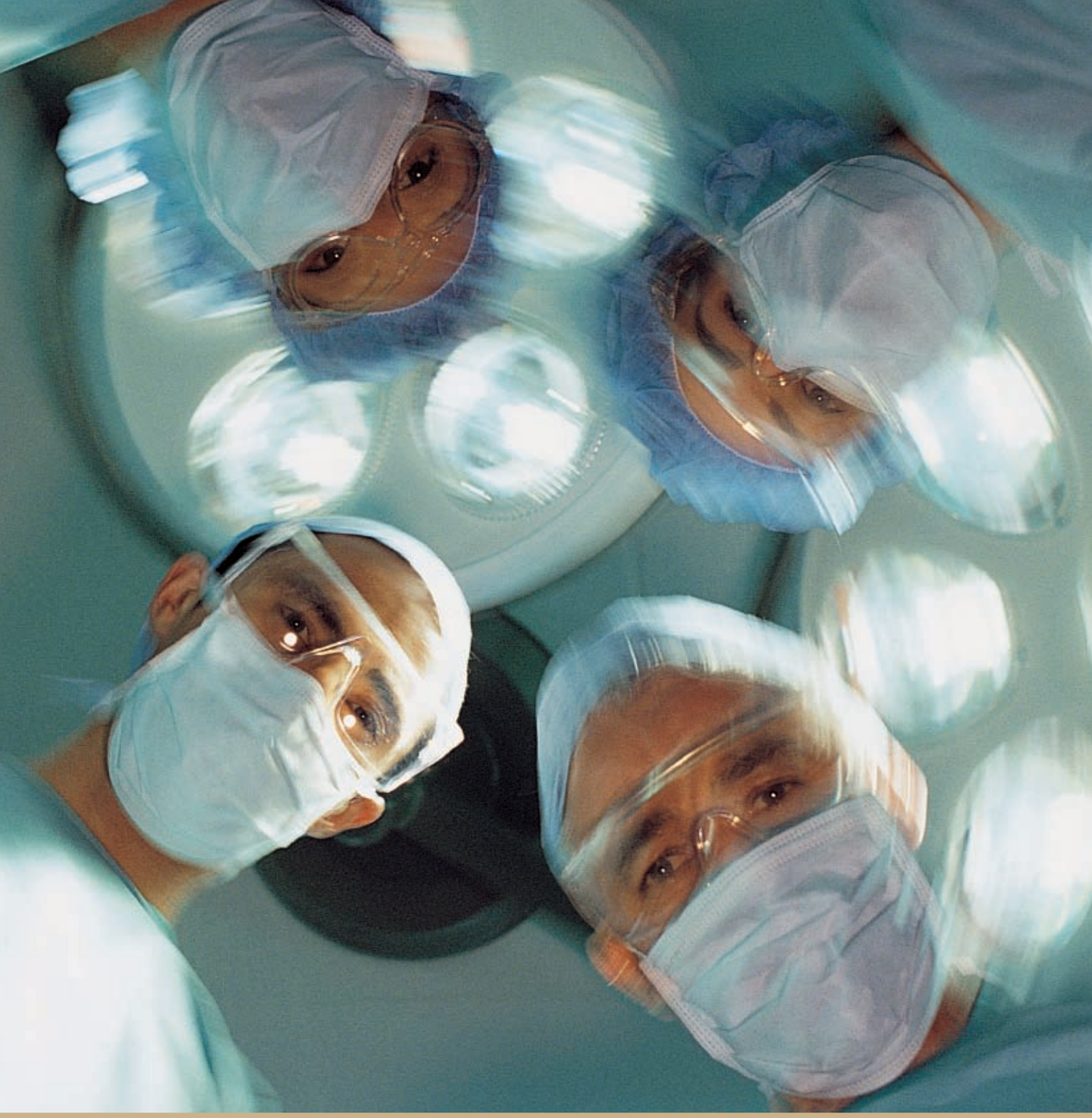

GUIDELINE FOR DEVELOPING STANDARDS

Patient Safety – our primary goal

IFPN

International Federation of Perioperative Nurses

International Federation of Perioperative Nurses

Introduction

Surgery has many risks for patients and the team. Some patients, the very young and the elderly are more vulnerable and should have special care to protect them. All members of the surgical and anaesthetic team are specially trained to reduce risks for the patient and themselves.

We believe that by using Universal Precautions the care team can reduce risks and avoid discrimination between patients. Blood borne viruses are a specific risk, which the team will protect themselves from by using appropriate personal protective equipment. (1)

Staff knowledge, dress and behaviour

The team will be dressed in accordance with infection prevention practice for example: freshly laundered clothes, clean special shoes and hair covering. The team will respect the patient and environment using specialised knowledge and behaviour to prevent incidents to the patients.

Environment

Preparation of the operating room

Staff must check that the Operating Room (OR) is clean, all necessary equipment is available and ready to use. The ventilation is effective.

