OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Preoperative preparation and postoperative care of the surgical patient

(previously titled 'Perioperative preparation and management')

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH

This document should be read in conjunction with this Disclaimer

Contents

Pre-operative

Routine care

Aim

To ensure the consistent delivery of benchmarked best practice standards to pre and post- operative patients at KEMH.

Key points

1. **Consent**: See WA Health Consent to Treatment Policy and Procedure
   - Surgical procedures (other than in an emergency or where another exception applies- see policy) performed under anaesthesia (general, spinal, epidural and regional) and intravenous sedation, require the patient's explicit consent sought and documented.[1]
   - The health practitioner ultimately responsible for providing treatment (e.g. lead surgeon) must be satisfied that the consent process has been properly undertaken and the patient has reached a decision to provide or withhold consent to the proposed treatment [1] (p2). See 'WA Health Consent to Treatment procedure' for full explicit consent process.
   - The nurse / midwife shall check that a valid consent is present in the patients' medical records **prior** to administering any pre medications. If there is a discrepancy, medical team and perioperative coordinator shall be notified immediately.
   - **For patients lacking capacity to consent:** Refer to WA Health Consent policy regarding guardianship. Check that a copy of Enduring Power of Guardianship is present in the notes with the consent (where relevant).
   - Only when all aspects of consent are satisfied can the patient be given a premedication or be transferred to theatre.
2. **EC**: 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. Document discussions with senior staff in the medical record.
3. Fasting is necessary prior to sedation or general anaesthesia to minimise the risk of regurgitation and pulmonary aspiration. When emergency surgery is required, patients may sometimes undergo general anaesthesia unfasted with appropriate precautions taken by the anaesthetic team.
4. Patients 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.
5. Medi alert bracelets must be left in situ and must not be taped. Note these on the Preoperative Perioperative Checklist (MR290).

6. 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.
7. Hearing aids may be left in situ. A labelled receptacle shall accompany the patient for safe keeping, in case the hearing aid is removed intraoperatively.
8. Dentures may remain in situ unless specified by the anaesthetist. If the patient chooses to wear their dentures to the operating theatre, a labelled denture cup shall accompany them in case they are removed during anaesthetic.
9. Glasses or contact lenses shall be removed prior to transfer to operating theatre.
10. All patients 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 the Preoperative Perioperative Checklist (MR290).
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 patient against the consent form to confirm that the consent fulfils the following criteria:
    - Verification that patient details (name, date of birth, UMRN) 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 the proposed treatment is no longer appropriate due to a change in the patient's circumstances. See WA Health Consent to Treatment Procedure (p4).
    - (if relevant) Check that a copy of Enduring Power of Guardianship is present in the notes with the consent.
4. Ensure the patient 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 patient has fasted as per Anaesthetic Clinical Guidelines.
6. Assess:
    - Pressure injury risk: Complete 'Pressure Injury Prevention and Management Plan' (MR260.05)
    - Complete Falls Risk Assessment and Management Plan MR260.04
    - Caesarean patients- complete the risk assessments within the Postnatal Pathway. See also Caesarean birth guideline.
7. Ensure assessment of the patient's risk for venous thromboembolism (VTE). According to medical staff instructions, commence VTE prophylaxis.
8. Record the patient's baseline vital signs; temperature, weight and height on the Preoperative Perioperative Checklist MR290 as close to the time of giving the pre medication as possible. Ensure a routine urinalysis has been performed and documented.

