Queen Victoria Hospital
NHS Foundation Trust

PATIENT DEMOGRAPHIC:		DO NOT WRITE IN THIS SECTION	
PATIENT SURNAME:			METADATA
PATIENT FORENAME(S):			ERAS+++
NHS NUMBER: AFFI	PATIENT ID		
HOSPITAL NUMBER: L	BEL HERE	Form Version: V0.1	
DATE OF BIRTH:		Version Owner: REBECCA SPENCER	
		Original Template Location: N:\EDM Project Management\bForms\Completed	
		Date of PDG Approval: 09/02/2021	Date of EDM Approval: 16/02/21

CONSULTANT:

ALLERGIES:

Enhanced Recovery after Surgery (ERAS)
Breast Reconstruction Pathway
DIEP / MS-TRAM / SIEA abdominal flaps & TUG / LUG / DUG thigh flaps

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 & Sophie Kirk - Macmillan Breast Reconstruction Nurse Specialists
(Ex 4302 / 4306 / 4163) or Qvh.breastcare@nhs.net
Alex Molina – Consultant Plastic Surgeon & Lead for Breast
Colin Lawrence - Consultant Anaesthetist

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, 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 if patient is high risk				
Ensure patient is not smoking or using any nicotine products (e.g. vape)				
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 pre-op photographs if not already done in outpatients clinic				
Support garments discussed with patient				
Stop Tamoxifen* **3-4** weeks before surgery – date to be stopped: / /				
Anaesthetic review complete – discuss pain relief & PCA				
Gabapentin **600mg** PO prescribed for **induction** **300mg 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 15 injections (and prescribe on drug chart as above) *(1 for self-administration night before surgery & remaining 14 for discharge)*				
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®) **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: / / ***C-WING Ward Staff / MTR staff to complete***	**Initial**	**Yes**	**Variance**	**N/A**
Admission paperwork completed				
Baseline observations taken (Temp, Pulse, BP, Respiratory Rate & Sa02)				
Pre op weight kg				
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				
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 provided to patient				
4 x 200ml pre-op Nutricia Carbohydrate drinks have been taken by midnight **(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 @ 07:30***				
Ensure 2 x 200ml pre-op Nutricia Carbohydrate drinks have been taken by 06:30 **(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				
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:

Affix patient label

NHS
Queen Victoria Hospital
NHS Foundation Trust

Pre-operative checklist

Pre-operative Observations

Pulse_____bpm BP_____/_____

Purpose T _____

O_2 Sats_____% RR_____

Temp _____ ^{0}C Weight_____kg

Height_____cm INR _____

Glycaemic monitoring

Diabetic patient Yes ☐ No ☐

Type 1 / Type 2

Pre-op_____mmol/L at____:____

Intra-op_____mmol/L at____:____

Postop_____mmol/L at____:____

Barrier Nursing required:

Yes ☐ No ☐

If yes, specify:

_____

_____

ADMISSION AREA

	Yes	No	N/A
Notes / Drug chart	☐	☐	
Consent form / Patient marked	☐	☐	
Patient identification band in situ Allergies (specify).....	☐	☐	
Time of last food (24hr clock)			
Time of last drink (24hr clock) Type of drink			
Blood results Date ..... (If applicable)			
Group and Save ☐1 G&S sample sent ☐ 2 G&S sample sent ☐ x-matched blood____units			
VTE Assessment completed	☐	☐	
Anti-embolic stockings applied	☐	☐	
If NO state reason			
Check and confirm status on all women to childbearing age			
Could you be pregnant? YES / NO / N/A Pregnancy test result ..... (If patient declines to disclose, this must be documented)	☐	☐	☐
Electrocardiogram (ECG)	☐	☐	☐
Dentures / Caps / Crowns / loose teeth (Please circle if applicable)			
Contact lenses removed	☐	☐	☐
Hearing aid Left / Right Removed / Worn (Please circle if applicable)			
False nails / nail varnish / make-up removed (Please circle if applicable)			
Jewellery / Rings taped or removed (Please circle if applicable)			
Body piercing taped or removed Area of piercing			
Prosthesis / pacemaker / joint replacement / metalwork (specify) ..... (Please circle if applicable)			
Does the patient have a learning disability / dementia passport?	☐	☐	

Ward Nurse / Reg Pract	Signature	Full name (PRINT)	Date	Time

STOP

Patient not to leave ward / MTR unless completed

Name band ☐ Hospital number ☐ Consent ☐

Date of birth ☐ Marking ☐

General/Regional/Sedation Anaesthetic Surgical Safety Checklist

Patient safety champion of the day to take lead.

