West Hertfordshire Hospitals NHS
NHS Trust

CONFIDENTIAL PATIENT INFORMATION
DAY SURGERY
PATIENT PREPARATION

Date of Pre Operative Assessment:	Date of Surgery:

Patient Details – use addressograph where possible

Hospital Number: Surname: First Name: Address: Date of Birth: Sex:	Age: Telephone Number: Occupation: Religion:

Next of Kin Details – Will this person be escorting you home? Yes / No

Name: Address:	Relationship: Telephone Number:

Friend / Partner if preferred as first point of contact – Will this person be escorting you home? Yes / No

Name: Address:	Relationship: Telephone Number:

Escort Details if different from above

Name: Address:	Relationship: Telephone Number:

General Practitioner Details

Name: Address:	Telephone Number:

Address label

FOR HOSPITAL USE ONLY

Consultant ……..

Assessed by……..RGN…….HCA

Assessment Date ……

Operation date if known ……..

Planned operation ……..

……
Day case

Groin hernia/ Varicose vein patients
PROMS completed / Not required

Discharge Planning - **IMPORTANT SECTION FOR PATIENTS TO COMPLETE**

	Yes	No
Do you currently have community support – perhaps Home help, District nurse, Meals on Wheels, Intermediate Care.	☐	☐

If Yes, patient needs to make arrangements to stop and restart community support

I agree to make arrangements to have this care restarted on my discharge.…….
Patients' signature

Your surgery may be cancelled if you have not made arrangements to be in the company of a responsible adult for 24 hours after your surgery.

I am the patient / parent / guardian (delete as necessary).
I undertake not to drive a car, ride a bicycle or operate machinery for 24 hours after my general anaesthetic.
I am aware that any legal documents that I sign within 24 hours of having anaesthetic may be invalid.
I shall not drink alcohol for 24 hours after my general anaesthetic.
A responsible person will accompany me home after my admission.
I shall be in the company of a responsible adult for 24 hours after my anaesthetic.
I have access to a telephone for 24 hours after my discharge.
I understand the hospital is not accountable for my possessions.

Signature (of patient/parent/guardian) …….

All patients in readiness for your discharge following your surgery – please make certain that you have shopping, heating, travel arrangements in place prior to your admission for surgery. Patients having joint replacement please complete your Occupational Therapy form and have the appropriate equipment in your home prior to admission.

Communication needs

Is the patient able to communicate in English	Yes / No	
Is an Interpreter needed	Yes / No	If yes arranged Yes / No
Is sign Language required?	Yes / No	If yes arranged Yes / No
Do you have hearing difficulties	Yes / No	On admission, patient to bring hearing aids
Do you wear Contact lenses	Yes / No	On admission, patient to bring in container for lenses
Dentures / loose teeth/caps/crowns (circle)		On admission, patient to bring a pot for dentures
Do you have any body piercings?		All body piercings including earrings to be removed prior to admission

Medical History – DO YOU CURRENTLY HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH:-

	YES	NO	Date diagnosed -
Heart disease incl pacemaker	☐	☐	
MI (heart attack)	☐	☐	
Hypertension (high Blood pressure)	☐	☐	
Angina (chest pain)	☐	☐	
DVT/PE (blood clots)	☐	☐	
Stroke (CVA / TIA)	☐	☐	
Diabetes Type 1 / 2	☐	☐	Controlled by: Diet ☐ Tablets ☐ Insulin ☐
Epilepsy	☐	☐	
Jaundice	☐	☐	
Gastric acidity, hiatus hernia, Irritable bowel	☐	☐	
Kidney disease	☐	☐	
Arthritis	☐	☐	Type: Osteo ☐ Rheumatoid ☐
Asthma	☐	☐	Peak Flow ……..L/min (If less than 360 to see RGN)
Chronic respiratory disease	☐	☐	Peak Flow ……..L/min (If less than 360 to see RGN)
Thyroid disorders	☐	☐	

Sickle cell status (if relevant) N/A ☐ Positive ☐ Carrier ☐ Negative ☐

	Yes	No
Have you ever been notified that you are at risk of CJD or vCJD for public health purposes?	☐	☐

	Yes	No
Female patients:		
Are you currently pregnant?	☐	☐
Is there a possibility you may be pregnant?	☐	☐
All patients:		
Do you have any other health conditions	☐	☐

If yes, please write below:-

Previous Operations

Date / Year Approximate	Operation	Hospital

	Yes - please describe	No
Have you or your blood relatives had any problems following anaesthetic?		

