

SITE:			

Bowel Resection Clinical Pathway LOS 8 Days

☐ Right Hemicolectomy	☐ Left Hemicolectomy	☐ Anterior Resection

Instructions:

1.	Bolded Items Are Desired patient Outcomes/required Interventions
2.	 D, N = Day & Night Shift Initial shaded area when intervention occurred/complete. No Further charting is required if desired outcomes are met. If intervention "Not applicable" document "N/A" in shaded area
3.	If outcomes or interventions are not met , insert a " V " with a number (e.g. " V#1 ", " V#2 " etc) to indicate a variance. List variances by number in the variance section at the bottom of each day's column making reference to further documentation (nurses notes, PT notes etc).
4.	Review Discharge outcomes (on back page) daily and date/initial when Discharge Outcomes are met
5.	Fill in (blank line) to individualize pathway, as needed (e.g. Consults, PT/OT plans etc.)

Within Defined Limits (WDL)

William Dennieu L	iiiits (WDE)
VS	Check patient care guidelines manual for post op checks.
Blood work	Notify physician if hemoglobin <90 or call stat if symptomatic and/or hemoglobin <80. Check WBC and inform physician of abnormal values (> 12,000) Check if electrolytes within normal range (see lab manual). Inform physician of abnormalities.
Drain(s)	Empty drain q shift and prn. Drainage sanguinous OR day. Serosang until removal.
Dressing(s)	Dressing dry and intact. May have small amount of serosang ooze on OR day. Change dressing PRN
Incision(s)	Edges clean, approximated. No redness or excess swelling.
Voiding	Output >30cc/hr. Contact physician if output <30cc/hr over 4 hours. Urine output clear, not foul odour. Pt. voiding independently when foley discontinued.
Post Void Residual (PVR)	PVR <300cc. If PVR >300cc, check physician's orders for I&O catheterization

Patient Resource Materials:

1) FK.230.L324	Patient Information for Large Bowel Surgery
2) ED.150.P9194	Preparing for Surgery
3) FK.230.Af89	Going Home after Bowel Surgery
4) ED.150.P8452	Post-Operative Breathing and Leg Exercises

	1			
Date	PSSU	PREOP on ward (if applicable)		
NEURO Delirium		Assess/address risk factors: pain, retention, restraint, sensory impairment, lytes, alcohol, meds, hypoxia, nutrition. No evidence of delirium, e.g. confusion, agitation, anxiety DN		
RESP Impaired resp status	DB& C exercise teaching	DB&C while awake $-$ 5 deep breaths /hr 2 coughs /hr Titrate O_2 to keep sat \geq 92% or \geq baseline prn Chest sounds clear DN		
CVS Impaired CVS, DVT/PE	Inform physician if patient has taken ASA or other blood thinners in last five (5) days ECG (if ordered)	VS WDL Inform physician if patient has taken ASA or other blood thinners in last five (5) days ECG (if ordered)		
Hematology Anemia, electrolyte balance,	CBC, lytes, X-match (if ordered)	CBC, lytes, X-match (if ordered) Blood Work WDL D N		
GI Nausea/vomiting, nutrition	Bowel prep (as ordered) Clear fluids then NPO (as ordered)	Bowel prep (as ordered) NPO NG to suction Assess NG placement and monitor drainage characteristics. No nausea and/or vomiting DN Assess for abdo distention/ileus		
GU UTI, Decreased Urine output		Foley cath to straight drainage Monitor Ins/Outs Voiding WDL DN		
Pain	☐ Preop pain scale teaching ☐ Anesthetist referral	Education related to pain management, modality (PCA/Epidural/oral) & management of side effects Rates pain ≤ 4 or level acceptable to patient. D N		
MUSC/SKEL Impaired mobility	Active Foot/Ankle/leg exercises *Post op exercise pamphlet given	Active Foot/Ankle/leg exercises		
General Wound/dressing care, drain management, cvc	Check: Regular Medications			
Psychosocial Anxiety/Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis	Nurse will discuss pt's concerns and fears related to surgery and diagnosis Pt describes anxiety as acceptable DN		
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	Review "Preparing for Surgery", "Patient Information for Large Bowel Resection" pamphlets.	Review "Preparing for Surgery", "Patient Information for Large Bowel Resection" pamphlets. Orient to unit and hospital routine Review pain scale/management Review purpose of lines, tubes drains (CVC, epidural, PCA, drain, foley cath). Patient and family understands outcome of surgery DN		
Variances				
Variances				

