

Guideline Summary: Minimally Invasive Surgery, Part 1

PURPOSE

To provide guidance for creating a safe environment of care for patients undergoing minimally invasive surgical procedures.

Guideline Summary: Minimally Invasive Surgery,¹ Part 1

#	Recommendation	Key Points
I	Health care organizations should establish a multidisciplinary team to create an efficient, safe environment for minimally invasive procedures.	• The multidisciplinary team, including perioperative RNs, physicians, surgical technologists, infection preventionists, biomedical engineers, and other members of the health care team should plan the room configuration. ◦ The room configuration plan should include ■ access to the patient and surgical field; ■ placement of equipment booms, video monitors, and overhead lights to reduce distractions and ergonomic hazards specific to minimally invasive surgery (MIS) (ie, slips, trips, falls in low lighting, collisions); ■ an adequate quantity of dedicated electrical circuits and appropriate placement and connection of power cords and cables; ■ systems to evacuate and filter surgical smoke during the MIS procedure and at the end of the procedure when pneumoperitoneum is released; ■ methods to control and minimize traffic; and ■ collaboration with vendors to achieve medical device intraoperability. • A representative of the health care organization's information technology department should be consulted and should identify information system requirements before new technologies are purchased. ◦ The image capture system must comply with Health Insurance Portability and Accountability Act requirements. ◦ Remote telecommunications technology requirements should be identified that meet the health care organization's strategic plan. • The multidisciplinary team should create a room layout with equipment positions for MIS systems based on procedure type(s), physical configuration, and recommendations by the equipment manufacturers.

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#	Recommendation	Key Points
		• The perioperative team should prepare endoscopic equipment (eg, camera, light source, insufflation device) and instrumentation according to the manufacturer's instructions for use and physician preference. ◦ The perioperative team should inspect MIS equipment and instrumentation before use, remove defective items from service, and send these items for repair or replacement according to the health care organization's policy and procedures. ◦ Items should be inspected for ■ cleanliness; ■ function and alignment of instrumentation; ■ corrosion, pitting, burrs, nicks, and cracks; ■ sharpness of cutting edges; ■ wear and chipping of instruments and plated surfaces; ■ missing parts; ■ integrity of insulation on insulated devices; ■ integrity of cables; ■ clarity of lenses; ■ integrity of seals and gaskets; and ■ other defects. • The perioperative team should be prepared to convert a laparoscopic procedure to an open procedure.
II	Potential patient injuries and complications associated with gas insufflation media used during MIS procedures should be identified, and practices that reduce the risk for injuries and complications should be established.	• Precautions should be taken to mitigate the risk for injury associated with gas insufflation during MIS. ◦ Insufflation flow rate should be set according to the surgeon's specification and the manufacturer's instructions for use. ◦ Manufacturer's instructions for use of insufflation equipment should be reviewed, followed, and readily available to users. ◦ The insufflator should be elevated above the level of the surgical cavity if possible. ◦ The insufflator and insufflation tubing should be flushed with the selected gas before the tubing is connected to the cannula (eg, Verres needle). ◦ The perioperative RN should verify that a hydrophobic filter is in place between the insufflator and the insufflation tubing. The filter should be compatible with the insufflator. ◦ During a hysteroscopy, insufflators designed and intended for hysteroscopy should be used. ◦ Endoscopic gas insufflator alarms should be turned on and sufficiently audible to be heard above competing noise. • When a gas cylinder is used, the perioperative RN should check the cylinder to verify that it contains the selected gas and that it is not empty before the procedure begins. A second full cylinder should be readily available for immediate replacement of an empty cylinder. • Insufflation pressure should be maintained at the lowest level necessary to achieve pneumoperitoneum within the specification of the surgeon.

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