National Clinical Programme in Surgery

Name:

Date of Birth:

Healthcare Record Number:

Or affix addressograph

PILOT DOCUMENT

Hospital Name

Patient Nursing Notes

FOR DAY CASE

ELECTIVE SURGERY PATIENTS

UNDERGOING GENERAL OR SPINAL ANAESTHETIC

NAME: _____

DATE OF PRE-ASSESSMENT:_____

DATE OF ADMISSION: _____

CONSULTANT: _____

Name:
Date of Birth:
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IMPORTANT

1. **This document is to be used only for <u>Day Case</u> elective surgery patients undergoing general or spinal anaesthetic who attend the Pre Assessment Clinic and Day Care Unit.**

2. **All entries in this document must be written clearly and legibly in permanent black ink.**

3. **All entries must be signed, dated and timed using the twenty four hour clock.**

4. **Each side of each page containing patient information must be correctly labelled with the patient's name and healthcare record number.**

5. **Any alterations to the nursing notes should be scored out with a single line, followed by signature, date and time and reason for amendment.**

6. **Abbreviations should not be used. In the event of abbreviations being utilised, they should only be used in accordance with National Hospital's Office guidelines (National Hospitals Office 2007).**

7. **Nursing assessment is initiated by Pre-Assessment Clinic Nurse. However, the Day Care Unit Nurse must check, confirm and sign that all details are correct at the point of admission.**

Abbreviations Used in this Document:

- **PAC: Pre Assessment Clinic**
- **DCU: Day Care Unit**
- **PHN: Public Health Nurse**
- **GP: General Practitioner**
- **HCG: Human Chorionic Gonadotrophin**

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Patient Assessment Details

GOAL: Nursing Assessment initiated by Pre Assessment Clinic Nurse and confirmed by Day Care Unit Nurse on day of admission.

Prefers to be known as:

Male ☐ **Female** ☐ **Age:**

Marital Status:

Occupation:

Letter required for work: Yes ☐ No ☐

Action:

Next of Kin Aware: Yes ☐ No ☐

Name:

Relationship:

Address:

Phone No:

Mobile No:

Alternative Contact:

Name:

Relationship:

Address:

Phone No:

Mobile Phone No:

G.P Name:

Address:

Surgery Telephone No:

Does the patient have a medical card? Yes ☐ No ☐

Public Health Nurse (PHN) Referral Required :

Yes ☐ No ☐ ***(Please refer to Discharge Plan)***

If yes, please specify name and contact details of PHN:

Addressograph details confirmed & correct:

Yes ☐ ***No*** ☐ ***(Destroy all old labels)***

Confirmed Diagnosis:

Proposed Surgery:

Proposed Date of Surgery:

Patient's Understanding of Reason for Admission:

Allergies as stated by patient:

Specify Reaction:

MRSA Status: **Positive** ☐ **Negative** ☐

Any recent hospital admission: Yes ☐ **No** ☐

Specify:

Swabs taken: Yes ☐ **No** ☐ **Date:**

Date & Time of Pre Assessment Clinic Assessment:

Pre Assessment Clinic Nurse's Signature:

Printed Name:

Date & Time of Admission to Day Care Unit:

Day Care Unit Nurse's Signature:

Printed Name:

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Current Medications

Anticoagulant	Yes ☐	No ☐	
Aspirin	Yes ☐	No ☐	
Clopidogrel (Plavix)	Yes ☐	No ☐	
Oral Contraceptive Pill	Yes ☐	No ☐	
Any unprescribed medications / complementary therapies	Yes ☐	No ☐	***Please specify:***

Advice given by PAC nurse re medications to be taken on day of surgery:

Medical Information/Past Health Status

Smoker: Yes ☐ No ☐ **How many per day?** **Ex smoker – for years/months:**

Alcohol – units per day/week:

Referrals

Date	Referrals	Form	Date Seen	Comment	Signature

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Nursing Assessment and Problem Identification

Maintaining a Safe Environment **Assessment questionnaire reviewed with patient: Yes ☐ No ☐**	**Communication** **Pre admission patient information / advice given at PAC: Yes ☐ No ☐** **Patient's anxieties / concerns:**
Respiratory	**Controlling Body Temperature**
Eating/Drinking	**Elimination**
Mobility **Waterlow Score Yes ☐ N/A ☐ Score:____** **Action:**	**Personal Cleansing and Dressing** RIGHT: 8 7 6 5 4 3 2 1 — 1 2 3 4 5 6 7 8 :LEFT **Oral Assessment:** **Dentition details Crown © Bridge (B) Dentures (D)**
Working and Playing	**Expressing Sexuality (Body Image)** **(Females only) Date of last menstrual period:_____**
Individual problems / other relevant information **Please use this space to specify any individual needs identified following assessment of the patient:**	

