Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

INPATIENT (>24hr) THEATRE PERI-OPERATIVE CARE PLAN

AFFIX PATIENT ADDRESSOGRAPH

Instructions for use:

- To be used for all **INPATIENT (>24hr stay)** theatre admissions (including **both** adult and paediatric patients undergoing elective or emergency surgery).
- To be used in conjunction with patient NEWS/PEWS/MEOWS chart, pre-assessment pathway, anaesthetic record, operation notes, consent form, intentionally retained items forms, Abbey/Wong-Baker pain tools and nursing and midwifery assessments.
- Handwriting must be legible and completed in **BLACK** ink.
- Date and sign care plan when initiated in each clinical area.
- Individualise as appropriate – tick/circle/specify to indicate the patient's status or implementation of specific interventions.
- Date/time/sign any additional entries/interventions.
- If need/outcome/interventions are changed/stopped/not applicable – DELETE by drawing a line through the entry, date/time/sign this deletion.

Contents:

Surgical Safety Checklist

BEFORE STARTING FIRST CASE ☐

Patient has been discussed in team brief and all safety checks have been completed

SIGN IN
Prior To Any Intervention

Led by Anaesthetist

- ❒ Patient identity
- ❒ Consent
- ❒ Surgical site marked appropriately ❒N/A
- ❒ Fasting status
- ❒ Airway assessment/plan
- ❒ Antibiotic required?
- ❒ Allergies
- ❒ Pregnancy status
- ❒ Blood product availability
- ❒ Monitoring appropriate
- ❒ Surgeon and all required staff are present

STOP BEFORE YOU BLOCK
Is everybody happy that the injection is about to be made to the correct side? (Tick if N/A ❒)

Anaesthetic Practitioner

Anaesthetist

TIME OUT
Before First Incision

Led by Operating Clinician/Anaesthetist

- ❒Introduction - if any new team members present
- ❒ Patient ID and procedure
- ❒Confirm allergies
- ❒ Patient position and operation site correct?
- ❒ Imaging displayed and reviewed
- ❒Significant blood loss possible?
- ❒ Sterility of instruments and prosthesis availability
- ❒ Thromboprophylaxis plan
- ❒ Infection prevention
  - ❒**Antibiotics within last 60 minutes?**
  - ❒**Patient warming in situ?**
  - ❒ **Glycaemic control?**
- ❒ ASA grade
- ❒ Concerns and critical steps
  - ❒**Anaesthetist**
  - ❒**Surgeon**
  - ❒ **Theatre staff**
  - ❒**Other disciplines**

SIGN OUT
After Final Count

Led by Circulating Practitioner

- ❒ Instruments and counts
- ❒ Confirm Procedure performed
- ❒ Specimens collected
- ❒ Ongoing Antibiotic and thromboprophylaxis requirements
- ❒ Plan for post operative care

In Recovery
Confirm all IV lines and cannulas have been flushed and any unecessary extensions and venflons removed ☐

Affix Patient Label Here

Date:
Location:
Hospital:
Planned Procedure:

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Signatures

To be completed by all staff using this document.

Name (PRINT)	Ward/Unit	Designation	Signature

Intentional Rounding Skin Assessment

Please use this assessment tool in order to grade the patient's skin integrity when indicated.

SKIN CHECK KEY			
A	Normal	G1	Red, Non-blanching
B	Red, blanching	G2	Intact or Open Blister
M	Moisture	G3	Slough, Necrosis
MBS	Moisture/broken skin	G4	Cavity to Bone
SDTI	Suspected Deep Tissue Injury	U	Unstageable
		F	Covered by Dressing

