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CARDIAC SURGERY CLINICAL PATHWAY

ACTIVITIES & OUTCOMES

Instructions for Use of Clinical Pathway Documentation

- The clinical pathway does not supersede existing physician orders.
- The 12-hour assessment record which includes the system assessment (head to toe) must also be completed for all patients each shift in addition to this clinical pathway.
- Clinical pathways may vary depending on the individual needs of the patient; the goal is to avoid significant variances from the standard.
- Initials are entered in each Care Category at the end of the shift to acknowledge that an outcome has been met.
- If an expected outcome is not met, please enter a variance, using an asterisk (*) in the relevant section, and a description in the nursing notes.

The Patient GOALS of this Pathway are to:

1. Prevent post-op complications
2. Extubate within 4 hours post-op
3. Ambulate within 24 hours post-op
4. Transfer out of CSICU POD 1
5. Discharge home POD 5
6. Control pain adequately for mobilizing, DB+C exercises, etc.
7. Provide effective discharge planning and teaching to patient and caregivers

Criteria for INCLUSION in the Pathway

- All patients having aortic valve, mitral valve, tricuspid valve, coronary artery bypass surgery and ascending aorta repair.

Criteria for EXCLUSION from the Pathway

- Descending aorta repair, TEVAR, non-cardiac surgical patients

Criteria for REMOVING a Patient from the Clinical Pathway

- A patient is deemed “off pathway” when significant deviations from the patient specific expected outcomes are noted.
- Nursing and physician team consensus is required to discontinue the clinical pathway.
- Please note the reason for a patient being “off pathway” in the nursing notes.

SURGERY PRE-OP ASSESSMENT INPATIENT UNIT		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Diagnostic blood work as per pre-printed pre-op order sets (unless done and available within 48 hours of admission) ▪ Type & cross match 2 units PRBC ▪ Capillary blood glucose QID (for diabetic patients) ▪ PA and left lateral CXR (unless done within 48 hours and available for inter-hospital transfer or within 6 weeks for elective patients) ▪ ECG (unless done within 48 hours of admission and available) +/- echocardiogram, carotid Doppler studies ▪ Consent for OR and blood transfusion completed ▪ Old chart ordered ▪ Pre-op checklist initiated ▪ Telemetry as per orders	▪ Physician aware of abnormal blood work results ▪ Pre-op checklist initiated ▪ Diagnostic tests completed or booked ▪ Consents signed as per protocol		
Consults ▪ Anaesthesia ▪ Psychiatry	▪ Consults initiated		
Patient/Family Teaching ▪ Review surgery planned (estimated length of OR time, CSICU and hospital stay) with patient and family ▪ Arrange to view pre-op video ▪ Review medication instructions, NPO, chlorhexidine wipes ▪ Orientation to CSICU and CP10A ▪ Review cardiac surgery patient guide with patient and family; ▪ Post-op mobility limitations and sternal precautions ▪ Possible changes in mood/depression ▪ Post-op delirium and management protocol ▪ Importance of deep breathing and coughing post-op ▪ Maintaining optimal nutritional status and bowel hygiene	▪ Instructions for admission and surgical preparation reviewed with patient and family ▪ Patient and family have watched pre-op video and reviewed post-op expectations and potential complications with nurse ▪ Cardiac Surgery patient education materials reviewed with patient and family ▪ Patient and family understand post-op course and possible complications		
Discharge Planning ▪ Discuss expected length of stay ▪ Discuss usual hospital post-op course ▪ Discuss post-op home needs	▪ These discussions have taken place with patient and when possible with family.		

