Patient addressograph / details

Name: ……

D.O.B: ……

Hosp No: ……

Consultant: ……

ALLERGIES……
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Enhanced Recovery after Surgery (ERAS)
Breast Reconstruction Pathway
for
DIEP / MS-TRAM and TUG

Queen Victoria Hospital ERAS pathway for breast reconstruction is a programme of care aimed at reducing the physical trauma of surgery and aiming for a complication-free recovery, thereby shortening hospital stay for patients.

Enhanced recovery after surgery is a collection of strategies in a structured pathway allowing the surgical and anaesthetic teams to aid recovery and enable earlier discharge.

The key elements included in the Enhanced Recovery Pathway are:

- Preoperative counselling
- Diet, exercise & wellbeing work up
- Preoperative feeding
- Structured early postoperative mobilisation
- Revised pain relief with minimal morphine use to decrease side effects
- Routine laxatives to prevent constipation
- Early removal of urinary catheters
- DVT prophylaxis
- Enhanced preoperative and postoperative nutrition via supplements

Useful Contact Details:

Pam Golton & Rebecca Spencer
Macmillan Breast Reconstruction Nurse Specialists - QVH Ex 4302 /4306
gvh.breastcare@nhs.net

Simon Mackey - Lead Breast Consultant - QVH Ex 4321
Tim Vorster - Consultant Anaesthetists - QVH Ex 4256

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Patient addressograph / details

Name: ……………………………...……………………..

D.O.B: ……………………………………………………..

Hosp No: …………………………………………………..

Signature Sheet

Date	Print Name	Signature	Initials	Profession
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Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……..

Pre-Assessment

Planned operation: _____

_____

_____

Pre Assessment- Date: / /				
Pre - Assessment paperwork completed				
Arm Precaution? Right ☐ Left ☐ Bilateral ☐				
Bloods checked & taken if not previously done (U+Es, LFT's, FBCs & G+S)				
Height, Weight & BMI rechecked ***(BMI must be 35 or under)***				
Height- cm/m, Weight- kg & BMI-				
Ensure MRSA swabs have been done				
Baseline Observations documented (Temp, Pulse, BP, Respiratory Rate & Sa02) & ECG done				
Allergies or NKDA documented on all nursing paperwork & drug chart				
Additional tests arranged as appropriate				
Send for photographs (if not already done at consultation appointment)				
Support garments discussed with patient				
Stop Tamoxifen* 4 weeks before surgery – date to be stopped: / /				
Anaesthetic review complete				
Gabapentin 600mg PO prescribed for **induction, 1st night & 2nd night ONLY**				
Patients for admission on morning of surgery- LMWH prescribed: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD (omit morning dose on morning of surgery) Give patient prescription to go to Pharmacy for Dalteparin 5,000 units x 8 injections (and prescribe on drug chart as above) (1 for self-administration night before surgery & remaining 7 for discharge) ***Instruct patient to bring them all in to hospital with them on admission.***				
Demonstrate to patient self-administration of Dalteparin injections & provide them with the administration patient information leaflet DIEP/MS-TRAMs – inject into thigh, TUGs – inject into abdomen				
6 x 200ml pre-op Nutricia Carbohydrate drinks provided (if being admitted on the day of surgery) & instructions on how to take them **(avoid in diabetic patients)**				
Please ensure patients are informed they need to drink 4 x 200ml pre-op Nutricia carbohydrate drinks **(avoid in diabetic patients)** the night before surgery and the remaining 2 x 200ml drinks on the morning of surgery before 06:30am.				

NB: If the patient is taking Letrozole (Femara®), Exemestane (Aromasin®), or Anastrozole (Arimidex®) they **do not need to stop these.*

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……...

