

Addressograph

**NHS Lothian - University Hospitals Division
Royal Infirmary of Edinburgh**

**Laparoscopic Cholecystectomy
Multidisciplinary Care Pathway**

Consultant Surgeon

Patient registered on PAS

Date of operation...../...../.....

Time of admission.....

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Key to Initials of ALL STAFF completing this ICP				
Print name	Designation	Initials	Signature	Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

A care pathway is intended as a guide to treatment and an aid to documenting patient`s progress. Clinicians are free to exercise their own professional judgements as appropriate. However any alteration to the practice identified within this care pathway should be noted as a Variance.

Please note variances from pathway with a code number and explain more fully on variance sheet at end of pathway. Key to variance numbers on variance sheet.

Common Abbreviations Used

BMI	BODY MASS INDEX	LMP	LAST MENSTRUAL PERIOD
BP	BLOOD PRESSURE	NA	NOT APPLICABLE
CM	CENTIMETRES	NOK	NEXT OF KIN
ECG	ELECTROCARDIOGRAPH	OPD	OUT PATIENT DEPARTMENT
FBC	FULL BLOOD COUNT	P	PULSE
HRT	HORMONE REPLACEMENT THERAPY	R	RESPIRATIONS
I.V.	INTRAVENOUS	R/O	REMOVAL OF
KG	KILOGRAMS	T	TEMPERATURE
		U+E	UREA AND ELECTROLYTES

Laparoscopic Cholecystectomy Integrated Care Pathway

Pre-admission Checklist to Register on Waiting List:

date/time.....

SURGEON TO COMPLETE

CONSULTANT:

Clinical Details:

Simple Biliary Colic (only patients suitable for combined W/L)

Previous acute cholecystitis If yes: date / /

Cholangiogram required Yes/ No

High risk CBD stones => inpatient care

High risk conversion* => inpatient care

*please state reasons.....

Place on waiting list pending results of: Endoscopy Other reasons.....

Urgent

Soon

Routine

Anticipate: Day Case

1 overnight stay please state reasons

In-patient stay => Day of Surgery admission admit one day pre-op

Combined Waiting List YES NO If NO, specify consultant.....

Pre-operative investigations

LFTs FBC (if history of anaemia)

ECG(over 60yrs+/-history ischaemic heart disease)

U&Es (if poor renal function/ on diuretics or anti-hypertensives) Other, please specify.....

Current Medication

Aspirin stop .../days pre-operatively

Warfarin stop 5 days pre-op and recommence post-operatively.
If for valve replacement admit for heparinisation

1. Length of Waiting time discussed and estimated at months
2. Proposed Operation discussed
3. Post-discharge home support discussed
4. Patient referred to pre-admission nurse
5. Patient requested to complete patient questionnaire in ICP
6. Patient provided with following written information:
Laparoscopic Cholecystectomy including consent form
General Anaesthesia

Signature/Print: _____ Designation: _____ Date: _____

PRE – ADMISSION ASSESSMENT

PATIENT TO COMPLETE THIS SECTION Pages 3-5

TO BE GIVEN TO THE PATIENT BEFORE OR ON ARRIVAL AT THE SURGICAL CLINIC

Please answer the questions to help us plan your care.

Do not worry if you have not heard of some of the conditions named.

You will be able to ask a nurse for advice. If any of the conditions affect you now, or has done so in the past, please tick Yes.

<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p style="text-align: center;">Patient Label</p> <p>Surname</p> <p>DOB/...../..... Age.....</p> <p>Hospital Number</p> </div> <p>Known as:.....</p> <p>Telephone Number.....</p> <p>Work telephone number.....</p> <p>Mobile Number</p> <p>Marital Status S / M / D / W</p> <p>Occupation</p> <p>Religion.....</p>	<p>Next of Kin</p> <p>Relationship.....</p> <p>Address</p> <p>.....</p> <p>.....</p> <p>Telephone No:</p> <p>.....</p> <p>Next of kin aware YES / NO</p> <p>Alternative Contact</p> <p>Relationship:.....</p> <p>Telephone No:.....</p> <p>Alternative Contact aware YES / NO</p>		
<p>GP</p> <p>GP Address</p> <p>Telephone No:</p> <p>Fax Number.....</p>	<p><u>Pre-assessment clinic</u> <i>Nurse to complete</i></p> <p>Date attended/...../.....</p> <p>Nurse assessor:.....</p> <p>Print</p> <p>Grade:</p>		
Have you ever had :	Yes	No	Please list :
1. Any surgical operations?			
2. Any anaesthetic or surgical problems?			
3. Is there any family history of anaesthetic problems?			

