Saskatoon Health Region	Policies & Procedures Title: **DAY SURGERY PATIENTS ON INPATIENT NURSING UNITS** I.D. Number: **1008**
Authorization: [X] Nursing Practice Committee	Source: Nursing Reaffirmed: April. 2018. (Pre-tests now 90 days) Date Revised: November 2017 Date Effective: March 2007 Scope: **SHR Urban Acute Care and HDH**

1. PURPOSE

1.1 To ensure consistent and safe patient care for Day Surgery patients throughout their stay.

2. POLICY

2.1 When patients have procedures that qualify as "Day Surgery" performed when the Day Surgery Unit is closed or over capacity, they shall be cared for on an inpatient unit.

2.2 Pre-operative criteria shall be met for each patient before undergoing a surgical procedure.

2.3 Post-op/discharge criteria shall be met for each patient prior to discharge.

3. PROCEDURE

3.1 The nurse ensures that all pre-operative criteria are met for each patient before undergoing a surgical procedure.

3.1.1 A completed History and Physical sheet is signed and dated within 90 days prior to current admission.

NOTE: *Contact surgeon if not completed.*

3.1.2 Tests completed, within 90 days prior to current admission, as ordered with results available or directed to the Operating Room (OR).

NOTE: *If any changes to the patient's medical condition, repeat tests as appropriate.*

3.1.3 Consent for Surgery (form #100362) signed and dated. (See SHR policy 7311-50-002).

NOTE: *The surgeon and/or OR staff may be notified if consent incomplete.*

3.1.4 A completed Day Surgery Record (form #101724).

NOTE: *A Nursing Admission Data Base and Careplan do not need to be completed if patient's stay is less than 24 hours. The patient signs the Day Surgery Record preoperatively, once pre and postoperative routines have been reviewed with the patient and questions answered, as applicable. Patients receive discharge instructions, as available (see Tri Site Day Surgery List of Discharge Instruction" Appendix (A)*

3.1.5 A completed Pre-operative Checklist (form #101284).

3.1.6 A completed and signed Preadmission Medication List/Physician Order Form (form #102728) with the best possible medication history. This includes reviewing with the patient all his/her prescriptions, over-the-counter, herbal medicine use and any prescriptions that will not show up on this list i.e. Cancer Clinic or TB medications. The date and time of his/her last dose will be noted for each medication and signed as a DSU review if the patient had a previous Pre Assessment Clinic (PAC) visit.

3.1.7 A completed Allergy/Intolerance Record (form #103420 (NCR) / #103420-1(Non NCR)) or Allergy/Intolerance Record Addendum if needed (form#103617 (NCR)/#103617-1 (Non NCR)).

3.1.8 The Release and Indemnification form (#102532 Appendix D) is explained and completed to ensure patient is informed of precautions to be taken following anesthesia/sedation.

3.1.9 All pre-operative physician orders are implemented including those on the Operating Room (OR) Booking Slip and Practitioners' Orders. Medications given pre-operatively in hospital are documented on the Day Surgery Record.

3.1.10 Abnormal test results and concerns regarding the patient's medical condition and medication history, or untoward changes, which may have an impact upon the surgical procedure or recovery, shall be reported to the surgeon/anesthetist.

3.1.11 Medical Directives, as appropriate, are completed and documented.

3.1.12 On admission all patients are given a discharge instruction sheet pertaining to his/her surgery, if applicable. This sheet is reviewed with the patient and questions answered. (See Tri Site Day Surgery List of Discharge Instructions – Appendix A).

3.1.13 Discharge teaching is documented on the Day Surgery Record. The patient must sign pre-operatively (prior to anesthetic/sedation) on the Day Surgery Record that he/she has received the Discharge Instructions.

3.1.14 The entire chart may remain on a clipboard.

3.1.15 The adult accompanying a child (up to 18 years of age) or mentally challenged adult is aware that he/she must remain with the patient during the patient's stay, as per unit policy.

