Aurora Health Care* Milwaukee, Wisconsin

PERIOPERATIVE NURSING RECORD Page 1

PREOPERATIVE STATUS

Date: ____________________ Time:__________

☐ Inpatient  ☐ Outpatient  ☐ Blood Band # __________

Allergies:____________________________________________________________________________________

O2 Sat. ______% ☐ Room Air ☐ O2______ L/min ☐ IV: ☐ Capped _______ gauge ☐ in place _______ gauge

PREOP TUBES: ☐ Foley ☐ NG ☐ Other _____________________________________________________________

Level of Consciousness: ☐ Alert ☐ Lethargic ☐ Sedated ☐ Comatose ☐ Other:______________

Skin condition: ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic ☐ Flushing ☐ Pale ☐ Jaundice ☐ Dusky

1. ☐ Potential for anxiety related to:
   ☐ Knowled deficit R/T Surgical Intervention
   ☐ Risk of death, alteration of body image or lifestyle change
   ☐ Impaired verbal communication
   ☐ Surgical experience

Nursing action/intervention:

☐ Clear concise explanations given
☐ Analyze/interpret preop. heath data
☐ Support provided to patient

Expected outcome: ☐ The patient verbalizes and/or demonstrates decreased anxiety.

☐ SHA Protocol  Narrative Notes:

☐ Prophylactic IV Antibiotic: ___________________________ (_______) Preop RN Signature

(Intraoperative Status)

Patient Identified by: ___________________________ (_______) RN Signature

INTRAOPERATIVE STATUS

OR #: Wound Class: Arrival: Operation Start: Operation End: Discharge:

Anesthesia: ASA _______ ☐ General ☐ Regional Block ☐ Epidural ☐ Spinal ☐ MAC ☐ Local ☐ Fully monitored

Surgeon: ___________________________ (_______) Initials
Assistant: ___________________________ (_______) Initials
Assistant: ___________________________ (_______) Initials
Second Surgeon: ___________________________ (_______) Initials
Assistant: ___________________________ (_______) Initials
Assistant: ___________________________ (_______) Initials
Anesthesiologist: ___________________________ (_______) Initials
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Anesthesia Resident: ___________________________ (_______)
Anesthesia Support/M.T.: ___________________________ (_______)
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Relief: ___________________________ (_______)
Balloons Tech: ___________________________ (_______)
Laser RN/Tech: ___________________________ (_______)
Others: ___________________________ (_______)

Circulator RN: ___________________________ (_______)
Circulator/Monitor RN: ___________________________ (_______)
Medication RN: ___________________________ (_______)

OPERATION:

__________________________________________________________________________________________

2ND OPERATION:

__________________________________________________________________________________________

DISCHARGE REPORT: ☐ SDS ☐ PACU ☐ Pt. Room ☐ Critical Care ☐ Other ____________

TRANSPORTED BY: ☐ Cart ☐ Wheelchair ☐ Bed ☐ Mobilizer ☐ Crib ☐ Other: ____________
GUIDELINES FOR USE OF AURORA PERIOPERATIVE RECORD

1. At the time of patient admission to the surgical area (Surgical Holding Area/O.R. Suite), initiate the use of the Metro Perioperative Nursing Record.

2. Complete/verify and fill in the appropriate blanks and boxes. Check (“✓”) in the appropriate box to indicate that the action has been completed. A blank box indicates the action is non-applicable. Circle Right/Left. thigh/knee, etc. as appropriate.

3. An asterisk (*) in the appropriate box and/or section indicates a significant finding which is documented in the nursing narrative notes.

4. Documentation of preoperative confirmation of the operative procedure and site is mandatory. Circle Right/Left when appropriate. Initials are required by the preoperative RN and the O.R. RN.

5. Circle the source of information used to confirm procedure and site. Medical record includes, but not limited to; Informed Consent, History and Physical, Progress Notes, Anesthesia Assessment, Nursing Assessments, etc. Preoperative assessment must occur prior to patient entering surgical suite. Check Inpatient box for all A.M. admissions and hospital inpatients, check Outpatient box for Outpatients/ Day Surgery.