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Do you smoke ? How many cigarettes (or ounces of tobacco) per day?	Yes	No
Do you drink alcohol ? How many units per week ?	Yes	No
Do you use any recreational drugs? Cannabis <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Ecstasy <input type="checkbox"/> Other: How often used(+ route eg smoke, IV):	Yes	No
Do you have stairs to climb ? How many?.....		
Will your journey home take less than 90 minutes?		
Do you have access to a telephone?		
Do you have someone to accompany you home in private transport?		
Will someone be present for your first 24 hours at home?		
Would you consider a short notice admission?		
Please indicate any unsuitable dates for operation eg holiday booked:		
<p>We operate a policy of using your own medicines from home. This allows you to continue with familiar tablets, eye drops and other treatments and avoids waste. Please bring your own medicines with you when you come in to hospital and ensure they are in their original, labelled containers.</p> <p>Advice on managing discomfort or pain will be given at pre-assessment and before you are discharged home after surgery.</p> <p>I shall be accompanied home by a responsible adult. A responsible adult will be at home with me, at least, overnight. I undertake not to drink alcohol within 24 hrs of my operation. I undertake not to drive a car or operate machinery within 24hrs following my operation I shall not travel home by public transport.</p> <p>Patient Signature :..... Date :.....</p>		

Thank you for your assistance in completing this section.

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CONSULTANT :

EXPECTED LENGTH OF STAY: Day case/23hr/Inpatient

DAY OF SURGERY PRE-OPERATIVE RECORD

CATEGORY	DATE / /	Initial	Var code
EDUCATION/ DISCHARGE PLANNING	Patient orientated to ward Pathway discussed Special needs assessed Remaining questions answered	.....	.....
MEDICAL STAFF	Consent Form signed Surgeon- Review Anaesthetist- review	.....	.....
MEDICATION	Patient has taken regular medication <input type="checkbox"/> N/A Patient has discontinued appropriate medication <input type="checkbox"/> N/A Administer premedication <input type="checkbox"/> N/A Allergies/sensitivities noted on pink perioperative record Red Bracelet insitu <input type="checkbox"/> Yes <input type="checkbox"/> N/A	.....	.....
THROMBO EMBOLIC PROPHYLAXIS	Prophylaxis to be prescribed: minihep <input checked="" type="checkbox"/> Flowtron boots <input checked="" type="checkbox"/> Mobilise <input checked="" type="checkbox"/> Other .....	.....	.....
VITAL SIGNS (Chart)	(TPBP) Please record results on front page of pink perioperative sheet	.....	.....
PREPARATION FOR THEATRE	Complete checklist in perioperative record	.....	.....
FLUIDS/IV THERAPY (Chart)			
MOBILITY/ EXERCISES	Bedrest once premed given YES N/A	.....	.....
ADMIN	Valuables Listed <input type="checkbox"/> Not applicable	.....	.....

SIGN/PRINTNAME:

Date/time.....

