PREOPERATIVE CARE

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Preoperative Care

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Purpose

Patients who are physically and psychologically prepared for surgery tend to have better surgical outcomes. Preoperative teaching meets the patient's need for information regarding the surgical experience, which in turn may alleviate most of his or her fears. Patients who are more knowledgeable about what to expect after surgery, and who have an opportunity to express their goals and opinions, often cope better with postoperative pain and decreased mobility. Preoperative care is extremely important prior to any invasive procedure, regardless of whether the procedure is minimally invasive or a form of major surgery.

Preoperative teaching must be individualized for each patient. Some people want as much information as possible, while others prefer only minimal information because too much knowledge may increase their anxiety. Patients have different abilities to comprehend medical procedures; some prefer printed information, while others learn more from oral presentations. It is important for the patient to ask questions during preoperative teaching sessions.

Objectives

Describe a comprehensive preoperative assessment to identify surgical risk factors.
Identify the causes of preoperative anxiety and describe nursing measures to alleviate it.
Identify legal and ethical considerations related to informed consent.
Describe preoperative nursing measures that decrease the risk for infection and other postoperative complications.
Describe the immediate preoperative preparation of the patient.
Develop a preoperative teaching plan designed to promote the patient's recovery from anesthesia and surgery, thus preventing postoperative complications.

Materials (if applicable)

- Gloves
- Stethoscope
- Informed consent form
- Preoperative checklist
- IV solutions and equipment (if ordered)
- Indwelling catheter set (if ordered)
- Antiembolism stockings and intermittent pneumatic compression device (if ordered)
- Medications (if ordered)

Information

ALERT

If the patient is having emergency surgery, focus on assessing the primary body system affected.

Report vital signs that are abnormal, not at the patient's baseline, or outside of the prescribed parameters. These findings may require surgery to be postponed. Document abnormal vital signs and actions taken in the patient's record.

Ensure that the patient or the patient's legal guardian signs a surgical informed consent before the patient receives preoperative medications.

OVERVIEW

Preparing a patient for surgery involves decreasing anxiety, ensuring patient safety, and decreasing the risk of complications. Anxiety interferes with the effectiveness of anesthesia and the ability of patients to participate in their care. Information about what will occur and which sensations to expect should be provided (Figure 1).

The law requires informed consent to help protect patients' rights, autonomy, and privacy. The surgeon should give the patient information about the extent and type of surgery, alternative therapies, usual risks and benefits, and the consequences of not having surgery as outlined in *The Patient Care Partnership* developed by the American Hospital Association (Table 1). The patient or the patient's legal guardian must sign a surgical consent form that includes this information. Informed consent must also be signed by a witness to verify that the person who signed the form is the patient or the patient's legal guardian.

TABLE 1 Information Needed for Informed Consent

Parameters	Examples
Name of procedure/surgery	Abdominal hysterectomy under general anesthesia.
Description of procedure/surgery	Removal of uterus only through an incision in the abdominal wall at the top of the pubic hairline, done while unconscious.
Person performing the procedure/surgery	Dr. Richard Jones assisted by Dr. William Smith.
Benefits of procedure/surgery	To remove uterus with fibroids and stop excessive bleeding. Abdominal route is necessary due to anticipated adhesions from prior abdominal surgery.
Potential risks and adverse effects of procedure/surgery	Risks of hemorrhage and infection from surgery, risks of excessive sedation and allergic reaction to drugs used with general anesthesia, accidental damage to bladder, intestines, and/or nerves controlling these organs.
Approximate length of time for procedure/surgery	About 1 hour; 1 to 2 hours in recovery room.
Approximate length of time needed for recovery	3 to 4 days on surgical unit; 4 to 6 weeks before resuming physically stressful work.
Alternative treatments	Removal of uterus vaginally, radiation to shrink fibroids.
Consequences of refusing treatment	Continuation of pain and vaginal bleeding, risk for developing anemia. After menopause, fibroids should regress.

