

ADMISSION ASSESSMENT AND HISTORY – DAY/NIGHT CARE: SURGERY

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|---|---|--|-------------|--|-----------|--------------------|--|--------|--------|------------------------|-----------------------------|---|-----|----|--|
| Pre-admission Date/Time: | | Admission Date/Time: | | | | | | | | | | | | | |
| <input type="checkbox"/> See Notes | | Reviewed and completed by: | | | | | | | | | | | | | |
| <input type="checkbox"/> See Notes | | <input type="checkbox"/> See Notes | | | | | | | | | | | | | |
| Language spoken/understood: <input type="checkbox"/> En <input type="checkbox"/> Fr <input type="checkbox"/> Other: | | <input type="checkbox"/> Translator required | Age | | | | | | | | | | | | |
| Diagnosis: | | | | | | | | | | | | | | | |
| Procedure and Date Booked: | | <input type="checkbox"/> Consult <input type="checkbox"/> Consent <i>on pt record</i> | | | | | | | | | | | | | |
| Key Contact: <i>(name, relationship, ph#)</i> | | | | | | | | | | | | | | | |
| Legal Substitute Health Care Decision Maker: <input type="checkbox"/> as above <input type="checkbox"/> Proxy <input type="checkbox"/> Personal Guardian <input type="checkbox"/> Nearest relative <i>(name, relationship, ph#)</i> | | Copy of documents <input type="checkbox"/> Proxy <input type="checkbox"/> Personal Guardian | | | | | | | | | | | | | |
| Advance Care Plan (Health Care Directives): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> on file | | Allergies: <i>(describe reaction(s))</i> <input type="checkbox"/> None Known <input type="checkbox"/> Medi Alert on <input type="checkbox"/> Agency Alert on <input type="checkbox"/> Facility specific Allergy/Intolerance record completed (if applicable) <input type="checkbox"/> Drug: <input type="checkbox"/> Food: <input type="checkbox"/> Latex: <input type="checkbox"/> Environment: | | | | | | | | | | | | | |
| Location: | | | | | | | | | | | | | | | |
| Test(s)/X-ray(s) completed to date: <input type="checkbox"/> On Record <input type="checkbox"/> CBC <input type="checkbox"/> Electrolytes <input type="checkbox"/> UA <input type="checkbox"/> CXR <input type="checkbox"/> ECG <input type="checkbox"/> Crossmatch <input type="checkbox"/> Other: | | | | | | | | | | | | | | | |
| PH | Personal care assistance | Yes | No | <input type="checkbox"/> Preop bath done | | | | | | | | | | | |
| | Devices brought | | | Dentures: <input type="checkbox"/> U <input type="checkbox"/> L <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lens Hearing aid: <input type="checkbox"/> Rt <input type="checkbox"/> Lt | | | | | | | | | | | |
| ELIM | Bowel problems | | | Date of last BM: | | | | | | | | | | | |
| | Bladder problems | | | | | | | | | | | | | | |
| NUTR | Feeding assistance | | | Diet: <input type="checkbox"/> Reg <input type="checkbox"/> Other: <input type="checkbox"/> NPO Last ate: Last drank: | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| MOB | Ambulation assistance | | | | | | | | | | | | | | |
| | Devices brought | | | <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Prosthesis <i>(list)</i> <input type="checkbox"/> See Mobility Record | | | | | | | | | | | |
| OBS AND MEAS | T °C | P (per min) | R (per min) | BP | BG mmol/L | SpO ₂ % | Apical Pulse | Wt(kg) | Ht(cm) | Pedal Pulse(s) (Rt) | LMP | Exposure to: | Yes | No | |
| | | | | | | | | | | (Lt) | <input type="checkbox"/> NA | HIV | | | |
| | | | | | | | | | | | | Hepatitis | | | |
| | | | | | | | | | | | | TB | | | |
| | Pain <input type="checkbox"/> Unable to verbalize pain Provoked by: Quality: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Stabbing <input type="checkbox"/> Burning <input type="checkbox"/> Crushing <input type="checkbox"/> Intermittent <input type="checkbox"/> Occasional <input type="checkbox"/> Other: Radiates/ Location: Severity: 0 1 2 3 4 5 6 7 8 9 10 Time (when it started, how long it lasts): | | | | | | | | | | | Other: | | | |
| | Systems Assessment <i>(CNS, CVS, Resp., GI, GUR, MS, Integ, EENT)</i> <input type="checkbox"/> See Assessment Addendum - Ambulatory | | | | | | | | | | | History of ARO: <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(list)</i> | | | |
| | History pertinent to this admission <i>(include previous surgery/anesthesia/reactions)</i> History of Myasthenia gravis <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | Facility ARO screening tool completed <i>(if applicable)</i> | | | |
| | <input type="checkbox"/> Facility VTE screening tool completed <i>(if applicable according to facility specific policy)</i> | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| MED | Current Medications: <input type="checkbox"/> NA <input type="checkbox"/> See Best Possible Medication History (BPMH) | | | | | | | | | | | | | | |
| | Pharmacy of Choice <i>(Name and Location)</i> : | | | | | | | | | | | | | | |
| TX PRO | Previous blood transfusion(s) <i>(describe reactions, if any)</i> | Yes | No | | | | | | | | | | | | |
| | Present treatments | | | <input type="checkbox"/> Home Care <input type="checkbox"/> O ₂ <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Chiropractor <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Complementary Therapies: <i>(describe)</i> <input type="checkbox"/> Other: | | | | | | | | | | | |
| TE | Learning needs | | | <input type="checkbox"/> Refer to Preop/Postop Teaching Record | | | | | | | | | | | |
| S | Safety needs | | | <input type="checkbox"/> Facility-specific falls risk assessment completed | | | | | | | | | | | |
| PSYCHOSOCIAL | Assistance available on discharge | | | Name and Phone #: | | | | | | | | | | | |
| | Alcohol use in last 24 hours <i>(if yes, when and how much?)</i> | | | | | | | | | | | | | | |
| | Smoker <i>(# per day)</i> | | | | | | | | | | | | | | |
| | Illicit drugs used <i>(describe)</i> | | | | | | | | | | | | | | |
| | Mental, emotional, behavioural status | | | | | | | | | | | | | | |
| Valuables: <input type="checkbox"/> Locked <input type="checkbox"/> At bedside | | | | | | | Orientation to: <input type="checkbox"/> Layout <input type="checkbox"/> Routine | | | | | ID | | | |