Ventilation

It is recommended that mechanical ventilation is in place, to control temperature and humidity, reducing potential infection from dust and airborne contaminants. (2)

Clean environment

The floor, OR furniture and all horizontal surfaces are free of dust and organic debris and are dry. This is undertaken by continuous action, before, during and after each patient procedure.

Equipment

All equipment to be used for patient care is regularly maintained according to manufacturer's instructions. It is checked before use and records kept. The staff have been trained especially to ensure it is fit for purpose and safe for use.

For each patient procedure:

- Necessary equipment is available, clean or sterile and ready to use.
- Drugs are available, stored securely, checked, labelled and documented throughout the procedure.
- Sponges and sharps are accounted for pre, intra and post operatively. Ideally instruments are included in the count and it is documented.

Safe disposal of waste includes separation of contaminated material, fluid and sharps. Special waste disposal guidance should be followed.

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Perioperative Care

- Single use devices are designed for one patient use. Potential harm may be done to the patient by re-using the device.
- Documentation of care provides a record as evidence of practice, staff involved in the procedure, equipment used and precautions taken. Ideally all patients have a peri-operative record of care.
- Reusable devices are cleaned properly to reduce pathogen potential between uses and are disinfected or sterilised according to the manufacturer's instructions. Ideally each device achieves sterility or the highest level of disinfection possible.
- Transfer of the patient to and from OR shall be suitable to the patient's level of mobility and state of consciousness. Staff are aware of safe handling techniques and use them.

Patient's Journey

Ideally, surgical patients have a visit to the hospital for pre-assessment. During this visit they will:

- Be able to ask questions.
- Be physically and mentally assessed as fit for surgery, including pre-existing medical conditions.
- Have pre-operative investigations.
- Be consented for the procedure.
- Have contacted with surgical and anaesthetic team members.
- Understand their pain management and discharge arrangements.
- Understand the anaesthetic plan.

If this visit is not possible then this will be undertaken immediately prior to surgery.. [3]

On arrival in OR

The patient is greeted by name.
Operating room nurses introduce themselves.
Safety checks are undertaken with ward and Operating Room nurse together.
Patient dignity is maintained by allowing full communication with aids for sight, hearing, speech and language accompanying the patient to the OR.

The surgical ward nurse and the Operating Room nurse will ensure, for each patient that:

- Patient identity has been checked.
- Informed consent has been given and documented as agreed locally.
- Complete patients record and X-rays are present.
- Special preparation for surgery has been completed; for example bowel preparation, eye lens measurement.
- Ideally the surgical side is clearly marked.
- A record of allergies is present.
- An assessment of skin condition has been made.
- Pre-operative medication has been given and is documented.
- There is a record of the presence (if applicable) of pacemaker or other implants.
- Clippers or depilatory cream have been used to remove excess hair from the operative site (if necessary). [4]
- There is a record of the last time the patient ate and drank.

References

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In the OR

Patient dignity and comfort is maintained as far as possible throughout the patient's stay in the operating room and recovery.

Patient positioning is undertaken by specially trained staff to prevent injury and allow anaesthetic and surgical access.

Patient's temperature is assessed, continually monitored and warming devices used as necessary.

Special protective measures are taken when X-ray or laser are used.

Electro-surgery requires trained and knowledgeable staff to manage it properly and safely.

Vital signs are assessed, continually maintained and documented throughout the procedure. Action indicated is undertaken.

The sterile field is prepared and maintained by specially trained staff throughout the procedure. Any break in the sterile field requires acknowledgement and action taken.

The surgical team scrub, gown and glove using aseptic method.

Prior to the surgical incision, the patient's skin is cleaned using an appropriate solution, avoiding pooling, allowing the skin to dry before isolation of the wound using drapes. Surgical team drape the patient respecting aseptic technique.

The team will respect the patient's vulnerability during surgery and will ensure that protective measures are taken as necessary.

In the absence of a perioperative nursing record, all care delivered will be documented, for example the patient's position, pressure and warming devices, tourniquet times and electro-surgery plate position, implants, drains and wound dressing.

Specimens will be handled in accordance with the pathologists instructions, labelled and documented.

Postoperative

A comprehensive handover of the patient's condition, status and surgery is given by the anaesthetist/anaesthetic nurse to the recovery nurse.

The patient is assessed, monitored and appropriate action taken regarding:

- Vital signs
- Postoperative nausea and vomiting.
- Pain (is managed with the patient).
- Warmth, comfort and regaining control.
- Surgical site (monitored for any internal or external bleeding).
- Fluid balance (inputs and outputs).

Care is documented.

Blood transfusions are carefully checked by trained staff and patients monitored for adverse reaction.

With the agreement of the anaesthetist, when the patient meets the discharge criteria, a full handover is given to the ward nurse.