King Saud University
King Khalid University Hospital

DEPARTMENT OF NURSING
OPERATING ROOM

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1.1 Vision

The King Khalid University Hospital Operating Room will be the healthcare leader in the Middle East and be recognized around the world as a premier medical institution dedicated for new surgical opportunities in education, research, training and providing quality perioperative nursing care service.

1.2 Mission Statement

The O.R. nursing staff supports the vision and mission of the hospital, surgery department and Nursing Department by providing quality perioperative nursing services.

Operating Room

The Operating Room Staff strongly believe that perioperative nursing service is a dynamic behavioral and technical process directed towards provision of quality patient care during surgical intervention. Our primary concern is to ensure a safe physical environment, protection of patients and delivery of holistic perioperative nursing care.

The O.R. staff are committed to improving their knowledge and skills through personal professional developments in order to facilitate implementation of scientific and technological advances in health care.

Post Anesthesia Care Unit (PACU)

The Recovery Room Staff (Post Anesthesia care Unit) strongly believe that all efforts should be directed towards provision of high quality of care for all those who have undergone surgery and anesthesia. Concern is to ensure a safe physical environment, protection of the patient’s airway and effective management of pain. We also value personal and professional development of staff in order to be able to give the best updated care possible.
1.3 Values

The Operating Room Perioperative Nursing Service Team believes in:

a. **Excellence and Leadership**: To achieve standard of nursing excellence through evidence based practice focusing quality perioperative nursing care.

b. **Integrity and Honesty**: To perform at all times in our most important principles of integrity and honesty with the highest nursing ethical standards.

c. **Respect and Collegiality**: To treat our colleagues, co-workers and most specially our patients with respect and dignity.

d. **Collaboration and Teamwork**: To cooperate and work with other members of the surgical team and departments by fostering efficiency, professional and personal growth.

e. **Compassion and Empathy**: To be committed in a caring way by being advocate and maximizing holistic care for the patient's well being and comfort during surgery.

f. **Innovation & Discovery**: To provide optimum level of perioperative nursing care through innovation & discovery in order to achieve maximum function of patient's well being and comfort.
1.4 Scope of Practice

A. Perioperative Nursing Practice is the nursing care to patients, families and significant others during the period of a surgical intervention. Perioperative Nursing Practice is carried out during the Immediate pre-operative, intra-operative & immediate post-operative periods. The nursing process takes into account supportive and potentially disruptive influences on health status and related problems, resulting from the patient's response and or adjustment to surgical intervention.

The standards of perioperative nursing practice provide a basic model by which the quality of perioperative nursing practice maybe measured.

The perioperative registered nurse is primarily accountable and responsible for the process of nursing practice to patients who are facing an operative & invasive procedure. The registered nurse shall assist the patient in meeting outcomes in order to implement the nursing process effectively. The nurses who are engaged in the practice of perioperative nursing shall be based on best practices and evidence based information to continuously update knowledge & skills. The registered nurse shall determine the range of practice by considering the care setting and the resources available.

B. Scope of Services

The King Khalid University Hospital Operating Room with 17 theaters is an integral agent in the total health care system, share and affirm the hospital’s goals of continuous improvement in quality patient care, motivation in educational planning and programs with the continuous interest and participation in medicine and nursing research.

The O.R. provides elective surgical service every Saturday to Wednesday and 24 hour daily emergency services. We provide a wide scope of surgical services including in- patient and out- patient surgical services.

As a leader in surgical services, we are committed to use the cutting edge technology, to provide superior, innovative and quality surgery as well as recovery services. We provide a full range of surgical technology and services including our newest state- of- the- art O.R I technology, da Vinci Robotic Surgical System, Medtronic Neuro Navigation system, different Laser technologies, Laparoscopic Advance technologies etc.

We cover a wide range of specialties which are under the following different departments and specialties.
1. Department of Surgery:
   1.1 General surgery
      a. Hepatobiliary Surgery
      b. Colorectal Surgery
      c. Breast & Endocrine Surgery
      d. Gastro-Intestinal Surgery
   1.2 Urology
      a. Adult
      b. Pediatric
   1.3 Pediatric Surgery
   1.4 Plastic Surgery
   1.5 Maxillo-Facial Surgery
   1.6 Neuro Surgery
   1.7 Thoracic Surgery
   1.8 Vascular Surgery
   1.9 Cardiac Surgery (King Fahad Cardiac Center) Now, operating separately but still under the umbrella of the Dept. of Surgery.

Note: Minimally Invasive Surgeries- Laparoscopic and Robotic Assisted Surgeries are being performed by these specialties: General Surgery, Urology, Pediatric & Gyne Surgeries.

2. Department of Orthopedics
   2.1 Unit 1- Pediatric Orthopedics
   2.2 Unit 2- Sports & Illizarov
   2.3 Unit3- Arthroplasty, Spine & Foot
3. Department of OB-Gynae

4. Department of Anesthesia
   4.1 Pain Management / ECT

5. Department of Nursing

1.4.1 Clinical Services

The Operating Room is a busy department performing between 8,000 to 10,000 operations yearly.

- Minimum cases per day: 20 to 35 cases
- Maximum cases per day: 50 to 65 cases
- Maximum cases per month: 600 to 900 cases
- Maximum cases per year: 8,000 to 10,000 cases

The effective functioning of the Operating Room and its team member is vital and essential in fulfilling the ultimate outcome in the restoration of the patient’s physical, mental, emotional, spiritual and social well-being (holistic care) with the emphasis of the optimum safety of the patient in the perioperative setting.

The patient’s population served by the Operating room is comprised of all age groups, from neonates to geriatric patients needing any type of surgical interventions.
1.4.2 Administration Services

The overall smooth running of the flow of events in the O.R. is the responsibility of the O.R. Medical Director & ADON-O.R. The ADON-O.R. should ensure full nursing staffing coverage for 24 hours perioperative nursing services. The perioperative nursing care is under the supervision of the ADON-O.R. who reports to the Director of Nursing.

The HN-O.R. is responsible for the daily allocation of staff in the all theatres. The Cardiac HN is responsible for Cardiac theatres staffing & HN-RR for Recovery Room (PACU) staffing.

O.R. Nursing Management Team:
- ADON x 1
- Educational Coordinator x 1
- HN-O.R. x 1
- HN-Cardiac x 1
- HN-RR x 1
- Charge Nurse x 16

1.5 Clients & Suppliers:

A. CLIENTS

1. Surgical Patients

The KKUH Operating Room is an integral part in the total health care system, and shares goals of quality assurance in patient care, motivation in education planning and programs, and continuing interest and participation in science, medicine and nursing research. Our clients are the surgical patients and the effective functioning of the Operating Room and its team members is vital and essential in our clients/patients' physical, mental, spiritual and social well being.

The surgical procedure is a traumatic interruption in a person’s normal state of equilibrium with some sacrifice of many of his or her control mechanisms. As advocates in his/ her care, the Operating Room staff accepts the responsibility of his/ her trust and confidence, and provides the competent intervention to care for the sedated and unconscious person in the dignified manner, that is appropriate.
The perioperative nursing care should be rendered effectively and efficiently in these 3 phases:

1. Pre-operative Phase- O.R. Holding/Reception
2. Intra-operative phase- Theatres x 17
3. Post-operative- Recovery Room (PACU)

The delivery of nursing care in the Operating Room is functional team concept. The nursing process is used in the Operating Room guided by the Operating Room standards as adapted in the O.R. Policies and Procedure. The perioperative nurse uses many interventions when caring for the patient having surgery, including proper identification and collecting pertinent data using appropriate assessment techniques to develop a plan of care for the theater are:
1. The patient remains free from infection unrelated to preoperative existing conditions.

2. The patient remains free from injury related to positioning, extraneous object or chemical, physical or electrical hazard.

3. The post-operative patient relates positive physical and psychological responses to the operative intervention experience.

2. Students - Medical, Nursing, Paramedical Students

The Operating Room also serves as a clinical setting for experience for students from the King Saud University & other Colleges. The students in all grades or levels of different fields are also our clients in O.R. for their clinical experiences & surgical training but also share surgical services to our main clients, the surgical patients. The framework of education is correlated with the university health care programs and constantly forms likewise, a stimulus for continuing education for the members of the Operating Room staff.
B. SUPPLIERS

The equipment and supplies needed in the O.R. are provided in the same process of procurement like other departments are doing which is through the Medical Supplies Department & Warehouse.

There are some equipment and supplies that are stock items and these can be ordered through the Central Stores and Warehouse. The O.R. non-stock items are purchased through the Department of Surgery and submitted to the Medical Supplies for processing. The O.R. Medical Director, O.R. ADON & the O.R. Non-Stock officer coordinate with each other with regards to the ordering of equipment & supplies for O.R. use with the approval and signature of the Chairman of the Department of Surgery. The surgeons coordinate with the O.R. Medical Director ,ADON-O.R. and O.R. Non-Stock Officer for any preferred new equipment/item needed in their surgeries wherein there is an attached justification letter and minutes of their division meeting that such item is agreed for purchase.

Departments that provide manpower's help and supplies to O.R.

- CSSD
- Radiology Department
- Medical Laboratory
- Blood Bank
- Pharmacy
- Laundry Department
- Biomedical Engineering & Maintenance Department
- Computer Department
- Infection Control Department
- Housekeeping Department
- Dietary & Nutrition Department
- Security & Transportation Department
1.6 Goals and Objectives:

1.6.1 Goals:

Our goal is to ensure quality perioperative nursing care services with the emphasis on monitoring outcome in standard of practice, infection control, evidence based practice, quality assessment and improvement as well as cost effective awareness. Therefore, the O.R. with the complex involvement in health care will always attempt to measure ourselves against the highest achievers of excellence in the health care field. This is our goal, so it must be done.

1.6.2 Objectives:

a. To provide quality and innovative perioperative nursing care to our patients that is professionally planned, implemented and evaluated.

b. To provide a safe and therapeutic environment to the surgical patient and a safe physical environment to the O.R. personnel.

c. To promote excellence in knowledge and skills of all O.R. personnel in order to facilitate implementation of scientific and technological advances in perioperative nursing.

d. To offer the most effective and least invasive treatment options to our surgical patients much less invasive than traditional surgery i.e. Laparoscopic and Robotic assisted surgeries, etc. by ensuring optimal safe level in perioperative nursing services.

e. To serve as a clinical setting for experience of medical, nursing and other paramedical interns and students of King Saud University and other colleges in Riyadh as well as training grounds for teaching and research.

f. To keep standards of perioperative nursing practice evaluated and revised in accordance to the current trends and evidence based practice.

1.7 Organizational Charts:

1. With Positions- O.R.

2. With Names- Nursing Department
1.8 Staffing Plan / Pattern

A. Brief Description:
The Operating Room team is a coordinated, highly specialized multidisciplinary group trained in the skills necessary to achieve the optimum effective surgical service. An atmosphere of respect for each individual is necessary and vital because of the close interactions and stressful circumstances which bring this team together in the Operating Room setting.

The Nurse Educator of O.R. and the unit Education Coordinator coordinates with ADON & HN's-O.R. in order to facilitate the orientation, competency verification, quality care improvement and continuing education of the Operating Room Staff. All operating room newly hired nursing staff receive a comprehensive core orientation by nursing department of education and through the Mentor & Preceptorship program. There is also specific orientation being done to newly hire health care assistants (porters) and housekeeping staff which are based on their job descriptions, adult learning methods and geared to individual learner depending on experience.

There are 17 operating theatres in the hospital-11 theatres in Main O.R., 4 theatres in Phase IV-O.R., 1 theatre in L.D.(O.B. Th.), Level 1 & 1 theatre in Ward 25-A, B.U.-O.R.(closed temporarily) The newly constructed theatres Th.1 & Th.45 are already opened for surgical services but this will depend on the availability of anesthesia & O.R. staff coverage.

The O.R. will be staffed for the operation of the abovementioned number of theatres from Sunday through Wednesday 7:30 am to 5:00 pm. The on-call teams will be available from 5:00 pm to 8:00 a, Saturday through Wednesday and the weekends and holidays-12 hours shift will be available for 24 hours emergency services.

The Operating Room is presently staffed with the following which are under Department of Nursing:
1. O.R. = 70 nurses
2. PACU (RR) = 14 nurses
3. Cardiac = 12 nurses

A surgical team should consist of 2 circulating nurse, 1 scrub nurse, an anesthetist, Surgeon and assistant. No surgical case will be done without a full surgical team.

The safe number of O.R. nursing staff assigned in each theatre is 3 O.R. staff consisting one Charge Nurse and 2 Staff nurses. However, in Cardiac theatre and at times in theatres with major & complicated cases, 4 staffs are allocated to maintain safe & smooth flow of events. The charge nurse in each theatre is responsible and accountable for the control and smooth flow of works in the theatre. During her
absence like vacation and sick leave, a senior O.R. staff nurse will cover. The Charge Nurse should remain in his/her respective theatre with the O.R. R.N.s assigned in order to assume responsibilities for all activities in the theatre. The HN/ Designee is responsible for the daily allocation of all O.R. staff in all the theatres including the O.R. Reception Area from Saturday to Wednesday except weekends and this is based on patient requirements & staff expertise.

How the Rota is developed?

We are utilizing the 3 shifts method (9.5 hrs.per shift for weekdays) and 12 hrs. shift ( 2 shifts) for Cardiac nurses and weekends for all staff at least once a month.

We have a 3rd team standby for on calls after 5:00 pm on weekdays from Saturday to Wednesday and 24 hours on calls staff for weekends-Thursdays & Fridays.

Regarding overtime, this is considered as additional time worked if there are cases done and time backs or compensations are given accordingly when O.R. is not busy or depending upon the length of time the staff worked.

Shortage of Staff:

If there is shortage of staff, giving overtime to some staff can cover the shortage. The transferring of responsibilities from one staff to another is the responsibility of HN with the approval of ADON.

Holiday Planner:

The number of staff who can go for holidays depends upon this calculation: Number of staff x 45 days divided by 354 days per year. Charge nurse & Acting Charge Nurse in each theatre are allowed to overlap for one week and two weeks can be allowed if justified with valid reasons. More staffs are scheduled to go on leaves during summer holidays when work in O.R. is not heavy.

Sick Leaves:

There is one staff coverage in each phase of O.R. In Main O.R., - 2 Phases(Phase 1 & 2) x 2 staff, Phase 3-RR x 1 staff & Phase IV-O.R. x 1 staff.

   Eid Holidays: Ramadan & Hajj Eid

   All the O.R.-R.R. staff will cover the Eid holidays.
B. Staffing Pattern in the Operating Room:

Duration & area of coverage: All theatres with different specialty sessions except Cardiac theatres- 3 shifts for 9.5 hours/per shift.

Saturday to Wednesday Coverage:

1. Morning Shift: 7:30 am to 5:00 pm = 16 theatres
   Total # of Staff = 48 to 51 staff
   CN x 1 & SN x 2 in each theatre
   CN x 1 & SN x 3 in Cardiac theatre or theatre that needs 4 staff to cover workload.

2. Evening Shift: 3:30 pm to 12 midnight – 2 theatres for emergency coverage. One or two twelve hours duty is scheduled for every evening duty staff to cover time shortage depending upon the month of Hejira Calendar.
   Total # of Staff: 4 staff
   CN x 1 & SN x 3

3. Night Shift: 11:30 pm to 8:00 am- 2 theatres for emergency coverage. One or two twelve hours duty is scheduled for every evening duty staff to cover time shortage depending upon the month of Hejira Calendar.
   Total # of staff = 4 staff
   CN x 1 & SN x 3 staff

4. Weekends (Thursdays & Fridays) - 12 hours duty
   • Morning Shift: 7:30 am to 8:00 pm – 2 to 3 theatres
     Total # of staff = 5-6 staff
     CN x 1 & SN x 4 to 5 staff
   • Night Shift: 7:30 pm to 8:00 am-2 to 3 theatres
     Total # of staff = 4 to 5 staff
     CN x 1 & SN x 4 to 5 staff

Third Team Standby for on calls:

1. Weekdays- Saturday to Wednesday- 5:00 pm to 8:00 am
   Total # of staff allocated =2 staff
2. Weekends- Thursdays & Fridays-24 hours from 7:30 am to 7:30am.
   Total # of staff allocated = 2 staff

For Cardiac Nurses

Duration of Coverage:

2 shifts of 12 hours for 5 days- Saturday to Wednesday
1 staff for 12 hours shift on weekends-Thursdays & Fridays
2 staff for on call 24 hours on weekends- Thursdays & Fridays
For Recovery Room Staff
Duration of Coverage:
- 3 shifts of 9.5 hours x 5 days- Saturday to Wednesday
- 12 hours shift for weekends- Thursdays & Fridays
  Total # of staff:
  - Morning Shift = 6 to 8 staff
  - Evening Shift = 2 staff
  - Night Shift = 2 staff

  Weekends for RR- 12 hours shift
  Total # of staff:
  - Morning Shift = 2 staff
  - Night Shift = 1 staff

O.R. Staff Professional Development:

There is a Unit PDP conducted every Saturday from 8:00 am to 9:00 am, lectures from nursing staff & surgeons and also additional in-service training from companies which is a requirement of the Medical Supplies Dept. for commissioning & training purposes. In addition for staff continuing education, Core PDP & Saudi Council CME courses are conducted by the Nursing Department of Education. The Nurse Educator and Education Coordinator are available as a resource person for any staff member who may identify a learning need. Topics for planned in-services are chosen based on annual needs assessment and current clinical issues. Documentation of competencies is mandatory for CPR, Fire Safety, Infection Control, and IV & Medication Calculation which are assessed annually for continuing education. Other in-service programs are also of great importance to the following topics which are incorporated to the Unit PDP to refresh staff and orient novice staff.

- Electrosurgical Generator Safety- Valleylab ESU & Ligasure, CUSA, Harmonic Ultrasonic Generator 300, etc.
- In-Service Training for da Vinci Robotic Surgical System
- ORICS (O.R. I Technology)
- Stapling Devices-Open & Laparoscopic
- Laser Technologies-Yag, CO2, etc.
- Orthopedic Power Drills & others
- Medtronic Neuro Navigation system
- Zeiss Neuro Microscope and other microscopes
- Other O.R. Basic Equipment
1.9 Communication and Reporting within the Department:

The Operating Room of KKUH is a part of the Surgical Services. The O.R. cooperates fully with Hospital Administration, Department of Surgery, Department of Anesthesia, Department of Orthopedics, Department of O.B. - Gynae, Department of Nursing and other departments like CSSD, Radiology, etc. in order to render safe, efficient and quality care to surgical patients.

The Operating Room is under supervision of the O.R. Medical Director who reports to the Chairman of Surgical Dept. & O.R. Committee.

The O.R. ADON reports to Director of Nursing for nursing matters and to O.R. Medical Director for all O.R. matters. All concerns and issues should be discussed through channel of communication.

The following meetings are convened regularly in order to disseminate information, discuss important agenda, problems & concerns; and plan to solve the problems as well as improve quality before implementations & actions to be assigned:

- O.R. Committee Meetings- Meetings as per required
- O.R. Nursing Staff with O.R. Medical Director as per required
- O.R. Unit Meeting for Nurses – once a month - 3rd week on Saturdays from 8:00 am to 9:00 am.
- O.R. Nursing Quality Improvement Meetings- Included in Unit meetings
- O.R. ADON & Head Nurses Meeting – as per required
- Nursing Administration Meeting-once a week, every Sunday at 10:00 am
- Nursing Admin Quality Management Committee- Every other Saturday at 2:00 pm
- Canadian Accreditation Focus Group(Surgical Care)-every Wednesday at 1:00 pm

Minutes of the meeting are recorded and filed for further and future references.
1.0 CONDITIONS:

All O.R. RN’s

2.0 PURPOSE:

All OR Registered Nurses are responsible and accountable to ensure safe and quality perioperative nursing care practice is carried out during the immediate pre-operative, intra-operative and immediate post-operative periods.

3.0 DEFINITIONS:

Perioperative nursing practice is the nursing care of patients, families and significant others during the period of surgical intervention. Perioperative nursing practice is carried out during the immediate preoperative, intra-operative and immediate post-operative periods. The nursing process takes into account supportive and potentially disruptive influences on health status and related problems, resulting from patient’s response and/or adjustment to surgical intervention.

4.0 POLICY:

The standards of perioperative nursing practice provide a basic model by which the quality of peri-operative nursing practice may be measured.

5.0 PROCEDURE:

The surgical Services registered nurse is primarily accountable and responsible for the process of nursing practice to patients who are facing an operative or invasive procedure. The registered nurse shall assist the patient in meeting outcomes. In order to implement the nursing process effectively, the nurses who are engaged in the practice of perioperative nursing shall:

5.1 Base patient care on best practices and evidence-based information
5.2 Continuously update knowledge and skills
5.3 Determine the range of practice by considering the care setting and the resources available.
5.4 Ensure the patient’s participation in health promotion, maintenance and restoration
5.5 Develop policies and procedures in collaboration with associated departments.

