West Middlesex University Hospital NHS
NHS Trust

Department of Colorectal Surgery

www.westmidcolorectal.org.uk

Enhanced Colorectal Pathway

PATIENT DETAILS			
Name		Ward	
Preferred Name		Consultant	
Hospital Number		Date of Admission	
Date of Birth		Date of Discharge	

Admission / Operation Details:

Guidelines for completing the Pathway

The person providing any element of care must initial or sign for it as specified in the pathway. All members of the multidisciplinary team must complete the accountability sheet. When a non-registered care provider makes an entry, the registered nurse must recognise his or her personal accountability for entries made by students or others under their supervision (NMC, 2008).

The pathway is designed to guide the basic care required for the period of the patients projected stay. It is not prescriptive and is not a substitute for the exercise of clinical judgement at any time. Variations reflect the individuality of each patient and are expected.

Each patient's achievement of specific goal is recorded by initialling the relevant box and no box should be left blank. Failure to achieve any goal or any deviation in management must be recorded as a variance in the space provided. This will allow for a detailed analysis of these deviations both concurrent and retrospective evaluations of care, thus identifying any issues which need to be addressed.

If the patient exceeds the length of stay, the cause of the delay should be documented. The pathway should be completed and an individualised plan of care drawn up to reflect their particular problem.

Expected Length of Stay By Procedure

Procedure	Length of Stay
Laparoscopic Operations	3 - 9 days
Laparotomy (except APER)	5 -10 days
Abdomino-Perineal Excision Rectum	8 -10 days
Reversal of Stoma	3 - 6 days

N.B. If you have any queries with the pathway, please do not hesitate to contact:

Shiela Tana - Senior Sister (Syon 1) Ext. 5781, Blp.298
Louise Newton - Colorectal Nurse Specialist Ext. 5892
Jason Smith - Consultant Colorectal Surgeon, Ext 5972

ACCOUNTABILITY SHEET

Name (Print)	Position	Sample Signature	Initials

RECORD VARIANCES ON TRACKING SHEET

Variation Codes

	Patient Condition		
1	Pyrexia	12	stoma complications
2	Wound infection related	13	High BP
3	Poor apetite	14	Low BP
4	Pain not well controlled	15	Confused
5	Nausea & vomiting	16	Incontinent
6	Chest infection	17	Poor venous access
7	Failed Twoc	18	Blood results (pls. Specify)
8	Poor mobility	19	Patient Non- Compliant
9	Low urine output	20	Low Oxygen saturation
10	Diarrhoea	21	Others
11	Constipation		
	Staff / Persons		
22	Doctor's decision (state changes)	27	Patient decision
23	Nurse decision (state changes)	28	OT decision (state changes)
24	Physio decision (state changes)	29	Tissue Viability Nurse decision
25	Family decision (pls. give explanation)	30	Staff 'other' Please state
26	Family not available		
	Department / System		
31	Pharmacy delay	35	Equipment not available
32	Transport delay	36	Social Services Delay
33	Laboratory delay	37	Community care unavailable
34	X-ray delay	38	TTA's Non- prescribed

PRE-ASSESSMENT FORM

(*To be completed by pre-assessment nurse and checked by doctor*)

Confidential Patient Information

Affix Patient label

Patient telephone Numbers		**Next of Kin**		
Home		Name:		
Work		Address:		
Mobile				
		Tel. Nos:	Home	
			Work	
			Mobile	
Language Spoken		Interpreter required: Yes		No

ADMISSION INFORMATION

TCI Date:		Procedure:	
Consultant Surgeon:		Patient Consented: Yes	No

Is this patient suitable for admission for day surgery? Yes No

If "No" Please state why? _____

If "No" can this patient come in on the of surgery? Yes No

If "No" please stae why not (include how many days in advance surgery, patient needs to come in):

