

	Admit to:		
	Attending:	House Staff:	Beeper #
	Diagnosis / Surgery:		
	Allergies:	Condition:	
	Weight: _____ kg	Height: _____	
	1. NURSING CARE: <ul style="list-style-type: none"> • Vital signs every 8 hours, call for T >101.5, P>120<50, SBP>180< 80 • Sequential compression sleeves X 48 hours • Incentive spirometry 10 times every hour while awake • I & O every 8 hours <input type="checkbox"/> Nothing Per Rectum <input type="checkbox"/> JP to bulb suction. Empty every 8 hours and document on I &O sheet <input type="checkbox"/> Discontinue JP on Post Op Day # 4 _____(date) <input type="checkbox"/> Foley catheter to gravity <input type="checkbox"/> For Colon Surgery Patients: Discontinue Foley on <u>Post op day # 2</u> - _____ (date) @ 8 AM, if urine output within previous 8 hours is greater than 250 ml. <input type="checkbox"/> For Pelvic or Rectal Surgery Patients: Discontinue Foley on <u>Post op day # 4</u> - _____ (date) @ 8 AM, if urine output within previous 8 hours is greater than 250 ml. <input type="checkbox"/> Change dressing prn and leave open to air on <u>Post op Day #2</u> - _____ (date) unless there is drainage. 		
	2. IV FLUIDS <ul style="list-style-type: none"> <input type="checkbox"/> LR @ _____ml / hour <input type="checkbox"/> Other fluids: _____ ml/hour 		
	3. DIET ADVANCEMENT <ul style="list-style-type: none"> <input type="checkbox"/> NPO today <input type="checkbox"/> Post-op day 1: CRS liquid & toast diet <input type="checkbox"/> Post-op day 2: For patients without a stoma – regular diet <input type="checkbox"/> Post-op day 2: For patients with a colostomy/ileostomy – low fiber diet 		
	4. ACTIVITY: <ul style="list-style-type: none"> <input type="checkbox"/> Out of bed to chair today <input type="checkbox"/> Ambulate in AM, 3 times daily <input type="checkbox"/> May shower with assistance on <u>Post op Day #3</u> - _____ (date) 		
	5. LABS: (On POD #1 _____ (date)) <ul style="list-style-type: none"> <input type="checkbox"/> HCT, Potassium <input type="checkbox"/> Other Labs: _____ 		
	MD SIGNATURE _____ BEEPER # _____		
LAHEY CLINIC			
<p>Authorization is given to the Pharmacy Department to dispense a generic & therapeutic equivalent drug when a brand name is ordered unless the medication ordered is circled.</p> <p style="text-align: center;">Physician Orders</p>	PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:		

Lahey Clinic Clinical Pathway - Care Guide <u>Colorectal Surgery Post-Operative Pathway</u>		PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:
Aspect of Care	Day of Surgery Date: _____	Expected Outcomes
Assessment	VS per routine Abdominal assessment	VSS Abdominal assessment WNL Documentation of flatus if present
Activity	OOB to chair Venodynes	OOB to chair tolerated Venodynes in place when in bed
Nutrition / Diet	NPO	Maintains NPO status
Treatment / Intervention	Incentive Spirometer q 1 hour while awake Empty & record JP output q shift, if applicable. Change dressing prn.	Using IS effectively JP output documented; MD notified for any abnormalities DSD maintained
Medications / Pain Management	Assess for pain every 8 hrs. Medicate as indicated. Steroids as ordered Heparin as ordered IVF as ordered	Pain is controlled at less than "4" on pain scale. Medications administered as ordered IVF maintained per order
Safety	Assess safety per Fall Risk protocol. Maintain safe environment.	Safe environment maintained
Consults	Enterostomal RN Nutrition Case Management	Consults initiated
Teaching	Refer to CRS patient teaching guidelines specific to patient's surgical procedure.	Patient verbalizes understanding of CRS patient teaching guidelines
Discharge Planning	Reinforce with patient that upon discharge he/she should be able to tolerate a diet, have adequate pain control with PO pain medication, exhibit no signs of infection, and be comfortable with stoma care, if applicable.	Patient verbalizes criteria needed to be in place upon discharge.
Psychosocial	Assess spiritual needs.	Clergy consult initiated if requested by patient+
Procedures & Tests	Labs per MD order	Labs WNL
Elimination	Record Intake & Output every shift. Nothing per rectum Foley to gravity, per MD order Monitor and record ostomy output if applicable.	Fluid balance maintained I & O documented Ostomy output documented

