#### 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:** $\checkmark$ = 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 DATE CATEGORIES **EXPECTED OUTCOMES** (modifications per orders) TIME ASSESSMENTS: Hemodynamically stable Vital signs, ht, wt Respiratory status WDL DIAGNOSTICS: Diagnostics/lab values WDL Lab and diagnostics as per Preadmission orders ECG completed ECG - in presence of heart disease, hypertension, smoking CXR completed or diabetes Nursing Admission History completed CXR - if heart or pulmonary disease Nursing Admission History COMFORT LEVEL: Indicates satisfaction with comfort level/pain control Pain Control information Regular assessment of comfort level Antiemetic information Understands options for control of nausea and vomiting Pt/family aware of pain control options Pt/Family aware of pain control options ACTIVITY: Expresses satisfaction with ability to manage ADL's Dangled at bedside night of surgery Pt understands post-op mobility and ambulation routines Up mobilizing and sitting in chair 3 times /day Understands DB&C importance DB&C starting night of surgery NUTRITION: Maintains nutritional status Assess nutritional status Understands ERAS nutrition guidelines pre-op May have solid foods until midnight before surgery Pt /family to bring 2 packages of gum to hospital 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 ELIMINATION: Bowel pattern WDL of pt condition Assess bowel function Understands bowel prep instruction if indicated Discuss bowel prep - if applicable TREATMENTS: Understands purpose of IPC's Measure for IPC's Stoma site marked Stoma site marking MEDICATIONS: Understands pre-op medication instructions Review instructions re: pre-op meds Understands post-op pain options Pain meds to aid with post-op pain Smoking Cessation PSYCHOSOCIAL: Expresses satisfaction with support systems Assess support system e.g. family, community, faith DISCHARGE PLANNING: Verbalizes expected LOS of 5-6 days Discuss length of stay and discharge needs Pt/family confirm discharge needs and arrangements CCAC referral Need for CCAC referral noted in Nursing History Understands reason for stoma site marking PATIENT/FAMILY EDUCATION: Ostomy resource package given Ostomy resource package given to patient to practice at home Pt/family understands ostomy teaching ERAS Patient Education Booklet - review and remind to Patient has ERAS booklet bring to hospital Patient and family to document during hospital stay Pt/family understands to bring book day of surgery Pt/family understands importance of documenting in booklet daily Enterostomal Therapist Nurse (ET) consult initiate CONSULTATIONS: ET nurse PT initiate PT Social Work initiate Consider - Social Work OT initiate - OT - Dietician Dietician initiate - Pastoral Care if applicable Pastoral Care initiate ADDITIONS/CHANGES TO CLINICAL PATHWAY:

INITIALS

+

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

Sciences Centre PATIENT CLINICAL PATHWAY BOWEL RESECTION WITH O Day of Surgery Surgical Procedure:	STOMY						
DATE: (YYYY/MM/DD)							
PATIENT GOALS/DESIRED OUTCOMES:							
THIS PATHWAY IS FOR A 24 HOUR PERIO KEY: ✓ = Care/Protocol &/or Outcome WDL (W			Patient ers blan			•	
CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	_					
ASSESSMENTS:	Hemodynamically stab	9					
Pre-op vital signs Post-op vital signs: q4h x 48h	Respiratory status WE	_					
RR/SpO <sub>2</sub> /sedation as per PCA/Epidural protocol	Chest sounds clear and/or Oxygen sats ≥92 Pre-op temperature ≤37.5		+				
Chest assessment q4h DB&C x 10 each hour while awake	Post-op temperature <38.5						
Oxygen therapy	DB&C complete					$\square$	
COMFORT LEVEL: Antiemetic PRN	Asymptomatic for nausea/vomitir Expresses satisfaction with comfort level/pain contr		+	-	 		
PCA/Epidural/Other	Pain score recorde	d					
Pain Score q4h Pain control information	Pt/Family aware of pain control option	s				1	
ACTIVITY:	Dangles at bedside with assist for 10-15 m	1					
Mobilizes as per ERAS protocol	Walking in hall with assi			┞──		_	_
NUTRITION: Start fluids 2 hours post-op then increase to transitional diet	Follwed ERAS fasting guidelines pre-c Hydration status WE		+				
as tolerated Chewing gum to aid in bowel motility	Tolerating di						
ELIMINATION: (check bowel prep)	Chew gum for 5 min between meals 3 X dau Bowel prep results WL						
Assess urinary catheter output q1h (call if < 20 cc/hr x 3)	Urinary catheter output satisfacto						
Abdominal assessment q12h	Appliance inta Stoma pink, viab	_					
Check appliance q4h Check stoma q4h	Bowel sounds Absent or Prese.	_		-	+		
Check ostomy drainage - assess colour, consistency, document amount	Abdomen so	Ħ	1				
TREATMENTS:	IPC's c	1					
IV fluids	Skin care q sh	_	_				
IPC's applied pre-op / maintained post-op Assess dressing q 4h, reinforce dressing as necessary	Dressing inta Dressing market Areas of oozing on dressing market						
Surgical drain if applicable	Surgical drain (colour, suction and volume	_					
MEDICATIONS: No nonsteroidal anti-inflammatory drugs (NSAIDs) if patient has an anatamosis	Pre-op medication give Pre-op antibiotic give						
Medications given as ordered pre-op							
Administer antibiotics as ordered pre-op DVT Prophylaxis	Antiembolytic Rx initiate Asymptomatic for DV		+		 		
Resume home meds as ordered	Asymptomatic for DV	·	+		1	1	$\vdash$
PSYCHOSOCIAL:	Family aware of routine						
Inform family of day of surgery routines	Active listening provided to support family copir Pt/family aware of surgical procedure dor	·		-	 		
DISCHARGE PLANNING:	CCAC referral initiated for ostomy ca						
CCAC referral	Pt/family aware of expected LOS 5-6 day						
Discharge Instruction Sheet	Discharge instruction sheet initiate Discharge plans in progres	_		-	 		
PATIENT/FAMILY EDUCATION:	Pt will look at stor	а					
Implement Ostomy Guidelines	Patient has ERAS booklet at bedsic Pt/family documents in activity log booklet dai						-
ERAS Patient Education Booklet	Furamity documents in activity log booklet dai	×	+		 		$\vdash$
CONSULTATIONS: ET nurse/SWOT consult for marking or remarking if not in pre-admit	ET consult initiated if not done pre-o	2				1	
PT	PT initia						
Consider - Social Work - OT	Social Work initia OT initia	_	+		 		
- Dietician	Dietician initia	э					
	Pastoral Care initia	e 🗌				1	1
- Pastoral Care if applicable ADDITIONS/CHANGES TO CLINICAL PATHWAY:			-	<u> </u>	 		