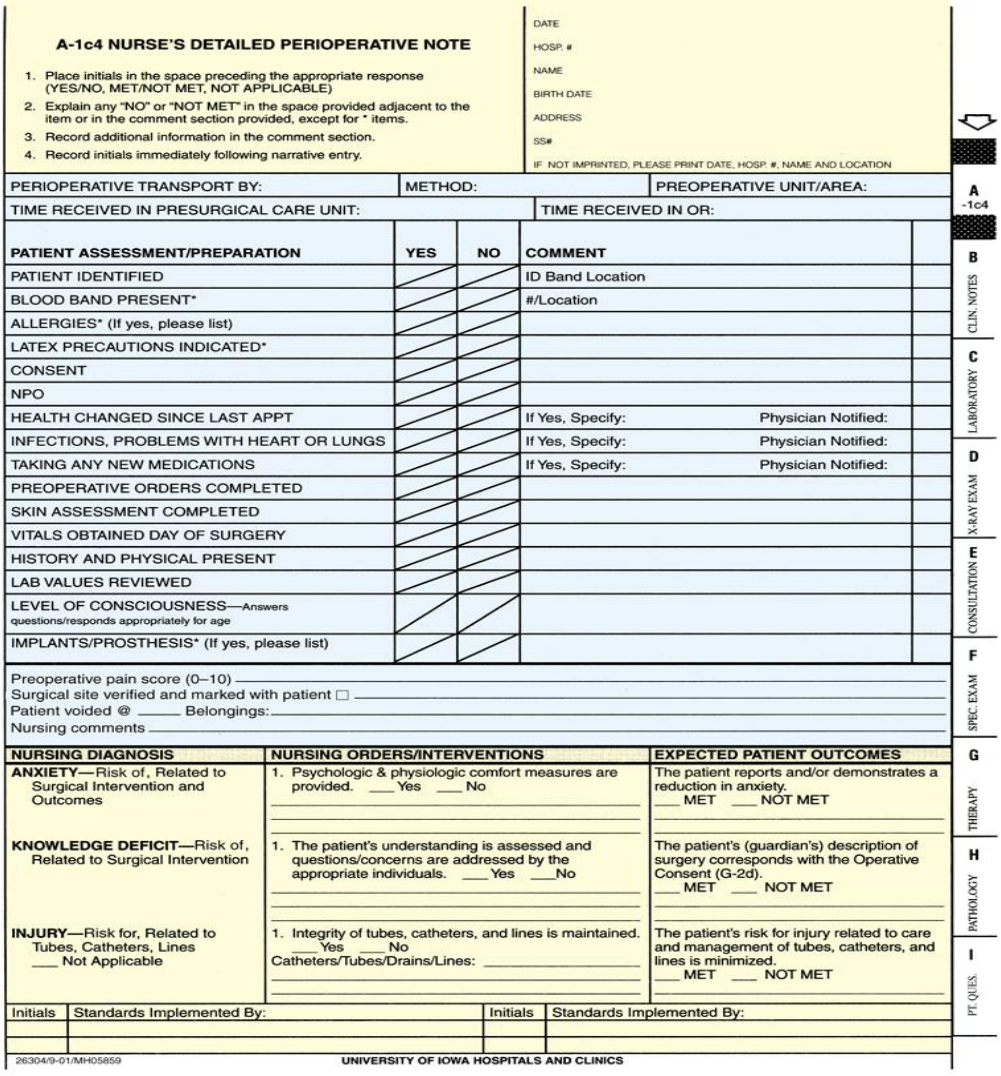
Preoperative medications may alter the level of consciousness and make the informed consent invalid. Acting as the patient's advocate, the nurse has an ethical responsibility to ensure that the patient understands the information and that the form has been signed and witnessed before the patient receives preoperative medication.

Patients who are illiterate can sign with a mark, if properly witnessed. Minors, unless married or declared emancipated, and individuals considered incompetent cannot legally sign an informed consent form. A parent or legal guardian must provide informed consent.

Some patients with do-not-resuscitate (DNR) orders require surgery for palliative care. DNR orders should not routinely be upheld nor routinely suspended during anesthesia and surgery. A patient's practitioners are responsible for discussing issues with the patient or family to determine whether to maintain the DNR order or to suspend it partially or completely during surgery. Practitioners also are responsible for documenting these discussions.

Another aspect of maintaining safety is minimizing the risk of injury from falls. Patient activity is typically restricted after administration of preoperative sedatives. Some surgeries (e.g., orthopedic, bariatric) require the patient to ambulate after surgery to help prevent postoperative complications.

