Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Colorectal Surgery Integrated Care Pathway

(Version 5.3: September 2015, Review Date September 2016)

This Integrated Care Pathway (ICP) is a multidisciplinary document and replaces all other documentation to form the patient's sole record of care. It is intended as a guide to good practice and is evidence based

Addressograph	
Unit no.:	DoB:
Name:	
Address:	

Age:

Consultant:

Patient known as:

Date of Admission:			
Operation:			
Date of surgery:			
Predicted date of discharge (PDD):	Actual date of discharge:		Length of post operative stay
Removed from pathway	Date:	Reason	

Pre Operative Assessment Outcome:

Please tick ✓ Y / N as appropriate

Suitable for Day of surgery admission (DOSA)?	**Y**	**N**	
Day before Surgery Admission (DBSA)	**Y**	**N**	Admit .....days pre-op
PACU/HDU / ICUbed required post-op?	**Y**	**N**	
Is the patient allergic to latex?	**Y**	**N**	If Yes theatre informed:
Is the patient's BMI > 40?	**Y**	**N**	If Yes theatre informed:
Does the patient need to be first on list?	**Y**	**N**	
Assessing Nurse: **Signature:**			**Date:**

1. The ICP is not a rigid document and clinicians are free to use their own professional judgement as appropriate, recording as a variance any alterations to the practice outlined, or any deviation from the expected plan of treatment.
2. When using the pathway for the first time, sign your name and details on the next page stating your discipline.
3. All sections should be fully completed in **black ink**. Please follow all instructions.
4. It is essential that all entries are signed and dated as indicated. Sign only for care that YOU have carried out or outcomes that have been met.
5. When completing the pathway insert:
   - Your initials if the outcome / plan has been met
   - **X** if it has not been met and appropriate code documented in the variance table to describe the relevant action taken. In recording variances, please give as much information as possible
   - **N/A** If the outcome / plan is not applicable to that patient
   - Sign only **once** in the pm section if caring for the patient over the course of a 12 hour shift
6. The Cardiff and Vale UHB **generic risk assessment book** must be used alongside this ICP to ensure that patients undergo appropriate risk assessment during their stay
7. **Diabetes core care** plans must be used for all diabetic patients
8. Relevant **acute pain care plans** must be used as appropriate
9. If the pathway is no longer suitable for a patient, discontinue the pathway, document why as a variance and fill in the date in the table on page 1.

SIGNATURE	PRINT NAME	INITIALS	JOB TITLE	Bleep /Extension

Appendix 3: Antiemetic advice

Give prophylaxis anti-emetics as prescribed

1st line: Cyclizine 50mg PRN IV/oral
2nd line: Ondansetron 4mg prn IV/oral
3rd line: Prochlorperazine 3-6mg bd PRN buccal

Postoperative fluid management:

- Hartmann's 1.5L over 24 hrs (=62.5 mls/hr)
- Oral intake 800mls on day of surgery.
- IVI down on post op day 1
- Oral intake 2000mls from day 1 (includes 3 nutritional supplement drinks)
- Aim for **mean** BP ≥60mmHg.
- If poor urine output or hypotension requiring iv fluids, use 250ml boluses of **colloid**.
- Patients with epidural analgesia **may** require more postoperative fluids than other anaesthetic/analgesic techniques due to the vasodilatory effects of the epidural
- Acceptance of a lower average urine output (0.3 mls/kg/hr averaged over 4 hours)in the first 24-48hrs post-operatively helps to avoid fluid overload with no adverse effect on the patient – as long as other parameters are normal and patient is euvolaemic with no renal impairment. In the absence of complications, oliguria occurring soon after operation is usually a normal physiological response to surgery.
- Oliguria soon after surgery does not necessarily reflect hypovolaemia and should be evaluated in the context of the patient's volume status. The key question is whether or not the oliguric patient has significant intravascular hypovolaemia which needs treatment. Clinical signs reflecting intravascular volume include capillary refill, jugular (central) venous pressure, and the trend in pulse and blood pressure. Urine output should be interpreted in the light of these clinical signs, bearing in mind the normal short term physiological effects of surgery on urine output.

Pressure areas checked. District Nurse arranged if any pressure damage (all categories 1-4)				628
Anti Embolic Stockings removed if for discharge. Check legs, heels and feet are all intact and blanching. District Nurse visit arranged if any pressure damage				629
Hygiene needs met including oral care				630
Physiotherapist: Mobility assessment				6PM
Discharge				
Complete discharge checklist and arrange TTH as appropriate				631
Actual date of discharge entered on clinical workstation				633
Appropriate referrals made to MDT to facilitate discharge				634
Stoma Care				
Patient has changed stoma bag independently x 2 (even if stoma has not functioned) 1 □ 2 □				635
CNS comments				

