MANAGEMENT OF THE PATIENT IN THE ANAESTHETIC SETTING

Preparing for Anaesthesia

Edge Hill University

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Preparation for Anaesthesia:

- Welcome to the Anaesthetic Care module. Before we start this unit of learning, take a moment to download the Unit 1 Worksheet that accompanies these web pages. The worksheets that accompany each unit of learning are designed to provide you with valuable portfolio evidence and reduce the amount of written work required for your practice assessment.
- The World Health Organisation (WHO) checklist was introduced world wide in 2009. The aim of this checklist is to improve the safety of anaesthetic practice, ensure that correct site surgery is undertaken, it encourages and improves communication between the theatre team and contributes to reducing surgical site infections.



Stop and Think:

Let go of the mouse and pick up your pen please...

- How well has the WHO surgical checklist been implemented into your theatre department?

- if any of these terms are unfamiliar then it is likely that the WHO checklist has not been fully implemented in your hospital/trust. If this is the case please take the time to bring yourself up to speed HERE.

Preparation for Anaesthesia:

Preparation and communication are two key elements in any theatre department. We will shortly discuss setting up the anaesthetic area in preparation for your patients however before we plan anaesthetic care it is crucial that we understand what an anesthetic is and what techniques may be used. So for now we will discuss anaesthesia as though your perioperative team have discussed the patients on your operating list, the care required for each patient and the patient safety requirements as outlined by the WHO checklist (2009). That would be the team brief...

Question:

At this moment in time, are you suitably qualified practitioner to assist the anaesthetist independently (without supervision)?

Make some notes...

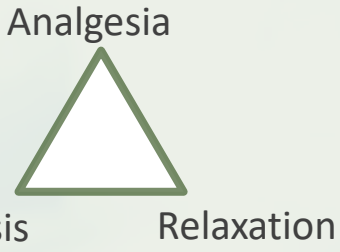
Take a few minutes to write down what you would like to achieve by undertaking this module. Keep this handy as we will be revisiting this throughout these units of learning.

Preparation for Anaesthesia:

Now that you know that your patient is safely prepared, let us consider anaesthetic techniques. The term triad of anaesthesia encompasses the three components of a balanced anaesthetic technique. Modern anaesthesia techniques may use all three components, just two of the components or alternatively just one. The three components of the triad are namely, unconsciousness(or narcosis), paralysis and analgesia.

The Triad of Anaesthesia:

- ***Narcosis (Induction & Maintenance)***
- Muscle Relaxation
- Analgesia (Pain Relief)



Question:

- What drugs are used to achieve the element of unconsciousness?

Preparation for Anaesthesia:

According to Simpson and Popat (2002: p3) most general anaesthetics can be divided into the three main components of the triad. They recognise that most types of operations will have a direct impact on which particular components are chosen for the patient's anaesthetic. Indeed deeper levels of anaesthesia may be achieved through correct consideration of each drugs properties and any counter affect of forbidden combinations.

Stop and Think:

- Some drugs forming one part of the triad also provide elements of the other two parts which must be taken into consideration...
- Can you think of an example...?
- What is the importance of this?

Preparation for Anaesthesia:

Propofol

- Propofol takes a little longer to work than thiopentone though it's worth noting that the eyelash reflex is unreliable and loss of verbal contact is a better indicator of loss of consciousness (Aitkenhead *et al*., 2001). Propofol finds favour with anaesthetists because it has very little hangover effect. It is cleared rapidly from the body though this may be slowed when used with fentanyl. There is no observable accumulation effects and so repeated doses can be administered. Because of this Propofol can be used for Target-Controlled Anaesthesia (TCA), Total Intravenous Anaesthesia (TIVA) or Intensive Care Unit use for ventilated patients. In each case once delivery of propofol ceases the patient wakes up almost immediately.
- Propofol does cause cardio-respiratory depression, particularly in healthy patients so atropine is indicated in patients with a pre-existing bradycardia. Apnoea is common particularly when used with opiates so careful monitoring is required.
- Propofol also has anti-emetic and analgesic properties.

