Preoperative Teaching: Preparing Patients for Abdominal Surgery

What Is Involved in Preoperative Teaching to Prepare Patients for Abdominal Surgery?

› Abdominal surgery, an operative procedure that involves an incision into the abdomen, encompasses a wide variety of surgeries. Common abdominal surgeries include small and large bowel surgeries, herniorrhaphy, appendectomy, cholecystectomy, gastrectomy, and laparotomy

• What: Preoperative education involves teaching the patient about his/her specific abdominal surgery, including what it is and why it is indicated; the risks and benefits of abdominal surgery; how to prepare for abdominal surgery; what to expect during hospitalization, including the surgery itself and the initial inpatient recovery period; strategies for preventing potential postoperative complications (e.g., pain, limitations in mobility, atelectasis, pneumonia, infection, and poor wound healing), including instruction regarding postoperative exercises; and community and online resources designed to support patients after abdominal surgery

• How: Learning and motivational activities (e.g., direct instruction, written materials, demonstration and return demonstration, Internet and other computer-mediated options) can be used when teaching patients about preparing for abdominal surgery – The most effective strategy for delivering preoperative patient education is to individualize the information using a combination of learning and motivational activities and to discuss topics that the patient identifies as relevant to his/her health situation

• Where: Education about preparing for abdominal surgery frequently begins in the outpatient clinician’s office or in a preoperative work-up clinic, and continues after admission to the hospital or outpatient surgery center for abdominal surgery – Providing consistent information throughout the continuum of care is important

• Who: Preoperative teaching prior to abdominal surgery is ideally approached as a team effort involving registered nurses, the treating clinician(s), and the patient. Physicians often provide the initial preoperative information about surgical procedures during a discussion with the patient about a diagnosis and potential treatment options. Preoperative teaching is a routine part of patient care for nurses and others (e.g., physical therapists) who work in a surgical setting. Preoperative teaching should not be delegated to assistive staff members. If desired by the patient, it is appropriate for family members and home caregivers to be present during the educational session

What Is the Desired Outcome of Preoperative Teaching to Prepare Patients for Abdominal Surgery?

› Teaching patients about preparing for abdominal surgery allows them to

• better understand the specific abdominal surgery, why it is indicated, and related risks (e.g., adverse anesthesia reactions, postoperative pneumonia, infection at the surgical site, deep vein thrombosis, blood loss) and benefits (e.g., improved overall health, improved quality of life)

• better understand the necessary routines before, during, and after surgery that are specific to their health status, including performing self-care skills (e.g., incentive...
spirometry [IS], wound care) and identification and management of symptoms (e.g., incisional pain, nausea)

• be able to describe how to prepare for the specific abdominal surgery, including bowel preparation, food and fluid restrictions, medication adjustment, and restrictions related to over-the-counter (OTC) medications, herbal preparations, and supplements

• be able to discuss what to expect during hospitalization, including the surgery itself (e.g., general vs. regional anesthesia, banked blood vs. autologous blood reinfusion, anticipated length of surgery), and typical course of recovery (e.g., gradual removal of tubes and lines; use of a patient-controlled analgesia [PCA] pump vs. taking oral analgesics, other pain management strategies; dietary changes; activity and physical therapy; opportunities to learn and practice self-care skills; anticipated length of inpatient stay; and criteria for discharge to home)

• experience reduced anxiety about the scheduled surgery and recovery

• demonstrate postoperative exercises to promote optimal postoperative recovery and reduce complications (e.g., respiratory complications following general anesthesia)

• understand the need for assistance after abdominal surgery and be able to identify supportive caregivers, if needed

• learn and be able to discuss strategies for coping with common challenges after abdominal surgery, including wound and skin complications, mobility difficulties, the rehabilitation period, and potential changes in activity and lifestyle

• identify resources (e.g., community support groups, online informational resources) designed to support individuals undergoing abdominal surgery

Why Is Preoperative Teaching to Prepare Patients for Abdominal Surgery Important?

