DT Procedure Rooms MSJ – Patient Admission and Preoperative Assessment, Ophthalmology Surgery

Site Applicability:

MSJ DT Procedure Rooms

Practice Level:

Basic: RN and LPN

Need to Know:

The surgical booking package in Cerner Powerchart is reviewed a day prior to the patient's scheduled procedure. The required documents in Powerchart are check for completeness including informed consent for the procedure, powerplan (pre-op orders), medical history, allergy, etc.

Any incomplete items on the powerform may result in surgical delays and/or cancellation and therefore **MUST** be communicated to the DT PR charge nurse or the surgeon as soon as possible for further instruction.

All pre-op patients will have a nursing assessment and vital signs taken. The patient's admission includes: **reviewing** the Pre-operative Summary and **completing** the pre-op nursing assessment and **Pre-op documentation** (Perioperative Preprocedure Checklist; Ophthalmology Assessment; Valuables and Belongings and COVID-19 Patient Screening powerform (Ad hoc Charting) in Powerchart.

Any changes in the patient current health status **MUST** be documented and communicated to the surgeon and/or DT PR charge nurse as soon as possible for further instructions.

Patient may wear comfortable, loose fitting clothing such as a blouse or shirt that can be opened down the front. Extra clothing is placed in a designated bin for the patient.

Patient may wear hearing aid(s) in the OR during the procedure. Notify and alert the OR staff so that the hearing aid(s) can be kept dry from prep and irrigation solutions.

Ensure the procedure site and side is marked as by the Surgical Site Identification Policy.

Patient receiving **regional blocks** and/or **Procedural Sedation and Analgesia (PSA**) must be monitored and assessed before, during and after receiving blocks and/or PSA. Document the patient monitoring and assessment on Interactive View and I&O in Powerchart. Monitoring parameters: see *Appendix A*

All reasonable efforts must be made prior to commencing a procedure to ensure the patient undergoing **PSA** has a responsible adult to accompany them home. A reasonable adult not being available to accompany the patient home post procedure will result in:

- Cancellation of a planned procedure; or
- An adequate period of observation until the patient meets discharge criteria (*see Appendix B),* and has returned to baseline cognitive and functional status as determined by the physician.
- A **further 1 hour period of observation** prior to discharge is required for patients who received unintended deep sedation or an unintended period of general anesthesia.

Guidelines and Protocol

Preparation of pre op patients

1. Patient should arrive in DT PR front registration desk at least **1hr** prior to their scheduled OR time.
2. The admitting clerk will:
   - ask the patient to perform hand hygiene and give new face mask
   - complete a **verbal** COVID-19 screening tool
   - register the patient in order of the OR slate rather than arrival time
   - print out the patient's facesheet and extra labels
   - apply the patient ID band; allergy band (if applicable) is applied by the admitting nurse
   - obtain the contact information of the person accompanying the patient upon discharge home
   - notify the DT PR charge nurse of any patient related issues
   - take the patient inside DT PR when patient is registered in CERNER.
3. Overflow patient will be seated in the waiting area.