3.1.16 The nurse documents patient's compliance with the SHR Fasting Guidelines, as below:

3.1.16.1 Children: Nothing other than the following after midnight.

- Breast Milk: up to 4 hours prior to surgery time
- Infant formula: up to 6 hours prior to surgery time
- Non-human milk: up to 6 hours prior to surgery time
- Clear fluids: up to 2 hours prior to surgery time

3.1.16.2 Adults: Nothing other than clear fluids after midnight.

- Clear fluids: up to 2 hours prior to surgery time

NOTE: *Clear fluids include water, apple juice, non-alcoholic and carbonated beverages, clear tea and black coffee. Sugar may be added to tea or coffee.*

NOTE: *The surgeon/anesthetist is notified of any non-compliance with these fasting guidelines.*

3.2 The nurse ensures safety and comfort of the patient pre and post-operatively.

3.2.1 Patients have been oriented to the nursing units. This will include patient telephone, bathroom and bedside unit.

3.2.2 Each patient has a call bell within reach.

3.2.3 A bedside report has been received from the PACU nurse on the patient's return.

3.2.4 Side rails are up on stretchers/beds/cribs post-operatively on return from PACU and following the administration of sedation, narcotic or anesthetic.

3.2.5 Patients are allowed to rest as necessary prior to eating and ambulation.

3.2.6 Patients are assisted with the first ambulation after surgery.

NOTE: *Assist with 2 nurses if patient has had a spinal anesthetic or lower limb peripheral block.*

3.2.7 The patient has the opportunity to express concerns and questions regarding their entire pre/post-operative experience and staff will provide answers /reassurance as appropriate.

3.3 The nurse ensures that all post-op/discharge criteria are met for each patient prior to discharge:

3.3.1 An assessment of the patient is done on arrival from PACU and repeated at least once prior to discharge and documented.

3.3.2 A Post Anesthetic Discharge Scoring System based on five main criteria (vital signs, activity, nausea and vomiting, pain, surgical bleeding) is used to guide the

postoperative assessment and aid in assessing patient's readiness for discharge. (See Post Anesthetic Discharge Scoring – Appendix B)

3.3.3 To qualify for discharge the patient must score > 9 or as directed by the surgeon. Discharge scoring is documented on the Day Surgery Record. (See Day Surgery Record Pre-Op Data – Appendix C)

3.3.4 The patient must have a score of 2 in the vital sign category to be eligible for discharge.

3.3.5 The patient, who has had anesthetic and/or sedation, must be accompanied home by a responsible adult in a car, taxi or ambulance (not public transit). It is recommended a responsible adult stay overnight with the patient. (See Release and Indemnification form #102532).

3.3.6 If the patient does not meet the discharge criteria, the surgeon will be notified.

3.3.7 Written discharge orders will be transferred to the appropriate Discharge Instruction (Appendix A) form and reviewed with the patient and/or family and sent home. A copy will be kept on the chart.

3.3.8 Patients will not be sent home after midnight unless the patient, family or physician specifically request and all other discharge criteria are met.

3.3.9 The patient will be required to void spontaneously prior to discharge in the following instances:

- If ordered
- Following the removal of an indwelling catheter
- If the patient has a previous history of voiding difficulties

NOTE: *Consider use of a bladder scanner on spinal anesthetic patients on admission from the Post Anesthetic Care Unit (PACU) to assess post-operative urinary retention. For surgical procedures where voiding is not a criteria for discharge, the patient should be advised to contact the responsible physician if unable to void within 6-8 hours after discharge.*

3.3.10 The patient will be monitored after narcotic administration to ensure an appropriate outcome and peak effect has been achieved without adverse effects.

- The patient will be monitored for a minimum of 30 minutes post IV injection, maintaining IV access.
- The patient will be monitored for a minimum of 45 minutes post IM injection.
- The patient will be monitored for a minimum of 60 minutes with respiratory rate, sedation & pain scale at baseline and 45 - 60 minutes after every oral dose of Dilaudid or Morphine, and documented.

3.3.11 Drinking is not a criteria for discharge unless specifically indicated. The patient should be able to swallow oral fluids.

3.3.12 If the patient has received Epidural/Intrathecal Epimorph, the physician will need to arrange for patient's overnight admission for observation.