GENERAL INFORMATION

Problem / Risk	***Quantify***	***Action***
GENERAL		
Height		
Weight		
BMI	BMI > 35	Inform anaesthetist
Urine check YES NO		
Protein?	MSU	
WC?	MSU	
Glucose?	BM and blood glucose	Inform anaesthetist if fasting bld. Glucose > 6mmols
(P, BP, SpO2 Please complete in examination section)		
YES NO		
Previous Operations	List any operations and dates	Inform anaesthetist if H/O major cardiac, pulmonary or neurosurgery
Problems with previous anaesthetics/ surgery (self/family) YES NO	Describe:	Inform anaesthetist if H/O serious reaction

Problem / Risk	*Quantify*	*Action*
List medical history chronologically		Inform anaesthetist if H/O serious medical condition ☐
Allergies: Drugs (e.g. penicillin, aspirin) Food (e.g. eggs, shellfish) Others (e.g. iodine, latex, plaster)		Inform anaesthetist if patient latex allergy ☐

Drug history including homeopathic medications

Drug Name	**Dose**	**Frequency**	
Has the patient taken steroids in the last six months YES ☐ NO ☐			Inform anaesthetist if patient is taking: 1. Oral Anticoagulants ☐ 2. Monoamine oxidase inhibitors e.g tranylcypromine, phenelzine isocarboxazid ☐ 3. Clopidrogel ☐

Does patient use:	YES	NO		
Cannabis	☐	☐		Inform anaesthetist ☐
Cocaine	☐	☐		
Ecstacy	☐	☐		
Opiates (heroin, methadone)	☐	☐	Consider Hepatitis B and C antigen if IV drug abuser	
Other illicit substance	☐	☐		

CARDIAC HISTORY

Physician:			Hospital	
	YES	NO		
Chest Pain / Angina Describe Pain Duration Precipitating Factors Relieved by Associated symptoms Frequency and last episode Does chest pain occur at rest	☐	☐	Perform ECG	Inform anaesthetist if H/O poorly controlled angina or chest pain at rest ☐
	YES	NO	MI w/in last 6 mos.	
Heart attack / MI	☐	☐	YES ☐ NO ☐	Inform anaesthetist if:
Cardiac Surgery / CABG	☐	☐	Reconsider date of surgery?	MI w/in last 6 mos. ☐

Angioplasty			Residual angina? YES ☐ NO ☐	Residual angina ☐
Percutaneous Coronary Intervention / Stent insertion			Can patient lie flat? YES ☐ NO ☐	Cardiac Surgery ☐ Unable to lie flat ☐
Heart Failure			Poor exercise tolerance? YES ☐ NO ☐	Poor exercise tolerance < 4 METs ☐
Swollen ankles			Perform ECG / U & E's	
Dates and details			List Previuos investigations	
	YES	NO		
Pacemaker in situ			Document pacemaker details. Ensure pacemaker checked in last 6/12	Refer for pacemaker check if no check in last 6 mos, ☐ Inform anaesthetist ☐
	YES	NO		
Fainting / blackouts Last episode Duration Frequency Precipitating Factors			Perform ECG	Inform Anaesthetist if more than one unexplained episode ☐
	YES	NO		
Palpitations? Last episode Duration Frequency Precipitating Factors Does the patient feel unwell with attack?			Perform ECG	Inform Anaesthetist if patient feels unwell or attack last > 15 minutes ☐
	YES	NO	if BP > 140/90 Repeat BP in 1/2 hour	
History of Hypertension?			1. BP mm/Hg	Refer to GP if still raised after 30 mins. ☐
Hypertensive in clinic (BP > 140/90)			2. BP mm/Hg	
	YES	NO		
Hx of Congenital Heart Disease?			Perform ECG	Order echocardiogram if none done within past year ☐
Rheumatic Fever				
Endocarditis				
Heart Murmur				inform anaesthetist ☐
Describe:				

RESPIRATORY HISTORY

Physician:			Hospital	
	YES	NO		
Asthma?			Previous hospitalisation? YES ☐ NO ☐	Refer to anaesthetist if poorly controlled or recent serious attack ☐
COPD?			ITU admission?	
TB?			YES ☐ NO ☐	

