nursing Care of the Surgical Patient
TASK(s):	Management of Post-Operative Complications
CFETP/STS REFERENCE(s):	8. Anesthesia Assist with respiratory complications Assists with cardiovascular complications Assists with allergic reactions to drugs/anesthesia 8.6.1. Malignant hyperthermia 8.6.2. Shock
TRAINING REFERENCE(s):	CDC 4N151A, Surgical Service Journeyman, Part I Volume 3, Preoperative and Postoperative Patient Care; Anesthesia, Units 2 and 3 Surgical Technology for the Surgical Technologist; A Positive Care Approach Standards, Recommended Practices and Guidelines
EQUIPMENT REQUIRED:	None
OBJECTIVE:	The trainee will demonstrate knowledge of more common potential postoperative complications, to include causes and symptoms of complications and initial management of these complications
REMARKS/NOTES:	Since this task involves potentially life-threatening situations for patients, ensure the trainee thoroughly understands the symptoms, causes, and treatment of the complications. This section of the QTP should NOT be used during actual hands-on patient care.
EVALUATION INSTRUCTIONS:	<ol style="list-style-type: none"> 1. This QTP should be evaluated in a training setting, during simulation or discussion of the subject tasks. 2. After the trainee has received instructions, allow sufficient time to review required knowledge. The trainee must satisfactorily demonstrate knowledge of all parts of each subject. 3. Use the appropriate checklist when evaluating to ensure all areas of the subject are covered. 4. Document competency upon satisfactory completion of the evaluation. Initial evaluation should be documented in the Specialty Training Standard (STS). All recurring evaluation should be documented using AF Form 1098, <i>Special Task Certification and Recurring Training</i>, or using an approved substitute record.

NURSING CARE OF THE SURGICAL PATIENT

PERFORMANCE CHECKLIST

Post-Operative Complications	SAT	UNSAT
<i>Pain Management</i>		
1. Identify typical areas/causes:		
a. Skin/subcutaneous tissue from incision(s)		
b. Deep tissue from manipulation, retraction, resection, etc.		
c. Airway/respiratory tract from drying agents, tubes, airways		
d. Localized pain/stiffness from immobilization or pressure		
e. IV site from catheter, infiltration, pressure		
f. Catheter/drain site pain from pressure/irritation		
2. Explain common actions/interventions		
a. Analgesic medication (professional staff administered)		
b. Put patient at ease as much as possible--keep informed of condition or status, likely events		
c. Position as comfortably as possible		
d. "Splint" incision site during movement, deep breathing, coughing		
<i>Nausea and Vomiting</i>		
1. Identify causes/triggers		
a. Gas, mucous, blood in stomach		
b. Narcotics		
c. Anesthetic agents		
d. Severe pain		
e. Rough handling during transport/positioning		
2. Explain common actions/interventions for nausea		
a. Deep breathing/coughing		
b. Oxygen therapy		
c. Cool, damp washcloth to sponge forehead/wrists		
d. Anti-nausea medication (professional staff administered)		
3. Explain common actions/interventions for vomiting		
a. Turn patient's head to side		
b. Lower head of bed		
c. Oral suctioning		
d. Assess for aspiration--report findings to professional staff		
<i>Body Temperature Fluctuation</i>		
1. Identify hypothermia symptoms/causes/complications		
a. Body temperature drop		
b. Cold rooms and solutions contribute		
c. Shivering/slow respiration lead to hypoxia		
2. Explain hypothermia treatment/intervention		
a. Rewarm patient using blankets, warm solutions, etc.		
b. Oxygen therapy		
3. Explain hyperthermia (fever) causes/complications		
a. Infection		
b. Pre-existing diseases/conditions		
c. Drug reaction		
d. Malignant Hyperthermia (MH)		
4. Explain hyperthermia treatment/intervention		
a. Generally not treated unless exceptionally high--except MH		
b. Rapid cooling, MH treatment per local protocol		

Post-Operative Complications	SAT	UNSAT
c. Infection and drug reaction may be treated with medication		
<i>Emergence Delirium</i>		
1. Identify typical symptoms		
a. Agitated, restless, thrashing		
b. Excited, "babbling," screaming, shouting		
c. Crying, moaning		
d. Disoriented, irrational		
2. Explain typical cause--hypoxia; contributors:		
a. Barbiturates		
b. Fear		
c. Poorly managed pain		
d. Full bladder		
3. Explain common actions/interventions		
a. Treat hypoxia (airway and oxygen)		
b. Safety restraint/positioning		
c. Hold/comfort (esp. children)		
d. Catheterization		
e. Medications (professional staff administered)		
<i>Identify/Explain other Complications (evaluate per local protocol)</i>		
1. Fluid/electrolyte imbalance		
2. Shock		
3. Hypoxia		
4. Hemorrhage		
5. Aspiration		
6. Wound dehiscence/evisceration		
7. Airway obstruction		
8. Cardiac arrest		
FINAL RESULTS/NOTES:		

FEEDBACK: Using this checklist as a source of information, discuss the trainee's performance indicating strengths, weaknesses, suggested improvements, etc.