Posterior Thoraco-Lumbar Procedure with Fusion

Site Applicability

Vancouver General Hospital

Practice Level

RN
LPN
OT
PT

Pathway Patient Goals

Overall Patient Goals:
Patient will recover from surgery with an expected 4 – 6 day length of stay (LOS) and experience a safe discharge home.

Specific Pathway Goals:

1. DAT from POD 0
2. Discontinue CVC POD 2
3. Discontinue indwelling urinary catheter @ 06:00 POD 2
4. Saline lock IV POD 2 or IV @ TKVO if on Patient Controlled Analgesia
5. Mobility goals:
   POD #1: bathroom and sitting up for meals as tolerated; Walking 20m X 2 (with PT & RN)
   POD #2: bathroom, sitting up for 2 meals; Walking 50m X 2 (with PT & RN)
   POD #3: bathroom, sitting up for 2-3 meals; Walking 100m X2 (with PT & RN); stairs with PT
POD #4, 5 and 6: bathroom, sitting up for 3 meals; Walking 100m X 2 and stairs independently

Inclusion Criteria

Elective patients undergoing Posterior Thoraco-Lumbar-Sacral Spine Fusion or Revision.

Home Discharge Criteria

Patients will be deemed ready for discharge when cleared medically by the Spine Physician (i.e. incision healing, pain controlled, post-operative x-ray completed and reviewed, and medically stable).
Patient will be discharged by Physiotherapy if goals for functional mobility met.
Patient will be discharged by Occupational Therapy if goals of Activities of Daily Living met.

Instructions

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

Post-op Day 0	
Focus of Care	**Expected Outcomes**
Safety Check & Fall Risk	• Complete bedside safety check • Complete Morse Falls Scale as per Falls & Injury Prevention Guideline (D-00-07-30033)**:** ○ **Not at risk: reviewed and no concerns**
Pain	• Complete Pain assessment as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Review pain management, use of PCA, breakthrough doses, oral medications and side effects with patient • Provide teaching pamphlets to patient – Pain Control after Surgery and PCA • **Pain rating ≤ 4 and at a level acceptable to patient and does not prevent participation in mobility and ADLs**
Neuro/Cognition, Delirium, Sleep	• Complete delirium assessment as per Delirium: Screening, Assessment and Management (CAM) DST (BCD-11-07-40081) or Intensive Care Delirium Screening Checklist ○ Notify Physician and Initiate Care Plan if CAM positive for Delirium • **Patient alert and oriented X 3** • **No Evidence of Delirium** • **Slept at least 4 hours at night**
Motor and Sensory Function	• Complete ISNCSCI assessment as ordered on admission from PACU • Repeat ISNCSCI assessment in 4 hours then Q shift if stable • Notify Spine Surgeon of NEW or INCREASED DEFICIT • **Motor/sensory assessment within normal limits or patient's baseline**
Respiratory: PE	• Assess RR & SS as per Pain Assessment and Documentation Standards (VCH.VA.0203) while receiving IV opioid • O2 at 2 – 4 L/min via nasal prongs X 48 hours while on PCA • Encourage deep breathing and coughing exercises Q1H while awake • **Respirations easy and regular, breath sounds clear, SpO2 > 94%**
Cardiovascular: DVT	• VS as per Vital signs and observation: Post-op monitoring DST (D-00-07-30113) • Complete IV/CVC site(s) assessment as per IV Therapy, Peripheral: Insertion, Care and Maintenance DST (BD-00-12-40080) or Non-Tunneled Central Venous Catheter (NT-CVC) – Basic Care and Maintenance DST (BD-00-12-40045) • Encourage active leg movement and ankle pumping • SCD to both legs X 24 hours Post-Op (Remove Q shift X 20 minutes) • **VS within normal limits** • **No evidence of DVT**
Anemia	• Review estimated OR blood loss • Assess hemovac drainage • **Hgb within acceptable limits** • Notify spine resident if Hgb < 80g/L or drops by ≥ 20 g/L from baseline or if patient symptomatic

