SITE: VCH Coastal Cerner Sites

GENSURG – CHOLECYSTECTOMY CLINICAL PATHWAY

Instructions:

I. Review once per shift for patient care guideline only. Do not record patient care on this document.
II. Document all tasks completed and any problems, interventions, and evaluations in CERNER EHR.
III. Review previous shift documentation - unless documenting on outcomes for the first time.
IV. **Bolded Items are desired patient outcomes/required Interventions**

Within Defined Limits (WDL)

VS	VS as ordered. Titrate O2 to keep SPO2 92% or greater (SPO2 88-92% for COPD patients). Notify Treating Provider of a new fever greater than 38.5 DegC.
Tube/Drain	Monitor tube/drain output q6h & PRN. **Penrose** – change dressing daily and prn. Drainage for OR Day sanguineous; Day 1 until removal serosanguinous to serous. **HS and other closed drains,** change dressing prn; Drainage – OR Day sanguineous; Day 1 until removal serosanguinous to serous. **Hemovac** drain: Strip q1h for 4 hour then q6h PRN. **NG**, if ordered, to low continuous suction.
Dressing	Dressing dry and intact. May have small amount of serosang ooze on OR day. Leave dressings to primary closed wounds for 48 hr unless directed.
Incision	Edges clean, approximated. No redness or excess swelling.
T-Tube	Maintain drain patency; avoid kinks, pressure or overflowing collection container. Record drainage. Drainage – bile, approx. 200-300cc/24H gradually decreasing.
Voiding	Monitor Intake and Output as ordered. Notify Treating Provider if urine output is less than 60 mL for two consecutive hours. Urine output clear, no foul odour. In and Out Catheterization if PRV greater than 500 mL, PRN

Patient Resource Materials:

1)	FK.800.G35	Patient Information for Gall Bladder Removal (Cholecystectomy)
2)	ED.160.D735	Drain Care - Discharge Information
3)	ED.150.P8452	Post Operative Breathing and Leg Exercises
4)	FN.200.P74	Preventing Pneumonia: ICOUGH

CHOLECYSTECTOMY CLINICAL PATHWAY			
	Preop	**OR Day**	**POD 1**
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**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP Respiratory impairment	iCOUGH Protocol if applicable	iCOUGH Protocol if applicable Titrate 0_2 to keep $Sp0_2 \geq 92\%$ or $Sp0_2$ 88–92% for COPD pts **Chest sounds clear**	iCOUGH Protocol if applicable Titrate 0_2 to keep $Sp0_2 \geq 92\%$ or $Sp0_2$ 88–92% for COPD pts **Chest sounds clear**
CVS Hypovolemia DVT/PE	VS x1 HT & WT	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** DVT prophylasix **No evidence DVT/PE**
Hematology Anemia,	HGB, X-match		Labs as ordered
GI Nausea/vomiting, constipation	Take a laxative two days before surgery NPO at hs	Ice chips/sips of water Assess abdo for distention, bowel sounds **No nausea and/or vomiting**	Diet as Ordered Assess abdo for distention, bowel sounds **No nausea and/or vomiting**
GU Urine output, PV loss		**Voiding WDL**	**Voiding WDL** Remove catheter if applicable
Pain	Pain Management: - pain scale/modalities explained	Education related to pain management, modality (PCA/Epidural/oral) & management of side effects **Rates pain $\leq$ 4 or level acceptable to patient.**	**Rates pain $\leq$ 4 or level acceptable to patient**
MUSC/SKEL Mobility	Leg exercise pamphlet	**Leg exercises** **Dangle**	Physio to assess and initiate treatment Dangle **Walk in room** Walk in hallway
General Dressing	Stop taking ASA, anticoagulant, vitamins/herbal preparations 5-7 days pre-op Take regular medications, pre-op unless otherwise ordered by anesthetist	**Dressing WDL** **T-tube WDL** **Drain WDL**	**Dressing WDL** **T-tube WDL (if applicable)** **Drain(s) WDL (if applicable)**
Psychosocial Fear and anxiety		Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Pain control, complications, hygiene, activity, constipation prevention	Assess homecare needs Discuss length of stay Review pamphlet "Patient information for Gall Bladder Removal Referral sent to: SW DCC	Orient to unit and hospital routine Reinforce pre-op teaching Review pain scale/management Review purpose of lines, tubes drains (CVC/IV, PCA, drain, T-tube). **Patient and family understands outcome of surgery**	Review and sign discharge outcomes and teachings Review pamphlet "Patient information for Gall Bladder Removal" Discharge home by 10 a.m. if discharge outcomes met and if Doctor's order

