Uterine Fibroid Embolization Pathway

Site Applicability

Vancouver General Hospital

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

Day of Procedure – Post Procedure	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check completed q shift
Fall Risk/Care Plan	• Not at risk: reviewed and no concerns • Falls prevention care plan in place: reviewed and no changes • Risk assessed and new fall prevention care plan completed
Cognition	• Alert and orientated x 3 (person, place, date)
Assessment	• Vital signs as per protocol (Q1H x 2, then Q4H after) and within normal limits • Head to toe assessment (within patient's normal limits) • Pulses to access site satisfactory • Bilateral neurovascular assessment completed/documented and satisfactory. • Groin/radial dressing access site(s) has scant discharge and no hematoma. Change prn • Bruising and swelling at puncture site(s) within normal limits
Pain and Symptom Management	• Patient describes anxiety as acceptable • Patient understands principles of using PCA for pain management • Pain level acceptable to patient • Pruritus controlled • Patient states back pain in not increasing in severity
Bowel/Bladder	• Foley insitu. Output more than 100 ml per 4 consecutive hours • Passing flatus
Nutrition and Hydration	• Allow food only when HOB elevated. Sips to DAT, as tolerated • IV insitu and infusing well (NS or other fluid - as ordered) • Nausea controlled
Activity & Rest	• Ambulated with assistance **Femoral Approach**: ○ Patient on bedrest for 6 hours. Document time bedrest ends ○ After 3 hours post procedure, patient HOB to 30 degrees **Radial Approach**: ○ Patient may ambulate. Restrict wrist movement
Teaching & Discharge Planning • Patient understands outcome of procedure • Reinforce post-procedure teaching • Patient has met the following discharge criteria: ○ Independent with ADLs ○ Pain managed with oral analgesia ○ Passing gas OR has had bowel movement • Patient has discharge pamphlet and reviewed with primary nurse • Confirmed discharge destination	

Day of Procedure – Post Procedure Day 1 or longer	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check completed q shift
Fall Risk/Care Plan	• Not at risk: reviewed and no concerns • Falls prevention care plan in place: reviewed and no changes • Risk assessed and new fall prevention care plan completed
Cognition	• Alert and orientated x 3 (person, place, date)
Assessment	• Vital signs as per protocol (Q1H x 2, then Q4H after) and within normal limits • Head to toe assessment (within patient's normal limits) • Pulses to access site satisfactory • Bilateral neurovascular assessment completed/documented and satisfactory. • Groin/radial dressing access site(s) has scant discharge and no hematoma. Change prn • Bruising and swelling at puncture site(s) within normal limits
Pain and Symptom Management	• Patient describes anxiety as acceptable • Patient understands principles of using PCA for pain management • PCA discontinued and using oral analgesia for pain management • Pain level acceptable to patient • Pruritus controlled • Patient states back pain in not increasing in severity
Bowel/Bladder	• Foley insitu. Output more than 100 ml per 4 consecutive hours • Foley catheter removed at 0600 today • Patient voiding more than 200 ml/4 hours. Call physician if unable to void adequate amount • Passing flatus
Nutrition and Hydration	• DAT, as tolerated • IV saline locked. Patient drinking well and tolerating fluids • Nausea controlled
Activity & Rest	• Patient up to BR with assistance or independently • Increasing activity until discharged home • Mobilizing independently

Teaching & Discharge Planning
• Patient understands outcome of procedure
• Reinforce post-procedure teaching as per discharge pamphlet
• Patient has met the following discharge criteria:
  ○ Independent with ADLs
  ○ Pain managed with oral analgesia
  ○ Passing gas OR has had bowel movement
  ○ Tolerating regular diet
• Patient has discharge pamphlet and reviewed with primary nurse
• Follow up with Primary Care Provider arranged
• Confirmed discharge destination	

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, High Acuity Unit, UBCH