

CREDIT VALLEY
THE CREDIT VALLEY HOSPITAL
CLINICAL PATHWAY
ELECTIVE COLORECTAL RESECTION
WITH OR WITHOUT COLOSTOMY

Inclusion criteria:	Segmental colon resection for Bowel Cancer. Laparoscopic resection. Scheduled and Urgent surgery only.
Exclusion criteria:	Emergency bowel resection for obstruction. Unfavourable metastatic disease.

Clinical Pathways are not considered a substitute for professional judgement.

Phase:	Physician's Office	Pre-Admission Clinic	Pre Surgery/Day of Surgery
Date:	/ / hrs	/ / hrs	/ / hrs
Patient Outcomes	<p>Surgery booked and patient introduced to plan of care Informed written consent for surgery and blood/blood products initiated in office Symptom management as required Appointments to be made by patient:</p> <ul style="list-style-type: none"> - Pre Admission clinic (28 days preop) - Pre-op consults as required <p><input type="checkbox"/> Message for Enterostomal therapy consult for stoma site marking and pre-operative teaching. (To be coordinated with pre-admission clinic visit)</p> <p><input type="checkbox"/> Pre-op Imaging - CT abdomen/pelvis - MRI as needed</p> <p><input type="checkbox"/> Oncology referral faxed if applicable</p>	<p>Patient/family will be knowledgeable of pre-op preparations and post-op care +/- Stoma site will be marked. Patient will be assessed by ET for:</p> <ol style="list-style-type: none"> 1. Coping strategies 2. Support systems 3. Emotional state 4. Knowledge base re: ostomy 5. Physical status 	<p>NPO from midnight _____ Preop medications taken _____ Review Health Record All preop tests completed on Health Record _____</p>
Teaching	<p>Physician initiates Pathway with patient/family Patient is given pre-op package Patient to book History & Physical with FP within 28 days of surgery or Internal Medicine as arranged by Surgeon Bowel preparation required as per Surgeon's assessment +/- antibiotic prophylaxis</p>	<p>Patient to bring pre-op package Pre-op teaching completed Pre-op video viewed Patient pathway reviewed (IV, drains, dressing, diet, NG tube, medications, activity, DB&C, F&A, sequential devices explained) Patient/family learning needs identified and addressed Instruct patient to shower/bathe pre-op Preop teaching Stoma care (S.T.)</p> <p>ELOS reviewed</p>	<p>Review information as per patient and family needs Review length of time in OR/PACU: Approximately 3-5 hrs Family will not be able to visit during the OR/PACU time. Family aware to be available for surgeon report approximately 2-3 hours after patient enters OR</p>
Discharge Planning Criteria	<p>ELOS reviewed _____ days Aware of CCAC involvement during hospitalization and post-discharge need for homecare, as assessed by CCAC.</p>		
Pathway Reviewed with Patient/Family (Initial):		_____ Yes _____ No	_____ Yes _____ No
Patient/Family Satisfied with Progress?		YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes	YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes
Signatures:		Initials _____ _____ _____	Initials _____ _____ _____