INDIVIDUAL CARE PLAN – DAY/NIGHT CARE: SURGERY

Date of Surgery _____

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

| DATE | | | | | | | | | | | | |
|-------------|---|--|------|--------|-------|----------|-------|----|---|---|---|---|
| VITAL SIGNS | TIME | / | / | / | / | / | / | / | / | / | / | / |
| | 230 | | | | | | | | | | | |
| | 220 | | | | | | | | | | | |
| | 210 | | | | | | | | | | | |
| | 200 | | | | | | | | | | | |
| | 190 | | | | | | | | | | | |
| | 180 | | | | | | | | | | | |
| | 170 | | | | | | | | | | | |
| | | WOUND/DRESSINGS | | | | | | | | | | |
| | BP | Site: | | | | | | | | | | |
| | ∨ | Dressing Type: | | | | | | | | | | |
| | ∧ | Packing: <i>(describe including count)</i> | | | | | | | | | | |
| | | <input type="checkbox"/> Dry and Intact on Admission | | | | | | | | | | |
| | | Notes: | | | | | | | | | | |
| | 130 | | | | | | | | | | | |
| 120 | | | | | | | | | | | | |
| 110 | | | | | | | | | | | | |
| 100 | | | | | | | | | | | | |
| 90 | | | | | | | | | | | | |
| 80 | | | | | | | | | | | | |
| 70 | | | | | | | | | | | | |
| 60 | | | | | | | | | | | | |
| | <input type="checkbox"/> See Wound Record | | | | | | | | | | | |
| | INTAKE AND OUTPUT RECORD | | | | | | | | | | | |
| | | TIME | ORAL | EMESIS | URINE | DRAINAGE | OTHER | ID | | | | |
| 50 | | | | | | | | | | | | |
| 40 | | | | | | | | | | | | |
| 30 | | | | | | | | | | | | |
| | Temp | | | | | | | | | | | |
| | Resp | | | | | | | | | | | |
| | SpO ₂ | | | | | | | | | | | |
| | Pain (0-10) | | | | | | | | | | | |
| | ID | | | | | | | | | | | |

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

| MEDICATIONS | TIME | MEDICATION | DOSE | ROUTE | FREQ | COMMENTS | ID | |
|-------------|------|------------|------|-------|------|----------|----|--|
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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 <input type="checkbox"/> removed <input type="checkbox"/> 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 | | | | | | | |
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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 | VS 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: | | | | |
| Category | Points | | Totals (a) and (b) | | | Accompanied by: | | | | |
| 1 | 1-7 | | Category | | | ID | | | | |
| 2 | 8-14 | | ID | | | ID | | | | |
| 3 | 15-21 | | | | | | | | | |
| 4 | 22 or more | | | | | | | | | |