Lahey Clinic Clinical Pathway - Care Guide <u>Colorectal Surgery Post-Operative Pathway</u>		PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:
Aspect of Care	Post- Op Day 1 Date: _____	Expected Outcomes
Assessment	VS per routine Abdominal Assessment Monitor for passing of flatus.	VSS Abdominal assessment WNL Documentation of flatus if present
Activity	Ambulate X 3 daily. Venodynes	Ambulation X 3 tolerated Venodynes in place when in bed
Nutrition / Diet	CRS liquid & toast diet Advance diet per protocol.	Tolerates CRS liquid & toast diet Pt. tolerates diet advancement
Treatment / Intervention	Incentive spirometry q 1 hour while awake Change dressing prn.	Using incentive spirometer effectively DSD maintained
Medications / Pain Management	Assess pain every 8 hrs. Medicate as indicated. Steroids as ordered Heparin as ordered (discontinue once ambulating TID). IVF as ordered	Pain is controlled at less than "4" on pain scale. Medications administered as ordered. IVF maintained per order.
Safety	Reassess safety per protocol. Maintain safe environment.	Safe environment maintained
Consults	Enterostomal RN Nutrition Case Management	Consults continued
Teaching	Refer to CRS patient teaching guidelines specific to patient's surgical procedure. Also teach patient wound assessment and signs and symptoms of wound infection.	Patient verbalizes and demonstrates understanding of teaching as outlined in CRS patient teaching guidelines. Patient verbalizes understanding of normal wound healing and signs and symptoms of wound infection.
Discharge Planning	Continue to reinforce with patient that upon discharge he/she should be able to tolerate a diet, have adequate pain control with PO pain medication, exhibit no signs of infection, and be comfortable with stoma care, if applicable.	Patient verbalizes criteria need to be in place upon discharge.
Psychosocial	Continue to assess spiritual needs.	Clergy consult initiated if requested by patient.
Procedures & Tests	Hct, K+	Labs WNL
Elimination	Record I & O every shift Nothing per rectum Foley to gravity per order Monitor and record ostomy output, if applicable.	Fluid balance maintained I & O documented Ostomy output documented

Lahey Clinic Clinical Pathway - Care Guide <u>Colorectal Surgery Post-Operative Pathway</u>		PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:
Aspect of Care	Post- Op Days 2 / 3 Dates: _____ / _____	Expected Outcomes
Assessment	VS per routine Abdominal assessment Monitor and record passing of flatus.	VSS Abdominal assessment WNL Documentation of flatus if present
Activity	Ambulate X 3 daily. May shower POD #3	Ambulation X 3 tolerated
Nutrition / Diet	Advance per protocol: If tolerated CRS liq & toast, Regular diet for patients without a stoma Low fiber diet for patients with a colostomy or ileostomy. If tolerates diet, anticipate discharge.	Tolerating solid food
Treatment / Intervention	For colon surgery patients: D/C Foley catheter if urine output from previous shift > 250cc. For pelvic or rectal surgery patients leave Foley catheter in place; see orders for POD # 4. Empty and record JP output q shift if present. Leave wound open to air if no drainage present.	Foley discontinued if appropriate Patient's urine output monitored for sufficient quantity JP output documented, MD notified for any abnormalities Dressing removed if no drainage present
Medications / Pain Management	Reassess pain every 8 hrs. Medicate as indicated. Once patient begins solid food, discontinue hydrocortisone and begin prednisone as ordered.	Pain is controlled at less than "4" on pain scale. Patient tolerating PO steroids upon initiation of solid food
Safety	Reassess for safety per Fall Risk protocol. Maintain safe environment.	Safe environment maintained
Consults	Enterostomal RN Nutrition Case management	Consults continued
Teaching	Refer to CRS patient teaching guidelines specific to patient's surgical procedure. Also teach patient wound assessment and signs and symptoms of wound infection.	Patient verbalizes and demonstrates understanding of teaching as outlined in CRS patient teaching guidelines. Patient verbalizes understanding of normal wound healing and signs and symptoms of wound infection.
Discharge Planning	Continue to reinforce with patient that upon discharge he/she should be able to tolerate a diet, have adequate pain control with PO pain medication, exhibit no signs of infection, and be comfortable with stoma care, if applicable.	Patient verbalizes criteria needed to be in place upon discharge.
Psychosocial	Continue to assess spiritual needs.	Clergy consult initiated if requested by patient.
Procedures & Tests	Labs per MD order	Labs WNL
Elimination	Record Intake & Output every shift. Nothing per rectum Foley to gravity, if not previously discontinued, per order. Monitor and record ostomy output if applicable.	Fluid balance maintained I & O documented Ostomy output documented

