Royal United Hospital Bath NHS
NHS Trust

Mini Manual

Pre-assessment – Pre-operative Findings

1. **Document pre-operative findings**
2. **Review pre-operative findings**

Support available:

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RUH

CERNER

BT Bringing it all together

Pre-operative Form

1. Document pre-operative findings

Step 1. Open the **Appointment Book**.

Step 2. Find the patient using the Clinic sign off list

Step 3. Select the patient.

Step 4. Click on the launch **PowerChart** icon.

Step 5. Click on the **Ad hoc reporting** icon.

Step 6. In the **Ad hoc reporting** window click on the **Surgery** folder and click in to the **Pre-Operative Assessment** tick box.

Step 7. Click the **Record** button.

Step 8. In the **Pre-Operative Assessment** window the mandatory pages of the form are indicated by the blue crosses.

Step 9. On the **Vital Signs** page enter observation details as required. Please note the height and weight are not entered on this page.

Step 10. On the **MUST** page enter the height and weight details including **Weight 3 – 6 months ago** if known. Right click in the field if you require reference text.

Step 11. Save the form by clicking on the **Save** icon.

Step 12. The HCA closes the patient's record in PowerChart ready for the nurse to complete the form.

Note: The partially completed form will be saved ready for completion by the nurse.

Pre-operative Form

2. Review Pre-operative findings

Step 1. The Nurse will open **PowerChart**.

Step 2. Click on the **Scheduling** icon. Type in pre in the **Resource** field and click on the **Binoculars**. In the **Find Resource** window click on the appropriate Pre-assessment Nurse and click **OK**.

Step 3. Scroll up or down as required to locate the patient's appointment. Right click on the patient's name and click on **Open Record** and then click on **Activity List**.

Step 4. In the **Activity List** window click on the **PowerForms** tab.

Step 5. Right click on the PreOperative Assessment form and click on **Record Details/Modify**.

Step 6. Within each page the mandatory fields are shown in yellow and will all need to be completed before the form is finalised by the nurse.

Step 7. The **Pressure Ulcer Risk Assessment (PURA)** page is not mandatory and the nurse is required to use their clinical judgement as to whether it is required or not. If the **Is PURA required at pre assessment?** field is clicked and set to **Yes** all the fields become mandatory.

Step 8. On the Pressure Ulcer and Wound Assessment page if the **Does the patient have any other wounds present?** field is mandatory. Right-clicking on the **Does the patient have any other wounds present?** field will display reference text if required.

Step 9. On the **Vulnerability Assessment** page the first four fields are mandatory. If the **Has the patient a "Community Transitional Plan" with them?** field is clicked and set to **Yes** the following four fields become mandatory. If the **Has the patient a "Passport to Hospital Care" with them?** field is clicked and set to **Yes** the following three fields become mandatory.

Step 10. The **Healthy Lifestyles** page is not mandatory. However, it is necessary to record all the leaflets that have been given to the patient. Click on the Alpha entry text fields to enter the details about the patient in each table on the form.

Step 11. On the **Discharge Risk Assessment** page the field is mandatory. If the fields is set to **Yes** the additional fields to the right of the field must be completed. Several of the tick boxes can be selected as required.

Step 12. On the **Admission Plan/Outcome** page all the fields are mandatory.

Note: The referral fields only report that a referral has been made and do not order a referral. All details of the referrals required should be added to the Order Entry Form. If further referrals are required the outcome needs to be input into the Order Entry Form when known.

Step 13. The form is complete when the blue cross next to each mandatory page has changed to a blue tick.

Note: If the patient is going to be seen by another pre-assessment nurse the form should be **saved** at this point and should only be signed when it is completed.

Step 14. Sign the form off by clicking on the **Sign** icon.

Note: The form can be modified by opening the **Form Browser** in the **Menu** and then right clicking on the form and clicking on **Modify**.

The completed form has been signed. A green tick will now be displayed to the left of the PreOperative Assessment task in the PowerForm tab in the Activity List and the status will be **Complete**.

Business Rules