PERIOPERATIVE PATIENT ASSESSMENT:
HELPING PATIENTS ACHIEVE THEIR GOALS

1933
PERIOPERATIVE PATIENT ASSESSMENT: HELPING PATIENTS ACHIEVE THEIR GOALS

AORN INDEPENDENT STUDY ACTIVITY
STUDY GUIDE WITH VIDEO

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PURPOSE/GOALS

The purpose of this independent study is to review the principles of perioperative assessment, with specific reference to the role of the perioperative nurse in this process. Sources of assessment data are described, including the surgical schedule, the patient’s chart, the patient interview and physical examination, and consultation with other health care professionals. Aspects of physiological and psychosocial assessment and reassessment are examined in detail. Implications for nurse managers are also mentioned.

OBJECTIVES

After viewing the film and completing the study guide, the participant will be able to:

1. discuss the benefits of a comprehensive patient assessment,
2. describe the sources of assessment data,
3. explain how perioperative assessment fits into the nursing process,
4. list the components of physiological and psychosocial assessment,
5. list the effects that characteristics of the patient may have on these aspects of the perioperative assessment process, and
6. discuss the implications of perioperative assessment requirements for nurses.

INTENDED AUDIENCE

This self-paced educational program is intended for use by perioperative nurses who conduct perioperative assessments of surgical patients.

GUIDE FOR STUDY

This study is intended for use in conjunction with the accompanying video, “Perioperative Patient Assessment: Helping Patients Achieve Their Goals.” We suggest that you take the following steps to complete this education activity:

1. Read the overview and objectives for this education activity and compare them with your own learning objectives.
2. View the video.
3. To reinforce your learning, return to the study guide and view the content, paying particular attention to those areas that reflect the objectives.
4. Consult the list of suggested readings for further information.

PERIOPERATIVE NURSING ASSESSMENT

AORN’s “Standards of Perioperative Clinical Practice” define assessment as follows: “Assessment is the systematic and ongoing collection of data, guided by the application of knowledge of physiological and psychological principles and experience, and is used to make judgments and predictions about a patient’s response to illness or changes in life processes. Assessment is essential to establishing a nursing diagnosis and predicting outcomes. Assessment may occur in a variety of settings.”

The objective of perioperative nursing assessment is to collect comprehensive data on the physiological and psychological status of the patient in order to identify functional and dysfunctional health patterns that may affect the patient during the perioperative period.

Many providers assess the patient before surgery, including the perioperative nurse, the surgeon or surgical resident, and the anesthesia care provider. This study guide is concerned with assessment data collected by the perioperative nurse. The location, timing, and method of assessment may vary with the particular circumstance of the facility and individual patient needs. Preoperative assessments may be performed in a variety of settings, and even frequently by phone. Regardless of the setting, it is important that some form of assessment, patient and family education, and discharge planning be done.

Assessment data may be collected at any time in the preoperative, intraoperative, or postoperative period, beginning with the patient’s decision to have surgical intervention and ending with a resolution of surgical sequelae. Assessment and planning before the day of surgery helps prevent delays or cancellations.

Assessment is considered the first step in the six-step perioperative nursing process. It provides a basis for clinical judgments that will ultimately result in the formation of nursing diagnoses; identification of expected outcomes; development and implementation of an effective, individualized plan for preoperative, intraoperative, and postoperative care that will meet the patient’s physical and emotional needs; and evaluation of the extent to which expected outcomes were achieved. (See Appendix I)

SOURCES OF ASSESSMENT DATA

Perioperative assessment involves the patient, significant others, and other health care providers. It may be accomplished through diverse means, such as interviews, reviews of records, and/or consultations. It begins with a review of the patient’s chart (if applicable), followed by a patient interview, a physical examination, and often conferences with other members of the health care team. All of this establishes a baseline for setting realistic goals relative to the impending procedure. If the primary goal in post-operative care is to return the patient to normal functioning, it is important to clarify what “normal functioning” is for each individual via careful preoperative functional assessment.

For inpatients, the perioperative nurse collects assessment data during a preoperative visit and through a chart review the afternoon or morning before surgery. For outpatient and same-day admission patients, information can be obtained from a patient questionnaire, the patient history, physical forms, physician’s orders sent to the facility from the physician’s office, previous medical records (eg, previous admission medical records sent to the surgery department the day before surgery), and pertinent information listed on the surgery schedule. Each of these sources provides certain pieces of information critical to the development of an appropriate plan of care. The perioperative nurse is responsible for ensuring that the preoperative assessment is complete and the patient’s emotional needs are met.

1. Surgical Schedule

The surgical schedule provides information regarding the patient’s age and sex, the planned operative procedure, the type of anesthesia, the names of the surgeon and anesthesia care provider, and the estimated duration of surgery. Review this information carefully before seeing the patient, because the type of procedure scheduled will influence your assessment.

2. Patient Chart

A thorough chart review provides the nurse with a preliminary understanding of the physiological and psychosocial characteristics of the patient. The patient’s chart contains data that have already been obtained by
other members of the health care team. Written information and information gathered by others should be verified with the patient.

- **Admission information** - Refer to the admission information sheet to obtain the patient’s legal name, admission telephone number, social security number, birth date, sex, marital status, religious preference, employment and insurance data, and next of kin and emergency contacts.1

  These data can provide important clues to areas that may need to be explored further during the interview, such as the availability of needed social support.

- **Informed consent** - Although it is the physician’s responsibility to obtain informed consent for the planned surgical procedure and to obtain informed consent from the patient, the nurse must confirm that the chart includes a valid informed consent and verify that the patient understands the risks and alternative procedures.12

- **Physician’s history and physical examination** - On the medical history and physical examination record, the physician will have noted the chief complaint and the reason for the surgery. This form also should contain important information about the patient’s physical condition and a description of the surgical site.

- **Medication sheet** - Review the medication sheet to determine what medications the patient is currently taking. To validate this information, it may be helpful to have the patient bring a list of his or her medications or the original prescription bottles to the preoperative interview. Be sure to review the medications the patient is taking. Significant others can verify the patient may have forgotten about earlier.

