Preoperative Patient Preparation

Site Applicability

SPH and MSJ Acute Care

Practice Level

Basic:

- *RN, RPN, LPN*

Need to Know

1. This procedure applies to all surgical patients admitted through units or departments **other than** Surgical Day Care (SPH)
2. For patients admitted through Surgical Day Care, refer to B-00-12-10171 Pre-Operative Admission for Patients Attending Surgical Day Care (SPH)
3. Perinatal patients (from 20 weeks gestation to 14 days following delivery), must be referred to Maternity CNL/CN
4. Ensure patient's BP cuff, chartlet and transport ticket sent with patient to OR
5. The perioperative pre-procedure checklist can be completed by more than one nurse. Ensure all information is reviewed and updated as needed prior to sending the patient to the OR

Procedure

Steps

1. Ensure the patient's ID band is on. Confirm the spelling of the name. Check at least one other patient identifier – date of birth or MRN. Cross-check these with the banner bar in Cerner to verify.
2. (Patient ID band on and verified is documented on the Preop Preprocedure Checklist.)
3. Go to Results Review on patient's chart to view recent lab work and diagnostic tests. Ensure any preoperative testing that was ordered has been completed and reported. Ensure the appropriate person (charge nurse/surgeon) and/or the OR is aware of significant abnormal results.
4. Ensure the COVID-19 Patient Screening Powerform is complete in Cerner (AdHoc→Pre-Op→COVID-19).
5. If COVID-19 testing is ordered, complete Patient Testing section of the COVID-19 Patient Screening Powerform.
6. If the patient's COVID status has changed to "yellow" or "red", communicate this to surgeon and OR and follow IPAC recommendations.
7. Ensure Baseline vital signs are measured and documented in Cerner within 4 hours of surgery.
8. Ensure the patient's weight and height is recorded in Cerner.
9. Check for preoperative PowerPlan/ad hoc orders such as, to hold or administer medication.

10. Complete the Perioperative Preprocedure Checklist (AdHoc→Pre-Op→Perioperative Preprocedure Checklist).
6. Note that all "yes", "no", or "N/A" choices must be completed. Further explanation is provided for sections listed below.

Patient Preparation

- **Procedure Location** – Indicate the location the procedure will be performed.
- **Last Food and Drink** – It is important to 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.
  If the patient's last oral intake is outside of the guidelines below, notify the OR.

  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
  Preoperative or oral medications may be taken with a sip (30 mL) of water.
- **Preop Carbohydrate Drink-** ERAS patients are instructed to "carb load" both the evening before and the morning of surgery. Note whether this has been completed.
- **Capillary Blood Glucose** – Must be done for patients with diabetes within 4 hours of surgery. Complete as needed or if ordered for other patients.
- **Pre Transfusion Testing Completed Prior to Admission** – For most patients, the answer is "no". However, if the patient attended Preadmission Clinic (PAC) and had their group and screen collected there in the last 60 days, the validity of the specimen must be confirmed by asking about pregnancy or 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 transfer to the OR. Indicate if the patient has an indwelling catheter- in progress note (simple) of Perioperative Preprocedure Checklist Powerform.
- **Last Bowel Movement** – All inpatients must have their last bowel movement recorded.
- **Last Dialysis**- For a patient on dialysis, indicate the date and time of last dialysis
- **Alcohol, Substance abuse or tobacco-** If use is "current" for alcohol, substance abuse or tobacco in Social History, document date/time of last use.
- **Possibility of Pregnancy** – All female patients of childbearing 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 (also document result of the pregnancy test in Interactive View and I & O, point-of care testing.)
- **Menstruation**- If applicable, document date and time of last menstruation. If currently menstruating, tampon or cup must be removed prior to transfer to OR and mesh underwear with peri-pad applied if required.
- **External Warming Device**- Applicable for Surgical Daycare only.