› Preoperative education about abdominal surgery is important because it increases patient knowledge regarding preparing for abdominal surgery, reduces anxiety regarding the experience, enhances ability to cope with the perioperative experience and recovery, and can decrease the risk for postoperative complications, particularly as a result of learning postoperative exercises (for details, see Nursing Practice & Skill … Patient Education: Teaching the Patient Postoperative Exercises; CINAHL Topic ID Number T705896)

› Patient education is required by The Joint Commission (TJC). Standard PC.02.03.01 requires hospitals to provide patient education that is individualized to the patient’s needs and abilities (TJC, 2017)

Facts and Figures

› Up to 40% of patients undergoing abdominal surgery have significant preoperative nutritional deficits; subsequently, they are at risk of poor postoperative outcomes, higher morbidity and mortality rates, increased length of stay (LOS), and added hospital expenses. Causes of malnutrition prior to surgery include decreased oral intake, a preexisting chronic condition, tumor-related cachexia, impaired absorption due to intestinal obstruction, and previous surgical bowel resection (Cerantola et al., 2011)

• Preoperative nutritional screening is recommended for all patients undergoing abdominal surgery. Depending on the degree of malnutrition, patients should be educated about the benefits of good preoperative nutrition, including reduced postoperative complications, costs, and LOS, and may be started on nutritional support (e.g., protein formulas) at least 5 days before surgery (Cerantola et al., 2011)

› In a comparative study of over 14,000 general surgical patients (34% smokers, 39% former smokers, and 27% who had never smoked), smokers had increased respiratory and cardiovascular complications and poorer outcomes related to wound healing. Hospital costs for current smokers were 11% higher than for patients who had never smoked; costs were 15% higher for patients who had previously smoked. Researchers involved in this study of veterans suggested that quitting smoking before surgery can improve postoperative outcomes and decrease complications (Kamath et al., 2012)

› In a Finnish study of 168 patients who underwent abdominal surgery, those who listened to their favorite music postoperatively had significantly lower respiratory rates and systolic blood pressure on the first and second days after surgery. Listening to music was perceived by these patients as a positive experience (Vaajoki et al., 2011)

› Older adults who have undergone abdominal surgery generally experience moderate to severe postoperative pain and often experience inadequate pain control. In an international study of 124 older adults, those who listened to relaxation tapes and mastered the techniques experienced reduced pain and anxiety after surgery along with increased independence in managing their pain (Rejeh et al., 2013)

› Adhesions, a common cause of complications from abdominal surgery, can lead to small bowel obstruction, injury at reoperation, female infertility, and chronic pain. Adhesions can also reduce quality of life, jeopardize life expectancy, and result in significant healthcare costs. In a meta-analysis of 5,191 patients, oxidized regenerated cellulose and hyaluronate carboxymethylcellulose was used effectively to reduce clinically relevant consequences of adhesions (ten Broek et al., 2014)
In addition, adhesions prolong operative time by 15 minutes, pregnancy rates drop by 50% after abdominal surgery, and chronic abdominal or pelvic pain persists in half of patients (ten Broek et al., 2013).

Researchers conducted a systematic review to evaluate the use of cardiopulmonary exercise testing (CPET) in predicting outcomes of patients undergoing non-cardiopulmonary intra-abdominal surgery. They determined that CPET is effective as a preoperative risk-stratification tool for predicting postoperative patient outcomes, and recommend that it be included in the preoperative assessment of patients scheduled to undergo abdominal aortic aneurysm (AAA) repair and liver, pancreatic, and intra-abdominal surgery (Moran et al., 2016).

**What You Need to Know Before Preparing Patients for Abdominal Surgery**

For scheduled surgical procedures, preoperative teaching is typically provided prior to the day of surgery and reinforced on the day of the surgery.

Preoperative teaching covers similar information when given in inpatient and outpatient settings, with a focus on what the patient will experience before and after surgery. Regardless of whether the patient will be alert, sedated, or under anesthesia during the operation, patients and family members might also want information about what will happen during performance of the surgical procedure.

Patients and family members often experience anxiety in the immediate preoperative period that can interfere with their ability to pay attention and absorb the information presented during preoperative teaching. For this reason, verbal and written information provided prior to the day of surgery might be more fully comprehended by the patient and family; understanding of preoperative teaching can then be reinforced as appropriate by additional verbal and written material on the day of the procedure.

In the case of outpatient surgery, a preadmission tour of the surgical facility can help decrease preoperative anxiety of patients and family members.