Lahey Clinic Clinical Pathway - Care Guide <u>Colorectal Surgery Post-Operative Pathway</u>		PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:
Aspect of Care	Post- Op Days 4 / 5 Dates: _____ / _____	Expected Outcomes
Assessment	VS per routine Abdominal assessment Monitor and record passing of flatus.	VSS Abdominal assessment WNL Documentation of flatus if present
Activity	Ambulate X 3 daily. May shower	Ambulation X 3 tolerated
Nutrition / Diet	Adv. diet per protocol: If tolerated CRS liq & toast, Regular diet for patients without a stoma. Low fiber diet for patients with a colostomy or ileostomy. If tolerates solid foods, anticipate discharge.	Tolerates diet advancement per protocol.
Treatment / Intervention	For pelvic or rectal surgery patients: Discontinue Foley @ 8:00 am <u>day 4</u> if urine output on previous shift is greater than 250cc. Discontinue JP per MD order on <u>POD #4</u> .	Foley discontinued if appropriate Patient's urine output monitored for sufficient quantity.
Medications / Pain Management	Reassess pain every 8 hrs. Medicate as indicated. Once patient begins solid food, discontinue hydrocortisone and begin prednisone as ordered.	Pain is controlled at less than "4" on pain scale. Patient tolerating PO steroids upon initiation of solid food
Safety	Reassess for safety per Fall Risk protocol. Maintain safe environment.	Safe environment maintained
Consults	Enterostomal RN Nutrition Case management	Consults continued
Teaching	Refer to CRS patient teaching guidelines specific to patient's surgical procedure. Also teach patient wound assessment and signs and symptoms of wound infection.	Patient verbalizes and demonstrates understanding of teaching as outlined in CRS patient teaching guidelines. Patient verbalizes understanding of normal wound healing and signs and symptoms of wound infection.
Discharge Planning	Continue to reinforce with patient that upon discharge he/she should be able to tolerate a diet, have adequate pain control with PO pain medication, exhibit no signs of infection, and be comfortable with stoma care, if applicable. If staples not removed by discharge, schedule staple removal on <u>POD # 7-10</u> with ETRN. Follow-up appointment with surgeon in 4 weeks. Follow-up appointment with ETRN in 4 weeks, same day as surgeon (if appropriate).	Patient verbalizes criteria needed to be in place upon discharge.
Psychosocial	Continue to assess spiritual needs.	Clergy consult initiated if requested by patient
Procedures & Tests	Labs per MD order.	Labs WNL
Elimination	Record Intake & Output every shift. Nothing per rectum Monitor and record ostomy output if applicable.	Fluid balance maintained I & O documented Ostomy output documented

Post-Operative Teaching Schedule for Colostomy or Ileostomy

Post-op Day 1 Date _____		The pouch will be changed. Document: <ul style="list-style-type: none"> • size of stoma • color of stoma • appearance of mucocutaneous junction and skin Show patient how to use clamp. Order sequence #s _____ for next pouch change.
Post-op Day 2 Date _____	AM PM	Have patient cut out skin barrier and assemble pouch. Review the clamp. Show the patient how to empty and clean pouch.
Post-op Day 3 Date _____	AM PM	Show correct measuring. Assist patient in changing pouch. Review dietary guidelines (see handouts). <ul style="list-style-type: none"> • For Ileostomies discuss possible complications: dehydration, food blockages, small bowel obstructions • For Colostomies discuss diarrhea and constipation. Review skin care treatment and prevention. Review patient handout.
Post-op Day 4 Date _____	AM PM	Have patient independently cut out skin barrier and assemble pouch. Review dietary guidelines and skin care. Patient should be able to state steps for: <ul style="list-style-type: none"> • changing their appliance • correct measuring of stoma • dietary guidelines • complications
Post-op Day 5 Date _____	AM	Have patient change appliance with minimal verbal cues. Discuss ordering of discharge equipment.

Lahey Clinic Burlington, MA	PATIENT ID Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:
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Post-Operative Teaching Schedule for Loop Ostomy (Ostomy with a Rod) and Fistula

<p>Post-op Day 1</p> <p>Date _____</p>	<p>The pouch will be changed. Document:</p> <ul style="list-style-type: none"> • size of stoma • color of stoma • appearance of mucocutaneous junction and skin <p>Show patient how to use clamp. Order sequence #s _____ for next pouch change Order sequence #s _____ for pouch with which patient will be discharged home.</p>
<p>Post-op Day 2</p> <p>Date _____</p>	<p>AM</p> <p>Have patient cut out skin barrier and assemble pouch with which s/he will be discharged home. Review the clamp. Show patient how to empty and clean pouch.</p> <p>PM</p>
<p>Post-op Day 3</p> <p>Date _____</p>	<p>AM</p> <p>Show correct measuring. Assist patient in changing pouch. Review dietary guidelines (see handouts).</p> <p>PM</p> <ul style="list-style-type: none"> • For Ileostomies, discuss possible complications: dehydration, food blockages, small bowel obstructions. • For Colostomies discuss diarrhea and constipation. <p>Review skin care treatment and prevention. Review patient handout.</p>
<p>Post-op Day 4</p> <p>Date _____</p>	<p>AM</p> <p>Have patient independently cut out 2nd skin barrier and assemble pouch. Review dietary guidelines and skin care.</p> <p>PM</p> <p>Change the pouch with assistance.</p>
<p>Post-op Day 5</p> <p>Date _____</p>	<p>AM</p> <p>Patient should be able to:</p> <ul style="list-style-type: none"> • change appliance with minimal verbal cues • correctly measure stoma • state dietary guidelines • state complications <p>Discuss ordering of discharge equipment.</p>

<p>Lahey Clinic Burlington, MA</p>	<p>PATIENT ID</p> <p>Last Name: First Name: LCN: Admit Location: Admit Physician: Admit Date:</p>
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