Preop, moderate sedation and postop

Consent, fasting and home medicines, sedation safety and reversal, the OR, postop assessment and complications

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1 AT A GLANCE

Most surgical harm is prevented before the first incision. In sedation, breathing is the danger. After surgery, airway and breathing come first.

Before surgery

- History: heart or lung disease, and every medicine, including supplements, tobacco, alcohol and marijuana.
- ★ **Family history of a severe reaction to anesthesia** can point to malignant hyperthermia. Ask about latex and anesthetic allergies.
- Weak kidneys clear anesthetic drugs slowly. Obesity raises the risk of sleep apnea; malnutrition and obesity slow wound healing.
- Make sure the tests are in the chart, do a final assessment, and report anything new to the surgical team.

Consent: The surgeon explains; the client understands and agrees freely. Check it before any sedating premedication. The nurse witnesses the signature and calls the surgeon if the client doesn't understand.

ASA fasting minimums (healthy, elective)

What	Stop before
★ **Clear liquids: water, pulp-free juice, clear tea, black coffee**	**2 hours**
Breast milk	4 hours
Formula, other milk, or a light meal like toast	**6 hours**
Fried or fatty food, meat	May need longer

Exceptions: In an emergency, or when the stomach empties slowly, the team weighs the aspiration risk: lighter sedation, a delay, or a breathing tube.

Home medicines to clarify before surgery

Medicine	Why it matters
ACE inhibitors, ARBs	Can drop the blood pressure during surgery
Blood thinners, antiplatelets, anti-inflammatory drugs, herbals like ginkgo	Raise bleeding risk; the provider weighs stopping them
Diuretics	Can lower potassium and blood pressure, though they may continue in heart failure
★ **Insulin, diabetes pills**	**Basal insulin is individualized, per orders**: often 75 to 80% of a long-acting dose, or half of NPH. Short-acting insulin and pills risk a low
Migraine triptans	Serotonin syndrome with ondansetron, a common surgical antiemetic

Clarify: Every home medicine is reviewed with the provider and anesthesia team. When in doubt, clarify the order.

Moderate sedation

- ★ The client **responds purposefully to voice or a light touch**, with no airway help needed. Only pulling away from pain: sedation has gone deeper.
- Given IV, often midazolam and fentanyl, by a credentialed RN trained in airway management. A sedative plus an opioid deepens breathing depression: small doses, step by step.
- One dedicated monitor, not the person doing the procedure. Pulse oximetry with alarms; watch or listen to the breathing; monitor exhaled carbon dioxide unless the client, procedure or equipment prevents it; blood pressure about every 5 minutes.
- Ready: oxygen, suction, sized airway equipment, a bag-mask, naloxone and flumazenil.

Oxygen falls: Stimulate, reposition the airway, check ventilation, stop or reduce the sedative, and get help. Oxygen alone can hide hypoventilation.

Reversal and going home

- Naloxone reverses opioids; flumazenil reverses benzodiazepines. Reversal is for rescue, not a routine end to sedation.
- ★ After a reversal agent, **watch for sedation returning** as it wears off. How long varies by drug and client, and may exceed 2 hours.
- Discharge: alert and oriented or back to baseline, stable vital signs, and a responsible adult with written instructions.
- A sedated child in a car seat: watch the head. If it falls forward, it can block the airway.

Teaching before surgery

- What they will do after: deep breathing, the incentive spirometer, coughing while splinting the incision.
- Leg exercises, early walking, compression, and clot signs: calf pain, one-sided swelling, redness.
- Tubes they may wake up with, like an IV, a nasogastric tube or a drain.

In the operating room

- Time-out before the incision: anyone can speak up.
- Pad bony prominences: positioning can injure nerves and skin.
- Counts: two people, out loud, at the start, when items are added, before closure. Count off: check the wound, recount, search the room, X-ray.
- ★ **Malignant hyperthermia:** earliest sign is an **unexpected rise in end-tidal carbon dioxide**, with a fast pulse and jaw rigidity; fever comes late. Stop the trigger and call for help; dantrolene follows.

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.

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1 AT A GLANCE, CONTINUED

Arrival on the unit

- ★ Head to toe, **airway and breathing first**: breathing pattern, lung sounds and saturation against baseline, oxygen settings.
- Circulation: blood pressure, pulse and rhythm, capillary refill, pulses, one-sided redness or pain in a leg.
- Passing gas or stool is the best sign the bowel is waking up.
- Report urine output below the client's own or weight-based target, and the trend. Adult oliguria is under 0.5 mL/kg/h.
- First dressing change per the surgical order. Until then, keep it intact, reinforce it, and report heavy bleeding.

