Breast Reconstruction – Autologous; Clinical Pathway

Site Applicability

Providence Health Care Acute Care Inpatient Units using the Cerner Electronic Health Record

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record or paper chart as per policy

Pathway Patient Goals

1. Patient is prepared both physically and psychologically for surgery prior to hospital admission
2. Patient has received education and is aware of the treatment plan and expected LOS
3. Patient is aware and understands discharge criteria

Inclusion Criteria

All patients admitted with autologous breast reconstruction

Exclusion Criteria

Patients who have contraindication for breast reconstruction

Pathway

Pre-Surgery (Pre-admission Clinic Visit or Pre-op on ward (if applicable)	
Care Category/Tasks & Activities	**Expected Outcomes**
Teaching & Discharge Planning	Discharge Planning: • Patient /Caregiver are aware of expected discharge • POD 4 for unilateral and POD 5 for Bilateral Provide patient with Support Group and Breast Cancer Resources: • Received patient education booklet • Websites: BC Cancer Agency, Canadian Cancer Society, HealthLink BC
Tests	Blood work and ECG (if ordered)
Medications	Review personal medications. Provide specific instruction on what medications to take or not to take before and after surgery as ordered by Anesthesiologist or Surgeon. Reinforce need to discontinue the following medications 7 days prior to surgery: • ASA or ASA products • Anti-inflammatory • Vitamin and Natural/herbal supplements (non- prescription, over-the-counter)
Consults	Anesthesia Transition Services Team referral form included in chart
Pain	Understands pain scale Understands PCA use (if applicable)
Nausea	Understands to notify the nurse and ask for medications to control nausea after surgery
Nutrition	Review fasting guideline: • Do not eat solid food after midnight the night before surgery • May drink clear fluids (water, apple juice or cranberry juice) only up to 2 hours prior to arriving to the hospital
Anxiety / Fear	If patient / family counseling at BCCA required, contact attending surgeon

Patient Teaching	Patient / Family understands rationale for: • Fasting guidelines before surgery • Post-op nursing assessments (i.e. the nurse will monitor and check the patient Q4H post-op) • Pain scale, relief options and importance of round the clock analgesia • Patient understands need to notify nurse when nauseated • Deep breathing, leg exercises and need to ambulate • Wound care (dressing and drain) • Early ambulation, arms and shoulders ROM exercises • Use of calf compression device until ambulating (if applicable) • Patient has realistic expectations about surgical outcomes • States expected length of stay • Has plan for transport home • Describes anxiety as acceptable

Day of Surgery – Post Op (Ward)	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range on admission, then Q4H and PRN Lab values within normal limits
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	Bedrest day of surgery until foley removed POD 1 at 06:00 HOB elevated 45 degrees with hips and knees flexed Calf compression device until ambulating Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place Fall Risk Assessment and Care Plan, if applicable

Elimination	Foley catheter to straight drainage then remove at POD 1 at 06:00
Anxiety / Fear	Patient describes anxiety as acceptable
Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Reinforce how to use PCA where applicable Strategies to cope with / prevent GI symptoms Wound care, dressing and drain management (TST referral) Initiate patient teaching on how to empty drain, measure and record drainage Review activity restrictions

Post Operative Day 1	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range on admission, then Q4H and PRN Lab values within normal limits
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	POD 1 morning up in a chair and start ambulating (walking in the hallway TID) HOB elevated 45 degrees with hips and knees flexed Discontinue calf compression device when ambulating Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place

	Fall Risk Assessment and Care Plan, if applicable
Elimination	Assess if patient able to void after foley catheter is removed (POD 1 at 06:00)
Anxiety / Fear	Patient describes anxiety as acceptable
Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Reinforce how to use PCA where applicable Strategies to cope with / prevent GI symptoms Wound care, dressing and drain management (TST referral) Initiate patient teaching on how to empty drain, measure and record drainage Review activity restrictions

Post Operative Day 2	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range on admission, then Q4H and PRN Lab values within normal limits, if ordered
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	Patient ambulating with minimal assistance (walking in the hallway TID) HOB elevated 45 degrees with hips and knees flexed Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place Fall Risk Assessment and Care Plan, if applicable
Elimination	Patient voiding independently