Pain Assessment Tools

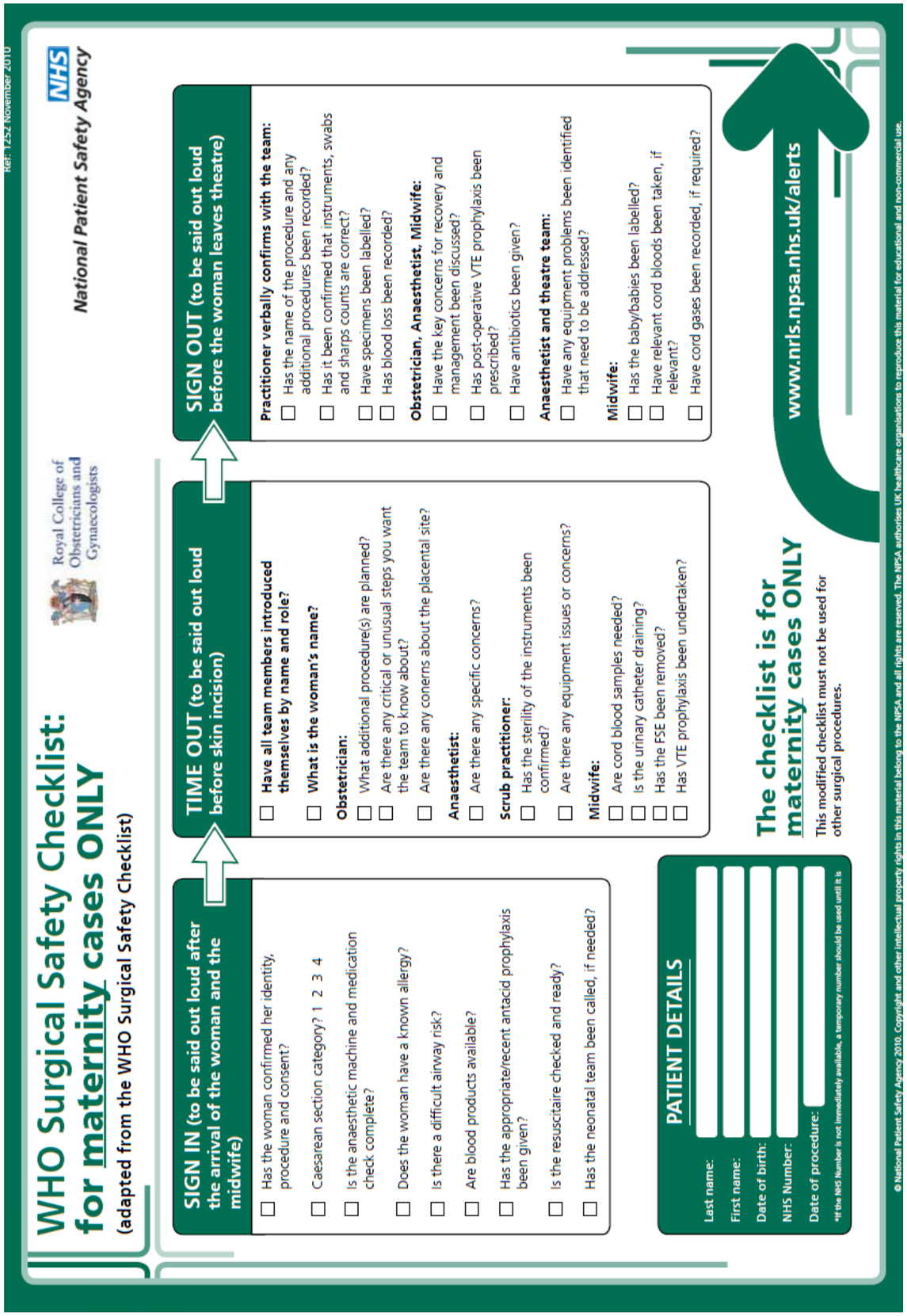
Patients with cognitive impairment/unable to self-report:

Use Abbey Pain/Screening Tool

Paedeatrics:

Use Wong-Baker Pain Scale

0	No Pain
1	Mild Pain
2	Moderate Pain
3	Severe Pain



Date, time and sign each entry:	Multi-disciplinary Communication

PATIENT INFORMATION

Date of Procedure:		**Consultant:**	
Planned Procedure:			

Patient Assessment

	Yes	No	Details		Yes	No	Details
DNACPR:				**Advanced Decision:**			
Power of Attorney:				**Cognitive Impairment:**			
Capacity to Consent:				**Communication Needs:**			
Learning Disability:				**Safeguarding/Child Protection Concerns:**			

Relevant Medical History

Record pre-operative observations on NEWS/PEWS/MOEWS chart.

