



CLINICAL PRACTICE GUIDELINE

Perioperative Preparation and Management

This document should be read in conjunction with the [Disclaimer](#)

Contents

Pre-operative

Pre-operative care: Routine	2
Procedure	3
Pre-operative hair removal	5
Procedure	5

Postoperative

Receiving a patient from recovery post-surgery	6
Procedure	6
Procedure	7
Minor surgery: Gynaecology, oncology & urogynaecology: Care following	8
Procedure	8
Major surgery: Gynaecology, oncology or urogynaecology: Care following	10
Procedure	11

References and resources	13
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Pre-operative care: Routine

Aim

To ensure the consistent delivery of benchmarked best practice standards to the pre and postoperative women at KEMH.

Key points

- Surgical procedures performed under anaesthesia require the woman's written consent (general, regional and local). See [WA Health Consent to Treatment Policy 2016](#).¹
- It is the responsibility of the medical officer to obtain consent. See [WA Health Consent to Treatment Policy 2016](#).
- The Resident / Registrar who consents the patient in EC for a surgical procedure should discuss the case with either the Senior registrar or the Consultant on call prior to booking the case with Perioperative Services. If it is a procedure involving an abscess in the perineal region, an experienced medical clinician should examine the patient prior to deciding on a surgical route of management.
- The nurse / midwife shall check the presence of a valid consent is present in the woman's notes prior to administering any pre medications. If there is a discrepancy, medical team and peri operative coordinator shall be notified immediately.
- Only when all aspects of consent are satisfied can the woman be given a premedication or be transferred to theatre.
- Fasting is required for all types of anaesthesia unless the surgeon or anaesthetist specifies / documents otherwise.
- Women undergoing a surgical procedure must have two patient identification bands in situ. These shall be on an arm and a leg, however if placing identification band on a limb is not practical, both wrists or both ankles is acceptable.
- Medi alert bracelets must be left in situ and must not be taped. Noted on perioperative check list.
- All items of metal shall be removed (i.e. jewellery, body piercing, hairclips), although a wedding ring may be left in situ. Any items that cannot be removed shall be covered with adhesive tape.
- Hearing aids may be left in situ. A labelled receptacle shall accompany the woman for safe keeping, in case the hearing aid is removed intraoperatively.
- Dentures may remain in situ unless specified by the anaesthetist. If the woman chooses to wear their dentures to the operating theatre, a labelled denture cup shall accompany her in case they are removed during anaesthetic.
- Glasses or contact lenses shall be removed prior to transfer to operating theatre.

- All women under 50 years of age who are scheduled for intrauterine surgery or a hysterectomy shall have a pregnancy test prior to going to theatre. Exceptions to this are women with pregnancy failure.

Procedure

1. Fully complete perioperative Pre op checklist.
2. Ensure any results from pathology or x ray are available.
3. Ensure the consent form has been completed and signed by the patient and medical officer. Check the consent with the woman against the consent form to confirm that the consent fulfils the following criteria
 - Verification that patient details (name, date of birth, unit medical record number) are the same on the consent form and the patient identification band.
 - Specific to the proposed procedure.
 - Valid: Consent is considered valid until the patient withdraws consent or there is a change on the patient's circumstances. See [WA Health Consent to Treatment Policy 2016](#).
4. Ensure the woman has two correct identification bands secured. These bands shall not interfere with the IV access site and must be placed on top of graduated compression stockings.
5. Ensure the woman has fasted as per [Anaesthetic Clinical Guidelines](#).
6. Assess the woman's skin integrity. Complete MR260.03 Comprehensive skin assessment. Document any skin problems. Ensure all wounds are covered.
7. Complete Falls risk assessment and management plan MR260.04
8. Ensure assessment of the woman's risk for venous thromboembolism (VTE). According to medical staff instructions, commence VTE prophylaxis.
9. Record the woman's baseline vital signs; temperature, weight and height on the preoperative checklist MR290 as close to the time of giving the pre medication as possible. Ensure a routine urinalysis has been performed.
10. Request / assist the woman to remove eye make-up and nail varnish. If the woman has acrylic nails, they may be left on.²
11. Complete the pre-operative hair clip. This shall be done as close to the scheduled surgery time as possible. See section: Pre-operative Hair Removal
12. Ensure women have showered and not applied creams, deodorants or perfumes prior to admission. For patients undergoing a caesarean section, a 2% chlorhexidine wash cloth should be used..
 - Where possible, wipes should be applied an hour before surgery.
 - Wipe the operative area in a back and forth motion to thoroughly cleanse the skin.
 - The Area closest to pubis to be left last.
 - Pay careful attention to skin folds and in abdominal creases.
 - Let air dry.

