University Of Shendi

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Assessment of pre and post oprative nursing care given to the patients in the surgical word

Dissertation submitted in requirement for partial fulfillment of the degree of MSc in medical surgical nursing

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قال تعالى:

(لا يكلف الله نفساً إلا وسعها لها ما كسبت وعليها ما أكتسبت ربنا لا تؤاخذنا إن نسينا أو أخطأنا ربنا ولا تحمل علينا إصراً كما حملته علي الذين من قبلنا ربنا ولا تحملنا ما لا طاقة لنا به وأعف عنا وأغفر لنا وأرحمنا أنت مولانا فأنصرنا علي القوم الكافرين) .

صدق الله العظيم

الآية 286 من سورة البقرة

Dedication

This work is dedicated

to all these candles that fired to lighten

my wayTo my husband Hythm Elzebear for

his patience, understanding and encouragement

To my brothers and sisters for Their Help and support

To my helpful teacher ustaz | Ahmed Abd Albagi And all my teachersTo my dearest sister |Sara Awed Alkareem

To my friends for their Valuable advice

To That man who put my feet in the right track to making research my supervisor Dr. Ehsir abas

To the dearest people in my life

with faith of respect.

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The magnificent thanks for Allah liege lord

who helped me to present this simple study.

My thanks extended to all those whom stood beside me, pushed me and helped me and to all those who received me and answered my questions, and I'm very grateful to individual that provided advice and Information's to me . My thanks torrential

to that one whom I can't remunerate,

to that who learned me how to make this study

My supervisor Dr. Ehsir abas

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Abstract

This study was conducted at the Elmek Nimir university Hospital in Shendi city. The aim of the study to assess the pre and post operative nursing care given to the patients in the surgical word, the sample was collected include all the patients whom arranged for surgical operations in the surgical department in Elmek Nimir Hospital. A check list and questionnaire were designed to record the pre and post operative nursing care given for each patient, fifty patients were recorded. The data collected was analyzed by using computer through SPSS program to show the results as percentage and tables.

The study reveals that all of nurses do good preparation to the patient regarding to explanation of the procedure, write consent of the patient to the operative procedure, preparation of the file, check the pre operative vital sign (blood pressure, pulse rate, and temperature) ECG, HB, fasting of the patient and changing in to the theater gown but only 20% checked their respiratory rate, 8% checked their weight and no patient check his height, 96%of the patients repaired their skin by shaving.

All patients transferred from theater by the nurses and the nurse maintained good position and check the drain and canulas and any other devices but only 15%check the vital sign to them and no patient check his oxygen saturation.

In continuous care the nurse checked the post operative note and administers the medications but only 6% measured their urine out put. Regard to the rehabilitation no patient received reassurance or learning and advice.

Introduction

Research objectives

Justification

Introduction

Surgery, whether elective or emergent, is a stressful complex event. Today, as a result of advances in surgical techniques and instrumentation as well as in anesthesia, many surgical procedures that were once performed in an inpatient setting now take place in an ambulatory or outpatient setting. Approximately 60% of elective surgeries are now performed in an ambulatory or outpatient setting (Russell, Williams & Bulstrode, 2000). This trend has increased the acuity and complexity of surgical patients and procedures. The number of surgical patients admitted for overnight hospital

stays is expected to continue to decrease. In the past, the patient scheduled for elective surgery would be admitted to the hospital at least 1 day before surgery for evaluation and preparation; these activities are now completed before the patient is admitted to the hospital. {1}

Today, many patients arrive at the hospital the morning of surgery and go home after recovering in the post anesthesia care unit (PACU) from the anesthesia. Often, surgical patients who require hospital stays are trauma patients, acutely ill patients, patients undergoing major surgery, patients who require emergency surgery, and patients with a concurrent medical disorder. Although each setting offers its own unique advantages for the delivery of patient care, all require a comprehensive preoperative nursing assessment and nursing intervention to prepare the patient and family before surgery.

Today's technology has led to more complex procedures, more complicated microsurgical and laser technology, more sophisticated bypass equipment, increased use of laparoscopic surgery, and more sensitive monitoring devices. Surgery might now involve the transplantation of multiple human organs, the implantation of mechanical devices, the reattachment of body parts, and the use of robots and minimally invasive procedures in the operating room (Mack, 2002). Advances in anesthesia have kept pace with these surgical technologies. More sophisticated monitoring and new pharmacologic agents, such as short-acting anesthetics

and more effective antiemetics, have improved postoperative pain management, reduced postoperative nausea and vomiting, and shortened procedure and recovery times. Concurrent with technologic advances have been changes in the delivery of and payment for health care. {**2}**

The special field known as perioperative and perianesthesia nursing includes a wide variety of nursing functions associated with the patient's surgical experience during the perioperative period. **Perioperative** and perianesthesia nursing addresses the nursing roles relevant to the three phases of the surgical experience: **preoperative**, **intraoperative**, and **postoperative**. And in this study I will assess the ability of ability of qualified nurse to offer proper pre operative preparation and post operative care of patient in surgical word **.{1}**

Justification

Preoperative and postoperative care is pressure to reduce hospital stays and contain costs and enhance the healing without complication has resulted in patients undergoing diagnostic preadmission testing and preoperative preparation before admission to the hospital. Many facilities have a presurgical services department to facilitate testing and to initiate the nursing assessment process, which may focus on patient demographics, health history, and other information pertinent to the surgical procedure. The increasing use of ambulatory or same-day surgery means that patients leave the hospital sooner, which increases the need for teaching, discharge planning, preparation for self-care, and referral for home care and rehabilitation services. Competent care of ambulatory or same-day surgical patients requires a sound knowledge of all aspects of perioperative and perianesthesia nursing practice.

Objectives

General objectives

- To assess the pre and post operative nursing care given to the patients in surgical word

Specific objectives

- Assess the pre operative preparation of surgical patient
- Assess the post operative care of surgical patient


Chapter tow

Literature review

Literature review

Pre operative patient preparation:-

The **preoperative phase** begins when the decision to proceed with surgical intervention is made and ends with the transfer of the patient onto the operating room table. The scope of nursing activities during this time can include establishing a baseline evaluation of the patient before the day

of surgery by carrying out a preoperative interview (which includes not only a physical but also an emotional assessment, previous anesthetic history, and identification of known allergies or genetic problems that may affect the surgical outcome), ensuring that necessary tests have been or will be performed (preadmission testing), arranging appropriate consultative services, and providing preparatory education about recovery from anesthesia and postoperative care. On the day of surgery, patient teaching is reviewed, the patient's identity and the surgical site are verified, informed consent is confirmed, and an intravenous infusion is started. If the patient is going home the same day, the availability of safe transport and the presence of an accompanying responsible adult is verified. Depending on when the preadmission evaluation and testing were done, the nursing activities on the day of surgery may be as basic as performing or updating the preoperative patient assessment and addressing questions the patient or family may have**. {1}**

Pre-Operative Preparation

1. Explain the procedure:

The physician's responsibility to provide appropriate information. It must be clear and simple explanation of what the surgery will entail. The surgeon must also inform the patient of the benefits, alternatives, possible risks, complications, disfigurement, disability, and removal of body parts as well as what to expect in the early and late postoperative periods. If the patient needs additional information to make his or her decision. **{3}**

2. Informed consent

Voluntary and written **informed consent** from the patient is necessary before nonemergent surgery.