3.3.13 If the patient has been ordered analgesic to be sent home on discharge from DSU, 12 hours of doses of either Dilaudid or Tylenol #3s can be sent home with the

patient(See SHR Policy 7311-60-004). An information sheet on the side effects of the narcotic and proper labelling will be done as per the "Tabs to Go" Project (SHR Infonet, Pharmacy, Resources/Apps http://infonet.sktnhr.ca/pharmaceuticalservices/Pages/MedicationstogoProject.aspx

3.3.14 In addition to the appropriate discharge instructions/criteria, Tonsillectomy/ Adenoidectomy patients are required to stay a minimum of 3 hours post surgery, must remain within 60 minutes of a hospital with 24 hour emergency care until the following morning and must go to the Emergency Room (ER) at the first sign of bleeding. These patients are required to have their pharynx checked by the surgeon or nurse prior to discharge. If the child does not allow this, the child can still go home if there are no external signs of bleeding.

3.3.14.1 Adenoidectomy patients must stay a minimum of 2 hours post surgery.

3.3.15 In addition to appropriate discharge instructions/criteria, Total Laparoscopic Hysterectomy/Laparoscopic Assisted Vaginal Hysterectomy (TLH/LAVH) patients must stay 6 hours post surgery in the DSU as per TLH/LAVH protocol.

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APPENDIX A

DAY SURGERY
SASKATOON HEALTH REGION

TRI SITE DAY SURGERY LIST OF DISCHARGE INSTRUCTIONS

NAME OF DISCHARGE INSTRUCTION	**FORM NUMBER**
ANESTHESIA	
Adult Discharge Pain Medication Chart	103753
PEDIATRIC Discharge Pain Medication Chart	103797
Paravertebral Nerve Block	103877
Femoral Nerve Block	103729
Infraclavicular Nerve Block	103730
Interscalene or Supraclavicular Nerve Block	103731
Popliteal Nerve Block	103732
Spinal Anesthesia	103879
CARDIOVASCULAR	
Coronary Angiogram/Percutaneous Coronary Intervention	102551
Pacemaker Insertion	102518
PEDIATRIC Cardiac Catheter	Copy for now
Power Pack Replacement Instructions	103725
DENTAL	
Dental Extractions	102546
Minor Dental Surgery	102547
Rapid Palate Expansions	104135
DIAGNOSTIC IMAGING	
Angiogram/Angioplasty	103995
Cerebral Angiogram	102556
Kidney Biopsy	102553
Liver Biopsy	102555
Lung Biopsy	102554
Outpatient Biopsy	103885
Outpatient Central Venous Port (Arm)	103986
Outpatient PICC	103987
Paracentesis	103988
Pleurx Catheter	103812

Radiofrequency Ablation (RFA)/Microwave Ablation	104204
Thoracentesis	103989
Thyroid Biopsy	102552
ENDOSCOPY	
Bronchoscopy	101415
EBUS –Endobronchial Ultrasound	Coming
ERCP -Endoscopic Retrograde Cholangiopancreatography	101416
Esophageal Dilation	102188
Gastroscopy / Upper Endoscopic Ultrasound	102189
Hemorrhoid Banding	101420
Sigmoidoscopy/Colonoscopy/ Lower Endoscopic Ultrasound	101417
ENT	
Adenoidectomy	103049
Auditory Brainstem Response (ABR)	103990
Cochlear Implant	103993
Direct Laryngoscopy or Microlaryngoscopy	103050
Myringotomies (Ear Tubes)	102436
Nasal Surgery	102435
Stapedectomy	103991
Tonsillectomy and Adenoidectomy - Adult	101762
Tonsillectomy and Adenoidectomy - Pediatric	101753
Tympanomastoidectomy	103992
Tympanoplasty	102437
GENERAL SURGERY	
Breast Biopsy or Lumpectomy	101738
Hemorrhoidectomy	101646
Hernia Repair	101661
Laparoscopic Cholecystectomy	101739
Pilonidal Abscess, Perianal Fistula/Abscess, Seton Suture	101658
Varicose Vein Stripping/Ligations	101752

