Patient identification label:
NHS number Forename Surname Date of Birth Hospital Number
Patient ID verbally confirmed against addressograph ☐

Adult Surgical Day Case Nursing Assessment

To be completed on day of admission

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Admission Date & Time	Hospital	Consultant/Surgeon		General Practitioner:
				Name
Source of admission	Ward / Department	Preferred name	Gender	Address
				Telephone number

	Yes	No	N/A	
Elective Surgical Booking Form & Health Screening Questionnaire completed?				**Information on pre-assessment verified as correct (if applicable)** ☐ Comments:
Full pre-assessment document completed?				
Confirm that the person has a carer/support for 24 hours post procedure, and aware of their responsibility.				☐
Confirm patient aware of predicted discharge time and transport arranged.				☐

Home Tel. No.		Occupation		Religion		
Mobile Tel. No.		Ethnicity		First Language		
Preferred Language		Interpreter Required?	Yes		No	Actions:
Method of Communication	E.g. speech, sign.					Actions:
Current Address (if different from permanent address)				Postcode:		

Does the patient have a learning disability?	Yes		No		Consider if they have a passport & care bundle
Are there concerns with cognitive functioning?	Yes		No		If yes, consider presence of dementia, capacity to consent to medical treatment, appropriate advocate

Allergies	Type of Reaction	Actions			
		Epi pen used?			
		Yes		No	
		Is the pen with the patient?			
		Yes		No	

Does the patient have a valid DNACPR form in place? Yes ☐ No ☐ N/A ☐ *Valid copy in the medical notes* ☐ (Do Not Attempt Cardio-Pulmonary Resuscitation)

Does the patient have a known infection / alert?		Infection alerts e.g. *Clostridium. difficile* MRSA screening undertaken

Please write in BLACK ink

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):	

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:				

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

Care Plan (Potential Problem, nursing goals & interventions)		Evaluation
Respiratory Complications	• Record NEWS by observing respirations, temperature, blood pressure and pulse on return to ward/unit; then ½ hourly observations for 1 hour followed by a review from the registered nurse as to frequency of observations prior to discharge • Observe chest movement for equal, bilateral expansion, observe colour and perfusion and position the patient to facilitate optimum lung expansion and reinforce pre-operative teaching of deep breathing exercises and coughing.	
Patient has undergone spinal / regional block	• Record observations as above, observe patient for signs of hypotension, respiratory depression, nausea/vomiting and pruritus • Ensure patient is informed that he/she will not be able to get off the trolley/bed for a minimum of 2 hours post spinal, provide them with call bell for summoning assistance • Before assisting patient to mobilise ensure patient is able to 'straight leg raise against gravity' • Patient must have a minimum of 4 hours post-operative recovery time prior to discharge • Ensure patient passes urine prior to discharge Patient provided with post spinal anaesthetic information leaflet prior to discharge.	
Wound / Drains	On return from theatre and prior to discharge; • Observe any drains including quantity and nature of drainage wound sites / wound dressings, for redness, tenderness and increased temperature • Observe pulse, blood pressure, respirations and colour.	
Nausea & Vomiting	• Assess nausea and vomiting at regular intervals following NEWS • Ensure patient has access to vomit bowl and tissues • Administer antiemetic as prescribed and note effectiveness of the medication given • If the patient is vomiting – assess the frequency, volume, notable characteristics of the vomit and timing.	
Potential problem of pain	• Assess the patient for pain also noting physiological signs indicative of pain, e.g. sweating, tachycardia, hypotension, and pallor or flushed appearance • Administer prescribed analgesia and observe effect • Try changing position of patient. Give attention, information and reassurance; assist with relaxation exercises • Ensure patient has adequate analgesia supply for discharge.	

Signature		Reviewer Signature		Time	

Date	Time	Nursing Notes	Signature

Date	Time	Nursing Notes	Signature

Please write in BLACK ink

Day Case Discharge Home Criteria and Checklist				Date of discharge	
Please ✓	Yes	No	N/A	Comments & Actions	
Observations completed and recorded on the NEWS chart?					
Vital signs stable - consistent with age and pre-operative / procedure baseline? **If no, actions taken?**				NEWS SCORE:	
Orientated to time, place and person?					
Passed urine prior to discharge?				If answered no, or N/A, specify why:	
Discharged with catheter in situ?				Urinary Catheter Passport Given □ Catheter care pack provided □ Referral for continence products completed □	
Minimal nausea/vomiting?					
Able to dress and walk (where appropriate)?					
Oral fluids tolerated?					
The patient has minimal/no pain prior to discharge?				It should be acceptable to the patient and controllable by oral analgesia.	
Patient advised on managing pain at home?					
Minimal bleeding – consistent with expected blood loss for procedure?				Minimal – does not require dressing change. Moderate – up to 2 dressing changes	
Dressings checked?					
Wound assessment and plan given to take home detailing need for suture removal?					
Spare dressings supplied as required?				If Yes, specify:	
Any other equipment required given to patient to go home?				If Yes, specify:	
Discharge needs discussed with patient or their family/significant other?					
Written and verbal instructions provided, including post-operative advice sheet and who to contact in an emergency?					
Patient given copy of consent?					