Rationale: To comply with legal and Trust policy requirements. And protects the patient from unsanctioned surgery and protects the surgeon from claims of an unauthorized operation. In the best interests of all parties concerned, sound medical, ethical, and legal principles are followed.

The nurse may ask the patient to sign the form and may witness the patient's signature; the nurse ascertains that the consent form has been signed before administering psychoactive premedication, because the

consent may not be valid if it was obtained while the patient was under the influence of medications that can affect judgment and decision-making capacity. Informed consent is necessary in the following circumstances:

- Invasive procedures, such as a surgical incision, a biopsy, a cystoscopy, or paracentesis
- Procedures requiring sedation and/or anesthesia, for a discussion of levels of sedation and anesthesia.
- A nonsurgical procedure, such as an arteriography, that carries more than slight risk to the patient
- Procedures involving radiation

The patient personally signs the consent if he or she is of legal age and is mentally capable. When the patient is a minor or unconscious or incompetent, permission must be obtained from a responsible family member (preferably next of kin) or legal guardian. An emancipated minor (married or independently earning his or her own living) may sign his or her own consent form. State regulations and agency policy must be followed. .**{4}**

3. Assessment of respiratory Status

Rationale: to insure potential optimal respiratory function. Patients are taught breathing exercises and use of an incentive spirometer if

indicated. Because adequate ventilation is potentially compromised during all phases of surgical treatment, surgery is usually postponed when the patient has a respiratory infection. Patients with underlying respiratory disease (e.g., asthma, chronic obstructive pulmonary disease) are assessed carefully for current threats to their pulmonary status. Patients who smoke are urged to stop 2 months before surgery, although many do not do so. These patients should be counseled to stop smoking at least 24 hours prior to surgery. Research suggests that counseling has a positive effect on the patient's smoking behavior 24 hours preceding surgery, helping reduce the potential for adverse effects associated with smoking such as increased airway reactivity, decreased mucociliary clearance, as well as physiologic changes in the cardiovascular and immune systems . **{3}**

4. Assessment of cardiovascular Status:

Rationale to ensure a well functioning cardiovascular system to meet the oxygen, fluid, and nutritional needs of the perioperative period. If the patient has uncontrolled hypertension, surgery may be postponed until the blood pressure is under control. Because cardiovascular disease increases the risk for complications, patients with these conditions require greater-than-usual diligence during all phases of nursing management and care depending on the severity of the symptoms,

surgery may be deferred until medical treatment can be instituted to improve the patient's condition. At times, surgical treatment can be modified to meet the cardiac tolerance of the patient. For example, in a patient with obstruction of the descending colon and coronary artery disease, a temporary simple colostomy may be performed rather than a more extensive colon resection that would require a prolonged period of anesthesia. **{5}**

5. Assessment of hepatic and renal function:

Rationale: to insure optimal function of the liver and urinary systems so that medications, anesthetic agents, body wastes, and toxins are adequately processed and removed from the body.

The liver is important in the biotransformation of anesthetic compounds. Therefore, any disorder of the liver has an effect on how anesthetic agents are metabolized. Because acute liver disease is associated with high surgical mortality, preoperative improvement in liver function is a goal. Careful assessment is made with the help of various liver function tests, because the kidneys are involved in excreting anesthetic drugs and their metabolites and because acid–base status and metabolism are also important considerations in anesthesia administration, surgery is contraindicated when a patient has acute nephritis. **{6}**

6. Assessment of endocrine Function

The patient with diabetes who is undergoing surgery is at risk for hypoglycemia and hyperglycemia. Hypoglycemia may develop during anesthesia or postoperatively from inadequate carbohydrates or from excessive administration of insulin. Hyperglycemia, which may increase the risk for surgical wound infection, may result from the stress of surgery, which may trigger increased levels of catecholamine. Other risks

are acidosis and glucosuria. Although the surgical risk in the patient with controlled diabetes is no greater than in the nondiabetic patient, the goal is to maintain the blood glucose level at less than 200 mg/dL. Frequent monitoring of blood glucose levels is important before, during, and after surgery.

Patients who have received corticosteroids are at risk for adrenal insufficiency. Therefore, the use of corticosteroids for any purpose during the preceding year must be reported to the anesthesiologist or anesthetist and surgeon. Additionally, the patient is monitored for signs of adrenal insufficiency.

Patients with uncontrolled thyroid disorders are at risk for thyrotoxicosis (with hyperthyroid disorders) and respiratory failure (with hypothyroid disorders). Therefore, the patient is assessed for a history of these disorders. **{7}**

7. Assessment of immune Function

An important function of the preoperative assessment is to determine the existence of allergies, including the nature of previous allergic reactions. It is especially important to identify and document any sensitivity to medications and past adverse reactions to these agents. The patient is asked to identify any substances that precipitated previous allergic reactions, including medications, blood transfusions, contrast

agents, latex, and food products, and to describe the signs and symptoms produced by these substances. Immunosuppression is common with corticosteroid therapy, renal transplantation, radiation therapy, chemotherapy, and disorders affecting the immune system, such as acquired immunodeficiency syndrome (AIDS) and leukemia. The mildest symptoms or slightest temperature elevation must be investigated. Because patients who are immunosuppressed are highly susceptible to infection, great care is taken to ensure strict asepsis. **{3}& {8}**

8. Assessment of nutritional status:

Perform a nutritional assessment to identify patients at risk of post operative nutritional complications.

Rationale To ensure adequate nutritional needs are supplied to promote cell regeneration. Optimal nutrition is an essential factor in promoting healing and resisting infection and other surgical complications

Assessment of a patient's nutritional status provides information on obesity, under nutrition, weight loss, malnutrition, deficiencies in specific nutrients, metabolic abnormalities, the effects of medications on nutrition, and special problems of the hospitalized patient. **{9}**

Nutritional needs may be determined by measurement of body mass index and waist circumference. Any nutritional deficiency, such as

malnutrition, should be corrected before surgery so that enough protein is available for tissue repair Dehydration, hypovolemia, and electrolyte imbalances can lead to significant problems in patients with co morbid medical conditions or in elderly patients. The severity of fluid and electrolyte imbalances is often difficult to determine. Mild volume deficits may be treated during surgery; however, additional time may be needed to correct pronounced fluid and electrolyte deficits to promote the best possible preoperative condition. **{10}**

9. Drug or alcohol use:

People who abuse drugs or alcohol frequently deny or attempt to hide it. In such situations, the nurse who is obtaining the patient's health history needs to ask frank questions with patience, care, and a nonjudgmental attitude. Because acutely intoxicated persons are susceptible to injury, surgery is postponed in these patients if possible. If emergency surgery is required, local, spinal, or regional block anesthesia is used for minor surgery. Otherwise, to prevent vomiting and potential aspiration, a nasogastric tube is inserted before administering general anesthesia. The person with a history of chronic alcoholism often suffers from malnutrition and other systemic problems that increase the surgical risk. Additionally, alcohol withdrawal delirium (delirium tremens) may be anticipated up to 72 hours after alcohol withdrawal.