Propofol

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Thiopentone

- Thiopentone has an interesting mix of properties that make it either suitable or unsuitable depending on the patient and situation. Thiopentone has a rapid onset making it ideal for rapid sequence induction (RSI) however it metabolises very slowly. The rate of metabolism is 10-15% per hour by hepatic means (Aitkenhead *et al*, 2001). What this means is that most of the thiopentone is still active within the body on waking and up to a third remains after 24 hours. Repeated doses can therefore produce an accumulation effect. It is not a drug of choice for day surgery.
- Thiopentone causes cardiovascular depression for up to 10 minutes post-injection though this is not as marked as for propofol it is greater than for etomidate. Thiopentone has little analgesic qualities and so opiates are required to complete the triad of anaesthesia. Thiopentone crosses the placental barrier and can therefore cause fetal depression. Despite this is it the drug of choice in RSI for cesarean section.

Thiopentone

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Etomidate

Etomidate has a quicker onset than thiopentone and only lasts 2-3 min. It has the advantage of producing less cardiovascular depression and less respiratory depression than either thiopentone though it can produce a tachycardia in large doses. This property makes it particularly useful in patients who are cardiovascularly unstable (for example, hypovolemic patients). Etomidate is metabolised in both plasma and in the liver and so is eliminated quickly.

Etomidate however, does have a number of undesirable side effects that makes it unsuitable for all but a small number of patients;

- Etomidate depresses cortisol synthesis and so the stress response is reduced.
- Pain on IV injection - etomidate is an irritant and can cause vessels to thrombose.
- Excitation.
- Post-operative nausea and vomiting (PONV).

Etomidate

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Ketamine

Ketamine hydrochloride is highly lipid soluble with an onset of 30-60 sec. and a duration of 10-15 min. It is also effective via the intramuscular route though onset is predictably much longer (15 min.). Ketamine also has strong analgesic qualities. It can cause amnesia for up to an hour post-injection.

Ketamine should be administered in a quiet, calm atmosphere due to emergence delirium (hallucinations). Ketamine is metabolised in the liver and excreted via the kidneys. It crosses the placental barrier causing respiratory depression. Ketamine has a positive inotropic effect raising heart rate and cardiac output. This makes Ketamine suitable for high risk patients. Ketamine may cause apnoea initially.

Ketamine is suitable for paediatric use.

Preparation for Anaesthesia: Intravenous Induction Agents

Stop and Think:

Which of these induction agents do you use in your area?

- Propofol
- Thiopentone
- Etomidate
- Ketamine

What is the rationale for choice of drug?

Preparation for Anaesthesia: Neuro-muscular blockade

The time of onset and duration of action of a muscle relaxants will differ depending which was has been used.

This can range from time of onset of 1.5 - 3 min. and a duration time of 15 - 45 min. Once a muscle relaxant has been administered to a patient, he/she will not be able to breathe for themselves, therefore it is important that the anaesthetist has good control of their airway in order that the patient can be adequately ventilated and oxygenated.

Once your patient is paralysed, tracheal intubation can be attempted by the anaesthetist.

Preparation for Anaesthesia: Intravenous Induction Agents

Suxemethonium

- Succinylcholine chloride is the only currently available depolarizing agent. It clings to alpha receptors at the post-synaptic receptor, opening the ion channel and causing depolarization and contraction of the muscle (fasciculation) by altering its structure. Action potentials are unable to move along the ion channels and subsequently, the muscle relaxes and does not repolarize.
- Not only is suxemethonium extremely fast-acting, making it ideal for emergency/urgent endotracheal intubation, it is metabolised very quickly by pseudocholinesterase (see right) prior to it reaching the neuro-muscular junction. In patients with normal pseudocholinesterase levels duration is 3-5 min (Aitkenhead *et al*.,, 2001;227)
- 'Dual Block' is a term used to describe the behaviour of the blockade following repeated doses of suxemethonium. Whilst blockade is non-competitive it can show signs of competitive blockade following multiple doses.
- Suxemethonium Apnoea is a concern. Click the link to read more...