Sign in Anaesthetist to lead

Before induction of anaesthesia

Anaesthetic practitioner and anaesthetist agree:

☐ Patient has confirmed identity, procedure and consent

☐ Signed by patient and surgeon

Patient has confirmed marking of intended surgical site (or not applicable)

☐ Verify site before block inserted ☐ N/A

☐ Confirm with surgeon correct implant / prostheses (if required)

Known allergy?

☐ Yes .....

.....

☐ No

Is there a known difficult airway / aspiration risk?

☐ Yes - and equipment / assistant available

☐ No

☐ Areas of pressure checked ☐ N/A

Risk of >500ml blood loss (7ml/kg in children)

☐ No

☐ Yes - adequate IV access fluids planned and discussed with team

Group & Saved

☐ Yes

☐ No

Cross-Matched

☐ Yes

☐ No

☐ N/A

Is glycaemic monitoring required?

☐ Yes

☐ No

Sign

Designation

Date

Time out Operating surgeon to lead

Before skin prep

Staff member calls out - whole team confirms:

☐ All team members have stated their name / role

☐ Confirm ID band, notes, consent form, drug chart and allergies

☐ Surgeon verifies procedure and surgical site

To scrub nurse:

☐ Sterility & safety of equipment checked

☐ Expected specimens

☐ Implants

Anticipated critical events to surgeon and anaesthetist:

Are there any critical issues?

☐ Yes ☐ No

Has antibiotic prophylaxis been given within 30 mins of knife to skin?

☐ Yes ☐ No ☐ N/A

Surgeon, are you anticipating blood loss of >500ml (7ml/kg in children)?

☐ Yes ☐ No ☐ N/A

VTE prophylaxis?

☐ Yes ☐ No ☐ N/A

Has essential imaging been displayed?

☐ Yes ☐ No ☐ N/A

Have patient warming devices been applied?

☐ Yes ☐ No

Sign & Print

Designation

Date

Sign out Operating Surgeon to lead

Before any member of team leaves operating room

Staff member calls out:

☐ Confirm the name of the procedure

Is the final count for instruments, swabs and sharps correct?

☐ Yes

☐ No

Check that specimens are labelled with:

☐ Correct patient name

☐ Description of specimen

☐ Correct site and side

☐ Destination

Has throat pack been removed?

☐ Yes ☐ No ☐ N/A

Are there any equipment problems to be addressed?

☐ Yes - and communicated for actioning

☐ No

Dental pack ☐ Yes ☐ No ☐ N/A

Tourniquet removed ☐ Yes ☐ No ☐ N/AIV line flushed ☐ Yes ☐ No

Has the Eye Shield been removed and recorded?

☐ Yes ☐ No ☐ N/A

To surgeon and registered practitioner:

☐ Key concerns for recovery and management for patient

Pressure area check? ☐ Yes ☐ No ☐ N/A

Datix ☐ Yes ☐ No

Sign out is now complete

Sign & Print *Surgeon / Anaesthetist*

Sign & Print *Theatre staff*

Designation

Date

Affix patient label

Queen Victoria Hospital

NHS Foundation Trust

NHS

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 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 / Gentamicin 160mg IV
ETT
2nd peripheral cannula inserted (large bore)
2nd G & S
Arterial Line/non-invasive BP (NiBP)
Indwelling Urinary Catheter (IDC) & temperature probe inserted
Warmed Fluids
Warming Mattress
Flotron 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)
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**

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……..