Data	OP Day	Post Op Day 1	
Date	OR Day		
NEURO -Delirium	No evidence of delirium, e.g. confusion, agitation, anxiety DN	No evidence of delirium, e.g. confusion, agitation, anxiety DN	
RESP -Impaired resp status	DB&C while awake $-$ 5 deep breaths /hr 2 coughs /hr Titrate 0_2 to keep sat \ge 92% or \ge baseline prn Chest sounds clear DN	DB&C while awake $-$ 5 deep breaths /hr 2 coughs /hr Titrate 0_2 to keep sat \ge 92% or \ge baseline prn Chest sounds clear DN	
CVS -Impaired CVS, DVT/PE	VS WDL DVT prophylasix No evidence DVT/PE DN	VS WDL DVT prophylasix No evidence DVT/PE DN	
Hematology Anemia, electrolyte balance	CBC, Potassium, Sodium Blood Work WDL DN	CBC, Potassium, Sodium Blood Work WDL DN	
GI Nausea/vomiting, nutrition	Ice chips Monitor Ins/Outs NG to suction Assess NG placement and monitor drainage characteristics. No nausea and/or vomiting DN Bowel sounds/flatus present DN No evidence of abdo distention DN	Ice chips Monitor Ins/Outs NG to suction Assess NG placement and monitor drainage characteristics. No nausea and/or vomiting D N Bowel sounds/flatus present D N No evidence of abdo distention D N	
GU UTI, Decreased Urine output	Foley cath to straight drainage Monitor Ins/Outs Voiding WDL DN	Foley cath to straight drainage Monitor Ins/Outs Voiding WDL DN	
Pain	Epidural or PCA as ordered Rates pain ≤ 4 or level acceptable to patient DN	Continue Epidural or PCA as ordered Rates pain ≤ 4 or level acceptable to patient DN	
MUSC/SKEL Impaired mobility	Active Foot/Ankle/leg exercises DN Physio referral on flagsheet D	Physio to assess and initiate treatment as required Sit at edge of bed/dangle Standing at bedside Up in chair min.D Ambulate; if able	
General Wound/dressing care, drain management cvc	Abdo Dressing WDL D N Drain(s) WDL D N	Abdo Dressing WDL DN	
Psychosocial Anxiety/Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis Pt describes anxiety as acceptable DN	Nurse will discuss pt's concerns and fears related to surgery and diagnosis Pt describes anxiety as acceptable DN	
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management Variances	Reinforce preop teaching Review pain scale/management Review purpose of lines, tubes drains (CVC, epidural, PCA, drain, foley cath).	Reinforce preop teaching Review pain scale/management Review purpose of lines, tubes drains (CVC, epidural, PCA, drain, foley cath).	

Date	Post Op Day 2		Post Op Day 3	
NEURO -Delirium	No evidence of delirium, e. agitation, anxiety	g. confusion, DN	No evidence of delirium, e. agitation, anxiety	g. confusion, D N
RESP -Impaired resp status	Titrate O₂ to keep sat ≥ 92% DB&C while awake Chest sounds clear	or ≥ baseline prn D N	Titrate O₂ to keep sat ≥ 92% DB&C while awake	
CVS	VS WDL	D N	Chest sounds clear VS WDL	DN
-Impaired CVS, DVT/PE	DVT prophylaxis No evidence DVT/PE	DN	DVT prophylaxis No evidence DVT/PE	DN DN
Hematology Anemia, electrolyte balance	Blood Work WDL	DN	Blood Work WDL	DN
GI Nausea/vomiting, nutrition	Ice chips. Or diet as ordered Monitor Ins/Outs NG as ordered Assess NG placement and m characteristics. No nausea and/or vomiting	nonitor drainage	Clear Fluids as tolerated Monitor Ins/Outs NG removed No nausea and/or vomiting	DN
	Bowel sounds/flatus prese	D N	No evidence of abdo dister	D N
GU UTI	Foley cath to straight drainag Voiding WDL	ge DN	Foley cath to straight drainage Remove Foley as per anest C&S urine on removal Voiding WDL PVR WDL	
Pain	Continue Epidural or PCA as Rates pain < 4 or level acco		Titrate Epidural or PCA as pe Rates pain < 4 or level acce	
MUSC/SKEL Impaired mobility	Walk x 2 Up to chair	D D	Up to Walk x 3 Up to chair	D D
General Wound/dressing care, drain management	Abdo Dressing WDL	DN	Change Dressing(s) prn Abdo Incision WDL	DN
Ç	Drain(s) WDL	D N	Drain WDL	D N
Psychosocial Anxiety/ Depression ADL's	Nurse will discuss pt's conce related to surgery and diagno Pt describes anxiety as acc	osis	Nurse will discuss pt's needs support/home care Pt describes anxiety as acc	
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	Begin Discharge teaching outcomes Review "Going Home after B	D	Continue Discharge teachi discharge outcomes Review "Going Home after B	D
Variances				

