SECTION 8: CARE OF THE CHILD WITH A SURGICAL CONDITION

8.1 Preoperative Preparation

8.1.2 Preoperative Preparation and Procedures

(This document replaces PNPM 8.1.3, 8.1.5, 8.1.6, 8.1.8),

Contents

Aim

To ensure the safest outcome for patients who require general anaesthesia or sedation for surgery and/or interventional procedures.

Key Points

- Patients/carers will be fully informed of the intended surgery, treatment or procedure by the treating clinician in accordance with CAHS policy Consent to treatment/surgery/intervention.
- Patients will be prepared in accordance with the procedures outlined in this document.
- Patients will fast accordingly prior to the scheduled procedure. Contact treating duty anaesthetist if there are delays in the procedure to ensure measures are undertaken to prevent dehydration for at-risk patients e.g. neonates/infants.
- Ward clinical manager (or ward co-ordinator after hours) must discuss staffing requirements with the hospital manager for patients requiring specialist nursing care and post operative management.

PATIENT PREPARATION

Fasting:

Key points

- The following fasting times must be followed to avoid unnecessary delays or potential cancellations. Food and drink must be finished prior to the stated times.
- Food also includes lollies and gum.
- Contact theatre coordinator or Duty Anaesthetist if any concerns related to the time of theatre or list allocation.

	Food & Cow's milk	Infant formula including thickened	Breast milk including thickened	Clear fluids including thickened
Infants 12 months and under	6 hours	4 hours	3 hours	Up to 2 hours[1] before procedure.

	Food (includes gum/lollies) cow's milk/ breast milk	Clear fluids including thickened
Patients over 1 year	6 hours	Up to 2 hours before procedure.

Medications

- Medications such as antibiotics, anticonvulsants, antihypertensive agents, cardiac drugs, ADHD medication and drugs for asthma are usually continued unless otherwise instructed by treating medical team or anaesthetist. Administration times may need to be adjusted in order to maintain therapeutic serum levels.[2] Liaise with anaesthetist or treating medical team for advice.
- The duration of the drug action will determine when the drug is to be given. It is particularly important that patients with epilepsy receive their drugs at the correct time.[3]
- Consider: giving drug(s) before fasting begins, especially for medications that must be given with food; or giving the drugs when the procedure has been completed and the patient is awake.
- If medication is to be given pre-operatively, give with the smallest amount of water possible.

Pre-Med

Refer to the following guidelines:

- Oral Conscious Sedation Of Children Being Performed By Non Anaesthetic Personnel.
- Midazolam (Pharmacy Drug Monograph)
- Protocol for the use of Topical Anaesthetic Agents. For children over 12 months only, unless otherwise requested by anaesthetist or surgeon.

Theatre Attire and Hygiene

Attire

- All patients > 50kg are to wear a theatre gown (rear fastening). Underwear can be worn underneath (briefs/boxers only; bra/crop-top not permitted).
- Children < 50kg can wear clean pyjama's; hospital provided or own pyjama's as long as:
  - there are no metal fastenings,
  - pyjamas are two piece and have full button front opening for access to the chest
- In emergencies or certain instances it may be necessary for the child to wear street clothing to theatre if removing the clothing risks further injury (eg. fractures, head/facial injuries). Inform the child/carer that the clothing may be damaged during the procedure (ie. cut or stained).
- If the patient walks to theatre, non-slip footwear is to be worn[1] (ask parent/carer to bring in suitable footwear/slippers).

Hair

- Long hair must be tied back with metal-free hair ties; hair clips/pins must be removed. Note: hair extensions with metal fastenings must be removed before theatre.
- Patients with evidence of head lice must wear a disposable theatre hat.
- Hair removal is not routinely performed. However if deemed clinically necessary by the surgeon, hair will be clipped as close to time of surgery and preferably in theatre.[3,4] Shaving is not recommended practice.[5]

Hygiene:

- Patients are to be encouraged to bathe evening before or morning of surgery.[5] If the patient declines, inform surgical team/theatres.
- Inspect the patient's surgical site and clean as necessary. If rash or lesions observed contact the treating surgical team.
- For emergency cases where practical ensure debris/contaminants are removed as much as possible from surgical site.
- If a Medic Alert bracelet is worn, place gauze square between the bracelet and the skin. Tape so as not to obscure the information on the bracelet.

Contact lenses

- To be removed prior to theatre. Patients to wear spectacles on day of surgery if required.

Body piercings

- Remove or tape jewellery. If this is not possible, document on the Preoperative and Theatre Checklist.[2] Piercings that are close to the surgical site must be free of metal.