Delirium tremens is associated with a significant mortality rate when it occurs postoperatively. **{10}**

10. Pre-operative teaching:

Nurses have long recognized the value of preoperative instruction Each patient is taught as an individual, with consideration for any unique concerns or needs; the program of instruction should be based on the individual's learning needs

Multiple teaching strategies should be used (e.g., verbal, written, return demonstration), depending on the patient's needs and abilities. Preoperative teaching is initiated as soon as possible. It should start in the physician's office and continue until the patient arrives in the operating room. **{11}**

When and What to Teach

- Ideally, instruction is spaced over a period of time to allow the patient to assimilate information and ask questions as they arise. Frequently, teaching sessions are combined with various preparation procedures to allow for an easy and timely flow of information.
- The nurse should guide the patient through the experience and allow ample time for questions. Some patients may feel too many

descriptive details will increase their anxiety level, and the nurse should respect their wish for less detail.

- Teaching should go beyond descriptions of the procedure and should include explanations of the sensations the patient will experience. For example, telling the patient only that preoperative medication will relax him or her before the operation is not as effective as also noting that the medication may result in light headedness and drowsiness. Knowing what to expect will help the patient anticipate these reactions and thus attain a higher degree of relaxation than might otherwise is expected.
- The ideal timing for preoperative teaching is not on the day of surgery but during the preadmission visit when diagnostic tests are performed. At this time, the nurse or resource person answers questions and provides important patient teaching. During this visit, the patient can meet and ask questions of the perioperative nurse, view audiovisuals, receive written materials, and be given the telephone number to call as questions arise closer to the date of surgery. Most institutions provide written instructions (designed to be copied and given to patients) about many types of surgery .

Also teaching include :

- Deep-Breathing, Coughing, and Incentive Spirometer
- Mobility and Active Body Movement
- Pain Management

- Cognitive Coping Strategies. **{11}**

11. Pre-operative fasting :

Rationale: To prevent aspiration of stomach content. Minimum nil by mouth time prior to anesthesia: fluids 4 hours & 8 hrs foods and milk. **{12}**

12. Preparing the Skin

The goal of preoperative skin preparation is to decrease bacteria without injuring the skin. If the surgery is not performed as an emergency, the patient may be instructed to use a soap containing a detergent-germicide to cleanse the skin area for several days before surgery to reduce the number of skin organisms; this preparation may be carried out at home.

Generally, hair is not removed preoperatively unless the hair at or around the incision site is likely to interfere with the operation. If hair must be removed, electric clippers are used for safe hair removal immediately before the operation.

1. The patient's skin is prepared by applying an antiseptic in concentric circles, beginning in the area of the proposed incision.

2. The prepared area should be large enough to extend the incision or create new incisions or drain sites, if necessary.
3. The application of the skin preparation may need to be modified, depending on the condition of the skin (e.g. burns) or location of the incision site (e.g. face).

There should be no hazard if alcoholic preparations are used correctly:

- the amount used should be adequate to keep the site wet for the recommended time;
- sufficient time must be allowed for alcohol-based skin preparations to dry thoroughly before commencing the procedure to ensure that all combustible ingredients have evaporated;
- the preparation should be allowed to evaporate completely before electrocautery diathermy or laser instruments are switched on; and Pooling of excess liquid below the patient should not be allowed to occur. **{3}{5}**

13. Potential Problems Prior to Surgery

Nursing personnel shall be responsible for notifying the physician and or appropriate department of any potential problems prior to sending the patient to surgery. **{3}**

14. Pre-Operative shower and path:

Purpose: to take advantage of the potential to decrease post-operative surgical site infections by cleansing the skin of the patient preoperatively.

Please remember to **Not Shave** any of the hair bearing areas at or near the planned

operative site for 48 hours prior to the operation.

- If the patient's condition allows, showering is recommended for whole body bathing.
- The patient should wash the entire body, including the scalp, on two consecutive occasions prior to having a surgical procedure. We prefer a shower or bath the evening before the operation and the morning of the operation.
- Each shower bath should consist of two consecutive thorough applications of CHG containing formulation followed by thorough rinsing. The recommended use of the preoperative skin cleansing soap is as follows:
- Wet the body, including the hair.
- Wash the hair using 1 ounce of the antiseptic soap and the body using another 1 ounce of the formulation. Scrub the areas of the planned operation and the surrounding areas for 30 seconds using a wash cloth.

- Rinse.
- Repeat.

Rinse thoroughly after the second application. After completing the shower bath and drying the skin, please do not apply any skin lotions, moisturizers, etc. **{13}**

15. Ensure the patient is wearing an identification bracelet containing the patient's name, date of birth, ward number and hospital identification number.

Rationale Maintain safety and prevent misidentification. **{3}**

16. check the vital sign:

Record the patients pulse, blood pressure, temperature, respiration rate and weight.

Rationale Maintain patient safety and establish a pre-operative baseline.

1. The results of all pre-operative investigations should be available:

i) Blood results, ECG x-rays and scan reports.

ii) Along with imaged results:

iii) X- ray, CT and MRI films.

Rationale: To ensure that all relevant material is available to the surgical and anesthetic team. **{13}**

17. preoperative medications:

Insure that any necessary prophylaxis against post-operative venous thrombosis e.g. antiembolic stockings, subcutaneous drug therapy, leg and breathing exercises is initiated.

Rationale To prevent venous stasis, deep vein thrombosis or compromise to the pulmonary system. **{14}**

18. Ask or assist the patient to change into a theatre gown. Theatre hat to go with the patient.

Rationale: To ensure the patients dignity and comfort. Clean clothing for theatre. **{3}**

19. Check and administer any prescribed medication adhering to Trust policy.

Rationale: To assist the patient to relax prior to surgery and to ensure safe administration of medication. **{14}**

20. Advise the patient, following the administration of a pre-medication not to get up unaided, assistance must be obtained from nursing staff.

Rationale To maintain the patient's safety as may be drowsy and uncoordinated. **{14}**

21. Check the patient's identification band; case notes and theatre computer sheet (brought by transporting theatre staff) contain the same information. **{3}**

Rationale To prevent misidentification and maintain patient safety

22. Ensure that the patient is accompanied to theatre by a member of the ward staff.

Rationale Minimize distress to the patient and maintain a safe transfer.

23. Ensure that patient case notes and x-rays accompany the patient to theatre.

Rationale Ensure surgical teams have full access to the patient's history.

24. Record all pre-operative care and communication in the nursing documentation.

Rationale Ensure effective communication.

25. Pre-Operative Checklist

A. The Pre-op Checklist shall be initiated by the nurse transcribing the pre-operative orders or orders for surgery

B. The nurse shall check the operative permit for completion, to include documentation of the operative site location and appropriate signatures.

