

CARE OF THE SURGICAL PATIENT

Module 4

I. Statement of Purpose

The purpose of this module is to prepare the nurse assistant to care for the perioperative patient in the pre-operative and post-operative phases and in preparation for procedures.

II. Terminology

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| 1. Ambulatory surgical unit (ambulatory surgery) | 21. Pre-op medication |
| 2. Atelectasis | 22. Pre-op precautions |
| 3. Auto-transfusion device | 23. Pre-operative (pre-op) |
| 4. Continuous suction drains | 24. Recovery room |
| 5. Dangling | 25. Regional anesthesia |
| 6. Embolus | 26. Shock |
| 7. Epidural analgesia | 27. Stable |
| 8. Guarding | 28. Surgical bed |
| 9. Hemorrhage | 29. Surgical check list |
| 10. Hypothermia (Polar Care) | 30. Surgical dressing check (for dryness) |
| 11. Incentive spirometer | 31. Surgical skin prep (prep) |
| 12. Intravenous line (IV) | 32. T-binders |
| 13. Jackson-Pratt drain (J/P) | 33. TED hose |
| 14. Local anesthesia | 34. Thrombophlebitis |
| 15. N.P.O. | 35. Thrombus |
| 16. Pain scale | 36. Turn, cough, deep breath (TCDB) |
| 17. Patient controlled analgesia (PCA) | 37. Vertigo |
| 18. Penrose drain | 38. Wound dehiscence |
| 19. Peripheral IV | 39. Wound evisceration |
| 20. Post-anesthesia care unit (PACU) | 40. Apnea monitor |

III. Performance Standards (Objectives)

Upon completion of 5 hours of class plus assignments and 8 hours of clinical experience, the learner will be able to:

1. Define basic terminology.
2. Recognize and report patients' concerns regarding surgery.
3. List care measures provided for the pre-operative patient.
4. Explain the nurse assistant's responsibilities while the patient is in surgery.
5. Describe patient care measures provided in the post-operative phase.
6. Explain the safe management of the patient with various tubes.
7. Identify various types of binders and state their purpose.
8. Explain the nurse assistant's role in providing comfort measures.
9. Give examples of hot and cold therapies.

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Module 4

IV. References:

1. Chancellor's Office, California Community Colleges (2004). *CNA Model curriculum*. Sacramento: Chancellor's Office, California Community Colleges.
2. Gerdin, J. (2004) *Health careers today* (3rd ed.) St. Louis: Mosby.
3. Gerdin, J. (2004) *Workbook to accompany health careers today*. (3rd ed.) St. Louis: Mosby.
4. Hegner, B., & Caldwell, E. (2003). *Nursing assistant: A nursing process approach* (9th ed.). Albany, NY: Delmar.
5. Sorrentino, S. A. (2004). *Mosby's textbook for nursing assistants* (6th ed.). St. Louis: Mosby Lifeline.

MODULE 4 - CARE OF THE SURGICAL PATIENT

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
Objective 1 Define basic terminology A. Terminology B. Clinical Application	A. Lecture/Discuss B. Use hangman to practice difficult terms C. Written test	
Objective 2 Recognize and report the patient's concerns regarding surgery. A. Concerns: 1. Pain - Considered 5th vital sign. 2. Length of recovery 3. Loss of control 4. Complications (i.e., mutilation, infections) 5. Fear of death 6. Personal situations (i.e., home, children, pets, bills) B. Care measures: 1. Listen attentively to any of patient's concerns. 2. Provide support, general information within the nurse assistant's knowledge. 3. Report any serious concerns to the licensed nurse.	A. Lecture/ Discuss B. Role playing C. Written test	Demonstrates ability to respond to patient's concerns by providing emotional support and by reporting serious concerns to licensed nurse.
Objective 3 List care measures provided for pre-operative patient. A. Reinforce patient teaching 1. Incentive spirometer 2. Leg exercises 3. Turn, cough and deep breathe 4. Early ambulation 5. Range of motion B. Psychological preparation 1. Relay questions patient has about doctor's orders to the licensed nurse. 2. Observe for signs of fear via body language and statements.	A. Lecture/ Discuss B. Review sample pre-operative checklist from hospital. Have students identify tasks appropriate to Nurse Assistant role. C. Lab practice 1) Surgical prep 2) Turn, cough, deep breath 3) Incentive spirometer D. Handout 4.3: Pre-operative checklist E. Written test	Provides appropriate pre-operative patient care in the clinical setting.