6.0 REFERENCE:
AORN
1.0 CONDITIONS:

All O.R. RN’s

2.0 PURPOSE:

All OR Registered Nurses are responsible and accountable in providing the needs of the surgical patients in a safe and cost effective manner.

3.0 POLICY:

Perioperative Nursing Standards and Processes are practiced and carried out continuously throughout the pre-operative, intra-operative and post-operative periods.

3.1 Perioperative nursing is practiced in an environment in which basic life sustaining needs are of the highest priority. It incorporates both technical and professional components of nursing practice, as outlined in “The Standards of Perioperative Nursing Practice.” It involves the direct nursing care of surgical patients having known or predicted physiological alteration.

3.2 Perioperative nursing also focuses on the psychological, physical, social and spiritual aspects of the patient.

3.3 Perioperative nursing provides continuity of care designed to meet individual patient needs through the nursing process. The Surgical Services nurse, through collaboration with other healthcare team members, assures continuity of care through the pre-operative, intra-operative and post-operative periods.

3.4 The Surgical Services nurse is expected to possess substantial knowledge, judgment and skill based on the principles of biological, physiological, behavioral, social and nursing sciences. Delivery of optimal levels of quality care, in a cost effective manner, is the primary function of the Surgical Services nurse.

4.0 PROCEDURES:

4.1 To ensure safe, high quality nursing care for the patient having an operative or invasive procedure in this hospital.
4.2 To assess, plan and implement optimum patient care.

4.3 To promote an atmosphere conducive to learning for all personnel

4.4 To maintain an ongoing performance improvement program that will assist in the maintenance and improvement of patient care

4.5 To maintain a safe and controlled environment for patients, staff and physicians

4.6 To provide efficient and cost effective services.

5.0 **REFERENCE:**
AORN
1.0 CONDITIONS:

All O.R. RN’s

2.0 PURPOSE:

All OR Registered Nurses are responsible and accountable in ensuring that perioperative nursing actions are performed with safety, skill, efficiency and effectiveness and this must be documented.

3.0 POLICY:

3.1 The plan for nursing care prescribes nursing actions to achieve the goals.

3.2 The plan for nursing care in the intraoperative setting reflects the perioperative assessment, priorities for nursing action and a logical sequence of nursing activity to attain stated goals, which are individualized to the patient’s needs.

4.0 PROCEDURES:

Nursing actions in the intraoperative setting include the following:

4.1 Patient identification
4.2 Surgical site identification
4.3 Informed consent verification
4.4 Verification of diagnostic test results in the patient’s medical record
4.5 Communication & verification of intraoperative information to members of the surgical team during timeout procedure.
4.6 Patient positioning according to physiological principles
4.7 Skin assessment and reassessment
4.8 Adherence to the principles of asepsis
4.9 Assurance of appropriate and properly functioning equipment and supplies

4.10 Provisions of comfort measures and supportive care to the patient, including emotional and spiritual support, as necessary
4.11 Environmental monitoring and safety
4.12 Physiological and psychological monitoring of the patient, including continued assessment of patient status
4.13 Obtain further diagnostic related to changes in the patient’s condition and/or reassessment analysis.
4.14 Maintenance of safe environment

5.0 REFERENCE:

AORN
1.0 **CONDITIONS:**

Applicable to all O.R. nurses

2.0 **PURPOSE:**

2.1 To ensure that all nursing staff are familiar with the safe evacuation routes in removing patients in an orderly manner in the event of fire.

2.2 To ensure all patients and OR nurses are evacuated horizontally when instructed to do so by senior officer and in extreme conditions if the fire has engulfed the whole floor and parts of the building as well as fire fighting equipments have been overwhelmed.

2.3 To ensure that all nursing staff should know how to handle and use fire extinguishers.

3.0 **POLICY:**

All OR RN’s are responsible and accountable to ensure that all patients will be evacuated from the OR in an orderly manner in the event of fire

4.0 **PROCEDURE:**

4.1 OR new nurses during their orientation period must learn about fire prevention and preparedness, fire evacuation plan and must know the locations where fire fighting equipments, smoke detectors, wall fire alarms; fire doors are located.

4.2 All OR nurses should be conversant with the locations of fire fighting equipments, wall fire alarms, smoke detectors, fire door etc.

4.3 In case of fire or smoke, the OR nurses who discovers it should activate the wall fire alarm by pressing the center of the glass with a thumb and dial 953 giving the following information.

4.3.1 Description / Type of Fire / Smoke.

4.3.2 Location of Fire

- Level 2
Block 9 could be the theatre 1, 2, 3, 4, 5, 6, 7 & Receiving Area
Block 6 could be for theatres 8, 9, 10 & 11 Recovery Room.
Block 24 (Phase IV-OR) could be for theatres 12, 13, 14 & 45

Fire Zones for OR
- Block 9 – Zone 71
- Block 6 – Zone 66
- Block 24 – Zone 58

4.3.3 Use appropriate fire fighting equipments to extinguish and control the spread of fire if confident & safe to do so.

4.3.4 Ensure fire doors are closed to delay / limit the spread of fire.

4.3.5 Evacuation must be under the control of ADON, HN or designee who makes the assignment / instruction.

4.3.6 At any given time, OR personnel must know that there are 3 categories of patients in the OR.

- Category I – Patients in the waiting / Holding Area
- Category II – Patients already inside the theatres, anesthetized and undergoing surgery.
- Category III – Patients in the Recovery Room, recovering from anesthesia after surgery.

4.3.7 All elective & emergency surgeries in progress should continue unless there is a need to evacuate the area.

4.3.8 All patients in the RR and the Reception / Holding Area should be evacuated first including all OR personnel not needed in the area.

4.3.9 If there is a fire in Block 6 & 9, the meeting area for patients and staff will be in the Reception Area before evacuating horizontally to a safe place in the same floor level, then vertically when instructed to do so as fire fighting equipments have been overwhelmed.

4.3.9.1 In Block 9, there is an area without fire exit access and if there is a big fire in the following theatres 3, 4, 5 and 6 + the sterile Storage Room, all the staff and patients beyond this point will be trapped but the key in fire prevention is the responsibility of all staff to maintain a safe working environment staff and patient will be evacuated to O.R. reception area & hallway leading to Block 6 exit or SICU.

4.3.9.2 In Block 24, Phase IV – OR, patients and staff will be evacuated through the 3 exits the double door leading to the corridor then the corridor then the safe area Ward 21B and the double door of Neuro Theatre leading to the old Engineering Dept. or to R.R. any nearest vacant theatre and double door leading to SICU.

4.3.10 With the senior person’s instruction, patients on OR tables undergoing surgery should be stopped and their wounds should be packed with wet
sterile lap sponges covered with sterile drapes and transferred in another
trolley with fire blanket while the anesthetists ventilates and oxygenates
the patients then wheeled to RR or nearest vacant theatre.

4.3.11 All surgical Team (Anesthetists, surgeons, nurses) working in the OR
should be responsible in transporting the patient to a safe place (RR) or
in another area if instructed to do so.

4.3.12 The anesthetist / anesthetist technician should shut off the flow of
oxygen / nitrous oxide and other medical gas but should maintain the
breathing of the patient with a valve mask respirator or ambu bag.

4.3.13 Disconnect all electrical powered equipment, any leads, lines or other
equipment that may be anchoring the patient to the area.

4.3.14 After a thorough check of the whole area, the ADON, HN or designee
should ensure no one is left and closed the fire door when leaving and
anyone not accounted for should be reported to the Fire Chief or
Department Head. An accurate count should be maintained to all
patients and staff members during evacuation.

4.3.15 No one to return to the area until the all clear and safe signal sign is
announced by the Fire Chief or from Hospital Administration.

4.4 All OR personnel are responsible to maintain a safe working environment at all
times by adhering to the following:

4.4.1 All OR nurses should attend the Unit Fire Safety Lecture at least once or
twice a year.

4.4.2 All OR nurses must ensure that the Fire Annual Assessment is updated
which is mandatory for the renewal of contact.

4.4.3 All OR personnel should participate in fire drills conducted for
preparedness in ensuring an effective and efficient response to a fire
occurrence in OR in a smooth and coordinated manner.

4.5 All OR personnel should know by heart these acronyms as response components
of the Fire Safety Plan.

4.5.1 Acronym RACE to follow in the event of fire
R – Rescue all patients in danger
A – Activate the wall fire alarm call 953
C – Confine the fire
E – Extinguish the fire and Evacuate if required

4.5.2 Acronym PASS on how to operate the fire extinguisher
P – Pull the pin
A – Aim the nozzle at the base of the fire
S – Squeeze the handle
S – Sweep the stream over the base of the fire.
5.0  **FORMS AND ATTACHMENTS:**
O.R. Fire Evacuation Plan

6.0  **REFERENCE:**

6.1  AORN
6.2  Fire & Safety Training Manual
6.3  KKUH Fire Prevention Broad Policy Guideline
1.0 CONDITIONS:

Applicable to all OR Nurses

2.0 PURPOSE:

2.1 To ensure that all O.R. Personnel should know the locations of all fire fighting equipment including wall fire alarms and be able to activate, handle and use them in the event of fire.

2.2 To ensure that all OR Personnel should know the locations of all fire doors and that these serve as exits and should be clear and accessible at all times; then be closed to limit fire in the event of fire.

3.0 POLICY:

All OR RN’s should be conversant with the locations of all the fire fighting equipment in the Operating Room in the event of fire.

4.0 PROCEDURE:

4.1 All OR RN’s should be able to locate immediately all fire fighting equipment, wall fire alarms, fire doors etc. in case of fire / smoke.

4.1.1 Block 9 – Zone #71

1. Near Theatre 2:
   Tri-Dry Chemical Fire Extinguisher x1
   Wall Fire Alarms x2

2. Near Robotic Storage Room:
   Hose Reel x1
   CO2 Fire Extinguisher

3. Patient Reception / Holding Area
   Tri-Dry Chemical Fire Extinguisher x1

4. Patient Reception Area Main Entrance – Fire Door
5. In front of Theatre 7
   Wall Fire Alarm x1

4.1.2 Block 6- Zone #66
1. Near Doctor’s Changing Room:
   Tri-Dry Chemical Fire Extinguisher x1
   CO2 Fire Extinguisher
   Halon Extinguisher x1

2. Near Theatre 10:
   Hose Reel x1
   CO2 Fire Extinguisher x1

3. In front of Recovery Room:
   Wall Fire Alarms x2

4. Utility Room (Disposal Area):
   Fire Door

4.1.3 Block 24 – Zone #58
1. In front of ABG Room:
   Tri-Dry Chemical Fire extinguisher x1

2. From SICU going to Phase IV – OR:
   Fire Door

3. Main Entrance to Phase IV – OR:
   Fire Alarm x2
   Fire Door

4. Exit Door near Neuro Theatre (End of Corridor)
   Fire Door
   CO2 Fire Extinguisher

4.1.4 Block 3 – Zone #61
1. Nurse’s Changing Room Entrance
   Tri-Dry Chemical Fire Extinguisher x1

2. Door Leading to SICU & Phase IV – OR
   Fire Door x2

5.0 **REFERENCE:**

Fire Evacuation Manual
1.0 **CONDITIONS:**

Applicable to all O.R. Nurses

2.0 **PURPOSE:**

To ensure that all patients and personnel are evacuated from the O.R. in an orderly manner in the event of fire ensuring an effective and efficient response

3.0 **POLICY:**

All OR Nurses are responsible and accountable to ensure that they are familiar with the safe evacuation process and must know their individual responsibilities in removing / evacuating patients in an orderly manner.

4.0 **PROCEDURE:**

4.1 Anesthetist

4.1.1 He is the leader of the team.

4.1.2 Responsible for the oxygenation and total physiological status of the patient.

4.1.3 Responsible in shutting off the flow of O2, nitrous oxide and other medical gasses but maintaining the breathing of the patient with a valve to masks respirator / ambu bag.

4.1.4 Responsible in giving instructions when patient is ready to be moved.

4.2 Anesthetic Technician:

4.2.1 Ensures that all the necessary equipment needed like ambu bag, portable monitor, etc. are available.

4.2.2 Remove ECG cables, pulse oximeter probe, BP cuff.
4.2.3 Disconnect the anesthesia machine, any leads, I.V.lines and other equipment that may be anchoring the patient to the area.

4.3 Surgeon:
4.3.1 Packs the wound with wet lap sponges (wet with saline) and secure it properly in place.
4.3.2 Assists in the transfer and transport of the patient.

4.4 Scrub Nurse
4.4.1 Prepares the wound packing and hand it to surgeon.
4.4.2 Ensures that the wound pack (lap sponges soak with saline – not dripping) is covered with sterile gauze dressings and secured properly.
4.4.3 Removes all instruments and cables anchored to drapes.
4.4.4 Responsible in checking other tubing’s, catheters, etc. connected to the patient.
4.4.5 Assists the surgical team in transferring the patient from the O.R. table to another trolley if patient is evacuated out from O.R. or patient is transported with the same O.R. table and is transferred to another vacant theatre not affected with the fire.

4.5 Circulating Nurse:
4.5.1 Responsible for activating the fire alarm and informs H.N.
4.5.2 Assists the scrub nurse in packing the wound by ensuring the security of the wound packing.
4.5.3 Removes all instruments away from the patient.
4.5.4 Put or switch off any equipment not needed.
4.5.5 Responsible in bringing the necessary patient’s documents (patient’s blue & yellow files, etc.) during evacuation.

4.6 Head Nurse
4.6.1 Informs ADON or Supervisor (during evening, nite & weekends) and asks for further instructions.
4.6.2 Gives instructions to staff regarding the process of evacuation.
4.6.3 Responsible in checking the theatre before leaving.
4.6.4 Ensures no one is left and close all fire doors when leaving and anyone not accounted for should be reported to the Fire Chief & ADON-OR.

4.7 ADON
4.7.1 Informs DON & O.R. Medical Director
4.7.2 Coordinates with Nursing Administration and Fire Chief for further instructions.
4.7.3 Gives further instruction to HN & staff for the smooth and coordinates manner of evacuation.

4.7.4 Ensures that all O.R. Nurses should participate in fire drills and fire lectures & fire update.

4.7.5 Ensures that the staff’s Fire Annual Assessment is updated which is mandatory for the renewal of contract.

4.8 Staff who discovers the fire should initiate the following safety actions in case of fire:

4.8.1 Rescue all those in danger first and activate the fire alarm by pressing the center of the glass with a thumb to break the glass.

4.8.2 Dial 953 and give the following information:

   4.8.2.1 Identify yourself.
   4.8.2.2 Fire area: level, block & zone #
   4.8.2.3 Description of fire.

4.8.3 Inform the head nurse

4.8.4 Try to extinguish the fire, if you are confident, capable and if it is safe to do so.

4.8.5 Always make sure that there is an exit behind you when you are trying to extinguish the fire.

4.8.6 Evacuate if necessary to area of safety.

5.0 **REFERENCE:**

   Fire and Safety Training Manual
1.0 CONDITIONS:

Applicable to All OR Nurses and O.R. Personnel

2.0 PURPOSE:

2.1 To respond quickly in a well coordinated manner during a disaster whether internal or external.

2.2 To ensure all staff are being oriented to the department’s disaster plan and to familiarize themselves with the procedures to follow when a possible disaster is notified as standby or when a disaster is confirmed.

2.3 To ensure preparedness by coordinating and following the commanding officer for further instructions once an emergency disaster is confirmed.

2.4 To ensure an up to date list of names of all OR-RR staff with their addresses, telephone / mobile numbers that should be available in the nursing department and in the OR office for the purpose of contacting them when in dire need of manpower during a disaster.

3.0 DEFINITIONS:

Disaster Preparedness – is the preparation of our health care facilities and health care workforce in the O.R. in order to cope with emergency situations so as not to disrupt the delivery of health care services in the event of emergency / disaster.

4.0 POLICY:

All OR nurses should be able to respond immediately in an organized manner by ensuring the safety of patients, staff and hospital properties during a disaster whether internal or external.

5.0 PROCEDURE:

5.1 O.R. new nurses during their orientation period must learn about the emergency plan in case of a disaster whether internal or external.

5.2 A command call should be received from DEM and Nursing Department thru Supervisor on duty or ADON if she is already informed to initiate necessary
actions for the preparation of OR in order to receive victims in an orderly manner by ensuring adequate staffing and equipment / supplies to be needed.

5.3 Coordinate with the Nursing Dept. and other departments i.e. DEM, Anesthesia Dept., Surgery Dept., CSSD, Blood Bank, Wards and delegate responsibilities to OR staff for the proper preparation of theatres.

5.4 ADON / Designee should find out how many victims / patients may require surgery in order to know how many OR staff needed to be called when a disaster is confirmed during the normal working hours, the ADON / designee should inform HN to notify all surgeons who are presently operating at the time and the elective lists should be stopped but to finish the cases already in progress and then the theatres should be prepared to receive the emergency disaster cases. All empty theatres should be used first.

5.5 When a disaster is confirmed during the outside working hours (evening and night shift and weekends) the following procedures should be followed:

5.5.1 If no operation is in progress the OR Charge Nurse /designee of the shift should inform ADON and call the other staff needed.

5.5.2 If there are operations in progress, the OR Charge nurse / designee of the shift should ask the Nursing Supervisor on duty to inform ADON and to call other OR staff needed.

5.5.3 The OR Staff living in Diriyah Housing should be contacted first as they can come immediately to the hospital.

5.5.4 OR Staff Disaster Coordinators from each housing and OR staff live out Coordinators are responsible to contact the rest of the OR staff needed and coordinate with the Nursing Supervisor / ADON / Designee for their transport.

5.6 Staff from other departments is not allowed to be deployed to work in the theatres during a disaster as they don’t have OR experiences.

5.7 Once the number of cases requiring surgery is assessed and confirmed for surgery; the ADON / designee should decide how many staff are required to do shifts to cover all the theatres with disaster cases.

5.8 Extra hours worked by the OR staff during a disaster should be recorded and compensated.

6.0 REFERENCE:

KKUH Disaster Manual
1.0 CONDITIONS:

All OR RN’s

2.0 PURPOSE:

2.1 For effective organization and booking of elective cases.
2.2 For efficient running of the O.R. theatres.
2.3 To maximize theatre time and provide quality peri-operative service.

3.0 DEFINITIONS:

3.1 Elective Cases: Pertaining to a procedure that is performed by choice and is not essential.

4.0 POLICY:

All HN/CN/Designee must ensure that all elective cases must be booked a day prior to surgery and the O.R. list (O.R. Theatre Schedule) must be submitted in the O.R. office on time.

5.0 PROCEDURE

5.1 All scheduled elective cases for surgery must be written legibly in the O.R. Theatre Schedule form and must be received in the O.R. office by 2:30pm (1430hrs).

5.2 The O.R. list must be submitted by the Senior Registrar / Registrar / Resident or Intern and must be checked by Head Nurse / Designee for any clarifications.

5.3 The O.R. lists must be entered in the computer by O.R. Secretary and must be checked again by the HN / Designee.

5.4 The O.R. printed list must be circulated to all departments for preoperative preparations and screening.
5.5 The allocated anesthetist must collect the duplicate copy of written O.R. list or printed copy for his preoperative screening of patients.

5.6 All original handwritten O.R. lists must be filled and kept in the O.R. office for future references.

5.7 The Senior Registrar / Registrar / Resident or Intern must inform the Anesthetist for any additional cases and any changes in the sequence of the list after submission to the O.R. for typing.

5.8 The list must commence at 8:00am (0800 hrs) and must conclude at 4:30pm (1630hrs) or depending upon the length of time the last case in each theatre finishes.

5.9 Any list starting at 7:30am (0730hrs) or earlier than 8:00am (0800hrs) must be communicated to the anesthetists allocated in that particular theatre.

5.10 All O.R. lists for Saturdays must be scheduled to start 9:00am (0900hrs) to enable all O.R. staff to attend their weekly one hour Unit Professional Development Program, equipment in-service training, unit meetings and CSSD / O.R. Staff Meeting, Nursing Quality Improvement Meeting.

5.11 Anesthetists are instructed not to anesthetize major cases after 3:00pm (15:00hrs) and minor cases at 3:30pm (15:30 hrs).

6.0 **REFERENCE:**

6.1 Old OR Policies & Procedures

6.2 OR Memo from Anesthesia Department

6.3 OR Committee Minutes of the Meeting
1.0 CONDITIONS:
   1.1 All OR RN’s
   1.2 O.R. Porters

2.0 PURPOSE:
   2.1 To ensure smooth running of all theatres.
   2.2 To ensure no delays of all elective surgeries.

3.0 POLICY:
   All OR RN’s and Porters are responsible and accountable: To ensure safe sending of patients for elective surgery from Ward or other department, to ensure the scheduled time of surgery is being followed.

