



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

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|--------------------------|--|-------------------------|---------------|
| Department: | Operating Room | | |
| Document: | Departmental Policy and Procedure | | |
| Title: | Assisting Patient for General Anesthesia | | |
| Applies To: | All Operating Room Staff | | |
| Preparation Date: | January 05, 2025 | Index No: | OR-DPP-012 |
| Approval Date: | January 19, 2025 | Version : | 5 |
| Effective Date: | February 19, 2025 | Replacement No.: | OR-DPP-012(4) |
| Review Date: | February 19, 2028 | No. of Pages: | 4 |

1. PURPOSE:

- 1.1 To relieve patient's apprehension.
- 1.2 To ensure a comfortable and safe environment for the patient.
- 1.3 To help protect patient against possible injury during intubation.

2. DEFINITONS:

- 2.1 **Assisting Patient for General Anesthesia** – the care given to a patient during administration of anesthesia until procedure has been completed.

3. POLICY:

- 3.1 The nurse should be familiar with methods used by Anesthesiologist.
- 3.2 A nurse does not administer any anesthetic drug unless he/she has had special education in anesthesia.
- 3.3 It is the nurse responsibility to keep the room quiet; talking should be kept to a minimum.
- 3.4 Any source of excitement to the patient should be eliminated.

4. PROCEDURE:

- 4.1 Stay at the patient's side during induction of anesthesia.
- 4.2 Put aside other duties to assist anesthesiologist until patient has been successfully anesthetized.
- 4.3 In case, the patient vomit and aspirate or any complications fatal to patient's life, be prepared to assist the anesthesiologist until situation is controlled.
 - 4.3.1 Suction should be ready at all times.
 - 4.3.2 Emesis basin should be within your reach.
 - 4.3.3 Know the mechanism of operating room tables, positioning will be helpful as well.

5. MATERIALS AND EQUIPMENT:

- 5.1 Anesthesia Machine
- 5.2 Intubation Kit (Laryngoscope, ET tubes, Suction Catheters, Oral Airways, McGills's Forceps)
- 5.3 Plaster, Gauze Bandage and Eye Pads
- 5.4 Suction Machine

6. RESPONSIBILITIES:

- 6.1 Nurse
- 6.2 Anesthesia Technician
- 6.3 Anesthetist






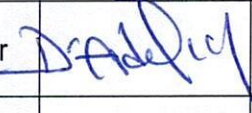

7. APPENDICES:


- 7.1 Anesthesia/Sedation Consent Form
- 7.2 Pre-Anesthesia/sedation Assessment form

8. REFERENCES:

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

9. APPROVALS:

| | Name | Title | Signature | Date |
|--------------|-------------------------------|---------------------------------------|---|------------------|
| Prepared by: | Ms. Naimah Naif Al Salem | Head Nurse of the Operating Room |  | January 05, 2025 |
| Reviewed by: | Mr. Hamed Matar Alanazi | Head of Anesthesia Technician |  | January 06, 2025 |
| Reviewed by: | Dr. Abdulghani Ibrahim | Head of the Operating Room Department |  | January 06, 2025 |
| Reviewed by: | Mr. Sabah Turayhib Al - Harbi | Director of Nursing |  | January 08, 2025 |
| Reviewed by: | Mr. Abdulelah Ayed Al Mutairi | QM&PS Director |  | January 12, 2025 |
| Reviewed by: | Dr. Tamer Mohamed Naguib | Medical Director |  | January 12, 2025 |
| Approved by: | Mr. Fahad Hezam Al - Shammari | Hospital Director |  | January 19, 2025 |

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| <p>KINGDOM OF SAUDI ARABIA</p>  <p>وزارة الصحة Ministry of Health</p> | <p>MRN: _____</p> <p>رغم الملف الطبي: _____</p> <p>Name: _____</p> <p>الاسم: _____</p> <p>Nationality: _____</p> <p>الجنسية: _____</p> <p>Age: _____ سنة _____ شهر _____ يوم</p> <p>العمر: _____ Years _____ Months _____ Days</p> <p>Date of Birth: _____ / _____ / 14 _____ H _____ / _____ / 20 _____</p> <p>تاريخ الميلاد: _____ / _____ / 20 _____</p> <p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>الجنس: _____</p> |
| <p>Hospital: _____</p> <p>مستشفى: _____</p> <p>Region: _____</p> <p>المنطقة/المحافظة: _____</p> <p>Dept./Unit: _____</p> <p>القسم/الوحدة: _____</p> | |