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
3. Listen to how patient phrases questions to help determine concerns. 4. Reassure patient as appropriate. C. Perform tasks from pre-operative checklist 1. Showering, bathing 2. Enemas - per hospital policy 3. Nonsterile douche - per hospital policy 4. Shave prep 5. Hospital gown 6. NPO after midnight or as ordered by physician 7. Vital signs 8. Remove dentures, if ordered. 9. Remove prostheses (i.e., hearing aids, glasses, contact lenses, splints, braces, artificial parts). 10. Remove jewelry, hair pins, makeup. 11. Tape wedding rings, if allowed. 12. Assure security of any items of value (i.e., give jewelry to family member with patient's permission). 13. Have patient empty bladder. Drain Foley if present. Record output. 14. Notify medication nurse when patient is ready. 15. Provide for safe environment after pre-operative medication (i.e., side rails up, safety belt fastened on gurney, call light in reach). D. Identify nurse assistant's role in pre-operational checklist E. Document on the preoperative checklist		
Objective 4 Explain the nurse assistant's responsibilities while the patient is in surgery. A. Prepare the room: 1. Surgical bed 2. Emesis basin 3. Facial tissue 4. Vital sign equipment	A. Lecture/ Discuss B. Lab Practice 1) Room set-up 2) O₂ and pulse oximeter set-up 3) Suction set-up C. Written test	Demonstrates ability to set up patient's room.

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
5. IV pole 6. Incontinent pads. B. Collect additional equipment as ordered 1. O₂ equipment 2. Pulse Oximeter 3. Suction		
Objective 5 Describe patient care measures provided in the post-operative phase. A. Post-operative checks 1. Note time of return. 2. Note level of consciousness. 3. Check dressings for location and condition (dryness). 4. Observe incisions, report any drainage, redness or swelling (assessing and changing the dressing is the responsibility of the licensed nurse). 5. Check IV for location and observe site for redness, swelling, warmth or drainage. 6. Observe to see that IV is dripping and tubing not kinked. B. Post-operative care measures 1. Assist in transfer from gurney to bed. 2. Vital signs a. Be aware of changes in vital signs that signal hemorrhage, i.e., decreasing blood pressure and increasing pulse. b. Elevated temperature may signal infection. c. Report abnormalities to licensed personnel promptly. d. Pulse oximetry 3. Observations a. Comfort: degree of pain or other discomfort b. Safety: side rails, call light within reach c. Equipment: report if disconnected or malfunctioning d. Changes in behavior: confusion, disorientation,	A. Lecture/Discuss B. Lab Practice: 1) Manual Skill 4.5a: Sequential pressure devices 2) Manual Skill 4.5b: Anti-embolic Stockings 3) Manual Skill 4.5c Turning a Surgical Patient & Dangle and Ambulate C. Handout 4.5d - Hazards of Immobility and Role of the Nurse Assistant D. Written test	Demonstrates ability to accurately perform post-operative checks and care measures.

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
- agitation e. Changes in skin color: pallor, gray, blue-tinged f. Nausea, vomiting g. Bowel activity, passing gas C. Care measures to prevent complications 1. Encourage a. Turn, cough and deep breathing b. Incentive spirometer c. Leg exercises 2. Apply TED hose and sequential compression devices, if ordered. 3. Reposition at least every 2 hours to prevent hypostatic pneumonia. 4. Apply binders, if ordered. 5. Assist with dangling and initial ambulation, as ordered 6. Review Hazards of Immobility and Role of the Nurse Assistant. D. Complications of Immobility: Deep Vein Thrombosis (DVT) – blood clot in lower extremity 1. General Information a. Deep vein thrombus (DVT) or blood clot occurs in pelvic veins or in deep veins of the lower extremities in post-operative patients. The incidence of DVT varies between 10% and 40% depending upon how serious the surgery is and how many other medical problems the patient has. b. DVT is most common following hip surgery, then prostate surgery and general thoracic or abdominal surgery. c. Blood clots located above the knee are considered the major source of pulmonary emboli (a blood clot that dislodges from the vein wall and travels to the lungs, causing death of lung tissue) 2. Causes		

