

## Care Map

Addressograph

Pre-op visit	Pre-op visit POD 0 POD 1 POD 2 POD 3/4							
Clinic	OR	Inpatient Unit	Inpatient Unit	Inpatient Unit				
□ Information regarding diagnosis, treatment □ Pre-admission package completion incl. consent to surgery & pre. op orders □ Bowel preparation if required □ Length of stay □ Smoking cessation □ Patient education/counseling: "My Surgery Binder", ERAS booklet/ letter, "Going Home After Surgery" guide, PEP (Patient Education Passport) □ Ostomy clinic appointment if required □ Initiate communication/Email: MRN, Patient Initials/ Registration, E-form, OR List, Pre-ad & OR date  Preadmission visit □ Diagnostic Tests: CBC; Electrolytes Creatinine, Blood Glucose, ECG, Chest X-ray & etc. □ Solid food until 12 midnight (Clear fluids day before surgery with bowel preparation) □ High carbohydrate clear fluids up to 2 hr. before surgery □ Pain management (EPCA; PCA; IV Lidocaine; oral medications) □ Daily activities, Gum, Patient controlled diet, My Activity Log	□ POCU-admission assessment preop analgesia □ Gabapentin 300 mg PO 1 h preop □ Celecoxib 400 mg PO 1 h preop □ Other  DVT Prophylaxis: □ Heparin 5000 units sc □ Other □ Antibiotics Prophylaxis □ Follow the ERAS protocol in OR and PACU  Inpatient Unit □ Pain assessment □ Deep breathing and leg exercises for 10-15 min □ Assist to sit at the side of the bed and dangle their legs for 10-15 and start leg exercises □ Ambulate within 2-4 hr. upon arrival to the unit □ Sips of clear fluids □ Assist patient to fill out "My Activity Log"	□ Pain management / APS □ Pain assessment score □ Deep breathing and coughing exercises every hour when patient is awake □ Sit up in a chair for all meals and during other times □ Early assisted ambulation in the room or hallway □ Independently ambulation in the room and /or in the hallway towards the later part of the day □ Patient Controlled Diet (PCD) □ Chew gum 1 stick for 5 minutes TID □ D/C Foley catheter for colon resection unless otherwise indicated □ Remind and assist patient to fill out "My Activity Log"	□ Pain management / APS □ Pain assessment score □ Deep breathing and coughing exercises every hour when patient is awake □ Sit up in a chair for all meals and during other times □ Independently/assisted ambulation in the room and /or in the hallway □ Patient Controlled Diet (PCD) □ Chew gum 1 stick for 5 minutes TID □ Remind and assist patient to fill out "My Activity Log" □ Plan to discharge home tomorrow (except LAR and patients with ostomy)_unless otherwise indicated □ Review the written discharge instructions with nurse navigator □ Provide D/C, scripts summary to patient and GP	□ Pain management / APS □ Pain assessment score □ Deep breathing and coughing exercises every hour when patient is awake □ Sit up in a chair for all meals and during other times □ Independently ambulation in the room and /or in the hallway □ Patient Controlled Diet (PCD) □ Chew gum 1 stick for 5 minutes TID □ Remind and assist patient to fill out "My Activity Log" □ Plan to discharge home LAR patients on 4 <sup>th</sup> day unless otherwise indicated □ Review the written discharge instructions with nurse navigator □ Provide D/C, scripts summary to patient and GP				

## **Ostomy Patient Education Care Guide**

Pre-op visit	POD 0 – post OR on unit	POD 1	POD 2	POD 3	POD 4
☐ ET RN to see all patients (include +/-)	□ Talk to patient about ostomy □ Type □ Involvement in care: family, cultural beliefs □ Expectations of patient involvement □ Have patient look at appliance □ Describe it □ Review characteristics of stoma and function (i.e. Normal expectations: gas, mucus discharge, edema) □ Involve family □ Open discussion with patient regarding ostomy □ Answer patient questions □ Alert ET RN patient is on unit □ Notify Dietician if patient has an ileostomy	□ Review stoma characteristics □ Demonstrate with a clean empty pouch how to open/close & connect appliance □ Patient perform return demo □ RN to assess patient dexterity when performing return demo □ Give patient clean, empty pouch to practice open/close, swivel & connect appliance □ RN perform pouch change □ Talk patient through procedure □ Show patient how to measure stoma (educate re: edema) □ Demonstrate how to release gas □ Educate on proper peri-stoma skin care (no cavilon or babay wipes; shaving if necessary) □ Open discussion with patient regarding ostomy □ Answer patient questions	Review stoma characteristics Review open/close, swivel & connect appliance Have patient perform pouch emptying and rinsing in washroom If gas present have patient demonstrate how to release gas Answer patient & family/caregiver questions If Patient had a rod speak to surgeon re: when rod will be removed and communicate with team	Review stoma characteristics, what to expect when going home  What is normal When and how to seek medical attention  Have patient demonstrate: Pouch change, & connect appliance Emptying and rinsing Release gas ET RN to see for indepth education and troubleshooting RN Navigator to see Ensure patient has supplies to take home Discharge kit provided to patient Answer patient & family/caregiver questions  Day before D/C Alert ET RN of plan to D/C Ensure CCAC forms filled out Alert CCAC	Review stoma characteristics Review when to seek medical attention Answer patient & family/caregiver questions Ensure patient takes supplies with them Provide patient with Stoma Clinic contact information Going home: D/C once seen by CCAC

<sup>\*</sup> Use this pathway for patients who DO NOT have a Rod in place

<sup>\*</sup> Involve patient family/caregiver throughout entire pathway