- The nurse shall check the patient for a **mark on the operative site** to designate he appropriate surgical site.
- The nurse shall check the **anesthesia consent form** for completion.
- If the surgical site is not noted or the anesthesia consent form is not completed, the nurse shall write "**INCOMPLETE"** in the

column under initials next to the item is not complete and place initials; then notify the Operating Room.

C. The nurse shall complete appropriate sections applicable on the Pre-Op Checklist for patients going to surgery, or special procedures.

D. The Pre-op Checklist shall be dated and signed with the transferring nurse's legible full legal signature prior to sending the patient to surgery and placed in the front of the chart so that it is readily available. The patient's generated medication administration record or the INVISION Transfer Medication Reconciliation Report and current lab shall be placed in the front of the chart.

E. This form is a permanent part of the medical record and shall be placed with the Nurses 24 Progress Record upon return to the unit. **{15}&{8}**

Postoperative preparation:

The **postoperative phase** begins with the admission of the patient to the PACU and ends with a follow-up evaluation in the clinical setting or at home. The scope of nursing care covers a wide range of activities during this period. In the immediate postoperative phase, the focus includes maintaining the patient's airway, monitoring vital signs, assessing the effects of the anesthetic agents, assessing the patient for complications, and providing comfort and pain relief. Nursing activities then focus on promoting the patient's recovery and initiating the teaching, follow-up care, and referrals essential for recovery and rehabilitation after discharge. **{13}**

Historically, the perioperative nurse's practice environment has been isolated, consisting of the area behind the double doors of the surgical suite. Although the nursing process guided nursing care, the fundamentals of assessment, diagnosis, planning, intervention, and evaluation were often misunderstood by practitioners unfamiliar with the delivery of surgical care. In recent years, the acceptance of a conceptual model for patient care, published by the Association of Perioperative Registered Nurses, formerly known as the Association of Operating Room Nurses has helped to delineate the relationship of various components of nursing practice and the effect on patient outcomes. The Perioperative Nursing Data Set (PNDS) is a language that describes the practice of perioperative nursing practice in four domains: safety, physiologic responses, behavioral responses, and health

care systems . The first three domains reflect phenomena of concern to perioperative nurses and are composed of nursing diagnoses, interventions, and outcomes that surgical patients and their families experience. The fourth domain, the health care system, comprises structural data elements and focuses on clinical processes and outcomes. The model is used to depict the relationship of nursing process components to the achievement of optimal patient outcomes. The patient will be assessed to detect problems in the following systems.

- Airway
- Breathing
- Circulation
- Disability
- Exposure

1. The patient will be allowed to recover from anesthesia and this will be achieved with:
    - Staff who are trained and proficient in the recovery of patients from anesthesia.
    - Safe equipment, checked daily.
    - Adequate supplies of equipment for management of airway, breathing and circulation compromise, including resuscitation equipment.

- Staffing levels should be sufficient to allow each unconscious patient to have one nurse in attendance until protective reflexes have returned.
- Staff will be able to recognize complications during recovery and competent to take the appropriate action. This may involve consultation or assistance from anesthetists or surgeon.
- There will be clear documentation of airway, breathing, cardiovascular and fluid balance observations.
- An anaesthetist must be available at all times that patients are in PACU.
- A member of the surgical operating team should be contactable while the patient is in PACU.
- Adequate supplies of respiratory stimulants, opiate antagonists and neuromuscular reversal agents. **{5}&{24}**

2. Airway and Breathing

- Airway patency, safety and breathing will be assessed as a first priority.
- Where necessary basic and advance maneuvers will be used to ensure that patients health is not harmed by airway or breathing compromise. This may involve consultation or assistance from an anaesthetist (or occasionally a surgeon).
- Oxygen therapy and pulse oximetry will be available for all patients in PACU.

- The PACU nurse will ensure the patient achieves adequate airway protection, adequate oxygenation and adequate ventilation prior to discharge from PACU.
- Nursing staff should be trained in basic life support. - Chest drains and the facility to insert a chest drain with underwater seal will be available in PACU.
- There will be adequate supplies of opiate antagonists, neuromuscular reversal agents and respiratory stimulants. **{5}**

3. Maintenance of Circulation.

- Cardiovascular status will be rapidly assessed after arrival in PACU, once airway patency, safety and adequate breathing is confirmed.
- Where necessary basic and advanced maneuvers will be used to ensure that patients' health is not harmed by cardiovascular compromise. This may involve consultation or assistance from anaesthetist or surgeon.
- Blood pressure and heart rate will be measured at a minimum of 5 minute intervals initially. Less frequent measurements may be appropriate as the patient's condition improves.
- Where appropriate monitoring of peripheral vascular status will be employed (e.g. Peripheral pulses, capillary return and distal temperature for patients following vascular surgery and for orthopaedic patients following application of casts or fracture surgery).

- In some cases more advanced cardiovascular monitoring such as invasive measurement of arterial and central venous pressures will be required. Only appropriately trained nurses will attend these patients and patients requiring this monitoring may need more than one nurse to look after them.
- Abnormalities in cardiovascular status, hydration, urine output or surgical drainage will be referred through the appropriate anesthetic or surgical channels and will be addressed before the patient leaves PACU.
- The patient will have stable cardiovascular system (within their normal values) before discharge from PACU.
- Equipment to enable non-invasive blood pressure, heart rate, continuous ECG and invasive pressure monitoring will be available.
- Fluid (crystalloid and colloid) and drugs to treat cardiovascular compromise will be available in PACU.
- Resuscitation equipment including a functioning defibrillator and 'arrest trolley' will be available in PACU.
- Nursing staff must be adequately trained to assist in resuscitation if required**. {16}&{25}**

4. assessment patient for Hemorrhage:

Hemorrhage is an uncommon yet serious complication of surgery that can result in death .It can present insidiously or emergently at any time in the immediate postoperative period or up to several days

after surgery .When blood loss is extreme, the patient is apprehensive, restless, and thirsty; the skin is cold, moist, and pale. The pulse rate increases, the temperature falls, and respirations are rapid and deep, often of the gasping type spoken of as “air hunger.” If hemorrhage progresses untreated, cardiac output decreases, arterial and venous blood pressure and hemoglobin level fall rapidly, the lips and the conjunctivae become pallid, spots appear before the eyes, a ringing is heard in the ears, and the patient grows weaker but remains conscious until near death. **{12}**

Transfusing blood or blood products and determining the cause of hemorrhage are the initial therapeutic measures. The surgical site and incision should always be inspected for bleeding. If bleeding is evident, a sterile gauze pad and a pressure dressing are applied, and the site of the bleeding is elevated to heart level if possible. The patient is placed in the shock position (flat on back; legs elevated at a 20-degree angle; knees kept straight). If the source of bleeding is concealed, the patient may be taken back to the operating room for emergency exploration of the surgical site. **{12}**

5. Maintenance of Temperature.

- The environment will be maintained at a comfortable level for the patients. Within the agreed environmental policy.
- Patients’ temperature will be measured using an appropriate thermometer site and thermometer.
- Hypothermic patients will be warmed passively or with external warming (e.g. force air warmer).
- Intravenous fluids will be warmed where appropriate.

