11. Preparation for Theatre

Preparation for a routine cold operation will start in the outpatient clinic with the discussion between surgeon and patient about the indications, contraindications and alternatives to surgery. A consent form will need to be completed and signed as an adjunct to this process. If the surgery is to be carried out under local anaesthetic it will usually be carried out in the outpatient department, and if under general anaesthetic as a day stay, but a minority of patients will be admitted to the ward.

At this stage the patient will usually be given a date for surgery out of the diary and be seen by a registered nurse who will carry out the process often called 'pre-clerking' or 'care planning', which is designed to ensure that the patient is fully prepared, that the appropriate investigations are carried out and that they know what to expect and where to come and when. If day surgery is planned the nurse will check that their physical health and social circumstances concord with the accepted criteria for day surgery.

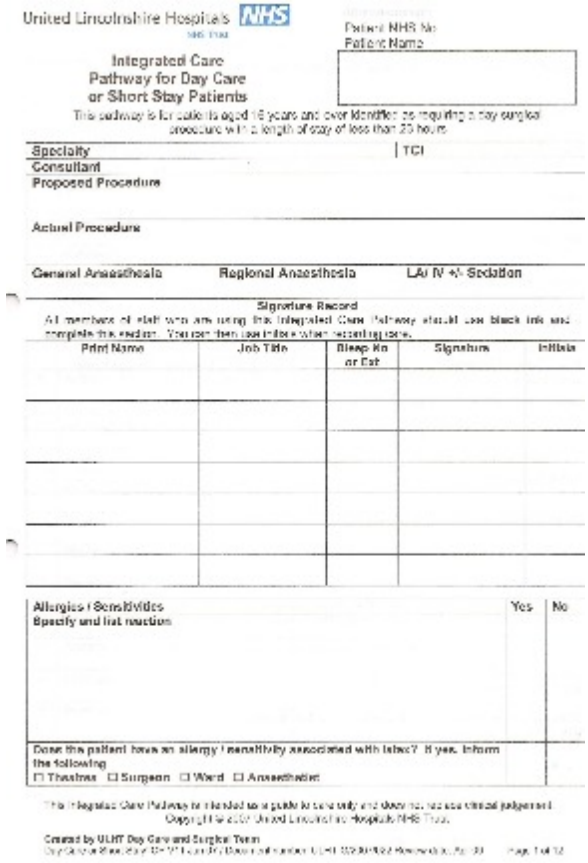
This will involve going through, with the patients, a fairly complicated care plan document, which includes a detailed assessment of their current and previous medical and social history, a systems review of symptoms they may have which might indicate any underlying cardiac or respiratory disease, and a social history which might have a bearing on their discharge from hospital and post-operative care after they no longer need nursing care on the ward. The assessment will usually include routine observations such as blood pressure, pulse, height, weight and body mass index. Current medication will be listed. The patient will be given instructions about not eating for six hours prior to surgery and not drinking for four.

Investigations will be ordered by the nurse under a protocol which will almost certainly follow the guidelines of the National Institute for Health & Care Excellence (NICE). This should ensure that no one should present on the day of surgery without the essential investigations having been done and checked, and resources should not have been wasted on requesting unnecessary tests.

It is usual practice that patients are admitted to hospital on the day of their surgery rather than the day before. On the morning of surgery there will be further checks to be made by the admitting nurse. It will need

Investigation	***Indication***
ECG	Pre-existing cardiac or respiratory disease Smoker over 40 Anyone over 60
Chest X Ray	Is almost never needed but may be requested if there is existing cardiac or respiratory disease
Full blood count	Over 60 Anyone for major surgery with significant blood loss More minor surgery with some blood loss with history of cardiac disease
Urea & electrolytes	Renal disease Diabetics Taking diuretics
Serum glucose	Diabetics On steroids Severe sepsis
Coagulation screen	Anti coagulants (INR) Liver disease Family or past history of problem bleeding
Sickle/ Hb. electrophoresis	Ethnic groups at risk if not previously tested or no history of previous anaesthetic if counselled and consented. North African, West African, South/sub Saharan African, Afro Caribbean, Eastern Mediterranean, Middle Eastern, Asian.

Pre-operative investigations in OMFS



United Lincolnshire Hospitals NHS

Patient NHS No
Patient Name

Integrated Care
Pathway for Day Care
or Short Stay Patients

This pathway is for patients aged 16 years and over identified as requiring a day surgical procedure with a length of stay of less than 23 hours

Specialty | TCI
Consultant
Proposed Procedure

Actual Procedure

General Anaesthesia | Regional Anaesthesia | LA/ IV +/- Sedation

Signature Record

All members of staff who are using this Integrated Care Pathway should use black ink and complete this section. You can then use initials when recording care.

Print Name	Job Title	Bleep No or Ext	Signature	Initials

Allergies / Sensitivities Specify and list reaction	Yes	No
Does the patient have an allergy / sensitivity associated with latex? If yes, inform the following ☐ Theatres ☐ Surgeon ☐ Ward ☐ Anaesthetist		

This Integrated Care Pathway is intended as a guide to care only and does not replace clinical judgement

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Created by ULHT Day Care and Surgical Team

The 12 page care plan booklet which is completed by a nurse in the presence of the patient as part of the pre admission for surgery process. Bureaucracy rules!

to be confirmed when they last ate or drank; they will need to be fitted with an identity band, and the consent form will be returned and signed. The patient will be dressed in a theatre gown, decorative finger rings will be taped, and dentures or spectacles removed and kept in a safe place, usually the bed side locker. Patients will be seen by the anaesthetist for a pre-operative assessment and by someone from the surgical team who will need to find out if there are any further questions or explanations which should be attended to and this will be confirmed on the consent form. If the operation is outside the mouth the operation site should be marked with a skin marking pen and the admission document signed to confirm that this has been done. You should ensure that you visit the ward or day unit with the surgeon in charge and familiarise yourself with their case history and examine them if you have not already had the opportunity to do so.

Pre-operative investigations are not all done as a routine; there is no point in carrying out a special test at some inconvenience and expense if it has a small chance of providing an abnormal result which may not change the management of the patient. There is also the potential problem that false positive results may postpone surgery and lead to more unnecessary tests and lead to inappropriate treatment.

Once the theatre is ready, with both surgeon and anaesthetist present, the senior nurse in change of the list will inform the theatre receptionist who will send a porter to the ward to fetch the patient. The patient will return with their named nurse and will be booked into the theatre by the receptionist. A nurse from the appropriate theatre will then come and receive the patient from the named nurse. She will ask the patient to confirm verbally their name and what procedure they are having carried out. She will also check the patient's name and hospital number on a band, which has been placed round their wrist as soon as they enter the ward. This is to ensure that the patient ends up in the correct theatre for the correct operation.

Once in the anaesthetic room the surgeon may wish to confirm the patient's identity and pass the time of day with them. The anaesthetist will again check the patient's wrist band and then start the anaesthetic assisted by the operating department practitioner. Once the anaesthetic has been administered the patient will be transferred to the operating theatre and the operation commences. You should scrub and participate in the surgery in whatever manner you are instructed to by the senior surgeon present.