4.0 PROCEDURE:
   4.1 The evening or night shifts RR nurses should prepare the “OR Patient Call Slips Forms” by writing clearly the theatre number, dates in Arabic and Gregorian calendars, patient’s name, patient’s hospital number, ward number, and the surgery performed.
   4.2 The O.R. Patient Call Slip should be signed by the OR nurse with the time when patient was sent for.
   4.3 The OR Receiving Nurses are responsible in sending the “Patient Call Slips” for all first cases in the theatres at least 30 minutes before the scheduled time for surgery.
   4.4 The OR receiving nurse should hand over the patients call slips to the OR porters and then the porters should bring the patient to the OR with the ward nurses for proper endorsement.
   4.5 No patient should be brought to OR unless the patients call slip is being sent from OR with the porter except in extreme emergencies.
   4.6 The succeeding / subsequent cases should be responsibilities of the charge nurses in each theater when to send and if they are busy she should call the OR receiving nurse to send for their next patient.
4.7 The OR receiving nurse should ensure that the patient call slip is handed over to the porter or should ensure that every call slip hanged at the external door of the Reception Area is taken by the porter in order to avoid delay of collecting the patient from the ward / other department.

4.8 Any problem that is causing the delay in sending the patient to OR from the ward / other department, the ward nurse should inform the OR Head Nurses that the necessary actions should be taken accordingly by informing concerned anesthetist and surgeon.

5.0 **FORMS AND ATTACHMENTS:**

Call Slip

6.0 **REFERENCE:**

6.1 KKUH Broad Policy & Procedures

6.2 Old O.R. Policies & Procedures
1.0 CONDITIONS:

All OR RN’s

2.0 PURPOSE:

2.1 For effective organization and booking of emergency cases.

2.2 For efficient running of the Operating Room.

2.3 To maximize the theatre time and provide quality perioperative service.

3.0 DEFINITIONS:

3.1 Emergency Cases: Cases that threatens the life or welfare of a patient.

3.2 Booking of emergency cases must be categorized as follows:

3.3 Category I: Life Threatening, extreme emergencies and cases that need to be done within 2 hours.

3.4 Category II: Emergency cases to be done within 6-12 hours.

3.5 Category III: Emergency cases to be done within 12-24 hours.

4.0 POLICY:

The HN/CN/Designee is responsible and accountable to ensure emergency cases are booked on the day of surgery with the category written in the O.R. list (O.R. Theatre Schedule).

5.0 PROCEDURE:

5.1 All emergency cases must be booked by the Consultant / Senior Registrar / Registrar / Resident or Intern with the O.R. Head Nurse / Designee.

5.2 The O.R. staff must inform the surgeon at the same time of any previous bookings by other specialties.
5.3 The Surgeon must inform the Anesthetist on-call regarding the patient and not the O.R. Nursing Staff.

5.4 All emergency cases must be done as soon as the theatre becomes available. No emergency cases must be booked for later time or on the day before surgery.

5.5 If a surgeon decides that his / her case must be done first before any of the other scheduled cases, then, he must personally contact and get the approval of the other consultant surgeons whose cases have already been booked, otherwise the service must follow first come first serve basis. All staff must cooperate to ensure the smooth running of the emergency services available.

5.6 When patient is category I Emergency, the anesthetist on call is authorized to start the case immediately in any available theatre during working hours.

5.7 In the event of all theatres being occupied and there is a life threatening case needing immediate surgery, the elective surgery list must be suspended to accommodate the emergency case if the emergency theatre is already occupied. It will be preferable to do this in the same specialty however it could be any room where the surgery is near completion.

5.8 Emergency services staffing are normally available for two rooms only, “A&E and OB-Gyne”. A third room will only be made available for cases which cannot be delayed and will be decided by the Consultant Surgeon on-call and must get the approval of the Consultant Anesthetist on-call.

5.9 The Anesthesia Department must be informed about the emergency case if there is any difficulty in locating the Anesthetist on–call during the working hours from 0730 hrs. to 1630 hrs.

5.10 The O.R. Nursing staff must not get involved in deciding the priority of any emergency cases.

5.11 The telephone # 7-1026 in the O.R. office must be reserved for booking emergency cases and must not be used for any personal calls. All medical staff must use this phone # to communicate to O.R. staff and they must respond to it quickly.

6.0 **REFERENCE:**

O.R. Committee Minutes of the Meeting
1.0 CONDITIONS:

1.1 All OR RN’s

1.2 All OR Porters

2.0 PURPOSE:

2.1 To ensure effective organization and smooth running of emergency theatre.

2.2 To ensure prompt actions to emergency cases.

3.0 POLICY:

All patients for emergency surgery should be dealt with immediately most especially extreme emergencies and life threatening.

4.0 PROCEDURE:

4.1 Upon receiving the emergency list of operation, the OR Receiving Area nurse prepares the “patient call slip” by writing clearly the patient’s name, hospital #, ward #, Arabic & Gregorian.

4.2 The HN or Charge Nurse or designee should inform the anesthesia technician and the OR nurses assigned for emergency to prepare the theatre accordingly.

4.3 Emergency cases are categorized into 3 categories:

4.3.1 Category I – Life threatening, extreme emergencies and cases that need to be done within 2 hours.

4.3.2 Category II – Emergency cases to be done within 6-12 hours.

4.3.3 Category III – Emergency cases to be done within 12-24 hrs.

4.4 The O.R. nursing staff should not get involved in deciding the priority of any emergency cases.

4.5 The O.R. staff should only send for the patient after final agreement by both anesthetist and surgeon-on-calls as to which case should be done first.

4.6 The HN or CN or designee should inform the anesthetist & surgeon-on-calls if any problem that may be causing the delay in sending the patient.
4.7 The HN or CN or designee should bleep the anesthetist & surgeon-on-calls before sending for the patient and both of them should agree to send for the patient.

4.8 The HN or CN or designee should send for the “patient call slip” to the ward with the O.R. porter by writing the time when patient is sent and signing the call slip.

4.9 The ward Nurse should not bring the patient to O.R. unless the “patient call slip” has been sent with the porter except in extreme emergency wherein patient comes directly from DEM. In such case, the “patient call slip” will be signed in O.R. by DEM nurses accompanying the patient and will bring with them the request for O.R. Schedule.

4.10 The OR-RR receiving nurse should indicate the time when patient sent for and time when patient is received direct form DEM.

5.0 **REFERENCE:**

Old OR Policy & Procedure
1.0 **CONDITIONS:**
All OR RN’s

2.0 **PURPOSE:**
To ensure effective and safe transfer of patients from DEM to Operating Room

3.0 **POLICY:**
All OR RN’s and DEM RN’s are responsible and accountable to ensure that only FOR LIFE THREATENING CASES, EXTREME EMERGENCIES AND IN A DISASTER SITUATION, patients can be brought directly to the O.R. from Department of Emergency Medicine (DEM).

4.0 **PROCEDURE:**

4.1 The admitting / treating surgical team must discuss the case with the on-call anesthetist that he / she agreed to do the case.

4.2 The admitting / treating surgical team must also arrange with the Blood Bank for emergency blood required for the patient.

4.3 The O.R. nurse in-charge must be informed by admitting / treating surgical team to prepare the room accordingly.

4.4 The DEM nurse must inform O.R. Nurse in Charge that the patient is ready to be sent for O.R.

4.5 The admitting / treating surgical team and anesthetist on-call must accompany the patient to O.R. with the DEM nurses.

4.6 No patient’s valuables are to be sent with the patient to the O.R. The Department of Emergency Medicine nurses are responsible for the transferring of the patient’s valuables to the Admission Department.

5.0 **FORMS AND ATTACHMENTS:**
DEM’s They Forms
6.0 **REFERENCE:**

KKUH Broad Policy and Procedure
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<th>Unit: SURGICAL AREAS</th>
<th>Policy Number: NURS.OR-013</th>
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<td>Nursing IPP's Committee</td>
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1.0 **Conditions:**
All OR RN’s, Ward RN’s

2.0 **Purpose:**
To ensure safe and effective patient transfer from ward to O.R.

3.0 **Policy:**
3.1 All OR RN are responsible and accountable to ensure that:

3.1.1 All patients undergoing surgical procedures must be provided with a safe, dignified and quality pre-operative care.

3.1.2 The correct patients information and criteria should be ensured and met before surgery.

3.1.3 Receiving the right patient with the right diagnosis and right side of operation prevents operating on the wrong patient and wrong site of operation.

4.0 **Procedure:**
4.1 The receiving OR nurse welcomes the patient and introduces herself to the patient.

4.2 The patient must be endorsed by the accompanying ward nurse to the receiving OR nurse using the pre-operative checklist provided in the patient’s blue file.

4.3 The following relevant points must be rigorously checked.

4.3.1 Identify patient by ID band on the right wrist against patient notes and verbal confirmation if this is possible. For pediatric patient, ID bands are placed in the right wrist and one in the ankle.

4.3.2 Ensure that all documentations, care plans, fluid and electrolyte balance chart, medications and other relevant information regarding the patient are endorsed.
4.3.3 Check X-rays, MRI, Ultrasound results, Laboratory investigation results, patient's observation file, yellow file etc. are endorsed to the receiving OR nurse.

4.3.4 Ensure that there is complete, signed and valid consent both written in Arabic & English and also indicating the correct surgical procedure, site of operation and it should be up to date.

4.3.5 The surgical operation site that is shaved (depending upon the type of surgery), cleaned and clearly marked should be endorsed properly to the receiving OR nurse.

4.3.6 The skin integrity must be endorsed and checked for any skin lesions, allergies, infectious skin disease, pressure sores, scars etc.

4.3.7 Ensure that patient's bladder is emptied and if drainage bag is in situ then it should be emptied.

4.3.8 Ensure that there are no jewelries, ornaments and external prosthesis on patients and if jewelries can't be removed then it should be secured properly with something that covers the skin and must be endorsed to the receiving OR nurse.

4.3.9 Check that all IV lines should be endorsed properly with the following important points.

4.3.10 Type of infusion, site of infusion, rate of infusion, IV pump in use, medications incorporated in the piggy bag, the amount remaining and IV with insulin therapy must be on IV pump.

4.3.11 For blood transfusion: type of blood, number of units given, remaining units and cross-matched blood.

4.3.12 Pre-medications given and other medications required during the surgical procedure must be endorsed to the receiving OR nurse.

4.3.13 Ensure that the patient must be on NPO as per surgical procedure to be done and must be endorsed to the receiving OR nurse.

4.3.14 If the patient is an infected case, it should be notified before surgery in advance and indicated in the submitted OR list of surgeons.

4.3.15 Ensure that the patient is in proper theatre attire and hair should be fully covered with an OR cap most especially female patients and undergarment should be removed depending upon the procedure.

4.4 Following the endorsement of the patient from wards to receiving OR nurse, the patient is moved to the waiting / holding area in a safe and dignified manner.

4.5 Patient must be covered properly and should not be exposed unnecessarily at all times in the waiting / holding area.

4.6 Patient should be observed at all times and provide reassurance when there is a delay of the surgical procedure by informing the patient at least every 15 minutes regarding the situation inside the theatre.

4.7 The patient should not be disturbed by any undue noise and a quiet environment should be maintained at all times.
4.8 The brakes of the trolley should be locked and the side rails are up all the times.

4.9 All patients should be individually separated by cubicle curtains to ensure dignity and privacy.

4.10 Female patient should not be in close proximity to male patients where this is possible.

4.11 Mothers are asked and encouraged to stay with their children in the receiving area but should be observed by the OR receiving nurse every now and then.

5.0 **FORMS AND ATTACHMENTS:**

Pre-operative Check List Form

6.0 **REFERENCE:**

6.1 Alexander’s Care of Patient in Surgery by Jane Rothrock

6.2 KKUH Broad Policy Guidelines
INTERNAL POLICIES AND PROCEDURES
CONCURRENCE / NON-CONCURRENCE FORM

To be completed by initiating department/person

From: ___________ (department/person) Tel. Extension No.:_______ Date: _____________

Name of Policy and Procedure: ___________________________ Number: ________________

☐ New Document ☐ Revised Document ☐ Reviewed Document (no changes done)

Comments: (a brief summary of purpose of the document or changes made)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

To be completed by the reviewers (affected departments).

You are requested to review the attached document(s) as there could be an effect or impact upon your department if the action is initiated. Please sign if you concur (agree) with the document, date and forward to the next person on the list. If you do not agree with the document, please provide an explanation and send your written comments to the sender (initiating) department.

* Non-concurrence must forward written comments to the originating department/person.
1.0 CONDITIONS:
OR RN’s

2.0 PURPOSE:
2.1 To ensure that the surgical consent is complete, signed and valid.
2.2 To ensure surgery for the right patient and with the right side.
2.3 To promote and ensure the utilization of ethical processes of surgery that is competent and legal.

3.0 POLICY:
3.1 All OR RN’s are responsible and accountable to ensure that:
3.1.1 Patient above 15 years have signed for the surgical consent.
3.1.2 If the patient is below 15 years the consent should be signed by the next kin: father, mother, guardian or any immediate family member.
3.1.3 High risk consent must be signed by 2 consultants.

4.0 PROCEDURE:
4.1 OR receiving nurse must ensure that the surgical consent is signed and up to date in both English and Heijra Calendars.
4.2 OR Receiving nurse must ensure that the correct surgical procedure is clearly indicated and written legibly in both Arabic and English.
4.3 OR Receiving nurse must ensure that the right surgical procedure and the site of surgery is clearly specified in the surgical consent form. The operation site must be clearly marked and the ward nurse should endorse to the OR receiving nurse.
4.4 OR Receiving nurse must ensure that the surgical consent is witnessed by 2 witnesses; the doctor who explained the procedure and who has the consent and any nursing staff or HCA.
4.5 If the patient is conscious and alert; OR Receiving nurse must confirm with patient who signed the consent.

4.6 If the patient is unconscious, the OR Receiving nurse must ask with endorsing Ward nurse in order to confirm who signed for the surgical consent.

4.7 In case of extreme emergency with the inability of patient to sign for the surgical consent and the unavailability of the next of kin, two consultants can sign for the surgical consent (it could be one surgical consultant and one anesthesia consultant or other consultants or doctors as appropriate for the department.

4.8 Patients with high risk consent must be clearly endorsed by the ward nurse to the OR Receiving nurse.

5.0 **FORMS AND ATTACHMENTS:**

5.1 Surgical Consent

5.2 High Risk Consent

6.0 **Reference:**

6.1 KKUH Broad Policy & Procedure

6.2 O.R. old Policies & Procedures
1.0 CONDITIONS:
   1.1 All OR RN’s
   1.2 All OR Porters

2.0 PURPOSE:
   2.1 To maintain the patient’s dignity at all times.
      2.1.1 During transportation to & from the ward.
      2.1.2 In the waiting area (O.R. Reception Area)
      2.1.3 During transportation from the Reception Area to the Theatre.
      2.1.4 Inside the theatre during surgery.
      2.1.5 During transportation from theatre to R.R.

3.0 POLICY:
   3.1 All OR RN’s are responsible and accountable to ensure:
      3.1.1 Patient’s dignity is maintained at all times.
      3.1.2 Patient’s psychological and cultural needs are met.

4.0 PROCEDURE:
   4.1 All patients for surgery must be dressed in the designed O.R. surgical apparel with O.R. cap / head cover.
   4.2 Female patient must be fully covered including their face during transportation to and from the O.R.
   4.3 Female O.R. Nurse must always be present with female patients. Female patient must not be left unattended unless she is with a female anesthesia technician.
   4.4 No physical examination of patient must be done in the waiting area.
4.5 All medical staff and O.R. personnel must ensure that patients are not exposed unnecessarily during physical examination, positioning and skin prepping in the theatres.

4.6 The presence of male O.R. and medical personnel in the theatres must be limited to those whose presence is absolutely necessary for female patient until anaesthetized. Male Anesthesia technician must be allowed inside the theatre prior to induction.

4.7 The rest of the male medical team and students must be allowed inside the theatre after the female patient is completely draped.

4.8 The Charge Nurse must have the authority to limit the number of male personnel entering the theatre during surgery on female patients.

4.9 Conversation and noise inside the theatres must be kept into a minimum. There must be no comments made regarding patients in both O.R. & R.R.

4.10 Male and female patients must be kept separate in the Reception Area / Recovery Room when possible.

4.11 Once female patient has recovered from anesthesia and she is fully conscious, her face must be covered when she is transferred back to the ward.

5.0 **REFERENCE:**

5.1 KKHUH Broad Policy Guidelines

5.2 AORN Best Practice Guidelines
1.0 CONDITIONS:
All O.R. RN’s

2.0 PURPOSE:
To ensure safe transfer and transport of surgical patients in O.R.

3.0 POLICY:
All OR RN are responsible and accountable to ensure safe transfer and transport of surgical patients using a roller or without.

4.0 PROCEDURE
4.1 Raise the OR table one or two (1-2) inches higher than the surgical stretcher, to prevent back strain. Ensure surgical stretcher is locked into place. Use the lift that was placed under the patient pre-op. The lift sheet should be placed to extend from above the patient’s elbows to below the buttocks. If the lift is soiled or wet, i.e., Betadine, blood it must be changed.

4.2 The Anesthetist / Anesthesia Technician will support the patient’s head and neck. OR circulating nurse on both side of the patient and the patient’s feet.

4.3 Grasp the sheet close to the patient’s body.

4.4 The Anesthetist / Anesthesia Technician will coordinate the transfer. OR personnel on both side of the patient will ensure the OR table and trolley do not move.

4.5 Once the patient is moved to the surgical trolley, raise both side rails, lock in place. Cover patient with a warm blanket. Place safety strap across the patient’s legs above the knees.

4.6 Position any IV’s, Foley bag or drainage bags onto the trolley for transportation.

4.7 Raise head of bed, per Anesthetist request.

4.8 Anesthetist and Circulating RN will take patient to R.R. or ICU.
4.9 Anesthetist will request O2 tank, Ambu bag, and cardiac monitor, if needed.
4.10 The same procedure is used when moving the patient from the surgical trolley to the OR bed.

5.0 **REFERENCE:**
1.0 CONDITIONS:
O.R. RN’s

2.0 DEFINITIONS:
Surgical Attire – Non – sterile apparel designated for the OR practice setting that includes 2 piece pant suits, head covering, O.R. clogs, mask and other protective cover.

3.0 PURPOSE:
3.1 Surgical attire provides a barrier between personnel and between patient and patient and personnel, through which contamination may pass.
3.2 Surgical attire also provides protection for personnel against exposure to infectious microorganisms and hazardous materials.

4.0 POLICY:
All nursing staff who enter the semi-restricted and restricted areas of the Operating Room’s surgical theatres should wear freshly laundered surgical attire or scrub suit intended for use only within the surgical areas.

5.0 PROCEDURE
5.1 All nursing personnel entering semi-restricted and restricted areas of the surgical suite shall be in operating room attire.

5.1.1 Operating Room attire consists of standard reusable woven fabric or single-use non woven scrubs and surgical hat or hood. All attire should be low-linting.

5.1.2 OR attire which is soiled or wet shall be changed.

5.1.3 All reusable attire shall be laundered after each use, by a laundry facility approved and monitored by the hospital.
5.1.4 OR attire shall be stored in an enclosed cupboard.

5.1.5 A cover gown or lab coat is to be worn whenever leaving the surgical suite.

5.2 All head and facial hair is to be covered while in the restricted areas of the surgical suite.

5.2.1 The surgical hat or hood is to be clean, free of lint and confine the hair. The surgical hat or hood is changed daily. Reusable hats or hoods shall be laundered after each use, by the laundry facility approved and monitored by the hospital.

5.3 All nursing personnel entering the restricted area of the surgical suite are to wear closed-toe and heeled non-fabric shoes. Clogs of fabric-constructed shoes are prohibited.

5.3.1 Shoe covers shall be worn if it is anticipated that splashes or spills will occur.

5.3.2 When shoe covers are worn, they are to be changed whenever torn, soiled or wet. Shoe covers are to be removed whenever leaving the surgical suite.

5.4 Nursing staff who are not “scrubbing in” shall wear long sleeved jackets. Jackets are to remain closed (buttoned).

5.5 All Nursing Services personnel shall wear high filtration masks in the surgical suites.

5.5.1 Masks shall be worn at all times in the surgical suites and the other areas where open sterile supplies or scrubbed personnel are located. Masks shall cover the nose and mouth and shall be discarded whenever removed.

5.6 Face shields or goggles/glasses shall be worn when splashing or spraying is anticipated.

5.6.1 Face shields/goggles/glasses that become contaminated shall be disposed of or decontaminated, as appropriate

5.7 Personal jewelry worn in the surgical suites shall be limited to the following:

5.7.1 Watch

5.7.2 Bracelets – none

5.7.3 Necklace – one (1) small single chain

5.7.4 Earrings – small studs; all other earrings worn are to be contaminated within a cap at all times

5.7.5 Rings – wedding set only or one (1) ring per band.

5.8 All Jewelry (rings and watches) is to be removed prior to hand washing/scrubbing; all other jewelry shall be totally confined within scrub attire or removed

5.9 Fingernails should be kept short (less than one-quarter (¼) inch in length) and well maintained. No artificial fingernails or extenders.
6.0 **REFERENCE:**

1.0 **CONDITIONS:**
Applicable to all O.R. RN's

2.0 **PURPOSE:**
2.1 To document all nursing activities performed which is legally and professionally important for clear communication as well as collaboration with the surgical team and for continuity of care.