ANESTHESIA / SEDATION CONSENT

| | |
|--|--|
| <p>If you have any questions or concern about this Consent, ask your physician before signing.</p> <p>I, the undersigned: on my behalf / on behalf of: _____</p> <p>acknowledge that the anesthetist has discussed with me the anesthesia method he/she will use for me which is suitable for my condition and its :</p> <p><input type="checkbox"/> General anesthesia <input type="checkbox"/> Conscious sedation</p> <p><input type="checkbox"/> Regional anesthesia (spinal or epidural)</p> <p>Others _____</p> <p>and he also discussed with me the other methods that could be used in case of any difficulty arises that prevent the using of the first choice anesthetic technique.</p> <p>The anesthetist has explained to me the possible side effects and complications of anesthesia and assured me that should any of these complications happen it would be dealt with promptly and effectively but without any guarantee of the outcome.</p> <p>He also informed me about the precautions and instructions I have to follow before the operation.</p> | <p>إذا كان لديك أي تساؤل أو استفسار : يرجى سؤال الطبيب قبل التوقيع .</p> <p>أقر أنا الموقع أدناه _____</p> <p>بالإصالة عن نفسي أو نيابة عن _____</p> <p>أن طبيب التخدير قد ناقش معي طريقة تخديري والتي تناسب حالتني وهي <input type="checkbox"/> تخدير عام <input type="checkbox"/> تخدير واعي</p> <p><input type="checkbox"/> تخدير ناحي (شوكي أو فوق الجافية)</p> <p>غير ذلك _____</p> <p>كما ناقش معي البدائل المختلفة والتي من الممكن اللجوء إليها في حال حدوث صعوبات تمنع الخيار الأول للتخدير.</p> <p>وشرح لي الأعراض الجانبية والمضاعفات المحتمل حدوثها نتيجة التخدير وأكد لي أنه في حالة حدوث أي من هذه المضاعفات (لا سمح الله) فإنه سيتم التعامل معها بحسم وفاعلية (حسب العرف الطبي) دون ضمان النتائج وأخبرني بالاحتياطات والتعليمات التي علي إتباعها قبل العملية.</p> |
| <p>TO BE FILLED ONLY FOR HIGH RISK CASES :</p> <p>The anesthetist has explained to me the high risk of anesthesia in my case due to :</p> <p>A. _____</p> <p>B. _____</p> <p>C. _____</p> <p>Hereby in give consent to anesthesia knowing the high risk in my case.</p> | <p>تملأ فقط في حالة الخطورة العالية</p> <p>شرح لي طبيب التخدير وجود خطورة عالية بالتخدير في حالتني نتيجة وجود : _____</p> <p>أ. _____</p> <p>ب. _____</p> <p>ج. _____</p> <p>وأوافق على التخدير رغم علمي بخطورة التخدير على حالتني ولا أحمل الاطباء أي مسؤولية.</p> |
| <p>Hereby I, knowing all above, I authorize the anesthetists of the hospital to choose the technique (method) of the anesthesia; and to do suitable procedure to my case .</p> <p>Signature of the Patient or Guardian (Relation) _____</p> <p>Name: _____ Signature: _____</p> <p>Date: _____ / _____ / _____ Time: _____</p> <p>Name of the Anesthetist: _____</p> <p>Signature: _____ Doctor's Stamp _____</p> <p>Date: _____ / _____ / _____ Time: _____</p> | <p>وعليه ومع علمي بكل ما سبق أفوض أطباء التخدير في المستشفى باختيار طريقة التخدير واتخاذ الإجراءات اللازمة حسب حالتني اسم وتوقيع المريض أو ولي أمره (يذكر نوع القرابة : _____)</p> <p>الاسم : _____ التوقيع : _____</p> <p>التاريخ : _____ / _____ / _____ الوقت : _____</p> <p>اسم طبيب التخدير _____</p> <p>التوقيع : _____ ختم الطبيب : _____</p> <p>التاريخ : _____ / _____ / _____ الوقت : _____</p> |


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ISSUED DATE:09/02/2013

1 OF 1



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| <p>KINGDOM OF SAUDI ARABIA</p>  <p>وزارة الصحة Ministry of Health</p> | MRN: _____ رقم الملف الطبي: |
| | Name: _____ الاسم: |
| | Nationality: _____ الجنسية: |
| | Age: _____ سنة _____ شهر _____ يوم _____ Years Months Days العمر: |
| | Date of Birth: ____/____/14 H ____/____/20 تاريخ الميلاد: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female الجنس: |
| Hospital: _____ مستشفى: | |
| Region: _____ المنطقة/المحافظة: | |
| Dept./Unit: _____ القسم/الوحدة: | |