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
a. Pooling of blood in lower extremities (venous stasis) b. Inactivity and immobility c. Some medical conditions (stroke, heart attack, congestive heart failure) d. Obesity e. Varicose veins f. Surgery and anesthesia g. Age, particularly over 65 years h. Damage to or stretching of blood vessels during surgery or trauma i. Central venous catheters, pacemaker wires j. Previous DVT k. Increased tendency of blood to clot (some diseases like cancer, blood diseases, protein deficiency in malnourishment, dehydration) l. Oral contraceptives and estrogen replacement m. Smoking 3. Symptoms of DVT a. Often have no symptoms b. Pain or cramp in the calf or thigh, progressing to painful swelling of entire leg c. Slight fever, chills, perspiration (diaphoresis), generalized feeling of discomfort d. Painful tenderness over inner thigh 4. Prevention a. Increased activity, early ambulation after surgery, frequent and proper repositioning b. Range of motion c. Anti-embolic stockings (TED hose) d. Purpose of anti-embolic stockings 1) To help prevent formation of blood clots 2) To promote increased blood flow in the legs by compression of deep veins 3) To improve venous return from the legs to the heart maintenance of anti-embolic stockings		

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4) Properly sized stockings need to be removed daily during bathing to inspect condition of skin. Do not leave off more than 30 minutes. 5) Wash stockings every 2 to 3 days to remove bodily secretions. 6) For patient's information at home, the stockings can usually be machine washed on delicate and machine dried on low for 15 to 20 minutes. 7) With correct care stockings last 3 to 4 months. 8) Do not use ointments on the leg when using anti-embolic stockings. e. Sequential compressions sleeves or devices f. Adequate fluids g. Avoid dependent positioning of lower extremities (elevate legs when up in chair, avoid knee gatch when in bed). h. Doctor may order anticoagulants for licensed nurse to administer; observe for signs of bleeding or bruising. i. Observe for pain in calf, fever or chills, painful swelling of leg, tenderness over inner thigh. j. Report any shortness of breath or chest pain immediately to the licensed nurse. E. Nursing Alert 1. A complaint of slight soreness of the calf is never ignored. Blood clots in the calf or thigh can break loose and travel to the lungs (pulmonary embolism). This is life threatening. 2. Close observation of patients and attention to their complaints of pain or discomfort is very important. 3. Report this to the licensed nurse. 4. Never rub or massage the lower legs.		

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
Objective 6 Explain the safe management of the patient with various tubes. A. Safety precautions 1. Know purpose and location of all tubes. 2. Check drainage for character, color and amount. 3. Keep tubing free of kinks. 4. Never disconnect tubing. 5. Never raise drainage collection bag above the level of the insertion site. 6. Never lower the IV bag below the level of the insertion site. 7. Never pull tubes when moving patient. 8. Never assume the responsibility for chest tube drainage or attempt to empty. B. Report the following changes: 1. Any signs of leakage or disconnection 2. Pain, discoloration or swelling at the sites of drainage/infusions 3. Changes in amount, color and character of drainage C. Intravenous therapy 1. Purpose of IV fluid replacement a. Replace fluids and electrolytes b. Prevent dehydration c. Administer IV medications d. Nutritional support, TPN, PPN 2. Signs of infiltration/infection (change in skin temperature at IV site , pain, burning, leaking, swelling, redness) 3. Report any IV pump alarms 4. Report disconnected IV tubing 5. Report blood back-up to licensed nurse 6. Bathing precautions 7. Flow rate a. Alert nurse when IV bag is low in volume. b. Check that the IV is dripping.	A. Lecture/ Discuss B. Show examples of tubes/drainage collection devices C. Lab Practice D. Clinical Observation E. Written test	Safely empties wound drains and accurately measures and reports drainage. Carefully observes all tubing and reports abnormal findings to licensed nurse. Safely places IV bag and tubing through patient's gown when bathing, without disconnecting tubing.