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES					
ASSESSMENTS:			<u> </u>	<u> </u>		
Post-op vital signs: q4h x 48h	Hemodynamically stable					
RR/SpO <sub>2</sub> /sedation as per PCA/Epidural protocol	Respiratory status WDL					
Chest assessment q4h	Chest sounds clear					
DB&C x 10 each hour while awake	Oxygen sats ≥92%		 	I		
Blood work as ordered if applicable	Temperature <38.5C					
Titrate off O <sub>2</sub>	DB&C completed		 	I		
	Blood work WDL	 	 <u> </u>	<u> </u>		<u> </u>
COMFORT LEVEL: Antiemetic PRN	Asymptomatic for nausea/vomiting					
	Expresses satisfaction with comfort level/pain control					
PCA/Epidural discontinue if ordered as per APS protocol Pain Score q 4h	Pt/Family aware of pain control options					
Pain Scole q 411 Pain control information	Pain score recorded					
	PCA/Epidural discontinued if ordered					
ACTIVITY:	Ambulate in hall with assist X 3					
Ambulate X 3	Up in chair for all meals with assist					
Chair for all meals	Ambulate to bathroom post catheter removal					
Leg exercises q1h						
NUTRITION:	Hydration status WDL					
Fibre reduced regular diet following ostomy	Begin to eat solid diet as tolerated					
nutrition guidelines	Chew gum for 5 min between meals 3 X daily					
Chewing gum to aid in bowel motility						
ELIMINATION:						
Assess urinary catheter output q1h (call if < 20 cc/hr x 3)	Urinary catheter output satisfactory		 	I		
discontinue if ordered	Urinary catheter discontinued if ordered					
Leave urinary catheter insitu if rectal resection	Urine output adequate post urinary catheter removal					
Abdominal assessment q12h	Passing flatus via ostomy					
Check appliance and stoma q4h	Stoma pink, viable					
Check ostomy drainage - assess colour, consistency,	Appliance intact					
document amount	Bowel sounds Absent or Present					
	Abdomen soft					
TREATMENTS:	IPC's on					
IV fluids	Skin care q shift					
IPC's	Surgical drain (colour, suction and volume)		 			
Surgical drain if applicable				I	 	
Assess dressing - reinforce dressing as necessary	Dressing intact			I –		
	Areas of oozing on dressing marked			<u> </u>		
MEDICATIONS: No nonsteroidal anti-inflammatory			 	I	 	
drugs (NSAIDs) if patient has anastomosis DVT Prophylaxis / Resume home meds as ordered			<u> </u>	I	 	
	Asymptomatic for DVT		 			
PSYCHOSOCIAL:	Activa listoping provided to support family		 	<u> </u>	 	-
Document significant findings on Clinical Progress Record	Active listening provided to support family coping	$\vdash$	 <u> </u>	<u> </u>	 <u> </u>	-
DISCHARGE PLANNING: CCAC referral for discharge	Discharge plans in progress			<u> </u>	 <u> </u>	-
Discharge Planning	CCAC referral initiated	 	 			
Discharge Instruction sheet	Pt/family aware of expected LOS 5-6 days	 	 			
-	Document on discharge instruction sheet		<u> </u>	<u> </u>		
PATIENT/FAMILY EDUCATION: Pain control information	/ Reinforce ostomy teaching, patient to visualize stoma watch video					
Follow Ostomy Guidelines	Demonstration of ostomy appliance emptying by nurse		 		 	-
ERAS Patient Education Booklet					 	-
	Pt/family documents in activity log booklet daily		<u> </u>	<u> </u>	 <u> </u>	
CONSULTATIONS: ET nurse	ET consult initiated			<u> </u>		
PT Consider - Social Work	PT initiate		 	<u> </u>	 	
- OT	Social Work initiate		 	<u> </u>	 	
- Dietician	OT initiate				 	<u> </u>
- Pastoral Care if applicable	Dietician initiate					-
	Pastoral Care initiate		<b> </b>	<u> </u>	 <u> </u>	-
ADDITIONS/CHANGES TO CLINICAL PATHWAY:					 <u> </u>	-
	INITIALS					
	INITIALS					