Suxemethonium
…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Vecuronium

- Vecuronium is a competitive blocker, competing with acetylcholine for alpha-receptors at the neuro-muscular junction. It takes about 3 min. to produce intubation conditions and lasts for about 30 min.
- Vecuronium causes very little histamine release or impact upon the cardiovascular system however it is excreted in the main via the kidneys and hepatic system. As such, Rocuronium should be avoided in patients who may be compromised in these areas.

Vecuronium

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Rocuronium

Rocuronium has the advantage of rapid onset without depolarization (60-90 sec.). However the duration of action may be as long as 45 min and so careful titration and timing is required.

- As with vecuronium it causes very little histamine release or impact upon the cardiovascular system and it is excreted in the main via the kidneys and in the bile. Rocuronium should be avoided in patients who may be renal or hepato-compromised.

Rocuronium

Rocuronium

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Mivacurium

- Mivacurium is a short-acting muscle relaxant. Caution is indicated in patients with plasma cholinesterase deficiency as paralysis will be prolonged (Mivacurium apnoea). Mivacurium is metabolised by plasma cholinesterase.
- Mivacurium has the advantage of being as quick onset and lasting as long as Atracurium whilst having the benefit of being antagonizable within 15 min.
- Mivacurium is associated with histamine release on rapid injection and is contraindicated in hepatic and renal impairment and also in obstetrics.

Mivacurium

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Atracurium

Atracurium besylate has a distinct advantage over other neuro-muscular blocking agents in that it has the ability to be excreted via 'Hoffman degradation' This is a phenomena whereby an agent is broken down at body temperature and pH (Aitkenhead et al., 2001; 229).

- This makes Atracurium the drug of choice in patients who are hepato or renally impaired though it is important to consider how reliance on this method of clearance may impact on recovery time.
- Atracurium is quicker in onset than vecuronium (2 min) and shorter acting (20 min). The latter finds favour with anaesthetists in ease of predicting the fade of neuromuscular blockade during shorter procedures.

Atracurium

…….. mg/ml.

Preparation for Anaesthesia: Intravenous Induction Agents

Cisatracurium

Cisatracurium is an atracurium derivative which has the same advantages and like atracurium can be broken down by Hoffman elimination making it an ideal agent in patients susceptible to or suffering from hepato-toxicity or renal failure.

- Onset and duration of action are longer than for atracurium.

Cisatracurium

……. mg/ml.

Preparation for Anaesthesia: Neuro-muscular blockade

The time of onset and duration of action of a muscle relaxants will differ depending which was has been used.

This can range from time of onset of 1.5 - 3 min. and a duration time of 15 - 45 min. Once a muscle relaxant has been administered to a patient, he/she will not be able to breathe for themselves, therefore it is important that the anaesthetist has good control of their airway in order that the patient can be adequately ventilated and oxygenated.

Stop and Think:

- If a patient has been administered a non-depolarising muscle relaxant...
- How will the anaesthetist assess if they are sufficiently paralysed to be intubated?
- How does this differ in comparison with a depolarizing muscle relaxant?

Once your patient is paralysed, tracheal intubation can be attempted by the anaesthetist.

Preparation for Anaesthesia: Analgesia

The third component of the triad of anaesthesia is analgesia or pain relief. Certain analgesic drugs are usually administered to help eliminate the pain of surgery and to reduce the sympathetic response to pain. Very often anaesthetists will administer an opioid analgesic, usually fentanyl, prior to an induction agent. The reason for this is that when the anaesthetist carries out laryngoscopy it will prevent the autonomic response and hopefully the heart rate will not increase as significantly. We will discuss opiates and opioids further in a later unit of learning.

Now that you are aware of the triad of anaesthesia and how the components of this are used to deliver a balanced anaesthetic technique, we can consider what other factors contribute to the type of anaesthetic that is delivered.



Make some notes...

- The type of anaesthetic delivered will depend on a number of factors:
- Take a moment to write down what these may be e.g. type/length of surgery.
- Provide a rationale for each factor.

