Surgical Specialty Nursing Guide Improves Nursing Confidence Betsy Hannam, BSN, RN; VA Portland Health Care System, HEALTH Portland OR

Background

At the VA Portland Health Care System (VAPORHCS) Portland hospital, nurses on a 28 bed medical/surgical unit were expressing a lack of confidence in managing post-operative patients. There are 10 surgical specialties that admit to this acute care unit. Within that unit, the staff of about 60 nurses could potentially receive a patient who has had one of over 80 surgical procedures. Nurses are expected to competently care for these patients and anticipate and efficiently manage possible acute issues. As a result, the new and seasoned nurses felt overwhelmed and intimidated, causing a lack confidence, by the need to provide optimal care for these patients given of the vast range of expected knowledge necessary to provide that level of care.

Purpose

To increase nursing confidence in caring for the diverse medical/surgical population, since selfconfidence directly affects nursing practice, and to create an easily accessible Surgical Nursing Guide through RN/provider collaboration.

Methods

In October of 2015, nurses on the medical/ surgical unit (n=18) were given a questionnaire using a 5 point Likert Scale to rate their confidence from "not at all confident" to "very confident" in three areas:

- Knowledge of commonly seen surgical procedures
- Speaking with providers regarding procedures
- Educating patients on procedures

The Unit Based Council, comprised of staff nurses, developed and widely distributed a Surgical Specialty Nursing Guide that had been edited by Physicians, containing 70 of the most commonly seen procedures on the unit. Each procedure included description, photos, postoperative complications, and appropriate management decisions.

After 2 months, staff nurses (n=20) were given the same questionnaire to assess their level of self-confidence.

Orthopedics

- Open Reductio and In ternal Fixatio (OR I F) Procedure in brief
- An open reductio and internal fixatio (ORIF) is a type of surgery used to fix broken bones. This is a two-part surgery. First, the broken bone is reduced or put back into place. Next, an internal fixatio device is placed on the bone. This can be done with screws, plates, rods, or pins that are used to hold the broken bone together. • Reasons for Procedure: This surgery is done to repair fractures that would
- not heal correctly with gastin or splightin alone. Surgical complicatios • Thromboembolic events, compartment syndrome (potentialy limb- and
- life-threatening), infectio, nerve or blood vessel impingement, avascular necrosis, posttraumatic arthritis and fracture blisters.
- Management Decisions (Ndtify team of any abnormal fini rgs): Thromboembolic events (PE, DVT, etc.)nPatie ts with significant fractures who are immobile for 10 days or longer have a 67% incidence of thrombosis (Canale). Ensure prophylactic measures in place; TED and SCD's as ordered (should come up from PACU with these), MOBILITY, Heparin or Enoxaparin
- Neurovascular checks Peripheral nerve injury is suspected if a patie experiences motor or sensory deficencies. Nerve injury may indicate immediate reductio of the fracture and possible nerve exploratio. Arte rial injury, indicated by decrease in pulses, may indicate realignment of limb.

Urology Cystectomy

Desoriptio

- Indicatios: Bladder Cancer or severe recurrent lower urinary tract issues such as neurogenic bladder, UTI's, etc
- Removal of bladdern4 optios for urinary tract reconstructio (urostomy Indiana pouch, neobladder, ureterostomy
- Neobladder: new bladdenmade from porteo of intestins, hooked to ureters and urethra • Continn t urinary diversion (indiana pouch): piece of intestin that
- connects from kidneys to small reservoir attached to abdominal wall Catheter used to empty bladder
- Ileal Conduit: Porteo of intestins that is sutured to ureters and other end creates a stoma attached to abdominal wall
- **Post-op Care:** • ICU post op, up to ward POD # 1-2
- JP, Foley (pelvic drain for approx. 1-3 days), urostomy, NGT (if needed) Pain control: PCA-> oral meds
- Mucus present in urine, secreted by intestins as result of irritatin effect of urine
- Neobladders and continn t cutaneousldiversions will need to be handirrigated to clear mucous at least BID initialy, patie t will need to learn
- how to do prior to discharge NPO ->clears->solids
- Ambulate POD #3 • IS, SCD's, prophylactic anticoagulatio gtartin 24-48 hours postop if Hct
- Nound Care • Lower abdominal incision
- JP drain (moderate to large output) Foley (pelvic drain) removed POD #2-:

Ear Nose and Throat

- Thyroidectomy • Indicated in hyperthyroidism when tumor, goiter size, or poor response to medicatio is present
- Can include all or a portio of the thyroid (subtotal thyroidectomy) • Typically results in requiring thyroid hormone replacement post-op.
- Pre-op care • Thyroid is treated with medicatio to hopefully bring as close to normal in
- regard to thyroid functio. • Iodine may be given leading up to surgery to decrease thyroid size and amount of blood vessels present.
- Post-op care Monitor airway
- Ensure gag reflex and swallow are present Pain management
- Post-op complicatios
- Hemorrhage- Most common in 1st 24 hours. Monitor back of neck as blood can pool in dependent tisues
- Respiratory distress- monitor for strido • Hypocalcemia and tetany- if parathyroid is damaged or blood flow is
- reduced to parathyroid. Observe for parethesias and muscle twitching. Laryngeal Nerve Injury- Can result in hoarse voice Thyroid storm - serious complicatio. Can manifest with fever, tachycardia,
- and systolic hypertension.
- Wound Care
- Provider will assess wound. Suture removal can occur as early as 3rd or 4th day post-op ParaThyroidectom
- Indicated for hyperparathyroidism. Peri-operative care is identical to the thy roidectomy with added attentio to observatio for s/s hypocalcemia.