Recovery

Date……

Transfer to Recovery- Time: : hrs	**Initial**	**Yes**	**Variance**	**N/A**
Observations within range				
Trial without O2. SpO2 > or equal to 95% / same as pre-op. If O2 is low then prescribe oxygen				
Arterial blood gas (ABG) review & arterial line removed if satisfactory				
Medication				
If PCA requested by Anaesthetist **(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). Ensure clear hand-over to EHRA about fluid balance. Maximum total intake of 2,100mls oral fluid in first 24hr period. No more than 1000mls from Recovery to 6am day 1. If patient thirst requires more fluids, trigger a medical review.				
IDC in situ & urine output >0.5mls/kg/hr				
2 x IV cannulas in situ and patent				
IV Fluid -Continued ☐ Discontinued ☐ (aim to discontinue ASAP)				
Sips of clear fluid tolerated (do not encourage a specific amount, patient to drink only when thirsty)				
Bair hugger (ONLY if requested by surgical team)				
Anti-embolism stockings in situ				
Flotron boots in situ				
Position				
Back of bed raised / 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				

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

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Recovery Clinical Notes

Date……

Date & Time:		Signature:

Post-surgery fluid intake

Maximum of 2,100mls in first 24 hours (all drinks included)

No more than 1000mls from Recovery to 6am day 1

If patient thirst requires more fluids, trigger a medical review

(E.g., total of 8.4 glasses/mugs in a day, or 8 glasses/mugs + 1 carton of OJ)

Please ensure glass/mug is empty before refilling

Tick box for every drink consumed

	Glass	Mug	Carton
Date of surgery: …… Time returned to ward: …… Date & Time 24 hour period ends:	☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls	☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls ☐ 250mls	☐ 85mls ☐ 85mls ☐ 85mls ☐ 85mls ☐ 85mls ☐ 85mls ☐ 85mls ☐ 85mls
Total:			

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 (ONLY if requested by surgical team)				
If returned from recovery on oxygen - providing SpO2 > or equal to 95% / same as pre-op, then discontinue.				
Observations (documented on NEWS chart & Flap Obs Chart)				
Cardiovascular observations within range				
Flap observations every 30 minutes until midnight then hourly (appendix 3)				
Doppler every 2 hours – satisfactory				
Wound/Pressure Area Care				
Dressings dry & intact				
Pressure areas intact				
Anti-embolism stockings in situ				
Flotron boots in situ				
Diet & Fluid				
Tolerating food. Input & Output clearly documented on fluid balance chart (including totalvolumes from theatre). Use specific chart for breast patients (see page 12) and mugs/glasses provided for accurate measuring. Maximum total intake of 2,100mls oral fluid in first 24hr period. No more than 1000mls from Recovery to 6am day 1. If patient thirst requires more fluids, trigger a medical review.				
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 **300mg** PO **(at night only)**				
Oral analgesia				
Laxatives				
Anti-emetics				
Check patients own regular medications have been prescribed				

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

Patient addressograph / details

Name: ……..……..

D.O.B: ……...

Hosp No: ……...

Post-Op: Afternoon/ 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)					
Blood results & fluid balance reviewed by surgeon					
Reviewed by Outreach Nurse					
Observations (documented on NEWS Chart & Flap Obs Chart)					
Cardiovascular observations within range					
Flap observations 1 hourly until midday then 2 hourly – (see appendix 3)					
Doppler every 4 hours					
Diet & Fluids					
Tolerating oral diet & fluids (do not encourage a specific amount to drink) Input & Output clearly documented on fluid balance chart (including total volumes from theatre). Use specific chart for breast patients and mugs/glasses provided for accurate measuring.					
Time 24hr fluid restriction ends…… (see pg.12) Total amount of oral fluid consumed in 24hrs…… *Maximum total of 2,100mls oral fluid in first 24hr period*					
Aim to eat at least 1 x meal in chair					
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)					
Post op weight kg					
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					
Flotron boots removed on mobilisation					
ADLs					
Assisted with wash					
Drain bag & cushion given to patient					
Seen by physiotherapy & exercise sheet given					
Sit out in chair & encourage mobilising throughout day					
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 **Morphine mg / Fentanyl mcg (see appendix 2 for PCA protocol)**					
Fit for transfer to main ward? **Yes** ☐ **No** ☐ Transfer to main ward – **Time: : hrs**					

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 2 hours until midnight then 4 hourly – satisfactory				
Doppler every 4 hours – satisfactory (see appendix 3)				
Bloods				
Check blood results have been reviewed by surgeon				
Diet & Fluids				
1 x IV cannula patent (if still required, otherwise remove).				
Tolerating diet & fluids (do not encourage a specific amount, patient to drink only when thirsty)				
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/SIEA & abdomen if TUG/LUG/DUG)				
Gabapentin **300mg** PO **(at night only)**				
Oral analgesia				
Laxatives				
Anti-emetics				
PCA patent *If still in situ* **(see appendix 2 for PCA protocol)**				

