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1.0 Introduction

Surgical services are delivered across both secondary- and tertiary-level hospitals in the Maldives. While tertiary hospitals provide comprehensive multi-specialty surgical care, a substantial proportion of surgical procedures are performed in secondary-level hospitals located throughout the Atolls. Ensuring the delivery of safe, effective, and high-quality surgical care remains a key objective of the Maldivian healthcare system.

Safe surgical care requires a coordinated and patient-centred approach throughout the surgical journey. Surgical care can be broadly divided into three phases: preoperative, intraoperative, and postoperative. Optimal management during each phase is essential to minimise perioperative risks, improve patient outcomes, and promote timely recovery (Centre for Perioperative Care [CPOC], 2021).

The provision of surgical care relies on a multidisciplinary team comprising surgeons, anaesthetists, perioperative nurses, and allied healthcare professionals. This team is often supported by physicians, paediatricians, and other specialists who contribute to the assessment and optimisation of patients with existing medical conditions and complex healthcare needs. Effective communication and collaboration among all members of the healthcare team are fundamental to ensuring safe and seamless perioperative care.

This guideline has been developed to support healthcare professionals involved in the perioperative management of surgical patients in the Maldives. The guideline focuses primarily on the preoperative and postoperative phases of care, providing recommendations to promote patient safety, optimise clinical outcomes, and standardise perioperative practices across healthcare facilities.

Detailed management of specific conditions and surgical procedures is beyond the scope of this document.

2.0 Scope of the Guidelines

This guideline covers adults presenting for surgical care. It is designed for use in all healthcare facilities where surgical care is provided, at both secondary and tertiary levels, with recommendations scaled to the management capacity of each level.

Intended users: surgical teams, anaesthesiologists, perioperative nurses, anaesthesia nurses, and anaesthesia technologists.

3.0 Key Principles of Preoperative and Postoperative Management

1. **Provide patient-centred care:** Perioperative care should be individualised and planned according to the patient's clinical condition.

2. **Establish an accurate surgical diagnosis and treatment plan:** The diagnosis, indication for surgery, proposed operative plan, expected outcomes, and potential risks should be clearly documented and communicated to the patient and relevant members of the multidisciplinary team.

3. **Conduct a comprehensive preoperative assessment:** Whenever possible, a detailed history should be obtained by both the anaesthesia and surgical teams.

4. **Perform a thorough pre-anaesthetic assessment:** A pre-anaesthetic evaluation should be undertaken for all patients undergoing procedures requiring anaesthesia. The assessment should focus on the patient's medical history, current surgical condition, medication use, previous anaesthetic experiences, organ function, perioperative risk factors, and airway evaluation. The assessment should identify opportunities for optimisation and facilitate planning for safe anaesthetic care (CPOC, 2021).

5. **Obtain informed consent:** Informed consent should be obtained before any surgical procedure, anaesthetic intervention, or invasive procedure, except in emergencies where immediate treatment is required to preserve life or prevent serious harm and the patient is unable to provide consent (McLeod et al., 2026).

6. **Promote early recovery and rehabilitation:** Postoperative care should be designed to support early (enhanced) recovery, restoration of physiological function, prevention of complications, and timely return to the patient's baseline functional status.

7. **Adopt a multimodal approach to postoperative pain management:** Multimodal analgesia should be offered as the standard approach to postoperative pain management. This should include appropriate non-pharmacological interventions, non-opioid analgesics, regional anaesthetic techniques, and other pharmacological modalities as indicated, guided by procedure-specific (PROSPECT) recommendations where available (El-Boghdadly et al., 2024; Joshi, Albrecht, et al., 2023).

8. **Facilitate multidisciplinary collaboration:** Effective perioperative care requires close collaboration among surgeons, anaesthetists, physicians, nurses, allied health professionals, and other specialists as required.

4.0 Establishing the Diagnosis and Indication for Surgery

A clear surgical diagnosis is fundamental to effective perioperative management. When surgery is indicated, the patient should be informed of the diagnosis, the details of the planned procedure, the expected course of management, and potential adverse outcomes. These discussions should be clearly documented, and informed consent should be obtained before surgery. The diagnosis and planned procedure should be communicated to the relevant members of the multidisciplinary team.

