

# Abdominal Perineal Resection-Laparoscopic

	Preop	DOS: HR, OR, PACU
Goals	<ul style="list-style-type: none"> <li>• PREOP labs/tests are complete within 30 days</li> <li>informed CONSENT process completed &amp; forms signed</li> <li>Pt/Family/SO verbalize understanding of PRE-OP TEACHING pt verbalizes understanding of ostomy care</li> </ul>	<ul style="list-style-type: none"> <li>• RECOVERS from procedure without complications No major intraoperative complications (CVA, NI) No evidence of excessive post-op bleeding</li> <li>• RECOVERS uneventfully from anesthesia Extubated in the OR PACU, Return to baseline O2 saturation level</li> <li>• Interventions for PAIN are effective pain score 4 or less</li> <li>• NAUSEA and VOMITING controlled</li> <li>• DRESSING intact with minimal/no drainage or bleeding Over abdominal and Perineal incision</li> <li>• OSTOMY POUCHING system intact output less than 1000ml/day peristomal skin pink and moist</li> <li>• Maintain Core body temp in PACU</li> </ul>
Individual Goals		
Treatments	<ul style="list-style-type: none"> <li>• Vital Signs &amp; Temp per until standard Height and Weight per orders</li> <li>Complete H&amp;P</li> <li>Consent Signed</li> </ul>	<ul style="list-style-type: none"> <li>• Vital Signs &amp; Temp</li> <li>• Assess Surgical Dressing Abdominal and Perineal incisions, JP drain sit-if present</li> <li>• Assess stoma Peristomal skin pink and moist</li> <li>• Assess measure ostomy output empty and record-if output more than 500ml in 8 hours call H.O.</li> <li>• Turn/cough/deep breathe, Incentive Spirometer Q2 hr while awake</li> <li>• DVT Prophylaxis and Sequential Compression Device per orders</li> <li>• Change Perineal pad qshift and PRN- record drainage in HED</li> <li>• Braden Skin Risk Assessment Q shift with nursing assessment-If Braden Score 15 or less: Initiate Orders For pressure ulcer prevention</li> <li>• IF JP drain present: Drain Care assess, empty, and record in PACU</li> <li>• I&amp;O per orders- record results in HED</li> </ul>
Activity	<ul style="list-style-type: none"> <li>• AD LIB</li> </ul>	<ul style="list-style-type: none"> <li>• BEDREST Until fully awake</li> <li>Out of Bed to Chair evening of surgery-on Roho Cushion</li> </ul>

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Diet	<ul style="list-style-type: none"> <li>• Clear Liquid Diet day before surgery</li> <li>Nothing BY Mouth After Midnight eve before surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Advance to Clear Liquid Diet When Awake</li> </ul>
Labs/ Tests	<p><b>TEMPLATE ONLY: PLEASE SEE PHYSICIAN ORDERS</b></p> <ul style="list-style-type: none"> <li>• Chest PA &amp; LAT XR</li> <li>Comprehensive Metabolic Panel</li> <li>CBC/PLT CT</li> </ul>	<p><b>TEMPLATE ONLY: PLEASE SEE PHYSICIAN ORDERS</b></p>
Meds/IV	<p><b>TEMPLATE ONLY: SEE PHYSICIAN ORDERS FOR INDIVIDUALIZATION</b></p> <ul style="list-style-type: none"> <li>• IF prescribed</li> <li>Bowel Prep</li> </ul>	<p><b>TEMPLATE ONLY: SEE PHYSICIAN ORDERS FOR INDIVIDUALIZATION</b></p> <ul style="list-style-type: none"> <li>• IV Fluid per orders unless pt. Creatinine over 1.5, then D5NS @ 100 ml/hr</li> <li>• Antibiotic per MD order</li> <li>• PCA Analgesia per orders</li> <li>• Antiemetic per orders</li> <li>• Famotidine INJ: or Nexium per orders</li> <li>• Toradol per orders</li> <li>• Home Medication Regimen Per MD order</li> <li>• For IBD patients: solucortef paper orders</li> <li>• Heparin Injection per orders</li> </ul>
Consults	<ul style="list-style-type: none"> <li>• VPEC</li> <li>•CM or MSSW Discharge needs</li> <li>•Wound, Ostomy, Continence (WOC) Nurse</li> </ul>	<ul style="list-style-type: none"> <li>• VPEC</li> <li>•CM or MSSW Discharge needs</li> <li>•Wound, Ostomy, Continence (WOC) Nurse</li> </ul>
Teaching/ Discharge Plan	<ul style="list-style-type: none"> <li>• Orientation to VUMC where to arrive for surgery, where to wait, etc</li> <li>•Review Procedure Print fro EDOCS and give to patient, teaching sheet, and after your abdominal surgery</li> <li>•Admission History &amp; Discharge Plan</li> <li>Initiate Discharge Planning</li> <li>• Medication reconciliation</li> <li>Preop: pt to verbally demonstrate ostomy care</li> <li>Postop teaching after surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Postop Processes Post op Care of ostomy, incision, self care, etc</li> <li>•When/How to Request Comfort Interventions</li> <li>•Review Procedures Print from EDOCS and give to patient, Ileostomy teaching sheet, and 'after your abdominal surgery'</li> <li>•Admission History and Discharge Plan •Psychosocial DB &amp; Multidisciplinary CCP</li> <li>•Review Discharge Needs with Pt/Family Significant Other</li> <li>• Medication reconciliation</li> </ul>