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
c. Never adjust roller clamps or flow rate. 8. Blood Products a. Signs of blood reactions: 1) Shaking 2) Chills 3) Elevated temperature 4) Flank pain 5) Rash, hives D. Wound drains 1. Use Standard Precautions when emptying drains. 2. Maintain drain compression (J/P, Hemovac). 3. Keep accurate record of output from wound drains, even in small amounts. E. Nasogastric tube 1. Observe for signs of distress (coughing, gagging, shortness of breath, nausea, vomiting) and report to licensed nurse. 2. Maintain patent drainage system. 3. Observe for signs of choking. F. Catheters 1. Types a. Urinary b. Suprapubic c. Condom cath 2. Safe Management a. Proper taping b. Assure drainage c. Observe color - clear or cloudy d. Report pain G. Oxygen tubing 1. Connections 2. Assure that cannula/mask is <u>on</u> patient 3. Patient comfort related to pressure sores/irritation		
Objective 7 Identify various types of binders and state their purpose. A. Purpose 1. Hold surgical dressings in place	A. Lecture/ Discuss B. Show samples	Demonstrates proper application of binders.

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2. Provide support 3. Prevent wound dehiscence B. Types 1. Abdominal (scultetus) 2. Breast 3. T-Binders, single and double 4. Montgomery straps		
Objective 8 Explain the nurse assistant's role in providing comfort measures. A. Pain management: 1. Splint incision 2. Back rub 3. Promptly report complaints of pain and lack of response to pain medication 4. Reposition for comfort 5. Equipment safety: a. Patient controlled analgesia (PCA) - only patient should push button b. Epidural catheter - prevent catheter removal with turning/movement B. Oral hygiene C. Environmental temperature control (blankets, thermostat) D. Review pain scale	A. Lecture/ Discuss B. Handout 4.8: Pain Scales C. Written test	Provides comfort measures to the patient in pain.
Objective 9 Give examples of hot and cold therapies. A. Treatment for injuries and wounds to help relieve: 1. Incisional pain 2. Cellulitis 3. Pressure sores 4. Sprain/strains 5. Arthritis pain/inflammation B. Heat and cold applications have opposite effects 1. Heat dilates 2. Cold constricts	A. Lecture and Discuss B. Lab Practice C. Clinical observation D. Written test	Appropriately demonstrates application of hot and cold therapies.

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C. Severe injuries can occur with both therapies 1. Observe precautions with each therapy 2. Some states or facilities do not allow nurse assistants to apply hot and cold therapies. 3. Check with licensed nurse and facility policy. D. Heat therapy 1. Prevent hypothermia after surgery 2. Speed healing 3. Control pain E. Cold therapy 1. Reduce swelling 2. Control bleeding 3. Control pain F. Equipment 1. K-pad 2. Warming and cooling blankets 3. Ice packs 4. Soaks and compresses 5. Sitz bath G. Hypothermia care 1. Examples: a. Cold constricts blood vessels and helps prevent swelling and reduce inflammation b. Cold applied immediately after a strain, sprain or contusion helps reduce swelling and bleeding. c. Cold applications can help relieve pain, stiffness and muscle spasm d. Ice collars, ice bags, disposable instant cold packs, gel-filled cold packs, hypothermia blanket (Polar Care). H. Nurse assistant's role with cold therapy 1. Complications can occur from cold therapy. 2. Know role limitations of nurse assistants in each facility and the proper procedure before applying cold therapy. 3. Use with caution in patients with circulatory		

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
problems. 4. Check with licensed nurse for specific instructions for each patient. 5. Know the precise location the compress is to be applied. 6. Always cover cold applications with soft cloth or flannel cover that comes with device. <u>Never place cold compress directly on bare skin.</u> 7. Check skin frequently (every 5 minutes) under cold applications. 8. Report any of the following complaints to the licensed nurse immediately: a. Complaints of numbness, pain, or burning b. Blisters or burns c. Pale, white, or gray skin d. Cyanosis e. Shivering 9. Leave application on only as long as directed by licensed nurse (never longer than 30 minutes). I. Hyperthermia care 1. Heat dilates blood vessels and increases blood flow to help speed healing. 2. Heat applications help relieve pain, relax muscles, reduce swelling, and decrease joint stiffness. J. Examples: 1. Hot compresses and hot packs, aqua-thermia pad, disposable hot pack. K. Nurse assistant's role with heat therapy 1. Complications can occur from heat therapy. 2. Know role limitations of nurse assistant in each facility and the proper procedure before applying heat therapy. 3. Know how to operate equipment used in the procedure. 4. Make sure temperature of water or pad is accurate as ordered. 5. Check with licensed nurse for specific instructions		