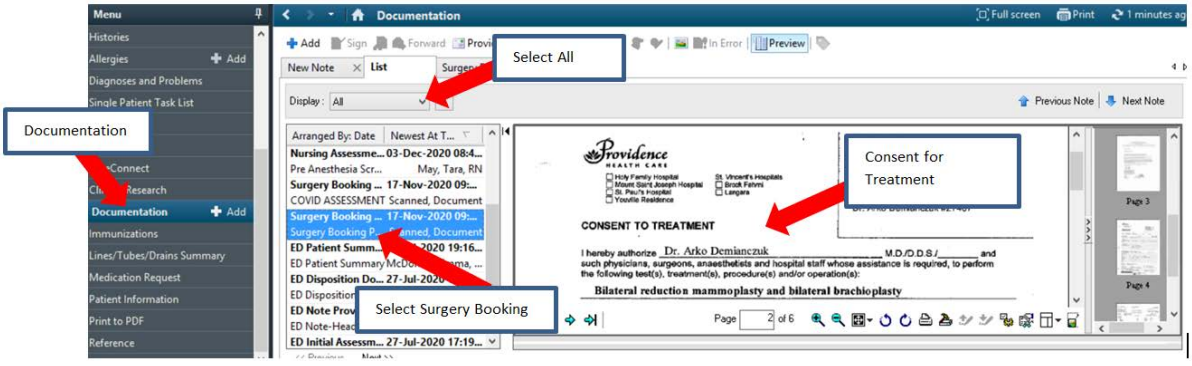
Review the patient Powerchart

1. Search patient in **Perioperative tracking**. Find the right patient and right encounter as displayed on the MSJ Preop tab.
2. The patient information is displayed on the blue "**BANNER BAR**" in Powerchart.
3. Verify the correct patient's chart has opened.
4. Review the patient **Pre-operative Summary** located on the **Menu** section**.** Click on the different tabs to see the quick overview of the patient including allergies; procedural information; Code status; Labs; Preoperative checklist, Documents (Surgical booking), etc.
5. Review the consent for correct site(s) and side(s) of procedure and ensure that consent is complete and within one year of completion. Consent is also located on the **Menu,** click on the *Documentation* section.

6. Review the patient's allergies and/or sensitivities as identified in *Allergy tabs* or click on the link *Allergies band* on the **Menu** or on the blue "**BANNER BAR"** in Powerchart.
7. Review preoperative history, diagnostics and assessment, as able. Communicate any pertinent information to team as appropriate.

Admit the patient

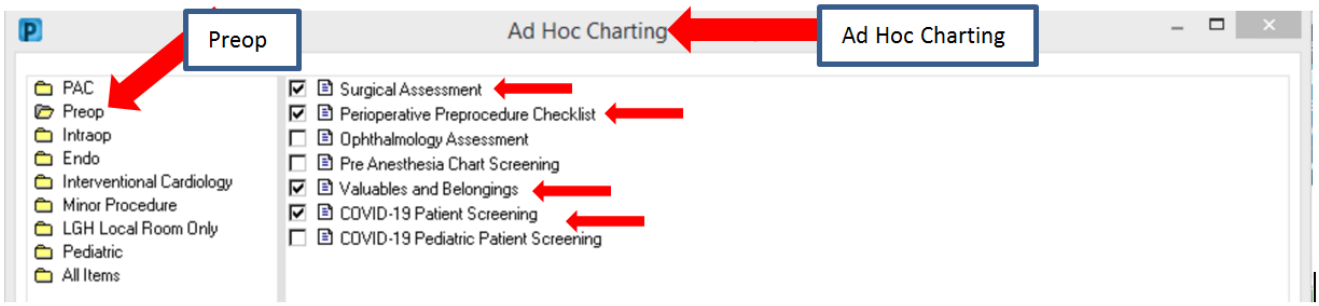
1. Meet and greet the patient. Introduce self and your roles.
2. Verify the patient using the patient information displayed on the blue "**BANNER BAR**" in Powerchart.
    a. Ask the patient to identify self, using at least two unique identifiers i.e. patient's full name, DOB and/or MRN (check arm band).
    b. Verify the patient allergies or sensitivities; **apply allergy band** (if applicable). Communicate to the team any changes in allergy or sensitivity status as stated by the patient. Update the **Allergy** powerform as needed.
    c. Check informed consent is complete and it matches the scheduled/planned procedure including the site and side. Ask the patient to point to the site and side of surgery to verify site and side. The consent is also found under "**Menu"** documentation.



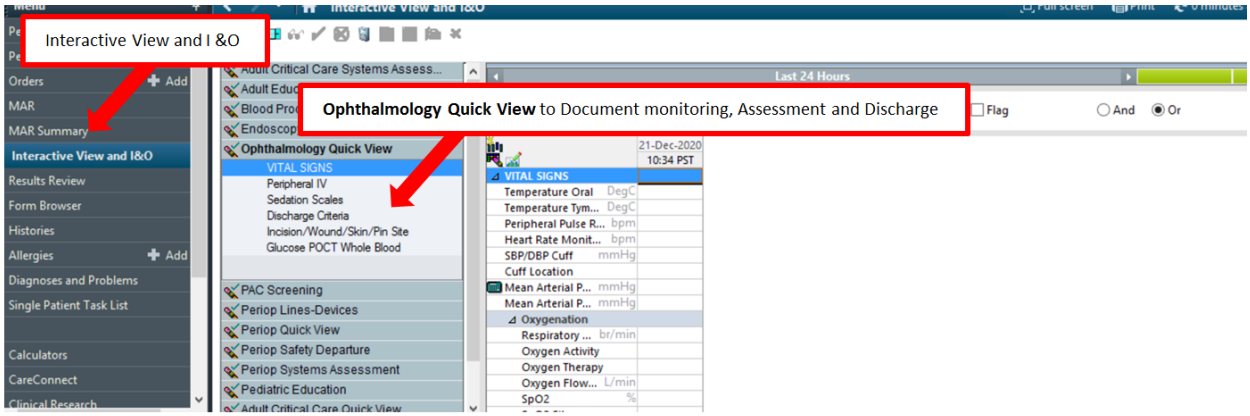
The consent is also found under "**Menu"** documentation.