Date & Time	Variance & Reason	Action Taken	Signature

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Admission & Day of Surgery

Admission- Date: / / Ward Staff / MTR staff to complete	**Initial**	**Yes**	**Variance**	**N/A**
Admission paperwork completed				
Baseline observations taken (Temp, Pulse, BP, Respiratory Rate & Sa02)				
Patient details are correct & name band in situ (around ankle)				
Measured for anti-embolism stockings, prescribed and applied				
Arm Precaution? Right ☐ Left ☐ Bilateral ☐				
If applicable, use pink wristband or write on affected arm with surgical skin marker "DO NOT USE"				
Starvation times confirmed with patient				
Ensure patient has removed all nail varnish & make up				
Ensure patient has removed all jewellery, including all rings				
Ensure patient to remove all hair bands / grips and clips (before theatre)				
Surgical gown & paper knickers given to patient				
4 x 200ml pre-op Nutricia Carbohydrate drinks have been taken by 00:00am **(avoid in diabetic patients)**				
Prescription Chart written				
Patient's height & weight documented on prescription chart				
Venous Thromboembolism (VTE) assessment completed				
LOW MOLECULAR WEIGHT HEPARIN (LMWH) PRESCRIPTIONS LMWH prescribed: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD (omit morning dose on morning of surgery) **Patients admitted via the ward to be given their injection the night before surgery by the ward staff**				
Morning of surgery- pre-op checks by MTR staff @ 07:30am				
Ensure 2 x 200ml pre-op Nutricia Carbohydrate drinks have been taken by 06:30am **(avoid in diabetic patients)**				
LOW MOLECULAR WEIGHT HEPARIN (LMWH) PRESCRIPTIONS Ensure LMWH has been prescribed: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD (omit morning dose on morning of surgery) **Check that patients admitted on day of surgery have self-administered 5,000 units Dalteparin the night before their surgery. Inform the surgeon if they have not.**				
No food has been eaten for 6 hours before surgery				
No oral fluids have been drunk for 2 hours before surgery (with exception of carbohydrate drinks)				
Gabapentin 600mg PO given as prescribed				
Reviewed & marked by surgical team				
Consent checked				
Reviewed by anaesthetist				
2nd Group & Save sample taken and cannula inserted				
Ensure patient has removed all nail varnish & make up				
Ensure patient has removed all jewellery, including all rings				
Ensure patient to remove all hair bands / grips and clips before theatre				
Warming Blanket (Silver-Foil Space Blanket) applied				
Theatre WHO checklist completed *(pages 8 & 9 in this booklet)*				

Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……...

Admission Clinical Notes

Date……

Date & Time:		**Signature:**

ALL STAFF HAVE AN EQUAL RIGHT AND RESPONSIBILTY TO VOICE CONCERNS ABOUT PATIENT SAFETY TO THE REST OF THE TEAM.

Queen Victoria Hospital NHS Foundation Trust
Surgical Safety Checklist

Ward Observations

Pulse _____bpm BP _____ / _____

O_2 Sats _____ % RR _____

Temp _____ °C Weight _____ kg

Purpose T _____

Mental State

Oriented ☐ Disoriented ☐ Sedated ☐ Agitated ☐

Limitations

Visual ☐ Auditory ☐ Language ☐ Mobility ☐

Barrier Nursing Required

Yes ☐ No ☐ Reason

_____

Prior to transfer to theatre (Registered Practitioner) **Must be countersigned if completed by HCA**	**Yes**	**No**	**N/A**	**Comments**
Patient Identity Band in situ, confirmed with patient & consent	☐	☐		
Consent form signed and dated by surgeon and patient	☐	☐		
Blood No availability ☐ 1 G&S sample sent ☐ 2 G&S sample sent ☐ x-matched blood available ☐				
Surgical site and side marked in indelible marker	☐	☐	☐	
Allergies - specify	☐	☐		
Pregnancy excluded (by gender, pre-/post-menarche, LMP or test)	☐	☐		
Previous axillary surgery requiring avoidance of arm for cannulation / BP	☐	☐		SIDE
Notes and drug chart available	☐	☐		
X-rays and photographs available	☐	☐	☐	
Recent blood results available	☐	☐	☐	
Pre-medication administered	☐	☐	☐	
Fasted of food for more than 6 hours	☐	☐		Time
Fasted of clear fluids more than 2 hours	☐	☐		Time
Thromboprophylaxis assessment completed	☐	☐	☐	Time
TED stockings in situ	☐	☐	☐	
Contact Lenses removed	☐	☐	☐	
Jewellery removed / taped	☐	☐	☐	
False teeth removed or firmly fixed in place. Loose teeth? (comment)	☐	☐	☐	
Make-up and nail varnish removed	☐	☐	☐	

Completed by _____(sign)_____(Print) ____/____/____ (date)

Countersigned if applicable _____(sign)_____(Print) ____/____/____ (date)

