Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Addressograph

Day Surgery Integrated Care Pathway
General Anaesthetic

Hospital Name			
Consultant			
Speciality			
Admission Date		**Time**	
Discharge date		**Time**	

Pre-Assessment	Addressograph

Pre-anaesthetic Date…….. **Time…….**

Planned Operation:

PERSONAL DETAILS

Home Telephone Number:		**Next of Kin**
Work Telephone Number:		**Name:**
Contact telephone Number:		**Relationship:**
Patient Known as:		**Address:**
Age:	**Occupation:**	
GP:		**Home Tel:**
Practice:		**Work Tel/Mobile:**
Preferred Language:		**Interpreter Required:**

Own Teeth **Yes No**	**Dentures** **Yes No**	**Crowns** **Yes No**
Bridge **Yes No**	**Loose/Broken Teeth** **Yes No**	**Patient Able to Open Mouth Wide** **Yes No**
Height **cms**	**Weight** **kgs**	**BMI**

Please record observations on NEWS chart.

Blood Glucose (if required) mmols

Addressograph

Any Known Allergies	Yes / No
If Yes Please List	

Please Tick Relevant Box	Yes	No	N/A
Do you wear Contact Lens?			
Do you wear a Hearing aid?			
Do you have a Pacemaker?			
Do you smoke? How many cigarettes (ounces of tobacco) per day……			
Do you drink alcohol? How many units per week? ……..			
Do you use or have you ever used any recreational drugs? Cannabis Cocaine Heroin Ecstasy Other Legal Highs			
Who will escort you home? ———————————————————-			
Will they supply you with suitable transport?			
Do you have a suitable adult to look after you for the first 24 hours?			
Do you have any broken skin, ulcers or pressure sores? If YES complete			
Are you able to Stand and transfer from a seat to a bed? If No complete manual handling form			
Any relevant social, domestic, mobility or communication problem?			

Addressograph

Are you taking:	Yes	No	If Yes Relevant investigations to be carried out
Anticoagulants			**FBC / INR**
Diuretics – Steroids – Lithium –			**U&E's / FBC**
Ace Inhibitors – Beta Blockers - Digoxin			**U&E's / FBC / ECG**

CURRENT MEDICATION

Including complimentary medicines/vitamins

	Yes	No	N/A
Is there any possibility you could be pregnant?			
Do you use oral contraceptives, a contraceptive injection or HRT?			
Date of last month period if applicable: Date:			
Pregnancy Test Result (Please circle relevant) Positive Negative			

Addressograph

Have you had any previous operations? Yes No (Delete as required)

Did you suffer any anaesthetic or surgical problems during or after your previous operations?

Has any member of your family had any complications with anaesthetics? Eg. Scoline Apnoea or Malignant Hyperthermia. If Yes (Family History of Scoline Apnoea) Bloods for Cholinesterase. Contact Path Lab Dept DGH and inform before you send the blood sample.	YES	NO

Have you ever been told you are at risk of CJD or vCJD for public health purposes? (If yes, practitioner to contact infection control team for advice).

MEDICAL HISTORY

Addressograph

Have you ever suffered from the following?	Yes	No	If Yes Relevant investigations to be carried out
A heart attack? Date:			Not Fit For Powys
Chest pain on exercise or at night (angina)?			ECG
High blood pressure?			U&E's / FBC / ECG
A heart murmur?			ECG
Rheumatic fever?			ECG
Shortness of breath?			Peakflow Result……
Chronic bronchitis?			Peakflow Result…… FBC / U&E's
Tuberculosis?			Organise Chest X-ray
Any recent chest infections? (In the last 6 months)			Organise Chest X-ray / Peakflow Result……
Asthma?			Peakflow Result……
Indigestion or heartburn?			None
A hiatus hernia?			None
Jaundice or liver infection?			LFT / Coagulation Screen
Diabetes?			BMS / U&E's / HbA1c
Kidney or urinary problems?			U&E's / FBC
Anaemia, sickle cell or thalassaemia?			FBC / HB / Electrophoresis
Excessive bleeding or bruising?			FBC / Coagulation Screen
Convulsions or fits?			None
A stroke/TIA?			None
Muscle disease or progressive weakness?			None
Arthritis?			FBC
Back or neck problems?			None
Hypo / Hyper Thyroidisim			U&E's / FBC / ECG / Thyroid Function Test

Addressograph

Have you any other conditions that we should be aware of?
Have you had COVID 19, if so were you in hospital?