9. Request / assist the patient to remove eye make-up and nail varnish. If the patient has acrylic nails, they may be left on.
10. Complete the pre-operative hair clip. See section in this document: Hair Removal
11. Ensure the patient has showered and not applied creams, deodorants or perfumes prior to admission.
12. For patients undergoing a caesarean section, a 2% chlorhexidine wash cloth should be used. **Note:** In non-elective caesarean sections when showering is not possible, chlorhexidine wipes should still be used, where practical.
    - 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 Perioperative checklist (MR290)

      See also WNHS Infection Prevention and Management policy: Prevention of Surgical Site Infections and O&G Caesarean Birth guideline.
13. Request / assist the patient into perioperative attire.
14. Ensure the patient is warm and supply blankets as required.
15. Request the patient to empty their bladder prior to surgery. Record the last void on the Preoperative Perioperative Checklist (MR290). If a premedication is prescribed, request the patient to void before this is administered.
16. For patients greater than 100 kgs, assist placement of hovermatt if required for patient transfer if requested or required.
17. Administer premedication as charted. Once given, advise the patient to remain in bed, raise the bedrails and ensure that the nurse call bell is within reach.
18. Collect the patient admission pack and escort them to theatre. The nurse / midwife shall remain with the patient until ISOBAR handover has been completed and theatre accept care of patient.
19. The nurse / midwife escorting the woman shall sign the Preoperative Perioperative Checklist (MR290).

Caesarean patients

Note: For patients who have had a Caesarean- refer to sections on ‘Transfer from the operating theatre’ and ‘Postoperative care’ within the Caesarean Birth guideline.

Hair removal

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. Shaving hair is strongly discouraged[2]- 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 blade[3] regardless of the timing of hair removal.[4]

Procedure

1. Avoid routine hair removal- if circumstances necessitate, clip on the day of surgery or as close as possible to the time of operation. Hair removal should occur outside of the operating theatre.[2]
2. Provide an explanation to the patient and obtain verbal consent.
3. Assess the operation site. Document the presence of lesions such as moles, warts or other skin conditions in the medical notes. 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. The clipper handle shall be cleaned between patients with a product that contains both a detergent and a disinfectant (e.g. Clinell wipe).

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
Obstetrics	
Caesarean	See Caesarean Birth guideline. Remove excess pubic hair only as required for the incision just prior to surgery.

Post-operative

Day surgery patients

- Acceptance to the Day Surgery Unit (DSU) is subject to the patient having met the requirements for discharge from the Post-Anaesthetic Care Unit (PACU). See Perioperative Services:
  - Post Anaesthetic Care Unit: Discharge Criteria and
  - Day Surgery Unit (DSU): Management of Patients

Ward patients

On the ward – prepare the room

1. Check the oxygen and suction is working correctly and that all equipment is present before collecting the patient.
2. Ensure an IV stand is available.
3. Place the additional following equipment in the patient's room:
   - Continence sheet; Perineal pads
   - Emesis container x2
   - Water jug, glass
   - Jug to empty IDC

Receiving a patient from post-anaesthetic unit (PACU) post-surgery

1. Confirm the patient's identity using the three core patient identifiers as per WNHS Policy: Patient Identification (family name and given name, UMRN and date of birth). Also check the baby's ID labels prior to leaving PACU.
2. Assess the patient in PACU- They must meet the PACU 'Criteria for discharge to the ward'.
3. Review the Operation Report MR207.01
   - Review postoperative orders
   - Review the ongoing orders for analgesia, intravenous hydration, indwelling catheter (IDC) etc.
4. Check the epidural/opiate infusion pump program as ordered and check the rate infusing and the rate prescribed are correct.
5. Check all dressings, drains, IV therapy and observations. Check all IV/arterial/epidural/naso-gastric lines are labelled appropriately.
6. Clarify any concerns before leaving the area.
7. Following iSoBAR clinical handover the PACU nurse / midwife and the ward nurse / midwife must sign the handover section of Handover to Recovery/Ward (MR325).
8. 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.

On return to the ward

1. Initial checks:
    - Return the patient to the room, position appropriately, 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 dependent pressure areas
    - Complete the Falls Risk Management Tool MR260.04. Precautionary measures to be in place, refer to the Falls: Risk Assessment and Management of Patient Falls - Procedure
    - For caesarean patients- refer to risk assessments in the Postnatal Care Pathway.
    - Perform baseline observations
2. Ensure all documentation is complete.
    - Complete relevant care plan
    - Check the:
        - Medication chart for analgesia. Check the Anaesthetic Chart (MR300) to see if analgesic or anti emetic has been given.
        - Post op Nausea and Vomiting (PONV MR327A)
3. Ensure dentures and medical records are returned to the ward with the patient.
4. Position the patient according to the surgical procedure performed. Recheck and document all sites/dressings/drains.
5. For routine post-operative observation frequency see section in this document: 'Care Following Surgery' and 'DSU' guideline. Perform, record and escalate post-operative observations as per relevant observation chart.
6. Ensure water, emesis container and the patient's bell are accessible to the patient.
7. Empty IDC/SPC and observe drainage on drainage bottles. Mark drainage at 2400 hours.