6. Prophylactic Antibiotic: must indicate Type, Dose, Route and Time of Administration. RN must sign when antibiotic starts infusing and confirm prophylactic antibiotic administration as part of Time Out.

7. The preoperative RN initiating and evaluating the preoperative care plan should sign the preoperative signature line on page 1. The RN initiating the intraoperative nursing care plan should sign the signature line on page 3. The RN evaluating the intraoperative outcomes should sign the signature line on page 3.

8. Protocols are site specific.

9. The RN who identifies the patient on admission to the O.R. must be documented.

10. Fully monitored indicates arterial blood pressure monitoring.

11. All names must be listed by first and last name along with credentials.

12. Nursing diagnoses are patient specific. Check the applicable nursing diagnoses for each patient. The Nursing Care Plan is in effect throughout the intraoperative period. Any changes made to the existing care plan need to be initialed.

13. “Time out” must be taken by entire surgical team for every procedure. Surgical team is comprised of surgeon, anesthesiologist, circulating RN, SA, PAC, scrub RN/ST. All components of the “Time Out” must be addressed per policy and time documented.

14. Check all the appropriate nursing interventions and complete the applicable blanks, initials, equipment numbers, etc.

15. The “in” and “out” times for surgical team members should be documented after their names if they are not present for the entire case.

16. Place correct date on the top of page 2 and 3 of OR Record.

17. Initial count refers to counts taken prior to the surgical procedure. A (“✓”) indicates a count was done, a blank box indicates a count is not applicable. Final refers to counts taken at the end of the surgical procedure. A (“✓”) indicates a consistent count. A blank box indicates the count is not applicable. If counts are inconsistent, document with an (*) in the box and document in the nursing narrative notes. RN and scrub initials should always be documented for initial and final counts, even if the count is not taken. This indicates who made the decision to take or not take the count. Additional counts may be instituted at the discretion of the surgical team and documented as appropriate.

18. The Foley output will be documented in the nursing narrative notes in procedures in which the Foley is discontinued. The intake and output in specialized procedures will be documented in the nursing narrative notes.

19. Document specimens according to number / letter and description per policy.

20. Document that specimens and final count status have been reported to surgeon at case end. Initial after each as appropriate.

21. Medications put on the sterile field, given by the RN, or given to anesthesia are to be documented on the appropriate Intraoperative Medical Orders and Intraoperative Medication Profiles.

22. Document on the appropriate forms for implants, lasers, cell saver, blood bank, Narrative Notes, etc. when applicable.

23. Initiate the "Sedation Assessment Record" or "Local Monitoring Record" as appropriate when an anesthesiologist is not present.

24. Patient status on discharge must be addressed.

References:
AORN Standards, Recommended Practices and Guidelines; 2007
NANDA, Nursing Diagnosis: Definitions and Classifications; 1997-1998
Preoperative Nursing Data Set, 2nd edition, 2002
Joint Commission: Universal protocol 2004

KEY TO ABBREVIATIONS:

<table>
<thead>
<tr>
<th>SHA</th>
<th>Surgical Holding Area</th>
<th>ESU</th>
<th>electrosurgical unit</th>
<th>O.R.</th>
<th>Operating Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>pt.</td>
<td>patient</td>
<td>Dx</td>
<td>diagnostic / diagnosis</td>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>M.T.</td>
<td>monitoring tech</td>
<td>ASA</td>
<td>American Society of Anesthesia</td>
<td>SA</td>
<td>Surgical Assistant</td>
</tr>
<tr>
<td>SDS</td>
<td>Same Day Surgery</td>
<td>R</td>
<td>Right</td>
<td>ST</td>
<td>Surgical Technologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>L</td>
<td>Left</td>
<td>PAC</td>
<td>Physician Assistant Certified</td>
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</tbody>
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PERIOPERATIVE NURSING RECORD

AHC 05635250 System (Rev. 06/11) Back