Height:		**Weight:**		**BMI:**	

Pre-Operative Pain Assessment

Pain Score : ……………………………………… Date & Time:…………………………… Signature: ………………………….

Pregnancy Status (For all patients of childbearing capacity)

1. Is there a possibility you could be pregnant (circle)? Yes No

If patient answers "No", circle box – no further action required.

If the patient answers "Yes" proceed to question 2:

2. Ensure patient is aware of risks of anaesthetic and surgical procedure to the foetus.
3. Date of onset of the last menstrual period: …………………………….
4. Document all discussions. Gain verbal consent for hCG (urine) pregnancy test (consider whether the patient has capacity (16+)/if the patient is Gillick competent (<16)).
5. If consent is obtained, perform test, document results and inform patient/parent/guardian and Theatre department.
6. Result: …………………………………………… Time & date of result (24hr clock) : ……………………………………….

THEATRE PRE-OPERATIVE CHECKLIST

Preferred Name:		Preferred Language:		Religious/Spiritual Preference:	

USER KEY			Remember: 1st Check (in admitting area by Registered Practitioner before pre-medication) 2nd Check (verification check by competent Theatre personnel)	1st Check	2nd Check
Yes	No	Not Applicable			
✓	✕	N/A			

	1st Check	2nd Check
Is the patient wearing two identification bands which corresponds with medical case notes?		
Is the consent form/form 4 legible, appropriately signed, checked for accuracy and completeness and corresponds with the operation list?		
Is the operation site marked and corresponds with laterality on consent form and operation list?		
Does the patient have any known allergies? If yes list below and specify type of reaction: …………………………………………………………………………………… …………………………………………………………………………………… Epi Pen used (circle): Yes No		
Does the patient have any pre-existing implants/prosthesis (e.g. hip/knee/breast implant)? If yes, specify (include laterality): ……………………………………………………………………		
Is the patient diabetic? If yes (circle) : Type 1 Type 2 BM result: …………… Time & date of result (24hr clock): ………………..		
Does the patient have a cardiac pacemaker or internal defibrillator? Type: ………………………………… Last checked: …………………………..		
Time & date of last food (24hr clock): …………………….. Time & date of last drink (24 hr clock): …………………… Type of drink: …………………………… Time enteral feed discontinued (24hr clock): ……………………		
Has a pregnancy test been undertaken? If yes, document result: …………………………………………		
If PR medication is required, does the patient give verbal consent?		
Has pre-medication been given, including prophylactic antibiotics or other prescribed medication?		
Has anaesthetic cream been applied? Time (24hr clock): ……………………………………		
Has blood been cross-matched and ordered?		
Is the patient on Warfarin? Latest INR:…………………….. Date taken:…………………		
Is the patient taking any anti-coagulation therapy? If yes, specify: ……………………………………		
Does the patient have a known infection/is being nursed in isolation (e.g. MRSA)? If yes, specify infection and inform Theatre before patient leaves ward area: ……………………………………		
Has a VTE assessment been undertaken?		