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Patient Information & Advice Given at Pre Assessment Clinic

Maintaining a Safe Environment:

Reiterate need for overnight supervision and escort home post operatively. ☐
Confirm patient's details, operation date and time of admission, procedure and consultant. ☐

Pain
Advice re pain and pain control post surgery ☐

Respiratory:

Advice re stopping smoking pre-operatively ☐
Advice re bringing inhalers on day of admission (if relevant) ☐

Communication:

Pathway discussed from pre-admission to post discharge ☐
Pre op advice to include:

- **Where to go on day of admission** ☐
- **What to bring** ☐
- **Fasting** ☐
- **Who you will see – Nurse, Anaesthetist, Surgeon** ☐

Post op advice to include:

- **Pain and pain control** ☐
- **Wounds** ☐
- **Eating and Drinking** ☐
- **Elimination** ☐
- **Fitness to return to work / sporting activities** ☐

Written information given ☐**: Please specify:**

Eating and Drinking

Nutrition advice given ☐
Informed re pre-operative fasting ☐
Specific advice for Diabetic patients ☐

Elimination

Advise patient that they will have to pass urine pre discharge ☐
Advise patient re importance of prevention of constipation pre and post operatively ☐
Instruction re bowel preparation (if relevant) ☐

Personal Cleansing and Dressing:

Leave valuables at home on day of surgery ☐
Remove all jewellery, make up and nail varnish ☐
Advise patient to shower morning of admission ☐
Advice re skin clipping and marking on admission ☐
Advise to bring dressing gown, slippers, towel, toiletries and over night bag ☐
Advise patient they can wash teeth / use mouth wash as normal ☐

Expressing Sexuality:

Advice re wound positions and marking ☐
Advice re returning to sexual activity post surgery ☐
Advice re loss per vagina post operatively and use of sanitary products ☐
Advice re stopping the oral contraceptive pill 4-6 weeks pre surgery ☐
Advice re alternative forms of family planning ☐

Mobility

Advice re importance of post op mobility in prevention of Deep Venous Thrombosis / Pulmonary Embolism ☐

Sleeping:

Advised re importance of sleeping and healing ☐
Information given re use of pre medication ☐

Maintaining Body Temperature

Advice re signs of infection post surgery ☐

Working and Playing

Advice re returning to work / normal activity post surgery ☐

Signed by PAC Nurse_____ **Date & time:** _____

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Tests & Investigations

Urinalysis:
If abnormality detected – specify: **Action taken:** **Signature: _____**

If any abnormalities identified or action required, please comment, sign, date and time.

Test / Investigation		**Date**	**Action / Signature**
ECG	**Yes ☐ No ☐ Not Required ☐**		
X Ray	**Yes ☐ No ☐ Not Required ☐**		
ECHO	**Yes ☐ No ☐ Not Required ☐**		
Stress Test	**Yes ☐ No ☐ Not Required ☐**		
24 Hour Monitor	**Yes ☐ No ☐ Not Required ☐**		
MRSA Screen	**Yes ☐ No ☐ Not Required ☐**		
Full Blood Count (FBC)	**Yes ☐ No ☐ Not Required ☐**		
Urea and Electrolytes (U&E)	**Yes ☐ No ☐ Not Required ☐**		
Blood Group / Hold	**Yes ☐ No ☐ Not Required ☐**		
Cross Match (X Match) **No of Units:**	**Yes ☐ No ☐ Not Required ☐**		
Coagulation Screen	**Yes ☐ No ☐ Not Required ☐**		
Thyroid Function Tests (TFTs)	**Yes ☐ No ☐ Not Required ☐**		
Human Chorionic Gonadotrophin (HCG) (in PAC)	**Yes ☐ No ☐ Not Required ☐**		
Human Chorionic Gonadotrophin (HCG) (on admission to DCU)	**Yes ☐ No ☐ Not Required ☐**		
Other:	**Yes ☐ No ☐ Not Required ☐**		
	Yes ☐ No ☐ Not Required ☐		
	Yes ☐ No ☐ Not Required ☐		

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Pre Admission Assessment Summary

Blood Pressure:		**Height**	
Pulse:		**Weight:**	
Respirations:		**Body Mass Index:**	
Oxygen Saturation:		**Glucometer Reading:** ***(if diabetic)***	

Referred to Anaesthetist **Yes** ☐ **No** ☐	**Outcome:**
Referred to Medical Consultant **Yes** ☐ **No** ☐	**Outcome:**

PAC Recommendation

This patient is suitable for:

Day Case Surgery: ☐ **Day of Surgery Admission:** ☐ **In-Patient Surgery:** ☐

PAC Checklist

Action	Yes / No	Comment
Bed Manager informed	**Yes** ☐ **No** ☐	
Relevant ward informed:	**Yes** ☐ **No** ☐	
Secretary:	**Yes** ☐ **No** ☐	
Other (please specify):	**Yes** ☐ **No** ☐	

