Pre-Operative Admission for Patients Attending Surgical Day Care

Site Applicability

St. Paul's Hospital (SPH) and Mount St. Joseph Hospital (MSJ) Surgical Day Care Units (SDC)

Practice Level

Basic: Registered Nurses and Licensed Practical Nurses (MSJ)

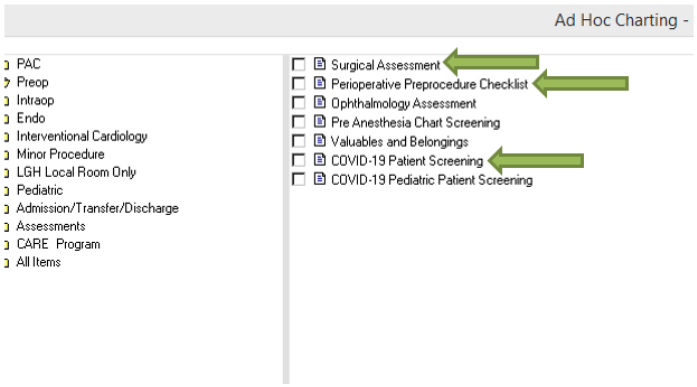
- Employed Student Nurses (ESN) and student nurse under the supervision of the most responsible nurse

Requirements

1. Perinatal patients (from 20 weeks gestation to 14 days following delivery) must be referred to maternity CNL/CN.
2. Baseline vital signs and capillary blood glucose (CBG) (when required) must be measured within 4 hours of surgery.

Need to Know

1. This procedure applies to both daycare surgery patients and same-day admit (SDA) patients.
2. Patients change prior to the nursing admission assessment, and are requested to remove all clothing, including undergarments, and jewelry.
3. For continuity of care, one nurse completes the entire admission process.
4. The nurse completes the following PowerForms in Cerner:
    - COVID-19 Patient Screening
    - Surgical Assessment
    - Perioperative Pre-procedure Checklist



5. Information collected at the Pre Admission Clinic (PAC) appointment (pre-populating form) does not need to be verified, except as outlined below.

Procedure

Prior to meeting the patient:

1. Review the slate booking, including the comments column. Take note of any comments relevant to the admission process.
2. Open the patient's chart in Cerner. From the face sheet in the chartlet, confirm the patient name, MRN, and encounter number on the banner bar.
3. Under Documentation (Surgical Booking Package), review the surgical consent form, ensuring the procedure agrees with the slate booking, both the patient and surgeon have signed it, and it is dated within the last year.
4. Check for any other applicable consents (e.g., Consent for Transfusion of Blood/Blood Products).
5. Also under Documentation, review the Nursing Assessment - completed by the PAC screening nurse for all patients.
6. Go to Care Connect to review recent lab work and diagnostic tests. Notify the appropriate person (charge nurse/surgeon/anesthesiologist) of significant abnormal results.
7. Go to Orders, and initiate preoperative orders as needed. If orders for blood work or other tests are not "STAT", change them to "STAT", with the exception of an ECG which is designated "URGENT" unless the patient is having chest pain. Check for duplicate orders and cancel as needed.
8. Initiate intra-op orders for gemcitabine and basiliximab.
9. Greet the patient and introduce self (name, role and responsibility).

Patient interview/assessment:

a. Check the patient ID band against the face sheet in the chartlet. Confirm the spelling of the name. Check at least one other identifier – birth date or MRN. Also confirm these are correct

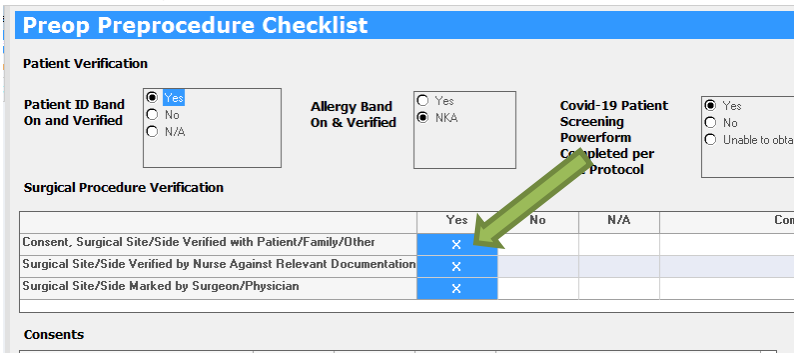
on the banner bar in Cerner. (Patient ID band on and verified is documented on the Preop Preprocedure Checklist.)