Date, time and sign each entry:	Multi-disciplinary Communication
……………………………	…………………………………………………………………………………………
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PACU HANDOVER	
Situation	➢ Positive patient identification ➢ Preferred name ➢ Preferred language ➢ Allergies ➢ Name of surgeon ➢ Type of anaesthesia ➢ Procedure performed (inc site and side)
Background	➢ Relevant medical history ➢ Infection status ➢ Communication/ needs ➢ Cognitive Impairment ➢ Religious/spiritual/cultural needs ➢ Mobility status
Assessment	➢ Procedure performed (inc site and side) • Intentionally retained items • Position • Fluid balance • Blood loss • Catheterisation • Stoma sites • Drains • Wound Infiltration • Wound closure • Dressings ➢ ABCDE ➢ Confirmation multi-lumen catheters have been clamped/shut/occluded with caps/needleless connectors ➢ PACU post-operative skin assessment ➢ VTE Prophylaxis ➢ Incidents/relevant information
Recommendation	➢ Post-operative instructions from surgeon ➢ Post-operative wound care ➢ Instructions for retained items ➢ Confirm infusion devices - including device number(s) ➢ Safety incidents/risk assessments ➢ Relevant forms/charts accompanying patient ➢ Additional questions/comments

Relevant SBAR prompts (see above) discussed during verbal handover and written documentation reviewed for accuracy and completeness:				
	Full Name (PRINT)	**Signature**	**Date**	**Time**
PACU Practitioner:				
Ward Practitioner:				

Is the patient wearing anti-embolic stockings?		
Does the patient have dentures/implants/caps/crowns/braces/loose teeth? If yes, specify (including laterality): …….. Confirm if: Removed ☐ In-situ ☐		
Does the patient have contact lenses/glasses/artificial eyes? If yes, specify laterality: …… Confirm if: Removed ☐ In-situ ☐		
Does the patient have hearing aid(s)? If yes, specify laterality:…….. Confirm if: Removed ☐ In-situ ☐		
Have false nails/nail varnish/make up been removed?		
Are jewellery/rings/piercings been removed or covered?		
Has a Patient Handling Assessment & Safer Handling Plan been completed? If yes, specify category:		
Has a Purpose T risk assessment been undertaken? If yes, circle decision: Current or previous pressure damage No pressure ulcer but at risk No pressure ulcer, not currently at risk Patient skin assessment (refer to key on page 1): …….. **(Please detail pre-existing skin damage below)** ……		
Has urine been voided? Time (24hr clock):		

Transferred to Theatre with (tick applicable):			
Intravenous Cannula Site(s):		CVP Line: Site:	
Intravenous Infusion(s) Type(s):		Arterial Line: Site:	
Nasogastric Tube: Size:		Urinary Catheter: (Including fluid balance chart)	
Infusion Devices: Type(s): Device number(s):		Other e.g. toy/comforter:	
NEWS/PEWS/MOEWS Chart(s):		Prescription Chart:	
Blood results, X-rays, ECG, relevant imaging/investigations:		Anaesthetic Chart:	

	Signature:	**Designation:**	**Date:**	**Time:**
Registered Practitioner completing checklist:				

Delegated Patient Escort:		
Name:	**Designation:**	**Signature of Registered Practitioner:**

Theatre Practitioner receiving patient and written handover:		
Name:	**Designation:**	**Signature:**

ANAESTHETIC CARE

Time in Anaesthetic Room (24hr clock): .....

Temperature on arrival to Anaesthetic room: .....˚C

Patient Monitoring (tick)

SpO_2 ☐ Non-Invasive BP ☐ ECG ☐ CVP ☐

Arterial Line ☐ Oxygen Analyser ☐ $EtCO_2$ ☐

Other ☐ Specify: .....

Type of Anaesthesia (tick)

General ☐ Spinal ☐ Epidural ☐ Caudal ☐ Sedation ☐

Local block ☐ Regional block ☐ Rapid Sequence Induction ☐ Nil ☐

Blocks only: Type/location(s) of block: .....

