Thyroid/Parathyroid Surgery Clinical Pathway

Site Applicability

Providence Health Care Surgical Units

Pathway Patient Goals

1. Patient will be discharged POD 1 *(except renal transplant or chronic dialysis patients)*
2. Patients will have no difficulty breathing or swallowing
3. Patient will have pain managed to a level acceptable to the patient
4. Patient's incision will not have excessive swelling or hematoma
5. Patient/caregiver will verbalize understanding of discharge instructions and follow-up
6. Patient will have no signs or symptoms of hypocalcaemia

Inclusion Criteria

1. Provider order for pathway (required)
2. All elective THYROID / PARATHYROID surgery admissions

Exclusion Criteria

1. Patients with multiple co-morbidities may require longer hospitalization
2. Any concurrent major surgery associated with the thyroid/parathyroid surgery

   Note: Renal transplant patient and chronic renal dialysis patients can expect to stay several days post-op for calcium adjustment.

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 or paper chart as per policy

Pathway

DAY OF SURGERY	
Care Category/Tasks & Activities	**Expected Outcomes**
Safety/Fall Risk	• Universal Falls Prevention (Safe Step) in place • Fall risk care plan in place, if appropriate • HOB elevated at 45 degrees at all times • Dysphagia screen • Suture scissors at bedside
Cognition	• Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess for delirium using CAM. CAM screen negative. • Assess and address risk factors for delirium: pain, urinary retention, constipation, sensory impairment, abnormal lab values, alcohol withdrawal, infection, sleep, environment, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• Perform routine vitals per protocol (on arrival to ward then Q4H), more frequently if unstable • If present, assess equipment in use and confirm settings • Head to toe assessment Q shift within patient's normal limits • Airway maintained (no excessive neck swelling or hematoma) • Assess for signs and symptoms of anemia/bleeding (weakness, pallor, blood loss, etc.) • Patient admission assessment and nursing care plan must be completed within 48 hours of admission • Chest sounds clear • No signs or symptoms of hypocalcemia (tetany, tingling toes, fingers or lips, muscular twitches, mental status changes, seizures) • Monitor for vocal deficits
Pain Management	• Pain assessment completed and documented on unit admission and at least Q4H • Pain level is acceptable to patient • Analgesia as ordered

Elimination	• Patient voiding without difficulty • Patient passing bowels without difficulty. Refer to date of last BM
Nutrition / Hydration	• Patient has no nausea and/or vomiting • Dysphagia screening completed before patient takes anything orally • Patient has no signs or symptoms of dysphagia after 90 mL water test • Fluid intake greater or equal to 750mL in 12 hours or keeping within restrictions • Tolerating diet • Eating more than 75% of meal trays
Skin/Dressings/Drains	• Skin integrity intact • No bleeding or hematoma noted • Monitor swelling • Steri-strips dry and intact • Drain (if present) in place and patent
Diagnostics	• Ensure all routine lab work is ordered, performed and results are available • Serum (ionized) calcium levels are within normal limits • Notify MRP if serum (ionized) calcium levels abnormal: ECG performed as per orders
Mobility	• Head of bed maintained at 45 degrees at all times • Patient up in chair for all meals • Patient participates in ankle pumping exercises (5 every hour) • Patient able to ambulate • Patient completes am/pm care with assistance • Patient practices 10 deep breaths/hour and coughing if secretions, while awake (encourage to breathe normally between each deep breath) • Night time sleep acceptable to patient
Medications	• Best possible medication history obtained and recorded • For renal patients, calcium gluconate infusion started and maintained as per Nephrology Consult Team orders
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge POD 1 • Patient has clothing at bedside for discharge POD 1 • Pathway reviewed with patient • Patient has transportation arranged for discharge

POST-OP DAY 1 (DISCHARGE DAY)	
Care Category/Tasks & Activities	**Expected Outcomes**
Safety/Fall Risk	• Universal Falls Prevention (Safe Step) in place • Fall risk care plan in place, if appropriate • HOB elevated at 45 degrees at all times • Dysphagia screen • Suture scissors at bedside
Cognition	• Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess for delirium using CAM. CAM screen negative. • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, abnormal lab values, alcohol withdrawal, sleep, environment, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• Perform routine vitals per protocol (Q4H), more frequently if unstable • If present, assess equipment in use and confirm settings • Head to toe assessment Q shift within patient's normal limits • Airway maintained (no excessive neck swelling or hematoma) • Assess for signs and symptoms of anemia/bleeding (weakness, pallor, blood loss, etc.) • Patient admission assessment and nursing care plan must be completed within 48 hours of admission • Chest sounds clear • No signs or symptoms of hypocalcemia (tetany, tingling toes, fingers or lips, muscular twitches, mental status changes, seizures) • Monitor for vocal deficits
Pain Management	• Pain assessment completed and documented on unit admission and at least Q4H • Pain level is acceptable to patient • PO analgesia as ordered
Elimination	• Patient voiding without difficulty • Patient passing bowels without difficulty. Refer to date of last BM

Nutrition / Hydration	• Patient has no nausea and/or vomiting • Swallowing without difficulty • Fluid intake greater or equal to 750mL in 12 hours or keeping within restrictions • Tolerating diet • Eating more than 75% of meal trays
Skin/Dressings/Drains	• Skin integrity intact • No bleeding or hematoma noted • Monitor swelling • Incision intact, no signs of infection • Drain (if present) discontinued as per orders
Diagnostics	• Ensure all routine lab work is ordered, performed and results are available • Serum (ionized) calcium are within normal limits • Notify MRP if serum (ionized) calcium levels abnormal; ECG performed as per orders
Mobility	• Head of bed maintained at 45 degrees at all times • Patient participates in ankle pumping exercises (5 every hour) • Patient ambulating • Patient completes am/pm care with assistance • Patient practices 10 deep breaths/hour and coughing if secretions, while awake (encourage to breathe normally between each deep breath) • Night time sleep acceptable to patient
Medications	• Best possible medication history obtained and recorded • For renal patients, calcium gluconate infusion started and maintained as per Nephrology Consult Team orders
Teaching & Discharge Planning	• Patient/caregiver aware of expected discharge today • Patient has arranged for support person at home for 72 hours post discharge • Patient has transportation arranged for discharge • Patient verbalizes understanding of who to contact for post-op follow-up • Patient has received prescription(s) • Patient has wound care pamphlet • Patient has all personal items and medications have been returned to patient at discharge

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