History of presenting complaint

Anaesthetic History

Date	Operation	Hospital

Previous anaesthetic problems _____

_____

_____

Family history of anaesthetic problems _____

_____

_____

Past Medical History

Cardiovascular	Yes	No	Expand here:
MI	☐	☐	
Angina / Chest pain	☐	☐	
Coronary artery stents	☐	☐	
Previous cardiac surgery	☐	☐	
Murmur / valvular heart disease	☐	☐	
Hypertension	☐	☐	
AF / Arrhythmia	☐	☐	
Heart failure	☐	☐	
Stroke / TIA	☐	☐	
Pacemaker	☐	☐	
DVT / PE	☐	☐	
Palpitations / faints / syncope	☐	☐	
Rheumatic fever	☐	☐	
Peripheral vascular disease	☐	☐	
Respiratory			
Asthma	☐	☐	
COPD / bronchitis / emphysema	☐	☐	
TB	☐	☐	
Sleep apnoea / snoring	☐	☐	STOP-Bang score:
Cough	☐	☐	Productive ☐ Haemoptysis ☐
Endocrine			
Diabetes	☐	☐	diet ☐ tablets ☐ insulin ☐
Thyroid disease	☐	☐	
Haematological			
Excessive bleeding / bruising	☐	☐	
Anaemia I blood disorders	☐	☐	
Sickle cell disease	☐	☐	
GI/GU			
Liver disease / jaundice / hepatitis	☐	☐	
Heartburn / acid reflux	☐	☐	
Hiatus hernia	☐	☐	
Stomach I duodenal ulcer	☐	☐	
Kidney I bladder problems	☐	☐	
CNS			
Epilepsy / fits	☐	☐	
Neurological disorder	☐	☐	
Anxiety / Depression	☐	☐	
Psychiatric illness	☐	☐	
Other			
Arthritis/joint problems	☐	☐	
LMP			Could you be pregnant? ☐ yes ☐ no
Inoculation risk	☐	☐	
High risk of new variant CJD	☐	☐	
Other	☐	☐	

Post op day 6 Date:

Plan: Discharge home today

Insert initials if achieved, a **X** if unachieved and N/A if not applicable

	am	pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 8 hourly as deemed appropriate. Actions taken as per EWS chart: document actions required on variance sheet.				60
Deep breathing promoted, patient able to deep breathe and cough.				61
If patient is expectorating, sputum is clear				62
Wound observed – ask doctor to review if any redness, swelling, oozing or skin discolouration **(document as a variance any actions taken)**				63
Ensure apyrexial				65
Fluid Balance				
Fluid balance chart discontinued				66
Ensure venflon has been removed				68
Passing urine without any difficulties				69
Weight recorded ..... Kg				612
Eating and Drinking				
Normal diet tolerated				613
Oral fluids encouraged (Aim for 2000mls in 24 hours)				614
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1 ☐ 2 ☐ 3 ☐				616
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				617
Flatus passed.				618
Faeces passed.				619
Pain and Nausea				
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and document as a variance				621
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and document as a variance (Nb Ibuprofen for 7 days post op only)				622
Nausea assessed with each set of observations and well controlled. If nausea not well controlled , action taken and document as a variance				624
Mobility and Skin				
Out of bed 8 hours in total				625
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐				626

Post Op Day 5

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Exercise tolerance

Maximum walking distance on flat ____________________ (yards / metres)

☐ **bed bound** ☐ **wheelchair** bed to chair ☐ **5m** end of room

☐ **25m** end of ward ☐ **100m** length of football pitch ☐ **400m**

☐ **2km** 30min walk ☐ **>2km** normal pace, no exercise limitation

Walking limited by ☐ joint pain ☐ breathing ☐ chest pain ☐ leg pain

☐ balance ☐ fatigue ☐ other ____________

Do you get SOB walking up a flight of 12 stairs? ☐ yes ☐ no

Do you get chest pain walking up a flight of 12 stairs? ☐ yes ☐ no

Orthopnoea ☐ yes ☐ no (No. of pillows)_____ **PND** ☐ yes ☐ no

Peripheral Oedema ☐ yes ☐ no

Canadian Cardiovascular Society functional classification of angina

☐ Class 0 – no angina

☐ Class I – angina only with prolonged activity. **No** limitation on normal activity

☐ Class II – angina with slightly more prolonged or slightly more vigorous activity than normal.
Slight limitation on normal activity

☐ Class III – angina with usual daily activity. **Marked** limitation on normal activity

☐ Class IV – angina at rest. **Severe** limitation on normal activity

Roizen's classification of dyspnoea

☐ Grade 0 – no dyspnoea while walking on the level at normal pace

☐ Grade I – Mild, non-specific restriction (speed not distance)
"I am able to walk as far as I like as long as I take my time"

☐ Grade II – Moderate, specific, outdoor limitation
"I have to stop for a while after ……" (a recognisable, distance limitation)

☐ Grade III – Marked dyspnoea on mild, indoor exertion.
"I have to stop and rest going from the kitchen to the bathroom"

☐ Grade IV – Dyspnoea at rest.