Consenting to share information: Discuss with patient

Your information will be shared with anyone involved in your care and support – this is to help you so that you do not need to repeat information that you have already provided and to help those providing your care to have a better understanding of your needs.

Are you happy with us sharing information with your next of kin or carer? YES/NO
If no please give details

Is there anyone who you DO NOT wish us to share information with?
Details:

There may be students in the unit who are on placement. Please ask the patient if they are happy for student to be involved in their care? YES/NO

Please inform patient that even if they answer yes, they can withdraw their consent for students to be involved in their care at any time.

You are advised not to bring any property, including cash, valuables and jewellery into the hospital.

Do not bring dressing gown/we will provide a gown if you need to change for your procedure.

Powys Teaching Health Board accepts no responsibility for the loss or damage to personal property of any kind, in whatever way the loss or damage may occur.

Addressograph

Investigations Required			
Investigations	**Yes**	**No**	**Comments/Type**
FBC			
U&E			
MRSA Swabs			
Clotting			
ECG as per protocol			>65 years old requires an ECG
Peak Flow			
Pregnancy test			
Thyroid Function Test			
Urinalysis			
Other:			

Accepted for day surgery in	**BWMH**		**LWH**		
Referred to anaesthetist:	**Name:**				
Referred To GP:	**Name:**				
Referred to Consultant:	**Name:**				
Not Fit Forms Completed	**YES**		**NO**		
Reason and response:					

Transferred to waiting list at:	**NHH**		**HH**		**PCH**	
Reason for transfer to DGH Waiting List						

Name of Registered Pre-Assessment Practitioner:
Signature of Registered Pre-Assessment Practitioner:

Patient Details
(Affix addressograph)

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

COMPLETE AND PRESCRIBE PROPHYLAXIS ON DRUG CHART

Unless contraindicated:

All patients admitted for elective surgery lasting more than30 minutes should receive combined thromboprophylaxis with:

- Mechanical methods from admission, until mobile
- Pharmacological thromboprophylaxis * starting 6-12 hours after surgery until mobile

PHARMACOLOGICAL THROMBOPROPHYLAXIS

Does patient have contraindications to pharmacological thromboprophylaxis?

No

Yes

PHARMACOLOGICAL METHODS

Prescribe the following according to PTHB policy:

Enoxaparin (Clexane) 4000 units (40mg) s/c od

Pharmacological considerations

Decrease LMWH dose if creatinine clearance <30ml/min or use UFH

Consider dose increase in patients >110kg

Consider dose reduction in patients <50kg

Patients receiving LMWH or UFH need platelet count checking on day 6

MECHANICAL METHODS

Choose **one** of the following

Anti-embolism stockings

Intermittent pneumatic compression devices

Contraindications to mechanical methods

Arterial insufficiency

Cutaneous infections

Peripheral neuropathy

Recent skin graft

***Contraindications to pharmacological thromboprophylaxis (Please tick which is relevant)**

Acute bleeding or at risk of bleeding

Uncontrolled systolic hypertension ≥ 180 mmHg

Bacterial endocarditis, pericarditis or thoracic aneurysm

New-onset stroke or risk of central nervous system bleed e.g. head injury or previous SAH

Severe liver disease

Known bleeding disorder: discuss with haematologist

Thrombocytopenia: platelets count < 70 x10-^{9}/l

Previous heparin induced thrombocytopenia (use Fondaparinux)

Known heparin allergy (use Fondaparinux)

Admitted for terminal care or end of life pathway

Patient Details
(Affix addressograph)

Procedure……

Date District Nurse arranged if necessary ……

Reason for not prescribing pharmacological thromboprophylaxis:

On Day of Admission	Addressograph

Has respiratory questionnaire been completed? **Yes/No** *(Please delete as appropriate)* If NO, please document why questionnaire has not been completed.	If patient/carer answered YES to any questions in respiratory questionnaire, please record results of LFT test POSITIVE / NEGATIVE *(Please delete as appropriate)* Patient will be re-listed for procedure at a later date. Please inform anaesthetist and surgeon.