PRE-ANESTHESIA /SEDATION ASSESSMENT FORM

| | | | | | |
|--|---------------|---|-----------|--|----------------|
| Weight: _____ | Height: _____ | PR: _____ | RR: _____ | BP: _____ / _____ | TEMP: _____ c° |
| Anesthesia Assessment done in: <input type="checkbox"/> OPD <input type="checkbox"/> Ward <input type="checkbox"/> OR Other: _____ | | Diagnosis: _____ Procedure: _____ | | ADMITTED THROUGH <input type="checkbox"/> Emergency <input type="checkbox"/> Routine <input type="checkbox"/> Day Case | |
| PATIENT HISTORY Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Drugs <input type="checkbox"/> Food <input type="checkbox"/> Others: _____ | | AIRWAY q No airway problems Teeth: <input type="checkbox"/> Appear normal <input type="checkbox"/> Decayed <input type="checkbox"/> Missing <input type="checkbox"/> Dentures: <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Removed Chin/Tongue: _____ Neck: _____ Other: _____ MALLAMPATI: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> VI | | | |
| Cardiac: <input type="checkbox"/> Negative <input type="checkbox"/> IHD <input type="checkbox"/> Hypertensive <input type="checkbox"/> Valve Disease <input type="checkbox"/> Arrhythmia <input type="checkbox"/> CHF <input type="checkbox"/> Previous MI/Date: _____ Other/Comments: _____ | | OTHER FINDINGS _____ _____ _____ | | | |
| Respiratory: <input type="checkbox"/> Negative <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> O2 Dependent <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Recent URI <input type="checkbox"/> Other: _____ <input type="checkbox"/> Smoking <input type="checkbox"/> amount: _____ | | TEST RESULTS ECG <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal _____ Chest X-ray <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal _____ Hb _____ <input type="checkbox"/> Blood Needed/ Derivatives: <input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____ ml Other: _____ | | | |
| Endocrine: <input type="checkbox"/> Negative <input type="checkbox"/> Diabetic <input type="checkbox"/> Thyroid disease | | ASA Classification: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> E | | | |
| Liver: <input type="checkbox"/> Negative <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis | | ANESTHETIC PLAN _____ _____ _____ | | | |
| Neurological: <input type="checkbox"/> Negative <input type="checkbox"/> CVA <input type="checkbox"/> Seizure disorder Other: _____ | | Patient Education Anesthetic plan, benefits, alternatives and risks are explained to patient <input type="checkbox"/> Yes <input type="checkbox"/> No If not explained to patient, give reason: _____ Patient appears to understand and accept the anesthetic plan and possible risks: <input type="checkbox"/> Yes <input type="checkbox"/> No Why: _____ | | | |
| Renal: <input type="checkbox"/> Negative <input type="checkbox"/> Renal Failure <input type="checkbox"/> Renal impairment <input type="checkbox"/> Dialysis, Last Dialysis: ____/____/____ | | ANESTHETIST RECOMMENDATIONS: <input type="checkbox"/> ICU Bed Requested <input type="checkbox"/> High Risk Consent <input type="checkbox"/> Additional Consultation: _____ _____ _____ | | | |
| Cancer: <input type="checkbox"/> Negative <input type="checkbox"/> Chemo /XRT <input type="checkbox"/> Other: _____ | | PHYSICAL EXAMINATION <input type="checkbox"/> Awake <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Comatose GCS ____/15 Cardiac: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular rhythm <input type="checkbox"/> Murmur: <input type="checkbox"/> Murmur: _____ | | | |
| Pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes Week: _____ | | Lungs: <input type="checkbox"/> Normal <input type="checkbox"/> Rales <input type="checkbox"/> Wheezing Physical Activity: _____ | | | |
| Other Disease(s): _____ _____ _____ | | Anesthetist Name: _____ Stamp & Signature: _____ Date: ____/____/____ Time: _____ | | | |
| Medications/ supplements: _____ _____ _____ | | Previous Surgery and Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Sedation <input type="checkbox"/> Regional <input type="checkbox"/> Local Complications: <input type="checkbox"/> No <input type="checkbox"/> Yes Family History of Anesthetic complications: <input type="checkbox"/> Yes <input type="checkbox"/> No History of PONV: <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |

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1 OF 1



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