3. The surgical site(s) and side(s) MUST be marked by the surgeon or delegate as per the surgical site and side identification procedure.

4. Complete the pre-op nursing assessment and **Pre-op documentation** (Perioperative Preprocedure Checklist; Ophthalmology Assessment; Valuables and Belongings and COVID-19 Patient Screening powerform (Ad hoc Charting) in Powerchart.

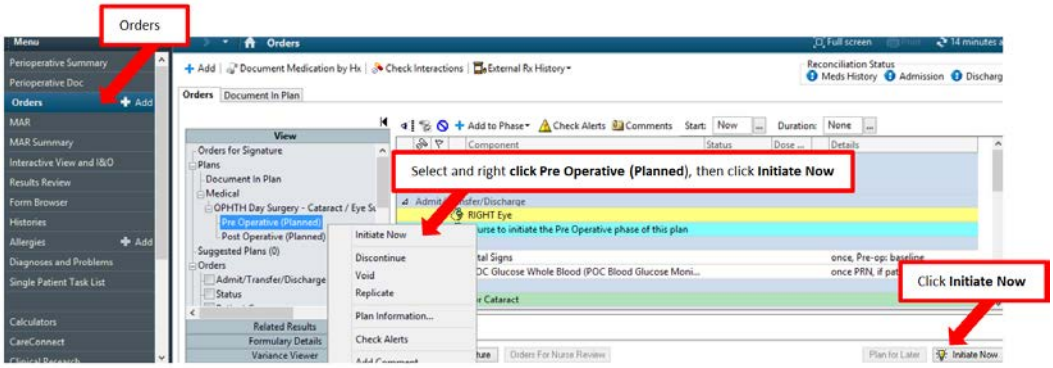


5. Take and assess vital signs. Document on **Interactive View and I&O.**

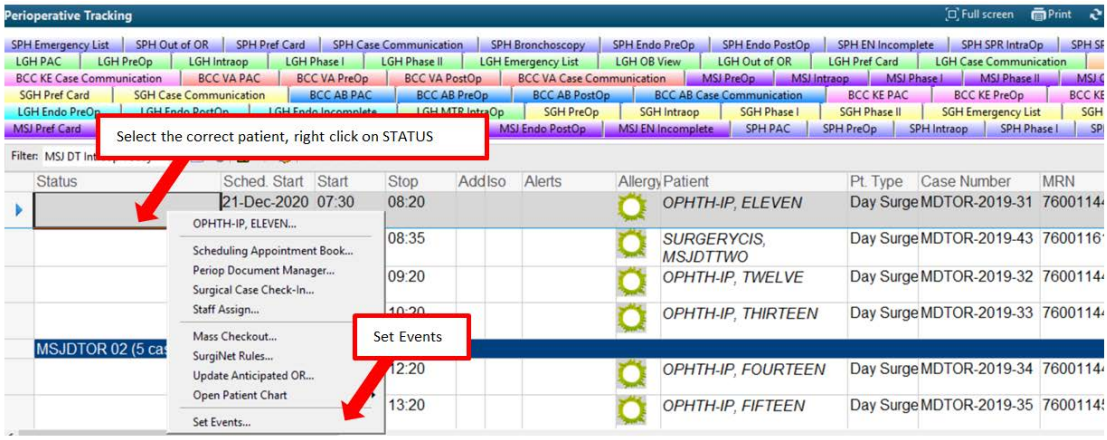


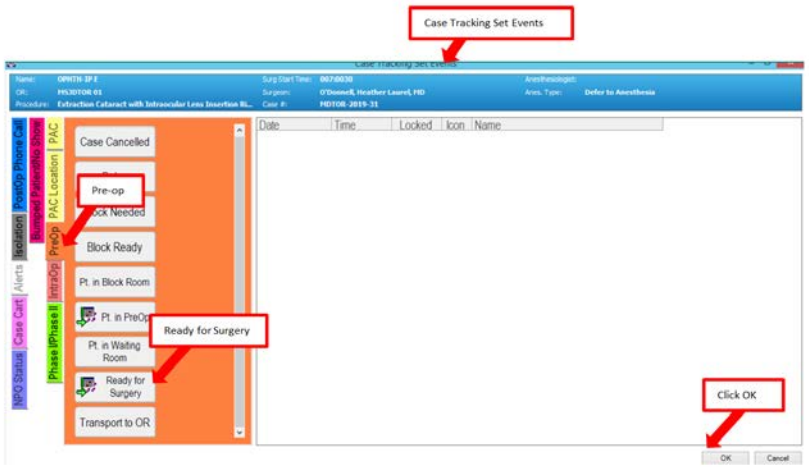
Go to **Orders powerplan** and **Medication Administration Record (MAR).** The MAR displays a patient's medication orders. It will also display all documented medications administered for the selected time frame and selected order status.

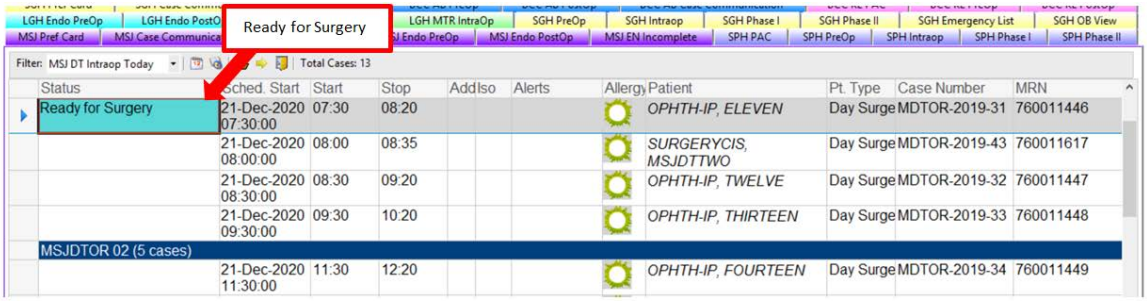
6. Initiate and administer pre-op meds as ordered by the physician. Complete documentation on **MAR.**



7. Give the patient opportunity to ask questions or clarifications regarding surgery. Inform the surgeon and/or the OR charge nurse of any patient or surgery related issues that potentially delay the OR and for further directives.
8. When patient is ready for OR, change the current patient status on Perioperative Tracking board to alert the OR. **Set Events** to "Ready for Surgery" on Case Tracking Events. The tacking board will change the current patient status to **"Ready for Surgery"**.







Eye assessment

Eyes should be assessed before eye drops administration. Check around the eye, conjunctiva and surrounding tissue for discharge, bruising, inflammation or signs of redness.

Patients should be asked whether they have any new problems with their vision such as eye irritation or inflammation, pain and discomfort. Report problems to the surgeon and /or the DT PR charge nurse immediately, as acute eye problems such as infection, acute glaucoma, orbital cellulitis or retinal detachment may result in serious eye complications if treatment is delayed.

Remove and document any vision aids the patient uses such as glasses or contact lenses prior to eye drops administration.

If applicable, remove all jewellery and make up that is within the eye areas to be prepped.

Instruct the patient NOT to touch the eyes. Observe good hand hygiene.

Fasting Guidelines:

Patient receiving:

1. **Topical eye drops, Ativan (SL) and Regional Eye blocks**
    - **NO FASTING** required. Patient may eat solid food (i.e. light breakfast) or drink liquids on the day of the procedure.
    - If PSA is required, follow the PSA fasting guidelines.