Other Chronic Lung Disease?			Perform PEFR (best of 3)	
Smoker? How much?			Consider Lung Function Test	
	YES	NO		
Can you lie flat?			How many pillows do you use?	Refer to anaesthetist if poor exercise tolerance <200 yards on flat, <1 flight of stairs (4 mets)
SOBOE?			Assess exercise tolerance (see below)	
Snoring / OSA				Consider referral to respiratory physician (at WMUH or previous) for treatment
Productive cough			Consider Lung Function Test	
	YES	NO		
Complex throat surgery?			Consider TFTs	Refer all patients to anaesthetist
Laryngectomy?			Perform CXR if none done w/in 6 mos.	
Radiotherapy to head or neck? Specify:				
Swallowing difficulties				
EXERCISE TOLERANCE (all patients)				
How far can the patient walk on the flat?			See cardiac and respiratory sections *If patient has limited exercise tolerance perform:* ECG Consider Lung Function Test	Refer to anaesthetist if poor exercise tolerance <200 yards on flat, <1 flight of stairs (4 mets)
	YES	NO		
Is patient able to climb a flight of stairs				
Limited by:				
Pain?				
Shortness of breath				
Others? (Specify)				
C N S				
Physician:			Hospital	
	YES	NO		
Fits / seizures?				Refer if poorly controlled
Last episode Frequency				
Confusion?				
Precipitating Factors				
History of falls?				
Treatment				
	YES	NO		
Stroke			Was event less than 6 mos. Ago?	Refer if event w/in 6 months
or Transient Ischemic Attack			YES NO	
Brain Haemmorrhage			Reconsider date of surgery	
Is patient at risk from Haemaglobinopathy? (e.g. sickle cell anaemia)	YES	NO	Consider Hb electro-phoresis (unless hosp. test result available)	Refer all haemaglobinopathy dse. patient to anaesthetist
			Disease YES NO	
Haemaglobinopathy?			Trait YES NO	

	YES	NO		
Clotting disorders			Describe:	Refer all cases of clotting disorder to anaesthetist
Bruising/excessive bleeding				
H/O of Family history of DVT			Is patient taking anticoagulants? YES NO	Inform anaesthetist if patient is taking anticoagulants
When?				
Precipitants?			Consider clotting	
Taking OCP				

	YES	NO		
History of Hodgkins disease			Patient will require immediate blood products	Inform anaesthetist if H/O mediastinal Hodgkin's disease
History of airway problems				
Detail				

OTHER DISORDERS

Physician:			Hospital	
	YES	NO		
Diabetes?			U & E	Refer to anaesthetist if abnormal blood results
When diagnosed			Glucose	
Controlled by			Hb A1C	
Diet			ECG	
Tablets				Patient ideally first on the list
Insulin				
	YES	NO		
Kidney disease?			FBC	Refer to anaesthetist if abnormal blood results
Describe:			U & E	
	YES	NO		
Liver disease?			FBC	Refer to anaesthetist if abnormal blood results
Describe:			U & E	
			LFT's	
			Clotting	
	YES	NO		
Jaundice?			identify cause (eg gall stones/hepatitis). if unknown consider Hepatitis B & C antigen test	Inform anaesthetist if Hepatitis B and C positive
Cause?				
				end of list Hep B & C
	YES	NO		
H/O peptic ulceration (gastric or duodenal ulcer)				Inform anaesthetist if H/O splenectomy
H/O heart burn				
H/O acid regurgitation into mouth				
Urinary problems				
Bowel problems				
Stoma Type:				
Splenectomy Details:				

	YES	NO		
Possible Pregnancy?			Perform pregnancy test	Inform anaesthetist if pregnant
Date of LMP/week gestation			if risk of pregnancy unclear	or breastfeeding
Breast Feeding			Reconsider date of surgery	
Diseases severely limiting:	YES	NO		
Neck movements			Assess neck extension	Inform anaesthetist if poor
			Consider cervical	neck extension
Rheumatoid arthritis			spine X-ray	
			(lateral flex./ext. views)	
Other:(State)				
			Assess mouth opening	Inform anaesthetist if poor
			YES NO	mouth opening <6cm
	YES	NO		
Mental Health Problems?			inform theatres & ward	Inform anaesthetist
Details:				
	YES	NO		
Known infections?			Describe site:	
(MRSA / VRE / ESBL etc.)			Send full screen and inform admissions, theatre, ward	
	YES	NO		
Chemotherapy / DXT?				Inform anaesthetist if to head
Details:				and neck