The most successful strategies for teaching patients about preparing for surgery are individualized educational interventions:

* All teaching should be patient-centered and evidence-based.
* Educational information should be provided in a culturally sensitive manner and in a language and at a level that can be easily understood by the patient.
* Patient education and teaching tools can include handouts, books, DVDs (e.g., demonstrating the proper technique for performing a particular exercise), and online resources. The materials should be tailored to address the patient’s specific needs and priorities.
  - Print materials should be clear, concise, and written at a 5th-grade reading level. Visually oriented informational handouts (i.e., those with diagrams and limited wording) should be patient-focused and easy to read.
  - Written materials (e.g., booklets, fact sheets) have received mixed reviews.
  - The effectiveness of print materials varies based on overall comprehensibility, visual appeal, legibility, text style, typeface, size, and layout.
  - Internet resources are available to most patients, although healthcare professionals disagree about the value of Internet information.
  - One strategy to enhance Internet use by patients is to provide a list of Websites for information on postoperative exercises that are thought to be accurate, current, and understandable.
* Simple, nonmedical language should be used for all patients, especially when low literacy levels are assessed.
  - Professional certified medical interpreters, either in person or by telephone, should be used when there are language barriers.

Educating patients preoperatively about postoperative exercises can be beneficial in reducing the risk of postsurgical complications following abdominal surgery:

* Coughing and deep breathing exercises reduce the risk of pulmonary complications (e.g., atelectasis, pneumonia).
* Incentive spirometry (IS) can be used in conjunction with deep breathing, coughing, early mobilization, and optimal analgesia to reduce pulmonary complications, but has not been shown to be more effective than deep breathing alone (for more information, see Nursing Practice & Skill ... Patient Education: Incentive Spirometry at the Bedside).
  - There is little evidence to support the benefit of IS in reducing pulmonary complications and improving lung function following cardiac or upper abdominal surgery. Guidelines issued in 2011 by the American Association for Respiratory Care state that (Restrepo et al., 2011):
    - IS should not be used exclusively; this modality must be used in conjunction with deep breathing, coughing, early mobilization, and achieving optimal analgesia.
    - IS not be routinely used to prevent atelectasis following abdominal or coronary artery bypass grafting surgery.
    - A volume-oriented, rather than a flow-oriented, IS be used.
- there are no evidence-based recommendations regarding frequency of use
• Knee-chest positioning relieves retention of intestinal gas and prevents increased pain and discomfort due to abdominal distention; using a rocking-chair motion can reduce postoperative ileus
• Leg and foot exercises reduce the risk of circulatory complications (e.g., deep vein thrombosis), foot drop, and toe deformities

Abdominal surgery often results in moderate to severe postoperative pain that can interfere with the muscles used for deep breathing. In addition to pharmacologic pain relief methods, nonpharmacologic pain relief methods can be used to focus attention, facilitate breathing, and promote relaxation
• Relaxation exercises can be performed to reduce postoperative pain. This nonpharmacologic strategy can be used independently or in conjunction with pain medication to increase the effect of the analgesic (Topcu et al., 2012)
• Educating patients regarding the benefits of listening to music following surgery allows them to choose music in advance and proactively plan for using this strategy after surgery

Preliminary steps that should be performed before teaching a patient about abdominal surgery include the following:
• Review the facility/unit-specific protocol for preoperative patient teaching, if one is available
• Review the treating clinician’s order for preoperative teaching, if available
  – Note the specific surgery to be performed
• Identify acceptable patient teaching resources about preparing for surgery that are available on site and via the Internet
• Review the patient’s medical history/medical record for
  – surgical history
  – current medications
• Verify completion of facility informed consent documents

Verify the availability of necessary supplies prior to initiating the educational session, which may include
• a teaching guideline or documentation form outlining key content areas
• corresponding written materials and multimedia materials that will vary based on the patient’s individualized needs and can include a copy of a facility-approved pain assessment tool and information on
  – steps the patient should undertake to prepare for surgery (e.g., bowel preparation, avoiding oral intake, and/or medications that should or should not be taken in the days before surgery)
  – what to expect in the immediate postoperative period, including how postoperative pain will be assessed and managed
• a PCA pump and/or an IS
• information about community and Internet resources (e.g., https://www.facs.org/~media/files/education/patient%20ed/app.ashx, https://medlineplus.gov/ency/presentations/100049_1.htm) designed to assist patients in learning about their specific abdominal surgery
• information on how to contact the healthcare team for questions or concerns

