ADMISSION ASSESSMENT AND HISTORY – DAY/NIGHT CARE: SURGERY – PEDIATRICS

Date/Time of Pre-admission: ☐ See Notes	**Admission Date/Time:**
	Reviewed and completed by: ☐ See Notes
Language spoken/understood: ☐ En ☐ Fr ☐ Other: ☐ Translator required	**Age**
Diagnosis:	
Procedure and Date Booked:	☐ **Consult** ☐ **Consent** *on pt record*
Key Contact: *(name, relationship, ph#)* ☐Parent ☐ Personal Guardian Copy of document ☐ Personal Guardian	
Advance Care Plan: Goals of Care completed ☐ Yes ☐ No ☐ on file	Location:
Allergies: *(describe reaction(s))* ☐ None Known ☐ Medi Alert on ☐ Agency Alert on ☐ Facility specific Allergy/Intolerance record completed *(if applicable)* ☐ Drug:	☐ Food: ☐ Latex: ☐ Environment:
Test(s)/X-ray(s) completed to date: ☐ **On Record** ☐ CBC ☐ Electrolytes ☐ UA ☐ CXR ☐ ECG ☐ Crossmatch ☐ Other:	

		Yes	No	
PH	**Personal care assistance**			☐ Preop bath done
	Devices brought			Retainers:☐ U ☐ L Braces:☐ U ☐ L ☐ Loose teeth ☐ Glasses ☐ Contact lens Hearing aid: ☐ Rt ☐ Lt
ELIM	**Bowel problems**			Date of last BM:
	Bladder problems			☐ Toilet trained
NUTR	**Feeding assistance**			Diet: ☐ Reg ☐ Other: ☐ Breast feeding ☐ Bottle ☐ Cup ☐ Formula:
				☐ NPO Last ate: Last drank:
MOB	**Ambulation assistance**			☐ Rolls over ☐ Sits up ☐ Crawls ☐ Climbs ☐ Walks
	Devices brought			☐ Wheelchair ☐ Prosthesis *(list)*

OBSERVATIONS AND MEASUREMENTS

T °C	**P**(per min)	**R**(per min)	**BP**	**SpO_2 %**	**Apical Pulse**	**Wt**(kg)	**Ht**(cm)	**Pedal Pulse(s)** (Rt) (Lt)	**LMP** ☐ NA

Pain ☐Unable to verbalize pain
Provoked by:
Quality: ☐Sharp ☐Dull ☐Stabbing ☐Burning ☐Crushing ☐Intermittent ☐Occasional ☐Other:
Radiates/ Location:
Severity: 0 1 2 3 4 5 6 7 8 9 10
Time (when it started, how long it lasts):

Systems Assessment *(CNS, CVS, Resp., GI, GUR, MS, Integ, EENT)*

☐ See Assessment Addendum – Pediatrics

Immunizations up to date ☐ Yes ☐ No *(If no, why not?)*

History pertinent to this admission: *(include previous surgery/anesthesia/reactions)*

Exposure to:	Yes	No
HIV		
Hepatitis		
TB		
Other:		
Other:		

Has had:	Yes	No
Rubella		
Chicken Pox		
Measles		
Mumps		
Other:		
Other:		

History of ARO: ☐ Unknown ☐ No ☐ Yes *(list)*

☐ Facility ARO screening tool completed *(if applicable)*

MED **Current Medications:** ☐ NA ☐ See BPMH **Pharmacy of Choice** *(Name and Location):*

		Yes	No	
TX & PRO	**Previous blood transfusion(s)** *(describe reactions, if any)*			
	Present treatments			☐ Home Care ☐ O_2 ☐ Physiotherapy ☐ Chiropractor ☐ Massage Therapy ☐ Complementary Therapies: *(describe)* ☐ Other:
TE	**Learning needs**			☐ Refer to Preop/Postop Teaching Record
S	**Safety needs**			
PSYCHOSOCIAL	**Assistance available on discharge**			Name and Phone #:
	Diversional activities			☐ Soother ☐ Blanket ☐ Favourite toy
	Alcohol use in last 24hrs *(If yes, when, how much)*			
	Smoker in home *(# per day)*			
	Illicit drugs used *(describe)*			☐ Patient use ☐ In the home
	Mental, emotional, behavioural status			