Sign In Before Induction of Anaesthesia(Surgeon, Anaesthetist,Anae pract)	**Yes**	**No**	**N/A**	**Comments**
Patient confirms: ◆**Identity** ◆**Site** ◆**Procedure** ◆**Consent**	☐	☐		
Site marked / not applicable	☐	☐		
Allergies - specify	☐	☐		
All necessary equipment available for difficult airway if required	☐	☐	☐	
Blood available if >500ml loss anticipated (Paed > 7ml/kg)	☐	☐	☐	
Imaging studies with patient / available in theatre	☐	☐	☐	
Implants / specialist surgical equipment available	☐	☐	☐	
Completed by _____(sign)_____(Print) ____/____/____ (date)				

Time Out – Complete team to participate before surgical intervention **Surgeon, anaesthetist and scrub practitioner confirm**	**Yes**	**No**	**N/A**	**Comments**
◆**Patient** ◆**Site** ◆**Site** ◆**Procedure**	☐	☐		
◆Has antibiotic prophylaxis been given within last 60 minutes	☐		☐	
◆Is essential imaging displayed	☐		☐	
◆**Has patient been discussed at a pre-list Team Safety Briefing** **If not**	☐	☐		
◆**Confirm all team members have introduced themselves by name and role.**	☐			
◆**Anticipated critical events**	☐			
◆**Surgeon reviews:**(anticipated blood loss, operative duration, equipment, etc)	☐			
◆ **Anaesthetist reviews**:(co-morbidities, post-op placement, blood availability etc)	☐			
◆**Nursing / Practitioner Staff reviews:** (safety concerns, equipment issues, sterility including equipment indicator results etc)	☐			
Completed by _____(sign)_____(Print) ____/____/____ (date)				

Sign Out (Before any member of team leaves operating theatre)	**Yes**	**N/A**	**Comments**
Correct name of procedure recorded	☐		
Instrument, needle and swab count correctly	☐		
Specimen(s) labelled correctly	☐	☐	
No Dental pack/ in situ	☐	☐	
Throat pack and/or tourniquet(s) removed. **NB Finger tourniquets**	☐	☐	
Any equipment problems to be addressed	☐	☐	
Completed by _____(sign)_____(Print) ____/____/____ (date)			

Recovery Handover and Discharge	**Yes**	**Comments**
Surgeon, anaesthetist and team handover key concerns for recovery/ward met	☐	

Completed by _____(sign)_____(Print) ____/____/____ (date)

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Induction & Intra Operative

Date……

STANDARD ANAESTHETIC PROTOCOL
Induction
Positioned on theatre table
All patients should have had LMWH (Dalteparin) subcutaneous injection 5,000 units the night before surgery
O_2 administered
Intravenous (IV) induction- Midazolam / Alfentanil / Remifentanil / Propofol
Tranexamic acid 1g IV at induction & 500mg 6 hourly **during procedure only**
Gabapentin 600mg PO
Antibiotics on induction Teicoplanin 600mg IV
ETT
2nd peripheral cannula inserted (large bore)
Cross Match 2 x units (immediate) and 2nd G & S (if not done in MTR)
Blood available in Burns fridge (Immediates only)
Arterial Line/LidCo non-invasive BP (NiBP)
Indwelling Urinary Catheter (IDC) & temperature probe inserted
Blood warmer
Warming Mattress
Flowtron Boots Applied
Maintenance
Remifentanil/Propofol
Ventilation – lung protective – 5-7mls/kg (ideal weight) at rate (12 -16, I:E ratio 1:1.5 or 2) suitable to keep CO_2 normal. PEEP of 5cm/H_2O in all patients to keep bases open and higher in obese.
Fluid Balance
Crystalloids in first instance. 1 - 3 litres during case for majority (minimum required)
Colloids (if this is Anaesthetist preference) – fluid limit
Aim for 'normal' fluid output (>0.5ml/kg/hr)
Analgesia
Surgical infiltration of local anaesthetic – dilute if necessary to ideal volume
Paracetamol 1g IV
Morphine/Diamorphine/Fentanyl – reduced dose 60mins before closure
Diclofenac/Ketorolac 30mins before closure (if not allergic & there are no contraindications to NSAIDs)
Additional Medication
Dexamethasone 6.6mg IV eight hourly
Ondansetron 4mg IV 10mins before completion of surgery
Muscle relaxant at surgical request
Vasoconstrictors
Considerations
Active management of non-surgical site pain and pressure care
Half Time Physiotherapy carried out
Pressure Areas protected & intact
Pulse Oximeter repositioned 4 hourly (at least)

Anaesthetic as per protocol – Initial-	**Yes**	**Variance**

Time	Variance & Reason	Action Taken	Signature

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Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……...