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation	Clinical Activities
for each patient. 6. Know the precise location the heat therapy is to be applied. 7. Patients who have circulatory problems or difficulty feeling heat or pain should have heat therapy performed by licensed nurse. 8. Heat is never applied to an area that has a metal implant such as pacemaker knee or hip replacement. 9. Always cover dry heat applications with soft cloth or flannel cover that comes with device. 10. Check skin frequently (every 5 to 10 minutes) under hot applications. L. Report any of the following complaints to the licensed nurse immediately: 1. Complaints of numbness, pain, or burning 2. Excessive redness 3. Blisters or burns 4. Pale, white, or gray skin 5. Cyanosis 6. Shivering M. Leave application on only as long as directed by licensed nurse (never longer than 30 minutes). N. Follow rules of electrical safety when using electrical appliance to apply heat.		

SAMPLE TEST QUESTIONS

Directions: Circle the best answer

1. You have been notified that Mr. Jones is being transferred back to his room. When he arrives, you notice that he is very relaxed from the medication, and that he has an IV still running in one arm. As you help settle him into bed, you would be careful to:
 - a. Discontinue the IV since the surgery is over.
 - b. Elevate the knees of the bed to prevent straining of abdominal muscles.
 - c. Raise the side rails before leaving the bedside.
 - d. Fill his water pitcher and encourage him to drink.
2. Since Mr. Jones returned to his room, you have assisted him to TCDB and to move his legs at least every 2 hours. By coughing, he will be less likely to develop the post-operative complication of:
 - a. Embolus
 - b. Pneumonia
 - c. Shock
 - d. Hemorrhage
3. You can help relieve Mr. Jones' gas pains by which of the following measures?
 - a. Providing a paper bag for him to breathe in.
 - b. Assisting him to turn or to get up and walk about.
 - c. Giving him only 7-Up to drink.
 - d. Having him breathe deeply and pant through his mouth.
4. Mr. Jones has a drain coming from under a dressing that is over a surgical incision. Which of the following should the nurse assistant do?
 - a. Report changes in the amount of the drainage to the licensed nurse.
 - b. Reassure the patient that increased pain is expected.
 - c. Be sure all drainage tubes are clamped.
 - d. Keep any drainage system open to air.
5. Blood clots (deep vein thrombosis - DVT) require early diagnosis and treatment. The main symptoms of deep vein blood clots are all of the following EXCEPT:
 - a. Swelling of the extremity
 - b. Tenderness and pain
 - c. Discoloration and open sores on the leg and foot
 - d. Fever and generalized feeling of discomfort and sickness.
6. Post-operative care of a patient with intermittent compression stockings involves:
 - a. Removing the stockings if patient becomes too warm.
 - b. Keeping patient on bed rest to obtain the best benefits from the stockings.
 - c. Removing the stockings for evaluation of the lower extremities.
 - d. Having the patient continue to wear the stocking until they are ready for discharge.

7. The nursing assistant has many responsibilities in order to provide care for the person before surgery. Which one of these statements is FALSE? The nursing assistant
 - a. May listen to the person voice concerns about the surgery.
 - b. May answer questions about the surgery.
 - c. May report a person's request to see a clergy member.
 - d. May report patient's communication of fear to the nurse.
8. Before surgery, the patient is in NPO for
 - a. 24 hours.
 - b. 2-4 hours.
 - c. 6-8 hours.
 - d. 12 hours.
9. Post-op patients are generally repositioned
 - a. Every 2 hours.
 - b. Every hour.
 - c. Every 15 minutes.
 - d. Every 30 minutes.

