London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Pre-Admission Clinic Visit

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS: Vital signs, ht, wt	*Hemodynamically stable* *Respiratory status WDL*								
DIAGNOSTICS: Lab and diagnostics as per Preadmission orders ECG - in presence of heart disease, hypertension, smoking or diabetes CXR - if heart or pulmonary disease Nursing Admission History	*Diagnostics/lab values WDL* *ECG completed* *CXR completed* *Nursing Admission History completed*								
COMFORT LEVEL: Pain Control information Antiemetic information Pt/family aware of pain control options	*Indicates satisfaction with comfort level/pain control* *Regular assessment of comfort level* *Understands options for control of nausea and vomiting* *Pt/Family aware of pain control options*								
ACTIVITY: Dangled at bedside night of surgery Up mobilizing and sitting in chair 3 times /day DB&C starting night of surgery	*Expresses satisfaction with ability to manage ADL's* *Pt understands post-op mobility and ambulation routines* *Understands DB&C importance*								
NUTRITION: Assess nutritional status May have solid foods until midnight before surgery Drinking clear fluids and high carbohydrate drink 2 hours before surgery - if no bowel prep Chewing gum 3 times/day to aid in bowel motility bring 2 packs to hospital	*Maintains nutritional status* *Understands ERAS nutrition guidelines pre-op* *Pt /family to bring 2 packages of gum to hospital*								
ELIMINATION: Assess bowel function Discuss bowel prep - if applicable	*Bowel pattern WDL of pt condition* *Understands bowel prep instruction if indicated*								
TREATMENTS: Measure for IPC's Stoma site marking	*Understands purpose of IPC's* *Stoma site marked*								
MEDICATIONS: Review instructions re: pre-op meds Pain meds to aid with post-op pain Smoking Cessation	*Understands pre-op medication instructions* *Understands post-op pain options*								
PSYCHOSOCIAL: Assess support system	*Expresses satisfaction with support systems e.g. family, community, faith*								
DISCHARGE PLANNING: Discuss length of stay and discharge needs CCAC referral	*Verbalizes expected LOS of 5-6 days* *Pt/family confirm discharge needs and arrangements* *Need for CCAC referral noted in Nursing History*								
PATIENT/FAMILY EDUCATION: Ostomy resource package given to patient to practice at home ERAS Patient Education Booklet - review and remind to bring to hospital Patient and family to document during hospital stay	*Understands reason for stoma site marking* *Ostomy resource package given* *Pt/family understands ostomy teaching* *Patient has ERAS booklet* *Pt/family understands to bring book day of surgery* *Pt/family understands importance of documenting in booklet daily*								
CONSULTATIONS: ET nurse PT Consider - Social Work - OT - Dietician - Pastoral Care if applicable	*Enterostomal Therapist Nurse (ET) consult initiate* *PT initiate* *Social Work initiate* *OT initiate* *Dietician initiate* *Pastoral Care initiate*								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