Recovery

Date……

Transfer to Recovery- Time: : hrs	**Initial**	**Yes**	**Variance**	**N/A**
Observations within range				
O_2 insitu & prescribed overnight				
Arterial blood gas (ABG) review & arterial line removed if satisfactory				
Medication				
PCA/block in progress – **(see appendix 2 for PCA protocol)**				
Morphine/Fentanyl/Diamorphine protocol for rescue analgesia				
Regular Anti-emetics prescribed				
Regular analgesia prescribed				
Regular laxatives prescribed				
Fluid Balance				
Input & Output clearly documented on fluid balance chart (including total volumes from theatre)				
IDC insitu & urine output >0.5mls/kg/hr				
2 x IV cannulas in situ and patent				
IV Fluid -Continued ☐ Discontinued ☐ (aim to discontinue & encourage oral)				
Sips of clear fluid tolerated				
Bair hugger (if requested by surgical team)				
Anti-embolism stockings in situ				
Flowtron boots in situ				
Position				
Patient head up				
Knees bent if DIEP / MS TRAM (Jack-Knife Position)				
Pressure areas intact				
Flap Observations (documented on Flap Obs Chart)				
Flap observations every 30 minutes – satisfactory (see appendix 3)				
Doppler every 2 hours – satisfactory				
Drains				
Unclamped - **Time: : hrs**				
Patent				
Drainage documented on fluid balance chart				
Anaesthetic review – satisfactory				
Surgical review – satisfactory				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……..

Recovery Clinical Notes

Date……

Date & Time:		**Signature:**

Patient addressograph / details
Name: ……..
D.O.B: ……...
Hosp No: ……...

OBSERVATION AND PAIN ASSESSMENT CHART

Date……..

TIME																			
INSPIRED O_2%																			
O_2 SATURATION %																			
TEMPERATURE ^{0}C	40																		
	39.5																		
	39																		
	38.5																		
	38																		
	37.5																		
	37																		
	36.5																		
	36																		
	35.5																		
	35																		
BLOOD PRESSURE	200																		
	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
	80																		
PULSE	70																		
	60																		
	50																		
	40																		
	30																		
	20																		
RESPIRATORY RATE																			
PUPIL SIZE/REACTION +/-																			
SEDATION SCORE																			
PAIN SCORE																			
NAUSEA Y/N																			
VOMITING Y/N																			
PHLEBITIS SCORE																			
INFILTRATION SCORE																			
COMMENTS																			

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Recovery Discharge Criteria

Date……

System	Criteria	Yes	N/A
Airway	Able to maintain own airway		
	Able to lift head clear of the pillow		
Breathing	Regular respiratory pattern with a rate ≥ 12 ≤ 21		
	SpO2 ≥ 95%, equivalent to pre-op, or as specified by the anaesthetist		
	Is oxygen prescribed if SpO2 is low and all other criteria are met		
Circulation	BP + Pulse are stable and within 10-20% of preoperative values Patient is well hydrated		
	Phlebitis/infiltration score recorded on observation chart		
Neurology	Patient is alert and oriented to time and place. Or is the same as pre-op		
Wound/Drains	Dressings are intact with only minimal strikethrough/spotting on dressings		
	Drains are patent and recorded on fluid balance chart		
IVI	IVI in progress as prescribed and documented on fluid balance chart		
Pain	Is controlled with a score of ≤ 1 and documented on the care plan		
	Is the regional block still effective, without compromising the individual's respiratory function?		
	Post-operative analgesia and other medications prescribed		
Post operative Nausea and vomiting (PONV)	Anti-emetics are prescribed		
	PONV is either absent or controlled		

Transferred to Enhanced Recovery Area (EHRA)
Named Recovery Nurse:
Patient transferred to SDU – Time : Hrs
Accepted in EHRA
Named SDU Nurse:

Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Afternoon/Night

Date……..