- Hyperthermic patients who require treatment will be identified. These patients will be given antipyretics (paracetamol) and passive or active external cooling applied. - Management of hypothermic and hyperthermic patients may involve consultation with and assistance from an anaesthetist or surgeon.
- The patients' normal body temperature should be maintained, or kept within acceptable safe/comfort levels. Normothermia will be achieved prior to discharge from PACU.
- Equipment will be available to allow fluid warming and active external warming.
- Nursing staff will be trained in use of this equipment. **{2}&{26}**

6. Relieving Pain and Anxiety

Opioid analgesics are administered judiciously and often intravenously in the PACU. Intravenous opioids provide immediate relief and are short-acting, thus minimizing the potential for drug interactions or prolonged respiratory depression while anesthetics are still active in the patient's system. In addition to monitoring the patient's physiologic status and managing pain, the PACU nurse provides psychological support in an effort to relieve the patient's fears and concerns.**{27}**

The nurse checks the medical record for special needs and concerns of the patient. When the patient's condition permits, a close member of

the family may visit in the PACU for a few moments. This often decreases the family's anxiety and makes the patient feel more secure

- The effects of analgesic interventions will be monitored to detect effectiveness of pain relief and complication of pain relief.
- Management of pain relief may involve consultation with and assistance from an anaesthetist or surgeon.
- Efficacy of pain relief will be recorded. Adverse effects will be recorded and reported to the anaesthetist.
- The aim is for the patient to experience no more than moderate pain (pain score of less than 5).
- Failure to achieve expected or adequate pain relief may require consultation with and assistance from an anaesthetist or surgeon.
- The patient may be discharged from PACU no less than 20 minutes after administration of an intravenous opiate bolus. This allows 15 minutes for the peak effect of the opiate to have elapsed, which will ensure appropriate time to assess efficacy and side effects of the drug administration.
- Analgesia required including advanced techniques (such as the use of spinal opiates) will be handed over to the ward nurse when the patient is discharged.
- Specialized Pain Control Techniques in PACU. Training will be given to staff in management of pain, intravenous administration of drugs and specialized equipment for the relief of pain, e.g. PCA or Epidural. **{17}&{18}**

7. **Controlling Nausea and Vomiting**

Nausea and vomiting are common problems in the PACU. The nurse should intervene at the patient's first report of nausea to control the problem rather than wait for it to progress to vomiting. Many medications are available to control nausea and vomiting without over sedating the patient; they are commonly administered during surgery as well as in the PACU. Intravenous or intramuscular administration of droperidol (Inapsine) is common, especially in the ambulatory setting. Other medications such as metoclopramide (Reglan), prochlorperazine (Compazine), and promethazine (Phenergan) are commonly prescribed.

- The effects of antiemetics interventions will be monitored to detect effectiveness of anti- emesis and complications anti-emesis.
- Management nausea and vomiting may involve consultation with and assistance from an anaesthetist or surgeon.
- Efficacy of antiemesis will be recorded. Adverse effects will be recorded and reported to the anaesthetist.
- Failure to achieve expected or adequate anti-emesis may require consultation with and assistance from an anaesthetist or surgeon.
- The aim is to prevent or reduce nausea and vomiting post operatively.

- The use of anti-emetic drugs will be in accordance with the hospital drugs policy.
- All staff will be trained in the awareness of reasons for emesis.
- Infection control policy should be followed when handling body fluids and disposing of them.
- Staff should be able to pass a nasogastric tube, recognized patency and secure it safely.
- Regular oral hygiene should be given.
- The patient can not be discharged from PACU until PONV is effectively controlled. **{19}&{28}**

8. Preventing Infection

- Gloves to be worn when handling all body fluids
- Staff will be aware of infection control policy and be committed to its prevention.
- Patient trolleys, equipment, shelves and cupboards will be cleaned regularly between patients.
- Items designed for single use will be used once and disposed of.
- Appropriate high standard care will be given to all patients in order to reduce the risk of infection.
- Appropriate observations will be carried out to detect signs of local and/or generalized infection.
- Strict aseptic care of catheters, tubes, drains, venous lines and wounds will be maintained.

- Existing infection will be treated where this is required and management will minimize the risk of acquiring any preventable infection as a result of being in hospital.
- Necessary steps will be taken to avoid or minimize risk of cross-infection between patients.
- All staff to adhere to hospital and unit infection control guidelines.
- The aim is to promote uncomplicated healing. This will include a clean, dry wound with no obvious signs of complication. Stomas should be well perfused.
- Aseptic technique will be used for wound dressings.
- When dealing with body fluids nursing staff will adhere to Infection Control Policy.
- Wound and drain inspection will be undertaken to detect complications. If detected; these will be reported to the appropriate person.
- Medication or dressings will be given or applied as prescribed and in accordance with the hospital policy. **{20}&{21}**

Determining Readiness for Discharge from the PACU

A patient remains in the PACU until he or she has fully recovered from the anesthetic agent. Indicators of recovery include stable blood pressure, adequate respiratory function, adequate oxygen saturation level compared with baseline, and spontaneous movement or movement on command.

Usually the following measures are used to determine the patient's readiness for discharge from the PACU:

- Stable vital signs
- Orientation to person, place, events, and time
- Uncompromised pulmonary function
- Pulse oximetry readings indicating adequate blood oxygen saturation
- Urine output at least 30 mL/h
- Nausea and vomiting absent or under control
- Minimal pain

Many hospitals use a scoring system (eg, Aldrete score) to determine the patient's general condition and readiness for transfer from the PACU .Throughout the recovery period, the patient's physical signs are observed and evaluated by means of a scoring system based on a set of objective criteria. This evaluation guide, a modification of the Apgar scoring system used for evaluating newborns, allows a more objective assessment of the patient's condition in the PACU The patient is assessed at regular intervals (eg, every 15 or 30 minutes), and the score is totaled on the assessment record. Patients with a score lower than 7 must remain in the PACU until their condition improves or they are transferred to an intensive care area, depending on their preoperative baseline scores. The patient is discharged from the phase I PACU by the anesthesiologist or anesthetist to the critical care unit, the medical

surgical unit, the phase II PACU, or home with a responsible family member. Patients being discharged directly to home require verbal and written instructions and information about follow-up carPost Anesthesia Care Unit: **{19}**

MODIFIED ALDRETE SCORE

Patient:_____ Room: _____ Final score:_____

Surgeon:_____ PACU nurse:_____

Area of Assessment	Point Score	Upon Admission	After		
Muscle Activity:			**1h**	**2h**	**3h**
Moves spontaneously or on command:	**2**				
▪ Ability to move all extremities	**1**				
▪ Ability to move 2 extremities ▪ Unable to control any extremity	**0**				
Respiration:					
▪ Ability to breathe deeply and cough	**2**				
▪ Limited respiratory effort (dyspnea or splinting)	**1**				
▪ No spontaneous effort	**0**				
Circulation:					
▪ BP ± 20% of preanesthetic level	**2**				
▪ BP ± 20%–49% of preanesthetic level	**1**				
▪ BP ± 50% of preanesthetic level	**0**				
Consciousness Level					
▪ Fully awake	**2**				
▪ Arousable on calling	**1**				
▪ Not responding	**0**				
O2 Saturation:					
	2				