Airway Management (tick)

Spontaneous Respiration ☐ Ventilated ☐ Airway Support e.g. BIPAP ☐

Supraglottic Airway ☐ Oropharyngeal Airway ☐ Nasopharyngeal Airway ☐

Oral Endotracheal Tube ☐ Naso-endotracheal tube ☐ Tracheostomy Tube ☐

Size:..... Type:..... Secured with:..... Cuffed/Uncuffed (circle)

Throat Pack: Inserted ☐ Removed ☐ N/A ☐

Non-routine airway equipment used: Yes ☐ No ☐ N/A ☐

If yes, specify: .....

RECOMMENDED MINIMUM DISCHARGE CRITERIA

Complete checklist using key below:

KEY	
Yes	N/A
✓	N/A

	Criteria	Key	Initial
A	The patient is fully conscious, able to maintain a clear airway and has protective airway reflexes.		
B	Breathing and oxygenation are satisfactory.		
	Oxygen therapy has been prescribed.		
C	Cardiovascular system is stable. Pulse and blood pressure are approximate to normal pre-operative values/within parameters set by the anaesthetist.		
	Intravenous/arterial access sites patent.		
	Patient has passed urine/is catheterised and fluid balance chart has been started.		
	Infusions are prescribed.		
	Multi lumen connectors have been removed or flushed.		
D	Patient is alert and able to obey commands.		
	GCS score is acceptable and does not show a trend of deterioration.		
	Pain and post-operative nausea and vomiting is adequately controlled and suitable analgesia/anti-emetic/TTH's are prescribed.		
	Adequate return of motor/sensory functions (inc colour, movement and sensation).		
E	Surgical site/drains/catheters are satisfactory.		
	Intentionally retained items have been documented.		
	Skin assessment has been undertaken.		
	Temperature > 36 degrees Celsius.		
	Mouth care has been provided.		
	Compression garments/post-operative VTE plan documented.		
	NG tube/other indwelling devices are satisfactory and placement has been confirmed.		

Time patient confirmed fit for discharge:		**Initials (PACU):**	

Risk Assessments Initiated (tick all applicable):	Tick:
Purpose T:	
Wound Assessment Care Plan:	
Other (please list):	

Access (tick) N/A: ☐

I/V Cannula: ☐ Site(s): ....

Size(s): .... I/V Bundle completed: ☐

CVP Line: ☐ Site:................................ Size:.............. Dressing: ....

Arterial Line: ☐ Site: .... Size:.............. Dressing: ....

Other e.g. PICC ☐ Specify: ....

Failed/removed cannulas ☐ Details: ....

Other Interventions (tick) N/A: ☐

Eye Protection: Eye Guards ☐ Eye Pads ☐ Specify laterality: ....

Nasogastric Tube ☐ Size: .... Secured with: ....

Forced Air Device ☐ Size: .... Temperature: ....°C

Fluid Warmer ☐ Cell Salvage ☐

Patient Positioning (tick)

Manual handling aids: Pat slide ☐ Transfer sheets ☐ Patient self-positioned ☐

Slide sheets ☐ If slide sheets used, confirm slide sheets removed before surgery commenced ☐

Supine ☐ Lateral ☐ Lithotomy ☐ Lloyd Davies ☐ Prone ☐

Sitting/Shoulder Table ☐ Hip Table/Traction ☐ Trendelenburg ☐

Reverse Trendelenburg ☐

Please detail laterality etc. (and if there is more than one surgical position):

....

....

....

Position of:

Right Arm: Across chest ☐ Arm board ☐ By side ☐ Arm/Hand Table ☐ Wrapped: ☐

Left Arm: Across chest ☐ Arm board ☐ By side ☐ Arm/Hand Table ☐ Wrapped: ☐

Right Leg: Flexed ☐ Extended ☐ Abducted ☐ Adducted ☐

Left Leg: Flexed ☐ Extended ☐ Abducted ☐ Adducted ☐

Other: ☐ Specify: ……………………………………………………………………………

Protective Measures (tick)

Pillow ☐ Head Ring ☐ Arm Supports ☐ Arm Board ☐ Arm Table ☐

Lateral Supports ☐ Knee Supports ☐ Shoulder Supports ☐ Prone Supports ☐

Heel Supports ☐ Gel Pads ☐ Sandbags ☐ Straps ☐ T-Bars ☐

Other ☐ Specify: ………………………………………………………………

Tourniquet (tick) **N/A:** ☐

Cuff integrity checked: ☐ Skin intact (tourniquet site): ☐

Site 1: ……………………………… Pressure: …………..Time Inflated: ………….. Time Deflated: ……………….