Medication prescribed and purchased over the counter medicines/ “health products”
Patients taking OCP/HRT should be provided with the pharmacy advice sheet re cessation

Drug	Dose	Frequency

	Yes	No
Do you take vitamin supplements	☐	☐
Do you take recreational drugs?	☐	☐
Have you had any steroids or antidepressant drugs in the last six months?	☐	☐

Allergies: Are you allergic to any Drugs/Antiseptics/Latex /Food Allergies/Intolerances/Plasters/Metals **Yes / No**
If yes, please state your allergy

Prescribed products to be stopped prior to operation – Provide patient with written confirmation.
Non prescribed including ALL vitamin / mineral supplements to be stopped 2/52 pre op.

Date of operation	Drug	Date of last dose

RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE) IN ADULTS

All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes

All medical, surgical, obstetric inpatients and day cases should be considered for thromboprophylaxis.
A formal risk assessment of thrombotic (VTE) and bleeding risk should be a carried out on admission or in the Pre operative assessment clinic.

Exclusions- tick relevant box if appropriate

- Haemodialysis □
- Endoscopy □
- Chemotherapy □
- Ophthalmological procedures with local anaesthetic/regional/ sedation and not full general anaesthetic □
- Non-cancer ENT surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic □
- Non-cancer plastic surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic □
- Non-cancer dental and maxillo-facial surgery lasting less than 90 minutes with local anaesthetic/regional/ sedation and not full general anaesthetic □
- Other similar minor procedures lasting less than 90 mins with local/regional sedation and not full general anaesthetic □

STEP ONE
Assess **all** patients admitted to hospital for level of mobility (tick one box).

STEP TWO
Review the patient-related factors shown on the assessment sheet against **thrombosis** risk, ticking each box that applies (more than one box can be ticked).

Any tick for thrombosis risk indicates HIGH risk of VTE, refer to page 3 of this form and also the WHHT "Anticoagulation and thromboprophylaxis guidelines"
If no box is ticked for thrombosis risk, the patient is at low risk of VTE.
The risk factors listed are not exhaustive; clinicians may consider additional risks in individual patients and offer thromboprophylaxis.

STEP THREE
Review the patient-related factors shown against **bleeding risk** and tick each box that applies (more than one box can be ticked).

Any tick should prompt clinical staff to consider if bleeding risk is sufficient to preclude pharmacological intervention.

STEP FOUR
Date and sign risk assessment form
Prescribe thromboprophylaxis in accordance with WHHT guideline for thromboprophylaxis following VTE risk assessment.

Adapted from Department of Health, VTE risk assessment template, Department of Health: London, March 2010

Hospital No
Surname
First Name
D.O.B.

West Hertfordshire Hospitals NHS
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RISK ASSESSMENT FOR VENOUS THROMBOEMBOLISM (VTE)

All patients should be risk assessed on admission to hospital. Patients should be reassessed within 24 hours of admission and whenever the clinical situation changes

STEP ONE		**MOBILITY– all patients (tick one box)**					
Surgical patient	**Tick**	Medical patient expected to have ongoing reduced mobility.	**Tick**	Medical patient NOT expected to have significantly reduced mobility.	**Tick**	Excluded patient	**Tick**
Assess thrombosis (VTE) and bleeding risk (STEP TWO AND THREE)				**Risk assessment now complete**			

STEP TWO		**THROMBOSIS (VTE) RISK**	
Patient related	**Tick**	**Admission related**	**Tick**
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age > 60		Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgical time > 90 minutes	
Obesity (BMI > 30 kg/m2)		Surgery involving pelvis or lower limb with a total anaesthetic + surgical time > 60 minutes	
One or more significant medical comorbidities (eg heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Personal history or first-degree relative with a History of VTE		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing contraceptive therapy			
Varicose veins with phlebitis			
Pregnancy or up to 6 weeks post partum (see separate obstetric guidance)			

STEP THREE		**BLEEDING RISK**	
Patient Related	**Tick**	**Admission related**	**Tick**
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorders (such as acute liver failure)		Other procedure with high bleeding risk	
Concurrent use of anticoagulants known to increase the risk of bleeding (such as Warfarin with INR >2)		Lumbar puncture/epidural/spinal anaesthesia expected within **next 12 hours (Heparin)** or **18 hours (Rivaroxaban)**	
Acute stroke (see Risk Assessment Guidance notes in Appendix to Anticoagulation Policy)		Lumbar puncture/epidural/spinal anaesthesia within **previous 4 hours (heparin) or 6 hours (Rivaroxaban)**	
Platelets <75 x 10^9/l, check on admission			
Uncontrolled hypertension (230/120 mmHg or higher)			
Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease)			

Preoperative assessment date: Name: Signed: Assessment to be confirmed by doctor on admission	On admission, date/time: Name: Signed:

STEP FOUR		RISK OF VTE			
HIGH Risk of VTE with low risk of bleeding		**HIGH Risk of VTE with significant risk of bleeding**		**Low risk of VTE**	
(1 or more ticks in Step 2, no tick in Step 3)	Tick	(1 or more ticks in Step 2, 1 or more ticks in Step 3)	Tick	(No ticks in Step 2)	Tick