The preoperative checklist (Figure 2) should be completed to ensure that all procedures have been carried out and that all necessary information and documentation for safe delivery of care is in the patient's chart. The preoperative checklist should be reviewed with the circulating nurse before transporting the patient to the operating room (OR).



A-1c4 NURSE'S DETAILED PERIOPERATIVE NOTE

1. Place initials in the space preceding the appropriate response (YES/NO, MET/NOT MET, NOT APPLICABLE)
2. Explain any "NO" or "NOT MET" in the space provided adjacent to the item or in the comment section provided, except for * items.
3. Record additional information in the comment section.
4. Record initials immediately following narrative entry.

DATE
HOSP. #
NAME
BIRTH DATE
ADDRESS
SS#
IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, NAME AND LOCATION

PERIOPERATIVE TRANSPORT BY:	METHOD:	PREOPERATIVE UNIT/AREA:
TIME RECEIVED IN PRESURGICAL CARE UNIT:		TIME RECEIVED IN OR:

PATIENT ASSESSMENT/PREPARATION	YES	NO	COMMENT
PATIENT IDENTIFIED			ID Band Location
BLOOD BAND PRESENT*			#/Location
ALLERGIES* (If yes, please list)			
LATEX PRECAUTIONS INDICATED*			
CONSENT			
NPO			
HEALTH CHANGED SINCE LAST APPT			If Yes, Specify: Physician Notified:
INFECTIONS, PROBLEMS WITH HEART OR LUNGS			If Yes, Specify: Physician Notified:
TAKING ANY NEW MEDICATIONS			If Yes, Specify: Physician Notified:
PREOPERATIVE ORDERS COMPLETED			
SKIN ASSESSMENT COMPLETED			
VITALS OBTAINED DAY OF SURGERY			
HISTORY AND PHYSICAL PRESENT			
LAB VALUES REVIEWED			
LEVEL OF CONSCIOUSNESS—Answers questions/responds appropriately for age			
IMPLANTS/PROSTHESIS* (If yes, please list)			

Preoperative pain score (0–10) _____
Surgical site verified and marked with patient ☐ _____
Patient voided @ _____ Belongings: _____
Nursing comments _____

NURSING DIAGNOSIS	NURSING ORDERS/INTERVENTIONS	EXPECTED PATIENT OUTCOMES
ANXIETY—Risk of, Related to Surgical Intervention and Outcomes	1. Psychologic & physiologic comfort measures are provided. ___Yes ___No	The patient reports and/or demonstrates a reduction in anxiety. ___MET ___NOT MET
KNOWLEDGE DEFICIT—Risk of, Related to Surgical Intervention	1. The patient's understanding is assessed and questions/concerns are addressed by the appropriate individuals. ___Yes ___No	The patient's (guardian's) description of surgery corresponds with the Operative Consent (G-2d). ___MET ___NOT MET
INJURY—Risk for, Related to Tubes, Catheters, Lines ___ Not Applicable	1. Integrity of tubes, catheters, and lines is maintained. ___Yes ___No Catheters/Tubes/Drains/Lines: _____	The patient's risk for injury related to care and management of tubes, catheters, and lines is minimized. ___MET ___NOT MET

Initials	Standards Implemented By:	Initials	Standards Implemented By:

26304/9-01/MH05859 UNIVERSITY OF IOWA HOSPITALS AND CLINICS

A -1c4 | B CLIN. NOTES | C LABORATORY | D X-RAY EXAM | E CONSULTATION | F SPEC. EXAM | G THERAPY | H PATHOLOGY | I PT. QUES.

Food and fluids are routinely withheld preoperatively. Practice guidelines for preoperative fasting in healthy patients undergoing elective procedures allow clear liquids up to 2 hours before surgery, a light breakfast (e.g., tea and toast) 6 hours before surgery, and a heavier meal 8 hours before surgery.[2] Each patient should have written orders that outline fasting requirements. Patient teaching should include food and fluid restrictions, medications permitted the morning of surgery, and the need for surgical site preparation the evening before surgery. Patients who smoke should also be encouraged to stop using tobacco products before surgery. Action the patient should take if these instructions are not followed should also be included.

Because many patients are admitted the day of surgery, much of preoperative preparation is the responsibility of the patient or the primary caregiver. Therefore, a preadmission nurse or nurse in the surgeon's practice must provide adequate verbal and written instructions.

