SITE: VCH Coastal Cerner Sites

NSURG - LUMBAR DISCECTOMY/MICRO DISCECTOMY 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**

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 1 – change to absorbent dressing if wound draining; if dry, apply dry dressing.
Incision:	Clean / approximated, no excessive redness or swelling. Check for CSF leak if patient have excessive serous drainage and headache.
Drain:	Remove Hemovac drain when less than 50mL over 12hr or on POD 2. Test drainage for CST if greater than 50 cc.
Post-op Checks:	Check Policy and Procedure Manual, Index P-1 and B-1
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 DISCECTOMY/MICRO DISCECTOMY

WDL – see front page

	PAC	SSCU	OR DAY	POST OP DAY 1
Cons	Physio / OT as required			
Tests	Outside xray to OR			
Assessments & 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	Dressing change after shower Incision: WDL → am
Meds	Review current medications Review physician's advice re: taking ASA, NSAID's, vitamins/herbal preparations Take regular medications pre-op with sip of water unless otherwise ordered	Confirm regular medications taken pre-op Pre-op antibiotics prophylaxis as ordered	Analgesic – offer regularly Anti-nausea prn	Analgesic po prn Laxative of choice (Colace) prn
Activity			Bed flat Up minimum of 2 X Stand / sit to void Turn every 2 – 3 hours	Walk in hall Shower Sit for breakfast Independent on stairs
Diet	Nothing to eat or drink after midnight evening prior to surgery	Confirm NPO status	Clear fluids – DAT	General diet
Bladder Bowel			Post – Op void Output: WDL →	
Teaching	Nursing Pre-Op: - Pre-Op video - Review Timeline - Patient Information Pamphlet	Reinforce pre-op teaching	iCough	Back education completed Exercise program completed
Discharge Planning	Arrange transport home by 10:00 a.m. on day of discharge		Confirm discharge plan	Discharge by 1000h with: - Pamphlets - Prescription(s) - Responsible adult

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WDL – see front page

DISCHARGE OUTCOMES AND TEACHINGS

TEACHING

Patients and 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 in sitting position.
    - 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)
    - Dressing 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 end of your 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 in physician's office. Provide staple remove to patient.
- 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