	Yes	No	N/A
Has the patient had any health problems since pre-assessment visit/phone call?			
Does the patient have a cough or cold?			
Has medication changed?			
Has the patient received post-op advice sheet?			
Confirm carer arrangements for 24 hours following patient care & escort home?			
WHO Surgical safety checklist explained?			

Has the Patient Starved **6 Hours for Solids Yes No** **3 Hours for Liquids Yes No** **2 Hours for Water Yes No**			
	Last Food at:	**Date**	**Time**
	Last Drink at:	**Date**	**Time**
	Last Water At:	**Date**	**Time**

On Day of Admission	Addressograph

Please record observations on admission on NEWS chart.

If applicable	Blood Glucose:	INR:

	Yes	No	N/A
Is there any possibility you could be pregnant?			
Date of last month period if applicable: Date:			
Pregnancy Test Result (Please circle relevant) Positive Negative			

Pre-operative Check list	Yes	No	N/A
Correct patient's identity			
Operation consent form signed & checked with operating list? Time:			
Site marked by surgeon? Time:			
Seen by Anaesthetist? Time:			
Notes, X-ray and relevant documents accompanying patient to theatre?			
Identity band in place? (Allergy band if required)			
All allergies noted?			
Dentures or prosthesis removed?			
Crowns or loose teeth noted?			
All jewellery removed or taped?			
Makeup and nail vanish removed?			
Hair clips removed and long hair secured?			
Urine recently passed?			
Pre-medication given if prescribed?			
Measurement for TED stocking if required?			
Ted Stockings Applied?			

Ted Stockings Please measure on admission	Right Leg	Calf: cm	Length cm
	Left Leg	Calf: cm	Length cm
	Size Required		

Anaesthetic Room	Addressograph

WHO Checklist Sign In Completed ……..

Please record observations on NEWS chart

PATIENT WARMED Yes / No ***(Please circle appropriate answer)***

Anaesthetic:

General	Local	Nerve Block	Spinal	Sedation	Other

Airway:

LMA	Endotracheal	Nasotracheal	Face mask	Other			
Size	Size	Size					
Eyes taped		Eye Pads		Throat Pack Yes / No			
Yes No		Yes No		Time IN:		Time OUT:	

Peripheral line:

Cannula Type	Size	Position

Monitors:

ECG Electrodes	Pulse Oximetry	Blood pressure cuff

Addressograph

Patients Position:

Supine	Left lateral	Right lateral	Prone	Semi Prone	Lithotomy/ Lloyd Davies	Other (specify)

Pressure relieving devices and attachments:

Flowtron Boots:		Heel pads:		Arm Board/Table:		Arm Guard	
Right Leg		Right Leg		Right		Right	
Left Leg		Left Leg		Left		Left	

TOURNIQUET YES / NO				
	Right Arm	Left Arm	Right Leg	Left Leg
Time On:				
Time Off:				
Pressure mmHg				
Total Length of time in Minutes				

Peri Operative Record	Addressograph

WHO Checklist Time Out Completed …….

Chlorhexidine alcohol base	Chlorhexidine aqueous base	Betadine alcohol base	Betadine aqueous base	Saline	Savlon	Other

Operation Performed:
Sutures: Absorbable / Non Absorbable **Description:**
Dressing:
Catheter/Packs:
Other Medication: (e.g. Suppositories, antibiotics etc)
Local Anaesthetic Name and Amount

	Minimal	Moderate	Excessive (please Measure)
Blood Loss			

SWAB COUNT	Yes	No	N/A
Instruments, blades, needles and swabs counted and found correct:			
Throat Pack/Swab removed:			

Diathermy				
Bipolar	**Monopolar**	**Pad Position**	**Site checked prior placing pad**	**Site checked On removal of Pad**
			INITIAL	**INITIAL**

Scrub Nurse Signature…….. Witness…….

Peri Operative Record	Addressograph

SPECIMENS Taken and Sent To: (Please Write Where Specimen Sent)……..

None	Number of Specimens	Histology	Cytology	Swab	Other

WHO Checklist Sign Out Completed
(before any member of the team leaves the operating room) ……..

Surgeon, Anaesthetist and Registered Practitioner confirm: **What are the key concerns for recovery and management of this patient?**
Name of Registered Practitioner:
Signature of Registered Practitioner:

Follow Up Requested:	None	Weeks	Months	Year

Tracer Form

Addressograph

Tracer Form Continued

Addressograph

OPERATION SHEET	Surname Mr. Mrs. Miss		Case No.
	FIRST NAMES		
Ward ……..	Or Addressograph		

Date

Surgeon ……..……...