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES				-			╞
ASSESSMENTS:	Hemodynamically stable	$\vdash$		+				⊢
ost-op Vital signs: q4h x 48h	Respiratory status WDL				<u> </u>			⊢
R/SpO <sub>2</sub> /sedation as per PCA/Epidural protocol	Chest sounds clear				<u> </u>			⊢
Chest assessment q4h				-				⊢
B&C x 10 each hour while awake	Oxygen sats ≥92%			-	<u> </u>			⊢
lood work as ordered if applicable	Temperature <38.5C			-	<u> </u>			⊢
itrate off O <sub>2</sub>	DB&C completed Blood work WDL			-	<u> </u>			⊢
-		$\vdash$		-				⊢
OMFORT LEVEL:	Asymptomatic for nausea/vomiting				<b>I</b>			⊢
CA/Epidural/Other - discontinue if ordered	Expresses satisfaction with comfort level/pain control			-				⊢
Intiemetic PRN	PCA/Epidural discontinued if ordered			-				⊢
ain Score q4h	Patient tolerating oral analgesia Pain score recorded							⊢
ain control information			_	-	<u> </u>			⊢
	Pt/family aware of pain control options							⊢
CTIVITY:	Ambulate in hall with assist X 3			1	<b>—</b>			
mbulate X 3 - may shower	Ambulate to bathroom post catheter removal			1				L
Chair for all meals	Up in chair for all meals			1				L
eg exercises q1h								L
IUTRITION:	Hydration status WDL							Γ
ibre reduced regular diet following ostomy nutrition guidelines	Tolerating prescribed diet							E
Chewing gum to aid in bowel motility	Chew gum for 5 min between meals 3 X daily							Г
LIMINATION:	Urinary catheter output satisfactory			1				Г
sess urinary catheter output q shift (call if < 20 cc/hr x 3)	Urinary catheter discontinued if ordered							Г
discontinue if ordered	Urine output adequate post urinary catheter removal							F
	Bowel sounds Absent or Present							F
ave urinary catheter insitu if rectal resection dominal assessment q12h eck stoma g4h	Passing flatus per ostomy							t
	Passing drainage per ostomy							F
Check appliance g4h	Stoma pink, viable							F
Check ostomy drainage - assess colour, consistency,	Appliance intact							F
document amount	Abdomen soft							F
Ostomy skin scoring tool (DET score)	Peristomal skin assessed & DET score recorded							F
REATMENTS:	IPC's discontinue as ordered if ambulating well				-			⊢
/ fluids - S/L if drinking well	Surgical drain (colour, suction and volume)				<u> </u>			⊢
PC's - remove		$\vdash$			I			⊢
Skin care g shift	Dressing intact	$\vdash$			I			⊢
Surgical drain - if applicable	Incision WDL		_	_	<u> </u>			⊢
Change initial dressing - gauze dressing			_	_	<u> </u>			⊢
		$\vdash$		-				⊢
MEDICATIONS: No nonsteroidal anti-inflammatory		$\vdash$			I			⊢
rugs (NSAIDs) if patient has anastomosis		$\vdash$			I			⊢
	Asymptomatic for DVT	$\vdash$	_	-	-	<b>—</b>	<u> </u>	⊢
SYCHOSOCIAL:		$\vdash$	_	-	-			⊢
Document significant findings on Clinical Progress Record	Active listening provided to support family coping	$\vdash$			<b>I</b>			⊢
DISCHARGE PLANNING:	CCAC referral initiated if not done day prior							L
CAC referral	Pt/family aware of expected LOS 5-6 days							Ľ
Discharge Instruction sheet	Document on discharge instruction sheet							Ľ
	Reinforce ostomy teaching / watch video							Ĺ
ATIENT/FAMILY EDUCATION:	Pt completes appliance change with assistance from nurse							L
ollow Ostomy Guidelines	Patient demonstrates emptying ostomy appliance							ſ
RAS Patient Education booklet	Pt/family documents in activity log booklet daily							Γ
ONSULTATIONS: ET nurse	ET consult initiated			1	1			t
PT	PT initiate			1				t
Consider - Social Work	Social Work initiate			1				t
- OT	OT initiate			1				t
- Dietician	Dietician initiate			1	1		<u> </u>	⊢
- Pastoral Care if applicable	Pastoral Care initiate			1	1		<u> </u>	⊢
DDITIONS/CHANGES TO CLINICAL PATHWAY:	rasioral Gale Initiate	$\vdash$			<del> </del>	<u> </u>	<u> </u>	⊢
DDITIONS/CHANGES TO CLINICAL PATHWAT:		$\vdash$					<u> </u>	┡