We will discuss this further when we address airway management.

Preparation for Anaesthesia:

We are now going to examine anaesthetic care and consider the way in which the concept of care is enacted. We will also be meeting our 3 patients and starting to question what care we will be providing, and crucially, the rationale behind this care. First of all though, we need to make sure we are all talking about the same thing. What do we mean by anaesthetic care?

Checklist:

Take a moment or two to jot down some activities that you would consider to be anaesthetic care.

Now let's consider individualised care. Take another look at your list of activities or care interventions...

How much of your list is 'individualised' or more to the point what aspects of care do you provide for every patient?

u should by now have some idea of how difficult it has been, over the years, for nursing colleagues to plan care on an individual basis when so much of the care we provide for one patient is provided for all. It is usually only when a complex case is imminent that there are additional measures put in place.

Preparation for Anaesthesia: Risk Assessment

Anaesthetic care is very much about risk management. We prepare an anaesthetic room for each patient in much the same way regardless of whether they require a local anaesthetic or a prolonged general anaesthetic for a complex procedure. This is because even the most straightforward of procedures may develop complications that require prompt remedial action. Preparing an anaesthetic room for all reasonably foreseeable eventualities is simply good practice.

As a consequence of this there are a number of activities that we undertake that practitioners regard as ‘getting ready' for a list’ that constitute anaesthetic care and for which we can provide a rationale.

Preparation for Anaesthesia: Risk Assessment

Question

When you jotted down your list of ‘anaesthetic care’ interventions – how many of the following did you include?

- Checking the anaesthetic machine
- Checking the airway equipment/adjuncts
- Stocking the sundries (syringes, needles, administration sets etc.)
- Checking the operating table tilts to head-down.
- Wiping down/disinfecting surfaces.

Over the years this approach has led to the adoption of care pathway documentation superseding the traditional nursing care plan. The predictability of anaesthetic preparation and benchmarking of the standard lends itself to the ease-of-use of a check-list approach to documenting care. Whilst the rationale for this approach supports its use there is a danger that many anaesthetic care interventions are considered to be routine preparation of an area rather than as elements of patient care.

Preparation for Anaesthesia: Enacting Anaesthetic Care?

Before we meet our patients we will need to prepare the anaesthetic area. As we have already discussed, we do not need to know immediately what our patients individual requirements are as we will be working towards the standard setup for general anaesthesia.

Checklist:

Now jot down a quick list of what you think should be in your anaesthetic room – please leave a column to the right of your list for a rationale.

We are going to use the rationale column to say why we get things ready – however we are going to do this in the context of patient care or needs. In explanation, against 'check laryngoscopes for function and cleanliness' we could write potential need to intubated/ need to prevent cross-contamination.

We are going to focus now on the elements of care that are incorporated into preparing the anaesthetic area.

Preparation for Anaesthesia: Enacting Anaesthetic Care?

Portfolio Building:

Use these checklists as evidence for your portfolio.

Don't forget to number each item and keep an index/contents so you can reference your evidence on your assessment documents.

Preparation for Anaesthesia: The Anaesthetic Area

We are referring to the anaesthetic room by the global term of 'anaesthetic area' in order that the principles may be applied with or without a dedicated room. We are going to look at preparation of our anaesthetic area under 5 sub-headings:

- The anaesthetic machine (oxygen delivery system)
- Monitors
- Airway management equipment
- Intravenous access and infusion
- Drug

We will guide you through a basic setting-up procedure (adult) for each of the above however you need to mindful that practice does vary from hospital to hospital. The checklists and materials included herein are for guidance only and should be read in conjunction with your own local policy documents.

Preparation for Anaesthesia: The Anaesthetic Area

Stop and think:

As you are working your way through this section, note down any areas of practice that are different from your own trust. These will make good discussion points later on.

The core text for this unit is Checking Anaesthetic Equipment (AAGBI 2012). You are advised to download this document as a reference.

Preparation for Anaesthesia: The Anaesthetic Machine (i)

Before considering the practicalities of the anaesthetic machine check we should summarise some key legal points that underpin this activity.

