GENSURG – BOWEL RESECTION CLINICAL PATHWAY

Site: VCH Coastal Cerner Sites

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	Monitor VS as ordered. Notify Treating Provider of a new fever greater than 38.5 DegC.
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.
Tubes/Drains	Monitor tubes/drains output q6h & PRN.. Drainage sanguinous OR day. Serosang until removal. Strip Hemovac q1h for 4 hour then q6h PRN.
Dressing(s)	Leave dressings to primary closed wounds for 48 hr unless directed. Change dressing PRN.
Incision(s)	Edges clean, approximated. No redness or excess swelling.
Voiding	Notify Treating Provider if urine output is less than 60 mL for two consecutive hours. Urine output clear, not foul odour. Pt. voiding independently when foley discontinued.
Post Void Residual (PVR)	In and Out Catheterization if PRV greater than 500 mL, PRN

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)	FN.200.P74	Preventing Pneumonia: ICOUGH

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**
RESP Impaired resp status	Follow iCOUGH Protocol if applicable	Follow iCOUGH Protocol if applicable Titrate O_2 to keep $SpO_2 \geq 92\%$ or Titrate O_2 to keep SpO_2 88-92%, for COPD pts **Chest sounds clear**
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 on arrival** 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**
GI Nausea/vomiting, nutrition	Bowel prep (as ordered) Clear fluids then NPO (as ordered)	Bowel prep (as ordered) NPO NG to suction (if ordered) Assess NG placement and monitor drainage characteristics. **No nausea and/or vomiting** Assess for abdo distention/ileus
GU UTI, Decreased Urine output		Foley cath to straight drainage Monitor Ins/Outs **Voiding WDL**
Pain	D Preop pain scale teaching D Anesthetist referral	Education related to pain management, modality (PCA/Epidural/oral) & management of side effects Rates pain ≤ 4 **or** level acceptable to patient.
MUSC/SKEL Impaired mobility	**Active Foot/Ankle/leg exercises** *Post op exercise pamphlet given	**Active Foot/Ankle/leg exercises** **Activity as tolerated**
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**
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**

BOWEL RESECTION		
Date	**OR Day**	**Post Op Day 1**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP -Impaired resp status	Follow iCOUGH Protocol if applicable Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**	Follow iCOUGH Protocol if applicable Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**
CVS -Impaired CVS, DVT/PE	**VS WDL** DVT prophylaxis No evidence DVT/PE	**VS WDL** DVT prophylaxis No evidence DVT/PE
Hematology Anemia, electrolyte balance	**Blood Work as ordered**	**Blood Work as ordered**
GI Nausea/vomiting, nutrition	~~Ice chips~~ Diet as ordered Monitor Ins/Outs NG to suction (if applicable) Assess NG placement and monitor drainage characteristics (if applicable)~~.~~ **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**	~~Ice chips~~ Diet as ordered Monitor Ins/Outs ~~-~~NG to suction (if applicable) Assess NG placement and monitor drainage characteristics (if applicable)~~.~~ **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**
GU UTI, Decreased Urine output	~~Foley~~ Urinary catheter to straight drainage Monitor Ins/Outs **Voiding WDL**	Urinary catheter as ordered Monitor Ins/Outs **Voiding WDL**
Pain	Epidural or PCA as ordered **Rates pain ≤ 4 or level acceptable to patient**	Continue Epidural or PCA as ordered **Rates pain ≤ 4 or level acceptable to patient**
MUSC/SKEL Impaired mobility	**Active Foot/Ankle/leg exercises** Physio referral ~~on flagsheet~~ in Cerner	Physio to assess and initiate treatment as required Sit at edge of bed/dangle Standing at bedside **Up in chair_____min.** Ambulate; if able
General Wound/dressing care, drain management cvc	**Abdo Dressing WDL** **Drain(s) WDL**	**Abdo Dressing WDL** **Drain(s) WDL**
Psychosocial Anxiety/Depression ADL's	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, 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). Initiate teaching for self administration of LMWH/dalteparin ASAP and complete in time for discharge for pts with malignancy.

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BOWEL RESECTION		
Date	**Post Op Day 2**	**Post Op Day 3**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP -Impaired resp status	Follow iCOUGH Protocol if applicable Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**	Follow iCOUGH Protocol if applicable Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**
CVS -Impaired CVS, DVT/PE	**VS WDL** DVT prophylaxis No evidence DVT/PE	**VS WDL** DVT prophylaxis No evidence DVT/PE
Hematology Anemia, electrolyte balance	**Blood Work as ordered**	**Blood Work as ordered**
GI Nausea/vomiting, nutrition	Ice chips OR Diet as ordered. Monitor Ins/Outs NG as ordered. Assess NG placement and monitor drainage characteristics (if applicable). **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**	Clear Fluids as tolerated OR Diet as ordered Monitor Ins/Outs NG removed (if applicable) **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**
GU UTI, Decreased Urine output	Urinary catheter as ordered **Voiding WDL**	Urinary catheter as ordered ~~C&S urine on removal~~ **Voiding WDL** **PVR WDL**
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**
MUSC/SKEL Impaired mobility	**Walk x 2** Up to chair	**Up to Walk x 3** Up to chair
General Wound/dressing care, drain management cvc	**Abdo Dressing WDL** Change Dressing if ordered **Drain(s) WDL**	Change Dressing(s) prn **Abdo Dressing WDL** **Drain(s) WDL**
Psychosocial Anxiety/Depression ADL's	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's needs for home support/home care. **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management	**Begin Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery"	**Begin Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery"