GYNECOLOGY	
Bartholin's Cyst Drainage	102461
Carbon Dioxide Treatment of External Genital Lesions (Vulva)	102466
Carbon Dioxide Treatment of Lesion of the Cervix	102464
Cone Biopsy	102467
Endometrial Ablation/Novasure	102470
Essure Tubal Sterilization	103387
Hysteroscopy/D&C	102468
Labial Reduction	103811
Laparoscopic Conservative Surgery for Endometriosis	102471
Laparoscopic Tubal Sterilization	100427
Laparoscopy	100423
Laser Ablation of Warts	102473
LEEP (Loop Electrocautery Excision Procedure)	102474
Myomectomy	104120
Myosure	104121
Pudendal Blocks/Trigger Point Injections	104103
Shirodkar Suture Procedure	102478
Tension-Free Vaginal Tape (TVT)	102545
Therapeutic D&C	102479
Total Laparoscopic Hysterectomy/ Lap Assisted Vaginal Hysterectomy	Coming
DC Instructions Following Vaginal or Vulvar Procedures	103386
NEUROSURGERY	
Glycerol Injection for Trigeminal Neuralgia	102482
Lumbar Discectomy	102475
OPHTHALMOLOGY	
Cataracts	103627
Corneal Transplant(Partial Thickness)	103629
Dacryocystorhinostomy (DCR)	103625
Descemet Stripping and Automatic Endothelial Keratoplasty (DSAEK)	103624
Enucleation	103623
Pterygium Surgery	Coming
Scleral Buckle	103630
Strabismus	100419
Tear Duct Probing	Coming
Trabeculectomy	103631
Vitrectomy	103632
General Ophthalmology Procedure	103626

ORTHOPEDICS	
Acromioplasty	103882
Bankart Repair and/or Capsular Shift Repair	103883
Bunionectomy	104049
Cast Care	101715
Hand or Arm Surgery	104048
Knee Arthroscopy	103880
Leg and Ankle Surgery	104045
Orthopedic Hardware Removal	104046
Physio Anterior Cruciate Ligament Reconstruction Manual	101912
Physio Rotator Cuff Manual	102179
Rotator Cuff Repair	102544
Shoulder Arthroscopy	103881
Ulnar Nerve Transposition	104047
Using Crutches	103426
PLASTICS	
Abdominoplasty new	104104
Axillary Sweat Glands Excision	104106
Blepharoplasty	102462
Breast Reconstruction with Expanders and Implants	103726
Breast Reduction	102463
Carpal Tunnel Release/Endoscopic Carpal Tunnel Release (ECTR)	102465
Dupuytren's Contracture	102469
Excisions-Ambulatory Care new	104111
Fat Grafting	103727
Gynecomastia	102472
Hand or Arm Surgery (Plastics)	104105
Jaw Fracture Repair new	104107
**Blended Diet – Dieticians	101463
Otoplasty	102476
Rhinoplasty (Plastics)	102477
Skin Grafts new	104109
Toenail Removal – Ambulatory Care	104110

UROLOGY	
Botox Injections for the Bladder	104134
Bulkamid (replaces Contingen)	103898
Circumcision	102417
Cystoscopy	104006
Green Light Laser	103087
How to Care for Your Catheter	102095
Hydrocelectomy/Spermatocelectomy	103895
Lithotripsy	104004
Mitomycin	103073
Nesbit	103897
Prostate Biopsy	104005
Scrotal Orchidectomy/Orchidopexy	102418
TURBT	104044
Ureteral Stent	103896
Ureteroscopy/with Laser +/- Stent Insertion	104001
Ureteroscopy with Stone Extraction	104002
Urethrotomy	104000
Varicocelectomy	104003
Vasectomy	101533
Vasectomy Reversal /Vasovasotomy	103999
MISCELLANEOUS	
Electroconvulsive Therapy	102636
Discharge Instructions (No Incision)	103747
Discharge Instructions (With Incision)	103746
Going Home with a JP Drain	104124
Renal – Patient Instructions for new AV Graft or AV Fistula	From RU
Renal – Patient Instructions for New CAPD-RU staff will give to Pt.	
VAC / Negative Pressure Wound Therapy	104108

APPENDIX B

Post Anesthetic Discharge Scoring:

The following are the areas that require scoring and/or consideration when determining the patient's readiness for discharge.

The Discharge Scoring system does not replace critical thinking and individual patient assessment.