Social History / Family History

Alcohol ____________ units/week

Cigarettes ____________ / day If ex-smoker, when quit? ____________

Recreational drug use ____________

Any prostheses / implants / body piercings ____________

Family history of disease ____________

Medication history

Allergies/Intolerance

Drug history obtained from:

GP Practice ☐ Patient ☐ Patient's own drugs ☐ Other ☐

Pt's Relative ☐ Rpt Prescription ☐ Nursing home ☐

Drugs on admission (including herbal/OTC)	Route/ Form	Dose	frequency	Indication	Stop Pre-op	Comments

Drugs discontinued in the last 3 months and why (e.g. steroids)	Pt advised to bring in own meds ☐

Additional comments: ____________________

____

____

Pharmacist signature ____________________ Bleep ______________ Date ____________

Check list: Analgesics Inhalers Creams HRT Warfarin OTC Laxatives Injections
Antacids OCP Alternative/herbal Patches Compliance aids Drops

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

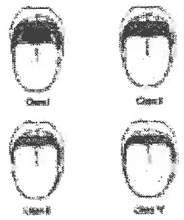
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐				526
Pressure areas checked. District Nurse arranged if any pressure damage (all categories 1-4)				528
Anti Embolic Stockings removed if for discharge. Check legs, heels and feet are all intact and blanching. District Nurse visit arranged if any pressure damage				529
Hygiene needs met including oral care				530
Discharge				
Complete discharge checklist (page 64)and arrange TTH as appropriate				531
Actual date of discharge entered on clinical workstation				533
Appropriate referrals made to MDT to facilitate discharge				526
Stoma Care				
Independent with stoma care				535
CNS comments				

Examination

Height _____ m Weight _____ kg BMI _____ kg/m^2

Airway

Mouth opening _____ cm Mallampati Class _____



Class I: soft palate, fauces, uvula, pillars visualised
Class II: soft palate, fauces, portion of uvula visualised
Class III: soft palate, base of uvula visualised
Class IV: hard palate only

Neck extension ☐ good ☐ restricted Teeth R L

Thyromental distance ☐ >6.5cm ☐ <6.5cm Warned? ☐

Cardiovascular

Pulse _____ / min ☐ reg ☐ irreg

BP _____ / _____ mmHg JVP _____

Heart sounds ☐ normal ☐ added I II I

If Murmur: Position _____ Radiation _____

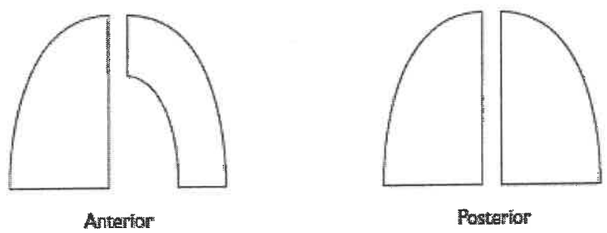
Peripheral oedema _____

Respiratory

SpO_2 in air _____ % Respiratory rate _____ PEFR _____ L/min

If BMI>30 kg/m^2, SpO_2 in air when supine _____ %

Chest clear ☐ yes ☐ no



Anterior Posterior

Examination by (print name) _____

Other relevant findings / specialist examination

Investigations ordered			
	Sent	Result	Action?
FBC			
U&E			
Coagulation screen			
G+S			
Blood Glucose			
HbA1c			
LFT			
TFT			
Sickle cell			
PSA			
CRP			
MSU			
MRSA swabs			
ECG			
CXR			
Other XR			
ECHO			
CPX test			
Spirometry			
Other			

10

Post op day 5 Date:

Plan: Discharge home today

Insert initials if achieved, a **X** if unachieved and N/A if not applicable

	am	Pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 8 hourly as deemed appropriate. Actions taken as per EWS chart: document actions required on variance sheet.				50
Deep breathing promoted, patient able to deep breathe and cough.				51
If patient is expectorating, sputum is clear				52
Wound observed – ask doctor to review if any redness, swelling, oozing or skin discolouration **(document as a variance any actions taken)**				54
Ensure apyrexial				55
Fluid Balance				
Fluid balance chart discontinued				56
Ensure venflon has been removed				58
Passing urine without any difficulties				59
Weight recorded ..... Kgs				512
Eating and Drinking				
Normal diet tolerated				513
Oral fluids encouraged (Aim for 2000mls in 24 hours)				514
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1 ☐ 2 ☐ 3 ☐				516
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				517
Flatus passed.				518
Faeces passed.				519
Pain and Nausea				
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and document as a variance				521
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and document as a variance (Nb Ibuprofen for 7 days post op only)				522
Nausea assessed with each set of observations and well controlled. If nausea not well controlled , action taken and document as a variance				524
Mobility and Skin				
Out of bed 8 hours in total				525

Post Op Day 4

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

POA Nurse's comments

Print name & Signature ____________________ Date ____________

11

I have explained the following (√):

	Yes	No	
Fasting instructions	☐	☐	
Short Stay Surgery Unit (SSSU) routine	☐	☐	
Day of Surgery Admission (DOSA) routine	☐	☐	
Day Before Surgery Admission (DBSA) routine	☐	☐	
Plan for current medication – anticoagulants/antihypertensives etc	☐	☐	
Postop analgesia	☐	☐	
Bowel prep	☐	☐	
No shaving operative site	☐	☐	
Need for escort home	☐	☐	
Travelling home by taxi or car	☐	☐	
Telephone available at home	☐	☐	
24 hour supervision at home	☐	☐	
Alternative child care arrangements	☐	☐	
Do not drink alcohol, drive a car, ride a bicycle, operate machinery, sign legal documents for 24 hrs after GA	☐	☐	
All other appropriate information given	☐	☐	
Opportunity for discussion/questions answered	☐	☐	
Surgical procedure patient information given	☐	☐	
'You and your anaesthetic' booklet given	☐	☐	
DOSA patient guide given	☐	☐	

I confirm that I have received the above information.

