

OBSTETRIC FISTULA POST-OP CLINICAL PATHWAY

Affix ID label -**OR-** Name, ID#, Age, & Sex

Surgery: VVF UVVF RVF

Date:	Pre-op: Admission	Pre-Op: Day of Surgery	Post-Op: Day of Surgery
	Eve Shift Nurse:	Night Shift Nurse:	Day Shift Nurse:
Day-month-year		Day Shift Nurse:	Evening Shift Nurse:
Patient and Family Teaching	 Explain surgery Type of Anesthesia (if spinal, they will be awake) How to use bathroom Catheter care Chance surgery won't be successful 	 Tell patient number on OR list: Explain surgical procedure and what to expect post-op (monitoring, IV, bedrest, catheter care, vag pack, etc.) Teach patient how to report post-op pain using pain scale 	 Encourage patient to report pain or nausea after surgery Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Avoid straining while having a bowel movement Maintain adequate fluid intake to ensure urine clear and without clots
Nursing Assessment	Bowel movement post-suppository No bowel movement- Fleet's enema done before 2200	 Document pre-op vital signs at 0600 Pre-op nursing assessment IV cannula patent 	Post-Op Monitoring Protocol: VS/OBS upon arrival, then every 30min X4, every 60min X4, every 4 hr X 48 hr Use pulse oximeter for SaO₂ upon arrival until stable Temp on arrival then every 2 hour until stable Assess for pain and nausea with vital signs Post-op nursing assessment upon arrival then every shift Spinal Anaesthetics Record with VS/OBS N/A Strict fluid intake/output every hour for first 12 hours assess from patient to catheter bag to ensure catheter secured well, draining well, not kinked, no visible clots present and pad dry Dry Intermittently Wet Constantly Wet "Verteral Stents Right Left Urine colour at 2000 Yellow Pink/blood tinged Tea Colored Bloody Clots present
Nursing Care	 Chlorhexidine shower Nothing per rectum after 2400 Place IV cannula Provide adult diaper Complete pre-op checklist 	 Complete Pre-op Checklist on OR Record Standard soap shower in AM before surgery 1st case to OR (no 30 min call) in AM, On Call other cases. Chlorhexidine scrub to perineum (wash off) New diaper –may leave on 	 Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact on-call fistula surgeon Stents not draining, flushed per post-op order Vaginal packing until POD Vaginal bleeding, notified Charge Nurse/TL Orders:
IV and Medications	 Glycerin suppository <u>before</u> 1800 Fleet enema if no BM by 2200 RVF: per MD orders 	 Ensure pre-op medications transcribed onto PRN Medication Sheet As per orders (1st to OR or on call) Give pre-med N/A Flush IV cannula Give 500 ml RL or NS bolus, once bolus complete continue fluids TKO 	 □ Give scheduled pain meds □ Vitamin C daily or BID scheduled Intravenous □ Visual Infusion Phlebitis Score
Activity and Safety			 Bedrest Bathroom Privileges Assist with turning. Be careful to keep catheter &/or stents from pulling
Nutrition and Fluid Balance	 Encourage fluid intake RVF: per MD orders Give 1.5L water bottle 	 Check NPO/Fasting orders from Anesthesia Fast from solids at Fast from liquids at Signs at bedside visible with fasting orders and patient/caregiver aware Have pt drink a cup of water immediately before NPO of clears 	 Clear Liquids Full Liquids Regular Advance diet as tolerated 2000 Fill water bottle to 500 ml, may fill to 1000 ml if urine bloody or clots present 2000 Total intake and output
Nursing Notes			