- **Nursing notes** - The inpatient unit nursing notes may contain information that could affect perioperative nursing activities, such as transportation to the OR or intraoperative positioning. They also will include records of vital signs and intake/output.

- **Nursing history** - The nursing history consists of a compilation of data accumulated by any and all professional nurses who have come in contact with the patient. Pay particular attention to any documented allergies, time and nature of last food/fluid intake, possibility of pregnancy, medications, diagnostic tests, including any blood tests and urinalysis, and any nursing diagnoses formulated by other nurses.

- **Patient directives** - It has become customary to include patient directives that specify the patient’s wishes about transfusions, resuscitation, prolongation of life, organ donation, and autopsy. It is important that the health care team act in accordance with such directives.

- **Reports of other professionals** - The chart may include reports from medical specialists, other nurses, the anesthesia care provider, physical and occupational therapists, respiratory therapists, dietitians, or social workers. Medical records may be in the form of the traditional source-oriented medical record, where each phrase is written in consecutive order, or in the form of a problem-oriented medical record, where data about the patient are recorded and arranged according to the patient’s problems instead of according to the source of the information.

3. **Patient Interview**

A preoperative health history often is obtained by having the patient complete a questionnaire and then asking questions to verify or elaborate on the information provided. You will be able to direct the patient interview more effectively if you review the chart and any information contained on the questionnaire before speaking to the patient.9

If feasible, conduct the patient interview in such a way that the patient won’t feel rushed. Create an atmosphere conducive to open communication by drawing the curtain or closing the door to create privacy and prevent distraction from other patients, staff members, or visitors. If necessary, turn off any radios or televisions, or ask nonessential persons to leave the room. If the patient prefers to have family members present, be sure to include them, but be aware that the presence of others may cause the patient to withhold vital information.

Begin the interview by giving your name and title and explaining the role you will be performing in regards to the patient’s surgery. Explain the purpose of the assessment interview and the value that can come from it. Be sure to ask permission before addressing patients by their first name, especially the elderly.10 Before asking questions, be aware that some of the patient’s today and tomorrow would not be possible, spend a few minutes getting acquainted with the patient and assessing his or her emotional condition.11 Sit close to the patient, and listen. Create a sense of empathy by demonstrating honesty, warmth, and interest, possibly through a light touch to the shoulder or elbow.

Most interviewers use an open-ended interview style. To gain greater insight into the patient, try some of the following techniques.

- Use direct questioning when brief answers are required.
- Use silence to allow the patient time to gather his or her thoughts and to give yourself time to reflect on what was said.
- To get the patient to elaborate on something, use actions such as a nod of the head, a puzzled look, or verbal statements such as “Mmm-hmm,” “Really?” or “Tell me more about that.”
- Be aware of body language and other nonverbal signals you may be giving and receiving.
- Verbally acknowledge the patient’s feelings of anger, depression, or frustration.
- Summarize pertinent points of the patient’s statements.

Allow the patient to give as thorough a history as possible, with a minimum of interruptions. Most patients will try to give complete, correct information, but their reports may be inaccurate for a variety of reasons. For example, the patient may not understand the question, not know how to answer the question, not remember the incident, be afraid of the diagnosis, be afraid of having surgery canceled or postponed, or not perceive the symptom as important or relevant.12 It is important that the health care significant or relevant for the behavior is lost.

4. **Physical Examination**

The physical examination usually is performed by the physician, but it may be performed by a nurse using the techniques of inspection, palpation, percussion, and auscultation.13

- In inspection, the eyes are used to observe the patient, concentrating on what to look at, rather than what to look for.
- Palpation uses the hands and fingertips to distinguish temperature variations, hard and soft, rough and smooth, stillness and vibration. Light palpation is used because sensitivity can be dulled by pressure.
- Percussion is used to detect tenderness or pain in the underlying tissues. It is accomplished by laying an outstretched middle finger over the area to be percussed and tapping the distal part using the tip of the middle finger of the opposite hand.
5. Consultation with Other Health Care Professionals

If necessary, consult with the patient’s physician or other members of the health care team to clarify the patient’s medical diagnosis, progress, and plans to meet medically oriented goals of surgery. Rely on other nurses to provide continuity of care by communicating information when a patient is transferred to another unit or health care facility.28

PHYSIOLOGICAL ASSESSMENT

Using the assessment techniques and data sources described above, perioperative nurses conduct both physiological and psychosocial assessments. Physiological assessment involves collecting baseline data on what is normal for the patient (eg, vital signs, nutrition, fluid balance).29 Past and present pathological conditions should be noted. If necessary, surgery can be delayed or canceled until certain conditions are resolved.30

The AORN “Competency Statements in Perioperative Nursing” define 16 measurable criteria that comprise competency “to assess the physiological health status of the patient.” (See Appendix 2.) Each of these competencies will be addressed in turn.

1. Verifies operative site

Verify the patient’s identity verbally and by checking the patient’s record and identification bracelet or wristband. Use two patient identifiers (eg, full name and date of birth). Verify the procedure to be performed, paying particular attention to the anatomic surgical site.28 In the case of bilateral organ, limb, anatomic site, or multiple structure levels, the site should be marked, using an indelible marker, before giving the patient narcotics, reducing mattress, and nutritional support.33 If the jewelry is metal, safeguards will be needed to prevent direct and indirect electrosurgical energy coupling during the procedure.

2. Notes condition of skin

Ask about recent skin problems or a family tendency toward chronic skin disorders. If skin problems exist, determine when they began and any associated symptoms and precipitating factors. Assess skin color, turgor, temperature, and presence of lesions, rashes, bruises, excoriations, or previous incisions. Skin color may be pale, flushed, dusky, cyanotic, jaundiced, normal, or “other.”28

Place attention to areas over bony prominences. If the patient comes to the facility with a pre-existing pressure sore, make sure that it gets prompt treatment. Patients at high risk for skin breakdown should be managed aggressively with mobilization, a pressure-reducing mattress, and nutritional support.32

Check the color of the patient’s nail beds. If the nail bed is white, nursing nail polish, it may need to be removed to assess peripheral filling of the bed. Also, polish could interfere with pulse oximeter readings.31 It is possible to measure oxygenation and peripheral filling at other sites, such as the ear lobes.

