HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Operating Room		
Document:	Internal Policy and Procedure		
Title:	Perioperative Documentation		
Applies To:	All Surgeon, Anesthesiologist and Operating Room Nurse		
Preparation Date:	January 05, 2025	**Index No:**	OR-IPP-010
Approval Date:	January 19, 2025	**Version :**	5
Effective Date:	February 19, 2025	**Replacement No.:**	OR-DPP-010(4)
Review Date:	February 19, 2028	**No. of Pages:**	5

1. PURPOSE:

1.1 To collect data about the surgical patient before surgical operation.

2. DEFINITIONS:

2.1 **Perioperative Period** – it begins when the patient is informed of the need for surgery, includes the surgical procedure and recovery and continues until the patient resumes his/her usual activities.

2.1.1 Perioperative encompasses 3 phases:

2.1.1.1 Preoperative

2.1.1.2 Intraoperative

2.1.1.3 Post – operative

2.2 **Perioperative Documentation** – to collect data about the surgical patient through interviews, physical assessment and evaluation of records to facilitate an individualized patient care plan and continuity of care.

3. POLICY:

3.1 DOCUMENTATION:

3.1.1 The patient's identification by using patient's two identifiers (4 names for the Saudi/ complete name for the Non – Saudi and Medical Record Number) must be present on all documents with the correct details.

3.1.2 All documents must be completed with correct and relevant data.

3.1.3 Write all data if an addressograph label is not available.

3.1.4 Write the date and time of each entry.

3.1.5 Write all information.

3.1.6 Write factual information only.

3.1.7 Uses approved abbreviations only.

3.1.8 Avoid using vague terms.

3.1.9 Write reports objectively.

3.1.10 Do not write over mistakes or between written lines.

3.1.11 Do not use ink or adhesive paper on any medical records.

3.1.12 Crosses errors with a single line and adds initials.

3.1.13 All observations must be recorded accurately.

3.1.14 Record all documents and chart in accordance with legal requirements and hospital policy.

3.1.15 Accurately completes all charts prior to the patients return to the ward.

3.1.16 All incident report is complete and accurate in case of unusual occurrences:

3.1.16.1 Inaccuracies in the Surgical Count

3.1.16.2 Patient Injury

3.1.16.3 Medication Errors

3.1.16.4 Staff Injury

3.1.16.5 Unsafe Condition

3.1.16.6 Loss or Hefty

3.2 **Guidelines to write a statement:**

3.2.1 The statement should be written as soon as possible after the occurrence of the event.
3.2.2 The statement should state only what the writer has personally witnessed.
3.2.3 Sentences should be short, clear, using simple language describing accurately the occurrence under discussion.
3.2.4 Opinion should not be given.
3.2.5 The statements must indicate the time and date of the occurrence.
3.2.6 The document is to be signed and dated.
3.2.7 If a witness is present. He/she should complete a statement.
3.2.8 Statements should be carefully checked to ensure the validity and accuracy.
3.2.9 Statement must be handed to the OR in charge who will submit it to the nurse manager.
3.2.10 Submit within 24 hours.

3.3 **Admission to the Operating Room: The Receiving Nurse:**

3.3.1 Will perform patient interview to identify psychosocial and cultural needs of the patient.
3.3.2 Perform a visual physical assessment of the patient to identify physical limitations considerations of the patient.
3.3.3 Will document assessment findings on the nursing record.
3.3.4 Will communicate assessment findings to the healthcare team for continuity of care.
3.3.5 SN's in the operating room & PACU Recovery will assess the patient intraoperative and post operatively to evaluate the effect the perioperative nursing.

4. PROCEDURE:

4.1 **Documentations:**

4.1.1 Pre – Operative identification and perioperative admission procedures.
4.1.2 Intraoperative Nursing Care.
4.1.3 Anesthesia Care.
4.1.4 Surgical Count Record.
4.1.5 Post – Operative Nursing Care and Observations.
4.1.6 Incidence Reporting.
4.1.7 Entries into the Drug Register.
4.1.8 Record of Specimens.
4.1.9 Implant tracking, and provide accurate documentation that details the planning, implementation and evaluation of all of the Nursing care delivered.

4.2 **Legal Requirements:**

4.2.1 **The Perioperative Nurse must:**

4.2.1.1 Comply with all statutory requirements for documentation.
4.2.1.2 Comply with the Health care facility's policy on documentation.
4.2.1.3 Documents events and care chronologically and contemporaneously.
4.2.1.4 Ensure that all of the documentation is accurate, objective and concise.