Caesarean patients

Note: For patients who have had a Caesarean- refer to sections on 'Transfer from the operating theatre' and 'Postoperative care' within the Caesarean Birth guideline.

Care following surgery: Gynaecology, oncology or urogynaecology

General post-operative complications can include:

- **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, delirium, cerebral vascular accident (CVA)

Key points

1. Routine management will be subject to an accurate assessment of each individual patient and may vary according to the patient'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 to the ward from PACU.
3. Should a patient's clinical condition deteriorate to the point where an ASCU admission is required, Clinical Guideline: Obstetrics and Gynaecology: Consultant Responsibilities 'ASCU: Consultant Responsibilities Flow Chart' shall be followed.
4. Standard Infection Control principles shall be consistently applied throughout a woman's episode of care. See Infection Prevention and Management Manual.
5. 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.

Post-operative observations

1. Monitor and record a **full set** of observations as per relevant observation and response chart (ORC). In addition, document (where applicable - see sections below):
- Wound sites / drains – measure and record as a baseline
- Urinary output – measure and record as a baseline
- Intravenous therapy rate and IV site(s)
- Vaginal loss
- Nasogastric tube drainage (if applicable)
- Opioid infusion- PCIA / PCEA, inspect the insertion site and record the dermatomes

2. The following observations shall be performed and recorded on the Adult ORC (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 patient's condition remains stable.

3. For minor procedures, the following observations shall be performed and recorded on the Adult ORC (MR 285.02):
- ½ hourly for 1 hour, then
- 1 hourly for 2 hours, then
- 4 hourly, providing the patient's condition remains stable.

4. Observations shall be recorded as often as dictated by patient condition. All deviations outside of normal limits shall be escalated as per relevant ORC. See WNHS policy: Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health) and Obstetrics and Gynaecology guideline Acute Deterioration (Adult): Resuscitation and Life Support'.

Note: Patients admitted to the ward for psychosocial reasons only, who would otherwise meet the clinical criteria for DSU, may have post-operative observations as per DSU guidelines, and then at a minimum of TDS.

Escalation and management remains as per the ORC.

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

Wound sites / drains

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

Fluid balance / hydration

- Manage intravenous therapy as ordered and monitoring IV site for complications as per Department of Health policy for: Insertion and Management of PIVC in WA Healthcare Facilities
- 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)

Medication

- Pain management: Assess pain score and offer analgesia as prescribed
- Post-operative nausea and vomiting- See PONV Chart
- VTE prophylaxis: Administer anticoagulants as prescribed
- Antibiotics: Check medication chart MR 810 and administer antibiotics if prescribed

Non-pharmacological VTE prophylaxis

- Refer to WNHS VTE guideline. Examples include: Graduated compression stockings; encourage deep breathing, coughing and a range of motion exercises (if required, refer the patient to the Physiotherapy Department); Encourage hydration and early mobilisation

Hygiene and comfort

- Position the patient for maximum airway ventilation and comfort.
- When the patient's condition is satisfactory, attend to hygiene needs, mouth care and if appropriate change the patient into their own clothes

Pressure areas and falls screening and risk reduction

- See WNHS Policy: Pressure Injury Prevention
- See WNHS Guideline: 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.
- Remove IV cannula once no longer needed.