PLEASE RECORD DEVIATIONS FROM PATHWAY ON VARIANCE SHEET

Peri-operative Record

PREOPERATIVE CHECK LIST	Ward Initials		Theatre Initials	
	YES	NO	YES	NO
1. Correct patient / correct procedure?				
2. Bracelet in situ with name, date of birth, ward and unit number?				
3. Teeth, dentures and crowns : In <input type="checkbox"/> / Out <input type="checkbox"/> Comments:				
4. Operation consent form signed?				
5. Operation site marked if applicable?				
6. Prescribed pre-medication given?				
7. Taken routine drug therapy?				
8. Removed: make-up contact lenses glasses hearing aid Jewellery (incl. body piercing items) rings taped hairclips				
9. Items accompanying patient to theatre: Wigs hearing aids prosthesis glasses other.....				
10. Has patient passed urine?				
11. Urinalysis (if not recently tested at pre-admission ie<3mths) NAD protein glucose ketones blood				
12. LMP:..... N/A Quickvue test				
13. Dressed for theatre?				
14. Anti-embolic stocking – N/A <input type="checkbox"/> , Yes <input type="checkbox"/> size				
15. Waterlow score recorded				
16. Last food? Date Time				
17. Last drink? Date Time				
18. Documents accompanying patient All medical notes <input type="checkbox"/> ICP <input type="checkbox"/> X-rays <input type="checkbox"/> Drug Chart <input type="checkbox"/> Blood results <input type="checkbox"/> Crossmatched <input type="checkbox"/> Other <input type="checkbox"/>				

Ward Nurse SIGN/PRINTNAME:**Theatre Practitioner SIGN/PRINT**.....

RIE

Peri-operative Record

DSU

Pre-operative medical assessment

Patient Label or Name: DOB: Hospital Number:

Proposed operation **Side:** **Operation date:**

Assessed by: Date: Time:

Grade : Con SpR SHO
Other

Assessed in (location): Drugs:

Relevant medical history:

Examination: **ASA**
CVS BP HR

Allergies:

Previous anaesthetics: uneventful

Information given to patient

Intended anaesthetic technique discussed with patient:

Post operative pain relief discussed
PR drug administration consent

Premedication: Yes No

Omit medication As charted Yes

Non routine instructions:

Personal

Weight (kg):
Height (cm):
BMI

Investigations

FBC:
U/E:
ECG:
CXR:
Other:

Airway

Teeth
Mouth:
Neck:

Instructions

Anaesthetist(s)	Grade	Discussed with consultant	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Comments

Intraoperative Care Record

Surgical Position Initials:	Equipment Used/Protection Eyes taped Flowtron Boots Heel pads Elbow supports Other
Mobility Initials:.....	Special Actions Taken
Diathermy Initials:.....	Position Problem/Action Taken
Skin Prep. Initials:.....	Details
Skin Closure Initials:.....	Details
Dressings N/A <input type="checkbox"/> Initials	Details
Drains N/A <input type="checkbox"/> Initials.....	Details
Catheters N/A <input type="checkbox"/> Initials.....	Details MIs in Balloon
Specimens N/A <input type="checkbox"/> Initials.....	Details
Packs N/A <input type="checkbox"/> Initials	Details:
Comments Print/sign.....	

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	Address
	DOB

INTRAOPERATIVE COUNTS

	Initial Count	Intraoperative	Intraoperative	Intraoperative	Final Count
Correct (Signature)					
Discrepancy And Action Taken					
Scrub Nurse	Comments		Total Blood Loss		
	1. Print _____ Sign _____				
	2. Print _____ Sign _____				

OPERATION SUMMARY (Surgeon or Deputy to complete)

Surgeon: _____ Assistants: _____

Operation Performed:

Postoperative Instructions: _____

Please record any further additional information on "additional information and variance recording sheet"

Follow-up required? Yes , No - If Yes, specify when: _____ /52

Signature/Print Surgeon.....

PLEASE RECORD VARIANCES AT END OF PATHWAY

<p>NHS Lothian- University Hospitals Division</p> <p>Laparoscopic Cholecystectomy</p>	<p><i>Addressograph, or Name</i></p> <p>Address</p> <p>DOB</p>
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FOR LABELS FROM PACKS/INSTRUMENTS USED FROM HSDU

NHS Lothian- University Hospitals Division INTEGRATED CARE PATHWAY LAPAROSCOPIC CHOLECYSTECTOMY	Addressograph, OR Name Address DOB
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Recovery Room