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FOR PATIENTS HAVING A GENERAL / SPINAL ANAESTHETIC

- **I shall be accompanied home by_____.**
- **A nominated adult will be at home with me at least overnight.**
- **I undertake not to drink alcohol within 24 hours of my operation.**
- **I undertake not to drive a car or operate heavy machinery within 24 hours of my operation.**
- **I shall not travel home alone by public transport.**

Patient's signature	**Date & time**
Witnessed by	**Date & time**

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Name:
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Date & Time (24 hr)	PRE ASSESSMENT CLINIC RECORD OF NURSING INTERVENTION AND EVALUATION	Signature

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Day Care Unit – Pre-Operative Nursing Care Plan

Assessment / Problem Identification:

……requires preparation for theatre for……..

Review, confirm and sign the PAC nursing assessment details	**Sign, Date & Time**

Goal: To prepare the patient physically and psychologically for surgery.

Plan: Welcome and orientate patient to the Day Care Unit.	
Confirm that patient received explanation in PAC re interventions and aftercare. Assess understanding and allow opportunities to ask questions.	
Complete Pre-Operative Checklist.	
Record baseline pre-operative vital signs in the Intra-Operative Record.	
Obtain urine sample for HCG (all female patients). Yes☐ No☐ N/A☐	
Assess patient's skin integrity and pressure areas. Ensure skin preparation is carried out *(hygiene & clipping).* Yes☐ No☐ N/A☐	
Administer Deep Venous Thrombosis prophylaxis as prescribed Yes☐ No☐ N/A☐ • Graduated compression stockings Yes☐ No☐ N/A☐ Time applied…… • Other: Please specify…… Time given:……..	
Intravenous (IV) Cannula inserted in Day Care Unit Yes☐ No☐ N/A☐ Time inserted ……. Inserted by:…….. Site…….	
Ensure safe transfer to theatre and give handover.	
	Sign, Date & Time

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Date & Time	RECORD OF NURSING INTERVENTION AND EVALUATION	Signature
	Patient admitted to Day Care Unit at…….. (time).	
	Patient transferred to Theatre at…….(time).	

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Day Care Unit – Post-Operative Nursing Care Plan

Assessment / Problem Identification:

……has undergone …… and is at risk of developing post-operative complications.

Goal: To reduce the risk of post-operative complications.

Plan:	
Reassure and re-orientate patient on return to the Day Care Unit	
Monitor and record vital signs as follows: • Quarter hourly x one hour • Half hourly x two hours • Hourly until stable / discharged Record temperature hourly.	
Observe and document patient's skin integrity and pressure areas. Assist patient to maintain a safe and comfortable position.	
Observe wound for signs of excessive bleeding, oozing or signs of infection. Using aseptic technique, change dressing as required. Record dressing change, condition of wound and surrounding skin in nursing notes. Inform surgical team. Wound site: _____ Method of Closure: _____	
Ensure intravenous (IV) site is patent and observe for any signs of infection / inflammation. IV cannula location: _____ Ensure IV fluids are infusing as prescribed and record all intake and output in Intake & Output chart.	
Assess pain using scale of 1 – 10. Monitor and record onset, type, location, duration and severity of pain.	
Administer analgesia as prescribed and monitor effect. Review with medical team if necessary. Reassure patient and offer comfort measures.	
Reintroduce oral fluids as soon as patient can tolerate same. Reintroduce diet as soon as patient wishes / can tolerate same.	
Check that patient has passed urine within six hours post surgery. Observe for signs of urinary retention and inform surgical team of same.	
Ensure that the patient's seventy two hour supply of "take home" analgesia has been arranged.	
Assess and document Day Care Unit Discharge Criteria Score two, four and six hours post surgery. **If any potential discharge problems identified, inform relevant personnel immediately – CNM / Nurse Manager on duty, Doctor, Bed Manager etc.**	
Commence relevant discharge documentation.	
	Sign, **Date & Time**

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Date & Time	RECORD OF NURSING INTERVENTION AND EVALUATION	Signature
	Patient returned to Day Care Unit from Theatre at…….(time).	
	Patient discharged from Day Care Unit at……..... (time).	