Enhanced Recovery Area (EHRA)	**Initial**	**Yes**	**Variance**	**N/A**
Reviewed by on-call Micro Fellow/Registrar & SHO				
Bair hugger in situ (if requested by surgical team)				
Observations (documented on NEWS chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations every 30 minutes –(see appendix 3)				
Doppler every 2 hours – satisfactory				
Wound/Pressure Area Care				
Dressings dry & intact				
Pressure areas intact				
Anti-embolism stockings in situ				
Flowtron boots in situ				
Diet & Fluid				
Tolerating clear fluids orally				
Offer something to eat (unless specifically instructed not to do so by surgeon)				
Fluid balance chart maintained				
2 x IV cannulas patent				
Indwelling urinary catheter (IDC) patent & output satisfactory				
Drains				
Drains patent				
Drainage documented on fluid balance chart				
Medications				
PCA patent **(see appendix 2 for PCA protocol)**				
LMWH: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD				
Gabapentin 600mg PO **(at night only)**				
Oral analgesia				
Laxatives				
Anti-emetics				
Check patients own regular medications have been prescribed				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Night Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Post-Op: Day 1

Date……

Enhanced Recovery Area (EHRA)	**Initial**	**Yes**	**Variance**	**N/A**
Give breakfast (unless specifically instructed not to do so by surgeon)				
Patient reviewed on ward round by consultant +/- team				
Repeat bloods requested (FBC's, Platelet Count + U&E's)				
Reviewed by Outreach Nurse				
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations 1 hourly – (see appendix 3)				
Doppler every 4 hours				
Diet & Fluids				
Tolerating oral diet & fluids				
Aim to eat at least 1 x meal in chair				
Fluid balance chart maintained				
Indwelling urinary catheter (IDC) removed on mobilisation				
1 x IV cannula patent (if remains state reason in variance)				
1 x cannula removed if/when IV fluids discontinued (if applicable)				
Drains				
Drains patent & drainage documented on fluid balance chart				
Remove drains on doctors instruction if drainage less than 30mls in 24hrs (clear/serous)				
Wound/Pressure area care				
Dressings dry and intact				
Pressure areas intact				
Bra & support garments in situ **prior** to getting out of bed (**DIEP/MS-TRAM-** knickers/binder or **TUG-** shorts)				
Anti-embolism stockings in situ				
Flowtron boots removed on mobilisation				
ADLs				
Assisted with wash				
Drain bag & cushion given to patient				
Seen by physiotherapy & exercise sheet given				
Sit out in chair				
Medications				
Oral analgesia				
Laxatives				
Anti-emetics				
Plan PCA to be discontinued after pain review & other analgesia prescribed				
PCA usage since surgery documented by pain team **mls**				
(see appendix 2 for PCA protocol)				
Fit for transfer to main ward? **Yes ☐ No ☐**				
Transfer to main ward – **Time: : hrs**				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Post–Op: Day 1 Clinical Notes

Date……..

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Day 1: Night

Date……

Ward	Initial	Yes	Variance	N/A
Observations (documented on NEWS chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap obs every hour (2 hourly from 00:00) – satisfactory				
Doppler every 4 hours – satisfactory (see appendix 3)				
Diet & Fluids				
1 x IV cannula patent (if still required). Otherwise removed.				
Tolerating diet & fluids				
Bowels sounds present / flatus / bowels open				
Drains				
Drains patent				
Drainage documented on fluid balance chart				
Wound/Pressure Area Care				
Dressings dry & intact				
Pressure areas intact				
Bra & support garments (knickers/binder or shorts) in situ				
Anti-embolism stockings in situ				
Medications				
LMWH: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD				
Demonstrate & assist patient to self-administer Dalteparin (thigh if DIEP/MS-TRAM, abdomen if TUG)				
Gabapentin 600mg PO **(at night only)**				
Oral analgesia				
Laxatives				
Anti-emetics				
PCA patent *If still in situ* **(see appendix 2 for PCA protocol)**				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	Variance & Reason	Action Taken	Signature

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……...

Day 1: Night Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Day 2

Date……

Ward	**Initial**	**Yes**	**Variance**	**N/A**
Patient reviewed on ward round by consultant / team				
Seen by Macmillan Breast Reconstruction CNS				
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations every 2 - 4 hours – satisfactory (see appendix 3)				
Diet & Fluids				
Remove IV cannula (if still remains)				
Tolerating oral diet & fluids				
Aim to eat all meals in chair				
Bowel sounds present / flatus / bowels open				
Drains				
Drains patent				
Drainage documented on fluid balance chart				
Remove drains on doctors instruction if drainage less than 30mls in 24hrs (clear/serous)				
Wound/Pressure Area Care				
Dressings dry & intact				
Blue gauze removed from umbilicus				
Pressure areas intact				
Bra & support garments (knickers or shorts) in situ				
Anti-embolism stockings in situ				
ADLs				
Independent with personal hygiene				
Sit out in chair				
Walk to toilet independently				
Walk up and down ward independently				
Medications				
Oral analgesia				
Laxatives				
Anti-emetics				
PCA / block discontinued (if still in situ) **(see appendix 2 for PCA protocol)**				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Day 2 Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Day 2: Night

Date…….