Nails

- Acrylic nails and nail polish can impair measurement of oxygen saturations.[6]
  If all artificial nails cannot be removed then at least one on each hand *must* be removed prior to the planned procedure.[7]

Patient Identification

- Patient must have two ID bands of the correct colour in situ in accordance with CAHS Patient Identification Policy. Both ID band details must be verified as correct with the patient/carer and correspond with medical record and consent form before the patient transfers to theatre.

Surgical Site Marking

- Ensure the surgical team have clearly marked the surgical site (where applicable) as per CAHS Policy Correct Patient, Correct Procedure, Correct Site: Procedure Matching.

Prevention of Venous Thromboembolism (VTE)

- Risk factors for VTE include: obesity, smoking, oral contraceptive pill, congenital heart disease; invasive devices; orthopaedic and neurosurgical procedures.
- Patients at increased risk of VTE may require preventive measures such as compression stockings or Flowtron boots and will be advised by the treating surgical team.
  Refer to Primary Prophylaxis of VTE Clinical Practice Guideline , and Compression Stocking: guide to use.

Documentation

It is the responsibility of the ward nurse to ensure the patient medical records and all relevant documentation accompanies the patient to theatre or radiology as follows:

Documentation	Additional Information
1. Patient Medical Records	All relevant volumes. Ensure two sheets of patient stickers are present.
2. Surgical Safety checklist MR844.03	Completed by theatre staff in pre-op bay or on collection from NICU/PICU/SDPU.
3. Preoperative and Theatre Checklist (MR844.01)	**Completed in full**

Documentation	Additional Information
4. Allergy reporting form (MR120):	**Completed in full** and to accompany all patients to theatre. Inform theatre coordinator at the earliest if: – latex precautions required (refer to CAHS policy Latex Minimisation) – there is family history of Malignant Hyperthermia
5. Operation/procedural consent	Must be valid and current as per Consent to Treatment/Surgery/Intervention. Ask the patient/carer to verbalise the procedure being performed – check this corresponds with the consent form and the theatre list. Contact theatre coordinator if any discrepancies or if consent form not present/complete.
6. Medication Chart (MR860)	Ensure current weight is documented. Inform theatre coordinator if patient weighs > 80kg.
7. Anaesthetic record (MR846.2)	
8. Anaesthetic history (MR840)	Completed by parents.
9. Post Anaesthesia Care Unit record (MR844C)	
10. CEWT chart	Appropriate to age.
11. Fluid order chart 12. **Daily intake/output chart**	(MR828) (MR935)
13. Pressure Injury Prevention Plan. 14. **Falls risk assessment tool.**	
15. ± Isolation precaution card.	If transmission-based precautions required send appropriate laminated card with notes and inform theatre at the earliest opportunity.
16. ± Nursing assessment and nursing care plan/clinical practice guideline.	If specific post-procedure care pathway is required eg. post Adenotonsillectomy care pathway (SDPU).

TRANSITION TO THEATRE

- Encourage patient to void prior to leaving the ward, where developmentally appropriate.
- Ensure all paperwork and patient identification is present ***and complete***, as above.
- Ensure the patient/carers understand the reason for the procedure prior to leaving the ward.
- Patients under the age of 16 are to be accompanied by a legal guardian or advocate (e.g. nursing staff, siblings/other family members >16years, foster carers). Only one parent/guardian will be permitted in the anaesthetic room.

NICU/PICU patients

- For those patients collected from the units by anaesthetic personnel the second 'Pre Op Check' (MR844.01 Preoperative and Theatre checklist) is to be completed by the registered nurse and anaesthetic personnel together as part of clinical handover prior to leaving the unit.
- The Surgical Safety Checklist will also be commenced by the anaesthetic personnel prior to leaving the unit. Exception may be where an emergency situation outweighs the benefit (refer to Surgical Safety Checklist Protocol OTPM section 6).

Mode of transport:

Ambulant/non-sedated patients

- can walk to theatre wearing non slip footwear or
- transfer in a hospital wheelchair, stroller or pram - use safety harness where age/developmentally appropriate
- infants/ children can be carried by parent, if parent wishes

Patients who have received a sedative premedication or non-ambulant patients

- Any child that has received sedation will be transferred to theatre on a trolley.
- Children unable to mobilise themselves from a bed to a trolley will be transferred using appropriate moving and handling equipment on the ward prior to transferring to theatre, and on return to the ward from theatre.