Signed ______________________________ Patient/Carer

Referred to: Smoking cessation ☐

Dietetics ☐

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 4

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

STOP-Bang Screening Tool for Obstructive Sleep Apnoea

-scored based on Yes/No answers (score: 1 or 0). Thus, the scores range from a value of 0 to 8.

S = Snoring. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
T = Tiredness. Do you often feel tired, fatigued, or sleepy during daytime?
O = Observed apnoea. Has anyone observed you stop breathing during your sleep?
P = pressure. Do you have or are you being treated for high blood pressure?
B = BMI>35kg/m2
A = Age>50 years
N = Neck circumference >40cm (=>size 16)
G = Male gender

Score of 0-2 = unlikely moderate/severe or severe OSA
Score of 5-8 = high probability of moderate and severe OSA

Preoperative nursing assessment

Pre-operative Nursing Assessment

Clinical Background Domain 3		If any issue identified requires further assessment please use domain 3 Summarise baseline information:
Allergies	☐	
Weight	☐	
History of medical condition & diagnosis	☐	
History of falls	☐	
Recent hospitalisation	☐	
Breathing difficulties	☐	

Disease Prevention Domain 4		If any issue identified requires further assessment please use domain 4 Summarise baseline information:
History of BP monitoring	☐	
Nutrition/current diet/swallowing ability/fluids	☐	
Drinking & smoking	☐	

Personal Care & Physical Wellbeing Domain 5

If any issue identified requires further assessment please use domain 5

Summarise baseline information:

Pain	☐
Oral health	☐
Foot care	☐
Nail/skincare including prevention of pressure areas	☐
Mobility in and outside the home	☐
Climbing stairs	☐
Continence	☐
Sleeping patterns	☐

Pressure areas checked. District Nurse arranged if any pressure damage (all categories 1-4)				428
Anti Embolic Stockings removed if for discharge. Check legs, heels and feet are all intact and blanching. District Nurse visit arranged if any pressure damage				429
Hygiene needs met including oral care				430
Discharge				
Complete discharge checklist (page 64)and arrange TTH as appropriate				431
Actual date of discharge entered on clinical workstation				432
Appropriate referrals made to MDT to facilitate discharge				433
Stoma Care				
Independent with stoma care				434
CNS comments				

Post op day 4 **Date:**

Plan: Discharge home today

Insert initials if achieved, a **X** if unachieved and N/A if not applicable

	am	Pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 8 hourly as deemed appropriate. Actions taken as per EWS chart: document actions required on variance sheet				40
Deep breathing promoted, patient able to deep breathe and cough				41
If patient is expectorating, sputum is clear				42
Wound observed – ask doctor to review if any redness, swelling, oozing or skin discolouration **(document as a variance any actions taken)**				44
Ensure apyrexial				45
Fluid Balance				
Fluid balance chart discontinued				46
Ensure venflon has been removed				48
Passing urine without any difficulties				49
Weight recorded ..... Kgs				412
Eating and Drinking				
Normal diet tolerated				413
Oral fluids encouraged (Aim for 2000mls in 24 hours)				414
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1 ☐ 2 ☐ 3 ☐				416
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				4127
Flatus passed				418
Faeces passed				419
Pain and Nausea				
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and document as a variance				421
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and document as a variance (Nb Ibuprofen for 7 days post op only)				422
Nausea assessed with each set of observations and well controlled. If nausea not well controlled , action taken and document as a Variance				424
Mobility and Skin				
Out of bed 8 hours in total				425
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐				426

Activities of Daily Living **If any issue identified requires further assessment please use domain 6**

Domain 6 **Summarise baseline information:**

Washing	☐
Bathing and showering	☐
Grooming and makeup	☐
Dressing and undressing	☐
Accessing & using toilet	☐
Transfer in and out of chair	☐
Transfer from bed	☐
Eating and drinking	☐
...lity to make choices and ...ntrol over environments	☐
Suitable equipment	☐

Senses **If any issue identified requires further assessment please use domain 7**

Domain 7 **Summarise baseline information:**

Sight	☐
Hearing	☐
Speech, communication, language and understanding	☐

...ental Wellbeing **If any issue identified requires further assessment please use domain 8**

Domain 8 **Summarise baseline information:**

Cognition & dementia	☐
Mental Health	☐

Relationships **If any issue identified requires further assessment please use domain 9**

Domain 9 **Summarise baseline information:**

Carers support & strength of caring arrangements	☐
Ability to care for others where necessary	☐

