HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER MATERNITY AND CHILDREN HOSPITAL

Department:	Operating Room		
Document:	Departmental Policy and Procedure		
Title:	Assisting Patient for Regional Anesthesia		
Applies To:	All Operating Room Staff		
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1. PURPOSE:

1.1 To relieve patient's apprehensions before during administration of anesthesia.
1.2 To protect patient's against injury.

2. DEFINITONS:

2.1 **Assisting Patient for Regional Anesthesia** – the care given to a patient during administration of regional anesthesia.

3. POLICY:

3.1 The nurse must remain alert and cooperate fully with the anesthesiologist.
3.2 A nurse must refuse to administer anesthetic drugs.
3.3 Limit conversation to a minimum

4. PROCEDURE:

4.1 Prepare all the necessary equipment.
4.2 Clean the area with Povidone – Iodine.
4.3 Drape the area.
4.4 Help the patient to maintain a good posture.
4.5 Explain to patient what to expect to gain cooperation.
4.6 Prepare for possible vomiting with suction and emesis basin.
4.7 Monitor the patient throughout the procedure for toxic reactions.

5. MATERIALS AND EQUIPMENT:

5.1 Kidney Basin with Sponge Holder
5.2 Sterile Gauze
5.3 Betadine
5.4 Sterile Towel
5.5 Syringes
5.6 Suction Machine

6. RESPONSIBILITIES:

6.1 Nurse
6.2 Anesthesia Technician
6.3 Anesthetist

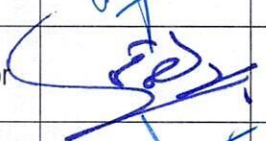
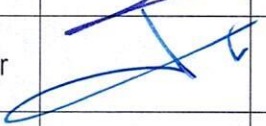
7. APPENDICES:

7.1 Anesthesia 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 07, 2025
Reviewed by:	Dr. Abdulghani Ibrahim	Head of the Operating Room Department		January 07, 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

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ :مستشفى

Region: _____ :المنطقة/المحافظة

Dept./Unit: _____ :القسم/الوحدة

MRN: _____ رقم الملف الطبي:

Name: _____ :الاسم

Nationality: _____ :الجنسية

Age: _____ ☐ Years سنة ☐ Months شهر ☐ Days يوم :العمر

Date of Birth: ____/____/14____H ____/____/20____ :تاريخ الميلاد

Gender: ☐ Male ☐ Female :الجنس

ANESTHESIA / SEDATION CONSENT

If you have any questions or concern about this Consent, ask your physician before signing.

I, the undersigned: on my behalf / on behalf of: _____

_____

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 :

☐ General anesthesia ☐ Conscious sedation

☐ Regional anesthesia (spinal or epidural)

Others_____

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.

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.

He also informed me about the precautions and instructions I have to follow before the operation.

إذا كان لديك أي تساؤل أو استفسار :يرجى سؤال الطبيب قبل التوقيع .

أقر أنا الموقع أدناه _____

بالأصالة عن نفسي أو نيابة عن _____

أن طبيب التخدير قد ناقش معي طريقة تخديري والتي تناسب حالتي وهي ☐ تخدير عام ☐ تخدير واعي

☐ تخدير نادي (شوئي أو فوق الجافية)

غير ذلك _____

كما ناقش معي البدائل المختلفة والتي من الممكن اللجوء إليها في حال حدوث صعوبات تمنع الخيار الأول للتخدير.

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.

TO BE FILLED ONLY FOR HIGH RISK CASES :

The anesthetist has explained to me the high risk of anesthesia in my case due to :

A._____

B._____

C._____

Hereby in give consent to anesthesia knowing the high risk in my case.

تملأ فقط في حالة الخطورة العالية

شرح لي طبيب التخدير وجود خطورة عالية بالتخدير في حالتي نتيجة وجود :

أ_____

ب_____

ج_____

وأوافق على التخدير رغم علمي بخطورة التخدير على حالتي وأحمل الأطباء أي مسؤولية.

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 .