b. Apply yellow wrist band to patient to inform staff: Do not use this limb (for IV/BP/Bloodwork)

c. Weigh the patient and measure height. (These will be recorded on Vital Signs/Measurements page of the Surgical Assessment.)

d. Go to Ad Hoc ☛Pre-Op☛COVID-19 Patient Screening and complete the Patient Screening and Patient Testing sections.
Review the current policies pertaining to Acute Respiratory Illnesses and follow Infection Prevention and Control Guidelines that may change accordingly.
If the patient's status is "yellow", communicate this to the surgeon, anesthesiologist, and OR nursing team. Obtain the COVID-19 swab and send to lab, as ordered.
If the patient's status is "red", isolate the patient and immediately notify the charge nurse.

e. Ask the patient to tell you in their own words what surgery they are having, including confirmation of side, if applicable. (To comply with regional policy.) Compare this to the booking on the slate. Contact the charge nurse if there are obvious differences.
(This is documented on the Preop Preprocedure Checklist under "Surgical Procedure Verification".)



f. Go to Ad Hoc ☛Pre-Op☛Surgical Assessment. Complete the Surgical Assessment according to the following guidelines.

Surgical Assessment

General Information

- For daycare surgery, the patient's discharge contact information is noted on the chartlet face sheet by the unit clerk.
- For an SDA patient, enter the information in this section if known at this time. Select "yes/no" re PAC appointment.

Allergies

- Confirm that any allergies and/or sensitivities are identified and documented on the banner bar and in the allergies folder in Cerner. If the patient's allergy and/or sensitivity status has changed, revise in Cerner.

- If the patient has any allergies, place a red allergy band on the same wrist as the ID band.
- Allergy band on and verified is documented on the Preop Preprocedure Checklist.

Vital Signs

- Measure vital signs.
- Record patient's weight as "measured" under dosing weight and enter again for "weight measured".
- Record patient's height under height/length measured or estimated. This will calculate the body mass index (BMI).

Advance Care Plan

- Ask the patient if they have an advance care plan. If they have one, ask them where it is located.

Past Medical History

- Any past medical history found in the patient's chart or CareConnect will be entered here by the PAC screening nurse. Review with the patient, add any new items, and then click "Mark all as Reviewed".

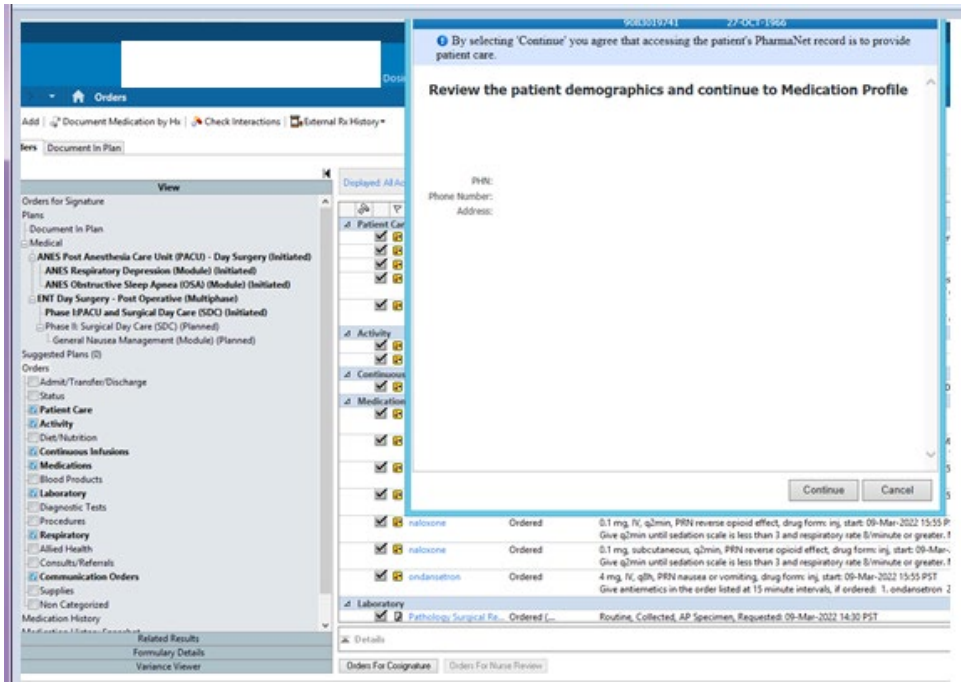
Patient Screening History

If the patient was pre-assessed, this form has already been completed (and is "greyed" out).