2.2 To encode in the HIS Theatre Management Menu for statistics purposes.

3.0 **POLICY:**
All OR RN’s should be responsible and accountable for the completion of perioperative documentation which is essential for the continuity of goal directed care and for comparing achieved patient outcomes to expected patient outcomes.

4.0 **Procedure**
4.1 The circulating RN will accurately document all care given to the patient from the time the patient arrives in the operating room to the time of transfer to the PACU or patient care unit.

4.2 The Circulating RN will verify and document the following information:
4.2.1 Preoperative diagnosis prior to surgery
4.2.2 Preoperative patient assessment
4.2.3 Patient skin condition on arrival and discharge
4.2.4 Disposition of glasses, dentures, hearing aids, etc. i.e. patient direct to O.R.
4.2.5 Postoperative diagnosis after completion of procedure
4.2.6 Surgical procedure performed
4.2.7 Procedure/ site identified by the surgical team before incision (time out)
4.2.8 Name of surgeon and assistants
4.2.9 Name of Anesthetist / Anesthesia Technician
4.2.10 Name of Visiting surgeon or Health Company representatives
4.2.11 Anesthesia starting and ending times
4.2.12 Surgery starting and ending times
4.2.13 Names of scrub and circulating nurses
4.2.14 Anesthesia classification
4.2.15 Wound classification
4.2.16 Special equipment
4.2.17 Sponges, sharps and instrument counts and verification
4.2.18 Specimens and cultures
4.2.19 Medications / IV fluids, blood or blood products used
4.2.20 Catheters, drains, packings and dressings
4.2.21 Implants, Prosthesis, Grafts
4.2.22 Radioactive implants
4.2.23 Laser, model, wattage, total time used
4.2.24 Tourniquet cuff, setting, time inflated and deflated
4.2.25 Electro surgical unit, grounding plate, settings
4.2.26 Positioning of patient, safety belt, positioning devices
4.2.27 Fluoroscopy and / or X-ray
4.2.28 Any pertinent observation of complications occurring during the patient’s stay in the operating room (comment portion)
4.2.29 Any Communication with family during the procedure i.e. Consent
4.2.30 Patient status at time of discharge, patient disposition, transfer method

4.3 The Scrub Nurse and RN must sign the sponge, needle and instrument counts at the completion of the procedure.

5.0 FORMS AND ATTACHMENTS:
5.1 O.R. Receiving / Holding Area Pre-operative Nursing Checklist
5.2 Nursing Operative Data
5.3 Recovery Room Record

6.0 REFERENCE:
1.0 CONDITIONS:

OR HIS Nurse.

2.0 PURPOSE:

To ensure maintenance of the Surgical Logbook.

3.0 DEFINITIONS:

Logbook: All the patient information operative procedure written and other important data written in the NOD is encoded in the HIS.

4.0 POLICY:

4.1 OR HIS Nurse is responsible and accountable to ensure that a copy of the operative record of all procedures done in the operating room or done in another area of the hospital by Surgical Services personnel will be maintained in the Surgical Logbook.

5.0 PROCEDURE:

5.1 The following information will be included for all procedures:

5.1.1 Medical record number
5.1.2 Patient name
5.1.3 Sex of patient
5.1.4 Date of birth
5.1.5 Surgeon
5.1.6 Assistant surgeon, if present
5.1.7 Anesthetist & Assistant
5.1.8 Circulating and scrub nurse
5.1.9 Date of procedure
5.1.10 Preoperative diagnosis
5.1.11 Operative or invasive procedure done
5.1.12 Postoperative diagnosis
5.1.13 Complications
5.1.14 Anesthesia and surgery (start and finish times)
5.1.15 Type of anesthesia
5.1.16 Sponge, needle, instrument count status
5.1.17 Drains and packing
5.1.18 Specimens and cultures
5.1.19 Implants

5.2 At the completion of the year the surgical statistic are compiled and distributed as follows:
5.2.1 Nursing Administration
5.2.2 Anesthesia Department
5.2.3 Medical Records Director
5.2.4 Surgical Services
5.2.5 Infection Control Practitioner

5.3 The Circulating RN is responsible for accurately completing the information on the operative records.

5.4 The Unit Secretary is responsible for placing a copy of the Intraoperative Nurses’ Notes (OR Record) into the Surgical Logbook in an accurate and timely manner. It is also the responsibility of the Unit Secretary to compile and distribute the monthly statistics if required.

6.0 FORMS AND ATTACHMENTS:

N.O.D.

7.0 REFERENCE:
7.1 International Code of Disease ICD – 9-CM
7.2 KKUH Computer Department Guidelines
1.0 CONDITIONS:
All O.R. and R.R. RN’s

2.0 DEFINITION:
2.1 Controlled Drugs – regulated by law with regard to possession and use of drugs.
2.2 Controlled drugs are the following:
2.2.1 Fentanyl
2.2.2 Sufentanyl
2.2.3 Morphine
2.2.4 Pethidine
2.2.5 Hydromorphone Hydrochloride, etc

3.0 POLICY:
All OR RN’s and RR Nurses are responsible and accountable to ensure safety of Controlled Drugs inside the O.R. Department.

4.0 PROCEDURE:
4.1 Scheduled drugs shall be locked within a secured area. (Drug Room near Dumb Waiter)
4.2 Only authorized personnel shall be given access to locked areas. (HN/CN/Designee)
4.3 Access to operating room theatres shall be strictly limited to authorized individuals. (O.R. nurses, anesthetists, technicians)
4.4 Non-controlled medications on top of or in an anesthesia cart located in an opening room suite or in a labor and delivery suite must be secured. The areas are considered secured when these areas are staffed and staffs are actively providing patient care.
4.5 All controlled substances must be locked within a secure area regardless of whether a patient care area is staffed or actively providing patient care.

4.6 Narcotic Form should be filled up properly for any narcotic and controlled drugs used.

4.7 Designated Drug Nurse is responsible in ordering and returning drugs to Pharmacy Dept.

4.8 If the drug nurse is not available two nurses have to witness in receiving and returning the drugs, empty ampoules, completed narcotic forms and PCA forms.

5.0 REFERENCE:

5.1 Comprehensive Drug Abuse Prevention and Control Act of 1970

5.2 CMS Hospital Conditions of Participation Final Rule, Effective January 26, 2007, Section 482.25


1.0 CONDITIONS:
All O.R. RN’s

2.0 PURPOSE:

2.1 To ensure patient’s safety all counts must be performed in all procedures in order to account for all items and to lessen the potential for patient’s injury as a result of any retained foreign body.

2.2 To count accurately throughout the surgical procedure thereby, the surgical team should consider its importance in order to minimize the risks of retention of items which they can be held liable.

2.3 To define all items to be counted not only on the 3 categories like sponges, sharps instruments, etc but also during the times when counts must be done and when documentation is required.

3.0 DEFINITIONS:

3.1 Instruments – are surgical tools – for cutting, dissecting, grasping, holding, retracting & suturing.

3.2 Sharps – are items with edges or points capable of cutting or puncturing, i.e. suture needles, scalpel blades, hypodermic needles, electro-surgical needles and blades.

3.3 Sponges – soft goods (gauze pads; cottonoids, peanuts, dissectors, tonsil and laparotomy sponges).

4.0 POLICY:

All OR RN’s are responsible and accountable to ensure the following:

4.1 Count Policy Guidelines should be applied effectively in counting swabs, instruments, needles, peanuts, loops nylon tapes, bulldogs, blades etc.

4.2 Counts must always be done with a second person and **NEVER BY THE SCRUB NURSE ALONE.** The scrub and the circulating nurse should count all items in unison and aloud. Counting should not be interrupted.

Minimum count for any operative procedures must be three:
4.2.1 Before the beginning or start of operation as a baseline.

4.2.2 Before any closure begins.

4.2.3 When skin closure is begun.

However the scrub nurse is entitled to do as many counts where he / she thinks is required.

4.3 If any uncertainty exists about a count, it should be repeated.

4.4 The circulating nurse should immediately record the count for each type of item on the count board.

4.5 If additional sponges, instruments, sharps, or other items are dispensed during the procedure, they are similarly counted and the circulating nurse must record the quantity added.

4.6 The name of the circulating nurse should be recorded in the NOD as soon as each count is completed.

4.7 Additional counts should be performed whenever there is a change / relief in scrub nurse.

4.8 Once items are counted, linen or trash bags should not be removed from the theatre until the procedure is completed and the patient is taken out of the theatre.

4.9 Additional counts should always be undertaken before a cavity within a cavity is closed. Ex. when uterus is closed in caesarian sections.

4.10 X-ray detectable sponges / swabs should never be used for dressing to avoid the appearance of a retained item or post-op x-ray studies.

4.11 Used needles should be kept in a needle pad or container to facilitate counting and to ensure their containments on the table.

4.12 Count Procedures must be the same standard practice in every theatre irrespective of sub-specialty.

5.0 PROCEDURE:

5.1 Instruments are checked by the scrub nurse with instruments checklist in the tray and the circulating nurse will record any discrepancies and report to CSSD technicians / supervisor immediately. The scrub nurse must sign the packing list at the end of the operation.

5.2 Swabs are counted by the scrub nurse and circulating nurse. Each type and size of sponge should be kept separate from the other types. The circulating nurse who did the count must be the one to record it on the board.

5.3 Needles, nylon tapes, blades, loops, peanuts, tonsil swabs, kitners, patties, bulldogs, screws must be treated the same and recorded on the board by the circulating nurse who did the count.

5.4 All swabs 4x4, 30x30, 45x45, peanuts, tonsil swabs, patties during an operation must be translucent and never be out and used for any other purpose.

5.5 If a package of sponges is dispensed to the field with incorrect quantity or number of sponges it should be handed off the field in its entirety, not to be
included in the bagged, labeled, and isolated counts but to be given to the Head Nurse for Quality Control purposes.

5.6 During surgery the scrub nurse should discard soiled sponges into a plastic lined bucket. The circulating nurse must separate and place it around the edge of the kick bucket.

Different types of swabs must be always kept separate:

Unit measures of items to be checked:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>a)</td>
<td>4x4 raytec gauze</td>
</tr>
<tr>
<td>b)</td>
<td>30x30 raytec gauze (lap sponges)</td>
</tr>
<tr>
<td>c)</td>
<td>45x45 raytec gauze (lap sponges)</td>
</tr>
<tr>
<td>d)</td>
<td>Peanuts/kitners dissecting swabs</td>
</tr>
<tr>
<td>e)</td>
<td>Tonsils swabs</td>
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<tr>
<td>f)</td>
<td>Patties</td>
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All the rest of the items; needles, blades, nylon tapes etc. are counted as one of each. Once the required numbers of each different swab are in the kick buckets, the circulating nurse must count them with the scrub nurse. There must be no extra or other type of swab in the kick bucket during the count.

5.7 The checked swabs must be tied together, put in plastic bag kept in one place in the theatre until the end of the operation. The counted and bagged swabs must be crossed off and initial of the nurse who did the check must be on both the bag and the board.

5.8 No items must be removed from the theatre during the operation unless the scrub nurse is aware and has given his / her approval.

5.9 The scrub nurse should inform the circulating nurse for any swab kept inside the cavity while the operation is going on and should be written on the board and cross off when the swab is removed to avoid discrepancies during the counting. The scrub nurse must always be aware of the number of swabs and instruments in the operating field at all times.

5.10 As the first layer of closure is begun, the scrub nurse and the circulating nurse should start the count consecutively, proceeding from the sterile field to the back table and then to the bagged sponges off the field. The scrub nurse should inform the surgeons of the results of the count.

5.11 If any item which is part of the count is missing the surgeon must be informed immediately. A thorough search for the item must be carried out.

5.12 The surgeon has to re-examine the wound and if still not found, the patient must be x-rayed to exclude the possibility of the item being inside the wound.
5.13 The HN / designee at the time must be informed immediately and if the item is still unaccounted for, an incident form should be completed by all staff nurses working in the room. This must be recorded in the nursing operative data.

5.14 Change of scrub nurse must be done only in exceptional circumstances and not as a routine; the relieving scrub nurse must do a complete count with the circulating nurse. All items must be accounted for before the change of scrub nurse takes place. Surgeon should be informed when a change of scrub nurse will commence.

5.15 Discrepancy in the count must be recorded in the Nursing Operative Data. Counts must be done during all procedures, however listed below are the operating procedures where it is not absolutely necessary to do a final count:

5.15.1 Closed endoscopic procedures
   5.15.1.1 Cystoscopy / Urethroscopy
   5.15.1.2 TURP
   5.15.1.3 Insertion / Removal of DJ and Ureteric catheter
   5.15.1.4 Arthroscopy only
   5.15.1.5 Bronchoscopy only
   5.15.1.6 Gastroscopy only
   5.15.1.7 Sigmoidoscopy only

5.15.2 Procedures where there is superficial incision / no incision
   5.15.2.1 Circumcision
   5.15.2.2 Repair of Hypospadias
   5.15.2.3 Skin Grafting
   5.15.2.4 Dermabrasion
   5.15.2.5 Removal of Sutures
   5.15.2.6 IV Cutdown only
   5.15.2.7 Liposuction
   5.15.2.8 Operation on Ear Lobe / Lip/ Eyelids

5.16 In procedures that may require the use of high volume of needles, the scrub nurse can count any filled needle pad with the circulating nurse and hand it off the field. The circulating nurse should then bag, sign and label it with the number of needles contained.

5.17 Broken needles and cut nylon tapes during the procedure must be accounted for in their entirety.

5.18 Raytec gauze (lap sponges) used for wound packing.
   When the surgeon has to leave raytec gauze (lap sponge) to pack the wound for hemostasis, it must be clearly documented in the nursing operative data, specially the type and number of gauze (lap sponge) left inside the wound. The surgeon has to sign the NOD (Nursing Operative Data) and the person-in-
charge of the operating room must be informed. The ICU /Ward nurse must also be informed during the handover of the patient.

6.0 **FORMS AND ATTACHMENTS:**
N.O.D.

7.0 **REFERENCE:**
7.1 AORN RECOMMENDED PRACTICES
7.2 Pocket Guide to the Operating Room by Maxine A. Goldberg
1.0  **CONDITIONS:**
O.R. RN’s

2.0  **PURPOSE:**
To ensure safe & proper preservation, documentation & reporting of physical proofs or evidences.

3.0  **DEFINITIONS:**
Physical evidence, i.e., bullets, fragments and drugs

4.0  **POLICY:**
All OR RN’s are responsible and accountable to ensure a chain of custody is established for physical evidence so that it may be used by law enforcement agencies.

5.0  **PROCEDURE:**
5.1   The scrub nurse will pass the evidence to the Circulating RN.
5.2   Do not handle bullets in metal instruments is possible. Metal instruments will scratch the bullet.
5.3   Place bullet in non-metal specimen container after removal from the patient.
5.4   Submit bullets to law enforcement per local and state regulations.
5.5   Patient’s personal belongings (ongoing criminal investigation):
   5.5.1 Place all patient items in a paper bag for those cases that are involved in an ongoing criminal investigation.
   5.5.2 Label belongings with patient’s identification information.
   5.5.3 Clothing removed from a patient shall be cut along the seams around bullet hole(s) or stab wound hole(s).
5.5.4 Disposition of patient belongings shall be according to local and state regulations.

5.6 The circulating nurse will replace the evidence, as is, in a container and label the container with the patient’s name, medical record number, location where evidence was collected, date and time collected and physician’s name.

5.7 The OR RN will turn over the evidence to the law enforcement agent after seeing proper ID.

5.8 The law enforcement officer will sign the proper document confirming possession of the evidence. This will include the agency’s name, officer’s name and badge number, date and time, and a description of the evidence. The Circulating RN will also sign this form.

5.9 The evidence document will be placed in the patient’s medical record. One (1) copy will be sent to the Surgical Services Nurse Manager and another copy will be sent to the Security Department.

5.10 The specimen name and site and its destination will be documented on the Nursing Operative Data Record and the Pathology Requisition Form.

5.11 If the law enforcement officer has not arrived to collect the evidence, the evidence will be given to hospital Security for safe keeping. The evidence document will be completed, as above, by the Security Officer accepting the evidence.

6.0 **REFERENCE:**

Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 **CONDITIONS:**

All O.R. Personnel entering the theatres and Restricted Areas, All O.R. Registered Nurses, Surgeons, Anesthetists, Technicians, etc

2.0 **PURPOSE:**

2.1 To ensure safe and effective procedure for establishing and maintaining a sterile field in which surgery can be performed safely.

2.2 To prevent contamination of the open wound, isolate the surgical site from the surrounding unsterile environment, and create a sterile field. Should be opened, dispersed and transferred by methods that maintain sterility and integrity. Ex. Wrapped edges should be secured when presented to a sterile.

3.0 **POLICY:**

All OR Registered Nurses are responsible and accountable in ensuring proper adherence to the principles of Aseptic technique eliminates or minimizes modes and sources of contamination hereby prevent surgical site infection.

4.0 **PROCEDURE:**

4.1 Items used within a sterile field should be sterile.

Rationale:

All materials is in contact with the wound and used within the sterile field must be sterile. Sterilization provides the highest level of assurance that an item is devoid of viable microbes.

4.2 All items presented to the sterile field should be checked for proper packaging, processing, moisture, seal integrity, package integrity, expiry date and the appearance of sterilization chemical indicator.

Rationale:

The inspection of packaging helps ensure that only sterile items are presented to the sterile field. Items of doubtful sterility must be considered unsterile.
4.3 All items introduced by methods that maintain sterility and integrity. Ex. Wrapped edges should be secured when presented to a sterile field.

Rationale:

When opening sterile supplies, circulating nurse should open the wrapper flap farthest away from the first and the nearest wrapper last, to prevent contamination by passing as unsterile arm over a sterile item.

4.3.1 Items should not be tossed onto a sterile field because they may roll off the edges and become contaminated, displace other items or penetrate the drape.

Rationale:

Good judgment must be used when presenting items to the scrubbed person or by placing them securely on the sterile field.

4.4 All scrubbed personnel should wear sterile gowns, and gloves.

Rationale:

Sterile gowns established a barrier that minimizes the passage of microorganisms between sterile and non-sterile areas.

4.5 Sterile gowns should be considered sterile in front from chest to the level of the sterile filed, and the sleeves should be considered unsterile from 2 inches above the elbow to the stockinet cuff.

Rationale:

The cuff should be considered unsterile because it tends to collect moisture and it is not an effective bacterial barriers.

Areas of the gown considered unsterile are the following:

4.5.1 neckline
4.5.2 shoulders
4.5.3 under the arm
4.5.4 back

4.6 Sterile drapes are used to create a sterile field.

Rationale:

Sterile surgical drapes establish aseptic barriers minimizing the passage of microorganisms from non-sterile to sterile area. Sterile drapes should be placed on the patient and equipment to be included in the sterile field leaving the incisional site expose.

4.6.1 Sterile drapes should be handled by scrubbed personnel only and handled as a little as possible.

Rationale:

The movement of sterile drapes from clean to dirty areas helps prevent contamination.
4.6.2 During draping process, drapes should be compact, held higher than the OR table and draped from the operative site to the periphery.

Rationale:
Rapid movement of sterile drapes creates air currents on which dust, but or droplet nuclei can migrate.

4.6.3 Sterile gloves should be protected by cuffing the drapes over the gloved hands.

Rationale:
Gloved hands should always be protected by cuffing the drapes over the gloved hand to avoid contamination.

4.6.4 Once the drape is in place it should not be moved.

Rationale:
Shifting or moving the sterile drape compromises the sterility of the field.

4.6.5 Only the top surface of a draped instrument table, mayo or the OR table is considered sterile.

Rationale:
The sides are not considered sterile. Any items that extends beyond the sterile boundary is considered contaminated and should not be brought back onto the sterile field.

4.7 A sterile field should be maintained and monitored constantly.

Rationale:
4.7.1 Once a sterile filed is established, it should not be left unattended.

4.7.2 When a breach of sterility occurs, team members must take immediate and appropriate action to correct the break in technique to reduce further risk of contamination.

4.7.3 If sterile set-ups are covered or left unguarded, they should be considered contaminated.

4.8 Movement around a sterile field must not cause contamination of the sterile field.

Rationale:
The patient is center of the sterile field during an operation.

4.8.1 Scrubbed personnel should move from sterile to sterile areas.

Rationale:
If they must change position, they should turn both to back or face to face while maintaining safe distance between each other.

4.8.2 Scrubbed members should avoid changing levels and should be seated only when the entire surgical procedure will be performed at this level.

Rationale:
Scrubbed personnel should remain in the position in which they began surgery.

4.8.3 Scrubbed persons should stay close to the sterile filed.

Rationale:
Scrubbed personnel should keep their arms and hands within the sterile field at all times to avoid any accidental contact with non-sterile items or areas. A safe distance should be maintained when approaching non-sterile objects and personnel. This safe distance or margin of safety is generally identified as minimum of 12 inches (30cm) or more and it is important in identifying safe boundaries between sterile and non-sterile areas.