VITAL SIGNS:

Vital signs must be stable and consistent with age and preoperative baseline. The patient must score a 2 to be eligible for discharge

2 BP and HR +/- 20% of pre-op and O_2 sat greater than92% on room air
1 BP and HR +/- greater than 20% and less than 40% of pre-op and/or O_2 sat greater than 90% on oxygen
0 BP and HR +/- greater than 40% of pre-op and/or O_2 sat greater than90% on oxygen

ACTIVITY:

The patient must be able to ambulate at preop level.

2 steady gait, no dizziness, able to ambulate consistent with surgical procedure or equivalent to pre-op status
1 requires assistance not consistent with procedure or pre-op status
0 unable to ambulate, i.e. due to dizziness

NAUSEA AND VOMITING:

The patient should have minimal nausea and vomiting prior to discharge.

2 no nausea or mild nausea with no active vomiting or controlled with medications
1 transient vomiting or retching
0 persistent moderate-severe nausea and vomiting

PAIN:

The patient should have minimal or no pain prior to discharge. Pain should be controlled by oral analgesics. The location, type and intensity of pain should be consistent with anticipated post-operative or procedural discomfort.

2 no pain or mild pain controlled with oral analgesics
1 moderate to severe pain controlled with IV analgesics
0 persistent severe pain

SURGICAL BLEEDING:

Postop bleeding should be consistent with expected blood loss for surgical procedure.

2 dressing/operative site dry and clean without evidence of active or unexpected bleeding and circulation, sensation, and movement adequate
1 dressing/operative site wet, but marked and not increasing and circulation, sensation, and movement adequate, if applicable
0 growing area of bleeding or circulation, sensation, and movement **not** adequate, if applicable

APPENDIX C

Saskatchewan Health Authority

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

DAY SURGERY RECORD

Page 1 of 2

Key: ☑ - Yes ☒ - No N/A - Not applicable * - If applicable

PRE-OPERATIVE DATA

Date: _____ Time of admission: _____ Mode: _____

Booked procedure: _____

_____

Emergency contact: _____ Phone number: _____

Patient will be accompanied home by: _____ Phone number: _____

HEALTH HISTORY (WNL = Within normal limits)	
SYSTEM	Pertinent positive or negative findings:
CNS – alert and orientated x 3, chronic pain, CVA, seizures, movement and sensation intact	❑ WNL
EENT – visual, hearing, nose, throat problems	❑ WNL
CVS – chest pain, palpitations, CAD, MI, cardiac stents/valves/ bypass, HTN, DVT/PE, circulatory problems	❑ WNL
RESP – SOB, productive cough, asthma/COPD, sleep apnea, smoking history	❑ WNL
GI – GERD, liver disease	❑ WNL
GU – voiding adequately, burning on voiding, renal disease	❑ WNL Blood type: _____* LMP: _____*
MS - up ad lib	❑ WNL
INTEG – rashes, open areas, bruises	❑ WNL

MEDICAL CONDITIONS/SURGICAL HISTORY CONTINUED:

❑ Diabetic BGM _____ at _____

❑ Previous anesthetic
❑ Problem with anesthetic
❑ Family history of problems with anesthetic

Time	Medications	Dose	Route	Initials

❑ I have received instructions about my procedure, and have had the opportunity to ask questions.

Patient signature: _____

*PAC visit date: _____ BGM _____ at _____

PAC V/S: BP _____ T _____ P _____ R _____ O_2Sat _____

PAC RN signature: _____

PHYSICIAN'S ORDERS

Activity level _____

Remove dressing in _____ days

Suture removal in _____ days

May shower in _____ days

Patient required to void prior to discharge: ❑ Yes ❑ No

❑ Return appointment _____

❑ Prescription

❑ Discharge when criteria met

For post-operative concerns call:

❑ Surgeon ❑ Family doctor ❑ Other _____

_____

_____

_____

_____

_____

DISCHARGE ANALGESICS: _____

_____

_____

Physician signature: _____

Nurse signature: _____

Form #101724 (Saskatoon Area) 01/2018 Category: Assessments/Histories

DAY SURGERY RECORD

Page 2 of 2

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

POST-OPERATIVE DATA

Key: ☑ - Yes ☒ - No N/A - Not applicable * - If applicable

Returned to Day Surgery Unit at: _____

Report received/admitted by: _____

❑ Gen ❑ Spinal/Epidural ❑ Local ❑ MAC ❑ PNB

Return V/S: BP _____ P _____ RR _____ O_2Sat _____

IV return: ❑ Intact and infusing _____ mL TBA

Procedure: _____

_____

Operative site return: _____

POST-PROCEDURE DISCHARGE SCORING SYSTEM			
Pre-op V/S TIME			
VITAL SIGNS 2 BP & HR +/- 20% of pre-op and O_2Sat greater than 92% on room air 1 BP & HR +/- greater than 20% and less than 40% of pre-op and/or O_2Sat greater than 90% on oxygen 0 BP & HR +/- greater than 40% of pre-op and/or O_2Sat less than 90% on oxygen			
ACTIVITY 2 Steady gait, no dizziness, able to ambulate consistent with procedure, or equivalent to pre-op status 1 Requires assistance not consistent with procedure or pre-op status 0 Unable to ambulate or did not attempt to ambulate			
NAUSEA & VOMITING 2 No nausea or mild nausea with no active vomiting or controlled with medications 1 Transient vomiting or retching 0 Persistent moderate-severe nausea and vomiting			
PAIN 2 No pain or mild pain controlled with oral analgesics and consistent with procedure 1 Moderate to severe pain with analgesics given 0 Persistent severe pain			
SURGICAL BLEEDING 2 Dressing/operative site dry and clean without evidence of active or unexpected bleeding & CSM adequate* 1 Dressing/operative site wet but marked and not increasing & CSM adequate* 0 Growing area of bleeding on dressing or CSM not adequate*			
TOTAL SCORE:			
Initials:			

NURSES PROGRESS NOTES: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

❑ Continued on Nursing Progress Notes

POST-PROCEDURE MEDICATIONS:

TIME	MEDICATIONS	INITIALS

Discharge V/S: BP _____ P _____ RR _____ O_2Sat _____

Discharge: IV removed _____ mL abs

❑ Alert and orientated or as pre-op

❑ Fluids taken ❑ Prescription given

❑ Voided* ❑ Discharge teaching given

❑ Post-procedure physician instructions transferred to instruction sheet

Discharged: ❑ Home ❑ Other _____

Discharged at: _____

❑ Walking ❑ Wheelchair ❑ Other _____

Date: _____

Nurse signature: _____

Form #101724 (Saskatoon Area) 01/2018 Category: Assessments/Histories

APPENDIX D

Addressograph

NAME: _____

HSN:

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

❑ RUH ❑ SCH ❑ SPH Other _____

RELEASE AND INDEMNIFICATION OUTPATIENT, AMBULATORY CARE AND DAY SURGERY PATIENT PROCEDURES

Today I am scheduled for a procedure which requires an anaesthetic or sedation.

I acknowledge and understand that Saskatoon Regional Authority and St. Paul's Hospital require, for my welfare and the safety of others, that I should leave the hospital accompanied by a responsible person following the procedure.

I must arrange for a responsible person to assist me to my residence or other accommodation. It has been recommended that a responsible person stay with me overnight.

I must not operate or drive any motor vehicle or operate heavy machinery, sign legal documents, drink alcohol or perform other duties requiring independent judgement such as child care for a period of at least twenty-four hours (24 hours) following the procedure, unless otherwise advised by my physician.

In consideration of the provisions of the facilities and services of Saskatoon Regional Authority and St. Paul's Hospital in relation to my procedure, I RELEASE the Saskatoon Regional Authority and St. Paul's Hospital, their employees or agents and all of the Medical Staff of the Hospital, of and from any and all claims or demands which I or my heirs or personal representatives should ever have as a result of any injury, loss or damage sustained by me as the result of my failure or inability to meet these requirements and instructions.

I agree that I am solely responsible for any adverse consequences to others which may be the result of my actions should I fail to take these precautions. I acknowledge and understand these instructions. The patient has been instructed on the above issues:

Dated this _____day of _____, 20_____.

_____	_____
Signature – Patient/Guardian	Signature (RN/RNP/LPN)
_____	_____
Name (Patient/Guardian) *Please Print*	Name (RN/RNP/LPN) *Please Print*
_____	_____
Date	Date

Word Form # 102532 07/10 Category: Consents/Release/Transport