How to Provide Preoperative Teaching to Prepare Patients for Abdominal Surgery

Perform hand hygiene
Identify the patient using two unique identifiers, according to facility protocol
Establish privacy by closing the door to the patient’s room and/or drawing the curtain surrounding the patient’s bed
Introduce yourself to the patient and/or family member(s), if present; explain your clinical role; assess the coping ability of the patient/family and for knowledge deficits and anxiety regarding abdominal surgery
• Determine if the patient/family requires special considerations regarding communication (e.g., due to illiteracy, language barriers, or deafness); make arrangements to meet these needs if they are present
  – Use professional certified medical interpreters, either in person or via phone, when language barriers exist
• When appropriate, patient education should be scheduled when family members or caregivers are available to support the patient in learning
Communicate in a culturally sensitive manner using language that is understandable to the patient
Assess patients for
• readiness to learn
  – Listen for cues that the patient is asking for information about abdominal surgery (e.g., “I’m not sure I’ll be able to take the pain after my operation.”) or ask questions to help identify what information is needed for optimal follow-up care (e.g., “It’s important to have someone help you with your personal care when you return home. Who do you think could help you?”)
Individualize the teaching approach based on the learner’s readiness as patients/families may be at different stages of readiness

- preferred learning style
  - Individuals are auditory, visual, or tactile learners, and learn by hearing (e.g., listening to other patients talk about their experience of having abdominal surgery), by seeing (e.g., a nurse demonstrating how a patient uses a PCA pump), and by doing (e.g., using an IS)

- patient-identified learning priorities
  - When there is incongruence between the patient’s priorities and the healthcare provider’s goals, all will need to explore why the incongruence exists

- learning barriers
  - Barriers can include impaired memory or cognitive difficulties; learning disabilities; physical limitations; language; low literacy; impaired hearing, sight, and/or speech; financial difficulty; and cultural, psychosocial, and/or emotional concerns
  - Barriers to learning should be assessed through patient interview while conducting the physical and mental evaluation and continued assessment should be performed throughout the course of care

- learning needs and desires
  - Carefully assess the patient’s clinical status and related learning needs to understand the unique challenges he/she faces
  - Some patients are preoccupied with comorbidities and concerns about how their daily routines and responsibilities (e.g., mobility limitations, work restrictions, surgery-related financial matters) will be handled during hospitalization and the recovery period

» Plan for timely delivery of relevant information
  - The overall plan for preoperative teaching should be comprehensive, but tailored to meet the patient’s specific learning needs, and should be divided into information segments that are scheduled at intervals to avoid overwhelming the patient
  - Identify high-quality teaching tools in advance to support teaching and learning
    - The assessment of learner characteristics, along with his/her clinical and developmental needs, should guide the selection of appropriate teaching tools
  - Skillfully integrate education into clinical care if the patient is receptive and his/her medical condition is stable

» Implement the individualized patient teaching plan
  - Discuss and set mutually achievable goals for learning with the patient
    - Anticipate a planned approach to teaching/learning, but be prepared to be flexible and individualize information based on the patient’s changing needs and desires
    - Provide choices in the learning experience and scheduled educational sessions (e.g., encourage the patient to identify the best time of day for learning and what information to cover first) and in making decisions about treatment choices
  - Use a variety of teaching/learning strategies for best results
    - Direct communication such as face-to-face interaction is fundamental to clinical care and education of postoperative patients, particularly for discussions about emotional and psychosocial concerns
    - Provide demonstration and seek return demonstration, as appropriate
    - Provide written materials, DVDs, and Internet resources, as appropriate
  - Use nonmedical language and, when available, a model or simple graphic depiction of the patient’s recommended surgery to educate about why it is indicated and the organs affected. Discuss how the patient’s current condition, comfort level, mobility, and functional abilities may be affected by the surgery

» Provide information related to the scheduled surgery, including
  - general information (e.g., when and where to arrive for surgery, family waiting areas and visitation practices, the option to complete an advance medical directive)
  - surgery-specific information (e.g., the type of anesthesia recommended, what to expect during the induction process, and estimated length of time for the surgery)
  - common risks (e.g., adverse anesthesia reactions, postoperative pneumonia, infection at the surgical site, deep vein thrombosis, blood loss requiring a transfusion) and benefits (e.g., improved overall health, improved quality of life) of abdominal surgery in general and of the specific procedure the patient will undergo (e.g., following a Whipple procedure, blood glucose levels are frequently elevated and insulin is required; gastric dumping syndrome can be experienced after bariatric surgery)
  - Explain how potential risks are monitored and treated during the inpatient stay and emphasize strategies that are performed to maximize patient safety
Describe the preparatory regimen for the intended surgery (e.g., details of NPO requirements, dietary restrictions, oral hygiene, showering and/or skin preparation, removal of make-up and nail polish, bowel preparation, low molecular weight heparin prophylaxis, medication and herbal adjustments, tobacco cessation)