4.9 Whenever a sterile barrier is permeated, it must be considered contaminated. This principle applies to packaging materials as well as to draping and gowning materials.

Rationale:
When moisture soaks through a drape, gown or package, strike-through occurs, and the item must be considered contaminated.

4.10 Policies and Procedures for maintaining a sterile filed should be written reviewed annually and readily available within the practice setting.

Rationale:
These recommended practices of aseptic techniques should be used as guidelines for developing policies and procedures within the practice setting.

4.10.1 Training of aseptic technique and practices requires experienced and skilled surgical team members to demonstrate these skills to new and inexperienced personnel.

Rationale:
Introduction and review of policies & procedures should be included in the orientation and on-going education of all perioperative personnel.

5.0 REFERENCE:

5.1 AORN Recommended Practices 2008 edition

5.2 Alexander’s Care of Patient in Surgery by Jane Rothrock
1.0 CONDITIONS:
All O.R. RN’s

2.0 PURPOSE:
To ensure the disinfections of hands and arms of the O.R. Nurses

3.0 DEFINITIONS:
3.1 Skin – is a major potential source of microbial contamination in the surgical environment.
3.2 Surgical Hand Antisepsis – refers to the antiseptic hand rub or wash performed before donning sterile scrub attire to eliminate transient bacteria.
3.3 Antiseptic Agent – Anti microbial substance applied to the skin to reduce the number of microbial flora.

4.0 POLICY:
All OR Surgical Scrub Team should disinfect their hands and forearms and then, don on sterile gown and gloves prior to performance of any surgical procedures.

5.0 PROCEDURE:
5.1 All surgical scrubs should be 5 minutes scrubs.
5.2 Remove all jewelries on your hands and wrists. Fold the sleeves above the elbow.
5.3 Turn water on and adjust for the temperature and make sure the water does not splash. (Note: New Scrub ware sink has automatic sensor.
5.4 Wet arms to elbow thoroughly and always hold hands above the level of the elbow and away from the body so that contaminated water cannot run from elbows to hands, the hands being the cleanest.
5.5 Obtain scrub solution (antiseptic) from elbow operated dispenser or foot operated dispenser.

5.6 Lather hands and arms to elbows. Use a circular motion, begin at fingertips of one hand and lather and wash between the fingers, covering from finger tip to elbow. Repeat this for the second hand and arm.

5.7 Obtain scrub brush if necessary (soft brush or sponge is recommended).

5.8 Scrub nails brushly (10 strokes for each hand across nails). It is important for all surgical staff to keep the fingernails short). Clean under each fingernail with a nail stick provided.

5.9 Discard brush properly.

5.10 Use more scrub solution, continue to lather arms, wash each arm for on minute then go to hands.

5.11 Lather both hands together for 1½ minutes each rinse each arm separately, fingertips first, holding your hands above the end of the elbow a total of 3 minutes.

5.12 Turn water off with elbow or it will turn off automatically with sensor: from new scrub ware sinks.

5.13 Pick-up sterile towel with fingertips, standing well back from sterile pack of gown making sure to touch only the towel and to allow no drips on the sterile area.

5.14 Dry hands thoroughly from fingertips to elbow one at a time using a different side of the towel on each arm.

5.15 Discard towel and proceed to gowning procedures.

5.16 Keep your hands above the level of your waist and do not touch anything before putting a sterile gown and gloves.

6.0 REFERENCE:

6.1 AORN Recommended Practice Guidelines No. 8 Edition

6.2 KKUH, Infection Control Manual
1.0 CONDITIONS:
All O.R. Scrub Nurses

2.0 PURPOSE:
To ensure maintenance of a sterile field by covering areas of the body and clothing with a sterile barrier

3.0 POLICY:
All OR scrub nurses after performing theatre Surgical Hand Scrubbing should done on sterile gown and gloves prior to performance of any surgical procedure.

4.0 PROCEDURE:
4.1 Open the sterile gown and glove package on designated flat surface in prescribed manner.

4.2 With your hands above the level your waist, approach the table where gown and gloves have been prepared and pick up the sterile towel touching only the sterile towel and step back. Allow the towel to fall open.

4.3 Start with one end of the towel, dry one hand and arm stopping 2 inches above the elbow. Note: When drying hands, do not go over areas already dried.

4.4 Invert the towel and with the other end, dry the other hand and arm, bend forward slightly to prevent any part of the towel from coming in contact with your scrub suit.

4.5 When both hands and arms are dry, discard the towel properly.

4.6 For unassisted Gowning. Grasp the pre-fold sterile gown by the neckline with both hands and step back from the table into an unobstructed area.

4.7 Hold the folded gown with the inside toward you, locate the neckline of the gown and hold the gown with both hands allowing the gown to unfold in front of you.
4.8 Hold the unfolded gown at shoulder level; push both hands and arms into the sleeves simultaneously. Note: When placing arms into the gown, maintain proper level of arms and hands. No higher than shoulders or lower than waist.

4.9 The circulating nurse assist by bringing the gown over the shoulders; by reaching inside the gown, closing and securing the gown at the waist and neckline. The hands should not be extended beyond the stockinet cuff of the gown.

5.0 **REFERENCE:**

1.0 **CONDITIONS:**

All O.R. scrub nurses who scrub and assist for the surgery

2.0 **PURPOSE:**

To ensure safe and effective assistance to another member of the sterile team donning sterile gown and gloves prior to the start of a procedure.

3.0 **POLICY:**

Other members of surgical scrub team should be assisted by the scrubbed person (usually scrub nurse) in gowning and gloving prior to the performance of any surgical procedures.

4.0 **PROCEDURE:**

4.1 Gowning Another Member of the Surgical Scrub Team

4.1.1 Open the sterile towel and hand it across the palm of the team member being gowned.

4.1.2 Unfold the gown carefully, hold at the neck pad so that the inside of the gown faces the wearer.

4.1.3 Keep gloved hands covered by the outside gown shoulders; place the gown on the arms of the wearer, as he or she slips into the sleeves of the gown and push up toward the shoulders.

4.1.4 Release the gown at shoulder height and adjust the sleeves in preparation for assisted open gloving.

4.1.5 The circulator assists with the gowning procedure by pulling the gown onto the shoulders from the inside of the gown and securing the back of the gown by fasteners at the neck and waist from the inside.

4.1.6 Gloving Another Member of the Surgical Scrub Team

4.1.7 Pick up the right glove, grasp it firmly with fingers under the everted cuff and present it so that the thumb and palm are facing the wearer. Announce the hand to be gloved.
4.1.8  Stretch the cuff sufficiently to allow hand access while protecting your gloved hand and apply resistance while the wearer pushes hand into the glove.

4.1.9  Release the cuff.

4.1.10 Present the left glove in the same manner. The wearer assists by stretching the cuff with the index finger of his or her gloved hand.

4.1.11 Apply resistance as needed; then release the cuff.

4.1.12 Offer a damp towel to remove powder from gloves, and discard towel after use.

5.0  **REFERENCE:**

5.1  Alexander’s Care of Patient in Surgery by Jane Rothrock. 12th Edition

5.2  Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 CONDITIONS:
   1.1 All O.R. RN’s (Circulating & Scrub Nurses)
   1.2 All Surgical Areas RN’s

2.0 PURPOSE:
   2.1 To ensure skin is prepared aseptically before the operation or any invasive procedures.
   2.2 To reduce the risk of surgical site infection by removing transient microorganisms.

3.0 DEFINITIONS:

   Antiseptic – is a product with antimicrobial activity capable of producing antisepsis.

4.0 POLICY:

   All OR Nurses are responsible and accountable to ensure that the surgical site & surrounding areas should be clean and free from soil, debris and transient microbes before applying antiseptic agent.

5.0 PROCEDURE

   5.1 The patient’s surgical site shall be assessed for moles, warts, rashes or other conditions prior to skin preparation and will be documented.

   5.2 Hair Removal:
      5.2.1 Hair at the surgical site shall be removed only if it will interfere with the procedure.
      5.2.2 Only Personnel trained and skilled in skin preparation techniques shall prepare the surgical site.
      5.2.3 Hair removal shall be completed as close to the surgery time as possible.
      5.2.4 Razors shall NOT be used in this hospital except for some cases.
      5.2.5 Patients shall not be instructed NOT to self–shave pre-operatively.
5.2.6 Hair removal shall not be performed in the surgical suite to prevent contaminating the surgical site and surgical field except for the following conditions:

Based on practice in Neuro Theatre, the male patient is shaved which is done inside the theatre.

For some GS surgeons new protocol in shaving can be done inside the theatre.

5.2.7 An electric clipper, with disposable or reusable head, or a depilatory cream if available may be used for shave preps. Disinfect reusable shaver heads between patients.

5.2.8 Nursing Staff shall be trained on the correct use of clippers.

Note: If patient’s hair is removed for head surgery, save the patient’s hair, placing it in a bag labeled with the patient’s information. The hair will be returned to the patient/family upon discharge.

5.3 Skin Cleansing and Surgical Prep:

5.3.1 Skin cleansing shall be done before the surgical skin prep.

5.3.1.1 The patient shall clean the area by showering, shampooing or washing the surgical site area with an antiseptic agent the night before the procedure, if able.

5.3.1.2 The surgical team may wash the surgical area, prior to prepping the skin with an antiseptic agent.

5.3.2 An antimicrobial agent with a broad-spectrum germicide action will be used for the surgical prep.

5.3.3 The surgical skin prep (with the antimicrobial agent) will be performed using sterile supplies, i.e., sterile gloves, sterile 4x4s, sterile sponge stick, sterile towels.

5.3.4 Always begin the skin prep from the surgery site, continuing to the periphery. Discard all prep sponges once the sponge reaches the periphery of the surgical area.

5.3.5 Areas of high microbial counts, i.e., pubis, open wounds, shall be prepped last.

5.4 Skin preparation for contaminated area differs. If possible, contaminated areas are sealed off with a towel or sponge, while remaining skin areas are scrubbed. The most contaminated area is scrubbed last with separate sponges which are discarded after one-time use.

The following areas within the operative area are considered contaminated:

5.4.1 Umbilicus
5.4.2 Stoma
5.4.3 Draining of sinuses
5.4.4 Skin Ulcers
5.4.5 Vagina
5.4.6 Anus
5.4.7 Traumatic wounds

Note:

GS protocol for patient’s undergoing abdominal procedure, cleaning of umbilicus is done in the ward and to be double checked inside the theatre before skin surgical prepping is done.

5.5 Do not allow prep solution to pool around or underneath the patient or under any equipment on the patient, i.e., electrodes, electro-surgical unit grounding pad.

5.6 Allow prep solutions ample contact time before applying the sterile drapes. (This helps achieve optimal effect of the prep solution).

5.7 If using flammable antiseptic prep solutions, allow time for complete evaporation of the solution before draping, to decrease the risk of fire.

5.8 Do not allow flammable prep solutions to be absorbed into the drapes that are in direct contact with the patient.

5.9 As part of the “time out” procedure, the surgical team shall ensure that:

5.9.1 The surgical site is dry before draping and before the use of the electro-surgical unit, cautery and/or laser.

5.9.2 There is no pooling of the prep solution around the patient.

6.0 **REFERENCE:**

6.1 Association of periOperative Registered Nurses (AORN), Perioperative Standards and Recommended Practices, 2008 Edition

6.2 CMS, Memorandum: Use of Alcohol-Based Skin Preparations in Anesthetizing Locations, January 12, 2007

6.3 CDC, Guideline for Surgical Site Infection, 1999
INTERNAL POLICIES AND PROCEDURES
CONCURRENCE / NON-CONCURRENCE FORM

To be completed by initiating department/person

From: ___________  (department/person) Tel. Extension No.:_______  Date: _____________

Name of Policy and Procedure: ___________________________ Number: ________________

☐ New Document  ☐ Revised Document  ☐ Reviewed Document (no changes done)

Comments: (a brief summary of purpose of the document or changes made)

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You are requested to review the attached document(s) as there could be an effect or impact upon your department if the action is initiated. Please sign if you concur (agree) with the document, date and forward to the next person on the list. If you do not agree with the document, please provide an explanation and send your written comments to the sender (initiating) department.

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1.0 CONDITIONS:
All OR RN’s

2.0 PURPOSE:
2.1 To ensure proper disposition of specimens taken from patient during and after surgery.
2.2 To ensure all specimens collected are sent to specific laboratories for study in which some results may be important for proper diagnosis and treatment of patient’s disease.

3.0 POLICY:
3.1 All OR RN’s are responsible and accountable to ensure the following:

3.1.1 All fresh and dry specimens must be sent to the laboratory immediately with the correct laboratory form completed by the surgeon. O.R. circulating nurse in the theatre must enter the specimen in the specimen registry book and then, send it to the laboratory.

3.1.2 O.R. nurses must ensure that all instructions given by surgeons regarding specimens collected are understood clearly, labeled legibly in the specimen container and documented properly in the NOD (Nursing Operative Data).

3.1.3 O.R. nurses assigned in the Reception Area are responsible in recording all the specimens in the Specimen Book and sending them to the respective laboratories.

3.1.4 Specimens sent to the laboratory must be recorded in the correct specimen book in according to the type of specimen i.e. fresh specimens, frozen sections, microbiology, cytology etc. Specimens must be sorted accordingly.

3.1.5 The O.R. Reception Nurse and the O.R. porter must both write their complete names and sign the specimen book.

3.1.6 The laboratory Receiving Technician must write his / her complete name and sign the Specimen book after receiving the specimens.
3.1.7 The porter must return the specimen book to the O.R. Reception Nurse who must ensure that all specimens are received properly.

3.1.8 In case of any problems in handling specimens, the O.R. Head nurse must be informed immediately and an incident report must be written. Head nurse must inform ADON and the surgeon who did the operation.

3.1.9 No specimen must be left unattended at the Reception Area but to be handed personally to the O.R. porter by the Reception Nurse who is sending the specimen to the laboratory.

3.1.10 Any specimen not matching with the laboratory request form must not be accepted by laboratory technician.

3.1.11 Routine Specimens must be sent to the laboratory before 1530Hrs. and 0800Hrs. the following day for specimens left in the O.R. Stat specimens for microbiology must be sent to the laboratory immediately. Microbiology lab. is open until 2300 Hrs. daily. Stat lab in A&E is open daily from 2330Hrs. to 0630Hrs. and accepts CSF specimen (Tel # 71978).

3.1.12 Gloves must always be worn in dealing with specimens and all specimens must be treated as potentially infectious.

3.1.13 All infected specimens must be documented in the laboratory request form with warning notice and place the appropriate sticker (Caution; orange stickers) in the specimen container.

4.0 PROCEDURE:

4.1 HISTOPATHOLOGY

4.1.1 O.R. nurses must discuss and follow instructions of surgeons regarding specimens for histopathology and must be recorded in the NOD (Nursing Operative Data).

4.1.2 The scrub nurse must ask permission from surgeon before passing any specimens off from the sterile field to the Circulating Nurse.

4.1.3 The Circulating Nurse must receive the specimen in an appropriate size specimen container and pour 10% Neutral Buffered Formalin by asking first the surgeon.

4.1.4 Each specimen must be placed in a separate container and labeled with the patient’s name, patient’s record #, date, time, surgeons name and the type of specimen. Each specimen must be labeled in sequence by indicating the number in the specimen container and the laboratory request form. i.e. Specimen # 1, Specimen # 2.

4.1.5 Small specimens or small biopsies must have a fixing volume about x10 the specimen size and about x5 for larger specimen / biopsies.

4.1.6 Larger specimens must not be forced into the container as this causes poor fixation and distortion of tissue morphology but it must be placed in an appropriate size container.
4.1.7 Labeling of specimen containers and filling up of request forms must not be done in advance.

4.1.8 The O.R. nurse must ensure that the surgeon must complete the histopathology request form before leaving the theatre.

4.1.9 After the surgery, the completed laboratory request form with specimen placed in a biohazard specimen plastic bag must be brought to the Specimen Room by the O.R. Scrub Nurse or the Circulating Nurse if not yet completed.

4.2 FROZEN SECTIONS

4.2.1 Frozen Section sample must be arranged with laboratory well in advance by surgeon and preferably by including in the theatre list of the day. Theatre list copy must be sent to Histopathology Lab.

4.2.2 Inform the Laboratory thru telephone # 7-1885 or 7-1063 about the impending arrival of a frozen section sample when the operation is commenced.

4.2.3 Tissue for frozen section diagnosis must be placed fresh in dry sterile container which is clearly labeled with the patient’s detail and the anatomical site from where the specimen was taken.

4.2.4 A completed histopathology form must be sent with the frozen section sample with indicated nearest telephone number and the surgeon’s bleep for the conveying of results by the consultant pathologist. No need to fill up many request forms provided going to the same place but only indicated the sequence by numbering the specimen containers.

4.2.5 Frozen section results must be taken verbally thru phone by doctors only who are inside the theatre and must write resulting a piece of paper the inform the surgeon immediately.

4.3 OTHER FRESH SAMPLES

4.3.1 Muscle Biopsy for enzyme and electron microscopy.

4.3.1.1 Place the biopsy in a tongue depressor by tying the ends and wrap a moistened but not soaked piece of plain gauze around the sample. The distal and proximal portion of the specimen is marked by surgeons.

4.3.1.2 The biopsy must be sent immediately with the completed histopathology form and the O.R. nurse must ensure it is received and signed by the laboratory technician.

4.3.1.3 The biopsy must be sent to the histopathology laboratory before 1630hrs.

4.3.2 Sural Nerve Biopsy
4.3.2.1 The surgeon must prepare the biopsy and should be at least 1-1.5 cm. long attached to a tongue depressor and wrapped with a saline moistened piece of plain gauze.

4.3.2.2 The surgeon must ensure no trauma to the biopsy at all cost.

4.3.2.3 The specimen must be delivered immediately to Histopathology laboratory with completed Histopathology request form and must ensure it must be received and signed by the laboratory technician.

4.3.2.4 The biopsy must be sent to the Histopathology Lab. before 1630hrs.

4.3.3 Renal Biopsy

4.3.3.1 The biopsy must be placed in saline moistened piece of plain gauze in a kidney dish and to be sent to Histopathology Lab. immediately.

4.3.3.2 The biopsy is usually processed for the following studies; immunofluorescence, EM and for routine histopathology.

4.3.4 Specimens for Microbial Culture: Ex. Lymph node, Lung, Bone etc.

4.3.4.1 The specimen must be sent fresh and placed in a sterile container.

4.3.4.2 The sample should be accompanied by completed lab. requests forms … one for microbiology indicating the type of culture study required and one for histopathology.

4.3.4.3 Specimens for culture only must be forwarded directly to the microbiology laboratory.

4.3.4.4 No formalin must be used for lymph node and lung biopsies.

4.3.5 Lymph Node Biopsy

4.3.5.1 Notify laboratory at least half an hour in advance of the lymph node biopsy arrival in order to allow appropriate preparations to be made.

4.3.5.2 The specimen must be sent fresh in a dry sterile container and must be transported to the laboratory immediately without delay with a completed Histopathology request form.

4.3.5.3 All lymph node samples should reach the Histopathology Laboratory before lunch time just in case a piece of the lymph node has to be sent to the flow cytometry laboratory.

4.3.6 Fresh Specimen for Photography – often Photography is required for interesting and important cases.

4.3.6.1 The photography request form must be completely filled up and surgeon’s simple diagram would be of help in identifying the areas of interest to be photographed.

4.3.6.2 The sample must be brought by surgeon or sent to the laboratory without fixative.
4.3.6.3 The photographer is often requested to come inside the O.R. to take photographs of the specimen as per surgeon’s request.

4.3.6.4 The surgeon must prepare the specimen on a small trolley lined with a medium green or small blue drape with the marked specimen on top to be photographed.

4.4 CYTOLOGY

4.4.1 Gynecological smears

4.4.1.1 The laboratory provides: slides, slide book and aerosol fixative “Cytotrep”.

4.4.1.2 The slide must be labeled before taking the specimen. It must be labeled with lead pencil on the frosted end of the slide and include the patient’s name and number.

4.4.1.3 The smear must be taken before gynecological examination and without any lubricant use.

4.4.1.4 The smear must be placed in the slide book and sent to the laboratory immediately with completed cytology form.

4.5 BODY Fluids – Peritoneal Fluid, synovial fluid, bronchial aspiration and urine.

4.5.1 Send not more than 50cc of unfixed and uncoagulated fluid to the laboratory immediately with the completed laboratory request form. (C&S and Cytology forms and it must be without saline & formalin).

4.6 FOREIGN BODIES

4.6.1 These maybe sent to the laboratory for identification. They are in placed in a dry, appropriately sized, closed container properly labeled and accompanied by completed laboratory request form.

4.6.2 Some foreign bodies may have a medico-legal implication and in such cases may be claimed by the police for investigation. The hospital Administration must be notified i.e. bullet.

4.6.3 Some specimens may be given to the patients such as kidney stones, gallbladder stones and foreign bodies i.e. peanut, seed according to surgeon’s order.