Site 2: ……………………………… Pressure: …………..Time Inflated: ………….. Time Deflated: ……………….

Method of exsanguination: …………………………………. Tourniquet(s) removed: ☐

Skin integrity assessed (after tourniquet(s) removed): ☐

Skin Assessment: ……………. (use key on page 1)

If skin integrity has changed, specify actions and complete relevant risk assessment.

Anti-embolism Devices (tick) **N/A:** ☐

Compression Stockings: ☐ Side: Left ☐ Right ☐

Sequential/Intermittent Device: ☐ Side: Left ☐ Right ☐

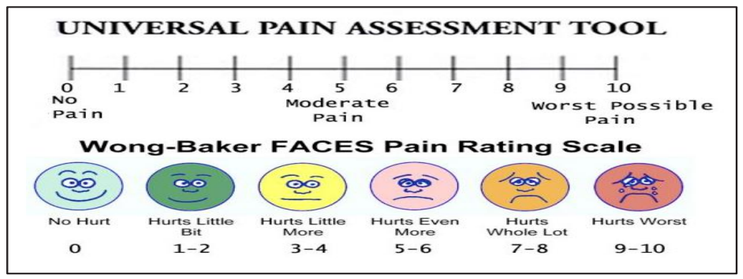
Date, time and sign each entry:	Timeline of Care Interventions
………………………	………………………………………………………………

Invasive Monitoring Record - For $EtC0_2$ and CVP Monitoring.

Date, time and initial each entry (24hr clock):														
$EtC0_2$ (e.g. 35-45 mmHg)														
CVP (e.g. 0-10 cm H20)														

Pain and Sedation Assessment Tools

0	No Pain
1	Mild Pain
2	Moderate Pain
3	Severe Pain



Opioid-Induced Sedation Scale with Interventions (Modified POSS score)

Score		Action
S	Sleeping, easy to wake	Acceptable- No action
0	Awake & Alert	Acceptable- No action
1	Slightly drowsy easy to wake	Acceptable- No action
2	Frequently drowsy, rousable, drifts off to sleep during conversation	Unacceptable; 1) Monitor respiratory status and sedation level closely until sedation ;level is less than 2 and respiratory rate is >10 2) Ask the patient to take deep breaths every 15 mins 3) If no improvement after 30 mins consider Naloxone (see below)
3	Unable to wake- no response to verbal and tactile stimulation	Unacceptable; 1) Administer oxygen 2) give Naloxone 100-200 microgram IV stat 3) Give further doses of 100 microgram every 2 minutes until respiratory rate >8 sedation score <2 4) Call the on-call Dr

Record pain assessment & sedation scores on Timeline of Care Interventions

Communication/Relevant Information/Significant Incidents

Chaperone/Family Member/Carer accompanied patient to anaesthetic room? Yes: ☐ No: ☐

Datix Completed: Yes ☐ N/A ☐

Datix Reference No:

Anaesthetic Practitioner (PRINT NAME): ..... Signed: .....

Date: ..... Time: .....

ALL TRACEABILITY STICKERS TO BE PLACED ON PAGE 9

ANAESTHETIC TRACEABILITY STICKERS

Other Interventions
Diabetic: Yes ☐ No ☐ If yes, type: ..... Sliding Scale ☐
Oral fluids/light diet provided: Yes ☐ No ☐ **(Consider fluid balance chart)**
Compression garments in situ: Yes ☐ N/A ☐

Wound Management	N/A: ☐
Dressing review: Time: ..... Condition:	
Dressing review: Time: ..... Condition:	
Dressing replaced/added: ☐ Time: ..... Reason: ..... Type:	
Time: ..... Reason: ..... Type:	

Pressure Risk Assessment

Skin assessment on admission to PACU (from scrub handover): ..... (use key on page 1)

Reassess skin if time in recovery > 1hr.