- **Pre-op Site Prep** – Document what skin prep was completed, and when. If ordered, ERAS patients should bathe or shower both the night before surgery and the morning of surgery, preferably with chlorhexidine 4% soap. If patient cannot shower or is unable to rinse off chlorhexidine 4% soap, chlorhexidine 2% wipes (no rinse) are to be used.
- **Bowel Prep** – If bowel prep is ordered, indicate whether it was completed, and the type of prep done. ("Mechanical" prep means using oral agents.)
- **Hair Removal** – Currently, hair removal is completed in the OR, thus "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 Patient ID band is on and verified.
- **Allergy Band-** If applicable, document Allergy Band is on and verified.
- **COVID-19 Patient Screening Powerform-** Ensure powerform is completed.
- **Surgical Procedure Verification** - Ask the patient to tell you in their own words what surgery they are having, including confirmation of site/side, if applicable.
  Verify surgical site/side against relevant documentation e.g. surgical consent form. For "Surgical Site/Side Marked by Surgeon/Physician", indicate "yes" or "no"**.**
- **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. (The consent should be signed by both the surgeon and the patient/Substitute Decision Maker and dated.) Notify the surgeon if there is a problem with the consent.
  - If the patient is unable to provide consent for whatever reason, or their ability is in question, refer physician to *Consent to Health Care* document (B-00-11-10110).If there is a substitute decision maker, *Identification of Substitute Decision Maker (PHC)* Form ID-2760 must be completed.
- **Chart Review** – Use Chart Review to ensure the patient preparation is complete, relevant documentation completed, and test results available. Communicate any outstanding item (e**.**g., medications still to be given) directly to the OR charge nurse via phone.
- **Prosthetics/Implants/Belongings** – If the patient has a prosthetic device, document the type. Consult with the OR if unsure about the need to remove.
  If the patient has an implanted device, indicate what and where.
  If "other personal belongings" are removed, indicate what. Jewelry and body piercings should be removed whenever possible to prevent intraoperative injury.
  Glasses, dentures, and hearing aids may remain on/in the patient for transfer to the OR. Send a labeled container with the patient and document what was sent with the patient to OR.
  When prosthetics, implants and/or belongings are removed, document items in the Valuables/Belongings section (see below).
- **Valuables/Belongings** – Complete as appropriate to the situation. Ensure the location or disposition of valuables and belongings are noted, including if the item is with or on the patient. Ensure belongings are labeled and secured in appropriate location e.g. cashiers.
- **Progress Note – Simple** – Any free text note can be added here.

Patient and Family Education

Ensure preoperative teaching (including any patient health education material) has been provided. Answer any questions the patient/family may have.

Related Documents

1. B-00-12-10171- Pre- Operative Admission for Patients Attending Surgical Day Care (SPH).
2. B-00-13-10039 - Admitting Patient to Operating Room, protocol
3. B-00-13-10040 - Belongings (Patient) in Operating Room, protocol
4. B-00-13-10102 - Hair Removal, Appropriate Clipping (no shaving), protocol
5. B-00-13-10211 – Physical Assessment: Postoperative Patients
6. B-00-12-10015 - Warming Patient Using Forced Air Warmer
7. BCD-11-11-4000 - Allergy Documentation Policy
8. B-00-07-10024 - Maternity Services: Care Approach for Patients Admitted to Other Programs
9. B-00-11-10110 - Consent to Health Care

References

1. Preoperative Patient Record Review (Perioperative)-CE (December 2021). St. Louis, MO. Elsevier. Retrieved March 8 2022 from www.elsevierskills.com
2. Preoperative Preparation (Perioperative)-CE. (December 2021). St. Louis, MO. Elsevier. Retrieved March 8 2022 from www.elsevierskills.com
3. Operating Room Nurses Association of Canada. (2022). Recommended Standards, Guidelines, and Position Statements for Perioperative Registered Nursing Practice (15th ed.), section 3, pp. 7-16.
4. Phillips, N.M. (2022). Berry & Kohn's Operating Room Technique (14th Ed). Elsevier Mosby.