	SURGICAL PATIENTS	**MEDICAL PATIENTS**
Risk of VTE	**Recommended prophylaxis**	**Recommended prophylaxis**
HIGH risk of VTE with low risk of bleeding	Enoxaparin 40 mg daily* + Anti-embolic stockings +/- sequential compression device + Early mobilisation	Enoxaparin 40 mg daily (**must be written up and given on the day of admission)** + Early mobilisation
HIGH risk of VTE With significant Risk of bleeding	Anti-embolic stockings +/- sequential compression device (SCD) + Early mobilisation	Anti-embolic stockings +/- sequential compression device (SCD) + Early mobilisation (Do NOT use anti-embolic stockings in stroke patients)
LOW risk of VTE	Early mobilisation	Early mobilisation

- **use Rivaroxaban 10 mg daily in elective hip or knee arthroplasty post-operatively only. Refer to WHHT Rivaroxaban guidelines**

OBSTETRIC PATIENTS - Refer to Obstetric Guidance in Appendix to Anti-coagulation Policy

Neurosurgical patients	
Major head injury/neurosurgical patients	Anti-embolic stockings Add Enoxaparin only if decision documented by registrar/consultant

CONTRAINDICATIONS	
Enoxaparin	**Anti-embolic stockings/SCDs**
CrCl <30ml/min – use unfractionated heparin 5000 units BD	Severe peripheral vascular disease
Active bleeding	Do not use SCDs if recent lower limb DVT (can use anti-embolic stockings)
Platelet count <75	Severe dermatitis
Untreated inherited bleeding disorder	Massive leg oedema
Previous HIT or allergy to enoxaparin	Leg deformity
On therapeutic anticoagulation	Peripheral neuropathy
Acquired bleeding disorder	Recent skin graft
Patient concerns about using animal products	Allergy to fabric
	Stroke patients (do not use anti-embolic stockings)

Timing: Rivaroxaban should start 6-10 hours post op (providing haemostasis secured) and then at 6pm daily thereafter. Enoxaparin should start 6 hours post op. In addition, Enoxaparin can be given the evening prior to surgery (excluding neurosurgery, see above). Mechanical VTE prophylaxis should be implemented at admission.
MEDICAL patients: Enoxaparin must be written up and given on the day of admission

Epidural/ Spinal Analgesia: Placement or removal of catheter should be delayed for 12 hours after administration of Enoxaparin. Enoxaparin should not be given sooner than 4 hrs after catheter removal.
Placement or removal of catheter should be delayed for 18 hrs after administration of Rivaroxaban. Rivaroxaban should not be given sooner than 6 hrs after catheter removal.

Duration: Continue until mobility no longer significantly reduced. High risk orthopaedic patients should receive prophylaxis for at least 10 days. Extended prophylaxis * is recommended for elective hip replacement, hip fracture and other high risk patients e.g. major cancer surgery in the abdomen and pelvis.
*Heparin 28 days, Rivaroxaban 30 days (elective hip replacement only)

Obesity: Use Enoxaparin 40mg twice daily if body weight >100kg (or 60 mg bd if body weight >150Kg)

Exclusions: Haemodialysis, endoscopy, chemotherapy, ophthalmological procedures without GA, other procedures <90 minutes (see laminated sheet for full information)

Baseline Observations – HCA / RGN complete for all patients

Pulse…..……..Reg Reg/irreg BP……. / …….mmHg ECG ……

Respiratory rate / min Peak flow……L/min Oxygen Saturation …… .% on air

Weight: …….. kg Height: …….. BMI …….. Urine analysis ……..

Alcohol intake units per week …… Smoking habit per day ……
(2F3M4) Referred to smoking cessation Yes / No

For diabetic patients - Random Blood Glucose reading … …..mmol/L

MRSA status

Is the patient known to have had MRSA Yes/ No Point of contact: ……Date of MRSA ……..

Swab : Groin/ Nasal/Wound (delete as appropriate) Date……

Orthopnoea

Number of pillows at night …….
Shortness of breath at night YES/NO
Shortness of breath lying flat on one pillow for 45 mins YES/NO
Shortness of breath on exertion – climbing 1 flight of stairs YES/NO
Shortness of breath at rest YES/NO

Maximum usual walking distance on flat ……..…… …..YDS/METRES

Bed bound	☐	Wheelchair	☐	5m	☐ (length of POA)
25 m (Length of ward)	☐	100m	☐	400m	☐ Distance between bus stops
2km 30 mins walk	☐	> 2km	☐		

Walking limited by:
Joint Pain ☐ Breathing ☐ Chest Pain ☐ Leg Pains ☐ Balance ☐ Fatigue☐
Other ☐