- For a patient who was not pre-assessed, review each system by asking the patient if they have any conditions related to that system. If the patient identifies a condition, mark it as "yes", and include a comment as needed. You do not need to read off all the conditions listed.
  Note: Some patients have no conditions, and the form will remain blank.

Medication History

- Best Possible Medication History (BPMH) must be completed for all Same Day Admit (SDA) patients. Ideally, BPMH is completed by Pharmacy via the PAC for patients with more than five medications.
- If BPMH has not been completed for an SDA patient, import the patient's external prescription history from PharmaNet. On PowerChart, go to Orders > External Rx History> and import the patient's external prescription history from PharmaNet. The history must be reviewed with the patient and modified as needed to reflect current home medications, including dose and schedule. Also record the date and time each medication was last taken.



- Daycare patients do not require BPMH. Under Progress Note - record information about any medication taken on the day of surgery (i.e., name, dose, time taken). Check last time diabetes med/insulin, birth control or any hazardous drug was taken.
- If noted that Hazardous Drug was taken within last 48 hours, ensure you input a Hazardous Drug Group 1 Process alert for Hazardous Drug Group 1 medications, that proper Safe Work Practices are followed, and that proper signage is posted and follows patient to the OR.

Note: If a patient's status changes from "daycare" to SDA while the patient is still in SDC, a BPMH will need to be completed.

- If the patient has discontinued anti-coagulants in preparation for surgery, record when the medication was stopped in the Progress Note.

Infectious Disease Risk Screening

- These questions must be asked on admission, even if already asked by the PAC nurse. Note that "healthcare in Canada within the last year" means an overnight stay in hospital or multiple admissions for invasive procedures.
- For any identified risk factor, the patient will be placed on contact precautions. Update the perioperative tracking board.
- For a SDA patient, order MRSA/VRE swabs.

Violence and Aggression Screening

- Complete for all patients and place purple sticker on chartlet for patients with a violence history.

Social History

- All patients must have Tobacco, Alcohol, and Substance Use assessed. If the patient currently uses tobacco, alcohol, or any other substance, the time of last use must be entered on the Preop Preprocedure Checklist.
- Depending on the type of surgery, SDA patients may also have information entered for Activity, Home/Environment, and Employment/School.

Procedure History

- Any Procedure History that is found in a patient's chart or CareConnect will be entered here by the screening nurse. Review with the patient and add any new items, then click "Mark all as Reviewed".

Anesthesia/Sedation

- Genetic (familial) problems with anesthesia are documented in Patient Screening History, under Anesthetic Concerns.

Numeric Pain Scale

- Baseline pain assessment is an adjunct to vital signs. Complete the first box only.