PERSONAL CARE AND SPIRITUAL NEEDS

	YES	NO		
Needs help to wash and dress				Wound Assessment
Able to use bath/shower				YES NO
Any adaptation				
Type _____				Waterlow Assessment
Is any help required _____				YES NO
Skin intact				
Wound present				Pressure Ulcer Grading
Type _____				1 2 3 4

Religion				
Special beliefs				
Practising		YES	NO	
Cultural issues: e.g. dress, food				
Expression of wishes/anxieties re diagnosis		YES	NO	
Any concerns regarding appearance due to condition		YES	NO	
Any special requirements		YES	NO	
Tell patient possibility of mixed bays		YES	NO	N/A

EXAMINATION

(to be performed by a doctor or nurse trained in patient examination)

NB: Any abnormality to be confirmed by a doctor

CVS

Pulse rate _____ beats/min regular / irregular

Heart Sounds _____

Murmur?

BP _____ mmHg

JVP _____

Ankle Oedema _____

RESP

Resp rate _____ breaths/min

SpO2 (air) %

Expansion

Percussion

Breath sounds

Added sounds?

SUMMARY

Investigation

FBC		U & E's		ECG		MRSA screen	
Clotting		LFT's		Echo		MSU	
G & S		TFT		CXR			
Crossmatch		HbA1c		C-spine Xray		Notes from other	
No. of Units		Glucose		ABG		hospital	
Hb elect		Other		Lung Function			
		specify:		PEFR		Pregnancy Test	
				Result:			

Fitness for Anaesthesia / Surgery

Does patient require anaesthetic assessment?	YES	NO
Is patient fit for anaesthesia and surgery	YES	NO
If NO, does booked surgical date need to be postponed	YES	NO
If NO, action required:		

Form completed by: (nurse or doctor)

Signature:	Date:
Print Name:	Time:
Designation:	Contact:

Form checked and confirmed by: (doctor only)

Signature:	Date:
Print Name:	Time:
Designation:	Contact:

Anaesthetic Reassessment: (if applicable)

Surgical History and Examination (free text or separate proforma)

Name	Hospital Number

Pre-operative - Day before surgery **Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Assessment	Patient reviewed by a surgical doctor				
	Nursing Assessment sheet completed				
	Waterlow score documented				
	MUST Tool completed				
	Identity band / Allergy band				
Investigations	Check bloods taken in pre-assessment				
	Group & save				
	Urinalysis				
	Check X-ray & ECG are available				
Observations	4hrly TPR/BP/O2 sats /LOC/				
	Document EWS & refer accordingly				
	Assess and monitor pain using 0-3 Pain Score				
	Analgesia given as prescribed				
	if diabetic record BM & treat per protocol				
Treatment & Procedures	Check patient is fully aware of planned surgery				
	Check consent form is signed				
	IV Cannula inserted **Y / N** Date: Time:				
	Check IV site & record phlebitis score				
Diet & Nutrition	Patient aware of free fluids only / encourage high energy drinks				
	Advise when to fast as per anaesthetic guidelines				
Elimination	Bowel preparation Required **Y / N** Given **Y / N**				
	Discuss urinary catheter				
Mobility / Activity	Discuss post-op mobilisation, breathing				
	& coughing exercises (physio. Info leaflet given)				
	Nurses/HCA to measure for anti-embolic stockings				
Medication	Drug chart prescribed				
	Patient's own medication stored appropriately				
Patient Education and Support	Patient orientated to the ward				
	Ensure call bell to hand				
	Discuss concerns and issues with pt & relative				
Discharge Planning	Expected date of discharge discussed				
	Social situation assessed				
	Refer to Dicharge Coordinator if appropriate				