Time

LM / ETT / Oral Airway	
S.V / IPPV	
Oxygen Therapy (L / Min)	
Oxygen Saturation	
Respiration	
Sedation Score	
Pain Score	
Nausea Score	
Urine	
Wound / Drain Check (1)	
Wound / Drain Check (2)	
SCORING SYSTEM	
Pain	200
0 No pain	
1 Mild pain, it does not distress me	
2 Moderate pain, it distresses me a bit	
3 Severe pain, it distresses me a lot	
S Score S if sleeping normally	150
Sedation	150
0 None, patient alert	
1 Mild, occasionally drowsy, easy to rouse	
2 Moderate, frequently drowsy, easy to rouse	100
3 Severe, somnolent, difficult to rouse	
S Normal, sleep, stirs to light touch	100
Nausea	50
0 None	
1 Mild nausea, no treatment required	
2 Nausea/vomiting helped by Rx	
3 Persistent nausea/vomiting despite Rx	
S Score S if sleeping normally	0
DRUGS GIVEN	

RECOVERY CARE EVALUATION	ANAESTHETIC POST OPERATIVE INSTRUCTIONS
	Oxygen : Post Op Fluids Charted : Yes <input type="checkbox"/> No <input type="checkbox"/> Special Instructions for care in recovery room :
Name (Print) :	Sign :
Name (Print) :	Sign :

PLEASE RECORD VARIANCES IN PATHWAY ON LAST PAGE

Fluid balance chart

DAY OF SURGERY/ POST-OPERATIVE CARE

Overnight admission

CATEGORY	DATE / /	TIME	INITIAL	Var. code
MEDICAL STAFF	Patient reviewed <input type="checkbox"/> N/A	.....	.....	.....
MEDICATION	Check / administer regular medication	ND E	..........	..........
PAIN MANAGEMENT	Record Pain Sedation Nausea Score	ND E	..........	..........
	Administer analgesia / anti-emetic as prescribed	ND E	..........	..........
	Routine check of Pain score 30 min post analgesia	ND E	..........	..........
VITAL SIGNS (CHART)	Monitor and evaluate TPR BP as dictated by clinical need Please tick and, on completion of each section, initial appropriate line.....Hrly <input type="checkbox"/>hrly <input type="checkbox"/>hrly <input type="checkbox"/>hrly <input type="checkbox"/>
	Oxygen administration .....L/min via N/A <input type="checkbox"/>
TEST/INVESTIG(CHART)				
FLUIDS/ IV THERAPY (CHART)	When patient able encourage fluids	.....	.....	.....
	IV THERAPY AS CHARTED	ND E	..........	..........
DIET(CHART)	When patient wishes - Resume <u>light</u> diet	.....	.....	.....
OUTPUT(Char)	Passed urine post-op <input type="checkbox"/> Yes <input type="checkbox"/> No	.....	.....	.....
SPECIALTY OBSERVATION (chart)	Check Wound dressing intact-NAD IVCannula-NAD check-drain <input type="checkbox"/> Yes <input type="checkbox"/> N/A	ND E	..........	..........
ACTIVITIES OF DAILY LIVING	On return to ward – provide assistance with basic hygiene Independent Hygiene / dressing Encourage mobilisation when able	.....	.....	.....
EDUCATION/ DISCHARGE PLANNING	Patient meets discharge criteria N/A <input type="checkbox"/> Outpatient appointment actioned (if applicable) Issue / explain discharge information (eg wound care, activities, pain management) GP letter issued	.....	.....	.....
ADMIN	Complete discharge documentation Valuables returned <input type="checkbox"/> Yes <input type="checkbox"/> N/A Notify support services as appropriate i.e. Practice Nurse <input type="checkbox"/> Yes <input type="checkbox"/> N/A	.....	.....	.....

WARD.....sign/print name

Post-operative care

Date...../...../.....

