# Surgery-Related (Pre- and Postoperative) Management – Clinical Protocol

## Assessment and Recognition

1. As needed, the physician will evaluate a resident who is scheduled to undergo surgery.
   
a. The assessment will focus on pertinent items including a recent medical history, level of cognition and function, controlling active medical co-morbidities (such as congestive heart failure and hypertension), estimating operative risk, identifying a baseline for comparing possible postoperative changes or complications, and identifying significant medication-related risks (for example, stopping anticoagulation or adjusting insulin preoperatively).

## Cause Identification

1. The physician will order appropriate preoperative diagnostic tests, as indicated.
   
a. Lab testing will focus on detecting significant, treatable asymptomatic conditions, undetectable by history or exam, that impact surgical risk. Tests should be fairly sensitive and specific; for example, hemoglobin/hematocrit and electrolytes; chest x-ray or blood gases where indicated; and PT/INR in an anticoagulated individual.

2. Operative risk estimation may be based on the American Society of Anesthesiologists classification:
   
a. Class 1: Normal healthy patient
b. Class 2: Mild systemic disease
c. Class 3: Severe, but not incapacitating, systemic disease
d. Class 4: Incapacitating, constantly life-threatening systemic disease
e. Class 5: Moribund patient

## Treatment/Management

1. As much as possible, the physician will address modifiable risk factors and potentially treatable active medical conditions prior to the individual’s transfer for surgery; for example, stabilize blood sugar and blood pressure, correct heart failure, optimize nutritional status, reduce or stop medications that may be problematic while hospitalized, stabilize renal function, etc.

## Monitoring

1. After readmission to the facility postoperatively, the physician and staff will maintain appropriate communication with the referring surgeon to ensure that the resident receives adequate postoperative care and that the staff and attending physician receive relevant medical information.

2. The staff and physician will review the continuing relevance of the preoperative medications and treatments, along with those added postoperatively, and adjust them accordingly.
3. The staff and physician will monitor for, and address, postoperative risks and complications such as infection, deep vein thrombosis, cardiac arrhythmia, bleeding, failure of surgical wounds to heal, urosepsis from indwelling catheters inserted in the hospital, delirium, depression, and so on.

4. The resident will have continuous monitoring by the nursing staff. The resident will have at minimum every shift charting for the first 72 hours past operatively. The nursing staff must notify the DON or designee prior to discontinuing every shift charting.

References

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