	• **No evidence of bleeding** (blood loss should not exceed 350mL/12hrs) • **No symptoms of anemia** (dizziness, hypotension, weak/rapid pulse, delirium, N&V)
GI: PONV; Nutrition, Bowel	• PONV Q4h as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Notify MD for unresolved PONV • **Patient states PONV is controlled** • Perform a swallowing screen if indicated (see DST – Dysphagia Management) • **No swallowing issues identified** • **Tolerating 75% diet** • Assess BM
GU: Fluids, Electrolytes, Bladder	• Review OR/PACU fluid • Maintain IV fluid as ordered • Foley catheter insitu • Assess urine output Q1H X 24 hours • Clear pumps and total intake and output at 06:00 and 18:00 • **Urine output > 0.5mL/kg/hour**
Surgical Site Infection, Skin	• Complete skin assessment as per Braden Risk and Skin Assessment (Adult) DST (BD-00-12-40078) • **No evidence of dural leak** • **Surgical site dressing dry and intact (change dressing 72 hours post-op or sooner if saturated)** • **Temp ≤ 38.5** • **No S&S of infection**
Functional Mobility	• Teach spine mobility precautions (i.e. spine neutral) and active log roll technique • If orthosis ordered, confirm patient brought from home or a request has been faxed to Orthotics • RN may initiate active mobilization as per orders if patient can tolerate and no neurological deficit present • **Patient actively turning, while maintaining neutral spine Q3H** • **Mobilization Goal: Bedrest / Dangle but may include Bedrest, HOB > 45°, dangled, stood, up to chair/commode, and/or up to BR**
Activities of Daily Living	• Simple self-care as tolerated in bed • Reinforce philosophy of care regarding "early activation/rehabilitation" • **Early participation in personal care activities (oral hygiene, pericare, etc.) as tolerated**
Psychosocial	• Initiate Social Work referral (if required) • **No psychosocial issues identified**
Medication Management	• **No issues identified with medications patient taking pre-hospital**
Teaching & Discharge Planning **Nursing:** • Reinforce that discharge will occur when all outcomes are met	

- Determine ELOS and anticipated discharge date
- Determine discharge destination
- **Identify possibly delays to discharge**

Post-op Day 1	
Focus of Care	**Expected Outcomes**
Safety Check & Fall Risk	• Complete bedside safety check • Review Morse Falls Scale as per Falls & Injury Prevent Guideline (D-00-07-30033): ○ **Not at risk: reviewed and no concerns**
Pain	• Complete Pain assessment as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Review pain management, use of PCA, breakthrough doses, oral medications and side effects with patient • Provide teaching pamphlets to patient – Pain Control after Surgery and PCA • **Pain rating ≤ 4 and at a level acceptable to patient and does not prevent participation in mobility and ADLs**
Neuro/Cognition, Delirium, Sleep	• Complete delirium assessment as per Delirium: Screening, Assessment and Management (CAM) DST (BCD-11-07-40081) or Intensive Care Delirium Screening Checklist ○ Notify Physician and Initiate Care Plan if CAM positive for Delirium • **Patient alert and oriented X 3** • **No Evidence of Delirium** • **Slept at least 4 hours at night**
Motor and Sensory Function	• Complete ISNCSCI assessment as ordered • Notify Spine Surgeon of NEW or INCREASED DEFICIT • **Motor/sensory assessment within normal limits or patient's baseline** • **PT motor/sensory assessment completed**
Respiratory: PE	• Assess RR & SS as per Pain Assessment and Documentation Standards (VCH.VA.0203) while receiving IV opioid • O2 at 2 – 4 L/min via nasal prongs X 48 hours while on PCA • Encourage deep breathing and coughing exercises Q1H while awake • **Respirations easy and regular, breath sounds clear, SpO2 > 94%**
Cardiovascular: DVT	• VS as per Vital signs and observation: Post-op monitoring DST (D-00-07-30113) • Complete IV/CVC site(s) assessment as per IV Therapy, Peripheral: Insertion, Care and Maintenance DST (BD-00-12-40080) or Non-Tunneled Central Venous Catheter (NT-CVC) – Basic Care and Maintenance DST (BD-00-12-40045) • Encourage active leg movement and ankle pumping • SCD to both legs X 24 hours Post-Op then d/c (remove Q shift X 20 minutes) • Start LMWH (24 hours post arrival in PACU) as ordered • **VS within normal limits** • **No evidence of DVT**
Anemia	• Assess hemovac drainage • **Hgb within acceptable limits**