The Law...

Duty of care: We owe each patient a duty of care and our ability to fulfil this is measured against the standard of care offered by our fellow practitioners (Bolam test). The current standard of care for anaesthetic equipment checks is generally held to be adherence to AAGBI guidelines.

Negligence: Resultant harm attributed to a failure to maintain this standard would be interpreted as negligence by a court of law.

You are invited to download and peruse the AAGBI guidelines before continuing. Remember, this is the accepted standard of care. Please note any elements of the checking procedure that you do not carry out as a matter of routine. Do you think that you are being negligent?

Preparation for Anaesthesia: The Anaesthetic Machine (ii)

Do you think that you are being negligent?

How well do you know your Anaesthetic Machine?

The modern Anaesthetic machine is loaded with safety features. Almost all of these are concerned with preventing delivery of the wrong gas or gas mixture. How many of these features can you identify?

Do you understand how they work?

Now take a look at this article by Smith & Wicker (2006). Smith & Wicker raise some key points regarding recording of the anaesthetic machine check. What impact does this have on your practice?

Record Keeping?

Do you record that the anaesthetic machine is checked and fully functional in each patient's notes?

Preparation for Anaesthesia: The Anaesthetic Machine (iii)

The Medicines & Healthcare Regulatory Authority (MHRA) have commissioned an eLearning module designed to guide Practitioners and Anaesthetists in the checking of Anaesthetic Machines.

- We will shortly ask you to follow the link (next page) to the MHRA web site and commence the interactive training module.
- There is also a short quiz (link on left) to further test your knowledge of this essential piece of equipment (portfolio evidence).

Before we do we would like you to consider the following key points:

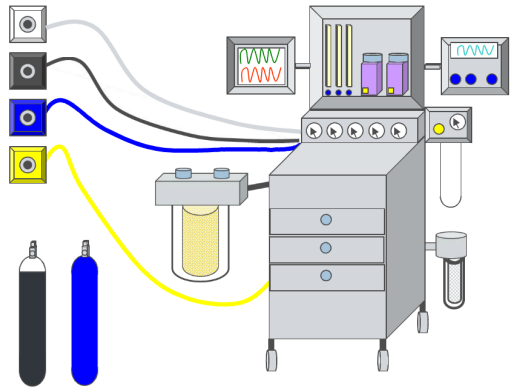
- AAGBI Guidelines (2012, 11) incorporates monitoring equipment - including ".. all monitoring devices, especially those referred to in the AAGBI's Standards of Monitoring during Anaesthesia and Recovery guidelines [14], are functioning".
- 'Anaesthetic Equipment' includes the trolley, table or bed.
- Even a rigourously checked machine can fail during use - there is no substitute for vigilance.

Preparation for Anaesthesia: The Anaesthetic Machine (iv)

You are invited to download and peruse the AAGBI guidelines before continuing. Remember, this is the accepted standard of care.

Please note any elements of the checking procedure that you do not carry out as a matter of routine.

Do you think that you are being negligent?



- CLICK HERE to commence the MHRA Anaesthetic Machine module. But first...
- CERTIFICATE for your PORTFOLIO: MDDL No longer issue certificates therefore you should print off the summary sheets for each of the 5 quizzes as you go along and present these to your mentor as evidence that you have passed.
- Don't forget the quick quiz (paper)...

Preparation for Anaesthesia: Anaesthetic Monitoring Equipment (i)

You are strongly recommended to download and read the key text: Recommendations for Standards of Monitoring During Anaesthesia and Recovery (AAGBI 2007).

Key Points:

AAGBI (2007; 8) Recommend the following items be available throughout all anaesthetics:

- Pulse oximeter
- Non invasive blood pressure monitor
- Electrocardiograph
- Airway gases: oxygen, carbon dioxide and vapour
- Airway pressure

Preparation for Anaesthesia: Anaesthetic Monitoring Equipment (i)

Modern anesthetic monitoring equipment is of modular form and performs a self-check. Preparation therefore, is based around ensuring that the self-check has completed successfully and that on starting up, the factory default alarm settings have been restored. Good anaesthetic care practice will include checking that on completion of the self-check that correct warnings are indicated e.g. your pulse oximeter should read -- and indicate that it is disconnected.

