Free Vascularized Fibular Graft Clinical Pathway

Site Applicability

Providence Health Care

Pathway Patient Goals

1. Acute care LOS 5 days
2. 100% of patients are prepared for surgery
3. 100% of patients have pain management to a level acceptable to the patient
4. 100% of patients are free of nausea/vomiting on POD 1
5. Activity goals:
    - POD 0 = Dangle
    - POD 1 = Up to chair and physiotherapy will instruct about exercises
    - POD 2 = One person assist to transfer, toilet and walk
    - POD 3-5 = Progressing to independence with walking and transfers

Inclusion Criteria

1. All Free Vascularized Fibular Graft admissions

Home Discharge Criteria

1. Able to transfer safely and access home with available support

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

Day of Surgery POD 0	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits • Neurovascular assessments completed as per protocol are within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Perineural catheter secured, insitu (if applicable) • PCA in place as ordered, (if applicable)
Elimination	• Urine output more than 360 mL in 12 hours • Catheter care, if Foley insitu • Bowel sounds present, abdomen soft, not distended. • Date of last bowl movement noted.
Nutrition / Hydration	• **No Caffeine, No Chocolate, No nicotine** • No nausea/vomiting • Fluid intake greater than 600 mL in 12 hours or in keeping with restrictions • Tolerating diet – eating more than 75% of meal trays • IV/CVC Site assessed Q shift & PRN, site intact, no redness, IV patent
Skin/Dressings/Drains	• Dressing assessed Q shift & PRN • Dressing dry and intact • Drain in place and patent (if applicable) • Braden Score documented
Activity	• Elevate foot 18 cm above heart when resting • Patient to sit at edge of bed • Ankle pumping exercises 5 times every hour to unaffected leg while awake • Practices deep breathing every hour and cough secretions, while awake • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Review with patient/caregiver o Orientation to room/environment o Medications being given o Plan for discharge home POD 5

Post-Operative Day 1 (POD1)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol and within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • Foley discontinued (if present) • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended • Note date of last BM
Nutrition / Hydration	• **No Caffeine, No Chocolate, No Nicotine** • No nausea/vomiting • Fluid intake greater than 600 mL in 12 hours or in keeping with restrictions • Tolerating diet – eating more than 75% of meal trays • IV/CVC Site assessed Q shift & PRN, site intact, no redness, IV patent
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Drain in place and patent (if applicable), drainage recorded
Activity	• Elevate foot 18 cm above heart when resting • OT to fabricate and apply foot drop splint • PT to review/begin week 1-3 exercise program • Foot drop splint in place unless exercising • Ankle Pumping exercises 5 times every hour and cough if secretions, while awake • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Patient/family aware of splinting schedule • Patient/family aware of weight bearing status • Patient knows expected discharge date: POD 5 • Patient has home prepared & equipment in place • Patient has arranged for support person at home for 72 hours post discharge

Post-Operative Day 2 (POD2) /Discharge Day	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits • Neurovascular assessments completed as per protocol are within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed Q4H and PRN • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output greater than 360 mL in 12 hours • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended
Nutrition / Hydration	• **No caffeine, No chocolate, No nicotine** • No nausea/vomiting • Tolerating diet – eating more than 75% of meal trays • Fluid intake 600 mL/12 hours or more, or keeping with restrictions
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Discontinue drain if less than 50mL/24 hours
Activity	• Elevate foot 18 cm above heart when resting • Foot drop splint in place unless exercising • Walk with walker non- weight bearing • Daily leg exercises • Practices deep breathing every hour and cough secretions, while awake • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Patient understands potential post-op complications • No concerns regarding meeting target discharge • Ensure OT reviews ADL and IADL's (meal preparation, transportation, groceries) and positioning for intimacy • Confirm that the patient has purchased the necessary equipment for discharge and home is prepared • Confirm that the patient has appropriate support at home if necessary • Assess patients educations about the drug, dosage, duration, etc. Re-enforce teaching PRN. • Confirm patient has follow up appointments • Ensure a discharge destination planned: home • Discuss unit and hospital routine

