Splenectomy Surgery Clinical Pathway

Site Applicability

Vancouver General Hospital (VGH)

UBC Hospital

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record (Cerner) or paper chart as per policy

POST – OR Day	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Orient to unit & hospital routine • Reinforce pre-op teaching (deep breathing, coughing and leg exercises) • Review pain scale/management • Review NG protocol and feeding schedule • Review purpose of lines, tubes and drains (CVC, epidural, PCA, hemovac drain, Foley catheter) • Patient and family understands outcome of surgery
Tests	• Standing orders for blood work
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) maintain oxygen requirements to saturation levels • Assess CVC site (free of infection, redness, sutures intact & CVC secured with safety pin) • Assess NG placement and monitor drainage characteristics • NG to suction (secured with tape and safety pin) • Nare and mouthcare Q2hrs prn • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (monitor for bleeding/evidence of hematoma) **DO NOT** change dressing x 48 hours unless indicated - **outline drainage with a pen** • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis) • Monitor and empty hemovac drainage Q6hrs prn (**No sanguineous/bilious drainage**) • **Strip hemovac drain** Q1hr x 4hrs then Q6hrs prn
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed • Plantar dorsi-flexion exercises Q1hr while awake • Dangle at edge of bed
Medications	• Patient controlled Analgesia (Epidural/PCA) • Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm • Sensory motor function within normal range/satisfactory • Pruritus controlled
Nutrition	• NPO • Sips of Clear Fluids

	• Clear fluids • Nausea controlled
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal dressing intact • Lap sites intact • Hemovac drain(s) output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable

Post-Op Day 1	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing, and leg exercises • Review pain scale/management • Review NG protocol and feeding schedule • Review progression of self care • Patient and family understand outcome of surgery • Provide and review "Going Home after Splenectomy Surgery" pamphlet with patient/family
Tests	• Bloodwork as ordered
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) maintain oxygen requirements to saturation levels • Assess CVC site (free of infection, redness, sutures intact & CVC secured with safety pin) • Assess NG placement and monitor drainage characteristics • NG to suction (secured with tape and safety pin) Nare and mouthcare Q2hrs prn • **NG clamped** (as per orders) • **NG removed** • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (monitor for bleeding/evidence of hematoma) **DO NOT** change dressing x 48 hours unless indicated - **outline drainage with a pen** • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis) • Monitor and empty hemovac drainage Q6hrs prn (**No sanguineous/bilious drainage**) • **Strip hemovac drain** Q6hrs prn
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q1hr while awake • ICOUGH protocol followed • Plantar dorsi-flexion exercises Q1hr while awake • Dangle, sit in chair • Assisting with am care
Medications	• Patient controlled Analgesia (Epidural/PCA) • Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q1hr until pain is controlled then Q4hrs prn (pain adequately controlled) • Sedation level within norm • Sensory motor function within normal range/satisfactory • Pruritus controlled

Nutrition	• Sips of Clear Fluids • Clear fluids • Full fluids • Nausea controlled
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • Foley catheter removed • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal dressing intact • Lap sites intact • Hemovac drain(s) output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable

Post-Op Day 2	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • Review NG protocol and feeding schedule • Review progression of self care • Enquire if patient received vaccinations prior to surgery – if not, coordinate **vaccination administration** • **Provide and review "Going Home after Splenectomy Surgery" pamphlet with patient/family**
Tests	• Standing orders for blood work
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) titrate oxygen requirements to saturation levels – wean to room air Assess CVC site (free of infection, redness, sutures intact & CVC secured with safety pin) • **Remove CVC** – start peripheral IV • Assess NG placement and monitor drainage characteristics NG to suction (secured with tape and safety pin) • Nare and mouthcare Q2hrs prn • **NG clamped** (as per orders) • **NG removed** • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (free of redness, swelling, hematoma, cellulitis) • **Expose** abdominal incision, staples in situ – incision well approximated • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis) • Monitor and empty hemovac drainage Q6hrs prn (**No sanguineous/bilious drainage**) • **Strip hemovac drain** Q6hrs prn • **Hemovac removed**
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hrs prn • ICOUGH protocol followed • Up in chair (2-3 times/day) • Assist with am care • Ambulating with assistance
Medications	• Patient controlled Analgesia (Epidural/PCA) • Wean Patient Controlled Analgesia – **initiate oral analgesics** • Analgesics prn

	• Antiemetic prn
Pain	• Pain assessment Q4hrs prn (pain adequately controlled) • Sedation level within norm • Sensory motor function within normal range/satisfactory • Pruritus controlled
Nutrition	• Clear fluids • Full fluids • DAT • Nausea controlled
Elimination	• Foley catheter to straight drainage (urine output > 30 mls/hr) • **Foley catheter removed** • Voiding adequately (urine output > 30 mls/hr) • Passing flatus
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal incision well approximated • Lap sites intact • Hemovac drain(s) output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing with assistance – returning to baseline level of function