Ward	**Initial**	**Yes**	**Variance**	**N/A**
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations every 2-4 hours (4 hourly from 00:00) (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids				
Bowels opened **yes / no**				
Drains				
Drains patent				
Drainage documented on fluid balance chart				
Wound/Pressure Area Care				
Dressings dry & intact				
Pressure areas intact				
Bra & support garments (knickers or shorts) in situ				
Anti-embolism stockings in situ				
Medications				
LMWH: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD				
Assist patient to self-administer Dalteparin (thigh if DIEP/MS-TRAM, abdomen if TUG)				
Oral analgesia				
Laxatives				
Anti-emetics				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..

D.O.B: ……...

Hosp No: ……...

Day 2: Night Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Post-Op: Day 3

Date……

Ward	**Initial**	**Yes**	**Variance**	**N/A**
Patient reviewed on ward round by consultant / breast team				
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations every 4 hours – satisfactory (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids				
Eat all meals in the day room				
Bowels opened				
Drains				
Drainage documented on fluid balance chart				
Remove all remaining drains regardless of drainage (unless specifically instructed not to by the breast reconstruction surgeon or the fluid is not serousanguineous)				
Wound/Pressure Area Care				
Dressings dry & intact (renewed where necessary)				
Pressure areas intact				
Bra & support garments (knickers or shorts) in situ				
Anti-embolism stockings in situ				
ADLs				
Independent with personal hygiene (shower)				
Independent mobilising to bathroom & around ward				
Medications				
Oral analgesia				
Laxatives				
Anti-emetics				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Day 3 Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Day 3: Night

Date……

Ward	Initial	Yes	Variance	N/A
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap obs every 4-6 hours (6 hourly from 00:00)– (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids				
Bowel opened **yes/no**				
Wound/Pressure Area Care				
Dressings dry & intact				
Pressure areas intact				
Bra & support garments (knickers or shorts) in situ				
Anti-embolism stockings in situ				
Medications				
LMWH: Dalteparin by subcutaneous injection. Patients weighing 50-100kg: 5000 units once a day at night. If patient >100kg then 5000 units BD				
Assist patient to self-administer Dalteparin (thigh if DIEP/MS-TRAM, abdomen if TUG)				
Oral analgesia				
Laxatives				
Anti-emetics				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	Variance & Reason	Action Taken	Signature

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Day 3: Night Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Day 4

Date……

Ward	**Insert**	**Yes**	**Variance**	**N/A**
Patient reviewed on ward round by consultant / team				
Observations (documented on NEWS Chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations BD – satisfactory (see appendix 3)				
Check platelet count				
Diet & Fluids				
Tolerating diet & fluids				
Eat all meals in the day room				
Bowels opened				
Wound/Pressure Area Care				
Dressings dry & intact (renewed where necessary)				
Pressure areas intact				
Bra & support garments (knickers or shorts) in situ				
Anti-embolism stockings in situ				
ADLs				
Independent with personal hygiene				
Mobilising independently				
Sit out in morning & afternoon (at least)				
Medications				
Oral analgesia				
Laxatives				
Anti-emetics				
CLAVIEN-DINDO GRADE – see appendix 1 for grading				

Date & Time	**Variance & Reason**	**Action Taken**	**Signature**

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Post-Op: Day 4 Clinical Notes

Date……

Date & Time:		Signature:

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Discharge

Date……..

Discharge	Insert	Yes	Variance	N/A
Wounds checked - dressings dry & intact (renewed where necessary)				
Spare dressings given (if applicable)				
'Essential Post-Op Information' discharge leaflet given to patient				
Confirm patient has received & understand physio exercises				
Ensure patient is aware of who to contact in case of concern				
PDC/wound check appointment made for 1 week & patient informed				
Consultant follow up appointment requested for 4 - 6 weeks post-op				
Softie/Priform offered (if necessary, for asymmetry)				
Nipple prostheses offered & documented on discharge paperwork				
Dalteparin for 7 days on discharge & yellow sharps bin (if patient was admitted on the day of surgery will have been given this in pre-assessment) – **ensure it is prescribed on eDN**				
Ensure patient is competent at self-administration of Dalteparin				
Demonstrate use of sharps bin				
Fill in hospital, ward details & date on sharps bin				
Give spare pair of anti-embolism stockings given (to wear for 3/52)				
TTO Medication given				
Return any of patients own medications				
Instructed to recommence Tamoxifen 2 weeks post-operation date (if applicable)				
eDN complete & copy sent to GP				

