



**NURSING
PERI OPERATIVE CHECKLIST
CARE PATHWAY
(Neonates)**

Patient Name:
DOB: Gender:
Hospital No:
H&C No: (or affix label)

Ward:

Proposed Surgery/Investigation:

Staff Information

This Care Pathway is to be used for all Neonatal patients in the Trust who are admitted for an anaesthesia surgical/investigation procedure. All Ward entries must be completed. All professionals using initials in the Pathway must complete the signature register below.

Initialling the Care Pathway

You should use your initials to confirm that an intervention has been carried out or an outcome achieved. If an intervention is not applicable, please tick the **N/A** box as well as initialling.

Variances: "What is a variance?"

Answering **NO** to any question/item on the pre operative checklist is any non-completion of a planned intervention, e.g. 'Consent form **NOT** completed correctly' **OR** an outcome not met, e.g. 'Fasting regime **NOT** adhered to.' When documenting **NO**, include reasons as well as action taken. This **must** be completed on **page 4** in the box provided. Reasons for answering **NO** take into account patient individuality and professional judgement, and can often be positive in nature.

Signature Register

This section serves as a record of your full signature and thus satisfies medico-legal requirements. Accordingly, all staff using initials in this Pathway **must** complete the details below

Name (<i>block capitals</i>)	Designation	Professional Registration Number	Initials	Full Signature

Abbreviations

BP	Blood Pressure
CJD	Creutzfeldt-Jakob Disease
CPAP	Continuous Positive Airway Pressure
CVL	Central Venous Line
DBM	Donor Breast Milk
DOB	Date Of Birth
EBM	Express Breast Milk
ETT	Endotracheal Tube
FBP	Full Blood Picture
IA	Intra Arterial
ID	Identification
IV	Intravenous
NIPPV	Nasal Intermittent Positive Pressure Ventilation
NG Tube	Nasogastric Tube
NIMATS	Northern Ireland Maternity System
OT	Orogastric Tube
PACS	Picture Archiving and Communication System
P D	Peritoneal Dialysis
Resps	Respirations
SpO ₂	Oxygen Saturation
Temp	Temperature
UAC	Umbilical Arterial Catheter
U&E	Urea and Electrolytes
UVC	Umbilical Venous Catheter

PRE OPERATIVE CHECKLIST <i>(To be completed by Ward Staff and checked by Theatre Staff)</i>	Ward				Theatre		
	Y	N	N/A	Inits	Y	N	N/A
PRE OPERATIVE VERIFICATION AND CONSENT							
Weight checked:kg Date:							
Dry Weight checked:kg							
Legible ID bands x2							
Patient's details correct (<i>name, hospital number, DOB and gender</i>) on both ID/labels and matches call slip/theatre slip							
Consent form completed correctly							
Operation site marked correctly as per consent form							
CJD risk assessment form (annex J) completed Result: high risk <input type="checkbox"/> low risk <input type="checkbox"/> unknown <input type="checkbox"/>							
Name of person(s) who has/have parental responsibility checked Name: Relationship: Name: Relationship:							
Patient's parent/guardian present if required							
Location of parent(s)/guardian:							
Contact number:							
Fasting: Last formula/breast milk feed at:							
Religion checked:							
Patient baptized/blessed							
Current Medication (<i>If yes, specify</i>)							
Skin integrity intact (including bruising). If No detail below:							
Allergy status checked None <input type="checkbox"/>							
Infection status checked None <input type="checkbox"/> Details:							
Implantable Electronic Device present If Yes specify:							
Diathermy compatible							
PATIENT PREPARATION	Y	N	N/A	Inits	Y	N	N/A
Phytomenadione administered							
Last wet nappy checked: hrs							
Catheterised							
Teeth present If Yes specify location:							
Toy/soother/comforter/religious items with child							
PATIENT COMMUNICATION AND MOBILITY PROBLEMS	Y	N	N/A	Inits	Y	N	N/A
Has the patient any injuries eg. back, neck, limiting joint conditions, that may affect positioning or other aspects of planned surgery. If Yes detail:							
Parent's first language if not English: Is Interpreter required/present Not required <input type="checkbox"/>							

Ward:

Patient Name:

DOB:

Hospital/H&C No:(or affix label)

BLOOD RESULTS	Ward				Theatre				
	Y	N	N/A	Inits	Y	N	N/A		
FBP and U&E results present									
Group and hold <input type="checkbox"/> or group and cross match units <input type="checkbox"/>									
Type of blood product requested: Adult <input type="checkbox"/> Paediatric <input type="checkbox"/> No:									
Platelets: <input type="checkbox"/> Fresh Frozen Plasma: <input type="checkbox"/>									
DOCUMENTS TO THEATRE WITH PATIENT	Y	N	N/A	Inits	Y	N	N/A		
Infant Chart <input type="checkbox"/> Nursing Notes <input type="checkbox"/>									
Transport chart									
Fluid balance chart									
Observation chart									
Xrays including scans: hard copy <input type="checkbox"/> PACS <input type="checkbox"/>									
Drug Kardex									
Patient ID labels									
Wound surveillance form									
MATERNAL AND NEONATAL HISTORY	Y	N	N/A	Inits	Y	N	N/A		
Maternal History and delivery checked None <input type="checkbox"/> If Yes detail below:									
Lines	Line Labelled	Line Lock (specify)	Y	N	N/A	Inits	Y	N	N/A
UVC									
UAC									
P D Line/catheter									
IV Lines									
CV Lines									
Broviac/Hickman Lines									
Arterial Lines									
Urinary Catheters									
Wound Drains									
Chest Drains									
NG Tubes									
Orogastric Tubes									
Other (specify):									

SPECIAL INVESTIGATIONS	Ward				Theatre		
	Y	N	N/A	Inits	Y	N	N/A

BASELINE OBSERVATIONS TO BE COMPLETED PRE TRANSFER

Temp: Heart Rate: BP: SpO₂:
 Resps: Blood Glucose: at hrs Blood Gas: Yes No

VENTILATION		CPAP	OXYGEN THERAPY
ETT Tube Size: Trache		Prong/Mask Size:	Self Ventilating Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Taped at:		Pressures:	Method – Ambient/Low Flow
Type of ventilation (name):		Oxygen:	O ₂ %cc's
Pressures: Rate: FiO ₂		NIPPV:	

Ward Staff Initials (*at theatre handover*): Date: Time:hrs

Theatre Staff Initials: Date: Time:hrs

If no to any of the items on the pre op checklist, please document reason(s) in the section below

Reason for No	Action Taken (If any)	Initials