The Joint Commission patient and family education standards are guidelines to ensure that patients, family members, and primary caregivers know about the surgical procedure, healing process, sutures,

dressing, drains, feeding tubes, pain control, and diet. Adults learn best when they understand the purpose or meaning of what is being taught.

The Joint Commission recognizes that wrong site surgery should never occur and developed the *Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery*. This protocol was implemented as an added safety measure to ensure that the correct person, procedure, and surgical site are verified at the time of scheduling the procedure, upon admission or entry into the facility, and each time the responsibility for care of the patient is transferred to another caregiver. If possible, patients should be involved in this process when they are awake and aware. If the case involves laterality (right versus left), multiple structures (e.g., fingers, toes, lesions), or multiple levels (e.g., spine), the final verification should include a site marking by the person performing the procedure. The site markings need to be visible after the patient has been prepared and draped.

PATIENT AND FAMILY EDUCATION

- Provide the patient and family with an explanation of the equipment and the procedure, including expectations for surgery and postoperative care.
- Explain to the patient and family that a licensed driver is required to take the patient home after surgery, if applicable.

ASSESSMENT AND PREPARATION

Assessment

1. Perform hand hygiene before patient contact.
2. Verify the correct patient using two identifiers.
3. Determine the patient's ability to answer questions regarding his or her health history and the pending surgery.
4. Review the patient's history.
    a. Determine whether the patient has an advance directive. If so, place it in the patient's record.
    b. Determine whether the patient as any allergies. Apply an allergy or sensitivity band and other safety bands, if applicable.
    c. Determine whether the patient has any cultural practices or religious beliefs that require modification of the patient's care plan.
5. Review the patient's currently laboratory profile. Notify the practitioner of any abnormal values.
6. Perform a physical assessment.

Preparation

1. Ensure that the patient and family understand preprocedure teaching. Answer questions as they arise, and reinforce information as needed.
2. Review the patient's preoperative orders.
    a. Obtain a chest x-ray and other x-rays if ordered.
    b. Obtain a 12-lead electrocardiogram if ordered.
3. For a same-day admission or an outpatient surgery, validate that preoperative preparations were completed as ordered. Specific preparations may include nothing-by-mouth (NPO) status, medication administration, skin preparation, and bowel preparation.

PROCEDURE

1. Perform hand hygiene.
2. Verify the correct patient using two identifiers.
3. Check the patient's record, and review or complete the preoperative checklist (Figure 2). Ensure that the informed consent form has been signed and witnessed.

Rationale: These reviews ensure that pertinent laboratory and diagnostic test results are available and preoperative preparations are completed.

4. Provide preoperative teaching, including an explanation of postoperative exercises, skin preparation, pain-control measures, and postoperative care.
5. Determine whether preoperative orders for bowel cleansing, bladder regimens, and skin preparations are needed.
6. Instruct the patient to remove all clothing, including undergarments, and to don a disposable head cover and hospital gown with the opening in the back.

Rationale: The head cover prevents the patient's hair from contaminating sterile surfaces. The gown opening provides easy access to the patient's body in the OR.

7. Instruct the patient to remove hairpins; clips; wigs; hairpieces; jewelry, including rings used in body piercing; and makeup, including nail polish and acrylic nails.

Rationale: Hair appliances and jewelry may become dislodged and cause injury during positioning and intubation. Rings decrease circulation in the fingers. Makeup, nail polish, and false nails impede the assessment of skin and oxygenation. Acrylic nails harbor pathogenic organisms.

    a. Tape wedding rings that cannot be removed.

When taping a wedding ring to the finger, do not create a tourniquet effect with the tape.

    b. Pin the patient's religious medals to the gown, if the organization's practice permits.

c. If permitted, allow the patient to remove an acrylic nail or nail polish from only one finger for pulse oximeter use.

8. Don gloves. Help the patient remove prostheses, including dentures; oral appliances; glasses; contact lenses; artificial limbs, eyes, and eyelashes; and hearing aids. Hearing aids may be left in place if the patient is required to follow instructions in the OR.

Rationale: Prostheses can be lost or damaged during surgery and may cause injury. Oral appliances may occlude the airway.