NB:

Immediate patients- will receive a separate follow-up appointment with their referring Breast Surgeon (for mastectomy results) 2 – 4 weeks post-op

Date & Time	Variance & Reason	Action Taken	Signature

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Discharge Clinical Notes

Date……

Date & Time:		Signature:

Appendix 1

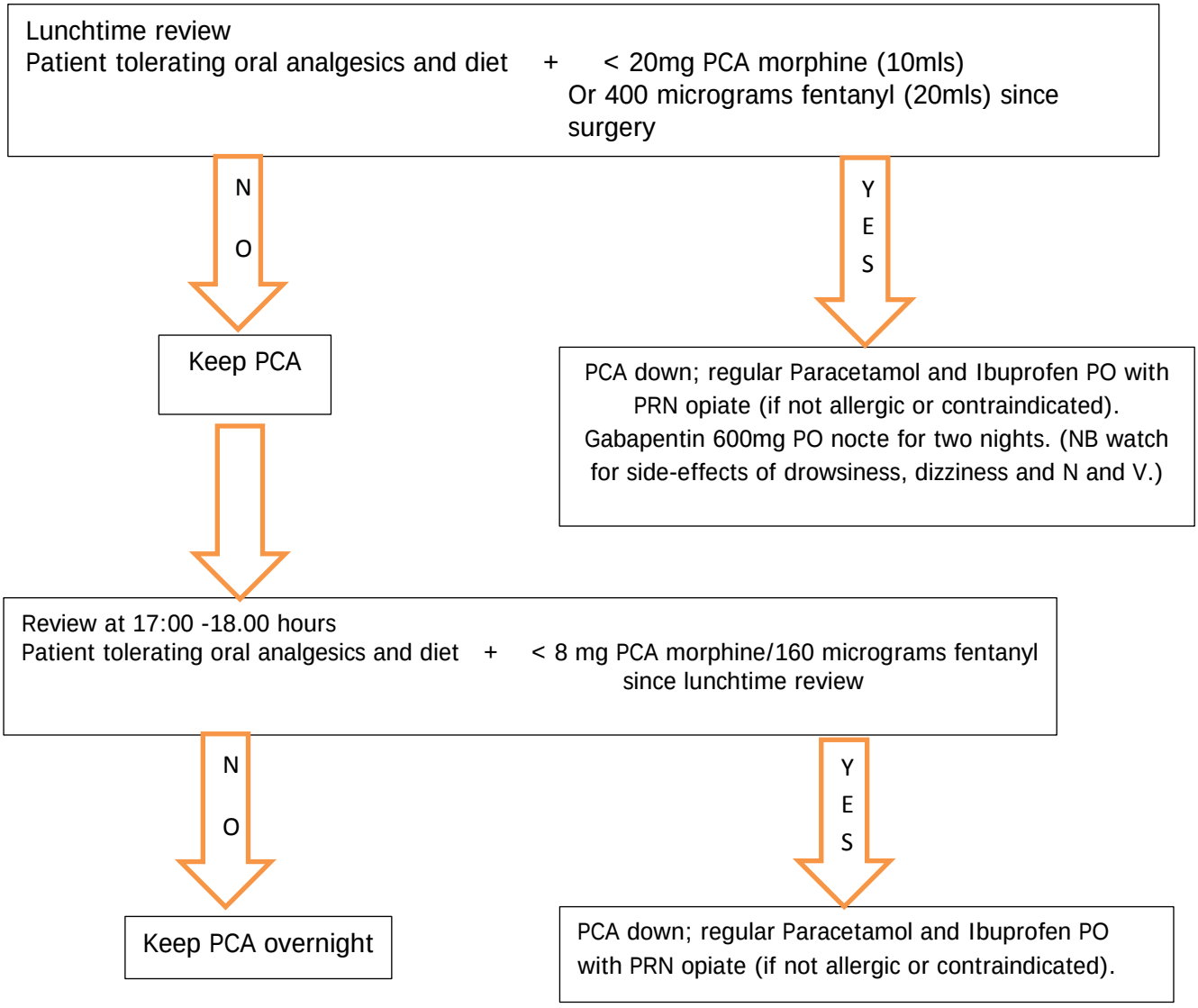
CLAVIEN-DINDO GRADING SYSTEM FOR THE CLASSIFICATION OF SURGICAL COMPLICATIONS

Grades	Definition
Grade I:	Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic and radiological interventions. Allowed therapeutic regimens are: drugs as antiemetic's, antipyretics, analgesics, diuretics and electrolytes and physiotherapy. This grade also includes wound infections opened at the bedside.
Grade II:	Requiring pharmacological treatment with drugs other than such allowed for grade I complications. Blood transfusions and total parenteral nutrition are also included.
Grade III:	Requiring surgical, endoscopic or radiological intervention
Grade III-a:	Intervention not under general anaesthesia
Grade III-b:	Intervention under general anaesthesia
Grade IV:	Life-threatening complication (including CNS complications: brain haemorrhage, ischaemic stroke, subarachnoid bleeding, but excluding transient ischaemic attacks) requiring IC/ICU management.