Patients requiring transfer to theatre on a bed

- Transfer to theatre on the bed is required for patients who have a clinical condition which prevents transfer to a trolley (eg. traction, unstable fracture, pain.)
- Beds must comply with the following:
  - 2 functioning safety side rails
  - Detachable bed head
  - Functional facility to raise and lower the height of the bed
  - A functional tilt facility
  - IV pole

Neonates

- Patients from NICU can be transferred on the Neonatal cot or incubator.
- The use of standard cots to transfer patients to and from theatre should be avoided where possible. Assessment must be made as to the risk and benefits of cot transfers.

In Theatre

Clinical Handover

- The ward nurse escorting the patient will provide a clinical handover using ISoBAR to the Anaesthetist or theatre/pre-op bay nurse.

Presence of Parents during Induction of Anaesthesia

There are many positive benefits from having parents accompany their children to the anaesthetic room and remaining with them until anaesthesia is induced.

- a reduced need for premedication with sedative/hypnotic drugs;
- a reduction in the incidence of side effects associated with these drugs;
- a reduction in the child's anxiety when s/he knows that separation from the parent will not occur in theatre.

Parents however must not feel obliged to accompany their child to the anaesthetic room if they do not wish to do so. Some parents have doubts about their own response to seeing their child suddenly become unconscious, while others feel that their child will cope better without them.[8]

Conditions of admission to the Anaesthetic Room

- The anaesthetist will make the final decision as to whether it is advisable for the parent to accompany their child to the anaesthetic room.
- Parents must not interfere with the normal process of anaesthesia and must leave immediately when requested to do so.
- Only one parent/carer can be admitted to the anaesthetic room.
- While in the anaesthetic room s/he will be expected to provide a supportive and sympathetic role with their child.
- For extremely anxious children or children with special needs the anaesthetist should discuss an anaesthesia induction plan with the parent/carer prior to the procedure.

Exceptions

- Due to the increased hazards during the start of anaesthesia in small infants[1], very ill children, and in emergencies, anaesthesia is often started in the operating room. In these circumstances parental presence will not be allowed.

Related policies, procedures and guidelines
Patient Identification (CAHS Policy 160)
Correct Patient, Correct Procedure, Correct Site (CAHS Procedure Matching Policy 144)
Consent To Treatment/Surgery/Intervention
Surgical Safety Checklist Protocol (OTPM Section 6)
Reporting Allergies and Adverse Reactions (PNPM 3.11.1)
Latex Minimisation
CAHS Clinical Handover Policy CAHS Restraint (physical) of Patients

References

1. Carstens J. Pre-operative Care: Fasting. In:. Acute Care Manual: Database of Recommended Practice JBI Adelaide [Internet]. 2009.
2. Chappy S. Perioperative Patient Safety. A Multisite Qualitative Analysis. AORN Journal. 2006;83(4):871-97.
3. Tanner J, Woodings D , Moncaster K. Preoperative hair removal to reduce surgical site infection. [Level I]. Chichester, UK: John Wiley & Sons, Ltd: [Cochrane Review]. In: The Cochrane Library, Issue 1; 2007.
4. Joanna Briggs Institute. Pre-operative hair removal to reduce surgical site infection. Joanna Briggs Institute: Best Practice Information Sheet 2007;11(4).
5. NHMRC. Australian Guidelines for the Prevention and Control of Infections in Healthcare: B4.3.3 Considerations pre-procedure. Commonwealth of Australia2010.
6. Crawford Mecham C, Parsons PE, and Finaly G, . Pulse oximetry. UpToDate [Internet]. 2014 [Accessed 17 December 2014]. Available from: http://www.uptodate.com/contents/pulse-oximetry.
7. Hinkelbein J, Koehler H, Genzwuerker HV , and Fiedler F Artificial acrylic finger nails may alter pulse oximetry measurement. Resuscitation. 2007;74(1):75-82. Pubmed Central PMCID: 17353079. Epub March 2013.
8. Kain ZN, Mayes LC, Caldwell-Andrews AA, Saadat H, McClain B , & Wong SM. Predicting which children benefit most from parental presence during induction of anaesthesia [Level III-3]. Paediatric Anaesthesia. 2006;16(6):627-34.

File Path:	Preoperative Preparation and Procedures		
Document Owner:	CNM SDPU		
Reviewer / Team:	CNM SDPU; CNS Theatre; HOD Anaesthesia		
Date First Issued:	January 1974	Version:	1.0
Last Reviewed:	5 February 2015	Review Date:	5 February 2018
Approved by:	HOD Anaesthesia	Date:	
Endorsed by:	Paediatric Nursing Practice Committee	Date:	5 February 2015
Document Sponsor:	Nursing Director, SSCCU		
Standards Applicable:	NSQHS Standards:		