	POD 1&2	Follow up Visit
Goals	<ul style="list-style-type: none"> <li>• No evidence of excessive post-op bleeding or infection</li> <li>• Interventions for PAIN are effective pain score 4 or less</li> <li>• NAUSEA and VOMITING controlled</li> <li>• INCISION healing progressively edges approximating, no increased swelling, or bleeding</li> <li>• OSTOMY POUCHING system intact output less than 1000ml/day peristomal skin pink and moist</li> <li>• DISCHARGE from hospital by 10 am POD3</li> <li>• WOCN documents pt teaching, pt independently demonstrates ostomy care by POD3</li> <li>• Prescribed DIET is consumed and tolerated</li> <li>• MOBILITY progressing OOB to chair and ambulates QID</li> </ul>	<ul style="list-style-type: none"> <li>• No evidence of infection</li> <li>• Interventions for PAIN are effective pain score 2 or less</li> <li>• INCISION healing progressively edges approximating</li> <li>• OSTOMY POUCHING system intact output less than 1000ml/day-peristomal skin pink and moist</li> <li>• Prescribed DIET is consumed and tolerated</li> <li>• MOBILITY: return to pre-op baseline activity level</li> <li>• Patient independently demonstrates correct ostomy care</li> </ul>
Individual Goals		
Treatments	<ul style="list-style-type: none"> <li>• Vital Signs &amp; Temp</li> <li>• Empty Ostomy pouch PRN if output more than 500ml in 8 hrs call H.O</li> <li>• Change wafer per orders on POD2</li> <li>• Remove POD 2 per MD order</li> <li>• Turn/cough/deep breath Incentive Spirometer Q2 hr while awake</li> <li>• DVT prophylaxis and Sequential Compression Device per orders</li> <li>• Nursing Convert Medications to PO as soon as patient tolerating oral diet</li> <li>• Drain Care assess, empty and record in HED</li> <li>• Assess pt for abdominal distention and flatus</li> </ul>	<ul style="list-style-type: none"> <li>• Vital Signs &amp; Temp</li> <li>• Measure Weight</li> <li>• Assess surgical dressing Abdominal and Perineal incisions</li> <li>• Assess stoma Peristomal skin pink and moist</li> <li>• Assess, measure ostomy output empty and record</li> </ul>
Activity	<ul style="list-style-type: none"> <li>• Out of Bed to Chair QID</li> <li>• Ambulate with Assist QID</li> </ul>	<ul style="list-style-type: none"> <li>• Progressive Ambulation return to baseline preop activity level</li> </ul>

	POD 1&2	Follow up Visit
<b>Diet</b>	<ul style="list-style-type: none"> <li>• Gatorade when pt tolerating clear liquid diet</li> <li>• Low Residue Diet when flatus or stool present</li> </ul>	<ul style="list-style-type: none"> <li>• Low Residue Diet</li> </ul>
<b>Labs/ Tests</b>	<p><b>TEMPLATE ONLY: PLEASE SEE PHYSICIAN ORDERS</b></p> <ul style="list-style-type: none"> <li>• PCV bld</li> <li>• Potassium</li> </ul>	<p><b>TEMPLATE ONLY: PLEASE SEE PHYSICIAN ORDERS</b></p>
<b>Meds/IV</b>	<p><b>TEMPLATE ONLY: SEE PHYSICIAN ORDERS FOR INDIVIDUALIZATION</b></p> <ul style="list-style-type: none"> <li>• IV Fluid per orders unless pt. Creatinine over 1.5, then D5NS @ 100 ml/hr</li> <li>• Antibiotic per MD order</li> <li>• PCA Analgesia per orders</li> <li>• Antiemetic per orders</li> <li>• Famotidine INJ or Nexium:per orders</li> <li>• Toradol per orders</li> <li>• Home Medication Regimen Per MD order</li> <li>• For IBD patients: solucortef paper orders</li> <li>• Heparin Injection per orders</li> <li>• Saline Lock when pt tolerating PO diet</li> </ul>	<p><b>TEMPLATE ONLY: SEE PHYSICIAN ORDERS FOR INDIVIDUALIZATION</b></p> <ul style="list-style-type: none"> <li>• Home Medications Per MD orders</li> <li>• IF on home PPI: meds per orders</li> </ul>
<b>Consults</b>	<ul style="list-style-type: none"> <li>• VPEC</li> <li>• CM or MSSW Discharge needs</li> <li>• Wound, Ostomy, Continenence (WOC) Nurse</li> </ul>	As indicated
<b>Teaching/ Discharge Plan</b>	<ul style="list-style-type: none"> <li>• When/How to Request Comfort Interventions</li> <li>• Postop Processes Post op care of ostomy, incision, self care, etc</li> <li>• Discharge Diet</li> <li>• Discharge Activity and self care</li> <li>• Reportable signs &amp; symptoms how &amp; when to contact HCP</li> <li>• Review Procedure Ensure patient understands information from EDOCS ileostomy teaching sheet, and "After you abdominal surgery"</li> <li>• Review Discharge Needs with Pt/Family/Significant Other</li> <li>• Discharge Prescription(s) written &amp; received by pt/family day before discharge</li> <li>• Medication reconciliation</li> </ul>	<ul style="list-style-type: none"> <li>• How and when to notify a healthcare professional after discharge</li> <li>• Reportable signs &amp; symptoms how &amp; when to contact Health Care Provider</li> <li>• Medication reconciliation</li> </ul>