▪ Able to maintain O2 sat >92% on room air	**1**				
▪ Needs O2 inhalation to maintain O2 sat >90%	**0**				
▪ O2 sat <90% even with O2 supplement					
Totals					
Required for discharge from Post Anesthesia Care Unit: 7–8 points					
Time of release Signature of nurse					

Promoting Home and Community-Based Care

To ensure patient safety and recovery, expert patient teaching and discharge planning are necessary when a patient undergoes same day or ambulatory surgery. Because anesthetics cloud memory for concurrent events, instructions should be given to both the patient and the adult who will be accompanying the patient home**. {11}**

Teaching patients self care

- The patient and caregiver (eg, family member or friend) are informed about expected outcomes and immediate postoperative changes anticipated in the patient's capacity for self-care
- Written instructions about wound care, activity and dietary recommendations, medication, and follow-up visits to the same-day surgery unit or the surgeon are provided.
- The patient's caregiver at home is provided with verbal and written instructions about what to observe the patient for and about the

actions to take if complications occur. Prescriptions are given to the patient.

- The nurse or surgeon's telephone number is provided, and the patient and caregiver are encouraged to call with questions and to schedule follow-up **.{6}**

Receiving the patient in the clinical unit

The patient's room is readied by assembling the necessary equipment and supplies: IV pole, drainage receptacle holder, emesis basin, tissues, disposable pads, blankets, and postoperative charting forms. When the call comes to the unit about the patient's transfer from the PACU, the need for any additional items that may be needed is communicated. The PACU nurse reports the baseline data about the patient's condition to the receiving nurse. The report includes demographic data, medical diagnosis, procedure performed, co morbid conditions, allergies,

unexpected intraoperative events, estimated blood loss, the type and amount of fluids received, medications administered for pain, whether the

patient has voided, and information that the patient and family have received about the patient's condition.

Usually the surgeon speaks to the family after surgery and relates the general condition of the patient. The receiving nurse reviews the postoperative orders, admits the patient to the unit, performs an initial assessment, and attends to the patient's immediate needs**. {22}**

Continuing care:

1. **Elimination**

- The aim is for the patient to have no deterioration in bladder or bowel function in line with post operative expectations.
- Observations of bladder, bowel/stoma function will be made and recorded. Any identified or suspected malfunction or concerns will be referred appropriately.
- Management of elimination should ensure privacy and dignity at all times.
- Toileting devices should be readily available.
- Strict aseptic technique will be used during bladder catheterization.
- Hourly urine measurements will be made for appropriate patients. **{20}**

2. **Hygiene**

- The aim is for the patient to be clean and comfortable and who has no effects because of lack of hygiene facilities.

- Eyes and mouth care should be carried out according to policy.
- The patients care should be planned to meet their individual needs and privacy and dignity must be maintained.
- The nursing staff will ensure pressure areas are checked regularly and use assistive devices as necessary. **. {23}**

3. Preventing Pressure Sores.

- The aim is for the patient to be comfortable with healthy intact skin.
- Every patient admitted to PACU will have their pressure sore risk assessed and a plan of action formulated on admission.
- Water low score on every patient will be documented on PACU care plan.
- The patient's skin condition will be observed for signs of redness or broken areas. These will be recorded and actively managed where necessary. This may require consultation with or assistance from an anaesthetist or surgeon. **. {27}**

Material and methodology

Methodology

Study design:

Descriptive, cross-sectional workplace-based study, to assess proper preoperative preparation and proper post operative care of surgical patient

Study area:

The study area is Elmek Nimir university hospital at Shendi city , river Nile state , Sudan , which is located north of Khartoum about 176 Kg most of them are farmers .

Study time:

This study was conducted during the period which extends from January 2010 to march 2010

Study population:

.All patients whom arranged for surgical operations

Sampling:

Include all the patients whom arranged for surgical operations in the surgical department in Elmek Nimir Hospital **.**

Sample size:

include 50 patients.

Materials

Data collection tools:

Data collection by check list checked by observation of the nurses and the patient file also use closed ended question to fulfill the purpose of the study.

Data collection technique:

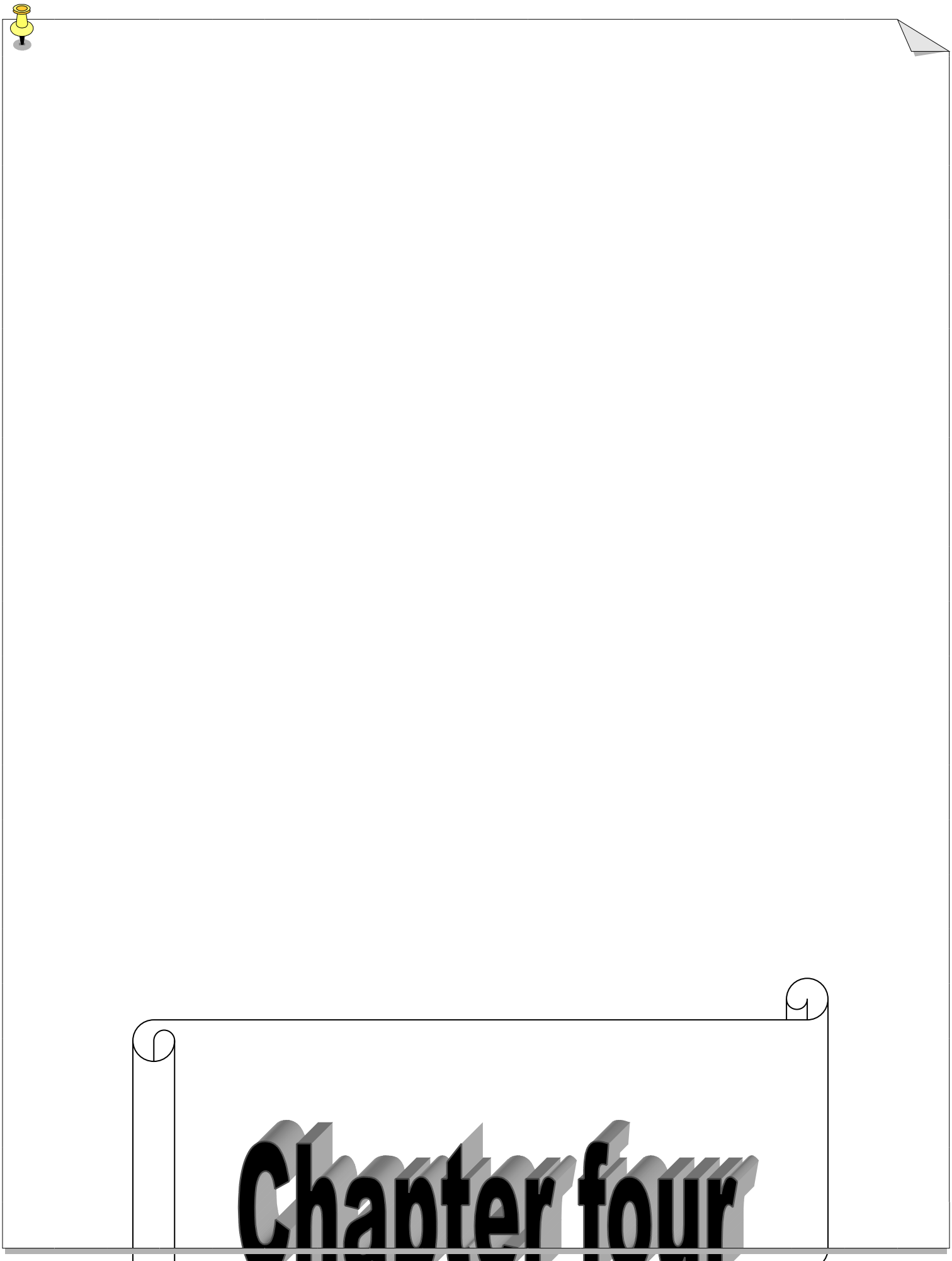
By check list and questionnaire about pre operative preparation and post operative care of surgical patient.

