Admitting Patient to Operating Room (OR)

Site Applicability

SPH and MSJ Operating Rooms and Surgical Procedure Rooms.

Practice Level

Basic:

- Perioperative Registered Nurses (RN)

Need to Know

1. The pre-op nurse (e.g. in-patient, Emergency Department (ED) and Surgical Day Care (SDC) units), will complete and sign the Periop Preprocedure Checklist in Cerner prior to sending a surgical patient to the OR.
2. The OR nurse reviews and completes any outstanding items on the checklist. For continuity of care, one nurse completes the entire admission process in the OR

Protocol

Prior to meeting the patient, the OR RN will:

- Review the slate booking, including the comments column. Take note of any comments relevant to the admission process.
- Open the patient's chart in Cerner. Confirm the patient's name, MRN, and patient encounter number on the banner bar.
- Review the patient's past medical history, including any problems related to anesthetic, or family history of adverse reactions.
    - For nearly all patients admitted through Surgical Daycare, this information will be available in the Nursing Assessment – Pre Anesthesia Screening Note.
    - For other patients (e.g., C-section, inpatient, patient from ED), search the Documentation section for pertinent reports.
- Review the surgical consent, ensuring the procedure, including site(s) and side(s), agrees with the booking. The consent must be signed by both patient and surgeon within the last year.
    - For most patients the consent is found in the Surgical Booking Package. If the consent is not seen in Cerner, check for a paper copy on the chartlet when you meet the patient.
- Check for any other applicable consents (e.g., Consent for Transfusion of Blood/Blood Products).
- Review relevant lab work and diagnostics (e.g., hemoglobin, INR, group and screen, ECG, x-ray, CT) as needed. The need for group and screen is determined by the Maximum Surgical Blood

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Order Schedule (MSBOS) in the Transfusion Medicine Manual, as well as the patient's condition and lab values.

- Review COVID-19 Patient Screening findings with the multidisciplinary team. Complete and sign.
- On the Periop Preprocedure Checklist, review information charted and note any incomplete or outdated items. Note that all "yes", "no", "N/A" choices must be completed.

  The details of the information to be included on the Periop Preprocedure Checklist are explained in Appendix A.

Upon meeting the patient, the OR RN will:

- Meet and greet the patient in SDC, pre-op holding, or the OR and identify themselves by name, title, and role.
- Confirm the patient's identity with at least two patient identifiers (i.e., name, date of birth and/or MRN). Verify these identifiers are consistent between the patient's identification (ID) band and the banner bar of the patient's chart in Cerner.
- Confirm that any allergies and/or sensitivities are identified and documented on the banner bar and in the allergies folder in Cerner. If the patient's allergy and/or sensitivity status has changed, revise in Cerner. If the patient has allergies, ensure the red allergy band is accurate and on same wrist as ID band.
- Ask the patient to state in their own words what surgery they are having, and confirm surgical site(s) and side(s), if applicable. Compare this to the surgical consent. Confirm that site and side(s) have been marked by the surgeon as per the surgical site identification policy.
- On the Periop Preprocedure Checklist, complete or update any items noted earlier. Indicate the checklist has been reviewed and sign.
- For any belongings that have come to the OR with the patient. Document the disposition of item(s) – e.g., returned to pre-op unit and by whom, remains with patient – update documentation on the Valuables/Belongings page.

Documentation

Complete sections in the Cerner Electronic Health Record or paper chart (downtime). See Appendix A

Patient and Family Education

Explain procedures to the patient and answer any questions as they arise

Related Documents

1. BCD-11-11-40000 - Allergy Documentation Policy
2. B-00-11-10110 - Consent to Health Care
3. B-00-11-10148 – Safekeeping of Patient and Resident Valuables
4. B-00-12-10015 - Warming Patient Using Forced Air Warmer
5. B-00-12-10171 - Pre-Operative Admission for Patients Attending Surgical Day Care (SPH)
6. BD-00-11-40014 - Surgical Site Identification Policy

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7. BD-00-12-10055 - Preoperative Patient Preparation
8. BD-00-13-10040 - Belongings (Patient): In Operating Room
9. Maximum Surgical Blood Order Schedule (MSBOS)

References

ORNAC. (2021). The *ORNAC standards, guidelines, and position statements for perioperative registered nurses* (15th ed.), 3-7 to 3-16.