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OBSERVATION CHART

Date:																				
Time (24 hour)																				
Temperature (° Celsius)																				
Pulse & Blood Pressure	**210**																			
	200																			
	190																			
	180																			
	170																			
	160																			
	150																			
	140																			
	130																			
	120																			
	110																			
	100																			
	90																			
	80																			
	70																			
	60																			
	50																			
	40																			
	30																			
	20																			
	10																			
Respiratory Rate																				
Pain Score																				
IV checked?																				
Wound checked?																				
Initials of Nurse																				

INTAKE & OUTPUT RECORD

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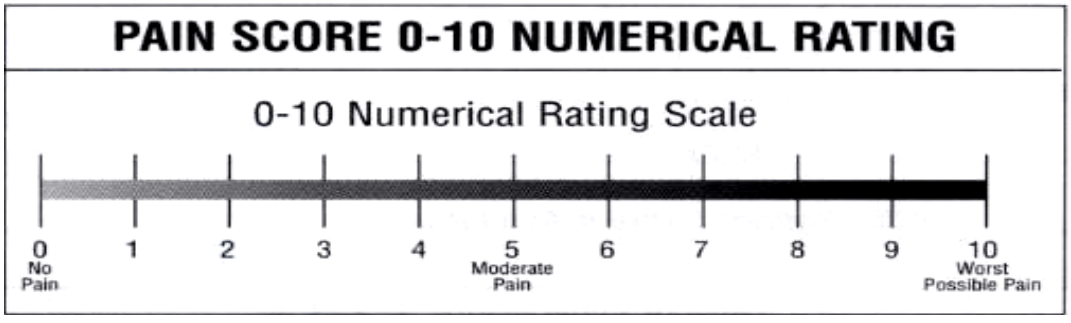
Intake			**Output**			
Time	**Type of fluid & volume**	**Route**	**Urine**	**Vomit**	**Other**	**Signature**
08.00						
09.00						
10.00						
11.00						
12.00						
13.00						
14.00						
15.00						
16.00						
17.00						
18.00						
19.00						
20.00						
21.00						
22.00						
23.00						
00.00						
Total						



Numerical Rating Scale
Instruct the patient to choose a number from 0 to 10 that best describes their current pain. 0 would mean 'No pain' and 10 would mean 'Worst possible pain'.

Day Care Unit Discharge Criteria

(Aldrete 1995)

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	TIME			
Activity	Able to move 4 extremities voluntarily or on command Able to move 2 extremities voluntarily or on command Unable to move extremities voluntarily or on command	2 1 0	2 1 0	2 1 0
Respiration	Able to breathe deeply and cough freely Dyspnoea or limited breathing Apnoeic	2 1 0	2 1 0	2 1 0
Circulation	BP +/- 20% of pre-anaesthetic level BP +/- 20 – 49% of pre-anaesthetic level BP +/- 50% pre-anaesthetic level	2 1 0	2 1 0	2 1 0
Consciousness	Fully awake Rousable on calling Not responding	2 1 0	2 1 0	2 1 0
Oxygen Saturation	Able to maintain saturation > 92% on room air Needs oxygen to maintain saturation> 90% Saturation < 90% even with oxygen	2 1 0	2 1 0	2 1 0
Dressing	Dry and clean Wet but stationary or marked Growing area of wetness	2 1 0	2 1 0	2 1 0
Pain	Pain Free Mild pain handled by oral medication Severe pain requiring parenteral medication	2 1 0	2 1 0	2 1 0
Ambulation	Able to stand up and walk straight Vertigo when erect Dizziness when supine	2 1 0	2 1 0	2 1 0
Fasting – feeding	Able to drink fluids Nauseated Nausea and vomiting	2 1 0	2 1 0	2 1 0
Urine Output	Has voided urine Unable to void but comfortable Unable to void and uncomfortable	2 1 0	2 1 0	2 1 0
	TOTAL SCORE			
	Nurse signature			

If score is 18 or greater, the patient is considered fit for discharge.

Please Note: No system covers all the social, psychological and physical elements necessary to ensure the patient is indeed fit for discharge. Clinical and professional judgement should be exercised in all decisions in relation to hospital discharge.

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Discharge Plan (to be commenced in Pre Assessment Clinic)

Any potential discharge problems identified and actions taken re same:

Signature:	**Date:**

	Nursing Instructions/Actions:		**Comments:**
Cannula/e removed	Yes ☐	Not applicable ☐	
Prescription given	Yes ☐	Not applicable ☐	
Temporary supply of medications dispensed from Pharmacy given.	Yes ☐	Not applicable ☐	
Day Care Unit *Patient Information & Advice* leaflet given	Yes ☐	Not applicable ☐	
Advice re removal of sutures / clips etc.	Yes ☐	Not applicable ☐	
Public Health Nurse referral sent	Yes ☐	Not applicable ☐	
Patient escorted from DCU by relative / friend / nominated person	Yes ☐	Not applicable ☐	
Follow-up appointments	Yes ☐	Not applicable ☐	

Any additional information:

Patient discharged from Day Care Unit at…….…… (time) on ……..(date).

Signature of Day Care Unit Nurse _____ Printed name: _____