Signature of the Patient or Guardian (Relation)_____

Name:_____ Signature:_____

Date: ____/____/____Time: _____

Name of the Anesthetist: _____

Signature: _____ Doctor's Stamp

Date: ____/____/____ Time: _____

وعليه ومع علمي بكل ما سبق أفوض أطباء التخدير في المستشفى باختيار طريقة التخدير واتخاذ الإجراءات اللازمة حسب حالتي

اسم وتوقيع المريض أو ولي أمره (يذكر نوع القرابة :_____)

الاسم :_____ التوقيع :_____

التاريخ ____/____/____ الوقت _____

اسم طبيب التخدير _____

التوقيع _____ ختم الطبيب :

التاريخ ____/____/____ الوقت _____

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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ___/___/14___ H ___/___/20___ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

PRE-ANESTHESIA /SEDATION ASSESSMENT FORM

Weight:	Height:	PR:	RR:	BP: /	TEMP: c°

Anesthesia Assessment done in:
☐ OPD ☐ Ward ☐ OR
Other : _____

Diagnosis: _____
Procedure: _____

ADMITTED THROUGH
☐ Emergency ☐ Routine
☐ Day Case

PATIENT HISTORY

Allergies: ☐ No ☐ Yes
☐ Drugs ☐ Food ☐ Others: _____

Cardiac: ☐ Negative ☐ IHD
☐ Hypertensive ☐ Valve Disease
☐ Arrhythmia ☐ CHF
☐ Previous MI /Date : _____
Other/Comments: _____

Respiratory: ☐ Negative ☐ Asthma
☐ COPD ☐ Emphysema
☐ O2 Dependent ☐ Sleep Apnea
☐ Recent URI ☐ Other: _____
☐ Smoking ☐ amount:

Endocrine: ☐ Negative
☐ Diabetic ☐ Thyroid disease

Liver: ☐ Negative
☐ Hepatitis ☐ Cirrhosis

Neurological: ☐ Negative ☐ CVA
☐ Seizure disorder Other: _____

Renal : ☐ Negative
☐ Renal Failure ☐ Renal impairment
☐ Dialysis, Last Dialysis: ___/___/___

Cancer : ☐ Negative
☐ Chemo /XRT ☐ Other:

Pregnancy: ☐ No ☐ Yes
_____ Week

Other Disease(s):
_____
_____

Medications/ supplements:
_____
_____

Previous Surgery and Anesthesia:
☐ General ☐ Sedation ☐ Regional ☐ Local
Complications: ☐ No ☐ Yes
Family History of Anesthetic complications:
☐ Yes ☐ No
History of PONV : ☐ No ☐ Yes

PHYSICAL EXAMINATION

☐ Awake ☐ Alert ☐ Oriented ☐ Comatose
GCS ____ /15
Cardiac: ☐ Regular ☐ Irregular rhythm
☐ Murmur: ☐ Murmur:

Lungs: ☐ Normal ☐ Rales ☐ Wheezing
Physical Activity: _____

AIRWAY

q No airway problems Teeth: ☐ Appear normal ☐ Decayed ☐ Missing
☐ Dentures: ☐ Upper ☐ Lower ☐ Removed
Chin/Tongue: _____ Neck: _____
Other: _____
MALLAMPATI: ☐ I ☐ II ☐ III ☐ VI

OTHER FINDINGS

_____
_____
_____
_____

TEST RESULTS

ECG ☐ WNL ☐ Abnormal _____
Chest X-ray ☐ WNL ☐ Abnormal _____
Hb _____ ☐ Blood Needed/ Derivatives : ☐ Yes ☐ No Amount _____ ml
Others: _____
_____
_____

ASA Classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ E

ANESTHETIC PLAN

_____
_____
_____
_____

Patient Education

Anesthetic plan, benefits, alternatives and risks are explained to patient ☐ Yes ☐ No
If not explained to patient, give reason: _____
Patient appears to understand and accept the anesthetic plan and possible risks:
☐ Yes ☐ No Why: _____
_____
_____

ANESTHETIST RECOMENDATIONS:

☐ ICU Bed Requested ☐ High Risk Consent:
☐ Additional Consultation: _____
_____
_____
_____
_____
_____

Anesthetist Name: _____

Stamp&Signature: _____

Date: ___/___/___ *Time:*

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