Surgery: UVF UVF UVF

Date:	POD# 1 Night Shift	POD# 1 Day Shift	POD# 1 Eve Shift
Deveration	Nurse_	Nurse	Nurse
Day-month-year Patient and Family Feaching		 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots 	 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots
Nursing Assessment	 Dry Intermittent Wet Constant Wet Vital signs per routine post-op, then Q 4 hours Physical Assessment Spinal Record with VS/OBS N/A Hourly urine output Urine color Vaginal Bleeding or discharge 	□ Dry □ Intermittently Wet □ Constantly Wet □ Vital signs Q 4 hours □ Physical assessment Q shift □ Spinal Anaesthetics Record with VS/OBS □ N/A □ Strict fluid intake/output every 2 hours x 4 □ assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry □ Ureteral Stents secure □ Right □ Left □Bilateral □ Urine colour at 1200 □ Yellow □ Yellow □ Pink/blood tinged □ Tea Colored □ Bloody □ Clots present □ Vaginal Bleeding or discharge □ Notify surgeon if saturating >2 pads in 4 hours	 □ Dry □ Intermittently Wet □ Constantly Wet □ Vital signs Q 4 hours □ Physical assessment Q shift □ Spinal Anaesthetics Record with VS/OBS □ N/A □ Strict fluid intake/output every 4 hours x 48 hrs □ assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry □ Ureteral Stents secure □ Right □ Left □Bilateral □ Urine colour at 2000 □ Yellow □ Pink/blood tinged □ Tea Colored □ Bloody □ Clots present □ Vaginal Bleeding or discharge □ Notify surgeon if saturating >2 pads in 4 hours
Nursing Care	 Catheter secure Catheter patent Clots present Irrigated catheter per post-op order x Urine pots changed Vaginal packing: In place Removed at 0600, intact 	 Peri-care BID when vag pack removed non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact on-call fistula surgeon Vaginal packing: In place Out Removed, intact 	 Peri-care BID when vag pack removed non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact on-call fistula surgeon Vaginal packing: In place Out Removed, intact
Wound Care	 N/A Dressing intact Dressing changed 	 N/A Abdominal repair: leave dressing intact x 48hrs., then remove and leave open to air Dressing clean, dry, & intact Dressing changed OTA Orders: 	 N/A Abdominal repair: leave dressing intact x 48hrs., then remove and leave open to air Dressing clean, dry, & intact Dressing changed OTA Orders:
IV & Medication	 ↓ VIP Score	 □VIP Score(score>2, remove & restart IV) □ IV Fluids@ml/hr □ Flush IV cannula at end of shift □ No IV cannula □ Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum 	 □VIP Score(score>2, remove & restart IV) □ IV Fluids@ml/hr □ Flush IV cannula at end of shift □ No IV cannula □Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum
Activity and Safety	 Bedrest Off bedrest 	 Bedrest Walking ad lib Assist to the bathroom for the first time 	Bedrest Encourage ambulation Other
Nutrition and Fluid Balance	 0400 water bottle filled to 1500 ml 0400 Total I&O & 24hr Total 	 Regular Other 1200 Water bottle filled to 1000 ml 1200 Total intake and output 	 Regular Other 2000 Water bottle filled to 500 ml 2000 Total intake and output
Nursing			

Surgery: VVF UVF RVF

Date:	POD# 2 Night Shift	POD# 2 Day Shift	POD# 2 Eve Shift
Day-month-year	Nurse	Nurse	Nurse
Patient and Family Teaching		 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots 	 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots
Nursing Assessment	 Dry Intermittent Wet Constant Wet Vital signs Q 4hrs Physical Assessment I&O Q 4 hours Urine color Vaginal Bleeding or discharge 	 Dry □ Intermittently Wet □ Constantly Wet Vital signs Q 4 hours Physical assessment Q shift Strict fluid intake/output every 4 hours assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry Ureteral Stents secure □ Right □ Left □Bilateral Urine colour at 1200 Yellow □ Pink/blood tinged □ Tea Colored Bloody □ Clots present Vaginal Bleeding or discharge Notify surgeon if saturating >2 pads in 4 hours 	 Dry Intermittently Wet Constantly Wet Vital signs Q shift Physical assessment Q shift Strict fluid intake/output every 4 hours assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry Ureteral Stents secure Right Left Bilateral Urine colour at 2000
Nursing Care	Catheter secure Catheter patent Clots present Irrigated catheter per post-op order x Urine pots changed Vaginal packing: In place Removed at 0600, intact	 Peri-care BID when vag pack removed non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact on-call fistula surgeon Vaginal packing: In place Out Removed, intact 	 Peri-care BID when vag pack removed non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact on-call fistula surgeon Vaginal packing: In place Out Removed, intact
Wound Care	 N/A Dressing intact Dressing changed 	 N/A Abdominal repair: leave dressing intact x 48hrs., then remove and leave open to air Dressing clean, dry, & intact Dressing changed OTA Orders: 	 N/A Abdominal repair: leave dressing intact x 48hrs., then remove and leave open to air Dressing clean, dry, & intact Dressing changed OTA Orders:
IV & Medication	VIP Score	 □VIP Score(score>2, remove & restart IV) □ IV Fluids@ml/hr □ Flush IV cannula at end of shift □ No IV cannula □Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum 	 □IV Fluids@ml/hr □ VIP Score(score>2, remove & restart IV) □ Flush IV cannula at end of shift □ No IV cannula □ Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum
Activity and Safety	 Bedrest Off bedrest 	 Bedrest Walking ad lib Assist to the bathroom for the first time 	Bedrest Encourage ambulation Other
Nutrition and Fluid Balance	 0400 water bottle filled to 1500 ml 0400 Total I&O & 24hr Total 	 □ Regular □ Other □ 1200 Water bottle filled to 1000 ml □ 1200 Total intake and output 	 Regular Other 2000 Water bottle filled to 500 ml 2000 Total intake and output
Nursing Notes			