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SAMPLE PRE-OPERATIVE CHECKLIST

1. Admission sheet
2. Surgical consent
3. Sterilization consent (if necessary)
4. Consultation sheet (if necessary)
5. History and physical
6. Lab reports (pregnancy tests also if necessary)
7. Surgery prep done and charted (if required)
8. Latest TPR and blood pressure charted
9. Pre-operative medication given and charted (if required)
10. Wrist identification band on patient
11. Fingernail polish and makeup removed
12. Metallic objects removed (rings may be taped)
13. Dentures removed (unless otherwise indicated)
14. Other prostheses removed (such as artificial limb or eye)
15. Bath blanket and head cap in place
16. Bed in high position and side rails up after pre-op medication is given
17. Patient has voided
18. Document urine output

Examine the surgical checklist above. List the items that are nursing assistant responsibilities.

SAMPLE PRE-OPERATIVE CHECKLIST - KEY

1. Admission sheet
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Examine the surgical checklist above. List the items that are nursing assistant responsibilities.

7. Surgery prep done and charted (if required and depending on facility's policy/role of C.N.A.)
8. Latest TPR and blood pressure charted
10. Wrist identification band on patient
11. Fingernail polish and makeup removed
12. Metallic objects removed (rings may be taped)
13. Dentures removed (unless otherwise indicated)
14. Other prostheses removed (such as artificial limb or eye)
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SEQUENTIAL COMPRESSION DEVICES

Several types of devices are available that supply intermittent compression over the lower leg, thigh or foot. Each device aids in the return of venous blood and helps prevent deep vein thrombosis and pulmonary embolism. They are usually used in addition to anti-embolic stockings.

The typical type of sequential compression device consists of a vinyl or plastic sleeve that fits over the foot, lower leg or thigh. It may come as a tube or as a wrap style that fastens with Velcro. It is attached to a control unit that is placed on the floor under the bed. The control unit has a small pump that inflates and deflates channels in the sleeve to provide increasing and decreasing pressure. Connecting tubing attaches to the sleeve and to the control unit completing a closed system. The pressure can be adjusted according to facility policy or as ordered by the physician.

The device should be removed at least twice daily for 20 to 30 minutes to allow for ambulation, bathing and inspection of the skin. Sequential compression devices are usually worn at least 3 days after surgery or until the patient is up and ambulating regularly or as long as the doctor orders.

EQUIPMENT:

1. Sequential compression sleeves
2. Connectors
3. Control unit

CRITERIA:

Safely cares for the patient on a sequential compression device

1. Wash hands, identify patient, introduce self, explain procedure and provide for privacy.
2. Position patient, exposing one leg at a time for application of sequential sleeve.
3. Align leg on the open sleeve according to instructions included in package.
4. Wrap the sleeve securely around the patient's leg and fasten the Velcro tabs, thigh section first. Make sure that no wrinkles are in the plastic of the sleeve and that at least two fingers can be inserted between the patient's leg and the sleeve.
5. Make sure the control unit is turned off.
6. Attach the connector on the sleeve to the correct end of the connector tubing. Check carefully to be certain there are no kinks or twists in the tubing.
7. Attach the other end of the connector tubing to the control unit.
8. Turn the power on and adjust or monitor the pressure according to your facility's policy.
9. Remain with the patient for at least a complete cycle to monitor comfort and the functioning of the unit.
10. Sleeves should be removed if the patient experiences numbness, tingling or leg pain. Notify licensed nurse if any of these symptoms occur.
11. Document time of application, type of device, condition of skin and comfort of patient.

PRECAUTIONS:

1. Do not apply to any patient experiencing skin rash or poor circulation evidenced by bluish-red coloring of lower legs and feet, sores on lower legs or feet, severe edema or leg pain, edema of the lungs from congestive heart failure.
2. Make sure that connectors and sleeves are properly applied.
3. Monitor the patient's condition frequently, according to facility policy.

SINGLE LEG APPLICATION:

1. Most brands of sequential compression devices can be used on only one leg, if necessary.
2. The unused sleeve is kept in the plastic wrapper and attached to the second sleeve connector.
3. The compression action of the pump will not work unless there is a closed system. By keeping the unused sleeve folded in the wrapper, the system will be able to reach the proper compression.