Whenever possible, a detailed history should be obtained by both the anaesthesia and surgical teams. This should include evaluation of the current surgical condition, planned surgical intervention, medical and psychological comorbidities, current medications, allergies, history of chronic pain, substance use disorders, previous surgical procedures, prior postoperative complications, and responses to previous perioperative treatment regimens. Relevant social and functional factors that may influence perioperative outcomes should also be considered.

5.0 Optimisation of Pre-Existing Medical Conditions

A comprehensive preoperative assessment should be undertaken for all patients undergoing surgical procedures. This assessment should include a detailed medical history, previous surgical and anaesthetic history, current medications, allergies, and a preliminary psychosocial evaluation. Factors that may influence perioperative risk, recovery, adherence to treatment, or postoperative outcomes should be identified and documented.

Pre-existing medical conditions should be systematically evaluated and their potential impact on perioperative outcomes assessed. Where feasible, identified medical conditions should be appropriately investigated, treated, and optimised before surgery (CPOC, 2021). Optimisation may include adjustment of medications, stabilisation of chronic diseases, management of acute illnesses, correction of reversible abnormalities, and referral to relevant specialists when indicated. Specialist referrals should be individualised and may need to be adapted according to local availability. Where the required services are unavailable locally, referral to a higher centre should be considered when deemed necessary by the consulting surgeon and anaesthesiologist.

The extent of preoperative optimisation should be guided by the urgency of the surgical procedure, the severity of the patient's underlying conditions, and the anticipated perioperative risk. Elective procedures should be deferred, when necessary, to allow adequate optimisation of significant medical conditions and to reduce the risk of perioperative complications. Emergency surgery in patients with significant unoptimised risk factors may proceed after a careful risk–benefit evaluation.

5.1 Specific Medical Conditions

5.1.1 Hypertension

For patients undergoing elective procedures, blood pressure should ideally be well controlled before the planned operation. Target levels are as follows (National Institute for Health and Care Excellence [NICE], 2023):

- **Under 80 years old:** 140/90 mmHg
- **80 years and older:** 150/90 mmHg

On the day of surgery, the procedure may proceed unless blood pressure readings fall within the severe range:

- Acceptable preoperative reading: <180/120 mmHg.
- **Hypertensive crisis (≥ 180/120 mmHg):** Elective surgery should be postponed and the patient referred for management of hypertensive urgency (McCormack et al., 2026).

Patients should generally continue regular antihypertensive medications on the day of surgery with a sip of water. The anaesthesiologist may advise withholding angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) on the morning of surgery to reduce the risk of severe intraoperative hypotension (Halvorsen et al., 2022).

5.1.2 Diabetes Mellitus

Good glycaemic control should be achieved before elective surgery. A target HbA1c of **<7%** is generally recommended where feasible. On the day of surgery, blood glucose levels should ideally be maintained below **180 mg/dL**. Perioperative insulin and medication adjustments should be individualised according to the type of diabetes, current treatment regimen, and fasting status (American Diabetes Association Professional Practice Committee, 2025).

5.1.3 Renal Disease (Chronic Kidney Disease or Acute Kidney Injury)

Renal function assessment should be considered in elderly patients, those with known medical comorbidities, and patients undergoing major surgery. Perioperative management should focus on optimising fluid balance, avoiding nephrotoxic agents where possible, and adjusting medication dosing according to renal function.

5.1.4 Cardiac Disease

Pre-existing cardiac disease has a significant impact on perioperative outcomes. Routine cardiac screening is not recommended; however, targeted evaluation should be performed when clinically indicated based on symptoms, functional status, and surgical risk.
Cardiac medications should generally be continued perioperatively, including administration with a small sip of water when appropriate. Antiplatelet therapy should be managed on an individual basis in consultation with the anaesthesia and surgical teams, balancing bleeding and thrombotic risks (Halvorsen et al., 2022).

5.1.5 Pulmonary Disease

Patients with chronic respiratory disease should be assessed for baseline respiratory function, adequacy of inhaled therapy, and risk of postoperative pulmonary complications. Smoking cessation, pulmonary rehabilitation, and optimisation of bronchodilator therapy should be encouraged where appropriate (CPOC, 2021).

