Clinical Pathway Elective Laparoscopic Cholecystectomy

SURNAME: ______________________ NHI: ______________
FIRST NAMES: ____
DATE OF BIRTH: ______/______/______ SEX: ______________
Please attach patient label here

☐ Elective

☐ Lap Cholecystectomy booked

Date Pre-admission: ____________ Date of Admission: ____________ Date of Surgery: ____________

INDICATIONS:

☐ Biliary Colic ☐ Cholecystitis ☐ Jaundice/Choledocholithiasis

☐ Cholangitis ☐ Biliary Pancreatitis ☐ Gallbladder polyp

Other:

____

____

PREADMISSION CHECK

Date:

BASELINE OBSERVATIONS	
Temp:	FBC:
Pulse:	U & Es:
B/P:	LFT'S:
RR:	INR:
O_2 Saturations = % on air	G & H:
WT:	ECG (if Cardiac Hx or over 45)
	CXR

Previous MRSA? /lives in R/H, P/H (take MRSA swabs):

Interpreter required: ☐ No ☐ Yes. Language: ______________ Booked (date / time): ______________

RACS information sheet given: ☐ No ☐ Yes

Medication: see Admission to Discharge Planner (CR2047)

- If no Warfarin, Clopidogrel, Aspirin etc, instructions given
  Last day for above medication (name and date):
  Replacement medication plan:
- If no diabetic meds instructions given, check for other antiplatelet preparations e.g. Arnica, Garlic, Ginko

Allergies: ____

☐ H/S assessment done (refer Admission to Discharge Planner - CR2047) Sign: ____________

☐ Consent form signed Sign: ____________

☐ Anaesthetic consent signed Sign: ____________

☐ Nursing assessment in Admission to Discharge Planner complete

☐ Information given re discharge time (i.e. 11:00 am day after surgery)

☐ Transition lounge explained

Name: __________________ Signature: ________________ Date: ________________

ORDA (Operating Room Day of Admission)

Date: ______________________________ Time: ______________________________

PREPARATION

☐ Pre-op checklist complete ☐ Clexane given / charted

☐ Usual morning meds taken ☐ Diabetic meds withheld

☐ If no Aspirin / Warfarin, last taken at: ☐ Clothes in bag

☐ Valuables signed off ☐ OR notified

AVAILABLE

☐ USS report ☐ ERCP report

ORDA nurse's name: ________________________ Signed: ______________________________

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OPERATION NOTE

Date: ______________________ Time: ______________________

Surgeon: ______________________ Assistant: ______________________

Findings: ____

Anaesthetist: ____

Procedure: ____

Name: ______________________ Signature: ______________________

ON WARDING *(tick or circle as appropriate)*

Date: ______________________ Time: ______________________

☐ Call bell within reach ☐ Patient orientated to ward

☐ Patient orientation folder ☐ Paracetamol given

☐ ½ hourly vital signs commenced and within normal limits *(record on observation chart)*

Pain Score:	1 2 3	4 5	6 7	8 9 10
Wound bleeding:	☐ Nil	☐ Minimum	☐ Moderate	☐ Heavy
Nausea:	☐ Nil	☐ Minimum	☐ Moderate	☐ Severe
Drain Amount:	☐ Nil	☐ Minimum	☐ Moderate	☐ Large
Type:	☐ Haem	☐ Serous	☐ Bile (report any bile to team)	
Site:	☐ Not leaking	☐ Stitch intact	☐ Dressing intact	
Tubing:	☐ Not kinked	☐ Securely attached, taped to body 8-10cm from site		

Name of receiving nurse: ______________ Signature: ____________ Time: ________

Notes *(Post-op problems should be commented on below)* : ______________________________________

Name: ______________________ Signature: ______________________

DAY OF SURGERY

Date: ______________________

OBSERVATIONS:	AM	PM	NIGHT
T / P / RR/ BP (TDS of stable) satis	☐	☐	☐
Pain controlled with analgesia	☐	☐	☐
Wound satis	☐	☐	☐
Redivac: min. drainage (report bile to team)	☐	☐	☐

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MEDICATIONS:	AM	PM	NIGHT
Nausea / Vomiting controlled by antiemetics	☐	☐	☐
Routine meds given	☐	☐	☐
ACTIVITIES:			
Mobilised around room	☐	☐	☐
FOF – LIFE as tolerated	☐	☐	☐
IVF disc. If tolerating FOF	☐	☐	☐
O2 disc if saturations normal	☐	☐	☐

Nurse's Name: ______________________ Signature: ______________________

Notes: ____

____

____

Name: ______________________ Signature: ______________________

DAY ONE (1st Post – op day)