Nurse led discharge criteria not met ☐	Specify reasons and actions taken:

	Yes	No	N/A	Comments & Actions
Next of Kin/Significant Other/Carer informed?				
IV cannula removed?				
District Nurse booked for home visits (if required)?				
Patient has appropriate clothing for discharge/transfer?				
Property - Patient packed own?				☐ Property Book completed
Is the patient being discharged to their own home? (If YES, consider house keys for access, heating on at home, food supplies at home)				If the patient does NOT have their house keys, where are they located?
Does the patient/ parent/ carer have the patients take home medication or own drugs to be discharged with?				
Does the patient/ parent/ carer understand the instructions for medication administration?				
Has transport been arranged?				Own ☐ Ambulance ☐ Ambulance Car Booking reference: Patient discharged to: Own home ☐ Nursing /residential home ☐ family/friend ☐
Will anyone be accompanying the patient?				☐ confirm patient has carer for 24 hours post procedure
If No, will anyone be at the patient's home to meet them?				
Patient provided with follow up appointment (if required)?				Specify arrangements:
General Practitioner (GP) letter:				☐ Posted ☐ Given to patient to take to surgery
Med 3 Certificate:				If Yes, then Med 3 Certificate issued
Are there any outstanding referrals to make?				If YES please outline:
Does the patient have a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decision that will to continue on discharge?				If Yes, Valid copy in patient's notes, signed by senior ☐ consultant Copy given to patient ☐ Carer ☐ GP ☐ Patient understands/is aware of the order ☐

Signature		Reviewer Signature		Date & Time	

References / Other related documents:
British Association of Day Surgery (BADS) 2011 Day Case and Short Stay Surgery
Hywel Dda University Health Board Surgical Day Case Admission Guidelines
Social Services & Wellbeing Wales Act 2014
Ambulatory Care Nurse Led Discharge Procedure (draft)
NICE guideline (NG45) Routine Preoperative Tests for Elective Surgery. April 20
1000 Lives Plus (2019) Reducing Surgical Complications.
Keck, J., Gerkensmeyer, J., Joyce Band Schade, J (1996). Reliability and validity of the FACES and Word Descriptor scales to measure procedural pain. Journal of Paediatric Nursing, 11(6): 368-374.
National Patient Safety Agency (2010) Rapid Response Report: Checking pregnancy before surgery.
National Institute for Health and Care Excellence (2016) Routine preoperative tests for elective surgery.
NHS Improvement (2018) SBAR communication tool-situation, background, assessment, recommendation.
Pasero, C (2009). Assessment of sedation during opioid administration for pain management. Journal of Peri Anesthesia Nursing. 24(3):186-90.
Royal College of Paediatrics and Child Health (2012) Pre-procedure Pregnancy Checking in Under 16s: Guidance for Clinicians
Welsh Government (2016) National Safety Standards for Invasive Procedures
Welsh Government (2003) Fundamentals of Care
Welsh Government (2015) Health and Care Standards
National Leadership and Innovation Agency for Healthcare (2010): All Wales Guidelines for Delegation
All Wales Minimum Standard Dataset for Documentation (2013) – currently under review
Hywel Dda University Health Board: Prevention and Management of Pressure Damage Policy
Hywel Dda University Health Board: Preparing Patients for, and Transferring patients to Theatre Procedure (LOCSSIP – draft currently under review)
Hywel Dda University Health Board: Record Keeping Policy for Nurses and Midwives
Hywel Dda University Health Board: World Health Organisation Surgical Safety Checklist (LOCSSIP – draft currently under review)
Hywel Dda University Health Board – Discharge and Transfer of Care Policy 370 (draft for consultation)

Glossary of Terms and Abbreviations	
BMI – Body Mass Index	NEWS – National Early Warning Score
CVP – Central Venous Pressure	PACU – Post Anaesthesia Care Unit
DNACPR – Do not attempt cardio-pulmonary resuscitation	PEWS – Paediatric Early Warning Score
ECG – Electrocardiogram	PICC – Peripherally inserted central catheter
HCG – Human Chorionic Gonadotropin	PR – Per Rectum
INR – International Normalised Ratio	Purpose T– All Wales Pressure Risk Assessment
I/V - Intravenous	PV – Per Vaginam
MOEWS – Maternity Obstetric Early Warning Score	SBAR - Situation, Background, Assessment, Recommendation handover format/tool
MRSA – Methicillin-resistant *Staphylococcus aureus*	TTH – Tablets to take home
MSU - Midstream Specimen of Urine	VTE – Venous Thromboembolism
NaCl – Sodium Chloride	WAASP - Adult Nutritional Risk Screening Tool (Weight, Appetite, Ability to eat, Stress factor, pressure ulcer/wound)

Pg.	Section	Guidance For Staff In The Use Of The Document
1-7	Day Unit Nursing Assessment	This assessment document is for use in the surgical day case areas and day case theatres. Should patients require a 24 hr stay following their surgery / procedure due to unforeseen circumstances the document will apply up to the 24hrs. For a longer length of stay an inpatient assessment document must be completed. Specify if you have seen the completed copy of the Elective Surgical Booking Form & Health Screening Questionnaire and document if there are significant changes or variances since this assessment. If concerns are identified, actions taken must be documented within the record of care.
	Signature List	Any person making an entry into the record must complete the signature list for traceability and adherence to requirements within policy
	Patient Assessment & Risk assessments	Complete the nursing assessment questions documenting additional information in the spaces provided. Additional assessments may be required, including falls, moving & handling, pressure damage, nutrition, mouth care and bed-rails.
11-30	Theatre Care Plan	To be completed by theatre staff only. Note pgs. 8-10, theatre checklist to be completed by both day case and theatre staff.
31-33	Nursing Care Plan & Nursing Notes	Document all nursing activities undertaken not captured elsewhere within the record, including additional assessments, interventions evaluation and variations to the plan of care.
34-35	Discharge criteria and checklist	Complete discharge criteria and checklist for all patients and document actions taken as required, prior to the patient leaving the clinical area and signed by the Registered Nurse. If the discharge criteria is not met, actions taken must be documented e.g. patient required an in-patient stay
38	Surgical Checklist	World Health Organisation adapted safety checklist.