5.1.6 Obstructive Sleep Apnoea and Obesity

Patients with suspected or confirmed obstructive sleep apnoea (OSA) and/or obesity require careful perioperative risk assessment because of the increased risk of airway complications and postoperative respiratory depression. Anaesthetic planning should account for airway management challenges, opioid sensitivity, and the need for enhanced postoperative monitoring (CPOC, 2025).

5.1.7 Liver Disease

Patients with liver disease require assessment of hepatic function, coagulation status, and nutritional state. Drug metabolism may be altered, and perioperative bleeding risk may be increased. Management should be individualised according to the severity of liver dysfunction.

5.1.8 Neurological and Neuromuscular Disease

Patients with raised intracranial pressure, neurological disorders, or neuromuscular diseases require individualised perioperative planning. Considerations include airway management, sensitivity to anaesthetic agents, respiratory function, and postoperative neurological monitoring.

5.1.9 Other Special Patient Groups

Certain patient populations, including pregnant patients and those undergoing cardiothoracic or major vascular surgery, require specialised perioperative protocols. These are beyond the scope of this guideline and should be managed according to dedicated specialty-specific standards.

6.0 Preoperative Investigations

Preoperative investigations should be individualised based on the patient's clinical condition, comorbidities, age, functional status, and the nature and complexity of the proposed surgical procedure. Routine testing in the absence of a clinical indication is not recommended (CPOC, 2021). Healthcare institutions should establish and maintain standardised protocols for preoperative evaluation to promote consistency, patient safety, and appropriate resource utilisation.

Serological screening for common blood-borne viral pathogens should be considered for patients undergoing major surgical procedures in accordance with institutional policies and national regulations.

Assessment and optimisation of anaemia should form an integral component of preoperative evaluation (Shander et al., 2023). Measurement of haemoglobin and haematocrit should be performed when clinically indicated, particularly in patients undergoing major surgery, those with suspected anaemia, or procedures associated with anticipated blood loss. Identified anaemia should be investigated and managed whenever feasible prior to elective surgery. For patients undergoing major surgery, a complete blood count should be considered.

Platelet count testing is not routinely required for all surgical patients. However, it may be considered when clinically indicated, particularly in patients with suspected haematological disorders, those receiving anticoagulant or antiplatelet therapy, or when neuraxial anaesthesia is planned at the discretion of the anaesthesia team.

Renal function testing (including serum creatinine), electrocardiography (ECG), and chest radiography may be considered in elderly patients, patients with significant pre-existing medical conditions, or when findings are likely to influence perioperative management. These investigations should not be performed routinely without a clinical indication (CPOC, 2021).

Additional investigations should be guided by the patient's clinical condition, the complexity and risk profile of the proposed surgical procedure, and the recommendations of the surgical and anaesthesia teams. Any abnormal findings identified during the preoperative assessment should be appropriately evaluated and managed prior to surgery whenever feasible.

Specialised diagnostic investigations, including but not limited to echocardiography, cardiac stress testing, pulmonary function testing, and sleep studies, should not be performed routinely. These investigations should be reserved for patients in whom the results are expected to influence perioperative management and should be undertaken only when clinically indicated and recommended by the relevant specialist team.

7.0 Pre-anaesthetic Assessment

A pre-anaesthetic assessment should be undertaken for all patients undergoing procedures requiring anaesthesia. For elective procedures, this assessment may be conducted through a dedicated pre-anaesthetic clinic (PAC), while for urgent or emergency procedures it may be performed at the bedside, in the emergency department, or in the operating theatre, depending on the clinical circumstances.

The pre-anaesthetic clinic serves several important functions. It provides an opportunity to establish rapport with the patient and family, evaluate the patient's surgical condition and overall health status, identify and optimise existing medical conditions, and assess perioperative risks. The clinic also facilitates appropriate specialist referrals and multidisciplinary consultations when required. When necessary, referral to a higher centre may also be considered during the PAC assessment. In addition, it enables the formulation of an individualised perioperative management plan, including anaesthetic strategy, medication management, fasting instructions, and postoperative care requirements.