Preparation for Anaesthesia: Anaesthetic Monitoring Equipment (ii)

Let's take that checking a bit further...

Checking that Factory Defaults have been restored:

- How often would you check this?
- Why would you change the alarm parameters?
- Who would change the alarm parameters?

In preparing this page we had a discussion around checking the saturation probe prior to use - by placing it on our own fingers. A colleague suggested that she would not place a manky old probe on her finger. This raises the question of infection control. Good practice would be to ensure that the equipment was cleaned according to manufacturers' guidelines - and then remain uncompromised by not putting it on the practitioner's finger to check. It is important to stress that this is a consideration for every patient - not just something to consider at the start of a list.

Preparation for Anaesthesia: Anaesthetic Airway Management

Click on the image (right) to take a closer look at an airway management tray...

This page discusses the standard airway management equipment setup for an anaesthetic room. As discussed earlier, this setup will be the same for most patients however additional equipment may be required if the anaesthetist has identified that one or more of your patients may be classed as a difficult intubation.



Infection Control::
On the previous page we touched upon infection control - take a close look at the picture above and jot down any infection control considerations that you can see.

Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Endotracheal (ET) Tubes
Sizes 9.0mm - 7.5mm (Cuffed)

The tubes in the picture have been cut to length as indicated (dotted line) by the manufacturer. This is probably the safest option to adopt as, although many anaesthetists have their own preferences - the ET tubes on the tray have to be ready to go, for everyone.

The pilot cuff should be pressure tested by inflating with air from the syringe (positive pressure) - avoid over inflation as this will distort and damage the cuff. The connector should be seated firmly in the distal end.



Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Guedel Airways
Size 1-4

Although previous practice has been to have the oropharyngeal airway ready for use it is now considered best practice for the airway to remain sealed in its packet until required. This is in respect of infection control.



Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Laryngoscopes
Laryngoscopes: McIntosh Blades 3 & 4.

Check for function and cleanliness. Function is checked by opening the blade which in turns closes the electrical circuit and illuminates the light. This should be transferred down the blade by a fibre optic carrier. There should be sufficient light produced for the anaesthetist to view the larynx.

Pictured are re-useable McIntosh blades which must be stringently cleaned and visually inspected for soiling. Disposable blades and handles are now considered gold standard due to infection risk.



Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Swabs

Sterile swabs are preferred in consideration of infection control. These are simply used to maintain cleanliness during the conduct of anaesthesia.



Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Stylet (not pictured)

If the anaesthetist anticipates a difficult intubation then a stylet may be used to preform the ET tube. This should ideally be sterile within packaging (though rarely is).



Preparation for Anaesthesia: Anaesthetic Airway Management Tray

Silastic Bougie (not pictured)

An absolute must-have in an anaesthetic area. This may be used by the anaesthetist to navigate beyond difficult structures in the mouth and oropharynx before 'railroading' the ET tube over the bougie.
Gold standard is that this is now considered to be a single-use item.



Preparation for Anaesthesia: Intravenous Access and Infusion



Surface



1- Syringes & Needles



2- IV Access



3- Oro/Nasopharyngeal Airways /Ryles Tubes/Sundries



4- Facemasks & Oxygen Kit



5- Catheter Mounts & Filters



6- Breathing Systems

Preparation for Anaesthesia: Intravenous Access and Infusion



1- Syringes & Needles



2- IV Access

Compare the above items with items listed in Skills Sections 6.6 and 6.7 of your Practice Assessment Document:

Make a list of the items you would expect to see - Are there any items missing?
Make brief notes on the function, use, and care of each item.

Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Top Shelf: Cardiovascular Drugs

- Adrenaline
- Atropine
- Ephedrine
- Glycopyrronium
- Hydrocortisone



Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Shelf 2: Induction Agents & Anti-emetics

- Thiopentone
- Propofol
- Etomidate
- Dexamethasone
- Cyclizine
- Ondansetron



Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Shelf 3: Reversal, Muscle Relaxants & Analgesia

- Doxepram
- Anexate
- Naloxone
- Vecuronium
- Mivacurium
- Parecoxib
- Paracetamol



Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Locked Cabinet: Controlled Drugs

- Fentanyl
- Morphine Sulphate
- Diamorphine
- Alfentanil
- Cyclomorphine
- Midazolam



Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Cupboard Door

- Salbutamol Nebulisers
- Glyceryl Trinitrate
- Labetalol
- Cefuroxime
- Co-Amoxiclav
- Gentamicin
- Flucloxacillin
- Isoflurane
- Sevoflurane





Preparation for Anaesthesia: Intravenous Anaesthetic Drugs

Stop and think:
Is this drug cupboard similar in contents to the ones in your trust? What else do you use that is not shown here?



Drug Proforma Worksheet:
Download the ***Drug Proforma Worksheet*** and print off a copy for each drug. This will make useful portfolio evidence.

Preparation for Anaesthesia: Our first patient...



Jane ARMITAGE

Wikipedia

As you can see from my case notes I am 30 years old and I will be attending Edge Hill University Hospital for an operation to fix an umbilical hernia.

I'm not sure what an umbilical hernia is. My doctor says it is a weakness in my stomach muscle and can be sorted out quite easily with a straightforward operation. She says I require a general anaesthetic and be treated as a day case. I have looked up 'umbilical hernia' and 'day case' on wikipedia and patientUK to learn more about it. My friend is attending University however, and he says that these, whilst useful generally, are not recognised as academic resources. I'm not sure what he means.

At the pre-operative assessment clinic the nurse told me I would be treated as a day case and that I would return home the same evening if all was well with my recovery from anaesthesia. Does this mean I'm going to sleep? She asked if there was someone to take me home and look after me for a couple of days following the anaesthetic. I said my partner, Sam was going to take a couple of days off work.

I'm a bit apprehensive about having an anaesthetic. I know people have them all the time and I had my tonsils out as a child without having any problems so I should not have any worries about a modern anaesthetic. Mind you, my dad was not allowed an anaesthetic last year - and he died a few months later. The pre-op nurse did say I was fit and active and she was happy that I was going to be a day case.

Preparation for Anaesthesia: Summary & Activity

Activity

- Using your Assignment Prep Journal...
- Write a brief account (150-300 words) of the issue or area of practice that raises a question for you. Using the library catalogue select a piece of literature that says something interesting about the issue. Say why you have selected that piece of literature - without quoting from it.
- Post your account under Anaesthetic Activity 1 (Discussion Board). Attach the literature you have selected. Use your subject title as the heading (unless somebody else has posted under the same topic - in which case click [reply] instead).

Preparation for Anaesthesia: Summary & Activity

Guidance

- The idea behind activity 1 is to get you to describe an issue in preparation for analysis. This also acts as a self-check for you in that you are able to determine whether you are able to effectively use the library catalogue and post a message with attachments.
- If you find any part of this activity technically dificult don't worry - simply ring your tutor with your PC turned on and close to hand.
- We would like to develop these information literacy skills so they become second nature - before you have the worry of an assignment.

Preparation for Anaesthesia: Summary & Activity

Portfolio 1

You are required to download, print and complete both workbooks from the links below:

- Medical Gases WORKBOOK This will provide you with portfolio evidence contributing to skills 5.1, 5.5, 5.6, 5.7
- Drugs WORKBOOK This will provide you with portfolio evidence contributing to skills 4.1, 4.4, 4.6

This concludes this unit of learning...let's see how much you have learned; You are now required to complete the quiz in the [Module Content] section.

Close this window to return to Blackboard.

Preparation for Anaesthesia: References

- ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN & IRELAND 2007. *Recommendations for Standards of Monitoring during Anaesthesia and Recovery* London: AAGBI http://www.aagbi.org/ [accessed 24/09/2009]
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