Date:

OBSERVATIONS:	AM	PM	NIGHT
T / P / RR/ BP (TDS of stable) satis	☐	☐	☐
Pain controlled with Paracetamol, NSAIDS	☐	☐	☐
Pain controlled with Opiods	☐	☐	☐
Wound is dry (use post – op opsite)	☐	☐	☐
Time drain removed (on Drs instructions):			
MEDICATIONS:			
Nausea / Vomiting controlled by antiemetics	☐	☐	☐
Routine medications given	☐	☐	☐
ACTIVITIES:			
Mobilise	☐	☐	☐
Shower	☐	☐	☐
TEDS removed (if mobilising well)	☐	☐	☐
Lite diet tolerated	☐	☐	☐
Time IVL removed:			
Patient informed of 11:00 discharge time	☐	☐	☐

Time O2 discontinued (if saturations normal): ______________________

Nurse's Name: ______________________ Signature: ______________________

Drs Rounds: ☐ Operation explained

Notes: ____

____

____

Name: ______________________ Signature: ______________________

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VARIANCE RECORD

Variance from clinical pathway? ☐ Yes ☐ NO

CRITERIA FOR VARIANCE

1. ☐ Length of stay > 2 days
Reason:

2. ☐ Operation variance ☐ Open procedure

   ☐ Bile duct exploration

3. ☐ Process issues ☐ Incomplete documentation

   ☐ Cancellation ☐ Incomplete preparation of patient

4. ☐ Other (state): ____

____

____

When documenting variance please state:

☐ Variance as number (if variance includes 1. put reason in brackets e.g. 1 (pain)

☐ Reason for variance

☐ Date and time that variance occurred

☐ What action has been taken

☐ Sign and date entry

NOTES: ____

____

____

____

Name: ____________________ Signature: _________________ Date: ____________________

Discharge Checklist:

☐ Wound Satis (opsite dressings) ☐ Tolerating Diet

☐ Instructions re GP follow – up given (wound check 7-10 days)

☐ Instructions on when to return to work ☐ Work CERT

☐ Instructions given on driving ☐ Transition Lounge transfer arranged

☐ Lab form for follow–up tests in community if required ☐ Prescription given

☐ Discharge Summary given ☐ Discharge Destination: ____________________

☐ Transfer letter (if applicable e.g. RH, PH) ☐ Transport organised

☐ Valuables returned ☐ Medications returned

☐ Signed by nurse discharging patient: ________________________ Date: ____________________

Please ensure variance documentation done

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Guidelines for Health Professionals

Clinical pathways (CPs) are designed to optimise, and standardise patient care. They serve as a guide for patient care only. It must be stressed that clinical judgement is still paramount and any abnormal findings should be discussed with medical team.

When do you put a patient on this pathway?
All adult patients who scheduled for elective laparoscopic cholecystectomy are suitable for ORDA process of admission. If any co-morbidities exist please ask surgeon if pathway is appropriate.

What happens if surgery was postponed?
Just continue the existing pathway from time of postponement but change the dates. If the ORDA day page is already filled in, use another ORDA page in it's place. Variance related to cancellation of the procedure should be filled out on the variance page.

When should the patient come off the pathway?
When a patient experiences any of the variances itemised on the back page. At this point, care is managed as before with a care plan and documentation put into clinical notes.
On the day of discharge, patient should be put back on the pathway to ensure all discharge outcomes are achieved.

What's different about documentation in a pathway?
The pathway has been designed to minimise the need for and reduce duplication of documentation. Tick boxes are provided to note that expected outcomes are reached. Comments such as afebrile or tolerating diet are not required. It **is** important however that you sign and date the care you complete (**NB** AM, PM, NIGHT shift columns). The pathway is still the legal document that records your care and therefore your accountability.
If there are no problems doctors should write "progress as per pathway" in NOTES section.
Every entry should be signed and dated.

What is a variance?
Any outcome that should happen, but doesn't **OR** unexpectedly happens that shouldn't. This can be anything from bile duct injury to patient not being prepared for OR adequately

How should variance be documented?
Variance should be documented in the NOTES section of the pathway and on the variance page. Responsibility for documentation of white areas in pathway lies with nursing staff. Shaded areas are for doctors. It is important that if variance occurs, a plan of action is decided upon, acted on, events documented, and medical team notified

Does the pathway replace care plans?
If the patient has NO variance-yes. However all variance must be managed using a plan of care. If this occurs write "see care plan" next to documentation about variance so the rest of the team knows to refer to it.
Clinical Pathways are guidelines to care only. Clinical judgement should always be used to assess and manage your patient safely.