INFORMATION GIVEN TO PATIENT AT PRE OPERATIVE ASSESSMENT

Reducing your risk of developing a blood clot
DSU information leaflet

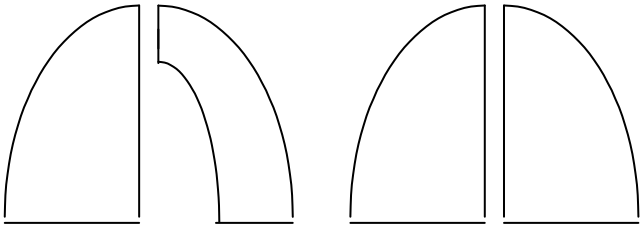
Type of investigation	Requested
ECG – aged 60 or more or if known cardiovascular disease	
MSU	
Swab for C&S	
FBC	
U&E	
MRSA swabs	
LFT (all Cholecystectomy patients)	
TFT (all patients with history of thyroid)	
Random Glucose	
HbA1c	
G&S (**all laparoscopy patients)**	
Other	

Respiratory System: - FOR RGN TO COMPLETE AS NECESSARY

Cervical spine movements flexion good/restricted extension good/restricted
Jaw flexibility Does the patient have difficulties opening their mouths wide yes/no

Trachea
Expansion R L
Air Entry good/poor/fair
HS/murmurs I …+ …II

	Yes	No	
Chest clear	☐	☐	
Wheeze	☐	☐	
Cough	☐	☐	
Sputum	☐	☐	Colour sputum ……..
Haemoptysis	☐	☐	



Anterior Posterior
Any other symptoms:

General Appearance

	YES	NO		YES	NO
Cyanosis	☐	☐	Ankle swelling	☐	☐
Anaemia	☐	☐	Leg ulcers / breaks in skin	☐	☐
Jaundice	☐	☐	Peripheral oedema	☐	☐
Varicose veins	☐	☐	Pressure sores	☐	☐

ASA STATUS

		ASA
Fit, adult, no known medical health problems besides current reason for surgery		1
Known medical problems or illnesses that do not limit physical activity (check with RGN)		2
Known medical health problems, that despite treatment limit my normal physical activity. For example, I find that walking causes breathlessness or chest pain. (must see an RGN)		3
Medical problems severely limit many aspects of daily life (must see an RGN)		4

Actions and Referrals from Pre operative Assessment

	No	Yes	
Has patient any health problems in the shaded boxes?	☐	☐	**If yes patient to see RGN**
Confirm that the VTE risk assessment is completed		☐	
MRSA swabs taken		☐	
PROMs completed	**N/A**	☐	**Groin Hernia / Varicose Vein**
POA outcomes completed		☐	
Day surgery	☐	☐	**Patients should default DSU.**

Site of admission recommended **SACH** **WGH**

ASA Status **I** **II** **III** **IV**

Summary

Signed: ……Date: …… Ext ……..

Consultant Anaesthetist

Signed: ……Date: …… Ext ……..

Review / Additional comments if required

Signed …… Date: ……

On admission Receiving surgical health professionals

Time of admission Date		
Expected discharge date		
	Yes	No
Confirm patient discharged arrangements are in place		
Does the patient require a Fitness to work certificate		
Does the patient have suitable escort home and cover for 24 hours		

Record any changes since Pre operative Assessment - if none state none.

	Yes	No		Completed
Has there been any change in address or telephone details?			If Yes update records	
Has there been any change with medication or allergies?			If Yes update records	
Has the patient visited the GP since POA?			If Yes update records	
Does the patient have any rashes, bruises, abrasions?				
If patient is female and of child bearing age, is there any chance of pregnancy?			If yes, Results of pregnancy test on admission	

NBM protocol – 6 hours pre surgery for food; 2 hours pre surgery for fluids;

Expected time of surgery		Time patient may eat/drink until
Time patient last ate		
Time patient last drank		

Mandatory checklist – VTE, MRSA, Bloods

✓ tick on completion

Consent completed	
VTE Thromboprophylaxis prescribed / N/A	
Ankle Size in cms	Right Left
VTE stockings applied unless contraindicated / N/A	Circle size S / M/ L / XL
Blood results available	
G&S / Cross match	
MRSA status	

Obervations on admission

Baseline Observations – HCA / RGN complete for all patients

Pulse…..……..Reg Reg/irreg BP……. / …….mmHg Temperature

Respiratory rate / min Oxygen Saturation …… .% on air

Patients with respiratory disease - Peak flow……L/min

For diabetic patients or those with BMI > 40 Random Blood Glucose reading … …..mmol/L