Adapted with permission from University of Alabama, Birmingham, Ala. Nov. 92

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Day of Surgery

Surgical Procedure: _____

DATE: (YYYY/MM/DD) _____

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS: Pre-op vital signs Post-op vital signs: q4h x 48h RR/SpO_2/sedation as per PCA/Epidural protocol Chest assessment q4h DB&C x 10 each hour while awake Oxygen therapy	*Hemodynamically stable*								
	Respiratory status WDL								
	Chest sounds clear and/or Oxygen sats ≥92%								
	Pre-op temperature ≤37.5C								
	Post-op temperature <38.5C								
	DB&C *completed*								
COMFORT LEVEL: Antiemetic PRN PCA/Epidural/Other Pain Score q4h Pain control information	*Asymptomatic for nausea/vomiting*								
	Expresses satisfaction with comfort level/pain control								
	Pain score recorded								
	Pt/Family aware of pain control options								
ACTIVITY: Mobilizes as per ERAS protocol	*Dangles at bedside with assist for 10-15 min*								
	Walking in hall with assist								
NUTRITION: Start fluids 2 hours post-op then increase to transitional diet as tolerated Chewing gum to aid in bowel motility	*Follwed ERAS fasting guidelines pre-op*								
	Hydration status WDL								
	Tolerating diet								
	Chew gum for 5 min between meals 3 X daily								
ELIMINATION: (check bowel prep) Assess urinary catheter output q1h (call if < 20 cc/hr x 3) Abdominal assessment q12h Check appliance q4h Check stoma q4h Check ostomy drainage - assess colour, consistency, document amount	*Bowel prep results WDL*								
	Urinary catheter output satisfactory								
	Appliance intact								
	Stoma pink, viable								
	*Bowel sounds **A**bsent or **P**resent*								
	Abdomen soft								
TREATMENTS: IV fluids IPC's applied pre-op / maintained post-op Assess dressing q 4h, reinforce dressing as necessary Surgical drain if applicable	*IPC's on*								
	Skin care q shift								
	Dressing intact								
	Areas of oozing on dressing marked								
	Surgical drain (colour, suction and volume)								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has an anatamosis Medications given as ordered pre-op Administer antibiotics as ordered pre-op DVT Prophylaxis Resume home meds as ordered	*Pre-op medication given*								
	Pre-op antibiotic given								
	Antiembolytic Rx initiated								
	Asymptomatic for DVT								
PSYCHOSOCIAL: Inform family of day of surgery routines	*Family aware of routines*								
	Active listening provided to support family coping								
	Pt/family aware of surgical procedure done								
DISCHARGE PLANNING: CCAC referral Discharge Instruction Sheet	*CCAC referral initiated for ostomy care*								
	Pt/family aware of expected LOS 5-6 days								
	Discharge instruction sheet initiated								
	Discharge plans in progress								
PATIENT/FAMILY EDUCATION: Implement Ostomy Guidelines ERAS Patient Education Booklet	*Pt will look at stoma*								
	Patient has ERAS booklet at bedside								
	Pt/family documents in activity log booklet daily								
CONSULTATIONS: ET nurse/SWOT consult for marking or remarking if not in pre-admit PT Consider - Social Work - OT - Dietician - Pastoral Care if applicable									
	ET consult initiated if not done pre-op								
	PT initiate								
	Social Work initiate								
	OT initiate								
	Dietician initiate								
	Pastoral Care initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

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London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 1

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS: Post-op vital signs: q4h x 48h RR/SpO_2/sedation as per PCA/Epidural protocol Chest assessment q4h DB&C x 10 each hour while awake Blood work as ordered if applicable Titrate off O_2	*Hemodynamically stable*								
	Respiratory status WDL								
	Chest sounds clear								
	Oxygen sats ≥92%								
	Temperature <38.5C								
	DB&C completed								
	Blood work WDL								
COMFORT LEVEL: Antiemetic PRN PCA/Epidural discontinue if ordered as per APS protocol Pain Score q 4h Pain control information	*Asymptomatic for nausea/vomiting*								
	Expresses satisfaction with comfort level/pain control								
	Pt/Family aware of pain control options								
	Pain score recorded								
	PCA/Epidural discontinued if ordered								
ACTIVITY: Ambulate X 3 Chair for all meals Leg exercises q1h	*Ambulate in hall with assist X 3*								
	Up in chair for all meals with assist								
	Ambulate to bathroom post catheter removal								
NUTRITION: Fibre reduced regular diet following ostomy nutrition guidelines Chewing gum to aid in bowel motility	*Hydration status WDL*								
	Begin to eat solid diet as tolerated								
	Chew gum for 5 min between meals 3 X daily								
ELIMINATION: Assess urinary catheter output q1h (call if < 20 cc/hr x 3) discontinue if ordered Leave urinary catheter insitu if rectal resection Abdominal assessment q12h Check appliance and stoma q4h Check ostomy drainage - assess colour, consistency, document amount	*Urinary catheter output satisfactory*								
	Urinary catheter discontinued if ordered								
	Urine output adequate post urinary catheter removal								
	Passing flatus via ostomy								
	Stoma pink, viable								
	Appliance intact								
	*Bowel sounds **A**bsent or **P**resent*								
	Abdomen soft								
TREATMENTS: IV fluids IPC's Surgical drain if applicable Assess dressing - reinforce dressing as necessary	*IPC's on*								
	Skin care q shift								
	Surgical drain (colour, suction and volume)								
	Dressing intact								
	Areas of oozing on dressing marked								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis DVT Prophylaxis / Resume home meds as ordered									
	Asymptomatic for DVT								
PSYCHOSOCIAL: Document significant findings on Clinical Progress Record									
	Active listening provided to support family coping								
DISCHARGE PLANNING: CCAC referral for discharge Discharge Planning Discharge Instruction sheet	*Discharge plans in progress*								
	CCAC referral initiated								
	Pt/family aware of expected LOS 5-6 days								
	Document on discharge instruction sheet								
PATIENT/FAMILY EDUCATION: Pain control information Follow Ostomy Guidelines ERAS Patient Education Booklet	*Reinforce ostomy teaching, patient to visualize stoma / watch video*								
	Demonstration of ostomy appliance emptying by nurse								
	Pt/family documents in activity log booklet daily								
CONSULTATIONS: ET nurse PT Consider - Social Work - OT - Dietician - Pastoral Care if applicable	*ET consult initiated*								
	PT initiate								
	Social Work initiate								
	OT initiate								
	Dietician initiate								
	Pastoral Care initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 2