Skin Reassessed: ..... (use key on page 1) Time (24hr clock): .....

If skin integrity has changed (from pre-op skin assessment on page 4), specify actions and complete relevant risk assessment.

N.B IF PRESSURE RISK ASSESSMENT HAS NOT BE COMPLETED PRE-OPERATIVELY (E.G. EMERGENCY SURGERY), PLEASE COMPLETE PURPOSE T RISK ASSESSMENT BEFORE PATIENT IS DISCHARGED FROM PACU.

Postoperative Fluid/Medicines Management

Drug/Fluid given:	Dose	Route	Time

POST ANAESTHESIA CARE

Time in to PACU (24hr clock): .....

Theatre handover received: ☐ Anaesthetic handover received: ☐

Patient transferred on O_2: Yes ☐ No ☐

Airway Management on arrival to PACU (tick)

Type of airway:

Supraglottic Airway (inc T-bag) ☐ Oropharyngeal Airway ☐ Nasopharyngeal Airway ☐

Oral Endotracheal Tube ☐ Naso-endotracheal tube ☐ Tracheostomy Tube ☐

O_2 (via facemask/nasal specs): ☐ L/min: .....

Airway Intervention:

Breathing Circuit ☐ Jaw Support ☐ Suction ☐ Other ☐ .....

If extubated in PACU state time (24hr clock): ..... Capnography ☐

Record capnography on page 19

Invasive Monitoring (tick) N/A: ☐

Arterial BP ☐ CVP ☐ Other ☐ Specify: .....

Record invasive monitoring on page 19

Access (tick) N/A: ☐

I/V Line(s) Flushed: ☐ I/V Bundle completed: ☐

Re-cannulated: ☐ Site(s): ..... Size(s): ..... Dressing: .....

Cannula removed: ☐ Site(s): ..... Dressing: .....

Temperature Management (tick)

Fluid warmed: Yes ☐ No ☐

Forced Air Device: Yes ☐ No ☐ Temperature: .....˚C

Warm blankets applied: Yes ☐ No ☐ Thermal Cap ☐

SURGICAL CARE

Pre-procedural accountable items checked (tick): ☐

Completed by (PRINT): Scrub Practitioner: .....

Circulating Practitioner: .....

Diathermy (tick) N/A: ☐

Site prepared: ☐ Skin intact: ☐

Diathermy Connected: ☐ Diathermy Smoke Evacuator: ☐

Site: ..... Type: .....

Skin Preparation (tick)

Betadine: ☐ If yes: Alcoholic: ☐ Antiseptic: ☐

Chlorhexidine: ☐ Savlon/Unisept: ☐ Chloraprep: ☐ NaCl: ☐

In situ pre-op: ☐ Catheterisation (tick) N/A: ☐

Site: ..... Type: ..... Size: .....

Volume in balloon (mls): ..... Inserted by (PRINT NAME): .....
(CONSIDER FLUID BALANCE CHART)

If a catheter is removed pre-operatively or post-operatively please document below:

Water removed from balloon (mls): ..... Urine drained (mls): ..... Time (24hr clock): .....

VTE N/A: ☐

Sequential/Intermittent Device Connected: ☐ Side: Left ☐ Right ☐

Wound Infiltration N/A: ☐

Site(s): ..... Medication: ..... Amount (mls): .....
Administered by: ..... Time given (24hr clock): .....

Site(s): ..... Medication: ..... Amount (mls): .....
Administered by: ..... Time given (24hr clock): .....

Site(s): ..... Medication: ..... Amount (mls): .....
Administered by: ..... Time given (24hr clock): .....