Name	Hospital Number

Pre-operative - Day of surgery **Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Assessment	Patient reviewed by a surgical doctor (if not yet done)				
	Nursing Assessment sheet completed (if not yet done)				
	Waterlow score documented (if not yet done)				
	MUST Tool completed (if not yet done)				
Treatment & Procedures	Check medical notes are completed and relevant results present / X-ray / ECG				
	Complete theatre checklist				
	Check consent form is signed if not yet done				
	Check patient is seen by anaesthetist				
	Post-operative pain relief explained				
	Anti-emetic for post-operative nausea explained				
	IV Cannula inserted **Y / N** Date: Time:				
	Check IV site & record phlebitis score				
Diet & Nutrition	No food 6 hrs pre-op, allowed Clear fluids up to 2 hrs pre-op				
Elimination	Give phosphate enema at 06.00 if prescribed				
Hygiene	Encourage pre-op bath or shower				
Medication	Give prescribed medication				
	Stop Tinzaparin prior to surgery				

Name	Hospital Number

Post-operative - Day of surgery **Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	TPR/BP/O2 sats /LOC documented at half hourly intervals x 4 hrs, hourly x 4hours until stable then 4 hrly				
	Oxygen therapy required _____ %				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Pain & Nausea Assessment	Type of Analgesia **Epidural** or **PCA** (pls. circle) **(Follow protocol x monitoring)**				
	Oral analgesia given as prescribed				
	Assess and monitor pain using 0-3 Pain Score				
	Give anti-emetics if pt. feeling nauseous				
Wound / Drains	Assess wound dressing. Leave dressing intact				
	Check drain amount, color & patency				
	Record drain output on the fluid chart every 6 hrly				
Diet & Nutrition	Free fluids as tolerated on evening of surgery				
	IV Fluids regime as prescribed.				
	Ensure 6 hrly Fluid balance chart documented.				
	Record oral intake, IV antibiotic ,IV infusion given				
	Check IV site & record phlebitis score				
Elimination	Monitor & record Hourly urine measurements. **Inform doctors if UO < 0.5ml/kg/hr**				
	Patient with stoma: Check stoma pink & healthy				
	Type of stoma: ileostomy / colostomy (pls. circle)				
	Refer to stoma care nurse				
Mobility / Activity	Encouage breathing & supported coughing exercise				
	Physiotherapy referral completed x laparotomy				
	Ensure anti-embolic stockings worn				
Hygiene	Post - op wash and/or mouth care given				
Patient Education & Support	Patient and visitors reassured				
	Ensure call bell to hand				

Name	Hospital Number

1st day Post-operatively **Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	4 hourly TPR/BP/O2 sats /LOC				
	Oxygen therapy required _____ %				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Pain & Nausea Assessment	Continue on **Epidural** or **PCA** (pls. circle)				
	Seen by the Acute Pain Nurse Specialist				
	Oral analgesia given as prescribed				
	Assess and monitor pain using 0-3 Pain Score				
	Give anti-emetics if pt. feeling nauseous				
Wound / Drains	Assess wound dressing. Leave dressing intact				
	Check drain amount, color & patency				
	Record drain output on the fluid chart every 6 hrly				
Diet & Nutrition	Encourage Free fluids as tolerated				
	May have light diet supper time if tolerated				
	Give High Protein drinks in between meals				
	IV Fluids continue as prescribed.				
	Ensure 6 hrly Fluid balance chart documented.				
	Record oral intake, IV antibiotic ,IV infusion given				
	Check IV site & record phlebitis score				
Elimination	Monitor & record Hourly urine measurements. **Inform doctors if UO < 0.5 ml/kg/hr**				
	Patient with stoma: Check stoma pink & healthy				
	Type of stoma: ileostomy / colostomy (pls. circle)				
	Flatus passed **Y N** Bowels opened **Y N**				
	Seen by stoma care nurse specialist				
	Stoma care plan commenced				
Mobility / Activity	Encoruage breathing & coughing exercise as per leaflet				
	Seen by physiotherapist x early mobility if appropriate				
	Nurses:Ensure patient sits out of bed aiming 2-3 x a day (No more than 20 minutes at a time x AP resections)				
	Nurse patients on their side when in bed				
	Ensure anti-embolic stockings worn / remove and re-apply / heal checks				
	Monitor pressure areas				
Anti-thrombus	Give tinzaparrin as prescribed				
Hygiene	Assisted wash and mouth care given				
Discharge Planning	Remind patient of expectations to ensure discharge on planned date. Discuss issues and concerns.				
	Speak to relatives about discharge plans				
	Ensure Discharge Coordinator review patient situation				
Patient Education & Support	Seen by the Colorectal Nurse Specialist				
	Ensure rest and sleep				
	Ensure call bell to hand				