Anxiety / Fear	Patient describes anxiety as acceptable
Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Reinforce how to use PCA where applicable Strategies to cope with / prevent GI symptoms Wound care, dressing and drain management (TST referral) Review patient teaching on how to empty drain, measure and record drainage Review activity restrictions

Post Operative Day 3	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range on admission, then Q4H and PRN Lab values within normal limits, if ordered
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	Patient ambulating with minimal assistance (walking in the hallway TID) HOB elevated 45 degrees with hips and knees flexed Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place Fall Risk Assessment and Care Plan, if applicable

Elimination	Patient voiding independently
Anxiety / Fear	Patient describes anxiety as acceptable
Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Reinforce how to use PCA where applicable Strategies to cope with / prevent GI symptoms Wound care, dressing and drain management (TST referral) Review patient teaching on how to empty drain, measure and record drainage Review activity restrictions

Post Operative Day 4 to discharge	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range Lab values within normal limits, if ordered
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	Patient ambulating independently Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place Fall Risk Assessment and Care Plan, if applicable
Elimination	Patient voiding independently
Anxiety / Fear	Patient describes anxiety as acceptable

Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Prescription given to the patient Strategies to cope with / prevent GI symptoms No dressing change until seen by plastic surgeon Patient may shower 24 hours after all drains are removed Wound care, dressing and drain management (TST arranged) Review/return demonstration on how to empty drain, measure & record drainage Provide measuring cups, alcohol swabs for drain care Review activity restrictions Review instructions on what to do or who to call if patient has a problem at home after discharge Follow up appointment with the surgeon (pre-arranged by the Breast Centre) Follow up appointment with the plastic surgeon (pre-arranged or patient to call the plastic surgeon's office)

Discharge Day	
Care Category/Tasks & Activities	**Expected Outcomes**
Cardio / Pulmonary	Clear breath sounds in all lungs Vital signs within patient's usual range Lab values within normal limits, if ordered
Incision Care TRAM / LD Flap	Monitor breast flap through dressing window on admission, then Q2H x 24H; then Q4H and PRN until discharge. Assess for temperature to touch, colour, capillary refill greater than 3 seconds and turgor. No evidence of bleeding, hematoma or swelling and bruising Dressing dry and intact
Drain Care / Wound Care	Assess on admission then Q4H and PRN Drains patent / volume less than 200 mL in 4 hours
Lymphedema	Axillary Node Dissection: • No swelling (edema) to affected hand, arm, chest and back Patient aware of importance to elevate affected arm on pillow Patient able to do ROM exercises on the affected arm(s)
Pain	Patient states pain is at an acceptable level
Nausea	Understands to notify the nurse and ask for medications to control nausea
GI	Patient states nausea is controlled Patient has no episodes of retching or vomiting
Nutrition	Patient is on regular diet
Mobility	Patient ambulating independently Physiotherapy ROM/mobility exercises and follow up prior to discharge Universal Falls Prevention (Safe Step) in place Fall Risk Assessment and Care Plan, if applicable
Elimination	Patient voiding independently
Anxiety / Fear	Patient describes anxiety as acceptable

Teaching / Discharge Planning	Nurse reviews deep breathing, arm ROM exercises, leg exercises, ambulation, pain management strategies For TRAM flap only: • Need to avoid coughing, patient to huff if urge to cough. • Support abdomen/teach patient to avoid stretching abdominal muscles Prescription given to the patient Strategies to cope with / prevent GI symptoms No dressing change until seen by plastic surgeon Patient may shower 24 hours after all drains are removed Wound care, dressing and drain management (TST arranged) Review/return demonstration on how to empty drain, measure & record drainage Provide measuring cups, alcohol swabs for drain care Review activity restrictions Review instructions on what to do or who to call if patient has a problem at home after discharge Follow up appointment with the surgeon (pre-arranged by the Breast Centre) Follow up appointment with the plastic surgeon (pre-arranged or patient to call the plastic surgeon's office)

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