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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		_					
ASSESSMENTS:	Hemodynamically stable			-				⊢
/ital signs g8h	Respiratory status WDL							
Chest assessment q8h	Temperature <38.5C							
DB&C q4h while awake	Blood work WDL			1				⊢
Blood work as ordered if applicable	DB&C completed			1				⊢
Titrate off O2				1				⊢
COMFORT LEVEL:	Asymptomatic for nausea/vomiting			+				
PCA/Epidural/Other - discontinue if ordered	Expresses satisfaction with comfort level/pain control			1				
Intiemetic PRN	PCA /Epidural discontinued if ordered			1				
Pain Score g8h	Pain score recorded			1				⊢
Pain control information	Patient tolerating oral analgesia			1				⊢
Dral analgesia	Pt/family aware of pain control options on discharge			1				
			_	+				⊢
	Up in chair for all meals			-				⊢
Abbilize	Ambulate in hallway X 4		_	-				⊢
Progressive ambulation to QID Aay shower	Ambulate to bathroom post catheter removal		_	-				⊢
	······································		_		<u> </u>			⊢
IUTRITION:	Hydration status WDL		_					
ibre 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		_	4	<b>I</b>			
LIMINATION:	Urine output qs		_	4	I			
emove urinary catheter if ordered for rectal resections	Urinary catheter discontinued if ordered							
Abdominal assessment q12h	Urine output adequate post urinary catheter removal			1				L
Check stoma q8h	Abdominal assessment WDL			1				L
k appliance q8h k ostomy drainage - assess colour, consistency,	Bowel sounds Absent or Present			1				L
	Stoma pink, viable							L
document amount	Appliance intact							L
ssess for rod removal if applicable	Passing flatus via ostomy / Passing drainage per ostomy							L
Ostomy skin scoring tool (DET) if discharged	Abdomen soft				1			L
	Peristomal skin assessed & DET score recorded if appliance changed for discharge							Γ
REATMENTS: IPC's - removed	IPC's discontinued as ordered if ambulating well			+	<u> </u>			⊢
Assess incision q shift - incision open to air/gauze dress(s)	<b>`</b>			1	-			⊢
as required	Incision WDL							⊢
Surgical drain - if applicable	Dressing intact		_	-	-			⊢
•	Surgical drain (colour, suction and volume)		_			<u> </u>		⊢
IEDICATIONS: No nonsteroidal anti-inflammatory Irugs (NSAIDs) if patient has anastomosis			_			<b>—</b>		⊢
DVT Prophylaxis / Resume home meds as ordered				-		<u> </u>		⊢
	Asymptomatic for DVT		_	+	I	I		⊢
PSYCHOSOCIAL:	A de la participación de la companya	$\vdash$		+		<u> </u>		⊢
Document significant findings on Clinical Progress Record	Active listening provided to support family coping	$\vdash$	_		<b> </b>	<u> </u>		┡
DISCHARGE PLANNING:	Pt/family aware of potential discharge today/tomorrow			-	I			
CAC referral completed ischarge planning and teaching goals met	Pt/family has transportation arranged for discharge			-	I			L
taple removal - date and arrangements	Discharge plans complete			_				L
repare for discharge before lunch	Patient has scripts for discharge			-	I			L
ischarge Medication Reconciliation	Discharge Instruction sheet complete - given to patient			_				L
vischarge Instruction sheet	Discharge Medication Reconciliation							
lectronic Discharge Summary ischarge medication scripts completed and signed	Electronic Discharge Summary complete and reviewed with patient							
· · · ·	Reinforce ostomy teaching / watch video	$\vdash$	_	+		<u> </u>		┢
ATIENT/FAMILY EDUCATION:	Pt emptying ostomy appliance with minimal assistance from nurse			1	1		<u> </u>	┢
ollow Ostomy Guidelines atient Education booklet								┢
	Pt/family documents in activity log booklet daily	$\vdash$			I		<u> </u>	┡
	Collect completed activity log booklet if discharged		_				<u> </u>	┡
ONSULTATIONS: ET nurse - ostomy supply list,	ET following							L
ADP form if applicable	PT following							L
PT Consider - Social Work	Social Work initiate							L
- OT	OT initiate							Ē
- Dietician	Dietician initiate							1
			_	1	1			t