Grade IV-a:	Single organ dysfunction (including dialysis)
Grade IV-b:	Multi-organ dysfunction
Grade V:	Death of a patient
Suffix 'd':	If the patients suffer from a complication at the time of discharge, the suffix "d" (for 'disability') is added to the respective grade of complication. This label indicates the need for a follow-up to fully evaluate the comp

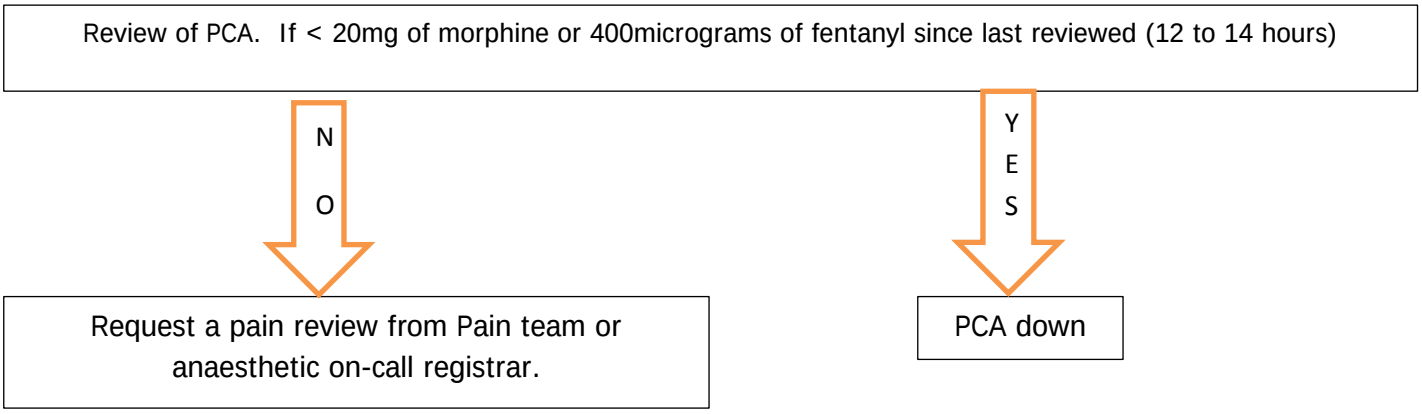
Appendix 2

PCA Flow chart for management post elective major surgery

Day One. Encourage mobilisation (cap PCA for this).



Day Two



Appendix 3

Post-Op Flap Guidelines for Breast Reconstruction

DIEP/ MS-TRAM Flaps

	Flap Obs	Dopplering	Comments
Post-Op	½ Hrly	2 Hrly (if instructed)	
Day 1	1 Hrly	4 Hrly (if instructed)	Into Bra- Keep Warm, Into Binder/Support Knickers & Mobilise
Day 2-3	2-4 Hrly		
Day 4+	BD		

TUG Flaps

	Flap Obs	Dopplering	Comments
Post-Op	½ Hrly	2 Hrly (if instructed)	
Day 1	1 Hrly	4 Hrly (if instructed)	Into Bra - Keep Warm & into Cycling Shorts - Mobilise with Knees together/No Abduction.
Day 2-3	2-4 Hrly		
Day 4+	BD		

LD Flaps

	Flap Obs	Comments
Post-Op	1 Hrly	
Day 1	2 Hrly	Into Bra – Mobilise
Day 2-3	4 Hrly	
Day 4+	BD	

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Breast Team
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