Today’s trends include piercing of various body areas accompanied by the insertion of jewelry. In some circumstances, the ring or jewelry can be removed, which creates the need for planning regarding the potential for infection and electrosurgical burns. If the area pierced is involved in the surgical site, prepping will be of major importance to eliminate excessive bacteria which tends to accumulate around foreign objects. If the jewelry is metal, safeguards will be needed to prevent direct and indirect electrosurgical energy coupling during the procedure.

3. Determines mobility of body parts

Ask the patient about any history and dates of musculoskeletal illness, traumatic incidents (eg, fractures), paralysis, or orthopedic surgery, particularly joint replacement. Identify any family history of osteoporosis or bone cancer.

Assess balance, posture, gait, mobility, range of motion, and any gross deformities or physical handicaps. Look at muscle size, symmetry, and strength, particularly grip strength. Assess the patient’s ability to perform activities of daily living required to live independently. Elderly patients may be reluctant to give accurate information about functional ability, interpreting it as a threat to their ability to live independently. It may be necessary to tactfully obtain family members’ perceptions of the patient’s ability to manage daily activities.31

4. Reports deviation of diagnostic studies

Determine what laboratory, radiologic, and other diagnostic studies the physician ordered, and confirm that the results are on the chart. Review results of those studies to determine whether they are within normal ranges. Ask the patient if he or she has notified the surgeon, if necessary. Surgery can be delayed or canceled until certain conditions are resolved.30

Recommendations for laboratory testing have decreased substantially in recent years as preoperative laboratory screening has shifted from a paradigm of general health screening to testing based on specific clinical indications. For example, testing electrolytes, previously a mainstay of “routine” preoperative testing, is no longer performed without a specific reason such as the presence of diabetes, dialysis, or use of diuretic or potassium supplements.37

5. Checks vital signs

Assess the patient’s pulse, temperature, blood pressure, and respirations. Measure weight and height, and note the patient’s chronological age. Begin by taking a radial pulse, noting rate, amplitude, and deficits. If abnormalities such as irregular beats or skipped beats are noted, assess the apical pulse for a full minute and correlate with the respiratory cycle. Peripheral irregularities may reflect a cardiac irregularity, such as a sinus dysrhythmia, or indicate possible peripheral vascular incompetence. Because the pulse rate ranges between 60 and 100 beats per minute for the average adult, consider factors that may affect this range, such as extreme physical fitness, recent activity, anxiety, age, and side effects of medication. Record findings and compare to the patient’s baseline.

Assess body temperature and note elevations above normal. A febrile state also may be reflected in pulse and respiration measures elevated above baseline and a lower blood pressure. Presence of a fever inevitably means that the patient’s surgery must be delayed.

Measure the patient’s arterial blood pressure in the brachial artery.4 Using the sitting position unless specified otherwise. In addition to measurement error, factors that can affect blood pressure readings include age, sex, race, diurnal variations, exercise, stress, obesity, medication effects, position changes, recent food ingestion, ambient room temperature, disease processes, smoking, pain, and crossing the legs.38 If bilateral readings are taken, record the higher reading, not both unless specifically requested. If the discrepancy between the arms is greater than 10 mm Hg, notify the physician.4 If the patient has a history of hypertension, ask if he or she is taking antihypertensive medications or has a need for electrolyte replacement. 

Respirations are best assessed with the patient sitting quietly, chest and abdominal breath sounds heard. Notify the surgeon of the temperature and radial pulse. Count each cycle of inspiration and expiration, preferably for a full minute. While counting, listen for sounds that accompany respirations. Abnormal sounds include audible wheezes and the sounds that accompany narrowing or obstructed upper airway passages, such as whistling. Factors that affect respiratory rate include anxiety, increased awareness of low level of pain, anxiety, increased ambient air temperature, and medications. Normal respiratory rate ranges between 14 and 22 breaths per minute in the average adult. Compare findings to the patient’s baseline and record.4 Always communicate abnormal vital signs to the surgeon and anesthesia care provider.

Review the patient’s medical and surgical history, age, weight, and height, including metric equivalents for height and weight. If the patient is less than two years of age, record the age in months.4 Obese or excessively tall individuals may require additional positioning equipment during surgery.

6. Notes abnormalities, injuries, and previous surgery

Obtain a history of previous hospitalizations, surgeries, or other invasive procedures, including blood transfusions. Review the patient’s history for any history of allergy or sensitivity to another part and any congenital abnormalities.

Note the dates and the reasons for any previous hospitalizations, their outcomes, and the type of anesthesia used. Note any previous problems with surgery or anesthesia, including a personal or family history of excessive blood loss during surgery, transfusion reactions, hyperthermia under anesthesia, low level of pseudocholinesterase (the enzyme necessary for reversal of anesthetic paralyzing agents), or postoperative nausea and vomiting. If available, include old medical records with the patient’s chart.

Ask female patients of childbearing age about the possibility of pregnancy. Because of the teratogenicity of many anesthetic agents, some experts advocate mandatory pregnancy testing in all women of menstruating age who have not had a tubal ligation or hysterectomy. Others
7. Identifies presence of internal and external prostheses/implants

Note the presence of any implanted electronic device (IEG), internal or external venous access devices, or any surgical intervention to manage surgical risks. Palpate for thrills and murmurs over heart valve areas, and check for cardiomegaly, which is present if the apex of the heart can be percussion past the midclavicular line.

Note the presence of neck vein distention. Neck veins should be distended only if the patient lowers the head to assume the supine position; they should not distend if the patient remains in a sitting position. Jugular venous distention is associated with increased cardiac risk in surgical procedures.

Palpate the lower extremities for edema by pressing with the thumb to depress the skin over the shins or dorsum of the foot for five seconds. Upon release of pressure, note any depression lasting more than 3 seconds. If present, there should be none. Rebound edema is called "pitting edema." Document the length of time pitting is evident, if any.

Palpate pedal pulses. They should be of symmetric quality and readily palpable. If nonpalpable, look for other signs of adequate peripheral circulation, such as skin temperature (warm), color (even without mottling or cyanosis), and response to blanching of the nail beds or distal toes (ie, capillary refill within three seconds). If the patient has cold or pale feet, absent or diminished peripheral pulses, cyanosis or flushing of the extremities, or leg cramps when walking, pay particular attention to leg and foot care in the postoperative period.