	• Notify spine resident if Hgb < 80g/L or drops by ≥ 20 g/L from baseline or if patient symptomatic • **No evidence of bleeding** (blood loss should not exceed 350mL/12hrs) • **No symptoms of anemia** (dizziness, hypotension, weak/rapid pulse, delirium, N&V)
GI: PONV; Nutrition, Bowel	• Assess PONV Q4h as per Pain Assessment and Documentation Standards (VCH.VA.0203) • **Notify** MD for unresolved PONV • **Patient states PONV is controlled** • Perform a swallowing screen if indicated (see DST – Dysphagia Management) • **No swallowing issues identified** • **Tolerating 75% of diet** • Assess BM and initiate bowel protocol
GU: Fluids, Electrolytes, Bladder	• Maintain IV fluid as ordered • Assess urine output Q1H X 24 hours • Clear pumps and Total intake and output at 06:00 and 18:00 • Assess need for Foley catheter (Follow Acute Spine Bladder Management Algorithm) • **Urine output > 0.5mL/kg/hour** • **Foley removed and patient voiding with PVR ≤ 100 mL X 3** • **Electrolytes within normal limits**
Surgical Site Infection, Skin	• Complete skin assessment as per Braden Risk and Skin Assessment (Adult) DST (BD-00-12-40078) • **No evidence of dural leak** • **Surgical site dressing dry and intact (change dressing 72 hours post-op or sooner if saturated)** • **Temp ≤ 38.5** • **No S&S of infection; WBC within normal limits**

Functional Mobility	• Review/teach spine mobility precautions (i.e. spine neutral) and active log roll technique
	• Assess Mobilization and document:
	  ○ Log rolling assessment (unable, with assist, or independent)
	  ○ Lying →← sitting assessment (unable, with assist, or independent)
	  ○ Sitting →← standing assessment (unable, with assist, or independent)
	  ○ Transfer bed to chair (unable, with assist, or independent)
	• PT assess ambulation: ability to walk 20m; use of equipment/aid (including unable, with assist, or independent)
	  ○ Refer to PT initial assessment analysis & plan
	• **Up to chair for meals as tolerated**
	• **Walking to bathroom as tolerated**
	• **Mobility Goal: walk 20m X 2 (once with PT & once with nursing/family)**
	• **Safe, reliable independent functional mobility achieved**

Activities of Daily Living	• Post-Op Activity Guidelines (as needed):

	○ Provide educational handout and reinforce/review post-op activity guidelines • Assess the following as: unable (caregiver taught), requires setup/supervision, or independent: <u>Orthosis Education</u> (as needed): • Provided educational handout and reinforce/review orthosis management (i.e. daily care and procedure to don/doff) ○ Don & Doff orthosis <u>Self-Care Screening/Teaching</u> (as needed) • Screen abilities and provide teaching for: ○ Dressing, Toileting, Grooming, Showering <u>Home and Community Responsibilities</u> (as needed) • Screen status and address needs related to: ○ Homemaking/family care (e.g. meal preparation, cleaning, child care, etc.) ○ Community- based ADLs (e.g. shopping, transportation, etc.) screened and no issues identified • **Understands, and able to follow post-operative activity guidelines** • **Safe, reliable independent (or plan in place) orthosis management** • **Safe, reliable independent (or plan in place) for self-care activities** • **Home & community responsibilities addressed**
Psychosocial	• Initiate Social Work referral (if required) • **No psychosocial issues identified**
Medication Management	• **No issues identified with medications patient taking pre-hospital**
Teaching & Discharge Planning **<u>Nursing</u>:** • Reinforce that discharge will occur when all outcomes are met • Determine ELOS and anticipated discharge date • Determine discharge destination • **Identify possibly delays to discharge**	