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 4 hours – satisfactory (see appendix 3)				
Diet & Fluids				
Remove IV cannula (if still remains)				
Tolerating oral diet & fluids (do not encourage a specific amount, patient to drink only when thirsty)				
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 discontinued (if still in situ) **(see appendix 2 for PCA protocol)**				

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 4 hours (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids (do not encourage a specific amount, patient to drink only when thirsty)				
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/SIEA & abdomen if TUG/LUG/DUG)				
Oral analgesia				
Laxatives				
Anti-emetics				

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 4-6 hourly – satisfactory (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids (do not encourage a specific amount, patient to drink only when thirsty)				
Eat all meals in the day room / sat in chair				
Bowels opened				
Drains				
Drainage documented on fluid balance chart				
Remove all remaining drains regardless of drainage (unless specifically instructed not to by the surgeon or the fluid is not serosanguineous)				
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				

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 6 hourly (see appendix 3)				
Diet & Fluids				
Tolerating diet & fluids (do not encourage a specific amount, patient to drink only when thirsty)				
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/SIEA & abdomen if TUG/LUG/DUG)				
Oral analgesia				
Laxatives				
Anti-emetics				

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: ……...

Discharge

Date……

Discharge	Insert	Yes	Variance	N/A
Wounds checked - dressings dry & intact (renewed where necessary)				
Check spare dressings given (inside complimentary drain bag)				
If being discharged with drain(s), apply BioPatch around drain site. Provide pt with x2 spare bottles, instructions for measuring, an orange clinical waste bag & instructions for reporting output (as per 'Going Home with Redivac Drain leaflet').				
'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 (unless there are specific instructions from the surgeon)				
Consultant / BCN follow up appointment requested for 6-8 weeks post-op				
Softie/Priform offered (if necessary, for asymmetry)				
Nipple prostheses offered & documented on discharge paperwork				
Check patient has a supply of Dalteparin at home for 7 days on discharge & and yellow sharps bin **(ensure it is prescribed on eDN)**				
Ensure patient is competent at self-administration of Dalteparin				
Give spare pair of anti-embolism stockings				
TTO Medication given				
Return any of patients own medications				
Instruct to recommence Tamoxifen **2 weeks post-operation date** (if applicable)				
Does the patient require a sick certificate/fitness to work?				
eDN complete & copy sent to GP				
NB:				
Immediate patients- please remind them that they will receive a separate follow-up appointment with their referring Breast Oncology Surgeon (for mastectomy results) 2 – 4weeks post-op				

Date & Time	Variance & Reason	Action Taken	Signature

Patient addressograph / details

Name: ……..……..

D.O.B: ……..

Hosp No: ……...