Name	Hospital Number
2nd day Post-operatively	**Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	4 hourly TPR/BP/O2 sats /LOC				
	Oxygen therapy required _____ % **Y** **N**				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Pain & Nausea Assessment	Continue on Epidural or PCA (pls. circle)				
	Seen by the Acute Pain Nurse Specialist				
	Oral analgesia given as prescribed				
	Assess and monitor pain using 0-3 Pain Score				
	Give anti-emetics if pt. feeling nauseous				
Wound / Drains	Assess wound dressing. Leave dressing intact				
	Check drain amount, color & patency				
	Aim to remove drain if output < 50 mls x 24 hours				
Diet & Nutrition	Encourage Free fluids as tolerated				
	May have light diet supper time if tolerated				
	Give High Protein drinks in between meals				
	IV Fluids continue as prescribed.				
	Ensure 6 hrly Fluid balance chart documented.				
	Record oral intake, IV antibiotic ,IV infusion given				
	Check IV duration **24 48 72** & record phlebitis score				
Elimination	Monitor & record urine output 4 hourly then FD if stabl **Inform doctors if UO < 0.5 ml/kg/hr**				
	Patient with stoma: Check stoma pink & healthy				
	Type of stoma: ileostomy / colostomy (pls. circle)				
	Flatus passed **Y** **N** Bowels opened **Y** **N**				
	Continue stoma care plan, educate patient				
Mobility / Activity	Seen and reviewed by physio				
	Encourage deep breathing & coughing exercise				
	Patient walking and/ or sitting out of bed x at least 2 x a day for at least 4 hours				
	Nurse patients on their side when in bed				
	Ensure anti-embolic stockings worn / remove and re-apply / heal checks				
	Monitor pressure areas				
Anti- thrombus	Give tinzaparrin as prescribed				
Hygiene	Assisted wash and mouth care given if required				
Discharge Planning	Remind patient of expectations to ensure discharge on planned date. Discuss issues and concerns.				
	Refer to OT if appropriate				
Patient Education & Support	Ensure rest and sleep				
	Ensure call bell to hand				
	Give night sedation if required				

Name	Hospital Number

3rd day Post-operatively

Date: **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	4 hourly TPR/BP/O2 sats /LOC				
	Oxygen therapy required _____ % **Y** **N**				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Pain & Nausea Assessment	Aim to discontinue Epidural or PCA removed per protocol				
	Seen by the Acute Pain Nurse Specialist				
	Oral analgesia given as prescribed				
	Assess and monitor pain : mild, moderate, severe				
	Give anti-emetics if pt. feeling nauseous				
Wound / Drains	Assess wound dressing. Leave dressing intact				
	Check drain amount, color & patency				
	Aim to remove drain if output < 50 mls x 24 hours if in situ				
Diet & Nutrition	Encourage Free fluids/ high protein drinks				
	May have normal diet				
	Refer to dietician if required- start food chart				
	IV Fluids discontinue if tolerating fluids				
	Ensure 6 hrly Fluid balance chart documented.				
	Record oral intake, IV antibiotic ,IV infusion given				
	Check IV duration **24** **48** **72** & record phlebitis score				
	Remove cannula if more than 72 hours or 3 days in situ Resite only if needed. Ensure epidural out first				
Elimination	Aim to remove catheter once patient is mobile. **ensure epidural discontinue first**				
	Monitor voiding & record on fluid balance chart				
	Patient with stoma: Check stoma pink & healthy				
	Type of stoma: ileostomy / colostomy (pls. circle)				
	Flatus passed **Y** **N** Bowels opened **Y** **N**				
	Continue stoma care plan, educate patient				
Mobility / Activity	Seen and reviewed by physio				
	Encourage deep breathing & coughing exercise				
	Patient walking and/ or sitting out of bed x at least 3 x a day for at least 4 hours				
	Nurse patients on their side when in bed				
	Ensure anti-embolic stockings worn / remove and re-apply / heal checks				
	Monitor pressure areas				
Anti- thrombus	Give tinzaparrin as prescribed				
Hygiene	Encourage personal hygiene, assisted wash if required				
Discharge Planning	Update patient and relative about discharge plans. Discuss issues and concerns.				
	Update Social Care Package/Needs if appropriate				
	Refer to OT if appropriate if not done previously				
	TTA's prescribed yet? ***Act now*** 				
Patient Education & Support	Ensure rest and sleep				
	Ensure call bell to hand				