Cardiovascular problems are particularly common in the elderly, especially in the presence of ischemic heart disease, congestive heart failure, arrhythmias, or recent myocardial infarction that must be treated or stabilized before the patient can have surgery. Ask if the patient has any history of progressive weakness, shortness of breath, syncope, diaphoresis, nausea, or vomiting and under what circumstances. Note any previous myocardial infarction, diabetes, stroke, or thromboembolism. Determine whether the patient is currently taking any medication for existing cardiovascular disease, such as nitroglycerin, digitalis, diuretics, antihypertensives, potassium supplements, heparin, or coumadin. Abruptly discontinuing medications, such as propranolol, can make angina worse and, in some cases, even bring on myocardial infarction. Verify that such medications have been withdrawn gradually over several days. Refer to the patient's vital signs.

8. Notes sensory impairments

Assess the patient's sensory abilities, including vision, hearing, and smell, and note the presence and severity of any deficits and the use of corrective devices. Sensory deficits can require adjustments to your interviewing techniques and can affect the patient's functioning and reaction to the surgical experience. For example, if a hearing deficit is noted, be sure there is adequate light during the patient interview to facilitate lip reading. Ask short, direct questions to avoid shouting, which can make speech perception difficult. If a hearing-impaired patient cannot read lips, use a preprinted health history questionnaire. If necessary, enlist the aid of family members or significant others.

9. Assesses cardiovascular status

Perioperative myocardial infarction is the leading cause of death after surgery. A thorough assessment of the cardiovascular system is necessary to detect cardiac problems such as hypertension, congestive heart failure, arrhythmias, or recent myocardial infarction that must be treated or stabilized before the patient can have surgery. Ask if the patient has any history of progressive weakness, shortness of breath, syncope, diaphoresis, nausea, or vomiting and under what circumstances. Note any previous myocardial infarction, diabetes, stroke, or thromboembolism. Determine whether the patient is currently taking any medication for existing cardiovascular disease, such as nitroglycerin, digitalis, diuretics, antihypertensives, potassium supplements, heparin, or coumadin. Abruptly discontinuing medications, such as propranolol, can make angina worse and, in some cases, even bring on myocardial infarction. Verify that such medications have been withdrawn gradually over several days. Refer to the patient's vital signs.

Tachycardia, tachypnea, and postural changes in blood pressure are all associated with cardiovascular disease. Assess the patient's activity level, exercise patterns, and any participation in cardiac rehabilitation activities.

Assaultate for heart sounds. Patients with auscultatory findings (ie, external carotid Doppler) for increased cardiac output as a result of increased venous and collateral blood flow. Assess the patient's respiratory rate, heart rate, and blood pressure.

Note the patient's respiratory rate, breath sounds, oxygen saturation, and arterial blood gases if ordered. Inspect the chest and auscultate the lungs directly through the chest wall, preferably with the patient sitting, legs dangling over the side of the examination table with the stethoscope beneath the patient's drapes or gown. A normal adult respiratory rate is between 14 and 22 breaths per minute, with even depth and rhythm; symmetric thoracic movements on inspiration; absence of audible sounds, retractions, or nasal flaring; and no use of auxiliary muscles. Palpate the lower extremities for edema by pressing with the thumb to depress the skin over the shins or dorsum of the foot for five seconds. Upon release of pressure, note any depression lasting more than 3 seconds. If present, there should be none. Rebound edema is called "pitting edema." Document the length of time pitting is evident, if any.

Palpate pedal pulses. They should be of symmetric quality and readily palpable. If nonpalpable, look for other signs of adequate peripheral circulation, such as skin temperature (warm), color (even without mottling or cyanosis), and response to blanching of the nail beds or distal toes (ie, capillary refill within three seconds). If the patient has cold or pale feet, absent or diminished peripheral pulses, cyanosis or flushing of the extremities, or leg cramps when walking, pay particular attention to leg and foot care in the postoperative period.

Cardiovascular problems are particularly common in the elderly, especially in the presence of ischemic heart disease, congestive heart failure, arrhythmias, or recent myocardial infarction (ie, within the past three to six months) myocardial infarction.

10. Assesses respiratory status

Determine if the patient has a history of pulmonary infections or urologic surgery, if he or she has experienced any recent changes in the color or appearance of the urine, pattern of urination, or ability to start or control urination. If the patient reports episodes of urinary incontinence, find out in what situation(s) the incontinence occurs. Note reports of intake/output, urinalysis, and renal function studies.

Note the presence of edema in pedal, pretibial, presacral, and periarticular tissues; altered level of consciousness; and gait and hand incoordination, any of which may be affected by the presence of renal disease. The glomerular filtration rate expresses efficiency of renal excretion and reabsorption. Resulting imbalances in fluids and electrolytes may contribute to cardiac complications or mental status changes.

11. Assesses renal status

Determine if the patient has a history of urinary tract infections or urologic surgery, if he or she has experienced any recent changes in the color or appearance of the urine, pattern of urination, or ability to start or control urination. If the patient reports episodes of urinary incontinence, find out in what situation(s) the incontinence occurs. Note reports of intake/output, urinalysis, and renal function studies.

Note the presence of edema in pedal, pretibial, presacral, and periarticular tissues; altered level of consciousness; and gait and hand incoordination, any of which may be affected by the presence of renal disease. The glomerular filtration rate expresses efficiency of renal excretion and reabsorption. Resulting imbalances in fluids and electrolytes may contribute to cardiac complications or mental status changes.

12. Notes nutritional status

To assess the patient's nutritional status and gastrointestinal functioning, find out if he or she has any history of gastrointestinal problems, along with the types of therapy used and their effectiveness. Ask about recent weight gain or loss; bowel and bladder habits; the presence, frequency, and nature of gastrointestinal bleeding, pain, constipation or diarrhea, incontinence, or vomiting; and ambient belching, gas, or flatulence. Acute gastrointestinal disorders, such as vomiting and diarrhea, may result in serious fluid and electrolyte imbalances.