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Phase:	Physician's Office	Pre-Admission Clinic	Pre Surgery Clinic/Day of Surgery
Date:	/ / hrs	/ / hrs	/ / hrs
	INTERVENTIONS:	INTERVENTIONS:	INTERVENTIONS:
Assessments	Current medications including non prescription/herbal medications	Database completed Consents reviewed Review of health history Completion of consults	Reconfirm Database and Consents Vital signs Complete pre-op checklist
Consults	Internal Medicine/Specialists as required Enterostomal Therapist for Stoma marking Refer to Family Doctor for outpatient symptom management	Pre-op Anaesthesia consult as indicated by: Pre-op Anaesthetic questionnaire, Surgeon's order, or level of anxiety +/- lack of knowledge	Endocrinology as needed
Tests	As ordered by Internal Medicine/Specialist Consider blood conservation measures if time allowed	MRSA screening questionnaire completed CBC, lytes, urea creat, X-match +/- PT, PTT, Hb, Sickle Cell, UFM Cardiac workup as applicable CX, ECG	PT, PTT, INR prn Capillary blood sugar prn Lytes prn
Treatments	Instruct patient on bowel preparation as required	Review bowel preparation instructions to be completed 1 day pre-op	
Medications	Based on Assessment. Refer to Internal Medicine for instruction on discontinuation of ASA, Warfarin, Clopidogrel. Recommended Hold on non prescription herbal meds 2-3 weeks prior to surgery and Clopidogrel 14 days prior to surgery. +/- antibiotic prophylaxis If anemic consider benefits of Erythropoetin Bowel prep	Nursing to review: Previously prescribed meds, discontinuation of anticoagulants and current usage of herbal medications. Anaesthesia consult service as needed, will advise medication to be taken on morning of surgery.	Identify meds taken am of surgery DVT prophylaxis
Nutrition	Instruct patient on special diet as part of bowel preparation as required	Review pre-op diet for bowel prep Clear fluids day before surgery Reinforce NPO after midnight day prior to surgery	Review NPO status
Activity/Safety			
Elimination		Verify patient has received bowel prep instructions	Passing loose clear stool Void prior to OR
Pain Management	Pre-op Anaesthesia consult for PCA/Epidural if patient meets criteria	Review PCA/Epidural analgesia	



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Phase: Date:	O.R. / / hrs	PACU / / hrs	Day of Surgery/Postop / / hrs	Postop Day 1 / / hrs
Patient Outcomes	Patient will have any concerns addressed Consents confirmed _____	Patient will be stabilized & discharged to post-op unit when criteria met. Patient will verbalize pain control _____	Vital signs stable. Patient/family will be informed of patient condition _____ Patient will verbalize pain control _____ Ostomy <input type="checkbox"/> Yes Location: _____	Vital signs stable Patient will: - Sit up in chair - Ambulate with assistance - Participate in ADL
Teaching	Review procedure with patient and preparedness of patient Orient patient to OR and procedures, treatments for example IV's, catheter, tubes and drains	Pain control e.g. PCA or Neuraxial analgesia started Initial DB&C Orientation to IV, drain, NGT, positioning, monitoring Family to be informed of patient condition	Orient to room +/- nursing unit DB&C PCA/Neuraxial analgesia Repositioning/turning Review IV, drains, dressing, catheter, NGT	Review: - Activity - NPO status - Bloodwork - Pain Management - Drain/NGT - IV - Catheter
Discharge Planning Criteria				Planned discharge date is written on bedside communication board
Pathway Reviewed with Patient/Family (Initial):			____ Yes ____ No	____ Yes ____ No
Patient/Family Satisfied with Progress?			YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes	YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes
Signatures:			Initials _____ _____ _____	Initials _____ _____ _____