4.7 OTHER IMPORTANT SPECIMENS:

4.7.1 ORTHO

4.7.1.1 All patients whose bones are saved in the O.R. Bone Bank. Culture swab and bone tissue specimens must be sent to the laboratory with completed request forms for C&S. Bone tissues must be sent fresh immediately and it not immediately add a drop of saline in order not to dry-up.

4.7.1.2 Pus / infected body fluid for aerobic and anaerobic in blood culture bottles as per surgeon’s order.

4.7.2 Urology
4.7.2.1  Testicular Biopsy must be placed in a specimen container with Bouin’s solution.

4.7.3  G.S.

4.7.3.1  Thyroid and Breast Samples should be marked with suture and labeled accordingly.

4.7.3.2  Lymph node from breast case must be labeled according to the level of spread.

5.0  FORMS AND ATTACHMENTS:
Attached all Specimen Forms

6.0  REFERENCE:
KKUH Laboratory Specimen Manual
1.0 CONDITIONS:
All O.R. Registered Nurses, All Housekeeping Staff

2.0 PURPOSE:
2.1 To ensure a clean environment for surgical patients.
2.2 To minimize health care workers and patients exposure to potentially infectious microorganisms.

3.0 POLICY:
All OR RN’s are responsible and accountable to ensure the following:

3.1 To maintain and provide an optimum aseptic environment inside the theaters.

3.2 Every morning before theatres are used, all OR lights, OR tables, equipment and furniture surfaces, exposed shelves and kick buckets are wiped down with damp cloth using disinfectant solution.

3.3 Terminal as well as cleaning of the theatres in between cases are the responsibilities of the OR housekeeping staff with the supervision of the OR nursing staff.

3.4 All walls in the Operating theatres are to be washed down, floors to be scrubbed and high cleaning to be done weekly during Thursdays and Fridays.

3.5 No delicate equipment and inside the cupboards are to be cleaned by housekeeping.

4.0 PROCEDURE
4.1 Prior to first scheduled procedure of the day:
4.2 Inspect and check theatre for cleanliness and orderliness for any visible dust, dried blood and / or debris.

4.3 Damp dust as necessary all countertops of all equipments and furniture using surface disinfectant.

4.4 During The Procedure:
4.4.1 Control traffic in and out of the theatres and minimize personnel going inside the theatre.

4.4.2 Cover with hypo chloride powder and paper towel the contaminated areas with blood or other potentially infectious materials as soon as possible after contamination occurs.

4.4.3 Disposed used swabs / sponges into blue plastic bags lined in the kick bucket and ready to be counted.

4.4.4 Transfer counted sponges to another plastic count bags as they accumulate and keep them in one place.

4.4.5 Discard blue plastic bags after final counts into the orange plastic bags.

4.4.6 Used sharps cuddy and should be disposed into an approved yellow puncture resistant container and close when about three quarters full ready for disposal.

4.5 End Procedures:

4.5.1 All used and unused instruments are brought by scrub nurse to the utility room.

4.5.2 Remove and keep all unused sterile single used items.

4.5.3 Call the cleaners to clean flat surfaces and other furniture which are visibly soiled, mop the floor; collect and remove trash.

4.5.4 Replace new plastic bags to trash trolleys and kick buckets.

4.5.5 Remove other equipment not needed for next case and prepare theatre with the right equipment, instrumentation and supplies to be used for the next case.

4.5.6 If there are no more cases to be done inside, supervise housekeeping staff in cleaning the theatre, OR table, table attachments, etc.

4.5.7 Thorough mopping and cleaning is needed after the cases.

4.5.8 Return OR equipment in their designated places.

4.5.9 Ensure the whole theatre is clean and ready for use.

4.6 Evening and Night Shifts Routine Cleaning by Housekeeping:

4.6.1 Thorough cleaning of all theatres and Recovery Room.

4.6.2 Clean OT corridors and hallways and changing room, Coffee Room and Utility Room and other areas.

4.7 General Cleaning – Thursday and Friday:

THURSDAY:

4.7.1 Supervise scrubbing, stripping of all theatres, Recovery Room, Sterile Lay-up Room, Coffee Room, Dirty Utility Rooms and Changing Rooms.

4.7.2 Clean wall, high dusting and cleaning of ceiling, ventilation ducts, OR lights, OR table accessories and filaments.
FRIDAY:

4.7.3 Supervise Stripping and Waxing of corridors of Main OR and Phase IV OR, damp dusting and cleaning doors, edges and ventilation panels and exhaust panels.

5.0 **REFERENCE:**

5.1 Old OR Policies and Procedures

5.2 Infection Control Manual
INTERNAL POLICIES AND PROCEDURES
CONCURRENCE / NON-CONCURRENCE FORM

To be completed by initiating department/person

From: ___________ (department/person) Tel. Extension No.: _____________ Date: _____________

Name of Policy and Procedure: ___________________________ Number: _________________________

☐ New Document ☐ Revised Document ☐ Reviewed Document (no changes done)

Comments: (a brief summary of purpose of the document or changes made)
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1.0 **CONDITIONS:**

All OR RN’s

2.0 **PURPOSE:**

To ensure patient safety by providing scopes and scope instrumentation sets that have been properly sterilized or disinfected according to the KKUH Infection Control Department during endoscopic procedures.

3.0 **POLICY:**

3.1 The O.R. Nursing Staff and other nursing staff assigned in different specialties using scope sets are responsible and accountable to ensure pre-cleaning of the scopes and other instrumentation before sending to CSSD for sterilization.

3.2 Rigid scopes must be cleaned and processed according to the Infection Control Policy Guidelines.

3.3 Clean flexible scopes are to be hanged in the scope cabinet or kept in the scope case.

4.0 **PROCEDURE:**

4.1 **RIGID SCOPES**

4.1.1 After each case separate all assembled components of scopes then, clean, flush the scopes with soap and water by using brush.

4.1.2 Soak in Cidex for at least 30 minutes for the next case.

4.1.3 Rinse thoroughly with sterile water and flush all the channels with sterile water using a bladder syringe.

4.1.4 Dry it with 30 x 30 lap sponge and keep it ready for use in the sterile trolley.

4.1.5 At the end of the day or after all the cases, clean and flush the scopes with soap and water with the use of the cleaning brush.
4.1.6 Blow and dry the scopes with medical air and then, pack and send to CSSD for sterilization.

4.1.7 For infected cases, rinse the scope in running water then; soak in Cidex for one hour. Rinse again and clean with soap and water using the cleaning brush. Blow, dry and pack then, send to CSSD for reprocessing.

4.2 FLEXIBLE SCOPES:

4.2.1 Clean and flush the used flexible scopes with soap and water by using cleaning brush syringe the soak in Cidex for the next case.

4.2.2 Rinse thoroughly with water and dry it with clean towel and blow / dry the channels.

4.2.3 Hang properly the cleaned flexible scopes in Scope Storage Cabinet.

5.0 REFERENCE:

5.1 Old O.R. Policies and Procedures

5.2 Alexander’s Care of Patient in Surgery by Jane Rothrock

5.3 Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 **CONDITIONS:**

All OR RN’s

2.0 **PURPOSE:**

2.1 To ensure all used instruments in infected cases are returned to CSSD.

2.2 To avoid missing and lost of instruments.

2.3 To ensure proper communication & endorsement of infected instruments to CSSD for the prevention of transmission of microorganisms.

3.0 **POLICY:**

3.1 All OR Registered Nurses are responsible and accountable:

3.1.1 To ensure that count of instruments is done before, during and after an infected surgery.

4.0 **PROCEDURES:**

4.1 To report any missing and broken instrument immediately to CSSD staff assigned in the OR and document it in the instrument set packing list’s remarks portion.

4.2 To ensure proper handling of infected instruments during surgery.

4.3 To ensure that all infected instruments are counted correctly before surgery ends by both scrub & circulating nurses and inform CSSD staff for any discrepancy.

4.4 To prepare the necessary barriers to be used in handling the infected instruments – ex. Face mask with shields, extra gloves, sticker indicator and orange plastic bag.

4.5 To ensure that all used infected instruments are opened and soaked in little amount of water, sharps and pointed instruments are in
separate container before putting in orange plastic bag before endorsing to CSSD staff.

4.6 To ensure that both names of scrub and circulating nurses are written legibly in the instrument’s packing list.

4.7 To ensure that all infected instruments used are not mixed with clean instruments and placed in the orange plastic bag with the proper label sticker indicator for infected cases.

E.g. For MRSA, MRO etc. – Round orange sticker.

For HIV+, HepBSAg+, Hep C+ - Caution Sticker

4.8 Inform CSSD staff that infected instruments are ready for handling over/endorsement.

4.9 Endorse and account all used infected instruments properly to CSSD staff if possible and the scrub nurse should sign the packing list.

4.10 Once all infected instruments are brought to CSSD by CSSD staff, the instruments should be checked and counted immediately and then inform the scrub nurse for the completeness or any missing instrument. If there is any missing instrument and not found, the scrub nurse should be responsible in replacing the instruments but failure of the CSSD staff to inform the scrub nurse regarding the missing / lost instrument, after 2 hours the CSSD staff should be responsible for the replacement new

5.0 **REFERENCE:**

OR Old Policy and Procedures and Practice Guidelines
1.0 **CONDITIONS:**

All O.R. Registered Nurses

2.0 **PURPOSE:**

To ensure safe handling of used suction liners and used suction canisters containing greater than 20 ml of any liquid, blood or blood products which are considered potentially infectious waste.

3.0 **POLICY:**

All OR RN’s are responsible and accountable to ensure proper disposal of used suction liners and cleaning of used suction canisters.

4.0 **PROCEDURE:**

4.1 Don personal protective equipment (PPE) or barriers when dealing with used suction liners.

4.2 Add adequate amount of gelling agent to the suction liner and ensure that all outlets of the liner should be safely closed.

   Note: The dosage of gelling powder depends on the composition of the fluid. Guide values should be noted with the following before adding gelling agent:

   - Fluid / H2O – approximate – 6g / liter
   - Isotonic Solution / NaCL – 20g / Liter
   - Blood / Secretions – 6g / liter

4.3 Disconnect used suction liner from canister and discard in the designated orange plastic bag.

4.4 Clean immediately if any accidental spillage occurs by using hypo chlorite powder.

4.5 Replace new suction liner to suction canister and secure all caps to suction ports and connections.
4.6 Clean used suction canisters at the end of day with disinfectant solution.

5.0 **REFERENCE:**

5.1 KKUH Infection Control Guidelines

5.2 Gelling Agent Literature
1.0 CONDITIONS:

1.1 All OR RN’s

1.2 CSSD Staff

2.0 PURPOSE:

2.1 To maintain accurate inventory of equipment / instruments in the OR / CSSD.

2.2 To ensure equipment / instruments are in proper order.

2.3 To ensure effective organization and quality service rendered for patients.

3.0 POLICY:

The OR Nursing Staff should ensure that the necessary documents are produced and processed for any borrowing / lending of equipment / instruments and supplies.

4.0 PROCEDURES:

4.1 Borrowing or lending of equipment / instruments to the two other hospitals company & individuals.

4.1.1 No equipment / instruments must be given to hospital, company and individuals without any written supporting documents.

4.1.2 A special request from must be completed by borrower and names must be written and signed legibly.

4.1.3 Request must be approved by the Hospital Administration and the Chairman of the Department of Surgery.

4.1.4 Any equipment from the OR must be checked with the borrower to ensure it is in working order before handing over to the borrower.

4.1.5 Instruments must be borrowed from CSSD and not from the OR. If the instrument is in the O.R., the O.R. staff must send it to CSSD through the dumb waiter and borrower must collect it from CSSD. The CSSD staff must check the instrument to ensure intactness and sterility before giving to the borrower.
4.1.6 Any damage / broken equipment / instrument must be repaired or replaced by borrower and an incident report must be written.

4.2 Borrowing of equipment / instruments within the hospital. (Internally).

4.2.1 Any equipment / instruments borrowed from OR / CSSD must be checked with borrower to ensure it is in proper working order before handing over to the borrower.

4.2.2 All instruments must be borrowed from CSSD and must be documented in their loan book.

4.2.3 Any damage / broken equipment must be repaired or replaced by borrower and an incident report must be written.

4.3 Receiving Equipment / Instruments / Products from Company or individual for loan, trial or evaluation and for patient’s use.

4.3.1 All requests must be communicated to the Director of Medical Supplies Department for approval through the Chairman of the Department of Surgery.

4.3.2 All equipment / instruments / products must be delivered via warehouse with supporting documents.

4.3.3 Equipment must be checked by Biomedical Engineering Department.

4.3.4 End user must receive the items / instruments / equipment.

4.3.5 Reusable instruments – must be received by Director of CSSD / or O.R. ADON and then inform Surgeon.

4.3.6 Equipment / Disposable items must be received by OR ADON and then inform surgeon.

4.3.7 The company’s representative must inform the Medical Supply Department and Biomedical Engineering Department that he is already collecting / retrieving the loan equipment / instruments with the supporting documents.

4.3.8 O.R. ADON / HN / Designee must ensure that the Company’s representative has signed that he already received the loan equipment / instruments intact and in working order with the presence of Biomed Engineering Staff.

4.4 Providing Technical Training and Support by Company’s Product Specialist to requesting surgeons for any product / instruments / equipment to be used during surgery / symposium.

4.4.1 For instruments / equipment – this must be communicated to the Department of surgery, Medical Supplies Department, CSSD and Biomedical Engineering Department.

4.4.2 The HN / Designee must be aware of the presence of any product specialists inside the O.R. and identify the surgeons to whom they are conducting the technical training and support.

4.4.3 An approved permission from Engineering Department should be given to O.R. HN before entering operating room.

4.5 Providing Service to other hospitals or individuals.

Example: Items for sterilization:
4.5.1 A letter of request must be written by individual or hospital’s representative and the reasons why it is required must be indicated.

4.5.2 Providing service must be approved by Hospital Administration.

4.5.3 The individual surgeons / hospital representative must go directly to CSSD and not to O.R. for sterilization of items.

4.5.4 The approval letter is valid for In-service only.

4.5.5 For personal instruments brought by surgeons to be used in O.R. there must be an approval letter from the Chairman of the Department of surgery and final approval from Director of CSSD.

4.6 All instruments must be borrowed and returned via CSSD only.

5.0 Procedure Forms and Attachments:

5.1 Borrowing and Lending request Form

5.2 O.R. Visit Permission Form

6.0 Reference:

6.1 OR Policy & Procedure

6.2 Policies Supplies Protocol

6.3 CSSD Policy and Procedure
INTERNAL POLICIES AND PROCEDURES
CONCURRENCE / NON-CONCURRENCE FORM

To be completed by initiating department/person

From: ___________ (department/person) Tel. Extension No.:_______ Date: _____________

Name of Policy and Procedure: ___________________________ Number: ________________

☐ New Document ☐ Revised Document ☐ Reviewed Document (no changes done)

Comments: (a brief summary of purpose of the document or changes made)
______________________________________________________________________________
______________________________________________________________________________

To be completed by the reviewers (affected departments).

You are requested to review the attached document(s) as there could be an effect or impact
upon your department if the action is initiated. Please sign if you concur (agree) with the
document, date and forward to the next person on the list. If you do not agree with the
document, please provide an explanation and send your written comments to the sender
(initiating) department.

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* Non-concurrence must forward written comments to the originating department/person.
1.0 CONDITIONS:
   1.1 All OR RN's
   1.2 All OR Personnel

2.0 PURPOSE:
   2.1 To avoid damage equipment cables, plugs and sockets
   2.2 To avoid patients and personnel electrocutions.
   2.3 To avoid power supply outage.

3.0 POLICY:
   All OR Registered Nurses are responsible and accountable to ensure adherence to safety precautions for handling electrical plug.

4.0 PROCEDURE:
   4.1 Disconnect electrical equipment from wall socket outlet, do not pull the cables or cords instead hold the plug firmly and pull it. If you cannot reach the plug, use a stool or ladder to be able to remove the plug properly.
   4.2 Do not lay the equipment cable on the floor to avoid stepping or removing carts on it.
   4.3 Do not use excessive force to insert the plug into the wall socket if it is difficult to insert, call the maintenance.
   4.4 Do not use two pin plugs and extension cords inside hospital premises which are strictly prohibited.
   4.5 Report to Bio-medical Engineering and Maintenance Dept. for immediate repair to any defective or broken equipment, switches, plugs, sockets, trunks covers, cables or exposed wiring. Hospital members are not allowed to do repair to.
   4.6 Do not ever use surgical tapes to repair broken electrical plugs and cables. These are conductive media and can cause electrical leakage. Instead report to Maintenance Dept. for repair.
4.7 Do not over roll the equipment cord around its Classics to avoid internal damage of the electrical wires.

5.0 **REFERENCE:**

5.1 KKUH Broad Policy & Procedure

5.2 Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 CONDITIONS:
All OR RN’s

2.0 PURPOSE:
To ensure optimum safety of the surgical patient during surgery, it is the responsibility of all personnel to prevent the cause of electro-surgical burns and other electrical hazards.

3.0 POLICY:
All OR Registered Nurses are responsible and accountable to ensure optimum safety of the surgical patient during surgery.

4.0 PROCEDURE:
4.1 Assess or check conditions of skin before application of the grounding pad.
4.2 Apply the grounding pad or inactive electrode properly to the patient by placing it on fleshy, non-hairy and should be close to the surgical site as possible.
4.3 Check patient and machine cable connections if done properly.
4.4 Keep the active electrode (electro-surgical pencil) in a holder or quiver when not in use and don’t leave it lying on the drapes.
4.5 Ensure unit is grounded in accordance with the manufacturer’s grounding instructions.
4.6 Follow electrical safety guidelines always and in the event of malfunction, report or call Biomedical Engineering Department immediately.

5.0 REFERENCE:
AORN Recommended Practices
1.0 CONDITIONS:
All OR RN’s.

2.0 PURPOSE:
To ensure proper storage of extra skins taken from patient after skin grafting and for utilization as needed whether in O.R. or in the wards.

3.0 POLICY:
All OR RN’s are responsible and accountable to ensure that extra skin for skin grafting is being stored in O.R. fridge and the maximum length of time that we can keep the skin in the fridge is 3 weeks. After 3 weeks of storage, the skin will be discarded.

4.0 PROCEDURE:
4.1 The skin is taken mostly on the thigh region of the patient depending upon the patient’s condition and is used for grafting purposes.

4.2 Extra skin is automatically for storage and the O.R. scrub nurse must spread it on moistened plain gauze but not totally soaked with saline and then roll the plain gauze with the skin and placed it in a completely labeled sterile specimen container.

4.3 The specimen container must be labeled with patient details such as name of the patient, hospital number, surgeon and it is very important to put the exact date of storage inorder to determine the correct expiry date of the skin.

4.4 The O.R. nurse must store the skin in the fridge in Theatre 11 Anesthesia room by placing it properly inside the fridge that can be visible.

4.5 The O.R. nurses assigned in Theatre 11 (Plastic) are responsible for the regular checking of the expiry date of the stored skin.

4.6 All expired stored skin must be discarded properly.
4.7 If skin is needed in the ward, the ward nurse must notify the O.R. HN / CN / designee and give the details of the patient. The O.R. nurse must find the correct skin from the fridge and give it to the ward nurse.

5.0 **REFERENCE:**

5.1 Alexander’s Care of Patient in Surgery, 12th Edition by Jane C. Rothrock

5.2 Plastic Surgeon’s Preferences
1.0 **CONDITIONS:**

All OR RN’s

2.0 **PURPOSE:**

To ensure proper handling of patient died in O.R.

3.0 **POLICY:**

All OR Registered Nurses are responsible and accountable to ensure that:

3.1 A resting period of one hour after the patient is certified as dead should be observed.

3.2 Surgeon should certify the patient as dead and complete the death notification form #00245 and the death report form F#123.

4.0 **PROCEDURE:**

4.1 After the patient is certified as dead, the nurse must clean the body from blood, remove the drains and tubes.

4.2 Fill the three identification tags.

4.3 Place the plastic shroud sheet on the transferring trolley.

4.4 Place the body on the shroud sheet.

4.5 Extend chin strap protecting face with cellulose pad.

4.6 Fold arms over abdomen to waist and tie, (for Moslem Patient right hand above the left hand).

4.7 Attach I.D. tags 1st to the body, 2nd to outside and 3rd goes with body file.

4.8 Tie the body securely.

4.9 Call the mortuary to collect the body after 2 hours the patient was pronounced dead.

4.10 Send the file back to the ward.
5.0 **FORMS AND ATTACHMENTS:**
   5.1 Form # 00245
   5.2 Form # 123

6.0 **REFERENCE:**
   KKUH Broad Policy and Procedure.
1.0 CONDITIONS:
O.R. RN's

2.0 PURPOSE:
To ensure safe and effective the placement of drapes and this is done immediately before surgery, on the patient’s abdomen. Draping is done by the surgeon or Scrub nurse, except where other members of the Surgical Services team are specified.