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Post-op Vital signs: q4h x 48h	*Respiratory status WDL*								
RR/SpO_2/sedation as per PCA/Epidural protocol	*Chest sounds clear*								
Chest assessment q4h	*Oxygen sats ≥92%*								
DB&C x 10 each hour while awake	*Temperature <38.5C*								
Blood work as ordered if applicable	*DB&C completed*								
Titrate off O_2	*Blood work WDL*								
COMFORT LEVEL:	*Asymptomatic for nausea/vomiting*								
PCA/Epidural/Other - discontinue if ordered	*Expresses satisfaction with comfort level/pain control*								
Antiemetic PRN	*PCA/Epidural discontinued if ordered*								
Pain Score q4h	*Patient tolerating oral analgesia*								
Pain control information	*Pain score recorded*								
	Pt/family aware of pain control options								
ACTIVITY:	*Ambulate in hall with assist X 3*								
Ambulate X 3 - may shower	*Ambulate to bathroom post catheter removal*								
Chair for all meals	*Up in chair for all meals*								
Leg exercises q1h									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urinary catheter output satisfactory*								
Assess urinary catheter output q shift (call if < 20 cc/hr x 3) discontinue if ordered	*Urinary catheter discontinued if ordered*								
	Urine output adequate post urinary catheter removal								
Leave urinary catheter insitu if rectal resection	*Bowel sounds **A**bsent or **P**resent*								
Abdominal assessment q12h	*Passing flatus per ostomy*								
Check stoma q4h	*Passing drainage per ostomy*								
Check appliance q4h	*Stoma pink, viable*								
Check ostomy drainage - assess colour, consistency, document amount	*Appliance intact*								
	Abdomen soft								
Ostomy skin scoring tool (DET score)	*Peristomal skin assessed & DET score recorded*								
TREATMENTS:	*IPC's discontinue as ordered if ambulating well*								
IV fluids - S/L if drinking well	*Surgical drain (colour, suction and volume)*								
IPC's - remove	*Dressing intact*								
Skin care q shift	*Incision WDL*								
Surgical drain - if applicable									
Change initial dressing - gauze dressing									
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*CCAC referral initiated if not done day prior*								
CCAC referral	*Pt/family aware of expected LOS 5-6 days*								
Discharge Instruction sheet	*Document on discharge instruction sheet*								
	Reinforce ostomy teaching / watch video								
PATIENT/FAMILY EDUCATION:	*Pt completes appliance change with assistance from nurse*								
Follow Ostomy Guidelines	*Patient demonstrates emptying ostomy appliance*								
ERAS Patient Education booklet	*Pt/family documents in activity log booklet daily*								
CONSULTATIONS: ET nurse	*ET consult initiated*								
PT	*PT initiate*								
Consider - Social Work	*Social Work initiate*								
- OT	*OT initiate*								
- Dietician	*Dietician initiate*								
- Pastoral Care if applicable	*Pastoral Care initiate*								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 3 - Potential discharge today or tomorrow