Surgical Irrigation N/A: ☐

Type: .....Amount in (mls): ..... Amount out (mls): .....
Type: .....Amount in (mls): ..... Amount out (mls): .....

Total amount in (mls): ..... Total amount out (mls): .....

Intentionally Retained Items **N/A:** ☐
(Items to be removed at a later date)

Site(s): .....

Item/type: ..... Quantity: .....

Time inserted (24hr clock): ..... Date: .....

Intentionally retained items form completed: ☐

Wound Drains **N/A:** ☐

Site: .....Type: .....Size: .....Secured with: .....

Opened: Yes: ☐ No: ☐ N/A ☐

Site: .....Type: .....Size: .....Secured with: .....

Opened: Yes: ☐ No: ☐ N/A ☐

Specimens (tick) **N/A:** ☐

1. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

2. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

3. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

4. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

5. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

6. .....Type: .....

   Formalin: ☐ Dry: ☐ Other (specify): .....

Specimen card and register completed: ☐

Patient does not require PACU admission: ☐
HANDOVER
Theatre → PACU/WARD

Time of handover (24hr clock): .....

Situation	➢ Positive patient identification ➢ Preferred name ➢ Preferred language ➢ Allergies ➢ Name of surgeon ➢ Planned procedure
Background	➢ Relevant medical history ➢ Infection status ➢ Communication needs ➢ Cognitive Impairment ➢ Religious/spiritual/cultural needs ➢ Mobility status
Assessment	➢ Procedure performed (inc site and side) • Intentionally retained items • Position • Post-operative skin assessment • Fluid balance • Blood loss • Catheterisation • Stoma sites • Drains • Wound Infiltration • Wound closure • Dressings ➢ VTE Prophylaxis ➢ Incidents/relevant information
Recommendation	➢ Post-operative instructions from surgeon ➢ Post-operative wound care ➢ Instructions for retained items ➢ Additional questions/comments

Relevant SBAR prompts (see above) discussed during verbal handover and written documentation reviewed for accuracy and completeness:				
	Full Name (PRINT)	**Signature**	**Date**	**Time**
Scrub Practitioner:				
PACU/Ward:				

SURGICAL TRACEABILITY STICKERS

Skin Closure N/A: ☐

Absorbent: ☐ ..... Non-absorbent: ☐ .....

Staples/clips: ☐ Steri-strips: ☐ Other ☐ .....

Maximum Wound Dimensions (cm/mm) Length: ..... Width: ..... Depth: .....

Dressings

Site: ..... Type : .....

Site: ..... Type : .....

Site: ..... Type : .....

Site: ..... Type : .....

Procedure Performed

Surgeon 1: ..... Assistant(s): .....

Surgeon 2: ..... Assistant(s): .....

Procedure: .....

.....

.....

.....

Estimated blood loss (if applicable): .....(mls)

Time procedure completed (24hr clock): .....

Final check completed for all accountable items: ☐

Scrub Practitioner 1 Signature: ..... Date & Time: .....

Scrub Practitioner 2 Signature: ..... Date & Time: .....

Circulating Practitioner 1 Signature: ..... Date & Time: .....

Circulating Practitioner 2 Signature: ..... Date & Time: .....

Post Procedural Checks

Diathermy plate removed: Yes ☐ N/A ☐

Skin integrity checked: Yes ☐

Skin Assessment (use key on page 1): .....

If key has changed, specify actions and complete relevant risk assessment.

.....

Communication/Relevant Information/Significant Incidents/Risk Assessments:

Risk Assessments Initiated (tick all applicable):	Tick:
Purpose T	
Wound Assessment Care Plan	
Other (please list):	

Datix Completed: Yes ☐ N/A ☐

Datix Reference No:

ALL TRACEABILITY STICKERS TO BE PLACED ON PAGE 14 & 15

SURGICAL TRACEABILITY STICKERS