Pre Operative Check List

		Yes	N/A	DSU / Ward Check Signature	Theatre Check Signature
1	Identity bracelet attached and correct. Ensure not on limbs to be operated on.				
2	Red allergy band attached and allergies noted in red above.				
3	Make up and nail polish removed from fingers and toes as necessary.				
4	Jewellery (inc. piercings and hair clips), are removed or taped. Ensure not on limb to be operated on.				
5	Loose teeth, dentures, crowns and bridges identified				
6	Prosthesis removed (eg Contact lenses, hearing aid etc. as applicable) – Metalwork identified				
7	Consent form has been signed, Notes, drug chart.				
8	Dressings documented and tampons removed (if applicable).				
9	Disposable or own underwear worn (as applicable).				
10	Patient has followed starvation guidelines				

Registered Practitioners Signature		Registered Practitioners Name	

PONV Score

Female gender History of PONV Post operative opioids Non-smoker	Yes / No Yes / No Yes / No Yes / No	Score 0-1 Low risk 2 Moderate risk 3-4 High risk
Total Number of ''Yes'' scores		
- for scores of 2 or above please give appropriate prophylaxis		

Pressure sore risk assessment record

Several scores may be added from each category where applicable

	Scores	**Total**
BMI	30-35 =1 35+ = 2 <20 =3	
Continence	Occ.incontinent =1 Faecally incontinent or catheterised = 2 Doubly incontinent = 3	
Skin	Tissue paper = 1 Dry = 1 Oedematous = 1 Clammy = 1 Discoloured = 2 Broken/spot = 3	
Mobility	Restless/fidgety = 1 Apathetic = 2 Restricted = 3 Inert/traction =4 Chairbound = 5 NB. Score of 3-5 requires moving/handling assessment	
Sex	Male = 1 Female = 2	
Age	14-49 = 1 50-64 = 2 65-74 = 3 75-80=4 81+=5	
Appetite	Poor = 1 NG Tube/fluids only = 2 NBM/Anorexic = 3	
Special risks	E.g. Terminal cachexia = 8 Cardiac failure = 5 Peripheral vascular disease = 5 Anaemia = 2 Smoking = 1	
Neurological defect	E.g. Diabetes = 4 CVA, MS. Paraplegia = 6	
Major surgery/trauma	Orthopaedic below waist or spinal or surgery > 2hrs =5	
0-10 = Low risk 10-15 = at risk 15-20 = high risk 20+ = very high risk **Total**		

Additional comments.

Pre Operative Marking Verification Checklist

Check 1 • Check the patient's identity • Check reliable documentation and/or images to ascertain intended surgical site • Mark the intended site with an arrow using an indelible pen	The operating surgeon, or nominated deputy, who will be present in the theatre at the time of the patient's procedure.	Signed: Print name:
Check 2 • Prior to leaving ward/day care area the mark is inspected and confirmed against the patient's supporting documentation • Relevant imaging studies accompany patient or are available in operating theatre or suite	Ward or day care staff.	Signed: Print name
Check 3 • In the anaesthetic room and prior to anaesthesia, the mark is inspected and checked against the patient's supporting documentation • Re-check imaging studies accompany patient or are available in operating theatre or suite • The availability of the correct implant (if applicable)	Operating surgeon or a senior member of the team.	Signed: Print name
Check 4 The surgical, anaesthetic and theatre team involved in the intended operative procedure prior to commencement of surgery should pause for verbal briefing to confirm: Presence of the correct patient • Marking of the correct site • Procedure to be performed	Theatre staff directly involved in the intended operative procedure.	Signed: Print name

If failure of any pre-operative check occurs the surgeon in charge should assess the situation and either return the patient to the ward/day care area or note and sign a decision to proceed at risk. If the patient is returned to the ward/day care area, a patient safety incident report form is completed in line with local governance procedures. A senior member of staff should offer an explanation and apology. If surgery is carried out at the incorrect site, immediately escalate this to the senior manager on duty.

Patient has been seen by …

Surgeon ☐ Anaesthetist ☐ Nurse ☐

WHO Surgical Safety Checklist

SIGN IN (to be read out loud)

Before induction on anaesthesia

Has the patient confirmed his/her identity, site, procedure and consent?
- □ Yes

Is the surgical site marked?
Yes No Not applicable

Is the anaesthesia machine and medication check complete?
- □ Yes

Does the patient have a:
Known allergy?
- □ No
- □ Yes

Difficult airway/aspiration risk?
- □ No
- □ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- □ No
- □ Yes, and adequate IV access/fluids planned

Has Pre-operative VTE assessment been undertaken?
Yes N/a

TIME OUT (to be read out load)

Before start of surgical intervention
for example, skin incision

Have all team members introduced themselves by name and role?
- □ Yes No

Surgeon, Anaesthetist and Registered Practitioner verbally confirm:
- □ What is the patient's name?
- □ What procedure, site and position are planned?