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Vital signs q8h	*Respiratory status WDL*								
Chest assessment q8h	*Temperature <38.5C*								
DB&C q4h while awake	*Blood work WDL*								
Blood work as ordered if applicable	*DB&C completed*								
Titrate off O_2									
COMFORT LEVEL:	*Asymptomatic for nausea/vomiting*								
PCA/Epidural/Other - discontinue if ordered	*Expresses satisfaction with comfort level/pain control*								
Antiemetic PRN	*PCA /Epidural discontinued if ordered*								
Pain Score q8h	*Pain score recorded*								
Pain control information	*Patient tolerating oral analgesia*								
Oral analgesia	*Pt/family aware of pain control options on discharge*								
ACTIVITY:	*Up in chair for all meals*								
Mobilize	*Ambulate in hallway X 4*								
Progressive ambulation to QID	*Ambulate to bathroom post catheter removal*								
May shower									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urine output qs*								
Remove urinary catheter if ordered for rectal resections	*Urinary catheter discontinued if ordered*								
Abdominal assessment q12h	*Urine output adequate post urinary catheter removal*								
Check stoma q8h	*Abdominal assessment WDL*								
Check appliance q8h	*Bowel sounds **A**bsent or **P**resent*								
Check ostomy drainage - assess colour, consistency, document amount	*Stoma pink, viable*								
	Appliance intact								
Assess for rod removal if applicable	*Passing flatus via ostomy / Passing drainage per ostomy*								
Ostomy skin scoring tool (DET) if discharged	*Abdomen soft*								
	Peristomal skin assessed & DET score recorded if appliance changed for discharge								
TREATMENTS: IPC's - removed	*IPC's discontinued as ordered if ambulating well*								
Assess incision q shift - incision open to air/gauze dress(s) as required	*Incision WDL*								
	Dressing intact								
Surgical drain - if applicable	*Surgical drain (colour, suction and volume)*								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*Pt/family aware of potential discharge today/tomorrow*								
CCAC referral completed	*Pt/family has transportation arranged for discharge*								
Discharge planning and teaching goals met	*Discharge plans complete*								
Staple removal - date and arrangements	*Patient has scripts for discharge*								
Prepare for discharge before lunch	*Discharge Instruction sheet complete - given to patient*								
Discharge Medication Reconciliation	*Discharge Medication Reconciliation*								
Discharge Instruction sheet									
Electronic Discharge Summary	*Electronic Discharge Summary complete and reviewed with patient*								
Discharge medication scripts completed and signed									
PATIENT/FAMILY EDUCATION:	*Reinforce ostomy teaching / watch video*								
Follow Ostomy Guidelines	*Pt emptying ostomy appliance with minimal assistance from nurse*								
Patient Education booklet	*Pt/family documents in activity log booklet daily*								
	Collect completed activity log booklet if discharged								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable	*ET following*								
PT	*PT following*								
Consider - Social Work	*Social Work initiate*								
- OT	*OT initiate*								
- Dietician	*Dietician initiate*								
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 4 - Potential discharge today or tomorrow