Post-op Day 2	
Focus of Care	**Expected Outcomes**
Safety Check & Fall Risk	• Complete bedside safety check • Review Morse Falls Scale as per Falls & Injury Prevention Guideline (D-00-07-30033) ○ **Not at risk: reviewed and no concerns**
Pain	• Complete Pain assessment as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Wean PCA/Ketamine as per POPs orders • **Patient tolerating oral analgesics as per POPS orders** • **Pain rating ≤ 4 and at a level acceptable to patient and does not prevent participation in mobility and ADLs**
Neuro/Cognition, Delirium, Sleep	• Complete delirium assessment as per Delirium: Screening, Assessment and Management (CAM) DST (BCD-11-07-40081) or Intensive Care Delirium Screening Checklist ○ Notify Physician and Initiate Care Plan if CAM positive for Delirium • **Patient alert and oriented X 3** • **No Evidence of Delirium** • **Slept at least 4 hours at night**
Motor and Sensory Function	• Complete ISNCSCI assessment as ordered • Notify Spine Surgeon of NEW or INCREASED DEFICIT • **Motor/sensory assessment within normal limits or patient's baseline**
Respiratory: PE	• Assess RR & SS as per Pain Assessment and Documentation Standards (VCH.VA.0203) while receiving IV opioid • Titrate O2 to keep SpO2 > 94% • Encourage deep breathing and coughing exercises Q1H while awake • **Respirations easy and regular, breath sounds clear, SpO2 > 94%**
Cardiovascular: DVT	• VS as per Vital signs and observation: Post-op monitoring DST (D-00-07-30113) • Complete IV/CVC site(s) assessment as per IV Therapy, Peripheral: Insertion, Care and Maintenance DST (BD-00-12-40080) or Non-Tunneled Central Venous Catheter (NT-CVC) – Basic Care and Maintenance DST (BD-00-12-40045) • Encourage active leg movement and ankle pumping • LMWH as ordered • **VS within normal limits** • **No evidence of DVT**
Anemia	• Assess Hemovac drainage • **Hgb within acceptable limits** • Notify spine resident if Hgb < 80g/L or drops by ≥ 20 g/L from baseline or if patient symptomatic • **No evidence of bleeding** (blood loss should not exceed 350mL/12hrs) • **No symptoms of anemia** (dizziness, hypotension, weak/rapid pulse, delirium, N&V)

	• Hemovac removed as ordered
GI: PONV; Nutrition, Bowel	• Assess PONV Q4h as per Pain Assessment and Documentation Standards (VCH.VA.0203) • **Notify** MD for unresolved PONV • **Patient states PONV is controlled** • **Tolerating 75% of diet** • Assess BM administer bowel protocol as ordered • **Patient had BM**
GU: Fluids, Electrolytes, Bladder	• IV/CVC TKVO if still on PCA/Ketamine and patient drinking well • Assess urine output Q6H • Clear pumps and total intake and output at 06:00 and 18:00 • Saline Lock IV/CVC if patient drinking well and no longer on PCA/Ketamine • **Adequate hydration is maintained** • D/C Foley at 06:00 (follow Acute Spine Bladder Management Algorithm) • **Urine output >0.5mL/kg/hour** • **Foley removed and patient voiding with PVR ≤ 100 mL X 3** • **Electrolytes within normal limits**
Surgical Site Infection, Skin	• Complete skin assessment as per Braden Risk and Skin Assessment (Adult) DST (BD-00-12-40078) • **No evidence of dural leak** • **Surgical site dressing dry and intact (change dressing 72 hours post-op or sooner if saturated)** • **Temp ≤ 38.5** • **No S&S of infection; WBC within normal limits**

Functional Mobility	• Review/teach spine mobility precautions (i.e. spine neutral) and active log roll technique
	• Assess mobilization and document:
	  ○ Log rolling assessment (unable, with assist, or independent)
	  ○ Lying ←→ sitting assessment (unable, with assist, or independent)
	  ○ Sitting ←→ standing assessment (unable, with assist, or independent)
	  ○ Transfer bed to chair (unable, with assist, or independent)
	• PT assess ambulation: ability to walk 50m; use of equipment/aid (including unable, with assist, or independent)
	  ○ Refer to PT analysis & plan
	• **Up in chair for MINIMUM 2 meals**
	• **Walking to bathroom as tolerated**
	• **Mobility Goal: walk 50m X 2 (once with PT & once with nursing/family)**
	• **Safe, reliable independent functional mobility achieved**

Activities of Daily Living	• Post-Op Activity Guidelines (as needed): ○ Provide educational handout and reinforce/review post-op activity guidelines • Assess the following as unable (caregiver taught), requires setup/supervision, or independent:

	Orthosis Education (as needed): ○ Provided educational handout and reinforce/review orthosis management (i.e. daily care and procedure to don/doff) ○ Don & Doff orthosis Self-Care Screening/Teaching (as needed) ○ Screen abilities and provide teaching for: ▪ Dressing, Toileting, Grooming, Showering Home and Community Responsibilities (as needed) ○ Screen status and address needs related to: ▪ Homemaking/family care (e.g. meal preparation, cleaning, child care, etc.) ▪ Community- based ADLs (e.g. shopping, transportation, etc.) screened and no issues identified • **Understands, and able to follow post-operative activity guidelines** • **Safe, reliable independent (or plan in place) orthosis management** • **Safe, reliable independent (or plan in place) for self-care activities** • **Home & community responsibilities addressed**
Psychosocial	• Initiate Social Work referral (if required) • **No psychosocial issues identified**
Medication Management	• **No issues identified with medications patient taking pre-hospital**
Teaching & Discharge Planning **Nursing:** • Reinforce that discharge will occur when all outcomes are met • Determine ELOS and anticipated discharge date • Determine discharge destination • **Identify possibly delays to discharge**	

Post-op Day 3	
Focus of Care	**Expected Outcomes**
Safety Check & Fall Risk	• Complete bedside safety check • Complete Morse Falls Scale as per Falls & Injury Prevent Guideline (D-00-07-30033) ○ **Not at risk: reviewed and no concerns**
Pain	• Complete Pain assessment as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Discontinue PCA/Ketamine as per POPs orders • Review principles of pain management at home including appropriate weaning of oral pain medications and management of constipation • **Patient tolerating oral analgesics as per POPS orders** • **Pain rating ≤ 4 and at a level acceptable to patient and does not prevent participation in mobility and ADLs**
Neuro/Cognition, Delirium, Sleep	• Complete delirium assessment as per Delirium: Screening, Assessment and Management (CAM) DST (BCD-11-07-40081) or Intensive Care Delirium Screening Checklist ○ Notify Physician and Initiate Care Plan if CAM positive for Delirium • **Patient alert and oriented X 3** • **No Evidence of Delirium** • **Slept at least 4 hours at night**
Motor and Sensory Function	• Complete ISNCSCI assessment as ordered • Notify Spine Surgeon of NEW or INCREASED DEFICIT • **Motor/sensory assessment within normal limits or patient's baseline**
Respiratory: PE	• Encourage deep breathing and coughing exercises Q1H while awake • **Respirations easy and regular, breath sounds clear, SpO2 > 94%**
Cardiovascular: DVT	• VS as per Vital signs and observation: Post-op monitoring DST (D-00-07-30113) • Complete IV/CVC site(s) assessment as per IV Therapy, Peripheral: Insertion, Care and Maintenance DST (BD-00-12-40080) or Non-Tunneled Central Venous Catheter (NT-CVC) – Basic Care and Maintenance DST (BD-00-12-40045) • Discontinue CVC • Saline lock IV if (IV TKVO if on PCA/ketamine) • Encourage active leg movement and ankle pumping • LMWH as ordered • **VS within normal limits** • **No evidence of DVT**
Anemia	• **No evidence of bleeding** • **No symptoms of anemia**
GI: PONV; Nutrition, Bowel	• **Patient states PONV is controlled** • **Tolerating 75% of diet** • Assess BM; administer bowel protocol • **Patient had BM**

GU: Fluids, Electrolytes, Bladder	• Assess urine output Q6H • Total intake and output at 06:00 and 18:00 • **Adequate hydration is maintained** • **Patient voiding with PVR ≤ 100 mL X 3**
Surgical Site Infection, Skin	• Complete skin assessment as per Braden Risk and Skin Assessment (Adult) DST (BD-00-12-40078) • Change dressing and document • **Incision well approximated – no redness, swelling, minimal or no drainage** • **Temp ≤ 38.5** • **No S&S of infection;**

Functional Mobility	• Review/teach spine mobility precautions (i.e. spine neutral) and active log roll technique
	• Assess mobilization ability and document :
	  ○ Log rolling assessment (unable, with assist, or independent)
	  ○ Lying ←→ sitting assessment (unable, with assist, or independent)
	  ○ Sitting ←→ standing assessment (unable, with assist, or independent)
	  ○ Transfer bed to chair (unable, with assist, or independent)
	• PT assess ambulation: ability to walk 100m; use of equipment/aid (including unable, with assist, or independent)
	  ○ Stairs, including number, with/without railing (unable, with assist, or independent)
	  ○ Refer to PT analysis & plan
	• **Up in chair for MINIMUM 2 meals**
	• **Walking to bathroom as tolerated**
	• **Mobility Goal: walk 20m X 2 (once with PT & once with nursing/family)**
	• **Safe, reliable independent functional mobility achieved**