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES						┝
SSESSMENTS:	Hemodynamically stable	+			<u> </u>		┢
tal signs g12h	Respiratory status WDL	-		I			⊢
nest assessment g12h	Temperature <38.5C				<u> </u>		⊢
B&C q8h	DB&C completed	-					⊢
	· · · ·	+		I		I	⊢
OMFORT LEVEL:	Expresses satisfaction with comfort level/pain control	_					⊢
ntiemetic PRN	Asymptomatic for nausea/vomiting						⊢
ain Score q12h	Pain score recorded						
ral Analgesia	Tolerating oral analgesics						
	Pt/family aware of pain control options on discharge						
CTIVITY:	Up in chair for all meals						L
obilize	Ambulates independently						E
rogressive ambulation to QID	Ambulate to bathroom						Г
ay shower							Г
UTRITION:	Hydration status WDL						Г
bre reduced regular diet following ostomy nutrition guidelines	Tolerating prescribed diet		1				t
newing gum to aid in bowel motility	Chew gum for 5 min between meals 3 X daily	1	1		<u> </u>		⊢
	Urine output as	+		<u> </u>	<u> </u>	<u> </u>	⊢
	Abdominal assessment WDL			<u> </u>	<u> </u>	<b> </b>	⊢
ess voiding ove urinary catheter if ordered for rectal resection ominal assessment g12h	Bowel sounds Absent or Present			<u> </u>	<u> </u>		⊢
	Passing flatus / drainage per ostomy	-					⊢
neck stoma g8h		-		<u> </u>			╀
neck appliance g8h	Stoma pink, viable	_					₽
neck ostomy drainage - assess colour, consistency,	Appliance intact						L
locument amount	Peristomal skin assessed & DET score recorded			I			L
ssess for rod removal if applicable	if appliance changed for discharge	_	L				₽
stomy skin scoring tool (DET) if discharged		_					₽
REATMENTS:	Dressing intact						L
ssess incision q shift - incision open to air/gauze dress(s)	Incision WDL			I			L
required	Surgical drain (colour, suction and volume)						Г
urgical drain - if applicable							Г
EDICATIONS: No nonsteroidal anti-inflammatory			1				Г
rugs (NSAIDs) if patient has anastomosis							Г
/T Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT						Г
SYCHOSOCIAL:							Г
ocument significant findings on Clinical Progress Record	Active listening provided to support family coping						Г
SCHARGE PLANNING:	Pt/family aware of potential discharge today/tomorrow						T
CAC referral completed	Pt/family has transportation arranged for discharge						t
scharge planning and teaching goals met		+	1				t
aple removal - date and arrangements	Discharge plans complete						⊢
repare for discharge before lunch	Patient has scripts for discharge			I	<u> </u>		╉
scharge Medication Reconciliation	Discharge Instruction sheet complete - given to patient			<u> </u>	<u> </u>		⊢
scharge Instruction sheet	Discharge Medication Reconciliation Electronic Discharge Summary complete and			<u> </u>	<u> </u>		╀
ectronic Discharge Summary	reviewed with patient			I			L
scharge medication scripts completed and signed		-					t
ATIENT/FAMILY EDUCATION:	Reinforce ostomy teaching / watch video	+	1	<u> </u>			t
bllow Ostomy Guidelines				<u> </u>	<u> </u>		╉
atient Education booklet	Pt completes appliance change with nurse observing		I	<b> </b>	<u> </u>		╀
	Patient emptying ostomy appliance on own		I	I	<u> </u>		₽
	Pt/family documents in activity log booklet daily		I		<u> </u>		₽
	Assess rod removal if applicable		I	L			₽
	Collect completed activity log booklet if discharged		<u> </u>				L
ONSULTATIONS: ET nurse - ostomy supply list,							
ADP form if applicable	ET following		L				L
PT	PT following						
onsider if applicable - Social Work	Social Work initiate						Γ
- OT	OT initiate						
							г

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES							╞
ASSESSMENTS:	Hemodynamically stable			+	<u> </u>			┢
/ital signs q12h,	Respiratory status WDL				<u> </u>			⊢
Chest assessment q12h	Temperature <38.5C							⊢
DB&C q12h	DB&C completed							
COMFORT LEVEL:	Asymptomatic for nausea/vomiting							
Intiemetic PRN	Expresses satisfaction with comfort level/pain control							
Pain Score g12h	Pain score recorded							
Dral Analgesia	Tolerating oral analgesics							F
-	Pt/family aware of pain control options on discharge							
ACTIVITY:	Up in chair for all meals							Г
Iobilize	Ambulates independently							F
Progressive ambulation to QID	Ambulates to bathroom							F
May shower								
IUTRITION:	Hydration status WDL							Г
ibre reduced regular diet following ostomy nutrition guidelines	Tolerating prescribed diet			1				Γ
Chewing gum to aid in bowel motility	Chew gum for 5 min between meals 3 X daily			1				t
LIMINATION:	Urine output as							Г
ssess voiding	Abdominal assessment WDL			1				t
bdominal assessment q12h	Bowel sounds Absent or Present			1				⊢
ck stoma q8h ck appliance q8h	Passing flatus/drainage per ostomy			1				t
Check appliance q8h	Stoma pink, viable							F
Check ostomy drainage - assess colour, consistency,	Appliance intact							F
document amount	Appliance change with patient/family if not done day before							⊢
ss for rod removal if applicable	Peristomal skin assessed & DET score recorded							⊢
Ostomy skin scoring tool (DET) if discharged	if appliance changed for discharge							L
REATMENTS:	Incision WDL							F
Assess incision q shift - incision open to air/gauze dress(s)	Surgical drain (colour, suction, and volume)							t
as required								F
Surgical drain - if applicable								⊢
IEDICATIONS: No nonsteroidal anti-inflammatory								Г
rugs (NSAIDs) if patient has anastomosis								Г
VT Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT							Г
PSYCHOSOCIAL:								Г
Document significant findings on Clinical Progress Record	Active listening provided to support family coping							F
DISCHARGE PLANNING:	Pt/family aware of potential discharge today/tomorrow							$\vdash$
CCAC referral completed	Pt/family has transportation arranged for discharge				I –			⊢
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							⊢
Electronic Discharge Summary	reviewed with patient							L
Discharge medication scripts completed and signed								Г
ATIENT/FAMILY EDUCATION:	Reinforce ostomy teaching / watch video							Г
RAS Patient Education booklet	Pt completes appliance change with nurse if not done day before			1				T
	Patient emptying ostomy on own			1				⊢
	Assess rod removal if applicable			1				$\vdash$
	Collect completed activity log booklet on discharge			1				t
				1				⊢
CONSULTATIONS: ET nurse - ostomy supply list, ADP form if applicable	ET following			1				t
PT		$\vdash$	_		<u> </u>		<u> </u>	⊢
Consider if applicable - Social Work	PT following Social Work initiate	$\vdash$		1	I			⊢
- OT	OT initiate		_	1	<u> </u>			⊢
ADDITIONS/CHANGES TO CLINICAL PATHWAY:	OT Initiate	$\vdash$			<u> </u>	<u> </u>	<u> </u>	⊢
				1				1