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Vital signs q12h	*Respiratory status WDL*								
Chest assessment q12h	*Temperature <38.5C*								
DB&C q8h	*DB&C completed*								
COMFORT LEVEL:	*Expresses satisfaction with comfort level/pain control*								
Antiemetic PRN	*Asymptomatic for nausea/vomiting*								
Pain Score q12h	*Pain score recorded*								
Oral Analgesia	*Tolerating oral analgesics*								
	Pt/family aware of pain control options on discharge								
ACTIVITY:	*Up in chair for all meals*								
Mobilize	*Ambulates independently*								
Progressive ambulation to QID	*Ambulate to bathroom*								
May shower									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urine output qs*								
Assess voiding	*Abdominal assessment WDL*								
Remove urinary catheter if ordered for rectal resection	*Bowel sounds **A**bsent or **P**resent*								
Abdominal assessment q12h	*Passing flatus / drainage per ostomy*								
Check stoma q8h	*Stoma pink, viable*								
Check appliance q8h	*Appliance intact*								
Check ostomy drainage - assess colour, consistency, document amount	*Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
Assess for rod removal if applicable									
Ostomy skin scoring tool (DET) if discharged									
TREATMENTS:	*Dressing intact*								
Assess incision q shift - incision open to air/gauze dress(s) as required	*Incision WDL*								
Surgical drain - if applicable	*Surgical drain (colour, suction and volume)*								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*Pt/family aware of potential discharge today/tomorrow*								
CCAC referral completed	*Pt/family has transportation arranged for discharge*								
Discharge planning and teaching goals met	*Discharge plans complete*								
Staple removal - date and arrangements	*Patient has scripts for discharge*								
Prepare for discharge before lunch	*Discharge Instruction sheet complete - given to patient*								
Discharge Medication Reconciliation	*Discharge Medication Reconciliation*								
Discharge Instruction sheet	*Electronic Discharge Summary complete and reviewed with patient*								
Electronic Discharge Summary									
Discharge medication scripts completed and signed									
PATIENT/FAMILY EDUCATION:	*Reinforce ostomy teaching / watch video*								
Follow Ostomy Guidelines	*Pt completes appliance change with nurse observing*								
Patient Education booklet	*Patient emptying ostomy appliance on own*								
	Pt/family documents in activity log booklet daily								
	Assess rod removal if applicable								
	Collect completed activity log booklet if discharged								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable									
PT	*ET following*								
Consider if applicable - Social Work	*PT following*								
- OT	*Social Work initiate*								
	OT initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

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London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 5 - Possible discharge today or tomorrow

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Vital signs q12h,	*Respiratory status WDL*								
Chest assessment q12h	*Temperature <38.5C*								
DB&C q12h	*DB&C completed*								
COMFORT LEVEL:	*Asymptomatic for nausea/vomiting*								
Antiemetic PRN	*Expresses satisfaction with comfort level/pain control*								
Pain Score q12h	*Pain score recorded*								
Oral Analgesia	*Tolerating oral analgesics*								
	Pt/family aware of pain control options on discharge								
ACTIVITY:	*Up in chair for all meals*								
Mobilize	*Ambulates independently*								
Progressive ambulation to QID	*Ambulates to bathroom*								
May shower									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urine output qs*								
Assess voiding	*Abdominal assessment WDL*								
Abdominal assessment q12h	*Bowel sounds **A**bsent or **P**resent*								
Check stoma q8h	*Passing flatus/drainage per ostomy*								
Check appliance q8h	*Stoma pink, viable*								
Check ostomy drainage - assess colour, consistency, document amount	*Appliance intact*								
Assess for rod removal if applicable	*Appliance change with patient/family if not done day before*								
Ostomy skin scoring tool (DET) if discharged	*Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
TREATMENTS:	*Incision WDL*								
Assess incision q shift - incision open to air/gauze dress(s) as required	*Surgical drain (colour, suction, and volume)*								
Surgical drain - if applicable									
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*Pt/family aware of potential discharge today/tomorrow*								
CCAC referral completed	*Pt/family has transportation arranged for discharge*								
Discharge planning and teaching goals met	*Discharge plans complete*								
Staple removal - date and arrangements	*Patient has scripts for discharge*								
Prepare for discharge before lunch	*Discharge Instruction sheet complete - given to patient*								
Discharge Medication Reconciliation	*Discharge Medication Reconciliation*								
Discharge Instruction sheet	*Electronic Discharge Summary complete and reviewed with patient*								
Electronic Discharge Summary									
Discharge medication scripts completed and signed									
PATIENT/FAMILY EDUCATION:	*Reinforce ostomy teaching / watch video*								
ERAS Patient Education booklet	*Pt completes appliance change with nurse if not done day before*								
	Patient emptying ostomy on own								
	Assess rod removal if applicable								
	Collect completed activity log booklet on discharge								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable									
PT	*ET following*								
Consider if applicable - Social Work	*PT following*								
- OT	*Social Work initiate*								
	OT initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 6 - Discharge day