Anticipated critical events
Surgeon:
- □ How much blood loss is anticipated?
- □ Are there are specific equipment requirements or special investigations?
- □ Are there any critical or unexpected steps you want the team to know about?

Anaesthetist:
- □ Are there any patient specific concerns?
- □ What is the patient's ASA grade?
- □ What monitoring equipment and other specific levels of support are required, for example blood?

Nurse/ODP:
- □ Has the sterility of the instrumentation been confirmed (including indicator results)?
- □ Are there are equipment issues or concerns?

Has the surgical site infection (SSI) bundle been undertaken?
- □ Yes/not applicable
  - ○ Antibiotic prophylaxis within the last 60 minutes
  - ○ Patient warming
  - ○ Hair removal
  - ○ Glycaemic control

Has VTE prophylaxis been undertaken?
- □ Yes/not applicable

Is essential imaging displayed?
- □ Yes/not applicable

SIGN OUT (to be read out loud)

Before any member of the team leaves the operating room

Registered Practitioner verbally confirms with the team:
- □ Has the name of the procedure been recorded?
- □ Has it been confirmed that instruments, swabs, tourniquets and sharp counts are complete (or not applicable)?
- □ Have the specimens been labeled (including patient name)?
- □ Have any equipment problems been identified that need to be addressed?

Surgeon, Anaesthetist and Registered Practitioner:
- □ What are the key concerns for recovery and management of this patient?

This checklist contains the core content for England and Wales

Name

Signature

Date and Time

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PATIENT DETAILS	
Last name:	
First name:	
Date of birth:	
NHS Number:	
Procedure:	

PERI OPERATIVE CARE

Start Time : Finish Time :

Please stick patient label here

Pre operative check	Yes	n/a
Consent form		
ID bracelet checked		
Allergies and allergy band		
Equipment checked		
Instruments pre checked		

Other		(√)		(√)
Skin prep used	Povidine Iodine		Alcoholic	
	Chlorhexidine		Antiseptic	
	Saline		Other	
Diathermy	Monopolar		Bipolar	
	Diathermy	-	Plate Site OK	
Sutures	Dissolvable		Non-dissolvable	
Infiltration				
Specimen	details			
			Checked and sent	

Dressings	(√)
Steristrips	
Mepore	
Blue Gauze	
Wool Bandage	
Crepe Bandage	
Spongostan	
ST Pad	
Opsite spray	
Other	

Tracking labels, Implants, etc

SURGICAL INFORMATION AND INSTRUCTIONS

Operation Performed: Date:

Histology Yes / No Removal of Sutures Yes / No When _____

OPD

Other Instructions

Surgeon (sign)		Surgeon (print)	
Assistant (sign)		Assistant (print)	

Address label here

ANAESTHETIC RECORD

Pre Operative Anaesthetic Assessment

General Condition	Consent for suppositories
Airway assessment	Allergies
Teeth	Drugs
CVS	Previous GAs
RS	
Other systems	
Conclusion	
ASA	

ANAESTHETIC ASSISTANT

Patient position

Patient safely transferred	
Supine	
Left lateral	
Right lateral	
Lithotomy	
Prone	
Trendelenberg	
Reverse Trendelenberg	
Other.....	

Position of arms

Across chest	
Down by side	
Left only by side	
Right only by side	
Arm board in place	
Protective padding on arm boards	

Pressure area care

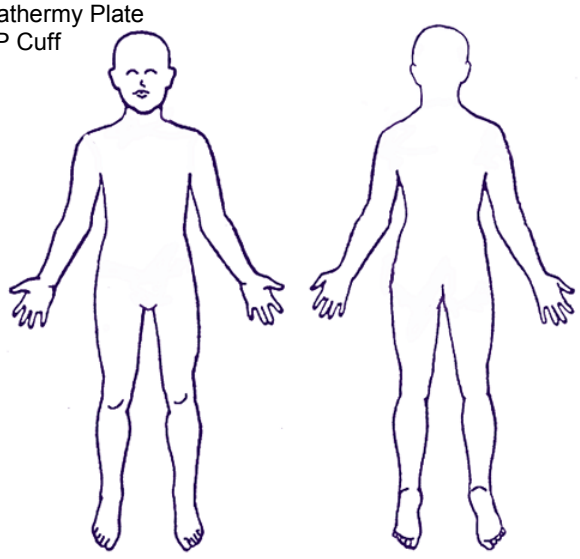
Heel pad	
Head ring	
Vein board	
Other …..	