Ask if the patient has a history of the presence of a Foley catheter, colostomy, or ileostomy. Check for the presence of teeth, dentures (upper/lower, partial), caps, or crowns.

List all medications used for gastrointestinal problems, including over-the-counter antacids, laxatives, enemas, and sodium bicarbonate. Auscultate, percuss, and palpate the abdomen and observe its contour (ie, obese, flat, distended, or high).

Confirm the patient's nothing-by-mouth (NPO) status. Ask the patient when he or she last ate or drank anything (including water). Although the patient should have been instructed not to eat or drink anything after midnight (or according to facility anesthesia protocols), it is important to make sure those orders were followed.

Evaluate the patient's fluid and electrolyte status and recent fluid intake and output. Mildly dehydrated patients are more likely to become hypotensive with induction of anesthesia; therefore, it is wise to have an IV infusion in place before induction.

Evaluate the patient's weight for signs of alteration in nutrition (ie, more or less than body requirements). Ask about typical eating patterns and salt intake, and note suspicious eating habits. If a history of intravenous drug use is obtained, assess for signs of nutritional alteration (ie, malnutrition). If you detect severe nutritional deficiencies, contact the physician. Poor nutritional status is highly correlated with delayed recovery, longer hospital admissions, and higher mortality rates, but there is some indication that nutritional supplements in the preoperative period may improve surgical outcomes. It may be desirable to postpone surgery until nutritional problems are corrected.

Because of metabolic changes, disease processes and their treatment, and environmental and psychological circumstances, the elderly are at increased risk for poor nutritional status compared to younger adults. Ten to 20% of the elderly have borderline nutritional status, which places them at risk for postoperative skin
breakdown, impaired wound healing, and infection. Patients most likely to be poorly nourished are those who are depressed, demented, immobilized, or isolated. The multifactorial nature of their nutritional risk makes assessment of nutritional status in the elderly a complex task. Simple nutritional screening tools can be used to evaluate mental condition, weight, appetite, ability to eat, gut function (eg, presence or absence of diarrhea, vomiting, nausea), medical condition, and presence and severity of pressure sores.

13. Verifies allergies

Carefully document any history of allergies or hypersensitivity reactions to foods (particularly egg, because egg antigens can be found in the suspending fluid of some vaccines), environmental allergens, chemicals, tapes, medications (eg, antibiotics, narcotics, local anesthetics), iodine products such as povidone iodine, soaps, hexachlorophene, or latex.

If the patient reports a history of allergies or hypersensitivity reactions, determine the agent involved and the type of reaction experienced. Any history of anaphylaxis, asthma, or other respiratory difficulties related to the presence of allergens, toxins, or antigens should be noted and communicated to the anesthesia care provider.

In recent years, severe anaphylactic reactions and even deaths have occurred because of latex allergies. The risk of serious anaphylactic reactions increases in patients who are sensitized to latex and who are exposed to latex-containing products. These risk factors include multiple intra-abdominal or genitourinary surgical procedures, especially starting in the phase must be thoroughly documented in retrievable form, so that arrangements can be made even before the patient is admitted. The earlier contacts are initiated with caregivers, durable medical supplies, and follow-up care discharge planning begins during the assessment phase. Collection and communication of physiological assessment data help identify potential needs for in-home caregivers, durable medical supplies, and follow-up care so that arrangements can be made even before the patient is admitted. The earlier contacts are initiated with appropriate social services or rehabilitation agencies and facilities, and the process is ongoing throughout the patient's hospitalization. To provide appropriate post-discharge care, these agencies will need access to complete assessment information, which is considered a legal document and an official aspect of the patient's record.

16. Communicates/documents physical health status

All physiological data collected during the assessment phase must be correlated and documented in retrievable form, so that they can be easily accessed by other members of the perioperative team, including other nurses, anesthesia care providers, and surgeons. Professional accountability demands documentation and communication of both the process and the outcome of nursing assessment and intervention to the entire perioperative team. Documentation of assessment findings helps promote continuity of care when patients are sedated and cannot answer questions reliably.

Any structured format used should enable the nurse to collect comprehensive data about the patient for the purpose of identifying and treating health problems.

PSYCHOSOCIAL ASSESSMENT

Psychosocial assessment involves assessing both the patient's and the family's knowledge level concerning the perioperative experience and ability to adhere to the prescribed therapeutic regime, implement self-care activities, handle fear, deal with anticipatory anxiety, recognize and resolve a body image disturbance, grieve successfully, and effectively cope with the stress associated with the surgery.

The AORN “Competency Statements in Perioperative Nursing” define the following nine measurable criteria that comprise competency to assess the psychosocial health status of the patient/family.

1. Elicits perception of surgery

Based on the patient’s verbal and nonverbal behavioral responses, assess for her perception of the impending surgery and the appropriateness of that perception. Attitudes toward surgery may include anxiety, anger, depression, body image disturbances, or relative calm.

Anxiety is a state of apprehension, tension, concern, or uneasiness in response to a real or imagined danger. Physiological manifestations of anxiety include pallor, cold, clammy skin, hand tremors, muscle tension, rapid pulse, and shallow breathing. Psychological manifestations include restlessness, wringing of hands, difficulty maintaining eye contact, general irritation, sullenness, withdrawal, crying, and defensiveness.

Anxiety may take the form of increased questioning or information-seeking about the perioperative experience, voice tremors or pitch changes, increased verbalization or rate of verbalization, and a narrowing focus of attention.

Most surgical patients will appropriately experience some degree of anxiety. The amount of anxiety a patient will experience depends on his or her current illness, past experiences, expectations, and coping mechanisms.

Children’s reactions to the environment vary. Their responses and behavior correspond with their age (eg, a toddler may display regressive behavior). It may be easy to assess and offer reassurance to obviously anxious children, but silent and cooperative children may be experiencing just as much anxiety or fear.

Recognizing the fears and fantasies of children can help prevent some of the transient disturbances associated with pediatric surgical experiences (eg, increased dependency, excessive fears, eating and sleeping disturbances). Prevention is essential. The nurse must help the patient to maintain their body image and self-concept. Explore any changes or crises, if any, that have occurred in the patient’s physical appearance or functioning during the past year. Assess the patient’s feelings about any changes in physical appearance that will occur as a result of surgery. Make a note if surgery will entail removal of, change in, or scarring of a body part that is significant to sexual identity or is visible to others. Patients may experience difficulty in integrating the impending body change and may feel that the body will be imperfect after surgery.