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Vital signs q12h,	*Respiratory status WDL*								
Chest assessment q12h	*Temperature <38.5C*								
DB&C q12h	*DB&C completed*								
COMFORT LEVEL:	*Asymptomatic for nausea/vomiting*								
Antiemetic PRN	*Expresses satisfaction with comfort level/pain control*								
Pain Score q12h	*Pain score recorded*								
Oral Analgesia	*Tolerating oral analgesic*								
	Pt/family aware of pain control options on discharge								
ACTIVITY:	*Up in chair for all meals*								
Mobilize	*Ambulates independently*								
Progressive ambulation to QID	*Ambulates to bathroom*								
May shower									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urine output qs*								
Assess voiding	*Abdominal assessment WDL*								
Abdominal assessment q12h	*Bowel sounds **A**bsent or **P**resent*								
Check stoma q8h	*Passing flatus/drainage per ostomy*								
Check appliance q8h	*Stoma pink, viable*								
Check ostomy drainage - assess colour, consistency, document amount	*Appliance intact*								
Assess for rod removal if applicable	*Appliance change with patient/family if not done day before*								
Ostomy skin scoring tool (DET) if discharged	*Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
TREATMENTS:	*Incision WDL*								
Assess incision q shift - incision open to air/gauze dress(s) as required	*Surgical drain (colour, suction, and volume)*								
Surgical drain - if applicable									
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*Pt/family aware of potential discharge today*								
CCAC referral completed	*Pt/family has transportation arranged for discharge*								
Discharge planning and teaching goals met	*Discharge plans complete*								
Staple removal - date and arrangements	*Patient has scripts for discharge*								
Prepare for discharge before lunch	*Discharge Instruction sheet complete - given to patient*								
Discharge Medication Reconciliation	*Discharge Medication Reconciliation*								
Discharge Instruction sheet	*Electronic Discharge Summary complete and reviewed with patient*								
Electronic Discharge Summary									
Discharge medication scripts completed and signed									
PATIENT/FAMILY EDUCATION:	*Reinforce ostomy teaching*								
ERAS Patient Education booklet	*Pt completes appliance change with nurse if not done day before*								
	Patient emptying ostomy on own								
	Assess rod removal if applicable								
	Collect completed activity log booklet on discharge								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable									
PT	*ET following*								
Consider if applicable - Social Work	*PT following*								
- OT	*Social Work initiate*								
	OT initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day 7 - Discharge day