- Do not rinse.
- Do not use on patients with a chlorhexidine allergy.
- Record on Preoperative checklist

N.B. In non-elective caesarean sections when showering not possible chlorhexidine wipes should still be used, where practical.

13. Request / assist the woman into perioperative attire.
14. Make the bed with clean linen.
15. Ensure the woman is warm and supply blankets as required.
16. Request the woman to empty her bladder prior to surgery. Record the last void on the pre-operative checklist MR290. If a premedication is prescribed, request the woman to void before this is administered.
17. Administer premedication as charted. Once given, advise the woman to remain in bed, raise the bedrails and ensure that the nurse call bell is within reach.
18. Collect the woman's medical record and escort her to theatre. The nurse / midwife shall remain with the woman until the perioperative nurse has greeted and checked all aspects of the perioperative nursing checklist and woman's preparation.
19. The nurse / midwife escorting the woman shall sign the perioperative nursing checklist.
20. Assist placement of hovermatt if required for patient transfer if requested or required.

Pre-operative hair removal

Aim

- To ensure that preoperative hair removal is undertaken appropriately ensuring skin integrity and reducing the risk of wound infection.

Background

Research into surgical site infection prevention has found that surgical site hair need not be removed in order to reduce the risk of infection. However, the decision to remove surgical site hair must also include consideration of the potential for access to the surgical site and the field of view. The use of razor blades has been shown to lead to an increase in the incidence of surgical site infection. Hair removal with clippers was found to be safer and resulted in a lower incidence of surgical site infections than shaving with a razor blade³ regardless of the timing of hair removal.⁴

Procedure

1. Provide an explanation to the woman and obtain verbal consent.
2. Assess the operation site. Document the presence of lesions such as moles, warts or other skin conditions in the medical notes.
3. When preparing the operative site, give consideration to the length of the incision, potential drains etc.
4. A single use disposable clipper blade shall be used for each patient and disposed of after use in a sharps container.
5. The clipper handle shall be cleaned between patients. Area to be clipped

General gynaecology	
Laparoscopy/minor surgery	Clip 2.5cm of pubic hair proximal to umbilicus – include any long hair in area of incision.
Vaginal surgery	Clip vulval/perineal area only (not abdominal pubic hair)
Major abdominal surgery	Remove all visible pubic hair with patient supine and legs closed.
Minimal invasive sling	Remove all visible abdominal, pubic and perineal hair.
Major oncology	
Vaginal surgery	Remove all vulval/perineal hair and through to mid-thigh and excessive hair on inner thigh. Clip long pubic hair.
Plus Gracillus graft	Remove all hair to mid-thigh.
Abdominal surgery	Remove all visible pubic hair with patient supine and all hair from anticipated area of incision.
Possible Gracillus graft surgery	Remove all hair to mid-thigh.

Receiving a patient from recovery post-surgery

Purpose

The safe transfer of care from the post anaesthetic care unit to the ward.