Post-Op Day 3	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • Review NG protocol and feeding schedule • Review progression of self care • Enquire if patient received vaccinations prior to surgery – if not, coordinate **vaccination administration** • **Discuss & review discharge plans in 1-2 days** • Discuss potential needs upon discharge (home support/home care nursing) • **Provide and review "Going Home after Splenectomy Surgery" pamphlet with patient/family**
Tests	
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%) on room air • Assess CVC site (free of infection, redness, sutures intact & CVC secured with safety pin) • **Remove CVC** – start peripheral IV • Assess peripheral IV site (free of infection, redness) • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (free of redness, swelling, hematoma, cellulitis) • **Expose** abdominal incision, staples in situ – incision well approximated • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis) • Monitor and empty hemovac drainage Q6hrs prn (**No sanguineous/bilious drainage**) • **Strip hemovac drain** Q6hrs prn • **Hemovac removed**
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hrs prn • ICOUGH protocol followed • Up in chair (2-3 times/day) • Independent with personal care • Independently mobilizing
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• Full fluids • DAT

	• Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea
Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal incision well approximated • Lap sites intact • Hemovac drain(s) output/colour within normal range/satisfactory • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing independently - at baseline level of function

Post-Op Day 4	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • Review feeding schedule • Review progression of self care • **Plan discharge home today/tomorrow** • Discuss potential needs upon discharge (home support/home care nursing) • **Inform patient/family of all resources arranged upon discharge** • **Inform patient re: timing of staple removal (if applicable)** • **Provide and review "Going Home after Splenectomy Surgery" pamphlet with patient/family**
Tests	
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) Pulse oximeter Q4hrs prn (>93%)– **on room air** • Assess peripheral IV site (free of infection, redness) • **Saline lock IV** • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (free of redness, swelling, hematoma, cellulitis) • **Expose** abdominal incision, staples in situ – **incision well approximated** • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis)
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hrs prn • ICOUGH protocol followed • Up in chair (2-3 times/day) • Independent with personal care • Independently mobilizing
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• DAT • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea

Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL - within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal incision well approximated • Lap sites intact • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing with assistance – returning to baseline level of function

Post-Op Day 5	
Focus of Care	**Expected Outcomes**
Teaching, Discharge Planning	• Reinforce deep breathing, coughing and leg exercises • Review pain scale/management • Review feeding schedule • Review progression of self care • **Plan discharge home today** • Inform patient/family of all resources arranged upon discharge • Inform patient re: timing of staple removal (if applicable) • **Provide and review "Going Home after Splenectomy Surgery" pamphlet with patient/family**
Tests	
Consults	
Assessments, Treatments	• Vital signs and temp as per post-op protocol (R12-20 min, P60-100, BP 90-150) • Level of consciousness (oriented x 3) • Chest auscultation Q4hrs prn (breath sounds clear; resp easy & regular, Ø SOB, Ø resp distress) • Pulse oximeter Q4hrs prn (>93%)– **on room air** • **Saline lock IV** • **Remove Saline lock** • Assess abdominal status Q4hrs prn (soft, non distended, bowel sounds x 4 audible) • Assess abdominal incision (free of redness, swelling, hematoma, cellulitis) • **Expose** abdominal incision, staples insitu – **incision well approximated** • Lap sites intact with steri-strips (free of redness, swelling, hematoma, cellulitis)
Adequate Airway	• Airway patent, can clear own secretions
Activity, Rest	• Elevate HOB 30° • Encourage deep breathing, coughing and leg exercises Q4hrs prn • ICOUGH protocol followed • Up in chair (2-3 times/day) • Independent with personal care • Independently mobilizing
Medications	• Analgesics prn • Antiemetic prn
Pain	• Pain assessment Q4hrs prn (pain adequately controlled) • Sedation level within norm
Nutrition	• DAT • Nausea controlled
Elimination	• Voiding adequately (urine output > 30 mls/hr) • Passing flatus • Note any normal BM • Note any diarrhea

Anxiety/Fear	• Nurse will anticipate and discuss patient's/families concerns and fears related to surgery • Information needs met
Desired Outcomes **WNL -** **within normal limits**	• Airway patent • Vital signs and temp stable within normal range/satisfactory • Abdominal incision well approximated • Lap sites intact • Patient states pain is at an acceptable level • Nausea controlled • Tolerates oral intake • Fluids and electrolytes balanced • Patient describes anxiety as acceptable • Mobilizing with assistance – returning to baseline level of function

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, General/Vascular Surgery, OTL-HNS & GI Medicine, VGH