Data analysis:

After collecting data will be analyzed by using Computer through SPSS program to should the result as percentage, pie, and chart.

Ethical consideration:-

Agree consent from Elmek Nimir Hospital Administers.


Chapter four

Results

*Result***S**

Preparation	Yes	No

	Frequent	percentage	Frequent	percentage
Explanation of the procedure	50	100%	0	0%
Perform consent	50	100%	0	0%
Preparation of file	50	100%	0	0%

Table (1) show the percentage of pre-operative preparation, including explanation of the procedure to the patient, written consent and preparation of patient file.

Preparation	Yes		No	
	frequent	percentage	Frequent	percentage
Weight	4	8%	46	92%
Height	0	0%	50	100%
Blood pressure	50	100%	0	0%
Pulse rate	50	100%	0	0%
Respiratory rate	20	40%	30	60%
Temperature	50	100%	0	0%

Table (2) shows the percentage of checkup done for physical fitness of the patient.

Preparation	Yes		No	
	frequent	percentage	Frequent	percentage
ECG	50	100%	0	0%
C X Ray	43	86%	7	14%
Blood urea	40	80%	10	20%
Serum cearatinine	30	60%	20	40%
HB%	50	100%	0	0%
Serum Na^+	35	70%	15	30%
Serum k^+	34	68%	16	32%

Table (3) the percentage of the pre-operative investigations done for the fitness of the patient.

Preparation	Yes		No	
	frequent	percentage	frequent	percentage
Shaving of the site of operation	48	96%	2	4%
Immediate pre-operative shower	40	80%	10	20%
Fasting	50	100%	0	0%
Changing in to theater gown	50	100%	0	0%

Tables (4) show the percentage of skin preparation and pre-operative fasting of the patient.

Teaching	Yes		No	
	frequent	percentage	frequent	Percentage
Deep breathing and coughing	0	0%	50	100%
Chest physiotherapy	0	0%	50	100%
Mobility and rang of motion	0	0%	50	100%
Coping strategies	0	0%	50	100%

Table (5) shows the percentage of pre-operative teaching of the patient.

Medication	Yes		No	
	frequent	percentage	frequent	Percentage
heparin	5	10%	45	90%
Antibiotics	50	100%	0	0%
sedation	0	0%	50	100%

Table (6) show the percentage of pre-operative medication administer to the patient.

Care	Yes		No	
	frequent	percentage	frequent	Percentage
Preparation of the bed by the nurse	50	100%	0	0%
Reception of patient by the nurse	50	100%	0	0%
Transfer the patient to the bed	50	100%	0	0%
Positioning of the patient	50	100%	0	0%
Check the patency of air way	50	100%	0	0%
Check the level of consciousness	0	0%	50	100%
Check the blood pressure	15	30%	35	70%
Check the pulse rate	16	32%	34	68%
Check the respiratory rate	15	30%	35	70%

Check the body temperature	15	30%	35	70%
Check the oxygen saturation	0	0%	50	100%
Check the hand warm	0	0%	50	100%
Check the drains and drainage	50	100%	0	0%
Check the canulas and lines	50	100%	0	0%
Check the devises	50	100%	0	0%
Check the operation site	50	100%	0	0%
Check the post-operative note	50	100%	0	0%
Urine out put	6	12%	44	88%

Table (7) shows the percentage of the immediate post-operative checkup.

Continuous follow up	Yes		No	
	frequent	percentage	frequent	Percentage
Medications	50	100%	0	0%
Nutrition	50	100%	0	0%
Mobilization	50	100%	0	0%
Sheeting of the bed	50	100%	0	0%
Turning and lifting	0	0%	50	100%
Back care	0	0%	50	100%

Observe of the bladder and bowl elimination	50	100%	0	0%
Strict aseptic techniques during catheterization	50	100%	0	0%

Table (8) show the percentage of continuous follow up of the patient

Measure	Yes		No	
	Frequent	percentage	frequent	percentage
Reassurance	0	0%	50	100%
Learning and advice	0	0%	50	100%
Exposure to patient with same condition	0	0%	50	100%
Written instruction to t he patient	50	100%	0	0%

Table (9) shows the percentage of rehabilitation measures.


Chapter five

Discussion

Discussion

This study was conducted to assess the pre and post operative care given to the patients in the surgical word. The period extends from January 2010 to March 2010. A check list and questionnaire include closed ended question to fulfill the purpose of the study is used.

In this study, in 100% of the patients the surgical procedures was explained to the patients, written consent was obtained from the patient and a file containing medical history and physical examination was prepared. The nurses measured the blood pressure, pulse rate and temperature as preoperative preparation. This results is supported by similar finding in similar study which stress that before any surgical treatment is initiated, a health history is obtained, a physical examination is performed during which vital signs are noted, and a database is established for future comparisons.**{2}**

In this study the nurses check the wieght of the patients and the respiratory rate in 8% and 40% respectively. They didn't check for the hieght of the patients. That is not supported by any study. In one study the maesurement of the wieght and hieght give informations abuot the nutritional status and provides information obout obesity, under nutrition, weight loss and malnutrition. Also they give informations about deficiencies in specific nutrients and metabolic abnormalities.**{9}**

Also the study show that pre-operative investigations were ECG and HB% are done for all patients , CX Ray was done for 86%, serum cearatinine was done for 60%, blood urea was done for 80% a, serum Na^+ was done for 70%and Serum k^+ was done for 68% which supported by {Blood tests, x-rays, and other diagnostic tests are prescribed when specifically indicated by information obtained from a thorough history and physical examination} **.{28}**

Also the study shows that in 96% of patient the skin preparation was done by shaving the site of the operation. Generally, hair is not removed preoperatively unless the hair at or around the incision site is likely to interfere with the operation. If hair must be removed, electric clippers or chemical product are used for safe hair removal immediately before the operation. **{3}**

About 80% of the patient had shower preoperatively. All patients were informed to fast overnight and changing in to theater gown in the morning. One study state that the preoprative fasting prevent aspiration of stomach content during operation. **{12}**

The study show that the preoperative teaching and physiotherapy was not done for any patient. One study state that the preoerative teaching is very important. So each patient is taught as an individual, with consideration for any unique concerns or needs; the program of instruction should be based on the individual's learning needs} **{16}**

Regarding to preoperative medications the nurses prepared pre operative antibiotics for all patients and administer heparin for 10% of the patients and no patient received sedation.