9. Assess the patient for any metal devices or implants (e.g., baclofen pump, pacemaker).

Rationale: Metal devices and implants interfere with electrocautery, and surgeons have to prepare for an alternative surgical approach.

10. Instruct the patient to give all personal items (jewelry, wallet, cell phone, and anything else of value) to family members. If family members are not available, secure valuable items per the organization's practice.

Rationale: Valuables left in the room may be lost or stolen.

11. Apply antiembolism stockings, as ordered.

12. If the patient does not have an indwelling catheter, assist him or her with voiding before administering preoperative medication.

Rationale: Voiding prevents incontinence and bladder distention during surgery and urinary retention with overflow postoperatively. Preoperative medication causes drowsiness and decreased voiding sensation.

13. Remove gloves, perform hand hygiene, and don clean gloves.

14. Ensure that the patient has a patent IV or indwelling catheter, if ordered. Consider IV fluid therapy if the patient's surgical procedure is delayed.

15. Draw specimens for laboratory tests, if ordered.

16. In the presence of the patient, label the specimen per the organization's practice.

17. Prepare the specimen for transport.

    a. Place the labeled specimen in a biohazard bag.

    b. If the specimen requires ice for transport, place the specimen in a biohazard bag then place the bag with the specimen into a second biohazard bag filled with ice slurry.

Rationale: Placing the specimen in a separate bag protects the label from being damaged.

18. Immediately transport the specimen to the laboratory.

Rationale: Sending the specimens immediately to the laboratory ensures accurate results.

19. Check the preoperative orders, and administer medications, as ordered.

Rationale: Medications reduce pain, anxiety, respiratory secretions, and the amount of anesthesia required. Antibiotics may be ordered prophylactically.

20. Place the patient on bed rest with a call light within reach, and instruct him or her not to get out of bed without assistance. Allow family members to remain at the bedside until the patient is transferred to the surgical area. Maintain a quiet, relaxing environment.

Rationale: The patient has an increased risk of injury if he or she attempts to ambulate after being sedated.

21. Assess vital signs as ordered and immediately before the patient goes to the OR.

Rationale: Abnormal vital signs indicate conditions that increase the risk of surgery.

22. Discard supplies, remove gloves, and perform hand hygiene.

23. Document the procedure in the patient's record.

MONITORING AND CARE

1. Monitor the patient for signs and symptoms of anxiety, and ask how the patient and family feel.

Rationale: Increased heart rate and blood pressure, dilated pupils, dry mouth, increased sweating, muscle rigidity, and shaking are responses to stress and anxiety. Asking the patient about feelings gives permission to express concerns, which can be further explored.

EXPECTED OUTCOMES

- Patient is able to state the surgical procedure being performed and its risks and benefits.
- Patient participates in preoperative and postoperative care.
- Patient states anxiety is decreased.
- Vital signs are within patient's baseline or expected range.
- Patient remains NPO.

UNEXPECTED OUTCOMES

- Patient is unable to give informed consent, and family member is unavailable.
- Vital signs are above or below patient's baseline or expected range.
- Informed consent has not been signed and witnessed.
- Patient did not remain NPO, which may indicate that he or she did not understand the instructions or forgot them.
- Patient is unable to state instructions or demonstrate postoperative exercises.
- Patient did not void before receiving preoperative medication.

DOCUMENTATION

- All preoperative preparations
- Patient's condition on transfer to the OR
- Presence of allergies or sensitivities
- Disposition of the patient's valuables and belongings
- Abnormal assessment findings
- Lack of signed and witnessed informed consent form
- Failure of patient to maintain NPO status
- Patient's cultural practices or religious beliefs that affect perioperative care and any modification of care plan
- Patient and family education
- Unexpected outcomes and related nursing interventions

PEDIATRIC CONSIDERATIONS

- The family should be involved in preoperative preparation to decrease the child's anxiety. Preadmission programs that prepare the family and child for same-day surgery decrease anxiety. Part of preoperative teaching should include giving the child the opportunity to handle the equipment that he or she sees, such as an anesthesia mask or drainage tube.
- The child's developmental level should be taken into consideration during preoperative preparation. Toys and games may be used to demonstrate preoperative procedures. These techniques reduce postoperative complications associated with anxiety.
- The family should be allowed to accompany the child to the holding area.

