C4L18 - Ashley Hay

(0:06 - 0:34)

Hi, welcome to course four. So we are going to be discussing some surgical skills. We'll start with planning a case and opening in the start of surgery.

But what I'd like to start with first is some surgical terms, because I know that in the lesson, we really dumped quite a lot of them on you. But they are there for good reason. Some of them are more common than others.

(0:35 - 1:27)

But these are definitely important terms that you want to make sure that you're familiar with. And, you know, like I typically mention, making flashcards, this is a great kind of study tool to be able to memorise this stuff. So there were a number of surgical terms, I would say all of them were really important.

There were two slides for that. So a lot of terms there for you. But just be patient, you know, it'll take you some time to get used to them.

And the more that you not only use the flashcards, but then of course, professionally, too. Once you kind of keep hearing them over and over, they will sink in a lot easier. But in preparing for your exam, I would definitely recommend, you know, watching the medical terminology video that's in the lesson, as well as making yourself some flashcards.

(1:28 - 3:45)

There was a few processes that we gave you kind of brief parts of a term. So these are portions of a term that are used over and over in surgical cases. So for example, the end term, ectomy, means removal of something.

So if you hear ectomy at the end of anything, you're thinking, oh, okay, that's going to be a removal, whereas an otomy is more like an incision. And an ostomy is a hole. So colostomy, a colostomy bag, right, we're kind of making a hole more than an incision.

And so an example of otomy would be a laparotomy, L-A-P-A, R, and then otomy. So laparotomy. That means an incision, right? So when we use it in that term, we know that we're making an incision in the abdomen.

And then for the term ectomy, we can think of a nice example for that. So I'll ask you, if we were removing the appendix, we know that ectomy means removal, what would that term be? Appendectomy, right? So there's a number of different terms on that slide. I think that some of the more common ones to be aware of were the three that we just covered, ectomy, otomy, ostomy.

Plasty is repair. Pexy is fixation. So a good example of that would be a gastropexy.

So this is where there's a little attachment of the stomach and then they fix it to the intestinal wall. Some other important terms on there for you. Trypsy, puncture as well, which we kind of know what the word puncture means anyway.

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So just remembering really that all of these endings to surgical terms are a little bit of a clue and an insight as to what's really going to be going on for that surgery. And so in that, it's important to anticipate what you want to be setting up and how you can best meet the needs of your team members as well as your patients. So when you can anticipate or predict kind of the needs of certain providers like surgeons during case management, that will really help you along the way being a surgical tech.

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And as well as, like we were saying, just knowing the basics of a term of what that means for a surgery and then being able to critically think of how you might need to set up for that. That will really help you. Some other things we did talk about were the elements of a case plan.

And this really just requires you to have a general knowledge of a procedure and what's going to be going on, what surgical techniques may or may not be used. And that sometimes is, you know, it coincides with providers, different surgeons as you get to know them, what approaches they like to surgery, what different kinds of materials and instruments that they like to use. And of course, too, you know, we talk about things like implants and grafts and all of that, you know, is definitely important to know and to plan for.

I would definitely make sure that you are quite confident and know the difference between an allograft versus an autograft. And make sure that you're reading your ebook. That will help you get some good examples of that too.

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So really in, you know, doing any case, right, we think perioperatively. So we not only think what we're going to need during the surgery, but it's important to remember what we might need before, during, and also after. So preop, intraop, postop.

So for preop case preparation, you know, you'll be assigned a certain, you know, schedule for what surgeries you're going to be kind of sitting in on. And then it will be your responsibility to be able to gather the needed supplies and instruments, again, from, you know, start to finish, not just during the case. And then of course, you know, you'll have to be flexible and adjust to the needs that we mentioned prior for, you know, surgeon's preference.

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So, you know, we talk about kind of the preference of the surgeon a lot, and we do definitely, you know, cater to them and, you know, try and provide them really with whatever they may need and anticipate their needs before they even realise that they need it. So things that they might have specific preferences about, and it's just helpful to keep mental or even written notes about these things once you do start hands-on training. You know, for particular surgeons, we talked about what instruments or special equipment do they like, but knowing things also like their glove and gown size really will kind of get you pretty far in terms of, you know, where you're at on their list of preferred people to work with.

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Some of them have preferred, you know, medications that they like to give in certain orders, preferred suture types and dressings. I've definitely seen preferred suture types. Some find, you know, certain stitches or sutures easier to work with than others, and some have a preference depending on what kind of case we're working on.

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And then just how this applies in the instruments are assembled. Sometimes they have preferences for that as well, and you may also hear their preferences known to, called like a pick list. Sometimes that's what we refer to that as.

(8:07 - 15:34)

And there was a nice little short video too on preference cards and kind of the creation and use of that. We talk about, you know, preparing sterile equipment a lot in surgery as a surgical tech, but we don't often talk so much about preparing non-sterile equipment. But truly, it's just as important, and one can absolutely affect the other.