Transfusion History

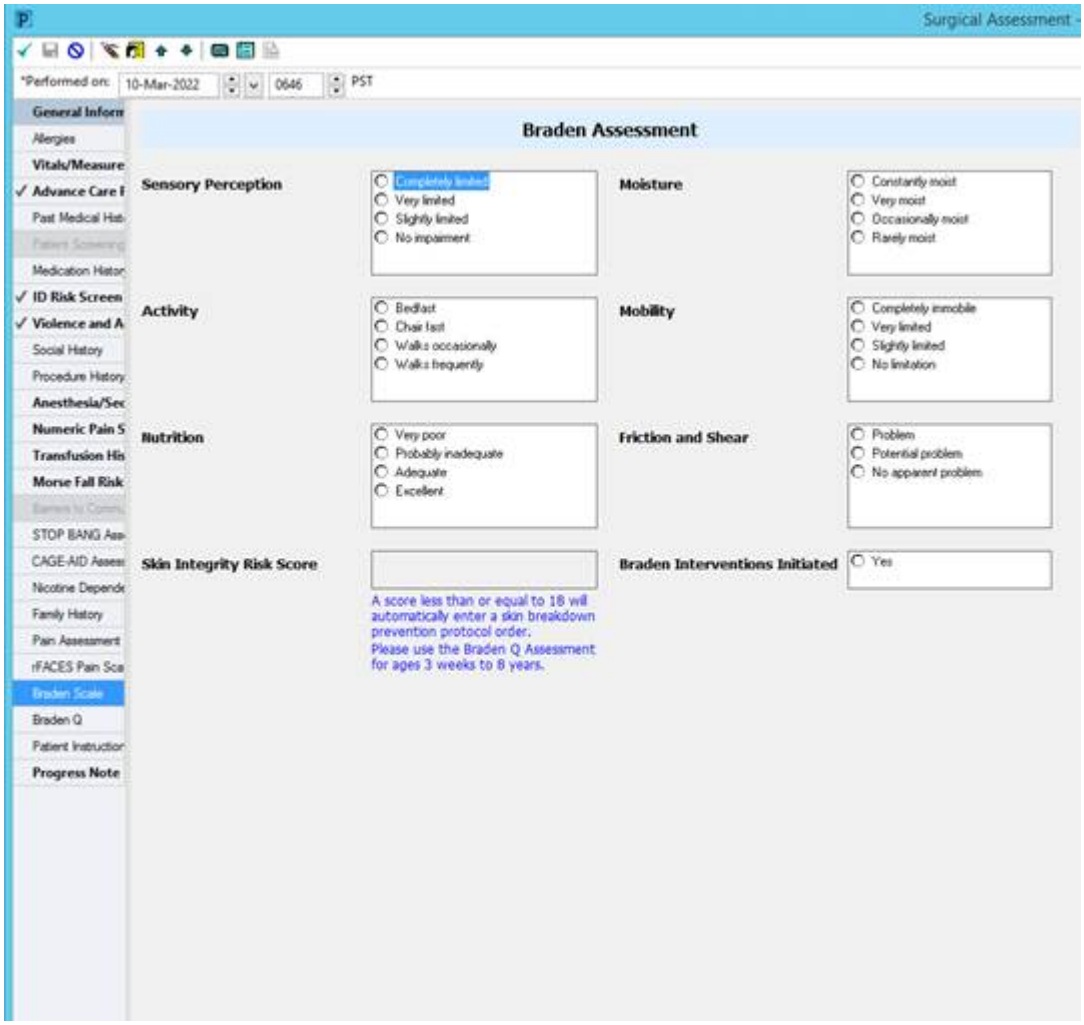
- Assess patient for a prior transfusion reaction or recent transfusion that may impact group and screen (G & S).

Falls Risk Assessment

- All patients must be assessed by the Morse Fall Risk and patients who score greater than 45 will have additional Fall Prevention Interventions started and documented.
- Universal Fall Prevention strategies are in place for all patients.

Braden Scale

- All inpatients must be assessed by the Braden Scale in Surgical Daycare, with Pressure Reducing Interventions initiated and documented as needed.
- If patient has no concerns with Skin Integrity and they state this in the interview, document this in the Progress Notes.



Progress Note – Simple

- In addition to information about medications mentioned above, document any other pertinent information and if patient stated that they have no concerns with Skin Integrity.

Perioperative Preprocedure Checklist

(Ad Hoc☛Pre-Op☛Perioperative Preprocedure Checklist)

Note that all **“yes”, “no”, “N/A”** choices must be completed.

Patient Preparation

Procedure Location

- Indicate the location the procedure will be performed

Last Food and Drink

- It is important to obtain accurate and complete information about last oral intake.
- Record the date and time of last intake, whether it was clear fluids, full fluids, or solid food, as well as the volume if fluid.

Note minimum fasting periods:

- Large or heavy meal (e.g., fatty or fried foods, meat) – 8 hours
- Light meal or full fluids (e.g., milk or fluids containing dairy products, opaque juice or juice with pulp) – 6 hours
- Clear fluids (e.g., water, clear juice, pop, black tea or coffee, jello) – 2 hours

  If the patient's last oral intake may be too recent (taking into account the time the surgery is booked), notify the anesthesiologist.

  Preoperative or regular medications may be taken with a sip (30 mL) of water.
- ERAS patients are instructed to "carb load" both the evening before and the morning of surgery. Assess whether they have completed this as instructed.

Capillary Blood Glucose

- Must be done for patients with diabetes.
- Complete as needed or if ordered for other patients.

Pre Transfusion Testing Completed Prior to Admission

- A patient who has had their G & S collected in PAC in the 60 days prior to surgery needs to have the validity of their specimen confirmed (by ensuring they have not been pregnant or received a blood transfusion in the last 90 days).

Last Void

- Indicate the date and time the patient last voided.
- Ask the patient to void just prior to surgery and update as necessary.
- For a patient on dialysis, indicate the date and time of last dialysis.

Last Bowel Movement

- All SDA patients must have their last bowel movement recorded.

Possibility of Pregnancy

- All female patients of childbearing age must be assessed for the possibility of pregnancy and whether or not they are currently taking hormonal birth control (Hazardous Drug Group 1 Medication) *"Is there any chance you may be pregnant? And are you on any form of oral birth control?"*

- If there is a possibility of pregnancy, a pregnancy test must be ordered and completed prior to transfer to the OR. (Document result of pregnancy test in Interactive View and I & O, point-of-care testing.)