General Surgery

Colectomv

- Severe uncontrolled GI bleed, bowel obstructio, colon cancer, ulcerative colitis diverticl itis, Chron's disease
- Procedure: Total: Removing the entire colon • Partian(subtotal): Removing part of the colon
- · Hemicolectomy: removing the R or L portio of the color Proctocolectomy: removing both the colon and rectum
- Pre-procedure care
- Bowel Prep NPO at midnight Antibotics
- Post-op care:
- Ileostomy care: Stoma assessment, whether it's pink, beefy, inverted or protrading, or fluhed Educatio to patie t regarding stoma and ostomy bag (placement or replacement), showering
- Antibotics pain managemen • Advance diet as tolerated from clear liquid, possible TPN and lipids, long termelow fibr diet
- Encourage mobility to stiml a te bowel motilty • Abdominal precautios, no liftig, or pushing over 30 pounds or do abdominal exercises

Vascular Fem-Pop Bypass

Procedure in brief:

- Femoropopliteal (fem-pop) bypass surgery is used to bypass diseased blood vessels above or below the knee · Femoropopliteal (fem-pop) bypass surgery is used to bypass narrowed or blocked arteries above or below the knee. The bypass restores blood flow
- to the leg. To bypass a narrowed or blocked artery, blood is redirected through a graft The graft is either a healthy blood vessel that has been transplanted or a man-made material. This graft is sewn onto both the femoral and
- popliteal arteries so that blood can travel through the graft and around the diseased par Femoral popliteal bypass is the surgical opening of the upper leg to directly visualize the femoral artery. It is performed to bypass the blocked portio a of the artery using a piece of another blood vessel. Blood vessels, or vein grafts used for the bypass procedure may be pieces of a vein taken from
- the legs. One end of the vein graft is attached above the blockage and the other end is attached below the blockgge, reroutin blood flo around the blockage through the new graft to reach the muscle. In some situatios, a prosthetic (madeiof artif i l material) graft may be used for the bypass graft, rather than a vein graf
- Indicatios include Indicated for people who have narrowed or blocked femoral or poplite arteries, which are near the surface of the legs. Usually the blockage must be causing significant symptoms or be limb-threatening before bypass surgery is considered
- Post op Complicatios • All surgeries carry a certain amount of risk. These risks include:
- Infectio from the incision Bleeding
- Heart attack or stroke Specific risks for this bypass surgery include
- Leg swelling Failed or blocked graft
- **Management Decisions:** Regular pulse checks

Neurosurgery

Cervical spine procedures Anterior cervical discectomy and fusion (ACDF)

- Procedure in brief: • This is a procedure to remove the intervertebral disc and allow bony fusion
- to make the segment immobile. • ACDF is performed for diagnoses including myelopathy, radiculopathy, or spinal instability. • It involves a 1-2inch anterior neck incision. The fascia is dissected until the
- carotid sheath is retracted laterally, and the esophagus and trachea are retracted medially. • Once the anterior vertebral bodies are identif d retractors hold open the
- wound while the disc is removed. • A spacer (plastic or bone) is inserted into this cavity, and a fusion construct
- is created using plates/screws or blades. • Then the fascia and skin are sewn together. • These patie ts typically go home post-op day 1.
- Post-op complicatios
- Because we manipulate the esophagus, mild pain with swallowing (odynophagia) or difficl ty swallowing (dysphagia) is expected.
- Excessive pain with swallowing or inability to swallow is an emergency. Special diets may need to be considered for the short term.
- Hoarse voice is common, and is usually associated with endotracheal tube placement. Vocal cord paresis due to recurrent laryngeal nerve injury occurs in 11%, but permanent disability is present only 4%.
- Radiculopathic pain or weaknessman occur following surgery as a consequence of the surgery or due to positioi g. If the neurological exam changes on yourmpatie t or differs from a charted exam, page the resident. • Surgical site hematoma is an emergency!!! Post-operative swelling under
- the incision is common, but trouble breathing, deviatio of the trachea, or excessive swelling concerning for hematoma needs immediate code called and resident paged. • CSF leak from durotomy is uncommon, but is managed with HOB > 30°.
- Management decisions: • Cervical collar: Somenpatie ts with 2 or more segments fused will wear a
- collar. The spine is not unstable in this case, but immobility by external brace allows internal bracing by bony fusioni • Activty: Mostpatie ts will ambulate that day, and discharge the following day. If there is a CSF leak, the HOB will need to be upright at alletims.
- Allmatie ts need to have a bladder scan for 6 hours without urigatin. Cath per orders.





Results

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Conclusions

The Surgical Specialty Nursing Guide increased nursing self-confidence in all three areas. Although self-rated confidence is a subjective measure, confidence is essential to nursing practice. This Nursing Guide has been shared with nurses in other units, who have updated it to reflect their unit-specific procedures. It has also been shared with the surgical overflow units to be utilized as their quick reference guide. Since initiating the Surgical Specialty Nursing Guide in October 2015, it has been sustained and continues to be a resource for nurses today.

Literature Review

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