Practitioner /Nurse/ODP ……

Anaesthetist …….

OPERATION SHEET CONTINUED:

Date

Allergies	Addressograph

Pre-Operative (once only drugs)

Date	Pre Procedure Medication	Dose	Route	Time to be given	Doctors signature	Administration Record	
						Given by	Time given
	Ametop Gel	1.5g	Topical				

Post Procedure and TTO Medication		Date	Time Given	Dose	Route	Given By	TTO's given to Patient	
Date	**Paracetamol 500mg**						Date	
Dose	Route **Oral**						Amount Given	
Signature	Frequency						Given By	
Date	**Ibuprofen Tablets 200mg**						Date	
Dose	Route **Oral**						Amount Given	
Signature	Frequency						Given By	
Date	**Ibuprofen Tablets 400mg**						Date	
Dose	Route **Oral**						Amount Given	
Signature	Frequency						Given By	
Date	**Codeine Phosphate 15mg**						Date	
Dose	Route **Oral**						Amount Given	
Signature	Frequency						Given By	
Date	**Codeine Phosphate 30mg**						Date	
Dose	Route **Oral**						Amount Given	
Signature	Frequency						Given By	
Date	Medicine						Date	
Dose	Route						Amount Given	
Signature	Frequency						Given By	

Allergies	Addressograph

Post Procedure Medication AS REQUIRED		Date	Time Given	Dose	Route	Given By
Ondansetron	Frequency **8 Hourly PRN**					
Dose 4mg	Route **IV/IM**					
Signature	Date					
Cyclizine	Frequency **8 Hourly PRN**					
Dose 50mg	Route **IV/IM**					
Signature	Date					
Prochlorperazine	Frequency **8 Hourly PRN**					
Dose 12.5mg	Route **IV/IM**					
Signature	Date					
Metoclopramide	Frequency **8 Hourly PRN**					
Dose 10mg	Route **IV/IM**					
Signature	Date					
Naloxone	Frequency **As Required**					
Dose 400mcg	Route **IV**					
Signature	Date					
Morphine Sulphate	Frequency **PRN**					
Dose 10mg	Route **IV/IM**					
Signature	Date					
Oramorph	Frequency **PRN**					
Dose 10mg/5ml	Route **Oral**					
Signature	Date					
Medicine	Frequency					
Dose	Route					
Signature	Date					

Recovery	Addressograph

Please record observations on NEWS chart.

Time:									
Wound Assessment/ PV Loss									
Pain Assessment									

Wound/PV Loss: **1**. Dry **2**. Slight Leakage **3**. Moderate Leakage **4**. Heavy leakage

Pain: 0 to 10 pain scale

Recovery Record:
Medication in Recovery:
Catheter/Drains Out Put:
Name of Recovery Practitioner:
Signature of Recovery Practitioner:

DAILY INTAKE-OUTPUT CHART

(Not to be filed in Medical Records)

Surname Mr./Mrs./Miss		Case No.
First Names		

Bodyweight .....

24hrs from ..... on ..... to ..... on .....

INSTRUCTIONS FOR 24 HOURS (PARENTERAL)

All intravenous fluid therapy and drug additives to these fluids must be prescribed on the **"INTRAVENOUS FLUIDS AND DRUG ADDITIVES"** form provided. Please refer to this form for fluid volumes which will be required when completing the **INTAKE** section below. (H.M.R. 111(W) IV).

NOTE The "Type" heading below refers to the particular fluids prescribed in the numbered section on the **"INTRAVENOUS FLUID AND DRUG ADDITIVES"** form.