The pre-anaesthetic evaluation should include a comprehensive review of the patient's medical, surgical, and anaesthetic history, current medications, allergies, and previous anaesthetic experiences. Particular attention should be given to existing medical conditions, organ function, functional capacity, and factors that may increase perioperative risk.

A focused physical examination should be performed, including assessment of the cardiovascular and respiratory systems, evaluation of relevant comorbidities, and a thorough airway assessment to identify potential difficulties with ventilation or tracheal intubation (CPOC, 2021). Where neuraxial or peripheral regional anaesthesia is planned, the spine or the relevant block site should be examined as needed.

The assessment should identify opportunities for preoperative optimisation, facilitate risk stratification, and support the development of a safe and individualised anaesthetic plan. Findings from the pre-anaesthetic assessment should be clearly documented and communicated to the surgical team and other relevant healthcare professionals involved in the patient's care.

The informed consent process for anaesthesia should also be undertaken during this assessment (McLeod et al., 2026).

8.0 Preoperative Medication Management

Clear and standardised instructions regarding the management of ongoing medications should be provided to all patients in the preoperative period. Decisions regarding continuation, modification, or temporary discontinuation of medications should be individualised and clearly communicated by the anaesthesia and surgical teams.

Patients should receive explicit instructions regarding which medications to continue on the day of surgery and which should be withheld. Where applicable, guidance should also be provided on overnight medication management prior to the procedure. Instructions should be clearly documented and communicated to all relevant healthcare providers to ensure continuity of care.

9.0 Surgical Scheduling and Pathways

Healthcare institutions should establish written policies and protocols governing the scheduling and prioritisation of surgical procedures. These protocols should promote equitable access to surgical services, optimise resource utilisation, and support patient safety throughout the perioperative period.

For elective procedures, institutions should implement standardised scheduling processes that define referral pathways, preoperative assessment requirements, and prioritisation criteria. Scheduling systems should ensure that patients have completed the necessary preoperative evaluation and optimisation before being listed for routine surgery.

Clear pathways should also be established for the management of emergency and urgent surgical cases. These pathways should outline processes for patient triage, clinical assessment, prioritisation according to urgency, communication among multidisciplinary teams, and timely access to operating theatre resources. They should also address the availability of surgical teams, anaesthesia personnel, nursing staff, and operating theatre space.

Institutional protocols should clearly define the roles and responsibilities of surgical, anaesthetic, nursing, and support staff involved in both elective and emergency surgical care. These protocols should be reviewed periodically to ensure efficiency, consistency, and alignment with current clinical standards and available resources.

10.0 Informed Consent

Informed consent is a fundamental component of ethical and patient-centred surgical care. Valid informed consent should be obtained before any surgical procedure, anaesthetic intervention, or invasive procedure, except in emergency situations where immediate treatment is required to preserve life or prevent serious harm and the patient is unable to provide consent. Written informed consent should be obtained, addressing both the anaesthetic and surgical components of care (McLeod et al., 2026).

Patients should be provided with clear, accurate, and understandable information regarding:
- The diagnosis and rationale for the proposed intervention.
- The nature and purpose of the procedure.
- Expected benefits and likelihood of success.
- Material risks and potential complications.
- Available alternatives, including non-operative management where appropriate.
- The likely consequences of declining treatment.
- The anaesthetic plan and anaesthesia-related risk stratification.
- Expected postoperative recovery, rehabilitation requirements, and follow-up care.

Information should be communicated in a manner that is appropriate to the patient's language, educational background, cultural context, and decision-making capacity. The patient must have the capacity to understand the information provided, appreciate the consequences of the decision, and communicate a choice. Where a patient lacks decision-making capacity, consent should be obtained from the legally authorised representative.

The informed consent discussion and the patient's decision should be documented in the medical record. Written consent should be obtained for all major surgical procedures, anaesthesia, blood transfusions, and other significant interventions. Significant changes to the diagnosis, treatment plan, anticipated risks, or clinical condition should prompt a review and reaffirmation of consent before proceeding with treatment.

11.0 Aspiration Risk Prevention and Fasting Guidelines

Prevention of pulmonary aspiration should be a priority in all patients undergoing anaesthesia. Appropriate preoperative fasting reduces the risk of aspiration and should be implemented according to established guidelines (Joshi, Abdelmalak, et al., 2023).