Safety If any issue identified requires further assessment please use domain 10

Domain 10 Summarise baseline information:

Abuse & neglect	☐	
Other aspects of personal safety	☐	
Public safety/hazards	☐	
Manual handling assessment	☐	

Managing in the home If any issue identified requires further assessment please use domain 11

Domain 11 Summarise baseline information:

Meal & Snack preparation	☐	
Make hot drink	☐	
Heavy housework (cleaning and laundry)	☐	
Keeping warm	☐	
Shopping	☐	
Care of the home	☐	

Immediate Environment & Resources domain 12 If any issue identified requires further assessment please use domain 12

Summarise baseline information:

Accommodation	☐	

Post Op Day 3

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 3

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

SOCIAL ASSESSMENT

Patient lives with: Are they fit and well? Yes ☐ No	Are they coping at home at present? Yes ☐ No ☐ Are there stairs / steps in the home? Yes ☐ No ☐
Does the patient care for anyone? Yes ☐ No ☐ If Yes who?	Does the patient have a carer? Yes ☐ No ☐ If Yes who?
Would patient or family like to see a Social Worker Yes ☐ No ☐ If yes, reason:	Is OT assessment required Yes ☐ No ☐
Are patient and family happy with social circumstances and to organise own support on discharge? Yes ☐ No ☐	Does the patient have complex discharge needs? Yes ☐ No ☐ Are there any adaptations / rails in the home? Yes ☐ No ☐
Discharge plans discussed and Family/social support plans for discharge discussed Yes ☐	
Date:	Nurse signature:

If social work referral required / discharge is complex complete Integrated Assessment forms

Colorectal nurse	**Name:**	**Signature:**
Stoma information pack provided Yes ☐ N/A ☐		**Comments:**
Colorectal nurse service and after care explained Yes ☐		
Importance of patient participation in care reinforced Yes ☐		
Stoma bag application – taught and demonstrated Yes ☐		
Sited for Stoma Yes ☐ No ☐ NA ☐		

Commence Drug chart: Prescribe the following, **unless contraindicated for this patient**

Thromboembolism	Complete thromboprophylaxis risk assessment **(insert here)**	yes ☐
	Enoxaparin (Clexane) ▪ dose as per thromboprophylaxis risk assessment ▪ Commence at 1800 if admitted day before surgery (Do not give on morning of surgery)	Yes ☐ N/A ☐
	Anti-embolism stockings (AES)	Yes ☐ N/A ☐
Bowel Preparation Refer to ward protocol for consultant preference	Phosphate enema prescribed	Yes ☐ N/A ☐
	Consultant has requested Picolax bowel prep	Yes ☐
Medications	**Omit any ACE inhibitors or Angiotensin II Receptor blockers on the morning of surgery.**	Yes ☐ N/A ☐
	Aspirin/Clopidogrel - stop 7days before surgery (discuss with anaesthetist)	Yes ☐ N/A ☐
	Continue patients other usual medications (See anaesthetic guidelines on 'Management of Perioperative Medicines')	Yes ☐ N/A ☐
	Warfarin – discuss management with POAC anaesthetist and consultant	Yes ☐ N/A ☐
Aperient	**Lactulose** 15ml bd from post-op day 1 **NB: Not for IRA (ileorectal anastomosis) or ileostomy**	Yes ☐ No ☐
Analgesia	**Paracetamol** 1g qds (IV/oral) from post-op **day 0**	Yes ☐
	Ibuprofen 400mg tds oral from **day 1** **For 7 days post op maximum** (unless contraindicated – see appendix 1)	Yes ☐ N/A ☐
	Tramadol 50-100mgs PRN (if Paracetemol and Ibuprofen not effective)	Yes ☐ N/A ☐
	Oxynorm 5mg PRN 1-2 hourly	Yes ☐ N/A ☐
Anti-emetics	**Cyclizine** 50mg PRN IV/oral	Yes ☐ No ☐
	Ondansetron 4mg prn IV/oral	Yes ☐ No ☐
Antibiotics	**Cefuroxime** 1.5gm IV on induction	Yes ☐ No ☐
	Metronidazole 500mg IV on induction	Yes ☐ No ☐
PPI	**Omeprazole** 20mg oral	Yes ☐ No ☐
Oxygen	**Oxygen** therapy continually post-operation	Yes ☐
Nutrition	**Carbohydrate loading:** Pre-op 4x200ml evening before surgery Pre-op 2x200ml up to 2 hours before surgery ▪ NB: Do **not** give within 4 hours of operation if previous gastric surgery or severe reflux	Yes ☐ N/A ☐
	Ensure plus: TDS post operatively	Yes ☐ N/A ☐

NB: Advice for discharge
Tramadol must be prescribed with caution (maximum 4 doses to be supplied), consider codeine or oramorph instead. Where codeine or oramorph are given, please prescribe lactulose for PRN use
Prescription of oromorph for discharge should be discussed with a senior member of the surgical team (Registrar or Consultant)

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 3

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Date:

WARD VISIT CHECKLIST

Patient has attended POAC for pre-assessment	
If DoSA - Patient advised to attend SSSU at 7.10am	
Nursing assessment completed	
Social assessment complete and post op needs identified	
MRSA screen completed if applicable	
Patients on warfarin – management plan in place	
Patients on aspirin – advised to stop 7 days before surgery unless patient has had previous MI or coronary A stents (in this case Aspirin to be continued)	
Patients on Clopidogrel – advised to stop 7 days before surgery	
Doctor to prescribe medication chart with regular meds	
Doctor to check bloods taken at POAC (valid for 6 months providing no change to medical condition)	
Bowel prep prescribed – please refer to Ward T2 protocol	
Doctor to complete thromboprophylaxis risk assessment and prescribe AES and clexane if appropriate	
Repeat G&S required? If so complete blood form and file in front of notes (ready for admission to SSSU)	
Colorectal nurse specialist seen for stoma teaching and key worker advice	
Research nurse input if required	
ERAS education record	
Understanding of Enhanced Recovery Programme & patient's role	
Fasting instructions given (no food for 6 hours – NBM from 6am)	
Carbohydrate pre-op drinks explained and if DoSA - given and patient told when to take (6 in total)	
Ensure drinks given	
Importance of early mobilisation explained	
Importance of keeping warm before and after theatre explained	
Deep breathing, leg exercises and preventing pressure ulcers	

Date and Time	Admission Notes	Signature and bleep number

Mobility and Skin					
Out of bed 8 hours in total					325
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐					326
Pressure areas checked all blanching with no discolouration / broken areas					328
Anti Embolic Stockings in situ (Legs, feet and heels checked all blanching and no discolouration / broken areas present)					329
Hygiene needs met including oral care					330
Other					
Risk assessment scores re assessed if any change in condition					331
Discharge					
Remind patient of ERAS programme requirements					332
Predicted date of discharge re- assessed and entered on clinical workstation					333
Appropriate referrals made to MDT to facilitate discharge					334
Complete discharge checklist and arrange TTH if appropriate					337
Stoma Care					
Patient has changed stoma bag independently x 2 (even if stoma has not functioned) 1 ☐ 2 ☐					335
CNS comments					

Post op day 3 Date:

Plan: remove catheter (for low anterior resection or APR surgery) and ensure ready for discharge home today or tomorrow

Insert initials if achieved, a **X** if not achieved and N/A if not applicable

	am	pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 8 hourly or as deemed appropriate. Actions taken as per EWS chart: **document actions required on variance sheet.**				30
Deep breathing promoted, patient able to deep breathe and cough.				31
If patient is expectorating, sputum is clear				32
Stop oxygen (if mobile and oxygen saturations > 94% on room air)				33
Wound observed no bleeding noted				34
Ensure apyrexial				35
Fluid Balance				
Fluid balance chart discontinued				36
Remove venflon if it has been in for >72 hours				38
If low anterior resection or APR surgery: catheter removed (ensure epidural removed first)				39
Weight recorded ..... Kgs				312
Eating and Drinking				
Normal diet tolerated				313
Oral fluids encouraged (Aim for 2000mls in 24 hours)				314
IV fluids restarted if not drinking >800ml over 8 hours				315
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1 ☐ 2 ☐ 3 ☐				316
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				317
Flatus passed				318
Faeces passed				319
Pain and Nausea				
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and **document as a variance**				321
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and **document as a variance**				322
Nausea assessed with each set of observations and well controlled. If nausea not well controlled , action taken and **document as a variance**				324

Day of admission. Date:.....

Insert initials if achieved, a **X** if not achieved and N/A if not applicable

Please sign for *either* pm or night

Doctor:	AM/PM	night	Variance Code
Record changes in health status since POA in multidisciplinary notes			DOA1
Record changes in medicines since POA in multidisciplinary notes			DOA2
FBC/U&E/LFT Valid for 6 months provided no change to medical condition Yes ☐ No ☐ If no then repeat on admission Yes ☐ N/A ☐			DOA3
If patient on warfarin INR check Yes ☐ Anaesthetist informed if INR > 1.4 Yes ☐			DOA4
G+S sample sent (2nd G+S sample for electronic blood issue)			DOA5

On admission: Nursing			
Patient fully aware of planned surgery			DOA6
Patient orientated to ward [NB: access to nutritional supplements & dining room]			DOA7
Repeat observations. (T, P, R, BP, SpO_2 + weight)			DOA9
Enoxaparin given before 20:00 hours			DOA10
Patient measured for Anti-embolic stockings and stockings supplied			DOA11
Identity band in place, patient details confirmed			DOA12
Bowel Preparation: Given as per consultant preference			DOA13
Nutrition			
Normal diet and fluids **(Unless undergoing bowel preparation)**			DOA14
Record weight (kg) **Insert weight.....(KG)**			DOA15
Recalculate Malnutrition risk assessment and record changes (WAASP)			DOA16
Carbohydrate loading – 4 x 200ml pre-op evening before surgery 1 ☐ 2 ☐ 3 ☐ 4☐			DOA17
Patient Education – nursing staff to advise patient			
Importance of mobility post op and deep breathing and limb exercises			DOA18
Surgery / treatment plan			DOA19
Importance of post op oral fluids, nutrition and nutritional supplements			DOA20
No food for 6 hours prior to surgery			DOA21
Patient's and relatives' roles in recovery process			DOA22
Discharge arrangements confirmed			DOA23

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 2

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 2

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Day of Operation (day 0); Date:..................