Appendices

- Appendix A - Form ID 2745- Consent to Treatment (PHC)
- Appendix B - Form ID 2760- Identification of Substitute Decision Maker (PHC)
- Appendix C - Form ID 2750- PHC Consent for Transfusion of Blood and/or Blood Products

Appendix A - Form ID 2745- Consent to Treatment (PHC)

Place Patient Form Label Here

CONSENT TO TREATMENT (PHC)

* 2 7 4 5 *

Consent Procedure

I hereby authorize _____ M.D./D.D.S./_____ and such physicians, surgeons, anesthetists and hospital staff whose assistance is required, to perform the following test(s), treatment(s), procedure(s) and/or operation(s):

_____

_____

The nature and possible effects, including the significant risks and alternatives to test, treatment or operation, have been explained to me and I understand the explanation and the alternatives.

If unexpected conditions are discovered during the above test, treatment or operation, I consent to such additional or alternative tests, treatments or operations as the health care provider named above finds immediately necessary.

I also agree to receive anaesthesia and such anaesthetics as may be considered necessary. I understand that it is my responsibility to refrain from driving a motor vehicle for 24 hours following my anaesthetic and to have a responsible adult accompany me home.

I understand that Providence Health Care participates in medical education and quality improvement and as a result I agree that:

1. supervised health practitioners-in-training who are in approved education programs may participate in my care;
2. tissues, bodily fluids, devices or implants removed in this procedure become the property of the hospital and may be used for such purposes, including teaching or research, as is approved by the hospital; and
3. my doctor or dentist may give information to the hospital about follow-up care in my doctor or dentist's office.

I understand that if I receive an implant/tissue from a source outside of Canada, Providence Health Care is required to provide information about me - including my name, address and the fact that I have this implant - to the provider of that implant/tissue so that I may be notified of any issues which arise about the device that could affect my health and safety. I further understand that it is possible that my personal information stored by the provider of the implant/tissue may be accessed by the government of that country without my knowledge or consent pursuant to applicable legislation. I authorize Providence Health Care to disclose my personal information to the provider of the implanted device or tissue as reasonably required.

X

Signature of patient	Date & time of signature
Signature of Substitute Decision Maker (Form ID - 2760 must be completed)	PRINT NAME
Signature of M.D./D.D.S/_____ obtaining consent	PRINT NAME
Witness signature (when MD not present at time of signing)	PRINT NAME

FORM ID - 2745 VERSION 2007 DEC 01 Page 1 of 2

Place Patient Form Label Here

CONSENT TO TREATMENT (PHC)

* 2 7 4 5 *

Consent Procedure

DECLARATION BY INTERPRETER:

I have accurately interpreted the conversation between _____ (health care provider) and _____ (patient or substitute decision maker) and interpreted this document to _____ (patient or substitute decision maker), who told me that he/she understood the explanation and consents to the treatment described on the other side of this form.

X _____ _____

Signature of interpreter Date & time of signature

_____

PRINT NAME

TELEPHONE CONSENT:

I have discussed the procedure outlined on the other side of this form and the expected benefits, significant risks, side effects, alternative course of action and the likely consequences of not having the treatment(s) with _____ (substitute decision maker) who is the patient's _____ (state relationship) and he/she has given verbal consent.

X _____ _____

Signature of M.D./D.D.S./_____ Date & time of signature

_____

PRINT NAME

X _____ _____

Signature of witness PRINT NAME

CERTIFICATE OF NEED FOR URGENT/EMERGENT HEALTH CARE:

I hereby certify that it is necessary to provide the following health care: _____ without delay in order to save this patient's life, to prevent serious physical or mental harm or to alleviate severe pain, and the patient is, in my opinion, incapable of giving or refusing consent, and has not previously indicated that consent would be refused, and I have been unable to consult with any available substitute decision maker within a reasonable time in the circumstances.