3.0 DEFINITIONS:
Barrier Material – are material that minimize or retards the penetration of microorganisms, particulate and fluids.

4.0 POLICY:
All OR Registered Nurses are responsible and accountable to ensure safe and effective placement of abdominal drapes.

5.0 PROCEDURE:
5.1 Place the following items on basin or on mayo table or back trolley in this order:
   5.1.1 Four (4) utility drapes around the incision site.
   5.1.2 Laparotomy Pack
5.2 Put four (4) utility drapes around the incision site.
5.3 Put first towel at near side of incision.
5.4 Put second towel at top of incision.
5.5 Put third towel at bottom of incision.
5.6 Go to the other side of the table and put fourth towel at far side of incision line. Prevent contaminating sterile field by reaching across.
5.7 Place lap sheep on incision site with side marked “head” facing the head, and unmarked side facing the foot.

5.8 Unfold each side of the drape, hold drape until Circulating RN and anesthesiologist take the top of drape and towel clip it to IV stand.

6.0 **REFERENCE:**

6.1 Alexander’s Care of Patient in Surgery, 12th Edition by Jane Rothrock
6.2 AORN Recommended Practices
6.3 Pocket Guide to the Operating Room by Maxine A. Goldman,
1.0 CONDITIONS:
O.R. RN’s

2.0 PURPOSE:
To ensure safe and effective placement of drapes and this is done immediately before surgery, on the patient’s arm.

3.0 POLICY:
All OR Nurses are responsible and accountable to ensure safe and effective placement of upper extremity drapes.

4.0 PROCEDURE:
4.1 Place drapes on basin, mayo stand or back trolley in this order:
   4.1.1 Orthopedic Pack
   4.1.2 One (1) arm stockinet
   4.1.3 2 sticky towel – U shape with plastic and 1 H2O resistant towel
   4.1.4 large Drape
   4.1.5 Five (5) Utility Drapes

4.2 Place barrier towel lengthwise on the rip of first sheet to open it. Place it two-thirds (2/3) up the board while the patient’s arm is held away from board. If a hand board is not used, a table is. Each of the five (5) sheets must be left folded in half when opened, for double thickness.

4.3 Open the second sheet on top of the first and tuck it under the patient’s shoulder and chest. Keep sheets almost entirely cuffed to prevent them from dropping below the sterile range.

4.4 Place U-shaped towel over tourniquet.

4.5 Use towel clip to hold the folded towel in position.
4.6 Place the barrier towel lengthwise under the operative site. This prevents moisture penetration.
4.7 Before using stockinet, consider if arm needs other draping, i.e., draping hand with towels. No other drapes are used when patient has a tourniquet.
4.8 Stretch the stockinet.
4.9 Place gloved hand inside the stockinet roll.
4.10 Grasp patient’s hand through the stockinet covering glove.
4.11 Unroll the stockinet up over the cuff of third sheet to the axilla, or as far as possible. Keep gloved hands behind the stockinet to prevent contamination.
4.12 Place limb sheet over arm and open the sheet to cover the sterile area.
4.13 If necessary, add another sheet to cover the foot of the table.
4.14 The Scrub Nurse and/or surgeon is responsible for properly draping the patient.

5.0 **REFERENCE:**
5.1 AORN
5.2 [http://www.aorn.org/PracticeResources/Toolkits/PatientHandOffToolKit/](http://www.aorn.org/PracticeResources/Toolkits/PatientHandOffToolKit/)
1.0 CONDITIONS:
O.R. RN’s

2.0 PURPOSE:
2.1 To ensure safe and effective placement of drapes, that is done immediately before surgery, on the patient’s leg.

2.2 Draping is done by the Surgeon assisted by the Scrub Nurse, except where other members of the Surgical Services team are specified.

3.0 POLICY:
All OR Registered Nurses are responsible and accountable to ensure safe and effective placement of lower extremity drapes.

4.0 PROCEDURE:
4.1 Place drapes on ring, mayo or back trolley in this order:

4.1.1 Orthopedic pack

4.1.2 2 Sticky Utility drapes

4.1.3 U-shape with plastic + 1 drape water resistant

4.1.4 One (1) leg stockinet

4.1.5 One (1) leg drape to cover the upper part

4.1.6 One (1) 6-inch stockinet x2

4.2 Stand at foot of operating table, open first U-shape towel and place it to patient’s mid-thigh while his/he leg is held away from the table. Circulating RN will hold leg until draping is completed.

4.3 A “U”-shape towel will be placed over the tourniquet.

4.4 Towel Clip the cuffled edges of the towel together.
4.5 Place barrier towel on half sheet, lengthwise under the operative leg. (Prevent moisture penetration and help maintain sterile field.)

4.6 Consider if leg needs other draping before using leg stockinet, i.e., enclosing foot in towel. Do not boot or add any extra drapes, if tourniquets in use stretch the stockinet.

4.7 Place gloved hand inside the stockinet roll.

4.8 Grasp patient’s foot through the stockinet covering glove.

4.9 Unroll stockinet to cuff of sheet. Keep hand behind the stockinet to prevent contamination.

4.10 Place leg through hole in 2 sheets around and unfold the limb sheet to cover sterile field.

4.11 The Scrub Nurse and/or surgeon is responsible for properly draping the patient.

5.0 **REFERENCE:**

AORN [http://www.aorn.org/PracticeResources](http://www.aorn.org/PracticeResources)
1.0 **CONDITIONS:**
O.R. RN’s

2.0 **PURPOSE:**
To ensure safe and effective placement drapes, which is done immediately before amputation of the patient’s leg begins.

3.0 **POLICY:**
All OR Registered Nurses are responsible and accountable to ensure safe and effective placement of drapes for lower extremity amputation.

4.0 **PROCEDURE:**
4.1 Place drape on basin stand, mayo stand or back trolley in this order:
   4.1.1 Orthopedic Pack
   4.1.2 Two (2) Sticky drapes
   4.1.3 U-shape with plastic & one H2O resistant drape
   4.1.4 One (1) 6-inch stockinet x2

4.2 Stand at the end of operating table, open first sheet and place it to patient’s mid-thigh while his/her operative leg is held away from the table. Circulating RN will hold leg until draping is completed. Have each sheet cuffsed over your gloved hand to prevent contaminating them. Bring it under the operative leg. Cuff it about one (1) inch above site of incision. Towel clip the cuffed edges of the sheet together. Tuck sheet up under patient’s buttock.

4.3 Roll 6-inch stockinet one (1) inch above site of incision.

4.4 Place leg through hole in extremity drape and unfold drape to cover sterile field.

4.5 The Scrub Nurse and/or surgeon is responsible for properly draping the patient.

5.0 **REFERENCE:**
AORN, [http://www.aorn.org/Practice](http://www.aorn.org/Practice) Resources/Toolkits.
1.0 **CONDITIONS:**

All O.R. RN’s

2.0 **PURPOSE:**

2.1 To ensure safe and effective placement of drapes, which is done immediately before the patient's radical mastectomy surgery begins.

2.2 Draping is done by the Surgeon assisted by the Scrub Nurse, except where other members of the Surgical Services team are specified.

3.0 **POLICY:**

All OR Registered Nurses are responsible and accountable to ensure safe and effective placement of radical mastectomy drape.

4.0 **PROCEDURE:**

4.1 Place drapes on basin stand, mayo stand or back trolley in this order:

   4.1.1 EENT pack

   4.1.2 Half drape

   4.1.3 Large drape x2

   4.1.4 Medium drape

   4.1.5 Sticky Utility Drape

4.2 Place half drape on the side of the patient’s leg from shoulder to waist side.

4.3 Place large drape on the arm board, drape the hand being held by Circulating nurse with medium drape folded like a triangle and wrap with crepe bandage.

4.4 Place the first sheet by starting drape and end of arm board and continue until drape is under patient’s shoulder and chest.

4.5 Place one (1) 30 x 30 each on the side of the shoulder and side of the neck.
4.6 Place four utility drapes around operative site:
   4.6.1 #1 with cuff above operative site
   4.6.2 #2 at patient’s waist
   4.6.3 #3 at midline of patient’s chest
   4.6.4 #4 above the shoulder

4.7 Place the ENNT sheet, unfold upper portion and secure it by sticking the drape enough to explore the operative site. Pull lower portion to cover the remaining exposed area.

4.8 Place large drape on top to cover the head part, use towel clip to secure the drape.

4.9 The Scrub Nurse and/or surgeon is responsible for properly draping the patient.

5.0 REFERENCES:
   5.1 AORN Recommended Practices
   5.2 Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 CONDITIONS:
O.R. RN's

2.0 PURPOSE:
To ensure safe and effective preparation and assistance in Rigid Sigmoidoscopy

3.0 DEFINITIONS:
Sigmoidoscopy – is an endoscopic visualization of the anal canal, rectum & sigmoid colon.

4.0 POLICY:
All Registered Nurses are responsible and accountable to ensure safe and effective preparation and assistance in Rigid Sigmoidoscopy Procedure.

5.0 EQUIPMENT:
5.1 Sigmoidoscope Set with Accessories
5.2 Light Source
5.3 4 x 4 Gauze
5.4 Long Biopsy Forceps/snare – if needed
5.5 K-Y Jelly
5.6 Long Applicator
5.7 Suction
5.8 Prep Set: Specimen jar (if indicated)

6.0 PROCEDURE
6.1 Place patient in the lithotomy position
6.2 Drape the patient appropriately
6.3 Anus is digitally lubricated and examined.
6.4 Sigmoidoscope is inserted and advanced under direct visualization.
6.5 Air may be insufflated for better visualization and/or definitive inspection of rectal mucous membrane.
6.6 Specimens are taken by the use of biopsy forceps or snare.
6.7 Suctioning and electro coagulation maybe needed.

7.0 **REFERENCE:**
Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 **CONDITIONS:**

O.R. RN’s

2.0 **PURPOSE:**

To ensure safe and effective preparation and assisting cystoscopy procedure.

3.0 **DEFINITIONS:**

Cystoscopy – is the endoscopic examination of the interior of the urethra, the bladder and the ureteral orifices.

4.0 **POLICY:**

All OR Registered Nurses are responsible and accountable to ensure safe and effective preparation and assisting cystoscopy procedure.

5.0 **EQUIPMENT:**

5.1 Cystourethroscope Monitor Trolley with light source, Camera, Recorder & Monitor.

5.2 Cystoscopes with corresponding obturators and sheaths Fr. 17 to Fr. 22

5.3 Penile Clamp (for male procedure)

5.4 Half Vaginal Speculum (for female procedure)

5.5 1000 cc. sterile water bag with tubing

5.6 Cystoscopy irrigation tubing

5.7 IV Pole

5.8 Cystoscopy Pack

5.9 K-Y Jelly (Sterile) (Xylocaine Jelly)

5.10 Preparation Set:
5.10.1 Prep bowl with 4 x 4 green gauze
5.10.2 Savlodil sachets x 4-6 each or Povidone iodine

6.0 **PROCEDURE:**
   6.1 Explain procedure briefly to patient if under local anesthesia.
   6.2 Position patient in lithotomy and drape patient with privacy.
   6.3 Cleanse the area with Savlodil and introduce Xylocaine Jelly
   6.4 Assist surgeon as needed.
   6.5 Provide emotional support to patient during procedure.
   6.6 If specimen is obtained, label immediately and follow established biopsy policy
       and procedure.

7.0 **REFERENCE:**
   Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 **CONDITIONS:**
O.R. RN’s

2.0 **PURPOSE:**
To ensure safe and effective preparation and assisting for cystoscopy and Urethral Dilatation Procedure.

3.0 **DEFINITIONS:**
Urethral Dilatation – is dilating the urethra to release urethral stricture, etc.

4.0 **POLICY:**
All OR Registered Nurses are responsible and accountable to ensure safe and effective preparation and assisting cystoscopy and urethral dilation procedure.

5.0 **EQUIPMENT:**

| 5.1 | Cystoscopy Irrigation Set with Fr. 17 to Fr. 22 + Light Cable |
| 5.2 | Sounds (male, female) – Storz, Simons, Hegars |
| 5.3 | Bladder Syringe |
| 5.4 | Cystoscopy irrigation tubing |
| 5.5 | Xylocaine Jelly |
| 5.6 | Storz Telescope 0° & 30° |
| 5.7 | K-Y Jelly (sterile) |
| 5.8 | Prep Set: Sterile Prep bowl with 4 x 4 green swabs, Savlodil solution – 5 to 6 sachets |
6.0 **PROCEDURE**

6.1 Prepare trolley for sterile equipment
6.2 Place patient in lithotomy position
6.3 Expose and prep surgical area with Savlodil
6.4 Apply/introduce xylocaine jelly for local anesthesia
6.5 Assist surgeon as needed

7.0 **REFERENCE:**

Pocket Guide to the Operating Room by Maxine A. Goldman.
1.0 **CONDITIONS:**
O.R. RN’s

2.0 **PURPOSE:**
To ensure safe and effective removal of suture for cleft lip and cleft palate.

3.0 **DEFINITIONS:**

3.1 Cleft lip – a congenital anomaly consisting of one or more clefts in the upper lip that results from the failure in the embryo of the maxillary and median nasal process to close.

3.2 Cleft Palate – a congenital defect characterized by a fissure in the midline of the palate resulting from the failure of the two sides to fuse during embryonic development.

4.0 **POLICY:**
All OR Registered Nurses are responsible and accountable to ensure safe and effective suture removal for cleft lip and cleft palate.

5.0 **EQUIPMENT:**

5.1 Suture Removal Set
5.2 4 X 4 Gauze
5.3 Q-tips sterile if needed
5.4 Steri-strips (optional)
5.5 Prep Set: Sterile prep bowl with 4 x 4 green swabs
Savlodil Solution – 5 to 6 sachets

6.0 **PROCEDURE**
6.1 Prepare trolley for sterile equipment
6.2 Place patient in comfortable position and remove dressing using aseptic technique.
6.3 Assess condition of skin, including healing of suture lines.
6.4 Cleanse area with Savlodil Solution.
6.5 Pat dry 4 x 4 gauze
6.6 Using forceps to lift each suture cut the suture with surgical scissors between the knot and the skin as close to skin as possible and remove one by one.
6.7 Reassess skin condition / wound closure.
6.8 Application of Steri-strips:
6.9 Apply liquid adhesive around suture line and allow to dry.
6.10 Place and adhesive strip on one side of the wound and pull the strip gently to other side.
6.11 Anchor the tape to the skin when wound edges appear to be aligned.

7.0 REFERENCE:
Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 CONDITIONS:
O.R. RN’s

2.0 PURPOSE:
To ensure safe and effective preparation and assisting in Incision and Drainage Procedure

3.0 POLICY:
All OR Registered Nurses are responsible and accountable to ensure safe and effective preparation and assistance in Incision and Drainage Procedure.

4.0 EQUIPMENT:
4.1 Incision & Drainage Set with the following: Hemostats, mosquitoes, Kelly forceps, metz and Kelly scissors, pick-up forceps and sponge forceps, etc
4.2 19 gauge needle 1½ inch
4.3 Betadine swabs
4.4 Basic Pack & Large Drape
4.5 Sterile 4x4 Gauze
4.6 Scalpel #15 & 11 blade
4.7 Xylocaine (as directed)
4.8 NU Packing Gauze

5.0 PROCEDURE:
5.1 Assemble all equipment listed above
5.2 Reinforce explanation of procedure to the patient if under local
5.3 Prepare the patient by placing the necessary position, shave area (as indicated) and clean area with Betadine swabs.

5.4 Position direct light over the surgical site.

5.5 Assist surgeon and patient as needed during the procedure.

6.0 **REFERENCE:**

Pocket Guide to the Operating Room by Maxine A. Goldman
1.0 CONDITIONS:

All registered Nurses (PACU)

2.0 PURPOSE:

To ensure safe and effective admission of patient in the PACU.

3.0 DEFINITIONS:

Post- anesthesia care unit (PACU), also called Recovery Room (RR) is a space a patient is taken to after surgery to safely regain consciousness from anesthesia and receive appropriate post-operative care and pain management.

4.0 POLICY:

All PACU RNs are responsible and accountable to ensure highest standard of post anesthesia care to all admitted patients and promote a safe, comfortable and therapeutic environment for the patient.

5.0 PROCEDURE:

5.1 The patient will be transferred from operating room at the completion of the procedure when the anesthetist feels that the patient is stable.

5.2 The patient will be accompanied to the PACU by the anesthetist and the O.R. circulating RN.

5.3 The PACU nurse shall receive post anesthesia patients endorsed from the anesthetist and the O.R. nurse who accompanied the patient.

5.4 On arrival in the PACU, the patient shall be monitored and a verbal and written report provided to the PACU nurse by the anesthetist.

5.4.1 The patient’s status on arrival to the PACU shall be assessed and documented.

5.4.2 Information concerning the pre-operative and intra-operative surgical/anesthetic course shall be endorsed to the PACU nurse.

5.5 The patient’s condition shall be monitored and documented giving particular attention to:
5.5.1 Airway (oxygenation, ventilation)
   5.5.1.1 giving oxygen.
   5.5.1.2 providing patent airway by proper positioning.
   5.5.1.3 providing oral/ nasal airway as needed
   5.5.1.4 suctioning of secretions

5.5.2 Breathing

5.5.3 Circulation

5.5.4 Drug to relieve pain, Drain care and checking of wound dressing, tubes and catheters, skin condition and documentation.

6.0 REFERENCE:
AORN http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/.
1.0 CONDITIONS:

All registered Nurses (PACU)

2.0 PURPOSE:

To ensure early notification of the attending anesthetist or surgeon for patients in the PACU for any problem encountered with post operative patients.

3.0 POLICY:

The PACU RNs should immediately notify the attending anesthetist/surgeon for any problem encountered with the post operative patients.

4.0 PROCEDURE:

4.1 PACU personnel are responsible for proper assessment of each patient and notification of the anesthetist when necessary.

4.2 When pain is present, DO NOT administer pain medication ordered in the postoperative floor orders by the surgeon. Refer to PACU pain management orders.

4.3 The attending anesthetist or surgeon will be notified of any of the following occurrences:

4.3.1 Pulse rate of less than 50 or greater than 120 per minute

4.3.2 Any arrhythmia or irregular pulse

4.3.3 Systolic blood pressure less than 90 mm Hg

4.3.4 Hypertension 40% or higher or lower than surgical blood pressure

4.3.5 Respirations are less than 10 per minute and/or there is difficulty with breathing

4.3.6 Uncontrolled pain management

4.3.7 Excessive nausea and vomiting

4.3.8 Immediate post OP complication like( allergic reaction)
5.0 **REFERENCE:**

AORN [http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/](http://www.aorn.org/PracticeResources/ToolKits/PatientHandOffToolKit/)
1.0 CONDITIONS:
All registered Nurses (PACU)

2.0 PURPOSE:
To ensure safe and effective monitoring of arterial line pressure.

3.0 DEFINITION:
Arterial Cannula Insertion is the insertion of an indwelling cannula into the redial, Ulnar, brachial, femoral, and dorsalis pedis artery for blood analysis and for invasive blood pressure monitoring.

4.0 POLICY:
All PACU RNs are responsible and accountable to ensure safe and effective monitoring of arterial line pressure and notifying anesthetist of abnormal findings.

5.0 PROCEDURE:
5.1 Monitoring equipment must be calibrated upon arrival of the patient to the PACU.
5.2 Arterial catheter blood pressure reading is to be checked against a cuff pressure upon admission to the PACU and as needed.
5.3 Arterial line site checks must be documented every 15-30 minutes on the PACU record. The anesthetist shall be notified of abnormal findings.
5.4 The arterial catheter alarm system will remain activated at all times. Alarm parameters should be set at 20 above and 10 below the patient’s normal arterial pressure.
5.5 Keep pressure bag at 200-300 mmhg to maintain catheter patency.
5.6 Calibration of Monitoring Equipment:
5.6.1 Attached transducer cable to pressure tubing
5.6.2 Level transducer air reference port at the same level as the patient’s right atrium
5.6.3 Open stopcock of transducer to air
5.6.3.1 Push “zero” button on monitor module to calibrate
5.6.3.2 Close stopcock of transducer to air and open to patient
5.6.3.3 Place 10 ml sterile syringe on stopcock
5.6.3.4 The distal stopcock must be covered with an injection cap
5.6.3.5 Ensure that the alarm is on

5.7 **Removal**

5.7.1 **Equipment:**

5.7.1.1 Dressing pack
5.7.1.2 Sterile gloves
5.7.1.3 Povidone 10%
5.7.1.4 Scalpel blade No. 11
5.7.1.5 Sterile gauze 4X4
5.7.1.6 Band aid
5.7.1.7 Sterile drapes

5.7.2 **Procedure:**

5.7.2.1 Obtain order from Physician
5.7.2.2 Explain the procedure to the patient
5.7.2.3 Prepare the necessary equipments
5.7.2.4 Ensure all roller clamps/stopcocks are turned off and the pressure bag is deflated
5.7.2.5 Position the limp in a comfortable and appropriate position with blue sheet underneath
5.7.2.6 Wash hands and remove dressing
5.7.2.7 Put on sterile gloves
5.7.2.8 Clean around the site with antiseptic and cut the suture if present
5.7.2.9 Remove the cannula with smooth motion whilst applying pressure just slightly proximal to the insertion site with sterile gauze
5.7.2.10 Firm pressure must be applied to site for approximately five minutes or until the oozing of blood ceased.
5.7.2.11 Clean the site and apply clean dressing.
5.7.2.12 Assess site and peripheral pulse of the affected limb for adequate circulation every 15 minutes for one (1) hour after removal
5.7.2.13 Document observation and information to the procedure
6.0 REFERENCES:

http://www.biomedcentral.com/1471-2369/9/15
1.0 **CONDITION:**

All registered Nurses (PACU)

2.0 **DEFINITION:**

Spinal anesthesia is the injection of a local anesthetic into the subarachnoid space, a wide space within the vertebrae that contains cerebrospinal fluid. A level of anesthesia will be achieved that is dependent on the dosage of the agent used, rate of injection, the specific gravity of the fluid injected, the position of the patient following injection and the physiological condition of the patient. The level of anesthesia is referred to as the "dermatome level." Each dermatome is a cutaneous area that gets its nerve supply from a single nerve root.

