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)

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

BOWEL RESECTION		
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** **D**_____ **N**_____
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 ≥ 92% or ≥ baseline prn **Chest sounds clear** **D**_____ **N**_____
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** **D**_____ **N**_____ 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** **D**_____ **N**_____ Assess for abdo distention/ileus
GU UTI, Decreased Urine output		Foley cath to straight drainage Monitor Ins/Outs **Voiding WDL** **D**_____ **N**_____
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** **D**____ **N**____
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. **D**____ 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** **D**_____ **N**_____
Variances		

BOWEL RESECTION		
Date	**OR Day**	**Post Op Day 1**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D**_____ **N**_____	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D**_____ **N**_____
RESP -Impaired resp status	DB&C while awake – 5 deep breaths /hr 2 coughs /hr Titrate 0_2 to keep sat ≥ 92% or ≥ baseline prn **Chest sounds clear** **D**_____ **N**_____	DB&C while awake – 5 deep breaths /hr 2 coughs /hr Titrate 0_2 to keep sat ≥ 92% or ≥ baseline prn **Chest sounds clear** **D**_____ **N**_____
CVS -Impaired CVS, DVT/PE	**VS WDL** **D**_____ **N**_____ DVT prophylasix _____ No evidence DVT/PE **D**_____ **N**_____	**VS WDL** **D**_____ **N**_____ DVT prophylasix _____ No evidence DVT/PE **D**_____ **N**_____
Hematology Anemia, electrolyte balance	CBC, Potassium, Sodium **Blood Work WDL** **D**_____ **N**_____	CBC, Potassium, Sodium **Blood Work WDL** **D**_____ **N**_____
GI Nausea/vomiting, nutrition	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**_____	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** **D**_____ **N**_____	Foley cath to straight drainage Monitor Ins/Outs **Voiding WDL** **D**_____ **N**_____
Pain	Epidural or PCA as ordered **Rates pain ≤ 4 or level acceptable to patient** **D**_____ **N**_____	Continue Epidural or PCA as ordered **Rates pain ≤ 4 or level acceptable to patient** **D**_____ **N**_____
MUSC/SKEL Impaired mobility	**Active Foot/Ankle/leg exercises** **D**_____ **N**_____ 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** **D**_____ **N**_____ **Drain(s) WDL** **D**_____ **N**_____
Psychosocial Anxiety/Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable** **D**_____**N**_____	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable** **D**_____**N**_____
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management	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).
Variances		

BOWEL RESECTION		
Date	**Post Op Day 2**	**Post Op Day 3**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**
RESP -Impaired resp status	Titrate O_2 to keep sat ≥ 92% or ≥ baseline prn DB&C while awake **Chest sounds clear** **D_____ N_____**	Titrate O_2 to keep sat ≥ 92% or ≥ baseline prn DB&C while awake **Chest sounds clear** **D_____ N_____**
CVS -Impaired CVS, DVT/PE	**VS WDL** **D_____ N_____** DVT prophylaxis _____ No evidence DVT/PE **D_____ N_____**	**VS WDL** **D_____ N_____** DVT prophylaxis _____ No evidence DVT/PE **D_____ N_____**
Hematology Anemia, electrolyte balance	**Blood Work WDL** **D_____ N_____**	**Blood Work WDL** **D_____ N_____**
GI Nausea/vomiting, nutrition	Ice chips. Or diet as ordered. Monitor Ins/Outs NG as ordered 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_____**	Clear Fluids as tolerated Monitor Ins/Outs NG removed **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** **No evidence of abdo distention** **D_____ N_____**
GU UTI	Foley cath to straight drainage **Voiding WDL** **D_____ N_____**	Foley cath to straight drainage **Remove Foley as per anesthesia orders** **D_____** **C&S urine on removal** **D_____** **Voiding WDL** **D_____ N_____** **PVR WDL** **D_____ N_____**
Pain	Continue Epidural or PCA as ordered **Rates pain < 4 or level acceptable to patient.**	Titrate Epidural or PCA as per physician order **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**
MUSC/SKEL Impaired mobility	**Walk x 2** **D_____** Up to chair **D_____**	**Up to Walk x 3** **D_____** Up to chair **D_____**
General Wound/dressing care, drain management	**Abdo Dressing WDL** **D_____ N_____** **Drain(s) WDL** **D_____ N_____**	Change Dressing(s) prn **Abdo Incision WDL** **D_____ N_____** **Drain WDL** **D_____ N_____**
Psychosocial Anxiety/ Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable** **D_____ N_____**	Nurse will discuss pt's needs for home support/home care **Pt describes anxiety as acceptable** **D_____ N_____**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	**Begin Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery"	**Continue Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery"
Variances		