Activities of Daily Living	• Post-Op Activity Guidelines (as needed):
	  ○ Provide educational handout and reinforce/review post-op activity guidelines
	• Assess the following as unable (caregiver taught) / requires setup/supervision / independent:
	  <u>Orthosis Education</u> (as needed):
	  • Provided educational handout and reinforce/review orthosis management (i.e. daily care and procedure to don/doff)
	  ○ Don & Doff orthosis
	  <u>Self-Care Screening/Teaching</u> (as needed)
	  • Screen abilities and provide teaching for:
	  ○ Dressing, Toileting, Grooming, Showering
	  <u>Home and Community Responsibilities</u> (as needed)
	  • Screen status and address needs related to:
	  ○ Homemaking/family care (e.g. meal preparation, cleaning, child care, etc.)
	  ○ Community- based ADLs (e.g. shopping, transportation, etc.) screened and no issues identified

	• **Understands, and able to follow post-operative activity guidelines** • **Safe, reliable independent (or plan in place) orthosis management** • **Safe, reliable independent (or plan in place) for self-care activities** • **Home & community responsibilities addressed**
Psychosocial	• Initiate Social Work referral (if required) • **No psychosocial issues identified**
Medication Management	• **No issues identified with medications patient taking pre-hospital**

Teaching & Discharge Planning

Nursing:

- Determine ELOS and anticipated discharge date
- Determine discharge destination
- Determine if assistance at home required
- Provide teaching to patient and/or family re:
    - Incision care – Demonstrate/return demo of dressing change with family/caregiver
    - Dressing/med supplies – Give and review Post-Operative Spine Incision Care Pamphlet (PHEM catalogue no. FB.723.P67)
    - Pain management– Give and review Pain Control After Surgery (PHEM catalogue no. FM.820.P161) and Opioid Tapering (PHEM catalogue no. EA.836.086) pamphlets
    - Post-op complication (DVT/PE, infection, constipation, motor/sensory)
- **Discharge Teaching is complete**
- **X-ray complete and reviewed by Spine Surgeon/Resident**
- **Discharge order obtained from Spine Surgeon/Resident**
- **Physician asked to complete dictated discharge summary**
- **Transportation home arranged for 10:00 discharge**
- **On day of discharge: My Discharge Plan complete (photocopied x 2 – copes in CML binder and pt chart, original given to patient)**
- **Photocopy pain medication prescription – copy in CML binder and give original to patient**

Allied:

Equipment/Supplies (as needed)

- Prescribe equipment/provide equipment resource/loan handout to patient (includes self-care equipment, mobility aids)

Community Referrals (as needed)

- Identifies which community care services are required and completes referral, including OT, PT, Dietician and/or Home Support Services
- **Ready for Discharge from OT and PT**
- **Equipment/supplies in place (on order)**

Post-op Day 4 and/or Supplemental Day	
Focus of Care	**Expected Outcomes**
Safety Check & Fall Risk	• Complete bedside safety check • Complete Morse Falls Scale as per Falls & Injury Prevention Guideline (link D-00-07-30033) ○ **Not at risk: reviewed and no concerns**
Pain	• Complete Pain assessment as per Pain Assessment and Documentation Standards (VCH.VA.0203) • Review principles of pain management at home including appropriate weaning of oral pain medications and management of constipation • **Patient tolerating oral analgesics as per POPS orders** • **Pain rating ≤ 4 and at a level acceptable to patient and does not prevent participation in mobility and ADLs**
Neuro/Cognition, Delirium, Sleep	• **Patient alert and oriented X 3** • **No Evidence of Delirium** • **Slept at least 4 hours at night**
Motor and Sensory Function	• Complete ISNCSCI assessment as ordered • Notify Spine Surgeon of NEW or INCREASED DEFICIT • **Motor/sensory assessment within normal limits or patient's baseline**
Respiratory: PE	• Encourage deep breathing and coughing exercises Q1H while awake • **Respirations easy and regular, breath sounds clear, SpO2 > 94%**
Cardiovascular: DVT	• VS as per Vital signs and observation: Post-op monitoring DST (D-00-07-30113) • Complete IV site(s) assessment as per IV Therapy, Peripheral: Insertion, Care and Maintenance (Link BD-00-12-40080) • Saline lock IV or remove • Encourage active leg movement and ankle pumping • LMWH as ordered • **VS within normal limits** • **No evidence of DVT**
Anemia	• **No evidence of bleeding** • **No symptoms of anemia**
GI: PONV; Nutrition, Bowel	• **Patient states PONV is controlled** • Assess BM; administer bowel protocol as ordered • **Patient had BM**
GU: Fluids, Electrolytes, Bladder	• **Adequate hydration is maintained** • **Patient voiding**
Surgical Site Infection, Skin • Braden Risk Assessment	• Complete skin assessment as per Braden Risk and Skin Assessment (Adult) DST (BD-00-12-40078) • Change dressing daily or Q2days • **Incision well approximated – no redness, swelling, minimal or no drainage** •

