Perioperative Care

Consent, NPO times, home medications, checklist and time-out; PACU priorities and Aldrete; post-op complications by timing, dehiscence, malignant hyperthermia

CONSENT AND THE PRE-OP CHECKLIST

- The surgeon (person doing the procedure) explains it and obtains consent; the nurse checks a signed form is in the chart and may witness the signature
- The client signs before any mind-altering premedication; questions, poor understanding or sedation: do not proceed, ask the provider to come back
- Signed consent must be on the chart before surgery, except in an emergency (CMS)
- Checklist: H&P, consent, nursing and anesthesia assessments, labeled results and images, blood, implants and devices ready
- Verify the correct client, procedure and site with the client taking part
- Ask about a personal or family history of anesthesia problems (malignant hyperthermia)
- Same-day surgery after sedation or anesthesia: a responsible adult must take the client home

NPO BEFORE ELECTIVE ANESTHESIA (ASA, HEALTHY CLIENTS)

INTAKE	STOP AT LEAST
Clear liquids: water, pulp-free juice, soda, clear tea, black coffee (no alcohol)	2 h
Breast milk	4 h
Infant formula, nonhuman milk, light meal (toast and clear liquid)	6 h
Fried or fatty food, meat	8 h or more

EXAM TIP These are minimum times, so a healthy client does not need to fast from midnight. Pregnancy, obesity, diabetes, reflux, bowel obstruction, emergencies and tube feeding fall outside the ASA times, and GLP-1 drugs slow emptying: the anesthesia provider decides.

HOME MEDICATIONS

DRUG	USUAL PLAN (PRESCRIBER ORDERS DECIDE)
Warfarin	Stopped 5 days before; bridging with LMWH is not routine in AF (more bleeding)
DOAC (apixaban, rivaroxaban, dabigatran)	Held 1 day before low-bleed, 2 days before high-bleed surgery; no bridging
Aspirin, clopidogrel, NSAIDs, supplements	The surgeon sets the plan; record the last dose and report any taken
Metformin, other oral diabetes drugs	Hold the day of surgery
SGLT2 inhibitor (-gliflozin)	Hold 3–4 days before (euglycemic DKA)
Insulin	Usually reduced, not stopped: basal to 75–80% (NPH to half); glucose 100–180, check every 2–4 h while NPO
GLP-1 agonist (-glutide)	Tell anesthesia: delayed emptying, aspiration risk; plan is individualized
Beta-blocker	Continue if taken long term; do not start one on the day of surgery

SITE MARKING AND TIME-OUT (JOINT COMMISSION)

- Verify the correct client, procedure and site, involving the client, before the procedure
- Mark the site when there is more than one possible location (side, digit, level); the licensed practitioner who will do the procedure marks it, with delegation only in limited cases
- Mark must stay visible after prep and draping; an alternative process covers refusal, mucosa, teeth, premature infants
- Time-out immediately before the incision, led by a designated member, with surgeon, anesthesia, circulator and tech
- Team agrees at least on client identity, site and procedure; repeat it if the person performing changes; document it

PACU PRIORITIES

1. Airway, breathing, SpO2: oxygen for clients at risk of hypoxemia; suction at the bedside
2. Circulation: pulse, BP, ECG available; dressings and drains for bleeding
3. Mental status, temperature (warm the hypothermic client), pain, nausea, fluids
4. After naloxone or flumazenil, watch longer: sedation and respiratory depression can return

Phase I discharge at 9 or more of 10. ASA: voiding or drinking is not required of every client, and there is no mandatory minimum stay.

MODIFIED ALDRETE	2	1	0
Activity	Moves 4 limbs	Moves 2	None
Respiration	Deep breath, coughs	Dyspnea, shallow	Apnea
Circulation (BP vs pre-op)	Within 20%	20–49%	50% or more
Consciousness	Fully awake	Rouses to voice	No response
SpO2	Over 92% on room air	Needs O2 for over 90%	Under 90% on O2

POST-OP COMPLICATIONS BY TIMING

WHEN	PROBLEM	CUES	NURSING ACTION
OR to first hour in PACU	Malignant hyperthermia	Rising EtCO2, tachycardia, rigidity, jaw spasm; fever late	See below
From PACU on	Hemorrhage	Blood on dressings or in drains; rising pulse, falling BP	Stay, call for help and the surgeon, fluids or blood, prepare for OR
First days	Atelectasis	Shallow breathing, dyspnea, cough, chest pain; mild cases may show nothing	Deep breathing, incentive spirometer, move and walk early
First days; prolonged if past day 4	Paralytic ileus	Distension, nausea and vomiting, no flatus or stool	NG to suction if vomiting, IV fluids and K+, opioid-sparing pain control, gum if ordered
Within 30 days (90 for some implants)	Wound infection	Pain, swelling, redness, heat, purulent drainage	Culture, report, antibiotics as ordered, hand hygiene
Mean day 9; 90% by day 15	Dehiscence, evisceration	Gush of pink fluid, 'something gave way' with a cough	See warning
Any time	DVT, PE	One swollen, warm, painful leg; sudden dyspnea, chest pain, fast heartbeat	Prevent: move early, compression stockings, anticoagulant as ordered

SAFETY Dehiscence or evisceration: stay with the client and have someone call the surgeon. Low Fowler with knees bent, cover with sterile saline-moistened gauze, keep NPO. Never push organs back in.

SAFETY Malignant hyperthermia: stop volatile gas and succinylcholine, get help and the MH cart, 100% O2 at 10 L/min, dantrolene 2.5 mg/kg IV repeated until signs ease, cool if over 39 °C (stop under 38 °C), treat high K+, keep urine over 1 mL/kg/h, monitor at least 24 h.

Sources (20) are listed with links at rnbasics.com/sheets/perioperative-care.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. RN Basics is an independent study aid not affiliated with any certifying body.