BOWEL RESECTION				1		
Date	Post Op Day 4			Post Op Day 5		
NEURO -Delirium	No evidence of delirium, e agitation, anxiety		usion, N	No evidence of delirium agitation, anxiety		usion, N
RESP -Impaired resp status	Titrate O_2 to keep sat $\geq 92\%$	or ≥ bas	·	Titrate O_2 to keep sat ≥ 9 .	2% or ≥ bas	seline prn
	Chest sounds clear	D		Chest sounds clear	D	N
CVS -Impaired CVS, DVT/PE	VS WDL DVT prophylaxis No evidence DVT/PE	D D		VS WDL No evidence DVT/PE	D	N N
Hematology Anemia, electrolyte balance	Blood Work WDL	D	_ N	Blood Work WDL	D	N
GI Nausea/vomiting, nutrition	Full Fluids as tolerated Monitor Ins/Outs Cap IV if tolerating fluids Dietitian referral sent	D		Diet as tolerated Maintain IV x 24 hours af removed.	ter Epidura	I catheter is
	No nausea and/or vomiting Bowel sounds/flatus prese		N	No nausea and/or vomi Bowel sounds/flatus pr		N
	No evidence of abdo diste	ntion D	N	No evidence of abdo dis	stention D	N
GU UTI	Foley cath to straight drainage Remove Foley as per anes	ge sthesia o D	orders	Foley cath to straight dra Remove Foley as per ar	nesthesia o D	orders
	C&S urine on removal Voiding WDL PVR WDL	D D D	 _ N _ N	C&S urine on removal Voiding WDL PVR WDL	D D D	N N
Pain	Titrate Epidural or PCA as p Rates pain < 4 or level acc		to patient.	Tolerating oral analgesic Rates pain < 4 or level a	acceptable	to patient.
MUSC/SKEL Impaired mobility	Pt up independently	D		Pt up independently Shower	D	
General Wound/dressing care, drain management	Change Dressing(s) prn Abdo Incision WDL	D	_ N	Change Dressing prn Abdo Incision WDL	D	N
-	Drain(s) WDL	D	N	Drain(S) WDL	D	N
Psychosocial Anxiety/ Depression ADL's	Inform patient/family of all re upon discharge. Pt describes anxiety as ac		_	Nurse will discuss pt's co related to surgery and dia Pt describes anxiety as	agnosis	
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection,	Continue Discharge teach discharge outcomes Review "Going Home after E	D	_	Continue Discharge tea discharge outcomes Review "Going Home after	D	
pain management	3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			No concerns regarding date		
Variances						