For elective procedures, recommended minimum fasting periods are as follows:
- At least **8 hours** for fatty or heavy meals
- At least **6 hours** for light meals or solids
- At least **4 hours** for breast milk
- At least **2 hours** for clear fluids

In emergency or urgent surgical situations, adherence to standard fasting times may not be possible. In such cases, the urgency of the procedure should be balanced against the increased risk of aspiration, and anaesthetic management should be adjusted accordingly. When proceeding with surgery in non-fasted patients, the risk of pulmonary aspiration should be clearly considered and

discussed as part of the informed consent process. Patients (or their caregivers) should be informed of the increased anaesthetic risk, and this discussion should be documented in the medical record.

In patients with medical or surgical conditions, or medications, associated with delayed gastric emptying, aspiration prophylaxis and rapid sequence induction and intubation should be considered.

Point-of-care ultrasonography of the gastric antrum may be useful for assessing gastric volume and content, and therefore the adequacy of fasting (Baettig et al., 2023).

12.0 Handover to Operating Room Team and Sign-In Process

A structured handover to the operating room (OR) team should be performed for every patient prior to the commencement of surgery. The **ISBAR** communication framework (Identify, Situation, Background, Assessment, Recommendation) should be used to ensure clear, concise, and standardised transfer of clinical information between teams (Kaltoft et al., 2022).

The handover should include confirmation of patient identity, the proposed surgical procedure, relevant medical history, current clinical status, allergies, any perioperative risks or concerns, and current medications.

A formal **sign-in process** should be conducted prior to anaesthesia induction as part of the surgical safety checklist. The WHO Surgical Safety Checklist (or an institutionally adapted version) should be completed for every patient undergoing anaesthesia or a surgical procedure (Armstrong et al., 2022). This should include verification of patient identity, confirmation of the planned procedure and surgical site, and confirmation that the surgical site has been appropriately marked. Relevant investigations, availability of required equipment (including checks of anaesthesia workstation function and monitoring equipment), and completion of necessary preoperative preparations should also be verified. All team members should actively participate in the checklist process, and any discrepancies or concerns should be addressed before proceeding.

13.0 Post-Anaesthesia Care Unit (PACU) Handover

A designated Post-Anaesthesia Care Unit (PACU) should be available within or in close proximity to the operating theatre complex where anaesthesia services are provided. The PACU should be appropriately staffed and equipped to ensure safe monitoring and management of patients during the immediate postoperative period, appropriate to the complexity of the surgical procedures performed in the institution.

A structured handover from the intraoperative team to the PACU team should be performed for every patient. This handover should be conducted using the **ISBAR** communication framework to ensure consistent, clear, and standardised transfer of clinical information.

The handover should include relevant details such as patient identity, surgical procedure performed, anaesthetic technique, intraoperative events, fluid management, blood loss, medications administered, allergies, and any perioperative complications or concerns. Clear postoperative instructions, including pain management plans and monitoring requirements, should also be communicated. Clear instructions should also be given on when to seek the help of the anaesthesiologist or surgeon during the immediate postoperative period.

The integrity and correct labelling of any surgical specimens must be confirmed before transfer, and specimens should be clearly handed over to the receiving team to ensure accurate handling, documentation, and processing.

PACU discharge criteria should be based on a validated tool. The Aldrete scoring system should be used to assess recovery and readiness for discharge from the PACU for all patients (Fang et al., 2023). This standardised tool evaluates key physiological parameters, including activity, respiration, circulation, consciousness, and oxygen saturation. The Aldrete score should be documented for all patients on arrival in the PACU and at regular intervals during recovery. A score of **9 or above** is considered indicative of adequate recovery and readiness for transfer from the PACU to the ward, provided there are no other clinical concerns.

In addition to the Aldrete score, clinical judgment should be used to assess overall patient stability, including pain control, haemodynamic stability, airway patency, absence of significant nausea or vomiting, and any procedure-specific considerations. Patients should only be transferred from the PACU when they meet both objective scoring criteria and clinical safety standards.

