

	<p>POLICIES & PROCEDURES</p> <p>Title: SAME DAY ADMISSION SURGERY UNIT STANDARDS OF CARE</p> <p>I.D. NUMBER: 1166</p>
<p>Authorization</p> <p><input checked="" type="checkbox"/> Unit Specific Manager of Nursing</p> <p><input checked="" type="checkbox"/> Nursing Practice Committee</p>	<p>Source: Nursing</p> <p>Reaffirmed: April, 2018. (Pre-tests now 90 days)</p> <p>Date Effective: November 2017</p> <p>Scope: SHR Urban Acute Care and HDH</p>

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1. PURPOSE

- 1.1 RN/LPN staff complement will be referred to as nursing staff throughout this document.
- 1.2 All nursing staff will adhere to the following Standards of Care when caring for patients in the Same Day Admission Surgery (SDAS) unit.
- 1.3 All nursing staff will incorporate Saskatoon Health Region (SHR) & site-specific policies and procedures into planning and care.
- 1.4 Patients will be assessed, prepared and sent for surgery or other procedures, during the SDAS visit.
- 1.5 Deviations from the Standards of Care will require notification to the physician.

2. POLICY

- 2.1 To ensure the provision of safe patient care, by ensuring that:
 - 2.1.1 Patient preoperative assessment and documentation is complete.
 - 2.1.2 Patient learning needs are met.
 - 2.1.3 Patients are prepared both physically and emotionally for the surgical procedure and discharge.
 - 2.1.4 Patients receive information to prepare for discharge.

NOTE: *If necessary, nursing staff can access the Multilingual Community Interpreter Services (MCIS) by phoning 888-990-9014 to enhance patient comprehension (See SHR Policy 7311-20-013).*

3. PROCEDURE

3.1 The nurse ensures that all preoperative criteria are met for each patient before undergoing a surgical procedure:

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

- Contact surgeon if not completed.

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

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

3.1.3 Consults/referrals completed as ordered and available on chart.

3.1.4 If the patient's surgery is *cancelled* the Pre Assessment Clinic (PAC) chart should be sent down to medical records.

If the patient's surgery is *postponed* prior to their surgery date and there is reason to believe it will be rebooked within the next 30 days the unit may decide to keep the PAC chart on the unit and get direction from the surgeon regarding the need for the consults/tests to be repeated prior to the new surgery date. After the 30 days the chart should be sent to medical records.

If the patient's surgery is *postponed* after they have arrived at the hospital on the day of surgery, the chart should be sent to medical records.

3.1.5 A Consent for Surgery form (#100362) signed and dated (See SHR Regional Policy [Consent/Informed Consent #7311-50-002](#)).

- The surgeon and/or OR staff may be notified if the consent form is incomplete.

3.1.6 A completed Nursing Admission Assessment form (#101500)/Acute Care Pediatrics Nursing Admission Assessment Form (#102691). The depth of the assessment is determined following the general observation of the patient and the documented and/or reported patient history.

- If the patient is readmitted within 30 days with the same diagnosis, a copy of the Nursing Admission Assessment form can be revised for the present admission except the systems assessment must be redone.

3.1.7 A completed Pre-operative Checklist (#101284).

- Children 12 years and under will have a repeat weight (in kgs) done the morning of surgery, compared to the previous weight on the history and physical form for accuracy, and documented.
- Height measurement (in cms) is required for all patients 2 years and older.

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

- 3.1.9 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)). This includes reviewing the severity and symptoms of all the patient's allergies/intolerances, for medication and non-medication reactions.
- 3.1.10 If patient is interested in Nicotine Replacement Therapy the pre printed orders (#102844) are added to his/her chart.
- 3.1.11 Antibiotic Resistant Organism (ARO) Screen form(#102780) completed and swabs sent as applicable for those patients who are expected to remain in hospital for at least 24 hours or more after their surgery or who have an alert from the lab requesting swabs.
- 3.1.12 A completed Braden Scale (# 103417) if the patient is bed ridden or wheelchair bound.
- 3.1.13 Applicable Clinical Pathways forms and orders on the patient's chart and completed as applicable.
- 3.2 The nurse ensures that patient learning needs are addressed by members of the multi-disciplinary team.**
- 3.2.1 The patient receives instruction regarding preoperative preparation, the surgical procedure, post-operative care, and discharge information/planning.
- 3.2.1.1 The patient's understanding of all pre-operative instructions will be assessed and documented on the Pre-Operative Teaching Record (#101725). (See Preparing a Patient for Surgery, pp 883-9, "Nursing Interventions & Clinical Skills, 8th Ed.).
- 3.2.1.2 The nurse documents if the patient followed the SHR Fasting Guidelines which are:
- 3.2.1.2.1 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
- 3.2.1.2.2 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 variation from these fasting guidelines.*
- 3.2.1.3 Teaching aides are utilized to reinforce verbal instructions, e.g. videos, pamphlets, handouts.
- 3.2.1.4 The patient's family is included in the teaching and discharge planning, when appropriate.

