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Perioperative Nursing Management

Adult Health Nursing

Preoperative assessment, preparation for surgery, informed consent, intraoperative nursing care, postoperative monitoring, prevention of complications and surgical wound care.

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CHAPTER 19 / ADULT HEALTH NURSING 19. Perioperative Nursing Management

1. Phases and preoperative assessment

Preoperative: decision for surgery to transfer to theatre. Intraoperative: theatre care through transfer to recovery. Postoperative: recovery through discharge and follow-up. Assess health history, allergies, medicines (including anticoagulants and diabetes agents), airway risk, previous anaesthesia, baseline observations, nutrition, infection, labs and functional status.

2. Preparation and consent

Verify procedure and site, identity, consent documentation, surgical checklist, fasting instructions based on anaesthesia protocol and relevant medications. Consent is an informed voluntary process led by the responsible clinician; nurses verify, witness as authorized and raise unresolved questions. Give clear explanations, psychosocial support, prescribed prophylaxis and skin preparation; clip hair only if necessary (avoid routine shaving).

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3. Intraoperative responsibilities

- Circulating nurse supports safety, equipment, documentation, positioning and communication.
- Scrub nurse maintains sterile field, instruments and counts using approved procedures.
- WHO surgical safety checklist: sign in before anaesthesia; time out before incision; sign out before leaving theatre.
- Prevent pressure/nerve injury, hypothermia, wrong-site surgery and retained items; manage specimens and counts accurately.

4. Postoperative assessment

Monitor airway, breathing, oxygenation, circulation, consciousness, pain, nausea, temperature and surgical site/drains. Recovery discharge based on approved criteria. Assess urine output and fluid balance, neurological status after regional anaesthesia and return of function.

5. Common complications

Complication	Signs and nursing response
Haemorrhage	Tachycardia, hypotension, bleeding, increasing drainage; urgent assessment/escalation.

Respiratory depression/atelectasis	Reduced ventilation or saturation; airway support, monitoring, prescribed respiratory care and mobilization.
VTE	Leg swelling or sudden breathlessness; urgent assessment, prophylaxis and mobilization as prescribed.
Surgical site infection	Increasing pain, redness, purulence, fever; aseptic care and reporting.
Ileus/retention	Distension, vomiting or inability to void; assess and escalate appropriately.
Dehiscence/evisceration	Wound separation; emergency escalation, protect exposed tissue with sterile saline-moistened dressing, do not push organs back.

6. Discharge and wound management

Assess readiness, reconcile medications, explain activity/weight-bearing restrictions, dressing, bathing, pain control and danger signs. Use teach-back. Support follow-up, pathology review and caregiver participation. Document handover, counts, adverse events and recovery observations.

7. Important Examination Questions

Long Answer Questions

1. 1. Explain pre-, intra- and postoperative nursing care.

Short Answer Questions

1. 1. Describe surgical checklist
2. 2. explain informed consent
3. 3. list postoperative complications.

Very Short Answer Questions (with answers)

1. 1. What is the time out? - Team verification before incision.
2. 2. Should routine shaving precede surgery? - No.

8. Quick Revision

- Verify patient, procedure and site.
- Monitor airway first in recovery.

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- Discharge instructions require teach-back.

9. Conclusion

Verify patient, procedure and site. Monitor airway first in recovery. Discharge instructions require teach-back.

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Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. When is the surgical safety checklist time out performed?

A. Before anaesthesia induction as the sign-in step

B. Before leaving theatre as the sign-out step

C. Before incision

D. Only after transfer to postoperative recovery

2. Which responsibility belongs primarily to the scrub nurse?

A. Coordinating nonsterile equipment and documentation

B. Monitoring recovery-discharge criteria

C. Teaching home wound care at discharge

D. Maintaining the sterile field, instruments and counts

3. A postoperative wound opens and organs are exposed. Which wound action is appropriate?

A. Protect exposed tissue with a sterile saline-moistened dressing

B. Push the organs back into the wound

C. Apply a dry tight dressing and delay review

D. Leave tissue exposed until the routine ward round

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Answer key and explanations

1. C - Before incision

Time out is the team verification immediately before incision.

2. D - Maintaining the sterile field, instruments and counts

The scrub nurse maintains the sterile field and manages instruments and counts using approved procedures.

3. A - Protect exposed tissue with a sterile saline-moistened dressing

Evisceration requires emergency escalation and protection of exposed tissue without replacing organs.

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