Procedure

In PACU

1. Confirm the patient's identity using Family name, medical record number and date of birth as per WNHS Policy: [Patient Identification](#).
2. Assess the patient for the following in the PACU
 - Airway maintenance
 - Respiration rate is ≥ 10 breaths per minute.
 - Oxygen saturations $> 95\%$ on oxygen.
 - Pulse is regular and within normal parameters.
 - Systolic blood pressure as per the Adult Observation and Response chart MR 285.02
 - Peripheries are well perfused.
 - The patient is able to respond to commands.
 - The epidural block is at / below T4 (if in situ). As per clinical guideline: [Anaesthetics](#): Dermatomes Testing.
 - Assess wound dressing integrity and type
3. Review the operation report MR 207.01.
4. Review the ongoing orders for analgesia, intravenous hydration, indwelling catheter etc
5. Review postoperative orders
6. Review the Epidural/opiate infusion pump program is ordered and check the rate infusing and the rate prescribed are correct.
7. Check all IV/Arterial/epidural/Naso-gastric lines are labelled appropriately.
8. Clarify any concerns before leaving the area.
9. The patient is transported to the ward area on their bed. Bedrails should be engaged during transportation. Ensure any prosthetic items are with the patient e.g. glasses, false teeth, hearing aid.
10. The patient must meet the PACU discharge criteria. See clinical guideline [Perioperative](#): PACU- Recovery Room Discharge Criteria.
11. Following isobar clinical handover the PACU nurse/midwife and the ward nurse / midwife must sign the handover section of the MR 325.

In the ward area

1. Check the oxygen and suction is working correctly and that all equipment is present before collecting the patient.
2. Make the bed linen into a pack and place in the patient's room.

3. Ensure an IV stand and infusion pump are available.
4. Place the additional following equipment in the patients room
 - Contenance sheet
 - Pillow
 - Emesis container
 - Water jug, glass and straw
 - Drainage holders as necessary
 - Tape for drains
 - Perineal pads

Procedure

1. Return the patient to the room, position appropriately and ensure brakes are on
Hang the IV, IDC and drains as required.
Remove any under sheets and check vaginal loss.
Check the epidural site and all dependant pressure areas.
Complete the Braden Scale MR 260.0
2. Perform baseline observations and complete the Falls Risk Management Tool MR 810
Check all dressings, drains, intravenous therapy and vital sign measurements before leaving PACU
3. Ensure all documentation is complete. Complete a nursing care plan.
Check the medication chart for analgesia and Post op nausea and vomiting (PONV MR327A).
4. Check the Epidural/opiate infusion pump program is ordered and check the rate infusing and the rate prescribed are correct.
5. Check the Anaesthetic chart (MR300) to see if analgesic or anti emetic has been given.
6. Ensure dentures, medical records and x-rays are returned to the ward with the patient.
7. Review the operation record for post-op orders.
8. Position the patient according to the surgical procedure performed. Recheck and document all sites/dressings/drains.
9. Perform and record vital signs as per sections in this document: Care following Minor Surgery and Care following Major Surgery
10. Ensure water, emesis container and the patient's bell are accessible to the patient.
11. Empty IDC/SPC and observe drainage on drainage bottles. Mark drainage at 2400 hours.

Minor surgery: Gynaecology, oncology & urogynaecology: Care following

Aim

Ensure standard benchmarked practice throughout KEMH on the appropriate management of women undergoing minor surgery.

Key points

- The expectation of ambulatory gynaecology, or day surgery unit, is that the woman is admitted, undergoes a procedure, and is discharged on the same day.^{5,6} Suitable procedures are usually elective with pain controllable as an outpatient, rapid return to normal fluid & food intake, and minimal risk of postoperative complications (such as haemorrhage or airway compromise).⁶
- According to the Australian Day Surgery Council standards for practice, suitable analgesia should be provided for at least the first day after discharge.^{6,7}
- Acceptance to the Day Surgery Unit (DSU) is subject to the woman having met the requirements for discharge from PACU following general anaesthetic guidelines. See Clinical Guideline: [Perioperative Services](#): PACU: Discharge Criteria.