		Hr	
TIME	min		
Oxygen Therapy (L / Min)			
Oxygen Saturation			
Respiration			
Sedation Score			
Pain Score			
Nausea Score			
Urine			
Wound / Drain Check			
IV cannula			
SCORING SYSTEM			
Pain	200		
0 No pain			200
1 Mild pain, it does not distress me			
2 Moderate pain, it distresses me a bit			
3 Severe pain, it distresses me a lot			
S Score S if sleeping normally	150		
Sedation			150
0 None, patient alert			
1 Mild, occasionally drowsy, easy to rouse			
2 Moderate, frequently drowsy, easy to rouse	100		
3 Severe, somnolent, difficult to rouse			100
S Normal, sleep, stirs to light touch			
Nausea			50
0 None	50		
1 Mild nausea, no treatment required			
2 Nausea/vomiting helped by Rx			50
3 Persistent nausea/vomiting despite Rx			
S Score S if sleeping normally			

Nurse Discharge Protocol

This protocol is designed to facilitate the smooth discharge of post-operative patients.

The Nurse in Charge may discharge patients who meet the discharge criteria.

For this to take place it is essential that all patients are seen by the surgeon post-operatively on the ward. He / she must complete a discharge summary / instructions and give authorisation for nurse discharge.

It is imperative that discharge drugs are prescribed at this point

If the patient does not meet the discharge criteria, the nurse will contact the appropriate member of the medical team to reassess the patient.

For those patients who insist on seeing a member of the medical staff before discharge, the nurse should be given a contact name / bleep number by the discharging surgeon.

I authorise Nurse Discharge from DSU if patient meets the stated Discharge Criteria.

Doctor's Discharge Summary:

Procedure:

Findings:

Instructions to patient:

For Follow-up? No , Yes - if Yes, no. of weeks:

Were Discharge drugs required to be prescribed? No , Yes

Signature of Doctor

Print Name

Date

Time

Designation

Contact name

Bleep no.

DAY SURGERY GENERIC DRUG KARDEX

Prescriptions must be dated and signed before administration

<u>Allergies</u>

<u>Addressograph label</u>

ONCE ONLY and PREMEDICATION

Date	Time	Drug	Dose	Route	Doctor's Signature	Time given	Given by	Checked by

POSTOPERATIVE MEDICATION (REGULAR)

			Date →								
			Time ↓								
Paracetamol	1 g	Oral									
Start date	Signature										
Ibuprofen	400mg	Oral									
Start date	Signature										
Drug	dose	route									
Start date	Signature										
Drug	dose	route									
Start date	Signature										
Drug	dose	route									
Start date	Signature										
Drug	dose	route									
Start date	Signature										

Addressograph

POSTOPERATIVE MEDICATION (AS REQUIRED)

Diclofenac	50mg	Date											
Oral	8hrly for pain	Time											
Start date	Signature	Initials											
Dihydrocodeine	30mg	Date											
Oral	4hrly for pain	Time											
Start date	Signature	Initials											
Cyclizine	50 mg	Date											
IM/IV/Oral	6hrly for nausea	Time											
Start date	Signature	Initials											
Ondansetron	4 mg	Date											
IM/IV/Oral	4hrly for nausea	Time											
Start date	Signature	Initials											
Drug	Dose	Date											
Route	Frequency & instructions	Time											
Start date	Signature	Initials											
Drug	Dose	Date											
Route	Frequency & instructions	Time											
Start date	Signature	Initials											
Drug	Dose	Date											
Route	Frequency & instructions	Time											
Start date	Signature	Initials											
Drug	Dose	Date											
Route	Frequency & instructions	Time											
Start date	Signature	Initials											

DISCHARGE MEDICATION

Examples of take home analgesia packs. Please prescribe on triplicate form "immediate discharge letter".

Drug	Dose	Route	Frequency & Instructions	Pack size
Paracetamol	1 g	Oral	4-6hrly PRN pain	500mg x32
Ibuprofen	400mg	Oral	6hrly PRN pain	400mg x 21
Diclofenac	50 mg	Oral	8hrly PRN pain	50mg x 21
Dihydrocodeine	30mg	Oral	4hrly PRN pain	30mg x 30
Dihydrocodeine	30mg	Oral	4hrly PRN pain	30mgx 8
Kapake	30/500	Oral	6hrly PRN pain	30/500 x 30

