HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	Preoperative and Postoperative		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 The purpose of patient assessment to determine the need and the type of care to be provided for patient undergoing surgical procedure.

2. DEFINITIONS:

2.1 **Preoperative Phase**- the time from when decision for surgical intervention is made and till the time when the patient is transferred to the operating room table.

2.2 **Postoperative Phase**- period of time that begins with the admission of the patient to the postanesthesia care unit and ends after follow up evaluation in the hospital.

3. POLICY:

3.1 All patients admitted to the OB & Gyn. Department for operative and/ or other invasive procedure, should be assessed by the Resident for physical, psychological and social needs of the patient.

3.2 Patients are initially assessed upon admission to the ward and reassessed at frequent intervals thereafter to:

3.2.1 Determine suitability and fitness of the patient to undergo specific surgical procedures.

3.3 All measures to be taken to prevent any medico-legal complications of the surgery to provide safety for the team performing the surgery.

3.4 The physician in – charge writes the plan of management for the patient during her hospital stay.

3.5 All patients scheduled for surgical operations should undergo routine laboratory investigations according to types of contemplated surgery.

3.6 Laboratory investigations should be according to pre-operative timing and the age of the patient.

3.7 Hard copies of the results of laboratory investigations should be attached in the patient's files and endorsed accordingly to the operating personnel.

3.8 For any discriminating results of the investigations, the surgeon and anesthesiologist should be informed.

4. PROCEDURE:

4.1 Upon admission to the ward, initial assessment is performed by the resident.
The assessment includes, but not limited to:

4.1.1 Proper identification of the patient.

4.1.2 The patient's procedure to be performed per the physician's written order, appropriate consent obtained and the patient understands of the procedure to be performed.

4.1.3 The patient's known allergies.

4.1.4 Baseline vital signs and ECG tracing.

4.1.5 The patient's functional status and mobility.

4.1.6 The patients' psychological and emotional status.

4.1.7 Any diagnostic test results relevant to the determination and treatment needs of the patient available on the medical record.

4.1.8 The patients' history of the physical examination are completed and or the medical record.

4.1.9 The patients' response and tolerance to the procedure are continually reassessed. Modification and changes in the plan of care based on reassessed data.

4.2 Preparing the woman for a surgical procedure.

4.2.1 Explain the procedure to be performed and its purpose to the woman. If the woman is unconscious, explain the procedure to her family.

4.2.2 Obtain informed consent for the procedure.

4.2.3 Assist the woman and her family to prepare emotionally and psychologically for the procedure.

4.2.4 Review the woman's medical history.

4.2.5 Attending Anaesthesiologist should examine the patient pre-operatively and makes pre-operative orders.

4.2.6 Documents the patient's diagnosis and preoperative orders in the patient's medical record to provide collaborative interdisciplinary care for the patient's optimal and fast recovery.

4.2.7 Send a blood sample for the haemoglobin or hematocrit and type and screen. Order blood for possible transfusion. Do not delay transfusion if needed.

4.2.8 Wash the area around the proposed incision site with soap and water if necessary.

4.2.9 Do not shave the woman's pubic hair as this increases the risk of wound infection. The hair may be trimmed, if necessary.

4.2.10 Monitor and record vital signs (blood pressure, pulse, respiratory rate and temperature).

4.2.11 Administer Premedication appropriate for the anaesthesia used.

4.2.11.1 Give an antacid (sodium citrate 0.3% 30ml or Magnesium Trisilicate 300 mg) to reduce stomach acid in case there is aspiration.

4.2.11.2 Catheterize the bladder if necessary and monitor urine output.

4.2.11.3 Ensure that all relevant information is passed on to other members of the team (Physician, Midwife, Nurse, Anesthesiologist, Assistant and others).

4.3 Postoperative care principles

4.3.1 Initial Care

4.3.1.1 Place the woman in the recovery position.

4.3.1.2 Position the woman on her side with her head slightly extended to ensure a clear airway.

4.3.1.3 Place the upper arm in front of the body for easy access to check blood pressure.

4.3.1.4 Place the legs so that they are flexed, with the upper leg slightly more flexed than the lower to maintain balance.

4.3.1.5 Assess the woman's condition immediately after the procedure.

4.3.1.6 Check vital signs (blood pressure, pulse, respiratory rate) and temperature every 15 minutes during the first hour, then every 30 minutes for the next hour.