Name	Hospital Number

4th day Post-operatively

Date: **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	6 hourly TPR/BP/O2 sats /LOC				
	Oxygen therapy required _____ % **Y** **N**				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Assessment	Continue with oral analgesia given as prescribed				
	Assess and monitor pain : mild, moderate, severe				
	Give anti-emetics if pt. feeling nauseous				
Wound / Drains	Assess wound dressing. Leave dressing intact				
	Aim to remove drain if output < 50 ml x 24 hours if in sit				
Diet & Nutrition	Encourage high protein drinks in between meals				
	Normal diet - monitor food intake & record				
	Check IV duration **24 48 72** & record phlebitis score				
	Resite cannula if more than 72 hours or 3 days if still needed or remove cannula if not needed.				
Elimination	Passing urine freely? **Y** **N**				
	C/o catheter if still in situ. Maintain fluid balance chart				
	If with stoma: Continue Stoma care education				
	Flatus passed **Y** **N** Bowels opened **Y** **N**				
	Seen and reviewed by stoma care nurse prior to discharge				
Mobility / Activity	Encouraged to mobilise around the ward.				
	Consider stair practice.				
	To sit out of bed 3x a day				
	Ensure anti-embolic stockings worn / remove and re-apply / heal checks				
	Monitor pressure areas				
Anti-thrombus	Give tinzaparrin as prescribed				
Hygiene	Encourage personal hygiene, assisted wash if required				
Discharge Planning	Are relatives clear about discharge plans?				
	Target date of Discharge:				
	Social Care Package in place/check with Discharge C.				
	TTA's amended and sent to pharmacy				
	Transport organised				
Patient Education & Support	Seen by Colorectal Nurse Specialist				
	Ensure rest and sleep				
	Ensure call bell to hand				
	Give night sedation if required				

Name	Hospital Number

5th day Post-operatively **Date:** **Ward:**

initial your updated assessment

Criteria	Activity	AM	PM	Night	VC
Observations	6 hourly TPR/BP/O2 sats /LOC				
	Oxygen therapy required _____ % **Y** **N**				
	Document EWS & refer accordingly				
	if diabetic record BM & treat per protocol				
Assessment	Continue with oral analgesia given as prescribed				
	Assess and monitor pain : mild, moderate, severe				
	Give anti-emetics if pt. feeling nauseous				
Wound	Review wound site and renew dressing				
Diet & Nutrition	Encourage high protein drinks in between meals				
	Normal diet				
	Ensure IV cannula removed				
Elimination	Passing urine freely? **Y** **N**				
	C/o catheter if still in situ. Maintain fluid balance chart				
	If with stoma: Continue Stoma care education				
	Ensure stoma care kit supply adequate				
	Flatus passed Y N Bowels opened Y N				
Mobility / Activity	Encouraged to mobilise around the ward.				
	To sit out of bed 3 x / day				
	Ensure anti-embolic stockings being worn				
Anti-thrombus	Give tinzaparrin as prescribed				
Hygiene	Encourage personal hygiene, assisted wash if required				
Discharge Planning	TTA's ready				
	If fit for discharge today, complete discharge checklist				
	If not, review social needs, assess if medihome can support				
	If home with catheter, refer to District Nurse				
	Are relatives clear about discharge plans?				
	Information booklet given to patient				
	Transport organised				
	Advise patient about removal of clips - fax sent to Lampton Day Unit				

Nursing Evaluation Sheet

Variance Tracking Record

Variance Code	State Reason and Action Taken	Signature

Multidisciplinary Sheet