MEASURING AND APPLICATION OF ANTI-EMBOLIC STOCKINGS

EQUIPMENT:

1. Tape measure (new one for each patient)
2. Scratch pad, order form or requisition form from Central Supply
3. Anti-embolic stockings (TED stockings or other brands)

CRITERIA:

Correctly measures and applies anti-embolic stockings

- A. Thigh length
 1. Measure upper thigh circumference at gluteal furrow.
 2. Measure calf circumference at widest area.
 3. Measure length from gluteal furrow to base of heel.
 4. Consult sizing chart from Central Supply or TED stockings order pad, if available.
 - TED thigh length with belt stocking fit a thigh circumference of up to 32 inches.
 - TED thigh length stocking fit a maximum thigh circumference of 25 inches.
- B. Knee length
 1. Measure calf circumference at widest area.
 2. Measure length from bend of knee to base of heel.
- C. Medicare usually covers two pair to insure that compression goes uninterrupted during laundering care. Check with the RN to see if one or two pair should be ordered.
- D. Different brands of anti-embolic elastic stockings are available. Each pair will have a large round hole in the toe to check for circulation. In some brands the hole will be on top of the toes and some will have the hole open under the toes.

APPLICATION OF ANTI-EMBOLIC STOCKINGS:

1. Obtain correct size of anti-embolic stockings.
2. Wash hands, identify patient, introduce self, explain procedure and provide for privacy.
3. With patient lying down, expose one leg at a time for application of stocking.
4. Insert hand into stocking as far as the heel pocket.
5. Grasp center of heel pocket and turn stocking inside out to heel area.
6. Position stocking over foot and heel. Be sure patient's heel is centered in heel pocket.
7. Pull a few inches of the stocking up around the ankle and calf.
8. Continue pulling the stocking up the leg. If there is a change in the sheerness of the stocking material, it should fall between 1" to 2" below the bend of the knee.
9. As thigh portion of the stocking is applied, start rotating stocking inward so gusset is centered over femoral artery. Gusset is placed slightly towards the inside of the leg. When using thigh length stockings, the top band rests in the gluteal furrow.
10. Smooth out wrinkles.

11. Align inspection toe to fall at base of toes either on the top or underneath, depending on brand.
12. Instruct patient on proper positioning of stockings to insure that he/she will not reposition the stockings incorrectly.
13. Repeat procedure on opposite leg.
14. Wash hands.
15. Report procedure and document size and style of stocking applied.
16. Document when stockings are removed along with condition of skin.
17. Report any tenderness in calves, thighs or toes.

TURNING A SURGICAL PATIENT

EQUIPMENT:

1. Pillows
2. Lift sheet

CRITERIA:

Safely turns a surgical patient

Instruct patient in splinting incision for comfort.

1. Obtain patient activity orders from licensed nurse.
2. Instruct patient in splinting incision for comfort.
3. Make sure that bed wheels are locked, curtains are pulled around bed for privacy and bed is raised to highest level for good body mechanics.
4. Lower head of bed if patient's condition allows.
5. Using good body mechanics, turn patient.
6. Position patient for comfort and in good body alignment.
 - a. Place pillow under head.
 - b. Position a pillow against back for support.
 - c. Place a pillow in front of the bottom leg and place the top leg on top of the pillow in a flexed position.
 - d. Check lower shoulder to make sure it is not squeezed in an abnormal position. Reach under shoulder and pull forward gently until patient is comfortable.
 - e. Support upper arm and hand with a pillow for comfort, either in front of the patient or back on the pillow behind the patient.
 - f. If abdominal incision is pulling, may place pillow under side of abdomen.
7. Place the signal cord within reach; raise side rails, lower bed to lowest position, open curtains around bed.