2. **Procedural Sedation and Analgesia (PSA)**

Type of Food	Minimum Fasting Duration
Meat, fried or fatty foods	8 hours
Light meal (such as toast and a clear fluid); or Infant formula; or Non-human milk	6 hours
Breast milk (no additions allowed to pumped breast milk)	4 hours
Clear Fluids	2 hours

Documentation:

1. Powerchart- Perioperative Preprocedure Checklist; Ophthalmology Assessment; Valuables and Belongings and COVID-19 Patient Screening, Interactive View and I&O- Ophthalmology Quick View

Related Documents and Resources:

1. B-00-12-10055 - Preoperative Patient Preparation
2. B-00-13-10040 - Belongings (Patient): In Operating Room
3. B-00-13-10046 – Procedural Sedation in Clinics and Procedure Rooms
4. B-00-13-10151 – Peribulbar/Retrobulbar Block: Care of the Patient Receiving
5. BCD-11-11-40000 –Allergy Documentation Policy
6. BD-00-11-40012 - Surgical and Procedural Checklist policy
7. BD-00-11-40014 - Surgical Site Identification policy
8. B-00-13-10108 - Lidocaine/Local Anesthetic Toxicity: Care and Management of the Patient
9. B-00-07-13002 - Antibiotic Resistant Organisms (ARO's) in the Operating Room (OR) and Post Anesthesia Care Unit (PACU): Infection Control Management

References:

1. AORN. (2018). Perioperative Standards and Recommended Practices.
2. ORNAC. (2019). Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (14th ed.).
3. Phillips, N. (2016). Berry & Kohn’s Operating Room technique. (13th ed.).
4. Rothrock, J.C. (2018). Alexander’s’ care of the patient in surgery (16th ed.).

Appendix A:

Monitoring parameters for Patients receiving regional Nerve Blocks
(Peribulbular/Retrobulbular block)

1. Monitor, assess and document **vital signs.**

2. Vital signs include: BP, pulse rate, respiratory rate, O_2 saturation and level of consciousness, skin colour warmth and level of pain.

3. **Monitorin**g is:
    - immediately after nerve block injection, then
    - at 1 minute x 1, then
    - every 5 minutes x 3

4. In the OR, pulse rate and O_2 saturation will be assessed, monitored and documented.

Appendix B:

Monitoring parameters for patients receiving PSA

1. Monitor, assess and document vital signs with every sedation dose.
2. Vital signs include: BP, pulse rate, respiratory rate, O2 saturation, level of consciousness, skin colour warmth and level of pain.

3. **Monitorin**g is:
   - every 5 minutes x 3, then
   - every 15 minutes until the discharge criteria from one to one monitoring is met

4. Patients receiving PSA MUST receive a complete 1:1 monitoring until the discharge criteria from 1:1 monitoring is met.

5. If the patient requires PSA top up while in the OR, the patient will be monitored and assessed for 1:1 monitoring until the discharge criteria from 1:1 monitoring is met.

Discharge Criteria Using Modified Aldrete Scoring System

Criteria for Discontinuing from One to One monitoring

- Modified Aldrete score for **Respirations** must be **2**; AND
- Modified Aldrete score for **Oxygen Saturation** must be **1 or greater;** AND
- **Total** Modified Aldrete score must be **8 or greater.**
- 30 minutes after the last dose of sedation or analgesia is given; **AND**
- 120 minutes after the last dose of IV reversal agent administered (if given).

Modified Aldrete Scoring System (NAPAN, 2014)

Category	Criteria	Point Value
Respirations	Able to deep breath and cough freely	2
	Dyspnea or limited breathing	1
	Apneic	0
O_2 Saturation	Able to maintain SpO_2 greater than 92% on room air	2
	Requires supplemental oxygen to maintain SpO_2 greater than 90%	1
	SpO_2 below 90% even with supplemental oxygen	0
Circulation	Blood pressure +/- 20 mmHg pre-procedure value	2
	Blood pressure +/- 20 mmHg to 50mmHg pre-procedure value	1
	Blood pressure +/- greater than 50mmHg of pre-procedure value	0
Level of Consciousness	Awake and oriented	2
	Wakens with stimulation	1
	Not responding	0
Movement	Moves 4 limbs on own	2
	Moves 2 limbs on own	1
	Moves 0 limbs on own	0

LEVEL OF PAIN SCORING

2 = No pain or mild pain (0 to 3 on pain scale)

1 = Moderate pain controlled with medication (4 to 5 on pain scale)

0 = Severe persistent pain (6 to 10 on pain scale)

SKIN LEGEND

Cl = cool **Cy** = cyanotic **Cd** = old **P** = pale **D** = diaphoretic **W**=warm

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	Professional Practice Standards Committee
Owners:	PHC
	Surgery MSJ