INSTRUCTIONS FOR 24 HOUR (ORAL)

TIME	INTAKE						OUTPUT					
	INTRAVENOUS FLUIDS			ORAL		Other	URINE		Gastric		Drainage	Other
	Type	Vol. set up	given vol.	Vol.	Type	Vol.	Vol.	S.G.	Vol.	Nature	Vol.	Vol.
c/f												
12 hour Total												
12 hour Total												
24 hour Total												

CUMULATIVE BALANCE + −

WH011 H.M.R. 210A (W)82 (WKJ120X)

Ward Post Procedure Observations	Addressograph

Please record observations on NEWS chart

Time:								
Wound Assess/ PV Loss								
Pain Assessment								
Blood Glucose (If appropriate)								

Wound + PV Loss: **1**. Dry **2**. Slight Leakage **3**. Moderate Leakage **4**. Heavy leakage
Pain: 0 to 10 pain scale

Date:	Patient's Record:	Signature:

Ward
Nursing Record Continued

Addressograph

Date:	Patient's Record:	Signature:

Discharge Criteria + Assessment

Addressograph

Criteria	Yes	No	N/A	Advised
Alert & orientated?				
Vital signs stable?				
Wound checked?				
Pain controlled?				
Eating and drinking?				
Nausea controlled?				
Urine passed?				
Transport arranged?				
Escort confirmed?				
Home care confirmed?				
Phone Call Confirmed?				
Take home medication provided?				
Supply of dressings if required?				
Instructions given regarding suture removal / dressing change?				
Out patient appointment arranged?				
Post-operative instructions given?				
Copy of discharge summary provided?				
Referred to Practice Nurse?				
Referred to District Nurse?				
Referred to Physiotherapist?				
Referred to other (specify)				
Cannula, ECG electrodes and name band removed?				

Nurse's signature: ……

Discharge time: ……. **Date:**……

Admission/names/times/discharge completed on WPAS	

Not Fit For Discharge	Addressograph

Not Fit for discharge
Specific reason: **Admitted to:** **Time:** **Consultant informed:** **GP Informed:** **Relatives informed:** **Please ensure all discharge documents are completed prior to discharge from ward.**

24 Hour Post Procedure Telephone Call

Addressograph

Operation Performed …….

Date of Procedure:……. Patient's Phone Number:…….

Spoke to:	**Patient**		**Family**	

1st Attempt Date:……. Time:……Comments:…… Initials:……

If no answer please leave the following message:
THIS IS THE STAFF CALLING FROM THE HOSPITAL WITH A COURTESY CALL FOLLOWING YOUR PROCEDURE ON _____ (Insert date)
IF YOU HAVE ANY CONCERNS, PLEASE CALL US ON 01874 615815 (Brecon) OR 01597 828725 (Llandrindod)
(please use appropriate number)
Please DO NOT leave your name in the message.

If any concerns has relevant team leader been informed Y/N

Is the patient experiencing the following	**Yes**	**No**	**N/A**	**Comments**
Bleeding at the operation site?				
Pain from the surgery?				
Is it relieved with medication?				
Sore Throat?				
Elevated temperature?				
Difficulty passing urine?				
Numbness pain in extremities?				
Patient has returned to normal diet?				
Could we have done anything different for you during your surgical experience?				

How did you find the service and care?

Name of Practitioner:
Signature of Practitioner:

NEWS2 CHART

NEWS2 CHART

National Early Warning Score (NEWS) Form

NEWS Score	ACTION
0 - 2	Continue observations at 12-hour intervals or as necessary.
3 - 5	**THREAT:** Inform nurse in charge and consider if patient has **sepsis**. For in-patients, if no sepsis, repeat observations after one hour. If stable observe every 6 hours or as necessary.
6 - 8	**SICK**: Inform nurse in charge. Consider **sepsis**. Repeat observations after 10 minutes. If still scoring ≥ 6 seek doctor's advice immediately.
9 or more	**NOW**: Have **Urgent** conversation with doctor to consider if **urgent** transfer needed if patient is not palliative care

When making an assessment or determining a NEWS score, please consider the patient's baseline observations

Note that this tool does not replace your clinical judgement when assessing a patient. If *anything* gives concern increase observations and/or request medical review.

Should patient score a NEWS of 3 or above, **begin the Sepsis Detection Tool.**

Actions and Notes

CAVPU.

C stands for new or increased confusion. If a patient shows new or increased confusion score 3. If a patient is Unresponsive (U), or responds only to Voice (V) or Pain (P) score 3.

Accept ≥ (equal to or more than) or ≤ (equal to or less than) guidance.

Some patients with long term conditions may always give observation values that generate a NEWS score. Continue to score as normal but ask the doctor to decide whether a certain level of scoring can be accepted without triggering the need for increased observation, medical intervention or transfer.

In the event of an acutely altered mental state alone consider monitoring the patient's blood glucose.