GERONTOLOGICAL CONSIDERATIONS

- Physiologic changes that occur with aging may require admission before surgery for additional diagnostic tests and stabilization of the patient's condition (Table 2).

Table 2 Physiologic Factors That Place Older Adult Patients at Risk for Surgery

Alterations	Surgery Risks	Nursing Implications
Cardiovascular		
Degenerative change in myocardium and valves	Reduced cardiac reserve	Assess baseline vital signs.
Rigidity of arterial walls and reduction in sympathetic and parasympathetic innervation to heart	Predisposes patient to postoperative hemorrhage and rise in systolic and diastolic blood pressure	Maintain adequate fluid balance to minimize stress to heart. Ensure that blood pressure is adequate to meet circulatory demands.
Increase in calcium and cholesterol deposits within small arteries; arterial walls thickened	Predisposes patient to clot formation in lower extremities	Instruct patient in techniques for performing leg exercises and proper turning. Apply antiembolism stockings, sequential compression devices
Integumentary		
Decreased subcutaneous tissue and increased fragility of skin	Prone to pressure ulcers and skin tears	Assess skin every 4 hours; pad all bony prominences during surgery. Turn or reposition.
Pulmonary		
Rib cage stiffens and enlarges	Reduced vital capacity	Instruct patient in proper technique for coughing and deep-breathing exercises and use of spirometer.
Reduced diaphragm excursion	Greater residual capacity or volume of air left in lung after normal breath increases, reducing amount of new air brought into lungs with each inspiration	Encourage deep breathing. Use incentive spirometer to enhance exhalation.
Lung tissue less distensible; alveoli enlarged	Reduced blood oxygenation	Assess oxygen saturation via oximetry (SpO_2).
Renal		
Reduced blood flow to kidneys	Blood loss causes decrease in circulation to the kidney	Monitor urinary output and laboratory data (i.e., blood urea nitrogen, creatinine).
Reduced glomerular filtration rate and excretory times	Limits ability to remove drugs or toxic substances	Assess for adverse effects of medications.
Reduced bladder capacity	Voiding frequency increases, and larger amount of urine stays in the bladder after voiding Sensation of need to void may not occur until bladder is filled	Instruct patient to notify nurse immediately when sensation of bladder fullness develops. Keep call light or bedpan within easy reach.
Neurologic		
Sensory losses, including reduced tactile sense, increased pain tolerance	Patient less able to respond to early warning signs of surgical complications	Inspect bony prominences for signs of pressure.
Decreased reaction time	Patient becomes confused easily after anesthesia	Orient patient to surrounding environment. Observe for nonverbal signs of pain. Maintain safe environment. Institute fall precautions.
Metabolic		
Lower basal metabolic rate	Reduced total oxygen consumption and nutritional needs.	Ensure adequate nutritional intake once diet is resumed.
Reduced number of red blood cells and hemoglobin levels	Reduces ability to carry adequate oxygen to tissues.	Administer necessary blood products. Assess for adequacy of oxygenation, fatigue, and infection.
Change in total amounts of body potassium and water volume	Greater risk for fluid or electrolyte imbalance	Monitor electrolyte levels.

- There should be a focus on wellness and the patient's strength.
- Education should occur when the patient is alert and rested. Teaching sessions should be kept short.
- Age-related changes, such as decreased vision, hearing, and short-term memory, may require the presence of family members or the primary caregiver during preoperative preparation.

HOME CARE CONSIDERATIONS

- Before admission for same-day surgery, patients should be instructed about NPO status, skin preparation, and procedures, such as enemas and douches. Patients often use enemas or douches at home.

- Patients having surgery in ambulatory surgery centers must be accompanied by a family member or friend to allow for discharge after the procedure (Box 1).