X _____ _____

Signature of M.D./D.D.S./_____ Date & time of signature

_____

PRINT NAME

It is recommended, but not mandatory, that a second medical staff member (not a resident) of Providence Health Care signs this form.

I agree with the need for the health care set out above for this patient and with the opinion on incapability.

X _____ _____

Signature of M.D./D.D.S./_____ Date & time of signature

_____

PRINT NAME

FORM ID - 2745 VERSION 2007 DEC 01 Page 2 of 2

Appendix B - Form ID 2760- Identification of Substitute Decision Maker (PHC)

Place Patient Form Label Here

IDENTIFICATION OF SUBSTITUTE DECISION MAKER (PHC)

* 2 7 6 0 *

Consent Other

Complete this form to confirm identification of the person appointed to make substitute consent decisions. If the patient has not identified a Prearranged Substitute Decision Maker, a Temporary Substitute Decision Maker will need to be appointed.

Confirmation of Prearranged Substitute Decision Maker

I am authorized to make the consent/refusal decision described the accompanying consent form in my capacity as:

☐ Committee of Person (provide copy of court order to health care provider as soon as time permits)

☐ Representative with authority to make this decision (provide copy of agreement to health care provider as soon as time permits)

☐ section 7 ☐ section 9

Name of Substitute Decision Maker	X Signature of Health Care Provider	Date	Phone # For SDM

Appointment of Temporary Substitute Decision Maker (TSDM)

I qualify to be chosen as the Temporary Substitute Decision Maker because I am (choose the person who ranks highest on the following list):

☐ the adult's spouse (includes common-law or same-sex partner in a marriage-like relationship)
☐ the adult's child
☐ the adult's parent
☐ the adult's brother or sister
☐ the adult's grandparent
☐ the adult's grandchild
☐ anyone else related by birth or adoption to the adult
☐ a close friend of the adult
☐ a person immediately related to the adult by marriage
☐ in the absence of any of the above, someone authorized by the Public Guardian & Trustee *(see over)*

I confirm that I:

- am at least 19 years of age,
- have been in contact with the patient during the last 12 months,
- have no dispute with the patient,
- am capable of giving, refusing or revoking substitute consent, and
- am willing to comply with the duties in section 19 of the *Health Care (Consent) and Care Facility (Admission) Act:*
  - I will consult as much as possible with the adult, and if I have been authorized by the Public Guardian & Trustee with any friend or relative of the adult who asks to assist,
  - I will comply with any instructions or wishes the adult expressed while he/she was capable, and
  - If the adult's instructions or wishes are not known, I will give or refuse consent based on the adult's known beliefs and values, or in the adult's best wishes if his/her beliefs and values are not known.

When deciding if it is in the adult's best interest to give, refuse or revoke substitute consent I understand that I must consider each of the following:

- the adult's current wishes
- whether the adult's condition or well-being is likely to improve with or without the proposed health care
- whether the benefit the adult is expected to get from the proposed health care is greater than the risk of harm
- whether a less restrictive or intrusive form of health care would be as beneficial as the proposed health care

Temporary Substitute Decision Maker

I have read and understood the statements and responsibilities above that apply to TSDM's and confirm that I am willing and able to act as this adult's TSDM.

X Signature of Temporary Substitute Decision Maker	PRINT NAME	Date	Phone

Health Care Provider

To the best of my knowledge the person named above is the appropriate individual to make health care decisions on this patient's behalf.

X Signature of Health Care Provider	PRINT NAME / TITLE	Date & time of signature

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REFERRAL TO PUBLIC GUARDIAN AND TRUSTEE FOR A TEMPORARY SUBSTITUTE DECISION MAKER (PHC)

* 2 7 6 0 *

Consent Other

Place Patient Form Label Here

Complete this form and fax to Public Guardian & Trustee at 604-660-9498 to arrange a TSDM

Re: _____
(patient name)

This patient is receiving, or it has been determined that he/she requires, health care in our facility. He/she is not capable of providing consent for treatment as defined under Section 7 of the *Health Care (Consent) and Care Facility Act* and does not have a Committee of Person or a Representation Agreement designating a health care decision maker.