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES		-+					╞
ASSESSMENTS:	Hemodynamically stable	$\rightarrow$	$\rightarrow$	_	 			⊢
/ital signs q12h,	Respiratory status WDL							⊢
Chest assessment q12h	Temperature <38.5C							F
DB&C q12h	DB&C completed							
COMFORT LEVEL:	Asymptomatic for nausea/vomiting							Г
Antiemetic PRN	Expresses satisfaction with comfort level/pain control							
Pain Score q12h	Pain score recorded							
Dral Analgesia	Tolerating oral analgesic							
	Pt/family aware of pain control options on discharge							
ACTIVITY:	Up in chair for all meals							
Aobilize	Ambulates independently							L
Progressive ambulation to QID May shower	Ambulates to bathroom							┡
,								┡
IUTRITION:	Hydration status WDL	$\rightarrow$	$\rightarrow$					┡
Fibre reduced regular diet following ostomy nutrition guidelines Chewing gum to aid in bowel motility	Tolerating prescribed diet	$\rightarrow$	$\rightarrow$				<u> </u>	┡
	Chew gum for 5 min between meals 3 X daily	$\rightarrow$	$\rightarrow$				<u> </u>	┡
ELIMINATION:	Urine output qs		$\rightarrow$					L
Assess voiding	Abdominal assessment WDL	$\rightarrow$	$\rightarrow$			<u> </u>	<u> </u>	┡
Abdominal assessment q12h	Bowel sounds Absent or Present	$\rightarrow$	$\rightarrow$					┡
Check stoma q8h Check appliance q8h	Passing flatus/drainage per ostomy	$\rightarrow$	$\rightarrow$				<u> </u>	┡
Check ostomy drainage - assess colour, consistency,	Stoma pink, viable							L
document amount	Appliance intact							L
Assess for rod removal if applicable	Appliance change with patient/family if not done day before							L
Dstomy skin scoring tool (DET) if discharged	Peristomal skin assessed & DET score recorded							L
	if appliance changed for discharge				 			┝
REATMENTS: Assess incision q shift - incision open to air/gauze dress(s)	Incision WDL Surgical drain (colour, suction, and volume)							⊢
as required								⊢
Surgical drain - if applicable								⊢
IEDICATIONS: No nonsteroidal anti-inflammatory								t
Irugs (NSAIDs) if patient has anastomosis								t
DVT Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT							t
PSYCHOSOCIAL:								t
Document significant findings on Clinical Progress Record	Active listening provided to support family coping		- 1					t
DISCHARGE PLANNING:	Pt/family aware of potential discharge today							t
CCAC referral completed								⊢
Discharge planning and teaching goals met	Pt/family has transportation arranged for discharge							⊢
Staple removal - date and arrangements	Discharge plans complete							┝
Prepare for discharge before lunch	Patient has scripts for discharge							⊢
Discharge Medication Reconciliation	Discharge Instruction sheet complete - given to patient							┡
Discharge Instruction sheet	Discharge Medication Reconciliation							L
Electronic Discharge Summary Discharge medication scripts completed and signed	Electronic Discharge Summary complete and reviewed with patient							L
								┝
PATIENT/FAMILY EDUCATION:	Reinforce ostomy teaching Pt completes appliance change with nurse							┝
RAS Patient Education booklet	if not done day before							L
	Patient emptying ostomy on own							Г
	Assess rod removal if applicable							T
	Collect completed activity log booklet on discharge							T
CONSULTATIONS: ET nurse - ostomy supply list,								T
ADP form if applicable	ET following							Γ
PT	PT following							Γ
Consider if applicable - Social Work	Social Work initiate							t
- OT	OT initiate							t
ADDITIONS/CHANGES TO CLINICAL PATHWAY:	or minuto		-+					t
								t
	INITIALS							ſ