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Phase:	O.R.	PACU	Day of Surgery/Postop	Postop Day 1
Date:	/ / hrs	/ / hrs	/ / hrs	/ / hrs
	INTERVENTIONS:	INTERVENTIONS:	INTERVENTIONS:	INTERVENTIONS:
Assessments	Preop checklist reviewed Skin condition pre and post surgery	Assessment as per PACU record	VS as per policy or as per APS standards for PCA/ Neuraxial analgesia Sedation/pain scale monitoring Fluid balance q4h x 24h dressing, Ostomy, bowel & chest sounds q12h	VS q4h or as per PCA/Neuraxial monitoring, Sedation/pain scale Bowel and chest sounds q12h Fluid balance q12h Dressing, Ostomy
Consults		Internal Medicine for ICU admission prn	RT for O2 protocol Physio	RT Physio
Tests		CBC, lytes prn Capillary blood glucose as per Endocrinologist orders Calcium prn Chest xray, ECG prn	Capillary blood glucose as per Endocrinologist prn	CBC, lytes, urea, creat ECG, prn Capillary blood glucose as per Endocrinologist prn
Treatments	Attach monitors Provide warm blankets +/- antiembolic stockings OR intermittent pneumatic compression devices (IPC)	O2, warming blanket, IV, DB&C, dressing, drains/N tube emptied, skin & mouth care prn +/- antiembolic stockings OR IPC	O2 protocol prn DB&C Foot & ankle exercises Skin care prn IV & replacement IV as per orders +/- antiembolic stockings OR IPC	O2 protocol prn, DB&C Foot & ankle exercises, IV & replacement IV as per orders +/- antiembolic stockings OR IPC
Medications	Cefoxitin 1 g IV v/o to anaesthesia from surgeon	As per Anaesthesia and/or Surgeon's orders	Antiemetics, antibiotics Medications as per home DVT prophylaxis Stress ulcer prophylaxis (ranitidine)	Antiemetics, antibiotics Medications as per home DVT prophylaxis Stress ulcer prophylaxis (ranitidine)
Nutrition	NPO/NGT	NPO/NGT	NPO NGT ice chips prn Provide mouth care prn	NPO NGT ice chips prn Provide mouth care prn
Activity/Safety	Conduct safety Teeth inspection Positioning supine or lithotomy/leg Holders & padding	Assist with repositioning/ turning Foot & ankle exercises	Turn q2-4 hrs Assess skin if patient receiving local anaesthetic in Epidural infusion Assist to sitting position Stands at bedside with assistance	AAT with assistance, sit in chair Skin assessment Bedbath
Elimination	Foley catheter Ostomy as applicable JP drain output	Foley catheter Ostomy as applicable JP drain output	Foley catheter Ostomy as applicable JP drain output	Foley catheter Ostomy as applicable JP drain output
Pain Management	As per Anaesthesia: PCA/Neuraxial analgesia	As per Anaesthesia: PCA/Neuraxial analgesia	PCA OR Neuraxial OR IV Narcotic analgesia as per orders	PCA OR Neuraxial OR IV Narcotic analgesia as per orders



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Phase:

Date:

	Postop Day 2-3	Postop Day 4-6	Postop Day 7-10
	/ / hrs	/ / hrs	/ / hrs
Patient Outcomes	Vital signs stable: _____ Afebrile: _____ Patient will verbalize pain control _____ Participate in ADL: _____ Patient will ambulate x3/day with assistance: _____	Vital signs stable: _____ Afebrile: _____ Patient will tolerate increase in diet: _____ Participate in ADL with minimal assistance: _____ Patient will sit in chair or at bedside for all meals: _____ Patient will be able to empty Ostomy with minimal assistance: _____ Clinical Indicator #1: Infection at wound site? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, obtain orders for wound culture	Vital signs stable: _____ Afebrile: _____ Tolerate DAT/new ostomy diet: _____ Independent with ADL: _____ Tolerate increased independent ambulation: _____ Patient will be able to change ostomy appliance with minimal assistance: _____ Clinical Indicator #2: Infection at wound site? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES, obtain orders for wound culture
Teaching	Review: - Activity: _____ - Pain management: _____ - Diet (NPO to clear fluids): _____ - Drain/NGT: _____ - IV: _____ - Catheter: _____ - Dressing: _____ - Bloodwork: _____ Initial ostomy teaching as applicable: _____	Review: - Activity - Diet (clear fluids to DAT/new ostomy) - Pain management - Dressing - Drain - Outpt. Oncology follow-up Continue with ostomy teaching as applicable All Teaching complete: _____	Review: - Activity - Diet (DAT/new ostomy) - Pain management - Dressing - Hygiene - Outpt. Oncology follow-up Complete ostomy teaching as applicable All Teaching complete: _____
Discharge Planning Criteria	Introduction to Discharge Criteria - Notify CCAC of expected D/C date - Update bedside communication board with D/C time and transportation arrangements	Ambulate independently Independent with ADL +/- Independent with ostomy care Tolerating diet (new ostomy diet) BM or passing gas if not ostomy +/- stool through ostomy Follow-up appointments made Oncology clinic 21 days post D/C CCAC arranged as necessary Prescriptions available Discharge teaching complete re: - Incision care, personal hygiene, activity, patient/family learning needs met, nutrition counseling All Discharge Criteria met: _____ Date/Time: ___/___/___, ___ h Obtain order for discharge when all criteria met	Ambulate independently Independent with ADL Independent with ostomy care Tolerating diet (new ostomy diet) BM/stool through ostomy Follow-up appointments made Oncology clinic 21 days post D/C CCAC arranged as necessary Prescriptions available Discharge teaching complete re: - Incision care, personal hygiene, activity, patient/family learning needs met, nutrition counseling All Discharge Criteria met: _____ Date/Time: ___/___/___, ___ h Obtain order for discharge when all criteria met
Pathway Reviewed with Patient/Family (Initial):	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Patient/Family Satisfied with Progress?	YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes	YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes	YES <input type="checkbox"/> NO <input type="checkbox"/> if NO, see progress notes
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	/ / hrs	/ / hrs	/ / hrs
	INTERVENTIONS:	INTERVENTIONS:	INTERVENTIONS:
Assessments	VS q8h or as per PCA/Neuraxial analgesic with sedation/pain scale, fluid balance q12h Bowel & chest sounds qshift O2 sat	VS q12h Fluid balance q12h Bowel & chest sounds q12h Reassess need for DVT prophylaxis	VS q12h Fluid balance q12h Bowel & chest sounds q12h Reassess need for DVT prophylaxis
Consults	RT Physio RD for all Ostomy patients RD for resections prn	RT Physio Enterostomal Therapist RD for all Ostomy patients RD for resections prn Oncology clinic post-op appt. 21 days post discharge	Enterostomal Therapist Physio RD for all Ostomy patients RD for resections prn Oncology clinic post-op appt. 21 days post discharge
Tests	CBC, lytes, urea, creat, ECG, CXR prn		
Treatments	Daily dressing change prn IV and replacement IV as per orders O2 protocol D/C replacement IV if NGT out DB&C Foot & ankle exercises +/- antiembolic stockings OR IPC	Daily dressing change prn unless otherwise ordered D/C IV as per orders DB&C Foot & ankle exercises +/- antiembolic stockings OR IPC	Dry dressing or leave incision to air, D/C clips as per Surgeon order DB&C Foot and ankle exercises +/- antiembolic stockings OR IPC
Medications	Antiemetics, antibiotics if prescribed Medications as ordered DVT prophylaxis Stress under prophylaxis (D/C when NGT removed)	Antiemetics, antibiotics if prescribed Medications as ordered DVT prophylaxis Stress under prophylaxis (D/C when NGT removed)	Antiemetics Medications as ordered DVT prophylaxis
Nutrition	Advance diet from sips to clear fluids if NGT discontinued and BS/flatus present Provide mouth care prn	Clear fluids to DAT/new ostomy diet Encourage fluids PO Provide mouth care prn	DAT/new ostomy diet Encourage fluids PO Provide mouth care prn
Activity/ Safety	AAT with assistance, sit in chair Assist with repositioning Skin assessment Bed bath/sink	AAT, sit in chair for all meals Encourage repositioning at night Skin assessment Bed bath/sink	AAT, sit in chair for all meals Encourage repositioning at night Skin assessment Sink or shower on Day # _____
Elimination	Assess for removal of catheter and encourage voiding	Voiding BM/ostomy	Voiding BM Ostomy
Pain Management	PCA OR Neuraxial OR IV/PO narcotic analgesia as per orders	IV/PO narcotic analgesia as per orders	PO narcotic analgesia as per orders