	• **Temp ≤ 38.5** • **No S&S of infection**

Functional Mobility	• Review/teach spine mobility precautions (i.e. spine neutral) and active log roll technique
	• Assess mobilization and document :
	  ○ Log rolling assessment (unable, with assist, or independent)
	  ○ Lying ←→ sitting assessment (unable, with assist, or independent)
	  ○ Sitting ←→ standing assessment (unable, with assist, or independent)
	  ○ Transfer bed to chair (unable, with assist, or independent)
	• PT assess ambulation, ability to walk 100m; use of equipment/aid (including unable, with assist, or independent)
	  ○ Stairs, including number, with/without railing (unable, with assist, or independent)
	  ○ Refer to PT analysis & plan
	• **Up in chair x all 3 meals**
	• **Walking to bathroom**
	• **Mobility Goal: walk 100m independently**
	• **Safe, reliable independent functional mobility achieved**

Activities of Daily Living	• Post-Op Activity Guidelines (as needed):
	  ○ Provide educational handout and reinforce/review post-op activity guidelines
	• Assess the following as unable (caregiver taught), requires setup/supervision, or independent:
	  <u>Orthosis Education</u> (as needed):
	  • Provided educational handout and reinforce/review orthosis management (i.e. daily care and procedure to don/doff)
	  ○ Don & Doff orthosis
	  <u>Self-Care Screening/Teaching</u> (as needed)
	  • Screen abilities and provide teaching for:
	  ○ Dressing, Toileting, Grooming, Showering
	  <u>Home and Community Responsibilities</u> (as needed)
	  • Screen status and address needs related to:
	  ○ Homemaking/family care (e.g. meal preparation, cleaning, child care, etc.)
	  ○ Community- based ADLs (e.g. shopping, transportation, etc.) screened and no issues identified
	• **Understands, and able to follow post-operative activity guidelines**
	• **Safe, reliable independent (or plan in place) orthosis management**
	• **Safe, reliable independent (or plan in place) for self-care activities**
	• **Home & community responsibilities addressed**

Psychosocial	• Initiate Social Work referral (if required) • **No psychosocial issues identified**
Medication Management	• **No issues identified with medications patient taking**

	pre-hospital

Teaching & Discharge Planning

Nursing:

- Determine ELOS and anticipated discharge date
- Determine discharge destination
- Determine if assistance at home required
- Provide teaching to patient and/or family re:
  - Incision care - Demonstrate/return demo of dressing change with family/caregiver
  - Dressing/med supplies – Give and review Post-Operative Spine Incision Care Pamphlet (PHEM catalogue no. FB.723.P67)
  - Pain management – Give and review Pain Control After Surgery (PHEM catalogue no. FM.820.P161) and Opioid Tapering (PHEM catalogue no. EA.836.086) pamphlets
  - Post-op complication (DVT/PE, infection, constipation, motor/sensory)
- **Discharge Teaching is complete**
- **X-ray complete and reviewed by Spine Surgeon/Resident**
- **Discharge order obtained from Spine Surgeon/Resident**
- **Physician asked to complete dictated discharge summary**
- **Transportation home arranged for 10:00 discharge**
- **On day of discharge: My Discharge Plan complete (photocopied x 2 – copies in CML binder and patient chart, original given to patient)**
- **Photocopy pain medication prescription – copy in CML binder and give original to patient**

Allied:

Equipment/Supplies (as needed)

- Prescribe equipment/provide equipment resource/loan handout to patient (includes self-care equipment, mobility aids)

Community Referrals (as needed)

- Identifies which community care services are required and completes referral, including OT, PT, Dietician and/or Home Support Services
- **Ready for Discharge from OT and PT**
- **Equipment/supplies in place (on order)**

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, Acute Spine Program, VGH