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL
FOCUS / PROBLEM		

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES		$\left  - \right $	$\vdash$			╞
ASSESSMENTS:	Hemodynamically stable	+		+			⊢
/ital signs q12h,	Respiratory status WDL						
Chest assessment q12h	Temperature <38.5C						F
DB&C q12h	DB&C completed						F
COMFORT LEVEL:	Asymptomatic for nausea/vomiting		1				Г
Antiemetic PRN	Expresses satisfaction with comfort level/pain control						F
Pain Score q12h	Pain score recorded						Γ
Dral Analgesia	Tolerating oral analgesic						Г
	Pt/family aware of pain control options on discharge						Γ
ACTIVITY:	Up in chair for all meals						Г
Mobilize	Ambulates independently						
Progressive ambulation to QID	Ambulates to bathroom						
May shower							
NUTRITION:	Hydration status WDL						Ľ
ibre reduced regular diet following ostomy nutrition guidelines	Tolerating prescribed diet						Ľ
Chewing gum to aid in bowel motility	Chew gum for 5 min between meals 3 X daily						
ELIMINATION:	Urine output qs						Г
Assess voiding	Abdominal assessment WDL		1	1			t
Abdominal assessment q12h	Bowel sounds <b>A</b> bsent or <b>P</b> resent		1	1			T
Check stoma q8h	Passing flatus/drainage per ostomy						T
Check appliance q8h	Stoma pink, viable						t
Check ostomy drainage - assess colour, consistency,	Appliance intact						t
document amount	Appliance change with patient/family if not done day before						t
Assess for rod removal if applicable	Peristomal skin assessed & DET score recorded						⊢
Ostomy skin scoring tool (DET) if discharged	if appliance changed for discharge			1			L
IREATMENTS:	Incision WDL				1		t
Assess incision q shift - incision open to air/gauze dress(s)	Surgical drain (colour, suction, and volume)						t
as required							t
Surgical drain - if applicable							L
MEDICATIONS: No nonsteroidal anti-inflammatory				1			L
drugs (NSAIDs) if patient has anastomosis							Г
OVT Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT						Г
PSYCHOSOCIAL:							Г
Document significant findings on Clinical Progress Record	Active listening provided to support family coping						Г
DISCHARGE PLANNING:	Pt/family aware of potential discharge today						t
CCAC referral completed	Pt/family has transportation arranged for discharge						t
Discharge planning and teaching goals met	Discharge plans complete		1	1			⊢
Staple removal - date and arrangements	Patient has scripts for discharge			-		-	⊢
Prepare for discharge before lunch							⊢
Discharge Medication Reconciliation	Discharge Instruction sheet complete - given to patient	_					⊢
Discharge Instruction sheet Electronic Discharge Summary	Discharge Medication Reconciliation			<b>I</b>			⊢
Discharge medication scripts completed and signed	Electronic Discharge Summary complete and			1			L
	reviewed with patient	_					⊢
PATIENT/FAMILY EDUCATION:	Reinforce ostomy teaching	 				<u> </u>	⊢
ERAS Patient Education booklet	Pt completes appliance change with nurse if not done day before		1	1			L
	Patient emptying ostomy on own		1	1			T
	Assess rod removal if applicable	-	1	1			t
	Collect completed activity log booklet on discharge		1	1			t
CONSULTATIONS: ET nurse - ostomy supply list,	iso and in a source of		1	1		<u> </u>	t
ADP form if applicable	ET following		1	1			t
PT	PT following		1	1			t
Consider if applicable - Social Work	Social Work initiate	 	1	1			⊢
- OT	OT initiate	 	1	1			⊢
ADDITIONS/CHANGES TO CLINICAL PATHWAY:		 	+			<u> </u>	⊢
ADDITIONS/CHANGES TO CLINICAL PATHWAT:		 _					⊢
	1						