4.3 **Intraoperative Documentation must:**

4.3.1 Document personnel providing the preoperative care.
4.3.2 Identify surgery and wound classification.
4.3.3 Document date and time of surgery, arrival in the Operating Room and anesthesia times.
4.3.4 Identify type of anesthesia.
4.3.5 Document pre-operative, post-operative and operative procedure:

4.3.5.1 Use of Intra-Operative X – rays
4.3.5.2 X – rays site
4.3.5.3 X – rays Technicians Name
4.3.5.4 Monitoring equipment used (ECG, NIBP, and SaO_2 etc.)

4.3.6 Patient's specimens and cultures taken during the surgical procedure.

4.4 **Document the patients overall skin condition on arrival and discharge from the perioperative suite:**

4.4.1 Skin integrity and condition.
4.4.2 Location of the skin preps and shave site.

4.4.3 Type of skin prep solution used.
4.4.4 Location and type of drains and wound packing.
4.4.5 Type of Foley catheter used and personnel inserting.
4.4.6 Dressing type and site.
4.4.7 Additional Nursing notes – any significant or unusual occurrence of perioperative patient outcomes.

4.5 **Implant Record:**
4.5.1 Placement and location of implants (e.g. prosthetic devices, grafts, tissue and bone).
4.5.2 Name of Manufacturer/Distributor.
4.5.3 Lot and Serial Number.
4.5.4 Expiration Date
4.5.5 Four names for the Saudi/ complete name for the Non – Saudi and Medical Record Number, Telephone Number (if applicable) & address.
4.5.6 Physician Implanting.

4.6 **Patient Positioning:**
4.6.1 Use of pat – slide or slide sheet when indicated for use.
4.6.2 Position on the table.
4.6.3 Position of the arms.
4.6.4 Use of leg or body straps.
4.6.5 Positional devices (e.g. stirrups, cloward's frame, chest roll and etc)
4.6.6 Use of padding or protective devices

4.7 **Equipment:**
4.7.1 Tourniquet – a. site b. pressure c. time on and off
4.7.2 Insufflator – Time on and off.
4.7.3 Electrosurgical Unit – a. serial number b. settings c. dispersive pad site

4.8 **Sponge and Instrument counts:**
4.8.1 The surgical count must be accurately documented in the patient's medical record.
4.8.2 The perioperative nurses must comply with the health care facility's policy in relation to the surgical count.
4.8.3 The perioperative nurse must comply with the AORN Standard "Recommended Practices for Counts – Sponge, Sharp and Instrument".
4.8.4 The perioperative nurses must ensure that the count sheet is retained in the patient's medical record.

4.9 **Sponge and Instrument counts:**
4.9.1 The perioperative nurses must ensure that the count sheet is signed by the nurses responsible for the counts.
4.9.2 Sponge, needle and sharp x 3.
4.9.3 Instrument count x 2.
4.9.4 Initial/signature of person counting.
4.9.5 Instrument intact.
4.9.6 Document person reporting counts, surgeon and person response.

4.10 **Intraoperative Fluid Balance:**
4.10.1 Type, amount and total infused
4.10.2 Blood products-listed unit number of each product used.
4.10.3 Estimated blood Loss
4.10.4 Total Urine output

4.11 **Medications:**
4.11.1 Irrigation (Normal Saline, Glycine, H2O)
4.11.2 Narcotics used/wasted
4.11.3 Antibiotics.

4.12 **Planning and Providing Care:**
4.12.1 Unit (PACU/Recovery, Neonatology, PICU etc.)
4.12.2 Name of the staff member handed over to.

4.12.3 Patient transfer status – a. spontaneous respirations b. intubated c. oral airway d. assisted respirations e. ambubag f. Jackson Rees circuit pediatric etc.

4.13 **Planning and Providing Care:**

4.13.1 Initial vital signs from PACU/Recovery

4.14 **Circulating Nurses signature and date:**

4.14.1 The patient's record should respect a continuous evaluation of the perioperative Nursing care and the patient's response to applied nursing interventions.

4.14.2 Ensure that any information documented on nursing care plans is made in a timely manner and only by the nursing staff directly involved with the patients care.

4.15 **Confidentiality:**

4.15.1 The perioperative nurse must ensure that the patient's rights to confidentiality are preserved.

4.15.2 Store records in areas to which only authorized staff are permitted, and comply with the Health Care facility's policy for the use of patient medical records in research activities.

5. MATERIALS AND EQUIPMENT:

5.1 Patient Chart
5.2 Medical Records
5.3 Laboratory Results
5.4 X – ray Reports

6. RESPONSIBILITIES:

6.1 Nurses
6.2 Anesthesiologist
6.3 Surgeon

7. APPENDICES:

N/A

8. REFERENCES:

8.1 Kingdom of Saudi Arabia, Ministry of Health, Bisha General Hospital, 2018.

9. APPROVALS:

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