Throat Pack (√)

In:	Out:

Body Picture

X – IV Cannula
G – Pulse Oximeter
M – Site marked
D - Diathermy Plate
B – BP Cuff
E – ECG Dots
S - Supports
T – Torniquet



Anaesthetist Name	
Designation Grade	

Anaesthetic Assistant	
Designation Grade	
Signature	

	Drugs	Dose
Induction	Propofol	
	Thipentone	
	Midazolam	
	Other ____	
Relaxants	Vecuronium	
	Atracurium	
	Mivacurium	
	Rocuronium	
	Suxamethonium	
	Other ____	
	Reversal Given	
Analgesics	Fentanyl	
	Alfentanil	
	Diclofenac	
	Ketorolac	
	Tramadol	
	Paracetamol	
	Parecoxib	
	Other ____	
Antiemetic		
	Ondansetron	
	Cyclizine	
	Other ____	
Maintenance	O2	
	N2O	
	Desflurane	
	Sevoflurane	
	Isoflurane	
	Other ____	
IV Fluid	Normal Saline	
	Hartmans	
	Other ____	

Airway Used	Size
Oropharyngeal	
Nasopharyngeal	
Laryngeal Mask	
Endotracheal Tube - Laryngoscopy Grade	
Other ____	

Ventilation
Spontaneous
IPPV
Circle absorber

Monitoring

ECG	NIBP
SaO2	FiO2
EtCO2	PNS
Vent alarm	EtVap
Temp.	
Other ____	

Drugs\Time																									
	220																								
	200																								
	180																								
	160																								
BP	140																								
	120																								
	100																								
HR	80																								
	60																								
	40																								
Resps	20																								
	0																								
	Temp																								
	SpO2																								
	EtCO2																								
	FiO2																								
	EtVap																								

Cannula

Site	
Type	
Flushed	
Inserted by	

Local / Regional Block

Time	
Drug	
Location	

Torniquet Information

Time inflated	
Time deflated	
Pressure mmHg	

Drugs\Time																								
220																								
200																								
180																								
160																								
BP 140																								
120																								
100																								
HR 80																								
60																								
40																								
Resps 20																								
0																								
Temp																								
SpO2																								
EtCO2																								
FiO2																								
EtVap																								

Post Operative Instructions		
Oxygen to be given as prescribed. Routine observations.		
Anaesthetists Signature:	Name:	Bleep:

RECOVERY CHART

Time in: **Time out:** **Procedure Performed:**

Patient status in recovery	Yes	No	Comments
Unconscious			Time regained consciousness :
Jaw Support, chin lift given			Time stopped :
Guedel airway			Removed at :
Laryngeal Mask			Removed at :
Nasopharyngeal			Removed at :
ET Tube			Removed at :
Packs			Removed at :
IV Infusion			Details:
Temp on arrival in recovery			

West Hertfordshire Hospitals NHS
NHS Trust

ASU. NEWS KEY 0 1 2 3	NAME:	D.O.B.	ADMISSION DATE:	
DATE				DATE
TIME				TIME

RESP. RATE	≥25	3		≥25	RESP. RATE
	21-24	2		21-24	
	12-20	0		12-20	
	9-11	1		9-11	
	≤8	3		≤8	
$Sp0_2$	≥96	0		≥96	$Sp0_2$
	94-95	1		94-95	
	92-93	2		92-93	
	≤91	3		≤91	
Inspired 0_2%	%	2		%	Inspired 0_2%
TEMP	≥39°	2		≥39°	TEMP
	38°	1		38°	
	37°	0		37°	
	36°	1		36°	
	≤35°	3		≤35°	
NEW SCORE uses Systolic BP BLOOD PRESSURE	230	3		230	NEW SCORE uses Systolic BP BLOOD PRESSURE
	220			220	
	210			210	
	200			200	
	190			190	
	180			180	
	170			170	
	160			160	
	150			150	
	140			140	
	130			130	
	120			120	
	110			110	
	100	1		100	
	90	2		90	
	80			80	
	70			70	
	60			60	
	50			50	
HEART RATE	>140	3		140	HEART RATE
	130			130	
	120	2		120	
	110			110	
	100	1		100	
	90			90	
	80			80	
	70	0		70	
	60			60	
	50			50	
	40	1		40	
	30	3		30	
CONSCIOUS LEVEL	Alert	0		Alert	CONSCIOUS LEVEL
	V / P / U	3		V / P / U	
Blood Sugar		0			Blood Sugar
NEW SCORE					NEW SCORE
Additional Parameters: Pain score 0-3					Pain Score
Bowel motions					Bowels
Daily weight					Weight
Target Saturations %					Target Sats
Monitoring Frequency					Monitor Freq
Escalation Plan Y/N n/a					Escal Plan
Initials					Initials
Blood transfusion obs					Transfusion