Appendices

Appendix A – Preoperative Checklist

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Appendix A: Completion of Periop Preprocedure Checklist

Patient Preparation

Procedure Location

- Indicates the location the procedure will be performed

Last Food and Drink

- Obtain accurate and complete information about last oral intake.
- Record the date and time of last intake, whether it was clear fluids, full fluids, or solid food, as well as the volume of fluid.

Note minimum fasting periods:

- Large or heavy meal (e.g., fatty or fried foods, meat) – 8 hours
- Light meal or full fluids (e.g., milk or fluids containing dairy products, opaque juice or juice with pulp) – 6 hours
- Clear fluids (e.g., water, clear juice, pop, black tea or coffee, jello) – 2 hours
- If the patient's last oral intake is too recent, notify the anesthesiologist.
- Preoperative or regular medications may be taken with a sip (30 mL) of water.
- ERAS patients are instructed to "carb load" both the evening before and the morning of surgery. Assess whether they have completed this as instructed.

Capillary Blood Glucose

- Must be done for patients with diabetes within 4 hours to the OR.
- Complete as needed or if ordered for other patients.

Pre Transfusion Testing Completed Prior to Admission

- A patient who has had their G & S collected in PAC in the 60 days prior to surgery needs to have the validity of their specimen confirmed (by ensuring they have not been pregnant or received a blood transfusion in the last 90 days).

Last Void

- Indicate the date and time the patient last voided.
- Ask the patient to void just prior to surgery and update as necessary.
- For a patient on dialysis, indicate the date and time of last dialysis.

Last Bowel Movement

- All SDA (Same Day Admit) patients must have their last bowel movement recorded.

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Possibility of Pregnancy

- All female patients of child bearing age must be assessed for the possibility of pregnancy.
- If there is a possibility of pregnancy, a pregnancy test must be ordered and completed prior to transfer to the OR. (Document result of pregnancy test in Interactive View and I & O, point-of-care testing.)

External Warming Device

- All ERAS patients are given a forced-air warming gown to wear.
- Warming gowns may be used for other patients for whom heated blankets are not sufficient.
- Never use the warmer without the forced-air warming gown.
- Warming gown is sent to the OR with the patient and is reapplied on the patient arrival in PACU.

Pre-op Site Prep

- Document what skin prep the patient completed, and when.
- All ERAS patients are instructed to bathe or shower both the night before surgery and the morning of surgery, preferably with chlorhexidine 4% soap.

Bowel Prep

- If a bowel prep is required, indicate whether it was completed, and the type of prep done. ("Mechanical" prep means using oral agents.)
- For all other patients, indicate "N/A".

Hair Removal

- Currently hair removal is completed in the OR, so "No hair removal performed" should be selected.
- If the patient has performed their own hair removal, select "Other" and describe how, when, and what they prepped.

Preop Preprocedure Checklist

Patient Verification

- Document from initial part of the patient interview.

Surgical Procedure Verification

- Document surgical site/side verification from initial part of patient interview.
- "Surgical Site/Side Marked by Surgeon/Physician" must be "**yes**" prior to patient transfer to OR.

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Consents

- The acceptable selections for this section are “yes” or “N/A”. “No” means there should be a certain consent, but it is missing, incomplete, or has not been done. If this is the case, notify the surgeon.
- All necessary consents must be completed prior to patient transfer to OR.

Chart Review

- The purpose of the Chart Review is to ensure the patient preparation is complete, relevant documentation completed, and test results available.
- If parts of the Chart Review are blank, consult with the anesthesiologist and surgeon as to what is required for this patient.

Prosthetics/Implants/Belongings

- If the patient has a prosthetic device, document the type
- If the patient has an implanted device, indicate what and where.
- Glasses, dentures, and hearing aids may remain on/in the patient to the OR. Ensure there is a labelled container with the patient for removal.
- As per the instructions on the Cerner form, if any prosthetics/implants/belongings are removed, complete the Valuables/Belongings form.

Valuables/Belongings

- NOTE: This form is used by nurses in all areas throughout the patient’s stay. It should be an up-to-date and accurate account of the location or disposition of valuables and belongings. Upon discharge, the nurse completes this form to ensure the patient has all their valuables and belongings.

Progress Note – Simple

- Any free text note can be added here.

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