BOX 1 Postanesthesia and Ambulatory Surgery Discharge Criteria

Postanesthesia Discharge Criteria
- Patient awake (or returns to baseline)
- Vital signs stable
- No excess bleeding or drainage
- No respiratory depression
- SaO_2 greater than 90%
- Pain controlled
- Report given

Ambulatory Surgery Discharge Criteria
- All postanesthesia care unit (PACU) discharge criteria met
- No intravenous (IV) narcotics for last 30 minutes
- Minimal nausea and vomiting
- Pain controlled
- Voided (if appropriate to surgical procedure/orders)
- Able to ambulate if age-appropriate and not contraindicated
- Responsible adult present to accompany patient
- Discharge instructions given and understood

Procedure (if applicable)

COMPETENCY-BASED CHECK OFF

TITLE: PREOPERATIVE CARE

COMPETENCY STATEMENT: The nurse demonstrates competence in preoperative care for patients.
Standard: Access and Continuity of care
Patient assessment
Care of patients
Quality, safety and environment
Patient and Family Education

PERFORMANCE CRITERIA:	**4**	**3**	**2**	**1**
Communication and Interpersonal Skills				
1. Displays effective verbal and non verbal communication: a. Acknowledge the patient (Privacy, Dignity, Culturally sensitive caring, aware on patients' Bill of Rights) b. Introduce her/ himself to the patient c. Verbalize the reason for the procedure intervention d. Explain the duration and outcome of the procedure e. Educates patient and family/ caregiver (where appropriate)				
Psychomotor Skill				
2. Performed hand hygiene before patient contact.				
3. Verified the correct patient using two identifiers.				
4. Determined the patient's ability to answer questions regarding his or her health history and the pending surgery.				
5. Reviewed the patient's history. Determined whether the patient had an advance directive, any allergies, and any cultural practices or religious beliefs that required modification of the patient's care plan.				
6. Reviewed the patient's currently laboratory profile. Notified the practitioner of any abnormal values.				
7. Performed a physical assessment.				
8. Reviewed the patient's preoperative orders. Obtained x-rays and a 12-lead electrocardiogram if ordered.				
9. For a same-day admission or an outpatient surgery, validated that preoperative preparations were completed as ordered.				
10. Checked the patient's record, and reviewed or completed the preoperative checklist. Ensured that the informed consent form had been signed and witnessed.				

11. Provided preoperative teaching, including an explanation of postoperative exercises, skin preparation, pain-control measures, and postoperative care.				
12. Determined whether preoperative orders for bowel cleansing, bladder regimens, and skin preparations were needed.				
13. Instructed the patient to remove all clothing, including undergarments, and to don a disposable head cover and hospital gown with the opening in the back.				
14. Instructed the patient to remove hairpins; clips; wigs; hairpieces; jewelry, including rings used in body piercing; and makeup, including nail polish and acrylic nails.				
15. Donned gloves. Helped the patient remove prostheses. Allowed hearing aids to be left in place if the patient was required to follow instructions in the OR.				
16. Assessed the patient for any metal devices or implants.				
17. Instructed the patient to give all personal items to family members, or secured valuable items per the organization's practice.				
18. Applied antiembolism stockings, as ordered.				
19. If the patient did not have an indwelling catheter, assisted him or her with voiding before administering preoperative medication.				
20. Removed gloves, performed hand hygiene, and donned clean gloves.				
21. Ensured the patient had a patent IV or indwelling catheter, if ordered. Considered IV fluid therapy if the patient's surgical procedure was delayed.				
22. Drew specimens for laboratory tests, if ordered.				
23. In the presence of the patient, labeled the specimen per the organization's practice.				
24. Prepared the specimen for transport. a. Placed the labeled specimen in a biohazard bag. b. If the specimen required ice for transport, placed the specimen in a biohazard bag then placed the bag with the specimen into a second biohazard bag filled with ice slurry.				
25. Immediately transported the specimen to the laboratory.				
26. Checked the preoperative orders and administered medications, as ordered.				
27. Placed the patient on bed rest with a call light within reach, and instructed him or her not to get out of bed without assistance. Allowed family members to remain at the bedside until the patient was transferred to the surgical area. Maintained a quiet, relaxing environment.				
28. Assessed vital signs as ordered and immediately before the patient went to the OR.				
29. Discarded supplies, removed gloves, and performed hand hygiene.				
30. Documented the procedure in the patient's record.				

References

(Levels of Evidence)

American Medical Association (AMA). (2006). Opinion 8.08-Informed consent. Retrieved December 2, 2014, from http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page (Level VII) (classic reference)*

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*In these nursing skills, a “classic” reference is a widely cited, standard work of established excellence that significantly affects nursing practice and may also represent the foundational research for practice.

Adapted from Perry, A.G., Potter, P.A., Ostendorf, W.R. (2014). Clinical nursing skills & techniques (8th ed.). St. Louis: Mosby.