	Yes	Initials
Confirm G+S sample sent (2nd G+S sample for electronic blood issue)		
No food for 6 hours prior to surgery		
Time at which patient can no longer eat:		
Carbohydrate loading (2 x 200ml to finish 2 hours before surgery) 1☐ 2 ☐		
Clear fluids (up to 2 hours pre-op)		
Time at which patient must be NBM:		
Theatre preparation complete		
Theatre check list completed		
Wearing AES (Anti-embolism stockings) if appropriate		
Patient's usual medications given as prescribed (omit ACEI and ARB on DoS)		
Patient's temp maintained above 36 pre op		

Post op: Day 0 (Day of operation)

Insert initials if achieved,
a **X** if not achieved and
N/A if not applicable

Date:

Plan – drink and eat as tolerated, sit in chair, pain well controlled, IV fluids, Oxygen and catheter in situ	**PM**	**Night**	**Variance Code**
Recovery – Oxygen in situ. Sats maintained above 97%.			0R1
Recovery – Patient sat up in bed and offered drink			0R2
RETURN TO WARD			
Breathing and circulation			
Observations and EWS score completed ½ hrly for 2 hrs, 1 hrly for 2 hrs and then 2 hrly. Actions taken as per EWS chart: **document actions on variance sheet**			OO
Deep breathing promoted, patient able to deep breath and cough.			O1
If patient is expectorating, sputum is clear			O2
Oxygen in place and oxygen saturations maintained above 97%			O3
Wound observed when observations recorded - no bleeding noted			O4
If drain in situ, output monitored and recorded on fluid balance chart and drain chart			O5
Fluid balance			
Fluid balance chart completed hourly			O6
Administer IV fluids (1.5L Hartmanns over 24 hrs = 62.5 mls/hr)			O7
Hourly catheter measurements (maintain 0.3 ml/kg/hour averaged over 4 hours) Expected 1hourly output =……………ml/hr			O8
Encourage oral fluids (800ml in total – including high protein drinks)			O9
VIP score completed for all venflons insitu and Score 0			O10
Eating and drinking			
High protein drink tolerated			O11
Normal diet tolerated and intake documented on food chart			O12
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present			O14
Pain and nausea			
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and document as a variance			O16
Single leg raise checked 2 hourly if epidural in place. Patient able to straight leg raise. (If patient not able to straight leg raise, refer to protocol as documented on epidural care plan and document as a variance)			O17
Epidural site checked 8 hourly- no redness, oozing or swelling present. (If redness, oozing or swelling refer to protocol as documented on epidural care plan and document as a variance)			O18

Post Op Day 2

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 2

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Nausea assessed with each set of observations and well controlled. (If nausea not well controlled , action taken and document as a variance)			O19
Mobility and skin			
Patient encouraged to reposition 2 hourly by day / 4 hourly by night			O20
Pressure areas checked all blanching with no discolouration / broken areas			O21
Anti Embolic Stockings in situ (Legs, feet and heels checked all blanching and no discolouration / broken areas present)			O22
Patient out of bed 6 hours **after surgery**, sit in chair for 2 hours: Time of return to ward:....................... Time sat out in chair: .... to			O23
Other			
Waterlow, Pat-e-bac, falls and WAASP risk assessments recalculated post op			O24
Stoma appears well perfused and appliance intact, change only if leaking			O25
Patient observed appliance change			O26

Post Op Day 0

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Pain and Nausea					
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and **document as a variance**					221
Discontinue epidural/PCA. Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled ,action taken and **document as a variance**					222
Nausea assessed with each set of observations and well controlled. If nausea not well controlled , action taken and **document as a variance**					224
Mobility and Skin					
Out of bed 8 hours in total					225
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐					226
Foot exercises whilst in bed / whilst sat out in chair					227
..essure areas checked all blanching with no discolouration / broken areas					228
Anti Embolic Stockings in situ (Legs, feet and heels checked all blanching and no discolouration / broken areas present)					229
Hygiene needs met including oral care					230
Other					
Risk assessment scores re assessed if any change in condition					231
Discharge					
Remind patient of ERAS programme requirements					232
Predicted and/or Actual date of discharge re- assessed and entered on clinical workstation					233
Appropriate referrals made to MDT to facilitate discharge					234
Stoma Care					
.atient has changed and emptied stoma bag twice today with supervision **(even if no output)** 1 ☐ 2 ☐					235
CNS comments					