Procedure

1. **Escort the woman to the Stage 1 recovery area in DSU.**

Orientate the woman, place call bell within reach and carry out postoperative orders

2a. **Observations:**

Assess the woman on immediate return as per post-operative assessment parameters:

- Level of consciousness
- Skin colour
- Pulse / Blood pressure / Temperature
- Respiratory rate / Oxygen saturation
- Wound site(s)
- Vaginal loss
- Pain score
- Post-operative nausea & vomiting.⁸

- 2b. Repeat the assessment within one hour.

If the woman is haemodynamically stable and alert repeat in four hours or prior to discharge

If haemodynamically unstable repeat assessment more frequently and arrange medical review as required. See also MR140a: WA Adult Observation and Response Chart and Clinical Guideline O&G: Clinical Deterioration: Recognising and Responding.

3. **Medications:**

Assess post-operative pain, nausea and vomiting,⁹ and manage as ordered on MR 335.

4. **Escort the woman to the second stage recovery area** prior to discharge home.

- 5a. **Activities of Daily Living**

Assist to change into own clothing.

- 5b. Ensure the woman has voided post operatively

- 6a. **Nutrition**

Offer light refreshments once the woman is awake, comfortable and in an upright position.

- 6b. Remove the cannula when the woman is tolerating diet and fluids.

7. **Discharge**

Discharge the woman according to discharge criteria on MR 335.

Advise the woman (and accompanying adult) of dressings (if appropriate), medications and follow-up appointments.⁶

Determine the woman's understanding of possible post-operative complications.

Provide the woman with the relevant information pamphlet and a contact place/ telephone number for emergency medical care.⁶

Major surgery: Gynaecology, oncology or urogynaecology: Care following

Purpose

- To identify early post-operative complications and provide appropriate management should they occur.
- To ensure standard benchmarked practice for post-operative care given to women at KEMH.

Key points

1. Routine management will be subject to an accurate assessment of each individual woman and may vary according to the woman's pre-operative history, surgical events and necessary supportive therapies.
2. Patient acceptance to the gynaecology ward is subject to the woman having met the criteria for discharge from the PACU following general anaesthetic clinical guideline. See Clinical Guideline: Perioperative Services: PACU: Discharge Criteria.
3. Patient observations shall be recorded as often as dictated by the patient's condition. All deviations outside of normal limits shall be escalated as per the Clinical Guideline: O&G: Clinical Deterioration: Recognising and Responding.
4. General post-operative complications can include ³
 - **Respiratory system** – atelectasis, pneumonia, hypoxia, pulmonary embolism.
 - **Cardiovascular system** – haemorrhage, hypovolaemic shock, thrombophlebitis, embolism, myocardial infarction
 - **Gastrointestinal system** – abdominal distension from paralytic ileus, constipation, nausea and vomiting, intra operative injury
 - **Genitourinary system** – urinary retention, fluid imbalance, renal failure, intraoperative injury/ haemorrhage
 - **Integumentary system** – wound infection, dehiscence or evisceration, pressure areas, surgical emphysema / haemorrhage
 - **Nervous system** – intractable pain, cerebral vascular accident (CVA)
5. Should a patient's clinical condition deteriorate to the point where an ASCU admission is required, Clinical Guideline: O&G: [Consultant Responsibilities](#) shall be followed.
6. Standard Infection Control principles shall be consistently applied throughout a woman's episode of care. See Infection Control Manual.
7. Patient self-care shall be encouraged as early as possible and is dependent on the patient's age, mobility, surgery performed and self-caring ability prior to admission.

Procedure

On return to the ward from PACU

1. Monitor and record vital signs. This includes
 - Temperature, pulse, respirations, colour / oxygen saturation.
 - Level of consciousness
 - Wound sites / drains – measure and record as a baseline
 - Urinary output – measure and record as a baseline
 - Intravenous therapy rate / site.
 - Vaginal loss.
 - Nasogastric tube drainage (if applicable).
 - Pain score / response to analgesia.
 - Opioid infusion- PCIA / PCEA, inspect the site and record the dermatomes.
2. The above observations shall be performed as follows, and recorded on the Adult Observation and Response Chart (MR 285.02)
 - ½ hourly for the first 2 hours, then
 - 1 hourly for 2 hours, then
 - 2 hourly for 2 hours, then
 - 4 hourly for 24 hours, providing the woman's condition remains stable.