BOWEL RESECTION		
Date	**Post Op Day 4**	**Post Op Day 5**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**
RESP -Impaired resp status	Titrate O_2 to keep sat ≥ 92% or ≥ baseline prn **Chest sounds clear** **D_____ N_____**	Titrate O_2 to keep sat ≥ 92% or ≥ baseline prn **Chest sounds clear** **D_____ N_____**
CVS -Impaired CVS, DVT/PE	**VS WDL** **D_____ N_____** DVT prophylaxis _____ **No evidence DVT/PE** **D_____ N_____**	**VS WDL** **D_____ N_____** **No evidence DVT/PE** **D_____ 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_____** **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** BM _____ **No evidence of abdo distention** **D_____ N_____**	Diet as tolerated Maintain IV x 24 hours after Epidural catheter is removed. **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** BM _____ **No evidence of abdo distention** **D_____ N_____**
GU UTI	Foley cath to straight drainage **Remove Foley as per anesthesia orders** **D_____** **C&S urine on removal** **D_____** **Voiding WDL** **D_____ N_____** **PVR WDL** **D_____ N_____**	Foley cath to straight drainage **Remove Foley as per anesthesia orders** **D_____** **C&S urine on removal** **D_____** **Voiding WDL** **D_____ N_____** **PVR WDL** **D_____ N_____**
Pain	Titrate Epidural or PCA as per physician order **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**	Tolerating oral analgesic **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**
MUSC/SKEL Impaired mobility	**Pt up independently** **D_____**	**Pt up independently** **D_____** Shower **D_____**
General Wound/dressing care, drain management	Change Dressing(s) prn **Abdo Incision WDL** **D_____ N_____** **Drain(s) WDL** **D_____ N_____**	Change Dressing prn **Abdo Incision WDL** **D_____ N_____** **Drain(S) WDL** **D_____ N_____**
Psychosocial Anxiety/ Depression ADL's	Inform patient/family of all resources arranged upon discharge. **Pt describes anxiety as acceptable** **D_____ N_____**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable** **D____N____**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	**Continue Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery"	**Continue Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date** **D_____**
Variances		

BOWEL RESECTION		
Date	**Post Op Day 6**	**Post Op Day 7**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**
RESP -Impaired resp status	Titrate O_2 to keep sat ≥ 92% or ≥ baseline prn **Chest sounds clear** **D_____ N_____**	**Chest sounds clear** **D_____ N_____**
CVS -Impaired CVS, DVT/PE	**VS WDL** **D_____ N_____** No evidence DVT/PE **D_____ N_____**	**VS WDL** **D_____ N_____** No evidence DVT/PE **D_____ N_____**
Hematology Anemia, electrolyte balance	**Blood Work WDL** **D_____ N_____**	**Blood Work WDL** **D_____ N_____**
GI Nausea/vomiting, nutrition	Diet as tolerated **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** **No evidence of abdo distention** **D_____ N_____** BM _____	Diet as tolerated **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** **No evidence of abdo distention** **D_____ N_____** BM _____
GU UTI	**Voiding WDL** **D_____ N_____** **PVR WDL** **D_____**	**Voiding WDL** **D_____ N_____**
Pain	Tolerating oral analgesic **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**	Tolerating oral analgesic **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**
MUSC/SKEL Impaired mobility	**Pt up independently** **D_____**	**Pt up independently** **D_____**
General Wound/dressing care, drain management	Change Dressing(s) prn **Abdo Incision WDL** **D_____ N_____** **Drain(s) WDL** **D_____ N_____**	Change Dressing prn Assess suture, staple removal. Assess drain removal **Abdo Incision WDL** **D_____ N_____** **Drain(S) WDL** **D_____ N_____**
Psychosocial Anxiety/ Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable** **D_____ N_____**	**Pt describes anxiety as acceptable** **D_____ N_____**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	**Continue Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date** **D_____**	**Continue Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date** **D_____**
Variances		

BOWEL RESECTION		
Date	**Post Op Day 8**	**Post Op Day 9**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**	**No evidence of delirium, e.g. confusion, agitation, anxiety** **D_____ N_____**
RESP -Impaired resp status	**Chest sounds clear** **D_____ N_____**	**Chest sounds clear** **D_____ N_____**
CVS -Impaired CVS, DVT/PE	**VS WDL** **D_____ N_____** No evidence DVT/PE **D_____ N_____**	**VS WDL** **D_____ N_____** No evidence DVT/PE **D_____ N_____**
Hematology Anemia, electrolyte balance	**Blood Work WDL** **D_____ N_____**	**Blood Work WDL** **D_____ N_____**
GI Nausea/vomiting, nutrition	Diet as tolerated **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** **No evidence of abdo distention** **D_____ N_____** BM _____	Diet as tolerated **No nausea and/or vomiting** **D_____ N_____** **Bowel sounds/flatus present** **D_____ N_____** **No evidence of abdo distention** **D_____ N_____** BM _____
GU UTI	**Voiding WDL** **D_____ N_____**	**Voiding WDL** **D_____ N_____**
Pain	Tolerating oral analgesic **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**	Tolerating oral analgesic **Rates pain < 4 or level acceptable to patient.** **D_____ N_____**
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 removal. Assess drain removal **Abdo Incision WDL** **D_____ N_____** **Drain(s) WDL** **D_____ N_____**	Change Dressing prn Assess suture, staple removal. Assess drain removal **Abdo Incision WDL** **D_____ N_____** **Drain(S) WDL** **D_____ N_____**
Psychosocial Anxiety/ Depression ADL's	**Pt describes anxiety as acceptable** **D_____ N_____**	**Pt describes anxiety as acceptable** **D_____ N_____**
Patient Teaching/ Discharge Planning Home Support, diet, activity, infection, pain management	**Complete Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery" Discharge by 10 a.m. if outcomes met and ordered by physician **D_____** **Patient not discharged today** _____ **Reason** _____	**Complete Discharge teaching and sign discharge outcomes** **D_____** Review "Going Home after Bowel Surgery" Discharge by 10 a.m. if outcomes met and ordered by physician **D_____** **Patient not discharged today** _____ **Reason** _____
Variances		

DISCHARGE OUTCOMES	
Discharge Time:	Destination:
Accompanied by:	Mode:

Outcome Met Date/Initial

Nursing:

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 practices. _____

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 activity 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 _____