BOWEL RESECTION		
Date	**Post Op Day 4**	**Post Op Day 5**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP -Impaired resp status	Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**	Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**
CVS -Impaired CVS, DVT/PE	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** **No evidence DVT/PE**
Hematology Anemia, electrolyte balance	**Blood Work as ordered**	**Blood Work as ordered**
GI Nausea/vomiting, nutrition	Full Fluids as tolerated OR Diet as ordered Monitor Ins/Outs Cap IV if tolerating fluids **Dietitian referral sent** **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**	Diet as tolerated OR diet as ordered Maintaing IV x 24 hours after Epidural catheter is removed. **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention**
GU UTI, Decreased Urine output	Urinary catheter as ordered Remove (?) C&S urine on removal **Voiding WDL** **PVR WDL**	Urinary catheter as ordered Remove (?) C&S urine on removal **Voiding WDL** **PVR WDL**
Pain	Titrate Epidural or PCA as per physician order **Rates pain ≤ 4 or level acceptable to patient**	Tolerating oral analgesic **Rates pain ≤ 4 or level acceptable to patient**
MUSC/SKEL Impaired mobility	**Pt up independently**	**Pt up independently** Shower
General Wound/dressing care, drain management cvc	Change Dressing(s) prn **Abdo Dressing WDL** **Drain(s) WDL**	Change Dressing(s) prn **Abdo Dressing WDL** **Drain(s) WDL**
Psychosocial Anxiety/Depression ADL's	Inform patient/family of all resources arranged upon discharge. **Pt describes anxiety as acceptable**	Inform patient/family of all resources arranged upon discharge. **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management	**Continue Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery"	**Continue Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date**

BOWEL RESECTION		
Date	**Post Op Day 6**	**Post Op Day 7**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP -Impaired resp status	Titrate O2 to keep SpO2 ≥ 92% or Titrate O2 to keep SpO2 88-92%, for COPD pts **Chest sounds clear**	**Chest sounds clear**
CVS -Impaired CVS, DVT/PE	**VS WDL** **No evidence DVT/PE**	**VS WDL** **No evidence DVT/PE**
Hematology Anemia, electrolyte balance	**Blood Work as ordered**	**Blood Work as ordered**
GI Nausea/vomiting, nutrition	Diet as tolerated **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention** BM	Diet as tolerated **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention** BM
GU UTI, Decreased Urine output	**Voiding WDL** **PVR WDL**	**Voiding WDL**
Pain	Tolerating oral analgesic **Rates pain ≤ 4 or level acceptable to patient**	Tolerating oral analgesic **Rates pain ≤ 4 or level acceptable to patient**
MUSC/SKEL Impaired mobility	**Pt up independently**	**Pt up independently**
General Wound/dressing care, drain management cvc	Change Dressing(s) prn **Abdo Dressing WDL** **Drain(s) WDL**	Change Dressing(s) prn Assess suture, staple removal. Assess drain removal **Abdo Dressing WDL** **Drain(s) WDL**
Psychosocial Anxiety/Depression ADL's	Inform patient/family of all resources arranged upon discharge. **Pt describes anxiety as acceptable**	**Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management	**Continue Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date**	**Continue Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery" **No concerns regarding meeting target d/c date**

BOWEL RESECTION		
Date	**Post Op Day 8**	**Post Op Day 9**
NEURO -Delirium	**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**
CVS -Impaired CVS, DVT/PE	**VS WDL** **No evidence DVT/PE**	**VS WDL** **No evidence DVT/PE**
Hematology Anemia, electrolyte balance	**Blood Work as ordered**	**Blood Work as ordered**
GI Nausea/vomiting, nutrition	Diet as tolerated **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention** BM	Diet as tolerated **No nausea and/or vomiting** **Bowel sounds/flatus present** **No evidence of abdo distention** BM
GU UTI, Decreased Urine output	**Voiding WDL**	**Voiding WDL**
Pain	Tolerating oral analgesic **Rates pain ≤ 4 or level acceptable to patient**	Tolerating oral analgesic **Rates pain ≤ 4 or level acceptable to patient**
MUSC/SKEL Impaired mobility	**Pt up independently**	**Pt up independently**
General Wound/dressing care, drain management cvc	Change Dressing(s) prn Assess suture, staple removal. Assess drain removal **Abdo Dressing WDL** **Drain(s) WDL**	Change Dressing(s) prn Assess suture, staple removal. Assess drain removal **Abdo Dressing WDL** **Drain(s) WDL**
Psychosocial Anxiety/Depression ADL's	**Pt describes anxiety as acceptable**	**Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Home Support, teaching diet, activity, infection, pain management	**Complete Discharge teaching and ~~sign~~ assess discharge outcomes** Review "Going Home after Bowel Surgery" Discharge by 10 a.m. if outcomes met and ordered by physician Document reason if patient not discharged today.	**Complete Discharge teaching and assess ~~sign~~ discharge outcomes** Review "Going Home after Bowel Surgery" Discharge by 10 a.m. if outcomes met and ordered by physician Document reason if patient not discharged today.

DISCHARGE OUTCOMES
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. Patient able to self administer LMWH/Dalteparin (patients with malignancy) **Dietitian/Nursing** Patient understands diet recommendations (if any).