Post-Operative Day 3 (POD 3)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol and within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed as per protocol • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended • Note date of last BM
Nutrition / Hydration	• **No Caffeine, No Chocolate, No Nicotine** • No nausea/vomiting • Fluid intake greater than 600 mL in 12 hours or in keeping with restrictions • Tolerating diet – eating more than 75% of meal trays
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift
Activity	• Elevate foot 18 cm above heart when resting • Foot drop splint in place unless exercising • Walk with walker/crutches non-weight bearing • Daily leg exercises reviewed • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Patient understands potential post-op complications • No concerns regarding meeting target discharge • Ensure OT reviews ADL and IADL's (meal preparation, transportation, groceries) and positioning for intimacy • Confirm that the patient has purchased the necessary equipment for discharge and home is prepared • Confirm that the patient has appropriate support at home if necessary • Assess patients educations about the drug, dosage, duration, etc. Re-enforce teaching PRN. • Confirm patient has follow up appointments • Ensure a discharge destination planned: home • Discuss unit and hospital routine

Post-Operative Day 4 (POD 4)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol and within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed as per protocol • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended • Note date of last BM
Nutrition / Hydration	• **No Caffeine, No Chocolate, No Nicotine** • Tolerating Diet
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift
Activity	• Elevate foot 18 cm above heart when resting • Foot drop splint in place unless exercising • Walk with walker/crutches non-weight bearing • Daily leg exercises • Night time sleep acceptable to patient

Teaching & Discharge Planning	• Patient has home prepared , equipment and support in place at home • No concerns reaching target discharge: tomorrow

Post-Operative Day 5 (POD 5) - Discharge Day	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol and within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed as per protocol • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended • Note date of last BM
Nutrition / Hydration	• **No Caffeine, No Chocolate, No Nicotine** • Tolerating Diet
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift
Activity	• Acceptable level of activity for discharge • Foot drop splint in place unless exercising • Walk with walker/crutches non- weight bearing • Daily leg exercises • Patient comfortable with stairs (if applicable)

Teaching & Discharge Planning	• If patient being discharged ensure the following: o Prescriptions given and Medication counselling completed o "Pain and ways to manage it" pamphlet reviewed o Patient is discharged accompanied by family or friend o Patient has wound care/post op instruction sheet o Patient has post-op exercise sheets o Patient has follow-up appointment o Patient requires additional therapy and information is provided • Personal items and medications returned to patient **If patient not discharged today, see additional Post Op Day.**

Additional Post- Op Day- Discharge Day	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• CAM Assessment - Patient oriented x 3 (person, place, time) • Notify MRP if any evidence of altered level of consciousness (delirium, confusion, agitation)
Assessment	• Vital signs completed as per protocol are within patient normal limits, afebrile • Neurovascular assessments completed as per protocol and within patient normal limits • Capillary refill (less than 3 seconds) to operative foot • Chest sounds clear
Pain Management	• Pain assessed as per protocol • Pain level is acceptable to patient • Importance of pain control reviewed with patient
Elimination	• Urine output more than 360 mL in 12 hours • No signs of urinary tract infection • Bowel sounds present, abdomen soft, not distended • Note date of last BM
Nutrition / Hydration	• **No Caffeine, No Chocolate, No Nicotine** • Tolerating Diet
Skin/Dressings/Drains	• Braden Scale • Dressing dry and intact, assessed Q shift • Incision approximated- no signs of infection
Lab	• Lab values within normal limits or as determined by MD
Activity	• Acceptable level of activity for discharge • Elevate foot 18cm above heart when resting • Foot drop splint in place unless exercising • Walk with walker/crutches non- weight bearing • Daily leg exercises • Patient comfortable with stairs (if applicable)

Teaching & Discharge Planning	• If patient being discharged ensure the following: o Prescriptions given and Medication counselling completed o "Pain and ways to manage it" pamphlet reviewed o Patient is discharged accompanied by family or friend o Patient has wound care/post op instruction sheet o Patient has post-op exercise sheets o Patient has follow-up appointment o Patient requires additional therapy and information is provided • Personal items and medications returned to patient

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