Discharge Clinical Notes

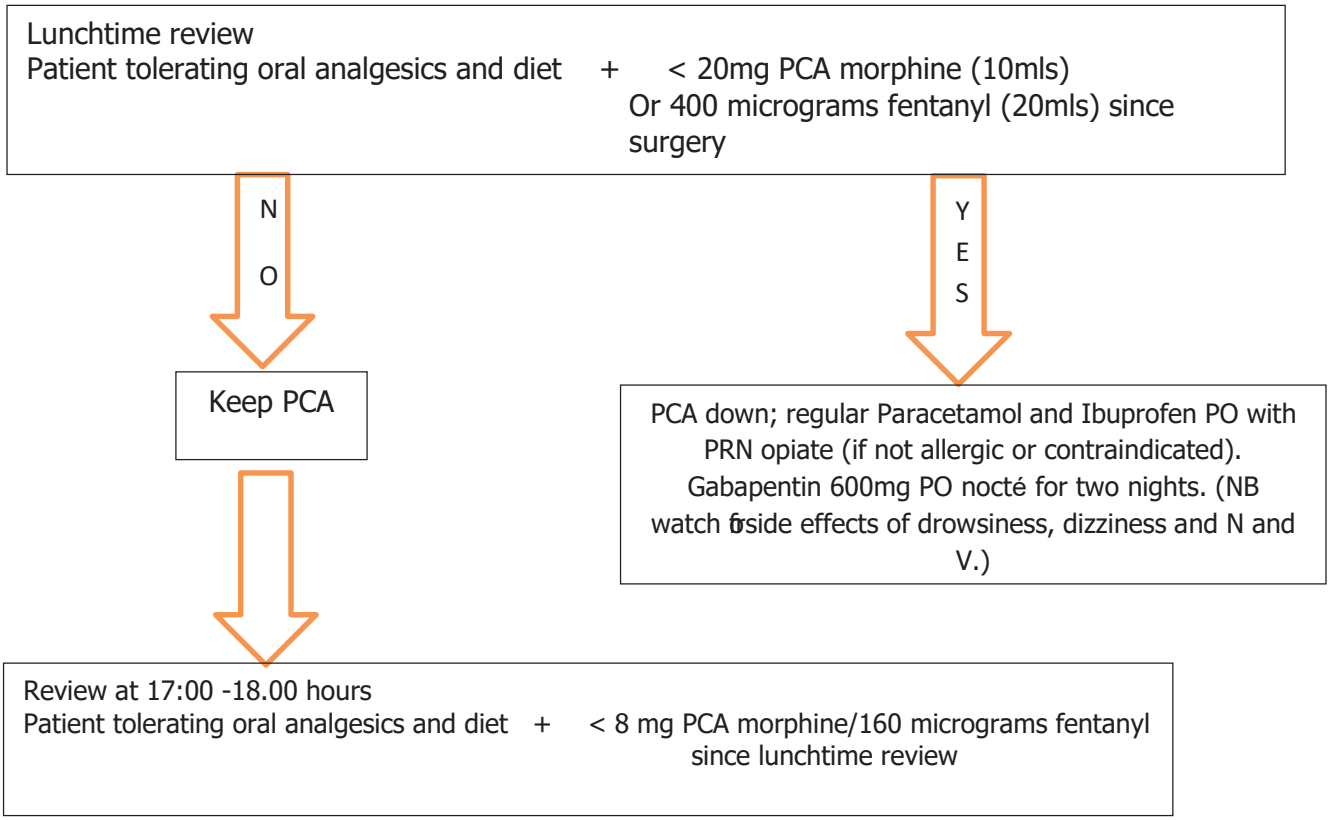
Date……

Date & Time:		Signature:

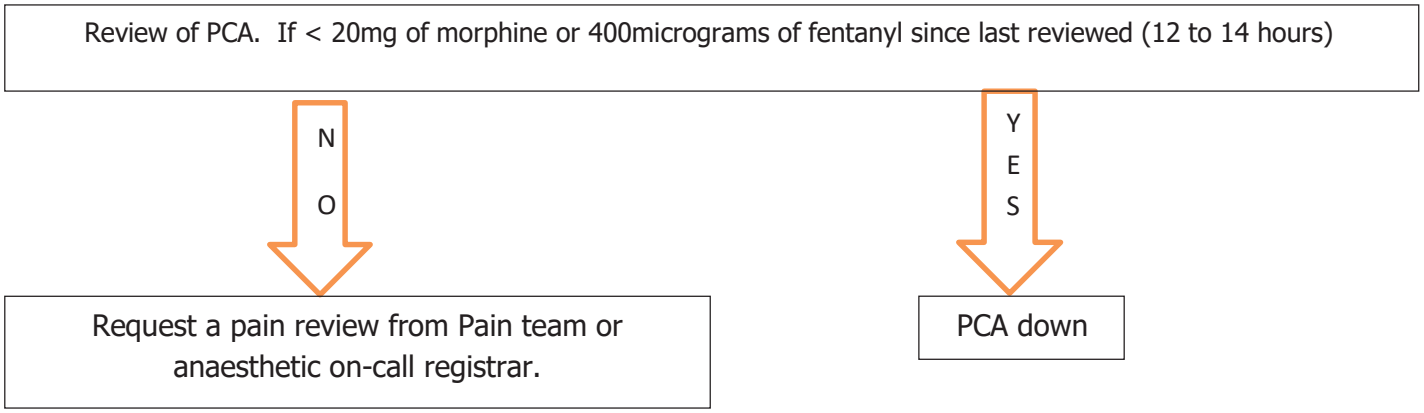
Appendix 2

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 all free flap breast reconstructions

	Flap Obs	Doppler
Post-Op	Every 30 minutes until midnight then hourly	2 hourly
Day 1	1 hourly until midday then 2 hourly	4 hourly
Day 2	2 hourly until midnight then 4 hourly	
Day 3	4-6 hourly	