Clinical Response to NEWS Triggers

NEWS SCORE	FREQUENCY OF MONITORING	CLINICAL RESPONSE
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations
1-3	Minimum 6 hourly (4 times/day)	• Inform trained nurse who must assess the patient • Trained nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required
4 or more **or** **3 in one parameter (i.e. red areas)**	Increased frequency to a minimum of 2 hourly (preferably hourly)	• Trained nurse to assess patient and take into account patient's 'norms' (e.g. low SpO2 with COPD, low BP may be 'normal' for patient) • Trained nurse should inform: 1. Nurse in charge 2. Patient's medical/surgical team immediately and/or 3. WGH: Critical Care Outreach (day) bleep 1265 or Clinical site practitioner (night)bleep 2995 HHGH/SACH: escalate as per local procedure • Consider MOVE (monitor, oxygen, venous access, ECG) • Consider transfer to a unit with monitoring facilities
6 or more	Patient requires continuous monitoring of vital signs	• Trained nurse to <u>immediately inform</u> medical team – should be at least a Specialist Registrar - & Nurse in charge • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients and with resuscitation and advanced airway skills (i.e. ICU anaesthetist, bleep 1113) • Consider transferring the patient to HDU or ICU or, if appropriate, to CCU

DATE & TIME	NEWS	REFERRED TO	ACTION

NEUROVASCULAR OBSERVATIONS													
DATE													
TIME													
LIMB													
COLOUR													
WARMTH													
MOVEMENT													
SENSATION													
PULSE													

PAIN SCORE	
No pain on movement	**0**
Mild pain on movement	**1**
Moderate pain on movement	**2**
Severe pain at rest/on movement	**3**

CONSCIOUS LEVEL	
Alert/ fully awake	**A**
Responds to voice	**V**
Responds to pain	**P**
Unresponsive	**U**

Criteria for discharge from recovery

The following criteria must be fulfilled before a patient can be discharged from the recovery room.
If after this time the patient is not meeting the discharge criteria, the anaesthetist MUST review the patient and make a decision regarding suitability for return to the ward.

Criteria	Yes	No	Comments
The patient is fully conscious, responding to voice or light touches, able to maintain a clear airway and has a normal cough reflex.			
Physiological observations should be within acceptable parameters:			
Oxygen saturation are satisfactory (>92% on room air) or within 5% of pre-op range			
Respiratory rate should be >10 and < 24 in adults, >14 and < 40 in paediatrics depending on age, and no worse than pre-op rates.			
Temperature should be within acceptable limits (> 36 C) or in line with temperature on admission to theatre (for further guidance refer to Nice CG65 (Management of Peri-operative Hypothermia Algorithm)			
The cardiovascular system is stable with no unexplained new cardiac irregularity or persistent bleeding. The patient's pulse and blood pressure should approximate to normal preoperative values or should be at a level commensurate with the planned postoperative care			
Patient should be free from pain, (or at a level which is acceptable to them), nausea and emesis as far as is possible			
Oxygen, fluid therapy, analgesia and antibiotics should be prescribed when required.			

Registered Practitioners Signature		Practitioners Name	

NURSING NOTES

Time returned to ward :

Pain score:

Temp:

Wound checked :

Time fluid / food offered :

If no, record action taken in nursing notes below

Has fluid been tolerated? Yes / No

Has food been tolerated? Yes / No

Has patient passed urine? Yes / No

Date & Time		Name & Signature

Discharge check

Observations on discharge:

Pulse……..Reg Reg/irreg BP……. / …….mmHg Temperature

Respiratory rate / min Oxygen Saturation …… .% on air

Patients with respiratory disease - Peak flow……L/min

For diabetic patients or those with BMI > 40 Random Blood Glucose reading … …..mmol/L

		Yes	N/A	Initial
1	Can breathe comfortably, exhibits no signs of respiratory distress			
2	Has returned to normal level of awareness			
3	Can walk without feeling faint			
4	Has minimal nausea and is not vomiting			
5	The patient has an acceptable temperature inline with temp on admission to theatre.			
6	Operation site is checked and satisfactory			
7	Cannula removed			
8	ECG dots removed			
9	Has a responsible adult as escort home and has someone at home overnight and 24 hours post surgery			
10	Has all discharge documentation including Fitness to Work Certificate			
11	Have relevant referrals been made: District Nurse, OPD			
12	Written and verbal post operative instructions given to patient / escort.			
13	Written and verbal information regarding DVT given to patient? **MANDATORY**			
14	Has had something to drink and eat (where relevant)			
15	Has passed urine (where relevant)			
16	Has correct medications to take home (where relevant)			
17	Day Surgery booklet completed and correct			

I confirm that discharge criteria were met and the patient discharge at ……

Or

If patient admitted to ward please complete following checklist

	Handed over by:
1. Overnight stay admission form	
2. IV / catheter careplan	
3. Take home drugs handed over to ward staff	
4. Relatives informed	
5. Medical staff informed	
6. Clerical staff informed	
7. Notes and all documentation handed to ward staff	

Patient was admitted to _____ Ward at _____

Signature Print Name