14.0 Promotion of Early Recovery and Rehabilitation (Enhanced Recovery Principles)

Postoperative care should be structured in accordance with **Enhanced Recovery After Surgery (ERAS)** principles to support early recovery, restoration of physiological function, reduction of postoperative complications, and timely return to baseline functional status (Ljungqvist et al., 2021). Care should be individualised based on the type and complexity of the surgical procedure, baseline patient health, and perioperative risk factors.

A multimodal and coordinated approach should be adopted across the perioperative pathway, emphasising patient engagement, multidisciplinary collaboration, and evidence-based interventions that minimise surgical stress and optimise recovery.
Key components of enhanced recovery include:

- **Early mobilisation:** Patients should be encouraged to mobilise as early as clinically safe to reduce the risk of thromboembolism, pulmonary complications, and functional decline.
- **Optimised pain control:** Multimodal analgesia should be used to facilitate early movement and participation in rehabilitation while minimising opioid-related adverse effects (El-Boghdadly et al., 2024).
- **Early return to nutrition:** Early oral intake should be encouraged when appropriate, with nutritional support tailored to individual patient needs and surgical considerations.
- **Fluid and physiological optimisation:** Careful management of fluids, electrolytes, and comorbid medical conditions should be maintained to support physiological stability and recovery.
- **Structured rehabilitation:** Physiotherapy and functional rehabilitation should be incorporated early where indicated to restore mobility, strength, and independence.

Postoperative management should be continuously reviewed and adjusted according to the patient's recovery trajectory, clinical condition, and response to interventions. Early identification and management of complications should be prioritised to support safe and effective recovery.

15.0 Multimodal Approach to Postoperative Pain Management

Multimodal analgesia should be adopted as the standard approach to postoperative pain management. This strategy involves the combined use of pharmacological and non-pharmacological interventions that act through different mechanisms to provide effective analgesia while minimising opioid requirements and related adverse effects (El-Boghdadly et al., 2024; Joshi, 2023).

A multimodal regimen should include appropriate non-pharmacological interventions, such as positioning, cold or heat therapy, relaxation techniques, and early mobilisation where appropriate. Non-opioid analgesics, including paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs), should form the foundation of pharmacological management unless contraindicated. Regional anaesthetic techniques, including neuraxial blocks and peripheral nerve blocks, should be utilised where indicated to provide targeted analgesia and reduce systemic medication requirements. Other adjuvant pharmacological agents may be considered based on the clinical context and pain mechanism. Where available, procedure-specific recommendations, such as those developed by the PROSPECT (PROcedure-SPECific Postoperative Pain ManagemenT) Working Group of the European

Society of Regional Anaesthesia and Pain Therapy, should guide the choice of analgesic techniques for individual surgical procedures (Joshi, Albrecht, et al., 2023).
Opioids should be used judiciously and reserved for patients with moderate to severe postoperative pain or when pain is not adequately controlled with non-opioid and regional techniques. When required, opioids should be prescribed at the lowest effective dose for the shortest appropriate duration. Their use should be guided by principles of safe prescribing, regular reassessment of pain control and side effects, and adherence to institutional opioid stewardship protocols (El-Boghdadly et al., 2024; Srivastava et al., 2021).

16.0 Post-surgical Discharge Planning

Discharge from post-anaesthesia care should be guided by standardised discharge criteria, including the use of a validated scoring system such as the **Post-Anaesthetic Discharge Scoring System (PADS; Fang et al., 2023)**, where applicable. Patients should only be considered for discharge when they meet defined clinical and functional recovery benchmarks, in addition to meeting institutional safety criteria.

A structured discharge process should be implemented to ensure safe transition of care from the hospital to the community or referring facility. At the time of discharge, patients should receive clear written and verbal instructions detailing the surgical procedure performed, the hospital course, postoperative recovery progress, medications, wound care instructions, activity limitations, warning signs of complications, and follow-up arrangements.

Patients and caregivers should be provided with guidance on when and how to seek medical attention if complications arise. Postoperative recovery should include a defined review process following surgery. This should include scheduled outpatient follow-up or review within the surgical pathway to assess wound healing, functional recovery, pain control, and the detection of any delayed complications. Early identification and management of postoperative issues should be prioritised to optimise outcomes and reduce readmissions.

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