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES	+				╞
ASSESSMENTS:	Hemodynamically stable	+				⊢
/ital signs q12h,	Respiratory status WDL					⊢
Chest assessment q12h	Temperature <38.5C					t
DB&C q12h	DB&C completed					F
COMFORT LEVEL:	Asymptomatic for nausea/vomiting		1			Г
Intiemetic PRN	Expresses satisfaction with comfort level/pain control					Γ
Pain Score q12h	Pain score recorded					Γ
Dral Analgesia	Tolerating oral analgesic					Γ
	Pt/family aware of pain control options on discharge					
ACTIVITY:	Up in chair for all meals					Γ
Iobilize	Ambulates independently					
Progressive ambulation to QID	Ambulates to bathroom					L
May shower						L
IUTRITION:	Hydration status WDL					L
ibre reduced regular diet following ostomy nutrition guidelines	Tolerating prescribed diet					L
Chewing gum to aid in bowel motility	Chew gum for 5 min between meals 3 X daily					Ĺ
LIMINATION:	Urine output qs					
Assess voiding	Abdominal assessment WDL					L
bdominal assessment q12h	Bowel sounds Absent or Present					
Check stoma q8h	Passing flatus/drainage per ostomy					Γ
Check appliance q8h	Stoma pink, viable					Г
Check ostomy drainage - assess colour, consistency,	Appliance intact					t
document amount	Appliance change with patient/family if not done day before					t
ssess for rod removal if applicable	Peristomal skin assessed & DET score recorded					t
Ostomy skin scoring tool (DET) if discharged	if appliance changed for discharge			1		L
REATMENTS:	Incision WDL					Г
ssess incision q shift - incision open to air/gauze dress(s)	Surgical drain (colour, suction, and volume)		1			Γ
as required						
Surgical drain - if applicable						
IEDICATIONS: No nonsteroidal anti-inflammatory						
Irugs (NSAIDs) if patient has anastomosis						
VT Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT					L
SYCHOSOCIAL:						
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					Г
Discharge planning and teaching goals met	Discharge plans complete		1			F
Staple removal - date and arrangements	Patient has scripts for discharge		1	1		t
Prepare for discharge before lunch Discharge Medication Reconciliation	Discharge Instruction sheet complete - given to patient	-				t
Discharge Instruction sheet	Discharge Medication Reconciliation	 1				┢
Electronic Discharge Summary	Electronic Discharge Summary complete and	 	<u> </u>	<u> </u>		⊢
Discharge medication scripts completed and signed	reviewed with patient			1		
PATIENT/FAMILY EDUCATION:	Reinforce ostomy teaching	 	1	<u> </u>		t
RAS Patient Education booklet	Pt completes appliance change with nurse	-	-	<u> </u>		┢
	if not done day before					
	Patient emptying ostomy on own					Г
	Assess rod removal if applicable					Γ
	Collect completed activity log booklet on discharge					Γ
CONSULTATIONS: ET nurse - ostomy supply list,						Γ
ADP form if applicable	ET following					Г
PT	PT following					Γ
Consider if applicable - Social Work	Social Work initiate					t
- OT	OT initiate		1			t
ADDITIONS/CHANGES TO CLINICAL PATHWAY:	51 million	-	1			t
			1	1		t
I		 _	1	-		t

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL

#### 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

CATEGORIES (modifications per orders)	EXPECTED OUTCOMES					
ASSESSMENTS:	Hemodynamically stable			<u> </u>		 ⊢
/ital signs g12h,	Respiratory status WDL		 			⊢
Chest assessment q12h	Temperature <38.5C		 			⊢
DB&C q12h	DB&C completed					F
COMFORT LEVEL:	Asymptomatic for nausea/vomiting				i —	F
Antiemetic PRN	Expresses satisfaction with comfort level/pain control					F
Pain Score q12h	Pain score recorded					F
Dral Analgesia	Tolerating oral analgesic					F
ů –	Pt/family aware of pain control options on discharge					F
ACTIVITY:	Up in chair for all meals				i —	Г
Nobilize	Ambulates independently					F
Progressive ambulation to QID	Ambulates to bathroom					Г
May shower						Γ
IUTRITION:	Hydration status WDL					Г
ibre 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					Γ
LIMINATION:	Urine output qs					Γ
ssess voiding	Abdominal assessment WDL					t
Abdominal assessment q12h	Bowel sounds Absent or Present					t
Check stoma q8h	Passing flatus/drainage per ostomy					t
Check appliance q8h	Stoma pink, viable					t
Check ostomy drainage - assess colour, consistency,	Appliance intact					F
document amount	Appliance change with patient/family if not done day before					⊢
ssess for rod removal if applicable						 ⊢
Ostomy skin scoring tool (DET) if discharged	Peristomal skin assessed & DET score recorded if appliance changed for discharge					
REATMENTS:	Incision WDL				i —	F
Assess incision q shift - incision open to air/gauze dress(s)	Surgical drain (colour, suction, and volume)					F
as required						F
Surgical drain - if applicable						Г
EDICATIONS: No nonsteroidal anti-inflammatory						Г
Irugs (NSAIDs) if patient has anastomosis						Г
WT Prophylaxis / Resume home meds as ordered	Asymptomatic for DVT					Г
PSYCHOSOCIAL:						Г
Document significant findings on Clinical Progress Record	Active listening provided to support family coping					Г
DISCHARGE PLANNING:	Pt/family aware of potential discharge today					Г
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		 	I		⊢
Discharge Medication Reconciliation						 ⊢
Electronic Discharge Summary	Discharge Medication Reconciliation					 ⊢
Discharge medication scripts completed and signed	Electronic Discharge Summary complete and reviewed with patient					
	*			<u> </u>		 ⊢
PATIENT/FAMILY EDUCATION: RAS Patient Education booklet	Reinforce ostomy teaching Pt completes appliance change with nurse					⊢
	if not done day before					
	Patient emptying ostomy on own					Г
	Assess rod removal if applicable					ſ
	Collect completed activity log booklet on discharge					L
CONSULTATIONS: ET nurse - ostomy supply list,						t
ADP form if applicable	ET following					L
PT	PT following					L
Consider if applicable - Social Work	Social Work initiate					⊢
- OT	OT initiate			<u> </u>		⊢
ADDITIONS/CHANGES TO CLINICAL PATHWAY:	OT muale				<b> </b>	⊢
SETTERS/OFFAILED TO CENTORE FAILURAT.						⊢
			 			 -

DATE AND TIME FOCUS / PROBLEM	SIGNIFICANT FINDING	INITIAL