Valuables: ☐ Locked ☐ At bedside **Orientation to: ☐ Layout ☐ Routine** **ID**

INDIVIDUAL CARE PLAN – DAY/NIGHT CARE: SURGERY

Date of Surgery_____

	INITIATOR	DESIRED OUTCOME	Outcome Met / ID	Time Init'd / ID	INTERVENTIONS	Time disc / ID
PERSONAL HYGIENE	self care deficit	Resumes self care			Pre-op bath with Chlorhexidine or	
	r/t effects of surgery				Other: _____	
					Assist with	
					Independent	
ELIMINATION	R/f urinary retention r/t effects of	Voids 1 hour prior to surgery			Note pre-op void	
	anesthesia	Voids before discharge			Post-op, assist to BR and note first voiding	
					Independent	
NUTRITION	R/f impaired swallowing r/t effects of	No choking			NPO	
	anesthesia	No regurgitation			Diet: clear fluids	
					full fluids	
					full diet	
					Independent	
MOBILITY	Impaired physical mobility r/t effects of	No injury			Bed rest following preop med	
	medication	Resumes previous level			Up with assistance first time postop and	
					prn	
					Independent	
OBS AND MEAS	R/f altered VS r/t effects of surgery	Early detection of			VS and BP q15min x , q30min x	
		complications			then q	
	Acute pain r/t effects of surgery	Pain relief			I and O	
					Pain assessment q	
MEDS					See Med record	
					See IV record	
TX AND PRO	Impaired skin integrity r/t surgical	Early detection of			Surgery prep	
	procedure	complications			Observe dressing/operative site q	
					Dressing reinforcement prn	
TEACHING	Knowledge deficit r/t surgical procedure	Demonstrates ability to follow			Explain diagnostic tests, procedures and	
		pre/post-op instructions			pre/post-op teaching	
SAFETY	R/f injury r/t	No injury			Side rails up when on stretcher/crib	
					Call bell within reach	
PSYCHOSOCIAL	Anxiety r/t surgical procedure	Verbalization for ↓ feelings			Keep pt/significant other informed re:	
		of anxiety			progress and encourage verbalization	
					of feelings	

RECORD OF CARE – DAY/NIGHT CARE: SURGERY

DATE

TIME / / / / / / / / / / / / / /

VITAL SIGNS

230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

BP v ^

P ●

Temp

Resp

SpO₂

Pain *(0-10)*

ID

WOUND/DRESSINGS

Site:

Dressing Type:

Packing: *(describe including count)*

☐ Dry and Intact on Admission

Notes:

☐ See Wound Record

INTAKE AND OUTPUT RECORD

TIME	ORAL	EMESIS	URINE	DRAINAGE	OTHER	ID

IV FLUIDS

TIME	IV SOLUTION / AMOUNT (mLs)	RATE (per min)	ADDITIVES	NEEDLE SIZE / TYPE / SITE	AMT ABSORBED (mLs)	COMMENTS	ID
				IV Total			

MEDICATIONS

TIME	MEDICATION	DOSE	ROUTE	FREQ	COMMENTS	ID

CHECKLIST AND NEEDS ASSESSMENT – DAY/NIGHT CARE: SURGERY

PREOPERATIVE CHECKLIST	UNIT			OR			COMMENTS
Patient detail:	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**	
ID Band on							
Allergy Band on							
Medi Alert Bracelet on							
Hospital gown on							
NPO since:							
Make up/nail polish removed							
Denture/Partial/Retainer removed							
Contact lens removed/glasses							
Prosthesis removed							
Jewelry ☐ removed ☐ secured							
Voided in last hour							
Preop med given at:							
VS/BP taken within last hr(s)							
On patient record:	**Yes**	**No**	**NA**	**Yes**	**No**	**NA**	
Consent signed							
Lab results							
ECG results							
Dr's history and physical							
Nurse's assessment							
Consultation report							
BP, Ht, Wt on anaesthetic record							
Addressograph							

Time to OR: **By:** ☐ Stretcher ☐ Wheelchair ☐ Walking	**ID**	**Time received in OR:**	**ID**

NEEDS ASSESSMENT						DISCHARGE CRITERIA				
	PREOP	**POSTOP**		**PREOP**	**POSTOP**		**Yes**	**No**	**NA**	**Comments**
Obtain baseline data	4 / 1	1	IV/Blood products	1	1	Alert/Oriented				
Hygiene/Skin/Oral	2	2	Respiratory treatment	1	1	Voided				
Undress/Dress	1	1	Suctioning		2	Ambulated				
Bowel management	1	1	Tubes	1	1	Diet/Fluids tolerated				
Bladder management	1	1	Skin/Wound *(prep/care)*	1	1	Vital Signs stable				
Mobility : assist		2	Specimen collection	1	1	Pain controlled				
: restricted	1		Special procedures	2	2	Drsg dry and intact				
Monitor feeding		1	Teaching *(pt/significant other)*	1	1	Rx given				
NPO	1	1	Safety measures	0.5	0.5	Meds returned				
Assess : q2h or ↓	1	1	Emotional *(pt/significant other)*	1	1					
: q1h or ↑		2	Behaviour mgmt *(pt/significant other)*	1	1					
I and O		1	Communication difficulties	1	1					
Medication(s)	0.5	0.5								
Totals (a)			**Totals (b)**			Date/Time of Discharge:				
			Totals (a) and (b)							
			Category			Accompanied by:				
			ID							**ID**

Category	Points
1	1-7
2	8-14
3	15-21
4	22 or more