- Review the prescribing clinician’s preoperative recommendations based on the patient’s condition and the anticipated surgical procedure (e.g., aspirin or aspirin-containing products to be discontinued 2 weeks before surgery, use of nonsteroidal anti-inflammatory drugs [NSAIDs] to be discontinued 48–72 hours prior to surgery, avoidance of OTC herbal and other preparations such as ginkgo biloba and clotting-related preparations)
- For most surgeries, patients will be asked to remove dentures/partial plates, glasses/contact lenses, appliances/prostheses, hairpins/hairpiece, jewelry, and undergarments; they should be informed of this before the date of the surgery and encouraged to leave these items at home
- Patients who are suspected of being malnourished should undergo nutritional screening and be educated about preoperative nutritional support, as needed
- Patients who are smokers should be informed of the hospital’s or surgery center’s smoking policy and may be referred to tobacco cessation experts/programs for counseling prior to surgery
- When the patient is expected to be discharged the same day of surgery, particularly if conscious sedation or general anesthesia is used, patients should be instructed to arrange for a responsible adult to drive them home after surgery. Many facilities prohibit patients from driving home, having an adolescent drive, or taking public transportation without supervision the same day as surgery

Provide summary information about the intraoperative experience to allay patient anxiety

- Provide a brief explanation of patient-specific intraoperative interventions (e.g., nurse verification of the correct patient, procedure, and site; making site markings related to the surgery; induction of anesthesia)
- If the patient will be alert during surgery, provide information about what sensations to expect (e.g., seeing bright lights overhead, feeling the cool room air and/or the warmth of a heated blanket, hearing beeps from nearby equipment), and strategies for coping (e.g., listening to music, distraction, guided imagery)

Provide summary information about what will happen during the initial recovery period, including

- activity restrictions
- diet restriction and advancement
- medications, particularly pain medication
- wound care
- use and removal of tubes and lines
- antiembolic stockings or a sequential compression device
- nausea and pain management, including how to use a pain intensity scale
- anticipated methods of administration of analgesics and antiemetics, and how to use a PCA pump if indicated
- surgery-specific routines and equipment such as a Foley catheter or nasogastric tube

Provide information about measures to prevent postoperative complications, including

- turning, positioning, and mobility
- how to perform deep breathing exercises
  - Place one hand on the abdomen
  - Inhale through the nose slowly to expand the abdomen and rib cage
  - Hold breath for 3 seconds to achieve sustained maximum inspiration
  - Slowly exhale through the mouth
  - Repeat 3–4 times at least every 2 hours, or as prescribed by the treating clinician
  - To encourage children to practice deep breathing, use play activities such as blowing bubbles or blowing paper windmills
- how to perform splinting and coughing
  - Position a folded towel, blanket, or pillow against the abdomen to provide support when coughing
    - Splinting helps to allay the patient’s fear that coughing will open the incision
    - Slowly raise the head while breathing in deeply through the nose
    - Slowly bend the head forward while exhaling slowly through pursed lips
    - Repeat these steps 2 times
    - After the third deep breath, firmly hold the pillow to the abdomen and cough
    - Have a tissue ready to collect secretions
- how to use a volume-oriented IS
  - Set the desired volume on the IS
- Hold the IS upright
- Take a normal breath and exhale
- Insert the mouthpiece of the IS between the lips and form a tight seal
- Take a slow, deep breath and observe the diaphragm rise to the desired volume, as tolerated
- Hold the inspiration for at least 3 seconds at the desired volume
- Remove the mouthpiece and breathe normally
- Repeat the procedure 4 or 5 times, according to facility protocol or treating clinician orders

- how to perform leg and foot exercises in bed
  - Point the toes of both feet toward the foot of the bed until the calf muscles tighten
  - Relax the feet
  - Pull the toes of both feet toward the chin until calf muscles tighten
  - Relax the feet
  - Circle the ankles, first in one direction and then in the other
  - Flex one knee and slide heel along the bed toward the buttocks
  - Extend the leg and relax
  - Repeat with the other leg
  - Repeat exercises according to facility protocol or treating clinician orders

- Combine procedural information (e.g., a step-by-step overview of the patient’s specific surgery), sensory information (i.e., what the patient can expect to hear, see, feel, smell, and touch), and strategies for coping with abdominal surgery to maximize learning. For example, “After surgery, you’ll be taken to the surgical unit. The nurses will ask you to rate your pain on a scale of 0–10, with ‘0’ being no pain and ‘10’ being the worst pain imaginable. They’ll also ask you to describe the pain, whether it is dull and aching or sharp and throbbing, and indicate where the pain is located. The nurses will use this information to help you to resolve the pain and be more comfortable. At first, you’ll have a patient-controlled analgesia machine called a PCA pump that will allow you to press a button when you feel pain.”

