Site: VCH Coastal Cerner Sites

NSURG - LUMBAR AND THORACO LUMBAR INSTRUMENTATION / FUSION CLINICAL PATHWAY

Instructions:

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

STANDARDS – WITHIN DEFINED LIMITS (WDL)

VS:	VS and NVS as ordered. Titrate O2 to keep SpO2 92% or greater.
Dressing:	OR Day to Day 1 – small amount of oozing, intact dressing. Notify Provider if dressing reinforced Day 2 – change to absorbent dressing if wound draining; if dry, apply dry dressing.
Incision:	Clean / approximated, no excessive redness or swelling
Drain:	Remove Hemovac drain when less than 50mL over 12hr or on POD 2.
Post-op Checks:	Check Policy and Procedure Manual, Index P-1, Post-operative Assessment and Management on the Unit and B-1, Back and Neck Surgery – Post-op Assessments/"Laminectomy Checks".
Pain:	The patient will report pain, ≤ 4 on a 0-10 pain intensity scale or whatever is acceptable to the patient.
Voiding:	Notify Provider if urine output < 60mL in 2 consecutive hours for catheterized pts.
PVR:	In and Out Catheterization if PVR > 400 mL, PRN. Insert indwelling catheter if patient unable to void and in&out catheterization performed x3, and notify provider.

CLINICAL PATHWAY
Lumbar and Thoraco Lumbar Instrumentation / Fusion

WDL – see front page

	PAC	SSCU	OR DAY	Post-op Day 1
Cons	PT, OT, SLT as required PRN			
Tests	Outside xray to OR			
Assessment & Treatment	Nursing - Admission assessment Shower with antiseptic soap evening and morning prior to surgery Physio - Admission assessment		Post-op checks Dressing WDL Drain WDL Drain removal _____ IV insitu Chest clear BP, TPR Bowel sounds, bladder, Spinal Motor and Sensory checks } q4h	Dressing WDL Drain WDL Spinal brace/collar as ordered IV discontinued Chest clear BP, TPR bowel sounds, bladder, Spinal Motor and Sensory checks } TID
Meds	Review current medications Review physician's advice re taking ASA, NSAID's, vitamins/herbal preparations Take regular medications pre-op with a sip of water unless otherwise ordered	Confirm regular medications taken pre-op Pre-op antibiotic prophylaxis as ordered	Analgesic – offer regularly → Anti-nausea prn →	Laxative of choice prn
Activity			HOB Log roll every 2-3 hours Stand/sit to void Up minimum x 1	AAT or ordered Walk in room May be up without brace initially Sit in chair for meals if comfortable
Diet	Nothing to eat or drink after midnight evening prior to surgery	Confirm NPO status	Clear fluids - DAT →	→
Bladder Bowel			Post-op void Output WDL →	Start stool softener BID
Teaching	Nursing Pre-op: - Pre-op Video - Review Timeline - Patient Information Pamphlet	Reinforce pre-op teaching	iCOUGH Protocol Log rolling →	Provide education booklet on Sx
Discharge Planning	Arrange transport home by 10:00 a.m. on day of discharge			

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WDL – see front page

	Date	Date	Date
	Post-op Day 2	**Post-op Day 3**	**Post-op Day 4**
Cons	PT, OT, SLT as required PRN		
Tests		Post-op xray as ordered prn	
Assessment & Treatment	Dressing change after shower Chest clear BP, TPR, Spinal Motor & Sensory Checks — BID Spinal brace/collar as ordered	Chest clear BP, TPR, Spinal Motor & Sensory Checks → BID Spinal brace/collar as ordered	Dressing change prior to discharge In am Spinal brace/collar as ordered
Meds	Analgesic po prn		
Activity	AAT or ordered Walk in room / hall with brace x 2 Sit in chair for meals as tolerated →	AAT or ordered Walk in hall / bathroom with brace minimum x 4	Independent Stairs
Diet	General →		
Bladder Bowel	If no BM, start stimulant laxative hs Stool softener BID → Output WDL →		
Teaching	Exercise program and back education initiated Review brace application / adjustment Pain management prn →	Home activity and exercises reviewed Back education exercise program completed	
Discharge Planning	Review discharge planning Patient aware of estimated date of discharge	**Finalize discharge plans**	**DISCHARGE BY 1000 AM**

DISCHARGE OUTCOMES AND TEACHINGS

TEACHING

Patients or caregivers must demonstrate awareness of:

- Patient Information Pamphlet
- Pain Management – patient understands the importance of taking analgesics and reporting severe pain to the physician
- Bowel functions and methods to prevent constipation
- Activity
  - Shower if able to stand safely
  - No tub bath for the first two weeks
  - Sitting; gradually increase sitting as long as is comfortable over several days
  - Lifting; avoid lifting or twisting for 6 weeks
  - Resume sexual activity as tolerated
  - Back education and exercise program
- Driving – in 1 to 2 weeks or when comfortable turning (to check traffic)
- Incision:
  - Report redness, swelling, discharge or fever (>38.5)
  - To be kept dry; change as needed
  - For most surgeries, dissolvable sutures are used. The clear end of these sutures may be seen at the ends of the incision. They may be clipped after 9 days, but do not pull on them
- Sutures/staples (if not dissolvable), are removed in 9 - 10 days
- Review medications on discharge
- Follow up appointment with surgeon _____

DISCHARGE OUTCOMES

Patients must have:

- A suitable pain control plan
- Incision approximated with minimal redness and no discharge
- Urinary function within normal limits
- Independent ambulation or be at pre-op functional level
- May require a responsible adult to supervise x 24h