Date	Post Op Day 6			Post Op Day 7		
NEURO	No evidence of delirium, e.			No evidence of delirium, e.		
-Delirium	agitation, anxiety	D	N	agitation, anxiety	D	_ N
RESP	Titrate O₂ to keep sat ≥ 92% of	or ≥ ba	seline prn			
-Impaired resp status		_			_	
	Chest sounds clear	D	N	Chest sounds clear	D	_ N
CVS	VS WDL	D		VS WDL	D	
Impaired CVS, DVT/PE	No evidence DVT/PE	D	N	No evidence DVT/PE	D	_ N
Hematology	Blood Work WDL	D	N	Blood Work WDL	D	_ N
Anemia, electrolyte						
balance						
GI	Diet as tolerated	_		Diet as tolerated	_	
Nausea/vomiting,	No nausea and/or vomiting		N	No nausea and/or vomiting		_ N
nutrition	Bowel sounds/flatus preser			Bowel sounds/flatus prese		
	N.	D	N	No. 11	D	_ N
	No evidence of abdo disten			No evidence of abdo dister		
	DM	D	N	DM	D	_ N
	BM	_		BM	_	
GU	Voiding WDL	D	N	Voiding WDL	D	N
UTI	PVR WDL	D		Volume VVDL		_ '\
Pain	Tolerating oral analgesic			Tolerating oral analgesic		
	Rates pain < 4 or level acce			Rates pain < 4 or level acc	eptable t	to patier
		D	N		ט	_ N
MUSC/SKEL	Pt up independently	D		Pt up independently	D	
Impaired mobility	i t up independently	D		i tup independently	D	_
impaired mobility						
General	Change Dressing(s) prn			Change Dressing prn		
Wound/dressing care,	g(-, p			Assess suture, staple remov	al.	
drain management				Assess drain removal		
J	Abdo Incision WDL	D	N	Abdo Incision WDL	D	_ N
	Drain(s) WDL	D	N	Drain(S) WDL	D	_ N
Psychosocial	Nurse will discuss pt's conce	rns and	l fears			
Anxiety/	related to surgery and diagno		ricaro			
Depression	Pt describes anxiety as acc		e	Pt describes anxiety as ac	centable	1
ADL's	l i accominate animaty at acc	D	N		D	N
Patient Teaching/	Continue Discharge teachir	ng and	sign	Continue Discharge teachi		
Discharge Planning	discharge outcomes	D		discharge outcomes	D	
Home Support,						
diet, activity, infection,	Review "Going Home after Be			Review "Going Home after B		
pain management	No concerns regarding med	_	arget d/c	No concerns regarding me	_	rget d/c
	date	D		date	D	
Variances						
v ai iai iCES						

Date	Post Op Day 8		Post Op Day 9		
NEURO -Delirium	No evidence of delirium, e.ç agitation, anxiety	g. confusion, DN	No evidence of delirium, e.g agitation, anxiety	J. confusion, D N	
RESP -Impaired resp status	Chest sounds clear	D N	Chest sounds clear	D N	
CVS -Impaired CVS, DVT/PE	VS WDL No evidence DVT/PE	D N D N	VS WDL No evidence DVT/PE	D N D N	
Hematology Anemia, electrolyte balance	Blood Work WDL	DN	Blood Work WDL	DN	
GI Nausea/vomiting, nutrition	Diet as tolerated No nausea and/or vomiting Bowel sounds/flatus preser No evidence of abdo disten	nt D N tion D N	Diet as tolerated No nausea and/or vomiting Bowel sounds/flatus presen No evidence of abdo distent	nt DN tion DN	
GU UTI	Voiding WDL	D N	Voiding WDL	DN	
Pain	Tolerating oral analgesic Rates pain < 4 or level acce	ptable to patient. DN	Tolerating oral analgesic Rates pain < 4 or level acce	ptable to patier	
MUSC/SKEL Impaired mobility	Pt up independently	D	Pt up independently	D	
General Wound/dressing care, drain management	Change Dressing(s) prn Assess suture, staple remova Assess drain removal Abdo Incision WDL Drain(s) WDL	I. D N D	Change Dressing prn Assess suture, staple remova Assess drain removal Abdo Incision WDL Drain(S) WDL	l. D N D	
Psychosocial Anxiety/ Depression ADL's	Pt describes anxiety as acc		Pt describes anxiety as acco		
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	Complete Discharge teaching discharge outcomes Review "Going Home after Bod Discharge by 10 a.m. if outcomerded by physician Patient not discharged toda Reason	Dowel Surgery" mes met and D	Complete Discharge teaching discharge outcomes Review "Going Home after Bod Discharge by 10 a.m. if outcomerdered by physician Patient not discharged toda Reason	owel Surgery" mes met and D	
Variances					

DISCHARGE	OUTCOMES	
Discharge Time:	Destination:	
Accompanied by:	Mode:	
		Outcome Met Date/Initial
Nursing:		D G G M M M M M M M M M M
Patient or caregiver, verbalizes signs and symptoms	of post-op complications and	
interventions. (DVT/PE, infection, pain, limb swelling,	, constipation)	
Patient verbalized hygiene and incision care practice	S.	
Effective pain control on oral analgesic		
Patient aware of need for follow-up appointment with	surgeon.	
Prescriptions given (if applicable)		
Patient understands no heavy lifting for 6 weeks.		
Patient able to continue own recovery from home.		
Patient verbalizes need for gradual increases in activ	rity to pre-op level.	
Dietitian/Nursing		
Patient understands diet recommendations (if any).		
Patient Off Pathway		
Date: Initial		
CCCP "Off Pathway" code inputted into HBOC	_Initial	