External Warming Device

- All ERAS patients are given a forced-air warming gown to don when they change. This gown is attached to an external warmer. Instruct the patient how to use the device (i.e., how to adjust temperature and how to turn off).
- Warming gowns may be used for other patients for whom heated blankets are not sufficient. (The gown may be worn over the regular gown.)
- Never use the warmer without the forced-air warming gown (risk of burns).
- Document the time warming is initiated.
- Discontinue warming if the patient is showing signs of overheating.
- Send the warming gown to the OR with the patient.
- See B-00-12-10015 for more information.

Pre-op Site Prep

- Document what skin prep the patient completed, and when. All ERAS patients are instructed to bathe or shower both the night before surgery and the morning of surgery, preferably with chlorhexidine 4% soap.

Bowel Prep

- If a bowel prep is required, indicate whether it was completed, and the type of prep done. ("Mechanical" prep means using oral agents.)
- For all other patients, indicate "N/A".

Hair Removal

- Currently hair removal is completed when necessary in the OR, so "No hair removal performed" should be selected.
- If the patient has performed their own hair removal, select "Other" and describe how, when, and what they prepped.

Preop Preprocedure Checklist

Patient Verification

- Document from initial part of the patient interview.

Surgical Procedure Verification

- Document surgical site/side verification from initial part of patient interview.
- "Surgical Site/Side Marked by Surgeon/Physician" must be "yes" prior to patient transfer to OR.

Consents

- The acceptable selections for this section are “yes” or “N/A”. “No” means there should be a certain consent, but it is missing, incomplete, or has not been done. If this is the case, notify the surgeon.
- If the patient is unable to provide consent for any reason, or their ability to provide informed consent is in question, refer to “Consent for Health Care” B-00-11-10110.
- All necessary consents must be completed prior to patient transfer to OR.

Chart Review

- Use the Chart Review to ensure the patient preparation is complete, relevant documentation completed, and test results available.
- Communicate any outstanding item directly to the OR (e.g., heparin to be given in OR).

Prosthetics/Implants/Belongings

- If the patient has a prosthetic device, document the type. Consult with the OR if unsure about the need to remove.
- If the patient has an implanted device, indicate what and where.
- If “other personal belongings” are removed, indicate what was removed. Jewelry and body piercings should be removed whenever possible to prevent intraoperative injury.
- Glasses, dentures, and hearing aids may remain on/in the patient for transfer to the OR. Send a labelled container with the patient.
- As per the instructions on the Cerner form, if any prosthetics/implants/belongings are removed, complete the Valuables/Belongings form.
- Ensure belongings are labelled.

Valuables/Belongings

NOTE: This form is used by nurses in all areas throughout the patient’s stay. It should be an up-to-date and accurate account of the location or disposition of valuables and belongings. Upon discharge, the nurse completes this form to ensure the patient has all their valuables and belongings.

Progress Note – Simple

Any free text note can be added here.

Patient and Family Education

Review the length of the surgery with the patient. For example, “Your surgery is scheduled to last about 1 hour”.

Review next steps – what will happen between now and transfer to the OR.

Related Documents

1. B-00-07-10024: Maternity Services: Care Approach for Patients Admitted to Other Programs
2. B-00-11-10110: Consent to Health Care
3. B-00-11-10148: Safekeeping of Patient and Resident Valuables
4. B-00-12-10015: Warming Patient Using Forced Air Warmer
5. B-00-12-10076: Admission of Patient to PHC Acute Care Nursing Unit
6. B-00-13-10039: Admitting Patient to Operating Room, protocol
7. B-00-13-10040: Belongings (Patient) in Operating Room, protocol
8. B-00-13-10102: Hair Removal, Appropriate Clipping (no shaving), protocol
9. BD-00-11-40014: Surgical Site Identification Policy
10. BCD-11-11-4000: Allergy Documentation Policy
11. Maximum Surgical Blood Order Schedule (MSBOS)

References

Andrews, S. & Cartwright, S. (2016). Preoperative evaluation. In L. Schick & P.E. Windle (Eds.), *Perianesthesia nursing core curriculum: Preprocedure, phase I and phase II PACU nursing* (3rd ed.) (pp. 69-96). Elsevier.

ORNAC. (2021). *The ORNAC standards, guidelines, and position statements for perioperative registered nurses (15th ed.), 3-7 to 3-16*.

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