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS:	*Hemodynamically stable*								
Vital signs q12h,	*Respiratory status WDL*								
Chest assessment q12h	*Temperature <38.5C*								
DB&C q12h	*DB&C completed*								
COMFORT LEVEL:	*Asymptomatic for nausea/vomiting*								
Antiemetic PRN	*Expresses satisfaction with comfort level/pain control*								
Pain Score q12h	*Pain score recorded*								
Oral Analgesia	*Tolerating oral analgesic*								
	Pt/family aware of pain control options on discharge								
ACTIVITY:	*Up in chair for all meals*								
Mobilize	*Ambulates independently*								
Progressive ambulation to QID	*Ambulates to bathroom*								
May shower									
NUTRITION:	*Hydration status WDL*								
Fibre reduced regular diet following ostomy nutrition guidelines	*Tolerating prescribed diet*								
Chewing gum to aid in bowel motility	*Chew gum for 5 min between meals 3 X daily*								
ELIMINATION:	*Urine output qs*								
Assess voiding	*Abdominal assessment WDL*								
Abdominal assessment q12h	*Bowel sounds **A**bsent or **P**resent*								
Check stoma q8h	*Passing flatus/drainage per ostomy*								
Check appliance q8h	*Stoma pink, viable*								
Check ostomy drainage - assess colour, consistency, document amount	*Appliance intact*								
Assess for rod removal if applicable	*Appliance change with patient/family if not done day before*								
Ostomy skin scoring tool (DET) if discharged	*Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
TREATMENTS:	*Incision WDL*								
Assess incision q shift - incision open to air/gauze dress(s) as required	*Surgical drain (colour, suction, and volume)*								
Surgical drain - if applicable									
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis									
DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL:									
Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING:	*Pt/family aware of potential discharge today*								
CCAC referral completed	*Pt/family has transportation arranged for discharge*								
Discharge planning and teaching goals met	*Discharge plans complete*								
Staple removal - date and arrangements	*Patient has scripts for discharge*								
Prepare for discharge before lunch	*Discharge Instruction sheet complete - given to patient*								
Discharge Medication Reconciliation	*Discharge Medication Reconciliation*								
Discharge Instruction sheet	*Electronic Discharge Summary complete and reviewed with patient*								
Electronic Discharge Summary									
Discharge medication scripts completed and signed									
PATIENT/FAMILY EDUCATION:	*Reinforce ostomy teaching*								
ERAS Patient Education booklet	*Pt completes appliance change with nurse if not done day before*								
	Patient emptying ostomy on own								
	Assess rod removal if applicable								
	Collect completed activity log booklet on discharge								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable									
PT	*ET following*								
Consider if applicable - Social Work	*PT following*								
- OT	*Social Work initiate*								
	OT initiate								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day _____ - Discharge day

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS: Vital signs q12h, Chest assessment q12h DB&C q12h	*Hemodynamically stable* *Respiratory status WDL* *Temperature <38.5C* *DB&C completed*								
COMFORT LEVEL: Antiemetic PRN Pain Score q12h Oral Analgesia	*Asymptomatic for nausea/vomiting* *Expresses satisfaction with comfort level/pain control* *Pain score recorded* *Tolerating oral analgesic* *Pt/family aware of pain control options on discharge*								
ACTIVITY: Mobilize Progressive ambulation to QID May shower	*Up in chair for all meals* *Ambulates independently* *Ambulates to bathroom*								
NUTRITION: Fibre reduced regular diet following ostomy nutrition guidelines Chewing gum to aid in bowel motility	*Hydration status WDL* *Tolerating prescribed diet* *Chew gum for 5 min between meals 3 X daily*								
ELIMINATION: Assess voiding Abdominal assessment q12h Check stoma q8h Check appliance q8h Check ostomy drainage - assess colour, consistency, document amount Assess for rod removal if applicable Ostomy skin scoring tool (DET) if discharged	*Urine output qs* *Abdominal assessment WDL* *Bowel sounds **A**bsent or **P**resent* *Passing flatus/drainage per ostomy* *Stoma pink, viable* *Appliance intact* *Appliance change with patient/family if not done day before* *Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
TREATMENTS: Assess incision q shift - incision open to air/gauze dress(s) as required Surgical drain - if applicable	*Incision WDL* *Surgical drain (colour, suction, and volume)*								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL: Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING: CCAC referral completed Discharge planning and teaching goals met Staple removal - date and arrangements Prepare for discharge before lunch Discharge Medication Reconciliation Discharge Instruction sheet Electronic Discharge Summary Discharge medication scripts completed and signed	*Pt/family aware of potential discharge today* *Pt/family has transportation arranged for discharge* *Discharge plans complete* *Patient has scripts for discharge* *Discharge Instruction sheet complete - given to patient* *Discharge Medication Reconciliation* *Electronic Discharge Summary complete and reviewed with patient*								
PATIENT/FAMILY EDUCATION: ERAS Patient Education booklet	*Reinforce ostomy teaching* *Pt completes appliance change with nurse if not done day before* *Patient emptying ostomy on own* *Assess rod removal if applicable* *Collect completed activity log booklet on discharge*								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable PT Consider if applicable - Social Work - OT	*ET following* *PT following* *Social Work initiate* *OT initiate*								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