3.0 **PURPOSE:**

To ensure safe and effective care of patients post spinal anesthesia.

4.0 **POLICY:**

All PACU RNs are responsible and accountable to ensure safe and effective care of post spinal anesthesia patients.

5.0 **PROCEDURE:**

5.1 Initial assessment of the anesthetic level provides a baseline so that any future deviation can be detected promptly.

5.2 Avoid rapid change of position to prevent orthostatic hypotension.

5.3 Monitor vital signs every five (5) minutes x three (3). Then, if stable, every 15 minutes for first two (2) hours, then every 30 minutes while in the PACU. The patient shall be encouraged to cough and deep breathe every 15 minutes to reduce the incidence of atelectasis.

5.4 Check the patient frequently for any signs of bladder distention. Catheterization may be required if the patient cannot void.
5.5 Spinal level shall be checked every 30 minutes. Nurses’ Notes shall reflect level, sensation and return of motor function.

5.6 Complications of spinal anesthesia are high or total spinal block, hypotension, nausea, vomiting, backache, palsies, bradycardia, urinary retention and headache. All complications shall be reported immediately to the anesthesiologist.

5.7 Spinal or dermatome levels are designated as follows:

5.7.1 Nipple line T-4: motor paralysis of lower extremities
5.7.2 Umbilicus T-10: motor paralysis of lower extremities
5.7.3 Groin T-L-1: movement of both feet
5.7.4 Thighs L-2 - L-3: flex knees and move legs

6.0 REFERENCES:

www.allnurse.com/PACU.nursing
1.0 CONDITION:

All registered Nurses (PACU)

2.0 PURPOSE:

To ensure a safe return of the surgical patient to his/her normal status.

3.0 POLICY:

All PACU RNs are responsible and accountable to ensure highest standard of post anesthesia care to all pediatric patients and promote a safe, comfortable and therapeutic environment for the patient.

4.0 PROCEDURE:

4.1 Airway Management:

4.1.1 Pediatric patients are subjected to the same admission process as adult patients with a few exceptions. Airway assessment is always the first consideration. The signs of respiratory distress are flaring of the nostril, sternal retractions, noisy breathing and cyanosis. Some common respiratory problems are described below.

4.1.1.1 Tongue obstruction is the most common problem. Oral airways are frequently used in children. Moving the oral airway and manipulating the jaw will often relieve tongue obstruction. If not contraindicated, place the child in side-lying or head down position.

4.1.1.2 Excessive secretions. All secretions shall be cleared by gentle suction. Care must be taken to choose the proper size suction catheter for pediatric airway management, as the introduction of a larger catheter may produce laryngospasm.

4.1.1.3 Stridor (or crowing) most often will be seen postoperatively in children who have been intubated. It is usually caused by airway
irritation and edema from the intubation. Provide humidified oxygen and elevate the head of the bed if not contraindicated; notify patient’s anesthetist.

4.1.4 Post intubation croup is seen frequently, with an increasing tendency in the one to four-year old age group. There may be several factors causing croup, including traumatic intubation, use of a too large endotracheal tube causing edema of the vocal cords, surgical trauma, prolonged and excessive coughing while on the endotracheal tube and the duration of intubation. Croup usually accompanies stridor and is recognized by a distinct "crouping" or barking cough. Provide humidified oxygen and elevate the head of the bed if not contraindicated; notify patient’s anesthetist.

4.1.5 Laryngospasm in children is treated essentially the same as in adults. Positive pressure with oxygen and an immediate call for help from the anesthesiologist is necessary. If the spasm is not "broken," administration of a muscle relaxant and reintubation may be indicated. In children, warm blankets will often prevent and sometimes stop a laryngospasm.

4.1.6 Loose teeth are an important aspect of airway obstruction to consider in a child. It is the responsibility of the PACU nurse to ensure that loose teeth are still intact upon arrival to the PACU. If the tooth, or teeth, is very loose, the nurse may be wise to ask for their removal.

4.1.7 Partial or complete respiratory paralysis is seen when the effects of muscle relaxants have not worn off or been adequately reversed. Reparalysis, if it occurs, usually will take place 15 to 20 minutes after the reversal agent was administered.

4.1.8 Drug overdosage, especially with narcotics, is a common source of respiratory depression. It is important to confer with the anesthetist for optimal pain management in a pediatric patient.

4.1.9 Aspiration and its complications are not very different in a child as compared to an adult. Children respond to treatment more rapidly than do adults.

4.1.10 Atelectasis can be reduced in the postoperative pediatric patient by aggressiveness on the part of the PACU nurse.

4.2 Post Anesthesia Sedation:

4.2.1 General considerations: Some children cry, not only from pain, but also from fear and anxiety. Respiration status must be carefully assessed before administration of pain medication. Careful assessment prior to administration of medication is key to appropriate pain management.
4.2.2 Alternatives to medication: Some children, who are not responding to sedation, may respond to a pacifier or a bottle of glucose water (if tolerated or allowed). Warmth from blankets and being held often instills a feeling of security in the frightened child.

4.3 Normal Vital Sign Ranges in Children:

4.3.1 Temperature:

4.3.1.1 Oral 36.4 - 37.4 degrees C (97.6 - 99.3 degrees F.)

4.3.1.2 Rectal 36.2 - 37.8 degrees C (97 - 100 degrees F.)
Anorectal temperatures will not be taken without physician order

4.3.1.3 Axillary 35.9 - 36.7 degrees C. (96.6 - 98 degrees F.)

4.3.2 Pulse and Respiratory Rates: ¹,²

<table>
<thead>
<tr>
<th>Age</th>
<th>Pulse (beats per minute)</th>
<th>Respiratory (breaths per minute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>70-170</td>
<td>30-50</td>
</tr>
<tr>
<td>11 months</td>
<td>80-160</td>
<td>26-40</td>
</tr>
<tr>
<td>2 years</td>
<td>80-130</td>
<td>20-30</td>
</tr>
<tr>
<td>4 years</td>
<td>80-120</td>
<td>20-30</td>
</tr>
<tr>
<td>6 years</td>
<td>75-115</td>
<td>20-26</td>
</tr>
<tr>
<td>8 years</td>
<td>70-110</td>
<td>18-24</td>
</tr>
<tr>
<td>10 years</td>
<td>70-110</td>
<td>18-24</td>
</tr>
<tr>
<td>Adolescence</td>
<td>60-110</td>
<td>12-20</td>
</tr>
</tbody>
</table>

4.3.3 Bradycardia is defined as a persistent heart rate (pulse) of less than 100-120 beats per minute (bpm) in the neonate and infant and less than 80 bpm in the child. Transient bradycardia can be normal in the neonate during feeding or sleeping; therefore, the term “bradycardia” is only applied to a persistent decrease in the heart rate.

4.3.4 Tachycardia is defined as a pulse over 200 bpm in the neonate and infant and above 140-160 bpm in the child. Transient tachycardia may occur with crying or other activity that increases the demand for oxygen. For instance, the child’s heart rate will increase 10 bpm for each degree Celsius elevation in temperature. Heart rate elevation will also be seen if ventricular stroke volume decreases, as in congestive heart failure, tamponade or low cardia output.

4.3.5 Normal Blood Pressure Ranges ³

<table>
<thead>
<tr>
<th>Age</th>
<th>Systolic (mm Hg)</th>
<th>Diastolic (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn - 12 hr (less than 1000 gm)</td>
<td>39-59</td>
<td>16-36</td>
</tr>
<tr>
<td>Newborn - 12 hr (3000 gm)</td>
<td>50-70</td>
<td>24-45</td>
</tr>
<tr>
<td>Newborn - 96 hr (3000 gm)</td>
<td>60-90</td>
<td>20-60</td>
</tr>
<tr>
<td>Age</td>
<td>Wrist Range</td>
<td>Ankle Range</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1-30 days</td>
<td>22-66</td>
<td>20-58</td>
</tr>
<tr>
<td>1-3 months</td>
<td>48-90</td>
<td>38-96</td>
</tr>
<tr>
<td>4-6 months</td>
<td>42-100</td>
<td>40-104</td>
</tr>
<tr>
<td>7-9 months</td>
<td>52-96</td>
<td>50-96</td>
</tr>
<tr>
<td>10-12 months</td>
<td>62-94</td>
<td>102</td>
</tr>
</tbody>
</table>

### 4.3.5 Mean Blood Pressure at Wrist and Ankle Using Flush Technique

### 4.4 FLUSH TECHNIQUE:

- **4.4.1** Lower the blood pressure cuff pressure cuff by 5 mm Hg and leave at that level for three to four (3-4) seconds. Repeat procedure until flushing is observed in the blanched limb.

- **4.4.2** Repeat procedure at least twice to confirm the reading.

- **4.4.3** Due to the immature temperature regulating system in the brain, temperatures can rise quickly and drop just as quickly in the small child. Continuous monitoring of temperature is mandatory to detect and treat any changes promptly.

### 4.5 Pediatric Emergencies:

- **4.5.1** Equipment and Supplies:

  - **4.5.1.1** A crash cart and pediatric-sized equipment and a flip chart with emergency pediatric medication dosages listed. Standard emergency drugs shall be on the cart, with pediatric dose Narcan, single pediatric dose vials of atropine and calcium readily available. Various sizes of endotracheal tubes and laryngoscope blades, small IV needles and suction catheters ranging from 6 Fr through 14 Fr should be easily accessible.

### 4.6 Fluid Therapy:

- **4.6.1** Pediatric parameters:

  - **4.6.1.1** Infants and children have a metabolic rate that is two to three (2-3) times higher than in an adult. Children can rapidly develop heart failure and
pulmonary edema from fluid overload. They can also become dehydrated rapidly.

4.6.2 Assessment:

4.6.2.1 Pediatric patients respond quickly to treatment of fluid related problems. Assessing heart and lung status and identifying "wet" sounds must become skills of the PACU nurse. Other clinical signs are skin color, labored breathing, flaring nostrils, crying, chest retractions and most important, oliguria.

4.6.3 Guidelines for fluid administration:

4.6.3.1 Administer fluids per physician’s orders
4.6.3.2 Use programmable infusion pumps per policy and procedure

4.6.4 Output:

4.6.4.1 Urine output in the pediatric patient should be 1-3 mL per kg per hour. If it is less than this, careful monitoring is required.

4.7 Blood loss:

4.7.1 It is extremely important to monitor blood loss in a child. There is a wide difference between loss of one-third (1/3) of the blood volume in an adult as compared to an infant. An insignificant percentage of a blood loss in an adult would be a critical loss to an infant, requiring replacement.

4.8 Other Complications:

4.8.1 Emesis:

4.8.1.1 Nausea and vomiting are seen frequently in children; often a child feels better after vomiting and the nausea subsides. However, some children require medication for control of nausea and vomiting.

4.8.2 Aspiration:

4.8.2.1 Aspiration of gastric contents is a threat that accompanies vomiting. The pediatric patient should be turned bodily to one side, if possible, to permit adequate drainage of vomitus from airway.

4.8.3 Hemorrhage:

4.8.3.1 Excessive bleeding in the pediatric patient can develop into shock more rapidly than in an adult. Frequent assessment of the wound site and cardiovascular status is necessary.

4.8.4 Delirium:
4.8.4.1 Emergence delirium of post anesthesia recovery usually manifests itself with the patient incoherently moaning, crying, kicking or thrashing. Protecting the child from injury is most important during these episodes. Titration of small doses of physostigmine have proven helpful to counter sedation and drug-induced confusion.

4.8.5 Distention:

4.8.5.1 Abdominal distention in infants is common after the surgical procedure and burping may be required to relieve the discomfort.

4.9 REFERENCES:

4.9.1 American Society of Perianesthesia Nurses, Competency Based Orientation Credentialing Program, 2002 Edition


4.9.3 Manual of Pediatric Nursing Procedures, Nedra Skale, p. 35.

4.9.4 Manual of Pediatric Nursing Procedures by Nedra Skale, p. 46.
1.0 CONDITION:
All registered Nurses (PACU)

2.0 PURPOSE:
To ensure safe and effective post anesthesia care given to Geriatric patients.

3.0 POLICY:
All PACU RNs are responsible and accountable to ensure highest standard of post anesthesia care to all geriatric patients and promote a safe, comfortable and therapeutic environment for the patient.

4.0 PROCEDURE:
4.1 Airway:
4.1.1 Administer oxygen with humidification:
   4.1.1.1 Supplements a decreased carbon dioxide/oxygen exchange
   4.1.1.2 Decreases hypoxia in chronic illnesses, such as anemia and cardiopulmonary diseases

4.1.2 Encourage deep breathing and coughing:
   4.1.2.1 Counters decreased muscle power and decreased ability to cough
   4.1.2.2 To avoid hypostatic pneumonia and atelectasis in a compromised pulmonary system

4.1.3 Observe for dyspnea and shortness of breath, which may be caused by:
   4.1.3.1 Preexisting cardiopulmonary disease
4.1.3.2 Other considerations, such as decreased energy and muscle power. There may also be residual effects of the muscle relaxants due to slowed elimination of the medication or a slowed response to the reversal agents.

4.1.4 Elevate the patient's head, if condition permits:
4.1.4.1 Facilitates lung expansion
4.1.4.2 Prevents pooling of blood

4.1.5 Avoid superimposed pulmonary infections:
4.1.5.1 Protect patient from aspiration
4.1.5.2 Avoid improper suctioning techniques

4.2 Fluid Administration:
4.2.1 Counter dehydration existing preoperatively caused by:
4.2.1.1 Multiple days of radiologic and/or Clinical Laboratory studies requiring extended NPO orders
4.2.1.2 Diuretic therapy
4.2.1.3 Preexisting poor nutritional status
4.2.1.4 Preoperative vomiting or diarrhea

4.2.2 Prevent fluid overload flow:
4.2.2.1 Preexisting cardiopulmonary disease
4.2.2.2 Administration of mannitol can mobilize fluid into the intravascular space and cause pulmonary edema
4.2.2.3 Severe leg elevation can trigger right heart failure
4.2.2.4 Delayed correction of fluid and electrolyte imbalances due to:
4.2.2.4.1 Altered renal function
4.2.2.4.2 Slowed glomerular filtration rate

4.3 Urinary Output:
4.3.1 Bladder distention due to:
4.3.1.1 Smaller bladder capacity
4.3.1.2 Preoperative administration of diuretic
4.3.1.3 Decreased awareness of bladder distention. This problem may cause an increased restlessness and hypertension with an inability to urinate. These patients require catheterization.

4.4 Activity - Stir Up Regimen:
4.4.1 Promotes circulation/ventilation
4.4.2 Permits assessment of neurological/mental status:
   4.4.2.1 Ascertain occurrence of intraoperative CVA
   4.4.2.2 Assess drug-induced somnolence
   4.4.2.3 Assess for fluid and electrolyte imbalance

4.5 **Comfort Measures:**
4.5.1 Positioning:
   4.5.1.2 Exercise care in turning geriatric patients. They may have osteoporotic
   changes that may precipitate pathologic fractures.
   4.5.1.3 Pad bony prominences such as elbow, ankles, trochanters and sacral
   spine. Pillows may be used for support of kyphotic spines. Sheepskin mattresses, air
   mattresses or foam pads may also be used to relieve pressure on bony prominences.

4.5.2 Skin care:
   4.5.2.1 Avoid excess adhesive application.
   4.5.2.2 Carefully remove tape; put counter traction on skin and slowly pull
   tape off.
   4.5.2.3 Avoid inflating blood pressure cuff higher than necessary.

4.5.3 Pain control:
   4.5.3.1 Decreased dosages are usually sufficient in PACU.
      4.5.3.1.1 Preoperative and anesthetic agents remain "on board"
      longer, due to altered renal elimination.
      4.5.3.1.2 Decreased sensory response to pain.
   4.5.3.2 Individual response to pain varies:
      4.5.3.2.1 Increased tolerance to medication present, if there has
      been chronic use of pain relievers or alcohol.
      4.5.3.2.2 Severe, unrelieved pain can trigger untoward
      cardiovascular response.

4.5.4 Warmth:
   4.5.4.1 Reduced tachycardia and oxygen demand
   4.5.4.2 Vasodilatation promotes lowered blood pressure

4.6 **Communication and sensory stimulation will reduce stress and anxiety:**
4.6.1 Continuous verbal communication will help to improve the patient's
   sensorium which may have been dulled by sedation and/or pre-existing
   confusion.
4.6.2 Touching (hand-holding, patting) is an effective communication technique.

4.6.3 Reality orientation:

4.5.6.3.1 At frequent intervals, the PACU nurse should tell the patient,
"Your operation is over and you are doing fine. You're not at home. You're at the hospital."

4.6.4 Providing dentures, glasses, hearing aids, etc., in the PACU lends effective psychological security.

5.0 **REFERENCE:**

www.allnurse.com/Pacu-nursing
1.0 CONDITIONS:
All registered Nurses (PACU)

2.0 PURPOSE:
To ensure safe and effective post operative care given to patients having a cesarean section with or without complications.

3.0 POLICY:
All PACU RNs are responsible and accountable to ensure safe and effective post operative care given to patients having a caesarian section with or without complications.

4.0 PROCEDURE:
4.1 Nursing interventions:
4.1.1 Vital signs taken every 15 minutes
4.1.2 Check dressing
4.1.3 Maintain patent IV line with adequate hydration
4.1.4 Assess respiratory and airway status
4.1.5 Administer analgesics
4.1.6 Assess intake and output
4.1.7 Encourage expression of feelings and give reassurance

5.0 REFERENCES:
www.allnurses.com/PACU.nursing
1.0 **CONDITION:**

All registered Nurses (PACU)

2.0 **PURPOSE:**

To ensure safe and effective management of patient with malignant hyperthermia.

3.0 **POLICY:**

All PACU RNs are responsible and accountable for the safe and effective management of patient with malignant hyperthermia.

4.0 **PROCEDURE:**

4.1 Patients experiencing malignant hyperthermia may exhibit a number of different symptoms, including, but not limited to:

4.1.1 Unexplained Masseter muscle rigidity

4.1.2 Unexplained tachycardia or cardiac dysrhythmia

4.1.3 Hypercarbia

4.1.4 Change in skin color from flush to mottling to cyanosis

4.1.5 Myoglobinuria

4.1.6 Altered renal function

4.1.7 Tachypnea

4.1.8 A later symptom is fever, with temperatures elevating rapidly, as much as 1.8 degrees F (1 degree C) every three (3) minutes, creating temperatures as high as 114 degrees F (45.5 degrees C).
5.0 REFERENCES:

5.1 Emergency Therapy for Malignant Hyperthermia, Malignant Hyperthermia Association of the United States (MHAUS), Effective May 2008.

1.0 **CONDITION:**
All registered Nurses (PACU)

2.0 **PURPOSE:**
To ensure safe and effective discharge of post operative patients from PACU to the ward.

3.0 **POLICY:**
All PACU RNS are responsible and accountable to ensure safe and effective discharge of post operative patients from PACU to the ward.

4.0 **PROCEDURE:**
4.1 The anesthetist will assess and decide the patients discharge in PACU.
4.2 Patients have to meet the following criteria:
   4.2.1 Awake, alert and oriented
   4.2.2 No active nausea and/ or vomiting
   4.2.3 Stable vital signs
   4.2.4 Free of pain and comfortable
   4.2.5 Numesic scoring system (Alderete score)
   4.2.6 Clinical assessment of dressing
4.3 Movement of lower extremities for patients under spinal or epidural anesthesia
4.4 The PACU RN calls the ward RN to collect the patient
4.5 Patient should be transported on a stretcher or patients bed with side rails on
4.6 Patients dignity is maintained at all times
4.7 All relevant information is documented and endorsed to the ward RN
4.7 The patient is accompanied by the ward RN and the porter during transport
5.0 **FORMS:**
Recovery Room Post Anesthesia Care Unit Form

6.0 **REFERENCES:**