3.3 The nurse ensures that patient physical needs are addressed:

- 3.3.1 All pre-operative physician orders are implemented including those on the OR Booking Slip, Practitioner's Orders (# 101091) and Consultation Request (#4051).
- 3.3.2 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.
- 3.3.3 On the day of surgery all medications taken prior to admission are documented on the Preadmission Medication List/Physician Order Form.
- 3.3.4 Medications will be given pre-operatively in hospital as ordered on the OR Booking Slip or Practitioner's Orders and documented on the Medication Administration Record. (MAR).

3.4 The nurse ensures that the patient's emotional needs are addressed by:

- 3.4.1 Giving the patient the opportunity to express concerns and questions regarding his/her entire pre/post-operative experience and by providing answers/reassurances as appropriate.
- 3.4.2 Treating the patient with dignity, respect, and sensitivity to privacy needs.
- 3.4.3 Giving care that demonstrates sensitivity to individual diversity and culture.
- 3.4.4 Handling personal information confidentially.

3.5 The nurse shall provide effective, professional nursing care for patients admitted to the SDAS unit by:

- 3.5.1 Recognizing any instability of a patient and immediately communicating that concern to the RN charge nurse with initiating emergent actions to maintain patient safety.
- 3.5.2 Being familiar with the Code Blue policy and location and proper use of the resuscitation cart. The RN will ensure that the resuscitation cart is fully stocked at all times (if applicable).
- 3.5.3 Having current CPR certification.
- 3.5.4 Showing respect, building trust, practicing open communication, and valuing the education and growth of fellow co-workers.
- 3.5.5 Being responsible for reading communication notices to keep updated on new information.

3.6 Staff will maintain competence and enhance their practice with ongoing education and evaluations by:

- 3.6.1 Accepting responsibility for continuing education, upgrading of knowledge and skills relevant to their area of practice.
- 3.6.2 Attending inservice education lectures in the hospital when possible. Staff are encouraged to maintain competence through attendance at workshops, conferences etc.
- 3.6.3 Communicate with other health care providers and peers to remain current with relevant practice changes.

- 3.6.4 Acting as a resource person for staff in other departments and family members who has questions regarding the procedure, post-procedure observations and/or complications.
 - 3.6.5 Becoming active members of their professional organizations.
 - 3.6.6 Participating in performance appraisals and/or formal evaluations according to policy, to evaluate skill and knowledge in the field.
 - 3.6.7 Participation in patient/staff satisfaction events, such as patient visits on the inpatient unit, audits, surveys etc.
 - 3.6.8 Demonstrating a willingness to accept change in nursing practice intended to improve patient care, as substantiated by research.
- 3.7 A safe environment will be maintained for both staff and patients:**
- 3.7.1 All equipment will be operated according to manufacturer's instructions.
 - 3.7.2 Bed /crib side rails are up when appropriate and call bells within reach.
 - 3.7.3 All staff will be familiar with the unit Fire Plan, WHMIS, and know how and when to initiate all EPP plans.
 - 3.7.4 All staff will take reasonable care to protect his/her safety or the health and safety of others at work as per Occupational Health and Safety Regulations.
 - 3.7.5 All staff will understand and utilize Standard Precautions.
 - 3.7.6 All positive ARO patients will be placed on Additional Precautions.
 - 3.7.7 If the patient is a known **contact** for a newly identified ARO case, the patient is not placed on additional precautions during their SDAS stay including the OR and PACU. **When that patient is admitted to an in-patient unit**, communication is required to the in-patient unit regarding the patient being identified as a "Contact" of a known ARO client and appropriate additional precautions implemented. (See Infection Prevention and Control Policy and Procedure Manual, 30-10, Contact Precautions).
 - 3.7.8 Staff members are encouraged to keep immunizations current.
- 3.8 Ethical and Legal issues will be addressed.**
- 3.8.1 Staff will discuss client care problems with the Manager of Nursing who will at her/his discretion consult with the SHR Ethics Committee, the Client Care Representative, or the SHR Lawyer.

REFERENCES

Perry, A., Potter, P., & Ostendorf, W. (2016). *Clinical Nursing Skills and Techniques*, (8th Edition). Mosby.

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Surgical Executive Committee, former Saskatoon Health Region, Saskatchewan Health Authority. Increasing the accepted pre-operative test times from 30 days to 90 days.