Surgery: VVF UVF RVF

Date:	POD# 3 Night Shift	POD# 3 Day Shift	POD# 3 Eve Shift
Day-month-year	Nurse	Nurse	Nurse
Patient and Family Teaching		 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots 	 Encourage pt to report pain or nausea post-op Teach Catheter care: not to pull, kink or twist; keep bag off floor when out of bed Report bladder fullness, pain, or spasm; or newly wet Maintain adequate fluid intake to ensure urine clear and without clots
Nursing Assessment	 Dry Intermittent Wet Constant Wet Vital signs Q shift Physical Assessment I&O Q 4 hours Urine color Vaginal Bleeding or discharge 	 □ Dry □ Intermittently Wet □ Constantly Wet □ Vital signs Q shift □ Physical assessment Q shift □ Strict fluid intake/output every 4 hours □ assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry □ Ureteral Stents secure □ Right □ Left □Bilateral □ Urine colour at 1200 □ Yellow □ Pink/blood tinged □ Tea Colored □ Bloody □ Clots present □ Vaginal Bleeding or discharge □ Notify surgeon if saturating >2 pads in 4 hours 	□ Dry □ Intermittently Wet □ Constantly Wet □ Vital signs Q shift □ Physical assessment Q shift □ Strict fluid intake/output every 8 hours □ assess from patient to catheter bag to ensure catheter draining well, not kinked, no visible clots present and pad dry □ Ureteral Stents secure □ Right □ Left □ Bilateral □ Urine colour at 2000 □ Yellow □ Pink/blood tinged □ Tea Colored □ Bloody □ Clots present □ Vaginal Bleeding or discharge □ Notify surgeon if saturating >2 pads in 4 hours
Nursing Care	 Catheter secure Catheter patent Clots present Irrigated catheter per post-op order x Urine pots changed 	 Peri-care BID non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact 	 Peri-care BID non-sterile sterile, incision present Catheter secure Catheter patent Irrigate catheter with normal saline PRN if obstruction suspected. Irrigate per protocol on post-op orders If urine output is <30 ml in one hour, flush as above and notify Charge Nurse who will contact
Wound Care	 N/A Dressing intact Dressing changed 	on-call fistula surgeon I N/A Abdominal repair: OTA Dressing clean, dry, & intact Dressing changed Orders:	on-call fistula surgeon ON/A Abdominal repair: OTA Dressing clean, dry, & intact Dressing changed Orders:
IV & Medication	□ VIP Score (score>2, remove & restart IV) □ IV Fluids @ml/hr □ Flush IV cannula end of shift □ No IV cannula	□VIP Score(score>2, remove & restart IV) □ IV Fluids@ml/hr □ Flush IV cannula at end of shift □ No IV cannula □Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum	□VIP Score(score>2, remove & restart IV) □ IV Fluids@ml/hr □ Flush IV cannula at end of shift □ No IV cannula □Oxybutynin per order for suspected bladder spasm. D/C 24 hours before catheter removed □ RVF: Nothing per rectum
Activity and Safety		 Encourage ambulation Other 	 Encourage ambulation Other
Nutrition and Fluid Balance	 0400 water bottle filled to 1500 ml 0400 Total I&O & 24hr Total 	 Regular Other 1200 Water bottle filled to 1000 ml 1200 Total intake and output 	 Regular Other 2000 Water bottle filled to 500 ml 2000 Total intake and output
Nursing Notes			

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