A patient who appears emotionless or apathetic with regard to the surgery actually may be depressed. Statements indicating a sense of hopelessness by the patient may warrant further evaluation. Depression at high levels of severity, can have adverse effects on post-operative outcomes. The depressed person frequently has symptoms, such as decreased energy and motivation, loss of appetite, and numerous physical complaints that may result in increased analgesic use.

The patient may worry about the anticipated loss of a body part or its usual functioning during or after surgery. Some patients may also fear that if surgical outcomes are basically corrective. Radical procedures may trigger anxieties about dismemberment, major alterations in body structures, paralysis, or possible death. If the patient reports distress at an anticipated loss, crying at frequent intervals, having a choked feeling, a change in eating or sleeping habits, changes in activity level or libido, or alterations in sexual function that threaten a patient’s body image, should be identified as a potential psychosocial problem.

Some patients will be angry about the need for surgery. Frequently, patients will tend to use passive-aggressive behavior to express anger, such as sulking or refusing to talk, rather than active, direct anger.

2. Elicits expectation of care

Patients may be worried or nervous about the outcome of the impending procedure, the amount of discomfort or
pain they will feel, or being away from dependent relatives. Others will be less anxious and will have confidence in doctors and nurses to carry out procedures successfully.8 Try to assess the patient’s beliefs about how surgery will affect his or her current lifestyle. Determine whether the patient is ready to accept that some degree of disability, sensory impairment, language barriers, diminished mental capacity, and low education attainment. All of these will have to be considered when planning nursing care.9

Assess readiness and ability to learn new information, paying particular attention to intellectual functioning, including any deficits in memory, intelligence, thinking, learning, and problem solving that are serious enough to affect daily life. In the elderly, cognitive functioning should be verified with a family member, if possible, and validated through mental status screening.9 Much of this evaluation can occur in the context of an informal interview. Asking the patient to describe events leading up to the need for a surgical procedure, how various activities of daily living are managed, and what plans have been made for postdischarge care will provide a fairly good indication of the patient’s cognitive processes. Formal mental status testing using a tool such as the Mini Mental State Exam also may be valuable in providing an accurate assessment of cognitive abilities.8

Often, attention span is one of the first cognitive functions to be disturbed. Attention to external conditions may be diminished, and the patient may have difficulty following directions or completing tasks. This is often a sign of depression. Attentiveness to external conditions also may be valuable in providing an accurate assessment of cognitive abilities.8

Items to be assessed under the broad category of sensorium and reasoning include level of consciousness; orientation to person, place, and time; recent and remote memory; ability to calculate and reason abstractly; judgment; and intelligence.8 For patients with diminished mental capacities (eg, patients with Down’s syndrome), use simple, clear language with concrete instructions, repeating instructions often. Allow enough time for the client to process the information and to express comprehension.9 Make sure another person is available to hear all information and instructions given and to supervise implementation of the plan of care at home.

5. Determines ability to understand
After the patient’s current knowledge level is ascertained and teaching needs are identified, it is important to assess the patient’s ability to understand further instructions. Barriers to comprehension of patient education include psychological, physiological, sensory, cognitive, language, and socioeconomic factors.83

6. Identifies philosophical and religious beliefs
Patients’ philosophical and religious beliefs may influence their attitudes toward health and illness and affect their cooperation with prescribed treatment regimens. Assess the patient’s religious affiliation, attitude toward blood, feelings about the use of anesthesia, and feelings toward blood transfusions, sacrament of the sick, and disposition of limbs. Clues to the individual’s values in relation to caring behaviors, norms, beliefs, and practices can be obtained by observing behaviors and verbal and emotional expressions. For example, some patients believe that illness is evil, and that only God can really help one survive, while others believe that humans control their own destinies and that one’s own actions are the cause of one’s own health or illness.8 Such beliefs influence the patient’s attitude toward their own illness and treatment.

7. Identifies cultural practices
It is important to remember that not all patients hold, or should hold, the same cultural values as the nurse. Culture, in the anthropological sense, broadly refers to the learned, shared, and transmitted values, customs, and practices of a particular group that guide thinking, decisions, actions, and patterned ways. Subcultures constitute groups of people who have cultural values similar to a larger society, but who also hold additional values particular to certain patterns of living. In the United States, we have subcultures that are defined by age, profession, or educational attainment, in addition to ethnic and/or cultural subgroups. These subgroups are typically defined by the values of a given culture or subculture different from the dominant culture in a population depends on the degree to which acculturation into a different or predominant cultural group has taken place.

Assess the following culture-specific factors when planning appropriate nursing interventions: perceptions of wellness or general health, perception of what constitutes illness, and how the patient wishes to be helped by family members or health care personnel. Every culture has prescribed ways of behaving (ie, taboos) in order to prevent actual or possible harm to self and others, as well as stories (ie, myths) that explain the reasons for behaving in a prescribed manner.8 All of these factors have an impact on the patient’s learning needs, ability to learn, and ability and willingness to perform self-care activities.
8. Communicates psychosocial data relevant to planning
Collection and communication of psychosocial assessment data help identify potential needs for assistance in the preoperative, intraoperative, and postoperative periods. Patients with identified psychosocial needs can be put in touch with appropriate support groups and counseling services.

9. Communicates/documents psychosocial status
Psychosocial assessment findings must be clearly communicated in the formal patient record. Health care facilities often use an inventory-type assessment form based on functional health patterns. The nurse uses the inventory format to question the patient about health patterns related to rest, sleep, food and fluid intake, and elimination. All too often, these inventory formats do not consider such important assessment areas as a patient’s home situation and conditions, sexual relationships, and coping strategies. Just like physiological assessment, documentation of psychosocial data is critical to continuity of care. Psychosocial data that must be recorded and communicated include the patient’s understanding of the planned procedure, mental-emotional behaviors, and preoperative teaching needs.