Routine care after surgery

- Walk as soon as orders allow. Help with the first transfers: low blood pressure on standing can cause a fall.
- Clot prevention as ordered: anticoagulants, sequential compression devices, antiembolism stockings, walking.
- Remove catheters once no longer needed; then follow the bladder scan protocol, assessing sooner for pain, distension or no void.
- Incentive spirometer: breathe in slowly, hold 3 to 5 seconds. 10 to 15 breaths every 1 to 2 hours, or as ordered.

Complications after surgery

Complication	Clues	First actions
★ **Respiratory depression**	Not just a rate under 12: assess sedation, depth, apnea and ventilation. On oxygen, saturation can look normal	Stop the opioid, stimulate, support airway and breathing, bag-mask if needed, call for help; then naloxone as ordered
Hemorrhage	Early: rising pulse, restlessness, cool, clammy skin. Pressure often falls late, so don't wait for it	Circle and reinforce the drainage; tell the surgeon how many dressings were soaked; fluids or blood as ordered
Paralytic ileus	No bowel sounds, no gas, distension, vomiting	NPO and IV fluids as ordered; NG suction only when indicated
Atelectasis, pneumonia	Breathlessness, low oxygen, crackles, cough, fever	Turn often, walk, spirometer and coughing
Wound infection	Redness, warmth, tenderness, more drainage, fever, a rising white count	Antibiotics follow the culture
★ **Evisceration**	Organs through the opening (dehiscence: the edges pull apart)	**Sterile saline-moistened, nonstick cover; call the surgeon at once.** Low Fowler's, NPO. Never push organs back in
DVT; pulmonary embolism	One-sided redness, warmth, swelling, calf pain. Sudden breathlessness, chest pain, coughing blood	DVT: report promptly. Possible embolism: call for emergency help, give oxygen

2 PRIORITY AND SAFETY CALLS

★ Saturation falls and the client won't respond during sedation: **stimulate, open the airway, check the breathing, stop the sedative and call for help**; then bag-mask breaths and reversal if needed.

Flumazenil alone won't reverse fentanyl. Reversal comes after the basics.

★ Premedication due, consent not signed: **hold the premedication and notify the surgeon**.

★ Opioid respiratory depression (sedation, slow or shallow breaths): **stop the opioid, stimulate the client, support airway and breathing, bag-mask if needed, and call for help**; then naloxone, as ordered.

3 EXAM ANCHORS

1. Sedation traps: relying on oxygen alone, reversing before the airway and breathing are managed, a sedated client driving, and consent after a sedative.
2. Ready to go home: alert and stable once the naloxone wore off, with a responsible adult to take her home.
3. Arrival after surgery: airway and breathing first, then circulation, pain, bowels, bladder and the dressing.
4. Traps after surgery: pushing organs back in, dry gauze on an evisceration, sitting the client bolt upright, and fast breaths on the spirometer.
5. Clues: slow breathing, a rising pulse (pressure falls late), no bowel sounds, crackles and fever.

4 SELF-QUIZ

1. Healthy, elective: clear liquids stop _____ hours before.
2. A light meal stops _____ hours before.
3. Sedation: the client responds to voice or a light _____.
4. Sedation: blood pressure about every _____ minutes.
5. Malignant hyperthermia: stop the trigger and call for help; _____ follows.
6. Passing gas or _____ is the best sign the bowel is waking up.
7. After an evisceration, place the client in low _____.

ANSWER KEY 1. 2 · 2. 6 · 3. touch · 4. 5 · 5. dantrolene · 6. stool · 7. Fowler's

5 SOURCES

1. Open RN, Nursing: Health Alterations, 2.3 Preoperative Nursing Care. wtcs.pressbooks.pub/healthalts/chapter/2-3-preoperative…
2. ASA, Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. asahq.org/~/media/sites/asahq/files/public/re…
3. ADA Standards of Care, 16. Diabetes Care in the Hospital. diabetesjournals.org/care/article/49/Supplement_1/S339/1…
4. Open RN, Nursing: Health Alterations, 2.5 Postoperative Nursing Care. wtcs.pressbooks.pub/healthalts/chapter/2-5-postoperativ…
5. APSF, Monitoring for Opioid-Induced Respiratory Depression. apsf.org/article/monitoring-for-opioid-induc…

Built from RN PocketPal course lessons: Preoperative care and moderate sedation (c06-l06); Postoperative care and complications (c06-l07). Every line on this sheet comes from those lesson scripts.

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