DANGLE AND AMBULATE A SURGICAL PATIENT

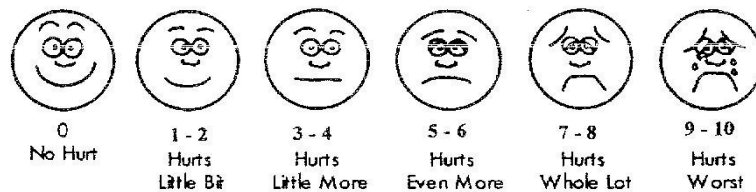
CRITERIA:

Safely dangles and ambulates a surgical patient

1. Check patient's pulse, blood pressure and respirations.
2. Assist patient to side of bed and put on non-slip slippers.
3. Assist patient to pivot and sit at side of bed.
4. Support patient and observe for abnormal signs.
5. Assist patient to put on robe.
6. Apply gait belt if allowed.
7. Assist the patient to stand.
8. Stand at patient's side until steady, holding the gait belt in the middle of the patient's back.
9. Stand slightly behind patient, on weak side, if applicable.
10. Encourage patient to walk with head up, standing erect.
11. Observe for signs of activity intolerance (increased pain, shortness of breath, pallor, diaphoresis).
12. Return patient to bed and make sure patient is safe and comfortable.
13. Report distance patient walked and how well patient tolerated activity to licensed nurse.
14. If patient has an IV, may need two people to assist with ambulation.

HAZARDS OF IMMOBILITY AND ROLE OF THE NURSE ASSISTANT

1. Cardiovascular complications - blood clots, orthostatic hypotension, increased work on the heart
 - Remind patient to do exercises given by the physical and occupational therapist.
 - Encourage intake of adequate fluids to prevent dehydration.
 - Early ambulation as allowed.
 - Proper positioning and avoidance of pressure on blood vessels.
 - Do not massage the calf of the leg.
2. Respiratory complications – slow and shallow respirations, pooling of respiratory secretions, hypostatic pneumonia, pulmonary embolism
 - Remind patient to turn, cough, take deep breaths and to use incentive spirometer.
 - Increase activity as soon as allowed by patient's condition and doctor's orders.
 - Encourage fluids as allowed to keep lung secretions thinned.
3. Gastrointestinal complications – poor appetite, poor nutrition, constipation, fecal impaction
 - Offer adequate fluids.
 - Prevent incontinence by timely offering of the bedpan and early mobility for access to the bathroom.
 - Monitor patient's appetite and ask RN to assess need for a dietician consult.
4. Urinary system complications – urinary retention, incontinence, increased risk of kidney stones, urinary tract infections
 - Keep accurate record of intake and output.
 - Observe for pain in the back and blood in the urine.
 - Observe for signs of urinary tract infection: pain with urination, frequent urination of small amounts, feeling the need to urinate all the time, concentrated or cloudy urine.
5. Musculoskeletal system complications – muscle wasting and atrophy, stiff joints, decreased balance, loss of endurance, osteoporosis, contractures, foot drop
 - Perform passive ROM exercises for patients who are unable to do them, and instruct patients who are able to do active or active-assistive ROM.
 - Position patients properly in bed, using good body alignment.
 - Remind and reinforce any exercises given to patient by physical or occupational therapists and RN.
6. Integumentary system complications – pressure on bony prominences, impaired circulation to skin layers, skin breakdown, pressure ulcers, infections
 - Observe for any sign of redness or sores on the skin.
 - Keep skin clean and dry.
 - Keep bedding free of wrinkles and crumbs.
 - Turn patient at least every 2 hours to reduce pressure on bony prominence

PAIN SCALES**WONG-BAKER FACES PAIN RATING SCALE**

FLACC SCALE
(FACE, LEGS, ACTIVITY, CRY, CONSOLOABILITY)
PAIN ASSESSMENT TOOL

Face	0 No particular expression or smile	1 Occasional grimace or frown, withdrawn, disinterested	2 Frequent to constant frown, clenched jaw, quivering chin
Legs	0 Normal position or relaxed	1 Uneasy, restless, tense	2 Kicking, or legs drawn up
Activity	0 Lying quietly, normal position, moves easily	1 Squirming, shifting back and forth, tense	2 Arched, rigid, or jerking
Cry	0 No cry (awake or asleep)	1 Moans or whimpers, occasional complaint	2 Crying steadily, screams or sobs, frequent complaints
Consolability	0 Content, relaxed	1 Reassured by occasional touching, hugging, or "talking to." Distractible	2 Difficult to console or comfort

General use permission granted for FACES scale from D.L. Wong and C.M. Baker at
<http://www3.us.elsevierhealth.com/WOW/facesReproductions.html>

Numeric Pain Intensity Scale