The above named patient does not have a qualified Temporary Substitute Decision Maker because:

☐ He/she has no nearest relative readily accessible or willing to act as TSDM

OR

☐ He/she has one or more near relatives but all are disqualified:

- ☐ is/are under 19 years of age
- ☐ has/have not been in contact with the adult during the preceding 12 months
- ☐ has/have a dispute with the adult relevant to this decision
- ☐ is/are not capable of giving, refusing or revoking substitute consent
- ☐ is/are not willing to comply with the duties demanded by this role

OR

☐ There is a dispute among near relatives about who is to be chosen.

In the opinion of the undersigned health care provider:

☐ There is **NO** friend or other person close to the adult who would be appropriate to act as a TSDM

OR

☐ There **IS** a friend or other person close to the adult who would be appropriate to act as a TSDM

Name: _____ Relationship: _____

Phone: _____ Address: _____

A temporary substitute decision maker is needed to make a decision on the following proposed care:

_____

Care Provider making referral: (name) _____

Telephone: _____ Fax: _____

Appendix C - Form ID 2750- PHC Consent for Transfusion of Blood and/or Blood Products

Place Patient Form Label Here

CONSENT FOR TRANSFUSION
OF BLOOD AND / OR BLOOD PRODUCTS (PHC)

* 2 7 5 0 *

Consent Blood Products

Re: _____
(Print Name of Patient)

1. My health care provider, (printed name)_____has told me that during my treatment it may be necessary to receive a transfusion of blood and/or blood products such as red blood cells, plasma, cryoprecipitate, or platelets.
2. My health care provider has also told me about the risks of receiving a transfusion from volunteer donors. I understand that risks exist even though the blood and/or blood products have been tested. I understand that in most cases the risks are small, however in some cases serious injury and/or death may result.
3. My health care provider has discussed with me autologous blood donation and other suitable treatments. I have been told that even if my own blood is used, it may still be necessary to give me other blood and/or blood products.
4. I have been given information on blood and/or blood products for transfusion and the chance to ask questions about the benefits and risks of blood and/or blood products for transfusion. My health care provider has answered my questions to my satisfaction.

I consent to the transfusion of blood and/or blood products if it becomes necessary during the course of my treatment.

EXCEPTIONS TO CONSENT: This patient has indicated special instructions for the transfusion of blood products:

_____ _____
(Patient's Initials)

_____ _____
Signature (Patient or Substitute Decision Maker*): Printed name (if Substitute Decision Maker)

_____
Date

_____ _____
Signature of Prescriber Printed name

***Possible Substitute Decision Makers include:**

- A Committee of the Person, as appointed by a Court Order
- A Representative as appointed by a "Standard" Representation Agreement (restrictions apply) & defined by the "Representation Agreement Act".
- A Representative as appointed by an "Enhanced" Representation Agreement & defined by the "Representation Agreement Act".
- A "Temporary Substitute Decision Maker" *[Appointment of a Temporary Substitute Decision Maker* form (Form ID - 2760 - page 1) must be completed OR a TSDM referral made to the office of the Public Guardian & Trustee (Form ID - 2760 - page 2)]

This form will remain valid only for the duration of hospital stay or treatment course (renew yearly). **Please verify date of signature.**

For additional information on Informed Consent for Blood/Blood Products visit the Providence intranet website:
http:\\intranet.phc.ca >Policies and Manuals > Transfusion Medicine Laboratory: Tel: 604-806-8003 Fax: 604-806-8627

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Persons/Groups Consulted:

Nurse Educators, OR SPH & MSJ

Nurse Educators, Surgery SPH & MSJ

Nurse Educator, Renal SPH

Nurse Educator, Cardiac Surgery SPH

Clinical Nurse Specialist, Surgery

Developed By

Nurse Educators SPH Surgery

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	Surgery