London Health Sciences Centre

PATIENT CLINICAL PATHWAY: BOWEL RESECTION WITH OSTOMY

Post-operative Day _____ - Discharge day

DATE:_____
(YYYY / MM / DD)

PATIENT GOALS/DESIRED OUTCOMES: _____

THIS PATHWAY IS FOR A 24 HOUR PERIOD BEGINNING 0700 to 0700

KEY: ✓ = Care/Protocol &/or Outcome WDL (*Within Defined Limits*) * = Significant findings Pt = Patient N/A = Not Applicable
→ = Significant findings remain unchanged. Complete all relevant sections and initial. Leave all others blank. S&S = Signs and Symptoms

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	DATE / TIME							
ASSESSMENTS: Vital signs q12h, Chest assessment q12h DB&C q12h	*Hemodynamically stable* *Respiratory status WDL* *Temperature <38.5C* *DB&C completed*								
COMFORT LEVEL: Antiemetic PRN Pain Score q12h Oral Analgesia	*Asymptomatic for nausea/vomiting* *Expresses satisfaction with comfort level/pain control* *Pain score recorded* *Tolerating oral analgesic* *Pt/family aware of pain control options on discharge*								
ACTIVITY: Mobilize Progressive ambulation to QID May shower	*Up in chair for all meals* *Ambulates independently* *Ambulates to bathroom*								
NUTRITION: Fibre reduced regular diet following ostomy nutrition guidelines Chewing gum to aid in bowel motility	*Hydration status WDL* *Tolerating prescribed diet* *Chew gum for 5 min between meals 3 X daily*								
ELIMINATION: Assess voiding Abdominal assessment q12h Check stoma q8h Check appliance q8h Check ostomy drainage - assess colour, consistency, document amount Assess for rod removal if applicable Ostomy skin scoring tool (DET) if discharged	*Urine output qs* *Abdominal assessment WDL* *Bowel sounds **A**bsent or **P**resent* *Passing flatus/drainage per ostomy* *Stoma pink, viable* *Appliance intact* *Appliance change with patient/family if not done day before* *Peristomal skin assessed & DET score recorded if appliance changed for discharge*								
TREATMENTS: Assess incision q shift - incision open to air/gauze dress(s) as required Surgical drain - if applicable	*Incision WDL* *Surgical drain (colour, suction, and volume)*								
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has anastomosis DVT Prophylaxis / Resume home meds as ordered	*Asymptomatic for DVT*								
PSYCHOSOCIAL: Document significant findings on Clinical Progress Record	*Active listening provided to support family coping*								
DISCHARGE PLANNING: CCAC referral completed Discharge planning and teaching goals met Staple removal - date and arrangements Prepare for discharge before lunch Discharge Medication Reconciliation Discharge Instruction sheet Electronic Discharge Summary Discharge medication scripts completed and signed	*Pt/family aware of potential discharge today* *Pt/family has transportation arranged for discharge* *Discharge plans complete* *Patient has scripts for discharge* *Discharge Instruction sheet complete - given to patient* *Discharge Medication Reconciliation* *Electronic Discharge Summary complete and reviewed with patient*								
PATIENT/FAMILY EDUCATION: ERAS Patient Education booklet	*Reinforce ostomy teaching* *Pt completes appliance change with nurse if not done day before* *Patient emptying ostomy on own* *Assess rod removal if applicable* *Collect completed activity log booklet on discharge*								
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable PT Consider if applicable - Social Work - OT	*ET following* *PT following* *Social Work initiate* *OT initiate*								
ADDITIONS/CHANGES TO CLINICAL PATHWAY:									
	INITIALS								

Patient's Name: ____

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

Adapted with permission from University of Alabama, Birmingham, Ala. Nov. 92