Wound sites / drains

- Note dressing type and integrity/document
- Monitor output- record on fluid balance chart (MR 740).
- Mark drainage bottles at 2400 hour.

Urinary output: This is to be performed with all observations

- Assess urinary output/ patients urge to void or bladder distension.
- Record the urine output- amount and colour.
- Notify the medical officer if the volume is less than 30mL / hour.
- Ensure the drainage bag is securely attached and draining.

Fluid balance / hydration

- Manage intravenous therapy as ordered and assess site for complications as per Clinical Guideline [Peripheral Intravenous Cannula Insertion and Management](#)
- Monitoring of a Peripheral IV Site.
- Monitor and record fluid intake / output from all sources on the MR 740
 - IV therapy.
 - Oral fluids / ice.
 - Urinary catheter.
 - Nasogastric drainage if in situ.

- Drainage tubing
- Emesis.
- Any fistula or stoma

Pain management

- Assess pain score and offer appropriate analgesia as prescribed.
- Position the patient for maximum airway ventilation and comfort.

Post-operative nausea and vomiting

- See Clinical Guideline, Anaesthetics: Post-Operative Nausea and Vomiting

Thromboembolic prophylaxis

- Administer anticoagulants as prescribed.
- Ensure graduated compression stockings are worn.
- Encourage deep breathing, coughing and a range of motion exercises. If required, refer the woman to the Physiotherapy Department.
- Encourage early mobilisation.

Hygiene

- When the woman's condition is satisfactory, attend to hygiene needs, mouth care and if appropriate change the woman into her own clothes.

Antibiotics

- Check the medication chart MR 810 and administer antibiotics if prescribed.

Pressure areas

- See WNHS Policy: [Pressure Injury Prevention](#)

Falls risk

- See KEMH Clinical Guideline, O&G: [Falls Risk Assessment and Management](#)

First post-operative day until discharge

- Continue to provide care as above.
- Assess for postural hypotension and motor / sensory loss prior to mobilising.
- Assess the need for continuing intravenous therapy. Diet and fluids to commenced as per the post op orders
- Administer an aperient in the evening of the third post-operative day, unless ordered otherwise. Bowel management for oncology patients must be discussed with the oncology team prior to initiation.
- Remove the indwelling catheter as per post-operative orders. Refer to Clinical Guideline 'O&G: [Bladder Management](#): IDC: Trial of Void' for ongoing management.
- Administer antibiotics and other medications as prescribed.
- Remove wound dressing prior to first shower, or as per post-operative orders.
- Assess the wound for signs of healing or infection. If complications are identified refer to the medical team.
- Re-apply a wound dressing if appropriate.

- Sutures / staples shall be removed as per post-operative orders.
- Discharge planning shall be commenced at the time of admission. Review available home support and determine whether additional support is required. Liaise with the relevant staff / departments and confirm arrangements.

References and resources

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Related policies

- [WA Health Consent to Treatment Policy 2016](#)
- WNHS Policies [Healthpoint access only]: [Patient Identification](#), [Clinical Handover](#), [Pressure Injury Prevention and Management](#); [Falls](#)

Related WNHS policies, procedures and guidelines








[Anaesthesia and Pain Medicine](#) Guidelines [Healthpoint intranet access only]

[Obstetrics & Gynaecology:](#)

- Bladder Management
- Clinical Deterioration: Recognising and Responding to
- Labelling of Injectable Medicines and Fluids
- Wound Care: Simple dressing

[Perioperative:](#)

- PACU: Discharge Criteria [Healthpoint intranet access only]
- Post-operative Care Following Local Anaesthetic
- Post-operative Care Following a General Anaesthetic
- Post-operative Care Following Spinal Anaesthesia:

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