CHOLECYSTECTOMY CLINICAL PATHWAY			
	POD 2	**POD 3**	**POD 4**
NEURO Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP Impaired resp status	**Chest sounds clear**	**Chest sounds clear**	**Chest sounds clear**
CVS Impaired CVS, DVT/PE	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** DVT prophylaxis **No evidence DVT/PE**
Hematology		Labs as ordered	
GI Nausea/Vomiting Nutrition	Diet as ordered Assess abdo for distention, bowel sounds, flatus **No nausea and/or vomiting**	Diet as Ordered Assess for flatus, BM Assess abdo for distention, bowel sounds, flatus **No nausea and/or vomiting**	Diet as Ordered Assess abdo for distention, bowel sounds, flatus **No nausea and/or vomiting**
GU Urine output, retention	**Voiding WDL**	**Voiding WDL**	**Voiding WDL**
Pain	**Rates pain ≤ 4 or level acceptable to patient**	**Rates pain ≤ 4 or level acceptable to patient**	**Rates pain < 4 or level acceptable to patient**
MUSC/SKEL Activity, mobility	Up in chair Wash at sink **Walk in hallway x2**	May shower **UP independently**	**Up independently**
General Dressing, drain t-tube	**Dressing WDL** **T-tube WDL (if applicable)** **Drain(s) WDL (if applicable)**	**Dressing change** **Incision WDL** **T-tube WDL (if applicable)** Assess drain removal as ordered **Drain WDL (if applicable)**	**Dressing change** **Incision WDL** **T-tube WDL (if applicable)** Assess drain removal as ordered **Drain WDL (if applicable)**
Psychosocial Anxiety	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	Review and sign discharge outcomes and teachings Review pamphlet "Patient information for Gall Bladder Removal" Discharge home by 10 a.m. if discharge outcomes met and if Doctor's order	Review and sign discharge outcomes and teachings	Review and sign discharge outcomes and teachings **No concerns about meeting target discharge date**

CHOLECYSTECTOMY CLINICAL PATHWAY			
	POD 5	**POD 6**	**POD 7**
NEURO Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP Impaired resp status	**Chest sounds clear**	**Chest sounds clear**	**Chest sounds clear**
CVS Impaired CVS, DVT/PE	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** **No evidence DVT/PE**	**VS WDL** DVT prophylaxis **No evidence DVT/PE**
Hematology			
GI Nausea/Vomiting Nutrition	DAT Assess for flatus, BM **No nausea and/or vomiting**	DAT **No nausea and/or vomiting**	Assess for flatus, BM DAT **No nausea and/or vomiting**
GU Urine output, retention	**Voiding WDL**	**Voiding WDL**	**Voiding WDL**
Pain	**Rates pain ≤ 4 or level acceptable to patient**	**Rates pain ≤ 4 or level acceptable to patient.**	**Rates pain < 4 or level acceptable to patient**
MUSC/SKEL Activity, mobility	May shower **Pt up independently**	**Pt up independently**	**Pt up independently**
General Dressing, drain t-tube	**Dressing change** **Incision WDL** **T-tube cholangiogram** **T-tube WDL (if applicable)** Assess drain removal as ordered **Drain WDL**	**Dressing change** **Incision WDL** **T-tube WDL (if applicable)** Assess drain removal as ordered **Drain WDL**	**Remove sutures/staples as ordered** **Incision WDL** **T-tube WDL (if applicable)** Assess drain removal as ordered **Drain WDL**
Psychosocial Anxiety	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	**Complete Discharge teaching and sign outcomes** **Discharge home by 10 a.m. if discharge outcomes met and if Doctor's order** Home care nursing referral if drain insitu on discharge. Review pamphlet "Discharge information for Drain Care"	Review and sign discharge outcomes and teachings **No concerns regarding meeting target d/c date**	**Complete Discharge teaching and sign outcomes** **Discharge home by 10 a.m. if discharge outcomes met and if Doctor's order** Home care nursing referral if drain insitu on discharge. Review pamphlet "Discharge information for Drain Care"

DISCHARGE OUTCOMES

Record: Discharge Time, Destination, Accompanied by, Mode

Discharge Outcomes:

Patient must have effective pain control on oral analgesics

Incision approximated with minimal redness and no discharge

Bowel sounds, and/or passing flatus, abdominal distention within normal limits

Patient must ambulate independently or a pre-op functional level

A suitable discharge plan is in place (support at home).

Referral to Home Care Nursing if required for drain or t-tube care (see orders)

Teaching: document variances according to instructions on Page 1
Patients or caregivers must demonstrate awareness of:

- Activity restriction in relation to lifting, driving, household activities, returning to work
- The signs of symptoms of common potential complications and appropriate action to be taken (e.g. wound infection, DVT/pulmonary embolus)
- Pain management – patients understands the importance of taking analgesics and reporting severe pain to physician
- Dietary recommendations (if any)
- Medications on discharge
- Methods to promote bowel functions and prevent constipation
- Follow-up appointment with surgeon
- Referral to Home Care Nursing if required for suture removal or drain care (see orders)
- Personal hygiene recommendations (e.g. incision care, drain care, T-tube care)