Post op day 2	**Date:**

Insert initials if achieved, a **x** if unachieved and N/A if not applicable

Plan: Discontinue PCA/Epidural

	am	pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 2 - 4 hourly as deemed appropriate. Actions taken as per EWS chart: **document actions required on variance sheet.**				20
Deep breathing promoted, patient able to deep breathe and cough.				21
If patient is expectorating, sputum is clear				22
Stop oxygen (if mobile and oxygen saturations > 94% on room air)				23
Wound observed no bleeding noted				24
If drain in situ – output monitored and recorded on drain chart and fluid balance chart				25
Fluid Balance				
Fluid balance chart completed hourly				26
Stop IV fluids (keep cannula for PCA/epidural duration). Consider restarting IVI if not drinking >800ml over 8 hours – document on variance sheet if restarted				27
VIP score completed for all venflons insitu and Score 0				28
Catheter removed (unless low anterior resection or APR)				29
Passing urine without difficulties				210
If low anterior resection or APR catheter in situ (monitor hourly urine output via catheter(maintain 0.3 ml/kg/hr averaged over 4 hours)				211
Weight recorded ……………… Kgs				212
If weight gain>3kg request surgical review				212a
Eating and Drinking				
Normal diet				213
Oral fluids encouraged (Aim for 2000mls in 24 hours)				214
IV fluids restarted if not drinking >800ml over 8 hours				215
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1 ☐ 2 ☐ 3 ☐				216
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				217
Flatus passed				218
Faeces passed				219

Post Op Day 0

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post-op: Day 1. Date:.............................

Insert initials if achieved, a **x** if unachieved and N/A if not applicable

Plan – remove IV fluids if drinking, remove urinary catheter (if not low anterior resection or APR surgery) and stop oxygen (if mobile and saturations> 94% on room air)

	am	pm or 12 hr shift	night	Variance Code
Breathing and Circulation				
Observations and EWS score recorded 2 -4 hourly as deemed appropriate. Actions taken as per EWS chart: document actions required on variance sheet.				10
Deep breathing promoted, patient able to deep breathe and cough.				11
If patient is expectorating, sputum is clear				12
Stop oxygen (if mobile and oxygen saturations > 94% on room air)				13
Wound observed no bleeding noted				14
If drain in situ – output monitored and recorded on drain chart and fluid balance chart				15
Fluid Balance				
Fluid balance chart completed hourly				16
Stop IV fluids (keep cannula for PCA/epidural duration). Consider restarting IVI if not drinking >800ml over 8 hours – document on variance sheet if restarted				17
VIP score completed for all venflons in situ and Score 0				18
Catheter removed **(do not remove if low anterior resection or APR or epidural insitu)**				19
Passing urine without difficulty and recorded on fluid chart. (maintain output of 0.3 ml/kg/hr averaged over 4 hours. Expected hourly output ……..)				110
If low anterior resection or APR surgery / epidural in situ monitor urine output 1 hourly via catheter(maintain 0.3 ml/kg/hr averaged over 4 hours)				111
Weight recorded ……………… Kg				112
Eating and Drinking				
Normal diet tolerated and intake recorded on food chart				113
Oral fluids encouraged (Aim for 2000mls in 24 hours)				114
IV fluids restarted if not drinking >800ml over 8 hours				115
Nutritional supplement drinks taken 3 per day **(Tick once taken)** 1☐ 2☐ 3☐				116
Patient checked for signs of gastric dilatation / paralytic ileus – ie: nausea / vomiting, increased pain, pulse >100 and/or abdominal distension – nil present				117

Post Op Day 1

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 1

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Flatus passed.				118
Faeces passed.				119
Pain and Nausea				
Epidural site checked 8 hourly- no redness, oozing or swelling present. If redness, oozing or swelling refer to protocol as documented on epidural care plan and **document as a variance**				121
Pain assessed with each set of observations at rest and deep breathing and pain well controlled. If pain not well controlled, action taken and **document as a variance**				122
Single leg raise checked 2 hourly if epidural in place. Patient able to straight leg raise. If patient not able to straight leg raise, refer to protocol as documented on epidural care plan and **document as a variance**				123
Nausea assessed with each set of observations and well controlled. If nausea not well controlled, action taken and **document as a variance**				124
Mobility and Skin				
Out of bed 8 hours in total				125
Walks (4 total at least 60m each) **(Tick once each walk achieved)** 1 ☐ 2 ☐ 3 ☐ 4 ☐				126
Foot exercises whilst in bed / whilst sat out in chair				127
Pressure areas checked all blanching with no discolouration / broken areas				128
Anti Embolic Stockings in situ (Legs, feet and heels checked all blanching and no discolouration / broken areas present)				129
Hygiene needs met including oral care				130
Discharge				
Remind patient of ERAS programme requirements				131
Predicted date of discharge re- assessed and entered on clinical workstation				132
Appropriate referrals made to MDT to facilitate discharge				133
Stoma Care				
Patient has changed and emptied stoma bag twice today with assistance 1 ☐ 2 ☐				134
CNS comments				

Post Op Day 1

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number

Post Op Day 1

Variances/ Multidisciplinary Notes

Please record all variances or multidisciplinary notes below

Date and Time	Variance code	Details, reason and action taken	Signature and bleep number