REASSESSMENT
Perioperative assessment does not end in the preoperative period. Data collection must be continuous and systematic throughout the patient’s perioperative experience. Nurses must be competent to continuously reassess all components of patient care based on new data. For example, frequent observation of the patient and reassessment of vital signs, with particular attention to respirations and consciousness, are necessary after premedication is administered. Oxygenation status is monitored throughout the perioperative period to identify potential complications as soon as possible. Postoperative complications may be asymptomatic or manifested by subtle symptoms, such as a mild fever or change in other vital signs, fatigue, weakness, or mental status. During this time, breath sounds and respiratory rate should be monitored frequently. Pulse oximetry monitoring of oxygen saturation should be routine in all patients. Blood pressure, pulse, and urine output also should be closely monitored.

IMPLICATIONS FOR NURSE MANAGERS
Obviously, careful assessment of all of these physiological and psychosocial factors takes time, and it is imperative that priorities be set for nursing activities. The challenge for nurse managers is to streamline the assessment process, while ensuring that patient care is not compromised. Numerous investigators have outlined ways in which hospital-based recordkeeping can be made more efficient, and computerized checklists and recordkeeping systems continue to evolve in ways that make collection, documentation, and communication of assessment data easier and more accurate. Each facility must find the system that seems to work best for its staff members and patients.

Another development that has had a significant impact on the process of perioperative assessment is ambulatory surgery. Sophisticated surgical techniques and shorter hospital stays mean that patients are in and out of the hospital much faster. It is estimated that approximately one-half of all surgical procedures are performed on an outpatient basis. Nurses must be competent to continuously reassess patients who are being admitted for assessment one or two days before surgery, patients often are assessed as outpatients, usually 10 to 14 days before their procedures.

Increasingly, facilities are going to “user-friendly, one-stop” preoperative evaluation clinics where elective surgery patients can give histories and undergo physical examinations, have laboratory and diagnostic tests performed, meet with anesthesia care personnel, and receive preoperative instructions. Patients can be referred to these clinics directly after they have been evaluated by a surgeon and scheduled for surgery (to take place within 30 days). They come with their medical records in hand, which at a minimum include a current surgeon’s history and physical examination and a signed surgical consent form.

The objectives of such programs are to optimize the health of the patient before surgery, assess preoperative and postoperative health care needs, and plan the most appropriate perioperative management. In addition, such programs can identify high-risk patients early enough to inform physicians, third-party payers, and patients of matters that may alter costs, claims, and distributions of financial responsibility.

SUMMARY
Thorough patient assessment increases the effectiveness, efficiency, and safety of nursing care rendered throughout the perioperative period by increasing awareness of the patient’s actual and potential health problems. Collecting data during the perioperative assessment phase enables the perioperative nurse to make appropriate nursing diagnoses, identify expected outcomes, plan and implement appropriate intraoperative care for the patient, and evaluate the extent to which the patient is returned to normal functioning postoperatively. Well-developed assessment skills, combined with clear documentation and communication with the entire perioperative health care team, help the patient achieve the desired surgical outcome without suffering any unnecessary complications.
### APPENDIX 1

AORN’s publication, *Standards, Recommended Practices, and Guidelines*, includes “Standards of Perioperative Clinical Practice.”

### Standard I: Assessment

The perioperative nurse collects patient health data.

**Interpretive statement:**

Assessment is the systematic and ongoing collection of data, guided by the application of knowledge of physiological and psychological principles and experience, and is used to make judgments and predictions about a patient’s response to illness or changes in life processes. Assessment is essential to establishing a nursing diagnosis and predicting outcomes. Assessment may occur in a variety of settings.

**Criteria:**

1. The priority of data collection is determined by the patient’s immediate condition or needs and the relationship to the proposed intervention. Pertinent data include, but are not limited to, current medical diagnosis and therapies; physical status and physiological responses; psychosocial status of the patient; cultural, spiritual, and life-style information; the individual’s understanding, perceptions, and expectations of the procedure; previous responses to illness, hospitalizations, and surgical, therapeutic, or diagnostic procedures; and results of diagnostic studies.

2. Pertinent data are collected, using appropriate assessment techniques.

3. Data collection involves the patient, significant others, and health care providers when appropriate. It may be accomplished through diverse means, such as interview, review of records, assessment, and/or consultation.

4. Data collection is systematic and ongoing.

5. Relevant data are documented in retrievable form.\(^{108}\)

### APPENDIX 2

AORN’s publication, *Standards, Recommended Practices, and Guidelines*, includes “Competency Statements in Perioperative Nursing.”

**Competency Statements**

**I. Competency to assess the physiological health status of the patient.**

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<tr>
<th>Measurable Criteria</th>
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<tbody>
<tr>
<td>1. Verifies operative procedure</td>
<td>1.1 Consent form</td>
</tr>
<tr>
<td>2. Notes condition of skin</td>
<td>2.1 Rashes</td>
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<tr>
<td>3. Determines mobility of body parts</td>
<td>3.1 Patient’s statement</td>
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<tr>
<td>4. Reports deviation of diagnostic studies</td>
<td>4.1 Laboratory values</td>
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<tr>
<td>5. Checks vital signs</td>
<td>5.1 Blood pressure</td>
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<td>6. Notes abnormalities, injuries, and previous surgery</td>
<td>6.1 Loss of extremity/body part</td>
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<td>7. Identifies presence of internal and external prostheses/implants</td>
<td>7.1 Pacemakers</td>
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<td>8.2 Visual deficit</td>
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<td>8.3 Tactile deficit</td>
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<td>8.4 Speech</td>
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<td>9.2 Arrhythmias</td>
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<td>9.3 Edema</td>
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<td>9.4 Electrocardiogram</td>
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<td>9.5 Hemodynamic parameters</td>
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<td>10.2 Breath sounds</td>
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<td>10.3 Oxygen saturation</td>
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<td>10.4 Arterial blood gases</td>
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<th>Examples</th>
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<td>11.2 Urimalysis</td>
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<td>11.3 Renal function studies</td>
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<td>12.2 Weight</td>
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<td>12.3 Skin turgor</td>
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<th>Examples</th>
<th>14.1 Skin changes</th>
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### II. Competency to assess the psychosocial health status of the patient/family.