So you need to be really aware of your certain stations and where things are, where they exist, and then where they are kind of allowed to move to within the room. So, you know, we've talked about this in prior lessons, just knowing things about like where the power sources are, where the suction is, oxygen, gas, all of that. And then just keeping in mind also that your sterile field should always be a minimum of one foot away from non-sterile areas.

I would suggest more if ever possible. So when opening a case, there are a few guidelines. You know, you want to always maintain your distance from a sterile surface.

And if you recall from prior lessons, we're never turning our back or reaching over a sterile field. We're placing trash and appropriate receptacles and having those kick buckets and things like that around the room in appropriate areas. You will break the sealed tape and, you know, for all of your items that have been prepared within the wrapper.

You'll place certain heavy items, you know, off on smaller tables, opening instruments and containers, everything aseptically. And, you know, we're opening sharps as well. And yeah, just

really being mindful about everything that we're doing, right? And all the things that we're opening.

And then once we kind of jump now, you know, just in high-level recapping some of this information, we talk about intraoperative case prep. So what's going to need to be prepared for, you know, during the case. And it's important to know that there's some priorities.

And as a healthcare provider, you will constantly be reprioritizing in your head all day because you may not be able to get to everything, start to finish in one shot. So it's important to start with your most priority items. These can start with things like towels, gowns, gloves, drapes, right? The basics.

Then we talk about things like light handles for different like intubation and what have you, suction tubing. Then we talk about, you know, the starting instruments. So what we're going to use at the beginning of a case, right? Frequently things like scalpels.

And then we think about what we're going to need to control any kind of bleeding from that. So then your next priority, you should be kind of critically thinking to like sponges, sutures, additional sharps, if you need. So, you know, I'm just trying to get you guys to kind of like think gradually.

And again, try not to get overwhelmed. This really will come much easier with time and experience. So just, you know, being aware of this stuff and the concepts of it for your exam is the most important.

And then you will find that you really put it into practise when you do start your bedside rotations. I know we've also talked a lot about communication among, you know, providers and patients and providing therapeutic communication. But you should know that intraoperative communication is extremely important and being able to pride yourself on, on, you know, proper communication and being able to pick up on different cues of your other providers during surgery will really help you.

So for verbal communication, you know, we're all going to be kind of talking to each other. It's important to know kind of when is your time to jump in and when is not. Because, you know, we really want to keep kind of chatter to a minimum and everybody wants to stay focused.

So the majority of the, you know, verbal communication kind of takes place really over the patient. So it's important that we're always speaking loud and clear and direct and making eye contact whenever possible because often, you know, we're masked and we're gloved and we're, so it's kind of harder to pick up on some nonverbal cues. But again, you know, I'm glad I just did this because hand signals, you know, we often try to keep those to a minimum and that's for good reason because we don't want to be accidentally reaching over sterile stuff.

We don't want to, oh, sorry, you know, I hit your gown. Now I have to get all, you know, really, you know, scrubbing again. And then also sometimes we can use hand signals to replace verbal

requests if the patient is not fully under general anaesthesia and we want to communicate things to each other that maybe we don't want to alarm or alert the patient, but we need to kind of intervene between, you know, our team to help them have the best outcomes.

There's also a surgical field setup video for sure. Setting up your back table, really important, and you're going to do it time and time again. So make sure that you are comfortable with that as well as counts, like make sure that you're reviewing in your ebook when to count, what's the purpose of a count for items.

And we know, right, it's so that way we prevent, hopefully, any items from being retained in the patient after surgery. So we, that's why there's very strict, you know, counting policies. And just realising who's responsible for the count.

It can be the surgical tech or the circulator. Sometimes they can, you know, work together as well. And then I guess also just knowing to exam-wise what, you know, lost items within the patient, right? What problems can these cause and how does this happen? So you'd be surprised, but sometimes it occurs, you know, that's why we have these policies in place.

So either, you know, the surgical tech or the circulator maybe wasn't keeping proper track of the counted items. And instead of speaking up, they just said, oh, that seems right. Please don't ever, ever do that.

It's not ever worth it to that poor patient. It is your job to always speak up if anything ever feels off or you're unsure. It is, it can very well mean that patient's life and massive infections and a lot of different kinds of problems.

So always put the patient before yourself in that scenario. If you have a cluttered or disorganised field, it's very easy to lose track. So that's another way that that can happen.

(15:35 - 16:09)

Sometimes, you know, we've seen cases where there's an improper count or perhaps no count completed. That's a huge no-no. So definitely look into surgical accounts, make sure that you're real comfortable with that.

And I think other than just reviewing, there's a really helpful comprehensive surgical checklist that we included from an organisation. You might find that useful even down the line. So that's something that I would suggest kind of save it, you know, take a screenshot and save it.

(16:10 - 16:15)

Okay, that's it for now. And let's keep moving through course four.