The study show that all patients transferred from theater by the nurses and the nurse maintained good position and check the drains and canulas and any other devices and the nurse checked the post-operative note and administers the medications. In only 30% of patients the nurses check the vital signs. Check of oxygen saturation was not done for any patient. The measurement of urine output was done for only 6% of patients. This is result is not supported by any study. One study stress that monotoring of respirotory function is very impotant. So besides checking the physician's orders and administering supplemental oxygen, the nurse should assess the respiratory rate, depth and ease of respirations. Also the nurses should monitor the oxygen saturation of the patien**. {8}**

Also the study show that the post-operative medication were given for all patients. The nurse use all measures for preventing the bed sores . they well arranged clean sheet on beds. They use antiseptics and talc powder to care for the back of the patients. They encarraged the mobility of the patients. Those patients with difficut mobility the nurse lift them and turn them in bed.

Regarding to rehabilitation measure all patients not received rehabilitation measure or any Learning or advice. This is not supported by

any study. One study state that the patients have always required detailed discharge instructions to become proficient in special self-care needs after surgery; however, dramatically reduced hospital lengths of stay during the past decade have greatly increased the amount of information that should be provided while reducing the amount of time in which to provide it) . **{28}**

Chapter six

Conclusion

Recommendation

Conclusion

- The study shows that all the patients recived good preoperative preparation and post operative care .
- The skin preparation was done by traditional shaving methods not by chemical removal.
- Most of patients the weight and height were not checked for them.
- Most of patients the pre operative respiratory rate and pre operative teaching were not done.
- Most of patients the immediate post operative vital signs, and oxygen saturation and urine out put were not checked .
- Most of patients were not received any rehabilitations measure.

Recommendation

Based on the study finding and conclusion, the following recommendations are required to be implemented:

- Application of educational posters in nurse's office consists of new trend in preparation and care of surgical patient.
- Important simple device like pulse oximetry should be available in the post oprative ward.
- Well designed charts should be availabe for monitoring and record of vital signs for each patient.
- Physiotherapist should be available in the surgical ward.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University Of Shendi

Post Graduate Medical Board

NURSING SCIENCE COLLEGE

M.Sc. MEDICAL SURGICAL NURSING

Patch NO (1)

Check list about Assessment of proper preoperative preparation and post operative care of patients in surgical word

1. Serial No. ☐

2. Perform consent form :

1. Yes ☐

2. NO. ☐

3. Preparation of file :

1. Demographic data ☐ ☐

2. History of present illness ☐ ☐

3. Past medical history ☐ ☐

4. Family history. ☐ ☐

5. Drug history ☐ ☐

4. physical examination :

1. weight ☐ ☐
2. Height. ☐ ☐
3. Blood pressure. ☐ ☐
4. Pulse rate. ☐ ☐
5. Respiratory rate ☐ ☐
6. Temperature. ☐ ☐

5. Assessment of cardiovascular system :

1. ECG ☐ ☐
2. Blood pressure. ☐ ☐
3. Pulse rate. ☐ ☐

6. Assessment of respiratory system :

1. Chest X ray. ☐ ☐
2. Respiratory rate ☐ ☐
3. lung sound ☐ ☐

7. assessment of kidney :

1. Urine out put. ☐ ☐
2. Blood urea. ☐ ☐
3. serum cearatinine ☐ ☐

8. Assessment of nutritional status :

1. HB%. ☐ ☐

2. Serum Na^+. ☐ ☐

3. Serum K^+ ☐ ☐

9. Preoperative medication :

1. Heparin. ☐ ☐

2. Antibiotics ☐ ☐

3. Sedation ☐ ☐

10. Changing in to theater gown and hat :

1. Yes ☐

2. No ☐

11. Check the patient name in theater sheet :

1. Yes ☐

2. No ☐

12. Companied to the theater by member of word staff :

1. Yes ☐

2. No ☐

Post operative care

 ☐ ☐

13. Check the post operative note.

14. Transfer from the bed ☐ ☐

15. Good positioning ☐ ☐

16. Check the for recovery from anesthesia by using Glasco Coma Scale

1. Yes ☐
2. No ☐

17. Check respiratory status

1. Air way is patent. ☐ ☐

2. Rate and sound ☐ ☐

3. oxygen therapy ☐ ☐

18. Check cardiovascular status

1. Blood pressure. ☐ ☐

2. Pulse rate. ☐ ☐

3. Hand warm or cool ☐ ☐

4. urine out put ☐ ☐

19. Wound ,drains, canulas, lines and devices

1. Check all drains and drainage. ☐ ☐

2. check the wound for bleeding ☐ ☐

3. Check canulas and lines. ☐ ☐

4. Check devices e.g. NGT, tracheotomy ☐ ☐

20. Check of the general status.

1. Patient responsiveness-sedation score ☐ ☐
2. Pain score ☐ ☐
3. Nausea score. ☐ ☐

21. Prevent of pressure Sores

1. Sheeting of the bed. ☐ ☐
2. Turning and lifting ☐ ☐
3. Back care ☐ ☐
4. Mobilization after fully recover ☐ ☐

22. Patient hygiene

1. Eyes and mouth care. ☐ ☐
2. The patients care should be planned to meet their individual needs and privacy and dignity must be maintained. ☐ ☐

University Of Shendi

Post Graduate Medical Board

NURSING SCIENCE COLLEGE

M.Sc. MEDICAL SURGICAL NURSING

Patch NO (1)

questionnaire about Assessment of preoperative preparation and post operative care of patients in surgical word

1. Serial No. ☐
2. did the nurse or the doctor explain the procedure to you and your family :
    1. Yes ☐
    2. NO. ☐
3. How the nurse prepared the site of operation for you?

1. Shaving. ☐ ☐

2. Chemical removal of hair ☐ ☐

3. none ☐ ☐

☐

4. Did you receive teaching about?

1. Deep-Breathing, Coughing, and Incentive Spirometer ☐ ☐
2. Chest physiotherapy ☐ ☐
3. Mobility and Active Body Movement ☐ ☐
4. Pain Management ☐ ☐
5. Cognitive Coping Strategies ☐ ☐

5. Did you have shower preoperatively?

1. Yes ☐
2. No ☐

6. Did you have any instruction to fasting overnight?

1. Yes ☐
2. No ☐

7. Did you receive teaching on discharge ?

1. Written instructions about wound care, activity and dietary recommendations, medication, and follow-up visits to the same-day surgery unit or the surgeon are provided. ☐ ☐

2. The patient's caregiver at home is provided with verbal and written instructions about what to observe the patient for and about the actions to take if complications occur. ☐ ☐