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<th>Examples</th>
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<td>1.2 Behavioral responses</td>
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<td>4.2 Lack of relevant information</td>
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<tbody>
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<td>16.2 Patient record</td>
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NOTES

11. Ibid.
12. Ibid.
13. Rothrock, 1367.
21. Ibid., 32.
23. Ibid., 28.
26. Ibid., 145.
28. Ibid.
34. Leckrone, “Preparing your patient for surgery,” 48-49.
45. Zambicki, 613-614; Keene, “Cardiovascular and respiratory assessment in the office setting,” 183.
47. Ibid., “Cardiovascular and respiratory assessment in the office setting,” 184.
49. Ibid., 141-142.
51. Ibid., “Nursing management of the elderly surgical patient,” 142.
55. Ibid., “Preoperative assessments: Can we afford to do without them?” 586.
58. Ibid, 610.
64. Zambricki, “Clinical aspects of the preanesthesia evaluation,” 615.
66. Fromm, Metzler, “Preparing the older patient for surgery,” 40.
73. “Competency statements in perioperative nursing,” 85-86.
75. L. Thompson, “Preoperative assessments: Can we afford to do without them?” 586.
78. Lusis, “Nursing management of the elderly surgical patient,” 141.
84. Zambricki, “Clinical aspects of the preanesthesia evaluation,” 615.

85. Ibid, 43; Luis, “Nursing management of the elderly surgical patient” 146.

86. Keene, “Perioperative assessment and nursing implications for the elderly,” 145.


88. Luis, “Nursing management of the elderly surgical patient,” 141.


91. Luis, “Nursing management of the elderly surgical patient,” 140.

92. Ibid, 144-145.


96. Ibid.

97. Ibid, 27.

98. Ibid, 27.


101. R M Tappen; J Muzic; P Kennedy, “Preoperative assessment and discharge planning for older adults undergoing ambulatory surgery,” AORN Journal 73 (Feb 01) 464.


106. Ibid.


SUGGESTED READINGS


11. To assess the patient for “pitting edema,” depress the skin
   a. over the shin for five seconds, and then release.
   b. over the neck veins for five seconds, and then release.
   c. over the shin for 15 seconds, and then release.
   d. over the axilla for five seconds, and then release.

12. The lungs should be auscultated with the patient
   a. sitting, with legs dangling over the side of the examination table.
   b. sitting, with the legs up on the examination table.
   c. supine, with the legs dangling over the side of the examination table.
   d. supine, with the knees bent and the feet on the examination table.

13. Data about alcohol intake and recreational drug use are
   a. not necessary.
   b. not reliable.
   c. essential.
   d. best obtained in the presence of family members.

14. Discharge planning begins during the
   a. assessment phase.
   b. planning phase.
   c. implementation phase.
   d. evaluation phase.

15. Cold, clammy skin may be a sign of
   a. inadequate room heating.
   b. poor circulation.
   c. anxiety.
   d. a febrile illness.

16. Destructive behavior toward self or others is a sign of
   a. anxiety.
   b. depression.
   c. poor coping mechanisms.
   d. type A behavior.

17. A history of noncompliance with previous instructions for self-care may be indicative of
   a. denial of illness.
   b. a perception that recommended therapeutic regimens are ineffective.
   c. a lack of understanding of the seriousness of the patient’s health problems.
   d. any of the above.

18. In the anthropological sense, prescribed ways of behaving to prevent actual or possible harm to self and others are called
   a. myths.
   b. taboos.
   c. cultures.
   d. philosophies.

19. By establishing preoperative evaluation clinics for outpatients, hospitals have
   a. increased laboratory use.
   b. increased surgical cancellation rates.
   c. decreased length of stay for surgical patients.
   d. improved patient outcomes.

POSTTEST

Multiple Choice: Please choose the one answer that best completes the following statements.

1. Assessment data are collected
   a. preoperatively.
   b. intraoperatively.
   c. postoperatively.
   d. all of the above.

2. Assessment data may be collected from
   a. the patient.
   b. the patient’s family members.
   c. other health care providers.
   d. all of the above.

3. In the course of the preoperative assessment, the perioperative nurse should
   a. obtain informed consent from the patient.
   b. ensure that a signed informed consent is in the patient’s chart.
   c. explain the risks and alternatives of the planned procedure.
   d. all of the above for this information.

4. When addressing the patient during the preoperative interview, the nurse should
   a. use the patient’s first name.
   b. use the patient’s title and last name.
   c. ask permission before using the patient’s first name.
   d. wait for the patient to say how he or she wishes to be addressed.

5. The information given by a patient during the assessment interview
   a. is always assumed to be correct.
   b. may not always be correct and should be checked against another source if there is any question about its accuracy.
   c. should always be checked against another source.
   d. must be accepted; there is no other source for this information.

6. Use of the hands and fingertips on the patient’s skin to distinguish temperature variations, hard and soft, rough and smooth, and stillness and vibration is called
   a. auscultation.
   b. percussion.
   c. palpation.
   d. inspection.

7. The patient’s identity should be verified
   a. verbally (whenever possible).
   b. by checking the patient’s chart.
   c. by checking the patient’s identification bracelet or wristband.
   d. all of the above.

8. Surgical sites should be marked preoperatively
   a. when the surgery involves limbs.
   b. when the surgery involves bilateral organs.
   c. when the surgery involves multiple structures or levels.
   d. all of the above.

9. When gathering information about medications that the patient is taking, it is important to include
   a. physician prescribed medications.
   b. over the counter medications and vitamins.
   c. herbal medications that the patient may be taking.
   d. all of the above.

10. When conducting a perioperative assessment of a hearing impaired patient, it may be helpful to
    a. have the patient face toward the light to facilitate lip reading.
    b. shout at the patient.
    c. ask short, direct questions.
    d. let the surgeon conduct the assessment.

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    b. depression.
    c. poor coping mechanisms.
    d. type A behavior.
Perioperative Patient Assessment

Answer Sheet

Question Answer

1. D
2. D
3. B
4. C
5. B
6. C
7. D
8. D
9. D
10. X
11. A
12. A
13. C
14. A
15. C
16. C
17. D
18. B
19. C

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