4.3.1.7 Assess the level of consciousness every 15 minutes until the woman is alert.

4.3.1.7.1 Ensure the woman has constant supervision until conscious.

4.3.1.7.2 Ensure a clear airway and adequate ventilation.

4.3.1.8 If vital signs become unstable or if the hematocrit continues to fall, quickly inform anesthetist and surgeon.

4.3.1.9 This information is documented on the Anesthesia Record and endorsed to the nursing staff who will continue the care of the patient.

4.3.2 Care in the ward:

4.3.2.1 If the surgical procedure was uncomplicated, give the woman a liquid diet.

4.3.2.2 If there were signs of infection, or if the caesarean was for obstructed labor or uterine rupture, wait until bowel sounds are heard before giving liquids.

4.3.2.3 When the woman is passing gas, begin giving her solid food.

4.3.2.4 If the woman is receiving IV fluids, they should be continued until she is taking liquids well.

4.3.2.5 If you anticipated that the woman will receive IV fluids for 48 hours or more infuse a balanced electrolyte solution.

4.3.2.6 If the woman received IV fluids for more than 48 hours, monitor electrolytes every 48 hours. Prolonged infusion of IV fluids can alter electrolyte balance.

4.3.2.7 Ensure the woman is eating a regular diet prior to discharge from hospital.
4.3.2.8 Dressing and wound care:
4.3.2.8.1 Keep the dressing on the wound for skin day after surgery.
4.3.2.8.2 If blood or fluid is leaking through the initial dressing, do not change the dressing.
4.3.2.8.1.1 Reinforce dressing.
4.3.2.8.1.2 Monitor the amount of blood/ fluid lost by outlining the blood stain on the dressing with a pen.
4.3.2.8.1.3 If bleeding increases or the blood stain covers half the dressing or more, remove the dressing and inspect the wound. Replace with another sterile dressing.
4.3.2.8.3 If the dressings come loose, reinforce with more tape rather than removing the dressing. This will help maintain the sterility of the dressing and reduce the risk of wound infection.
4.3.2.8.4 Change the dressing using sterile technique.
4.3.2.8.5 The wound should be clean and dry, without evidence of infection or seroma prior to the woman's discharge from the hospital.

4.3.3 Analgesia
4.3.3.1 Adequate postoperative pain control is important.
4.3.3.2 Avoid over sedation as this will limit mobility.

4.3.4 Bladder Care
4.3.4.1 If the urine is clear, remove the catheter 8 hours after surgery or after the first postoperative night.
4.3.4.2 If the urine is not clear, leave the catheter in place until the urine is clear.
4.3.4.3 Wait 48 hours after surgery before removing the catheter if there was:
4.3.4.3.1 Uterine rupture;
4.3.4.3.2 Prolonged or obstructed labour;
4.3.4.3.3 Massive perineal oedema;
4.3.4.3.4 Puerperal sepsis with pelvic peritonitis
4.3.4.4 If the bladder was injured (either from uterine rupture or during caesarean section or laparotomy):
4.3.4.4.1 Leave the catheter in place for a minimum of 7 days and until the urine is clear.
4.3.4.5 If the woman is not currently receiving antibiotics, give Nitrofurantoin 100mg by mouth once daily until the catheter is removed; for prophylaxis against cystitis.

4.3.5 Antibiotics:
4.3.5.1 If there were signs of infection or the woman currently has fever, continue antibiotics until the woman is fever-free for 48 hours.

4.3.6 Suture Removal
4.3.6.1 Remove skin sutures 5 days after surgery.

4.3.7 Fever
4.3.7.1 Fever (temperature 38 °C or more) that occurs postoperatively should be evaluated.
4.3.7.2 Ensure the woman is fever-free for a minimum of 24 hours prior to discharge from hospital.
4.3.7.3 Ambulation
4.3.7.4 Encourage foot and leg exercise and mobilize as soon as possible, usually within 24 hours.

5. MATERIAL AND EQUIPMENT:

5.1 Admission Form
5.2 Investigation Results
5.3 Consent Form
5.4 Operative note

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013

9. APPROVALS:

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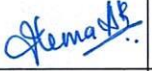
Prepared by:	Ms. Hema Robi	Nurse Specialist		January 08, 2025
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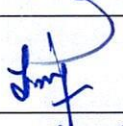
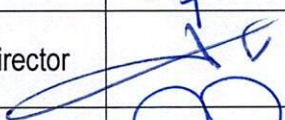
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2025
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 14, 2025
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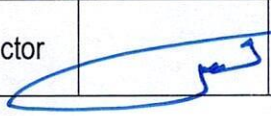
Approved by:	Mr. Fahad Hezam Al - Shammari	Hospital Director		January 22, 2025