- 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 IDC 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.
- Wound dressing – see Wound Care guideline and 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

1. Department of Health Western Australia. WA Health consent to treatment procedure. Perth: Department of Health WA; 2023.
2. National Health and Medical Research Council [NHMRC] and the Australian Commission on Safety and Quality in Healthcare [ACSQHS]. Australian guidelines for the prevention and control of infection in healthcare: NHMRC, ACSQHC; 2019. Available from: https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019
3. Tanner J, Norrie P, Melen K. Preoperative hair removal to reduce surgical site infection. **Cochrane Database of Systematic Reviews**. 2011 (11). Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004122.pub4/pdf
4. Paull T. Preoperative skin preparation: hair removal. JBI Evidence Summary JBI197. 2018. Adelaide (South Australia): Joanna Briggs Institute, [cited 2018 Feb 28].

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Charoenkwan K, Matovinovic E. Early versus delayed oral fluids and food for reducing complications after major abdominal gynaecologic surgery. Cochrane Database of Systematic Reviews [Internet]. 2014 [cited 2024, Apr 29]. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004508.pub4/full

Related policies

- WA Health Consent to Treatment Policy and Procedure
- WNHS Policies [HealthPoint access only]: Pressure Injury Prevention and Management; Patient Identification; Recognising and Responding to Acute Clinical Deterioration (Physiological and Mental Health)

Related WNHS policies, procedures and guidelines and forms

Anaesthesia and Pain Medicine Guidelines [HealthPoint intranet access only]

Infection Prevention and Management: Prevention of Surgical Site Infections policy

Obstetrics and Gynaecology:

- Acute Deterioration (Adult): Resuscitation and Life Support
- Bladder Management
- Consultant Responsibilities: 'ASCU: Consultant Responsibilities Flow Chart'
- Wound Care: Simple dressing
- Postnatal Care: Quick Reference Guide

Perioperative**:**

- Day Surgery Unit (DSU): Management of Patients (Post-operative care following local anaesthetic, GA, spinal anaesthesia)
- Post Anaesthetic Care Unit (PACU): Discharge Criteria [HealthPoint intranet access only]

WNHS Policies

- Falls Risk Assessment and Management of Patient Falls
- Pressure Injury Prevention and Management

Forms:

- MR 285.02 Adult Observations and Response Chart
- MR207.01 Operation Report/Day Surgery Discharge Summary
- MR260.03 Comprehensive Skin Assessment
- MR260.04 Falls Risk Assessment and Management Plan (FRAMP)
- MR290 Preoperative Perioperative Checklist
- MR325 Handover to Recovery / Ward

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Version history

Version number	Date	Summary
1	Sept 2017	First version **History**: In Sept 2017 amalgamated 5 individual guidelines from Obstetrics and Gynaecology, dated from August 1993 into one document. No content changed- remained as separate chapters. **Supersedes**: 8. C2.1 Routine preoperative care (date amended Jul 2015) 9. C2.1.2 Pre-operative hair removal (dated Oct 2014) 10. C2.2.1 Receiving patient from recovery (dated Mar 2014) 11. C2.2.2 Care following minor surgery for gynaecology, oncology, urogynaecology (dated Jul 2014) 12. C2.2.3.1 Care following major surgery for gynaecology, oncology, urogynaecology (dated Apr 2014)
2	May 2018	Full review. For a list of changes- see OGD Guideline Updates by month/year of review date
3	Nov 2024	• Consent section updated to align and link to latest Department of Health policy and procedure • Removed chapter on minor surgery care in DSU- replaced with link to DSU guideline for care • Condensed content, added links to related guidelines and removed duplicate content • Added a greater than 100kg parameter to dot point regarding Hovermatt patient transfer. • Hair removal (if req) by clippers; Shaving is discouraged • Patients admitted to the ward for psychosocial reasons only (who would otherwise meet the clinical criteria for DSU) may have post-operative observations as per DSU guidelines, and then at a minimum of TDS. Escalation and management remains as per ORC. • Inclusion of minor procedure post operative observations regime supported by GPA CPOC. • Removal of the term woman and replaced with patient, as requested by GPA CPOC.
3.1	Apr 2025	• Minor amendment- words added to title to enable better searching ability. No content changed.

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