- Review discharge criteria, including information on anticipated length of stay; emphasize the need for assistance after discharge and help the patient identify potential caregivers, if indicated

- Educate about the emotional and psychosocial challenges that are common after abdominal surgery and encourage the patient to discuss how abdominal surgery will affect his/her daily activities and lifestyle
  - Strategies for coping with emotional and psychosocial issues should be individualized based on the patient’s needs and preferences. For example, some patients benefit from increased family or community support, while others find it helpful to meditate, perform deep breathing exercises, or participate in guided imagery sessions. As appropriate, request referral to a mental health clinician for counseling on coping strategies and to a social worker for identification of community resources (e.g., a support group); encourage browsing related Internet sites for information and support

- Evaluate the patient’s response to teaching
  - Continually reassess learning throughout the course of care
  - Use a teach-back method to evaluate learner understanding
    - Have the patient restate health information and/or perform a return demonstration of a skill to allow the nurse to listen, observe carefully, and clarify, as needed
    - Remember that specific information is better recalled than general information
  - Use a self-efficacy (i.e., the extent to which a person believes he/she is capable of achieving a desired outcome) rating to understand how confident the learner is of understanding information or performing a skill. For example, ask the patient, “On a scale of 0–10, how certain are you that you will be able to follow the plan that we’ve discussed?” If the patient’s response is < 7, the plan will need to be readjusted (e.g., reiterate education until response is ≥ 7, explore alternate options, initiate greater involvement of family members in teaching)

- Document the following information in the patient’s medical record, and communicate any concerns with the multidisciplinary healthcare team so that information can be reinforced and the learning plan can be continued or modified accordingly:
  - All education provided about preparing for abdominal surgery, including specific teaching/learning strategies implemented
  - Assessment findings regarding readiness to learn, preferred learning style(s), learning needs/desires, and learning priorities of the patient
  - Identified barriers to learning and methods used to help overcome these barriers
  - Patient response to learning, including demonstrated level of understanding and/or ability to perform necessary skills
  - Plan for continuation of patient education, including whether or not specific information should be reinforced or taught again using a different teaching method
What to Expect After Providing Preoperative Teaching to Prepare the Patient for Abdominal Surgery

› After providing preoperative teaching to prepare the patient for abdominal surgery, the patient will
  • better understand his/her specific abdominal surgery, why it is indicated, and related risks and benefits
  • better understand care that is necessary before, during, and after surgery specific to his/her status, including self-care skills and management of symptoms
  • be able to describe how to prepare for his/her specific abdominal surgery, including bowel preparation, food and fluid restrictions, medication adjustments, and restrictions related to OTC medications, herbal preparations, and supplements
  • be able to discuss what to expect during hospitalization, including the surgery and typical course of recovery
  • understand the need for assistance after abdominal surgery and be able to identify supportive caregivers, if needed
  • learn and be able to discuss strategies for coping with common challenges after abdominal surgery, including wound and skin complications, mobility difficulties, the rehabilitation period, and changes in activity and lifestyle
  • learn and be able to discuss strategies for coping with common challenges after abdominal surgery, including wound and skin complications, mobility difficulties, the rehabilitation period, and changes in activity and lifestyle
  • be able to perform postoperative exercises to promote optimal postoperative recovery and reduce complications
  • experience delivery of consistent educational information throughout the course of care
  • perceive having received information that is culturally sensitive and understandable

Red Flags

› Unless supported by the patient, the use of family members, friends, and nonprofessional staff as interpreters is a violation of the patient’s right to confidentiality

What Do I Need to Tell the Patient/Patient’s Family?

› Based on assessed needs and desires, educate the patient about his/her specific abdominal surgery, including what it is and why it is indicated; the risks and benefits of abdominal surgery; how to prepare for abdominal surgery; what to expect during hospitalization, including surgery and initial inpatient recovery; strategies for preventing potential postoperative complications; and community and online resources designed to support patients after abdominal surgery

References