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CLINICAL PATHWAY
CARDIAC SURGERY
ACTIVITIES & OUTCOMES

SURGERY POST-OP DAY 0 CSICU

DATE: _____

CARE CATEGORIES DAILY TASKS AND ACTIVITIES	EXPECTED OUTCOMES	DAYS	NIGHTS
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work, ABGs as per PPOs ▪ Glucose monitoring as per PPOs ▪ Portable CXR, ECG (unless A-V or V paced)	▪ The results of the following are within acceptable range: ABG, SvO_2, CBC, CP7, ion Ca, Mg, Phos, LA, Coags ▪ CXR completed and reviewed by MD ▪ ECG completed and reviewed by MD		
Central Nervous System ▪ Sedation and analgesic administered as per pre-printed orders ▪ ICDSC as per nursing standard	▪ CPOT or VPS ≤ 3 ▪ RASS 0 ▪ ICDSC <4		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain MAP, SBP, HR, CI, SvO_2 per physician orders ▪ Temporary pacing as per nursing standards ▪ Monitor CT drainage with vital signs	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Inotropes stable (minimal titration) or weaned off ▪ Normothermic (Temp 36º to 37.5º C) within 2 hours post-op ▪ If chest tube drainage ≥ 200 ml/hr, inform CSICU physician		
Respiratory System ▪ Maintain PaO_2 above 80 mmHg ▪ Maintain SpO_2 ≥ 93% as per respiratory standard ▪ Assess weaning criteria respiratory standard	▪ Lung sounds within normal parameters for post-op patient ▪ Extubated within 6 hours post-op ▪ Chlorhexidine mouthwash pre/post extubation		
Gastrointestinal System ▪ Diet as ordered ▪ Screen for dysphagia post-extubation ▪ Insulin sliding scale as ordered	▪ Nausea and vomiting absent or controlled with antiemetic ▪ Tolerating clear fluids ▪ Tolerating oral medication ▪ Blood glucose maintained < 10 mmoL/L as per protocol		
Genitourinary System ▪ Maintain urine output between 0.5 to 1 ml/kg/h	▪ Urine output is between 0.5 to 1 ml/kg/h		
Skin ▪ Assess using Braden Scale on admission and every shift ▪ Dressings assessed as per nursing standard	▪ Braden scale risk assessment ▪ Dressing(s) dry and intact ▪ Chlorhexidine wash at 6 hours post-op ▪ Remove Hemovac if drainage less than 50 ml/hr		
Mobility & Exercise ▪ Sternal precautions ▪ Deep breathing & coughing exercises ▪ Activity per Physiotherapist	▪ Pain level allows effective deep breathing & coughing ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated as ordered		
Patient & Family Teaching ▪ Oriented to plan of care for the next 24 hours ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing	▪ Patient & family understand plan of care ▪ Patient & family understand pain control management ▪ Patient & family understand sternal precautions, importance of deep breathing & coughing		

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CLINICAL PATHWAY
CARDIAC SURGERY
ACTIVITIES & OUTCOMES

SURGERY POST-OP DAY 1 CSICU		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work, ABGs as per PPOs ▪ Glucose monitoring as per PPOs ▪ Portable CXR, ECG (unless A-V or V paced)	▪ The results of the following are within acceptable range: ABG, SvO_2, CBC, CP7, ion Ca, Mg, Phos, LA, Coags ▪ CXR completed and reviewed by MD ▪ ECG completed and reviewed by MD		
Central Nervous System ▪ Sedation and analgesic administered as per pre-printed orders ▪ ICDSC/CAM as per nursing standard	▪ VPS ≤ 3 ▪ RASS 0 ▪ ICDSC <4		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain MAP, SBP, HR, CI, SvO_2 per physician orders ▪ Temporary pacing as per MD/NP order or unit based standard	▪ Patient in stable intrinsic cardiac rhythm ▪ Hemodynamically stable ▪ Inotropes weaned off ▪ Normothermic (Temp 36º to 37.5º C) ▪ Invasive monitoring discontinued (Art line, PA catheter)		
Respiratory System ▪ Maintain PaO_2 above 80 mmHg ▪ Maintain SpO_2 ≥ 93% as per respiratory standard ▪ Assess weaning criteria respiratory standard ▪ Monitor CT drainage and D/C chest tubes as per MD/NP order	▪ No signs of respiratory complications ▪ Lung sounds within normal parameters for post-op patient ▪ Chest tubes removed if ≤150 ml for 4 hrs or as ordered ▪ Mouth care after meals		
Gastrointestinal System ▪ Diet as ordered ▪ Screen for dysphagia post-extubation ▪ Insulin sliding scale as ordered	▪ Tolerating prescribed diet ▪ No nausea or vomiting ▪ Insulin infusion weaned off ▪ Blood glucose QID		
Genitourinary System ▪ Maintain urine output between 0.5 to 1 ml/kg/h	▪ Urine output is between 0.5 to 1 ml/kg/h		
Skin ▪ Assess using Braden Scale on admission and every shift ▪ Dressings assessed as per nursing standard	▪ Braden scale risk assessment ▪ Dressing(s) dry and intact. Reinforce PRN. ▪ No evidence of skin breakdown ▪ Drains removed as ordered		
Mobility & Exercise ▪ Sternal precautions ▪ Deep breathing & coughing exercises ▪ Activity per Physiotherapist	▪ Initial stand ▪ Chair position or in chair for all meals ▪ Pain level allows effective deep breathing & coughing ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care for the next 24 hrs ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing	▪ Patient & family understand ○ Plan of care ○ Pain control management ○ Sternal precautions, importance of deep breathing & coughing		

SURGERY POST-OP DAY 1 RECEIVING UNIT		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation	▪ Physician and/or NP are aware of abnormal results ▪ Target INR established and anticoagulation ordered as needed		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain SBP & HR as per physician orders ▪ ECG strips Q4H or with a change in rhythm ▪ Temporary pacing as per MD/NP order or unit standard	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Temp 36º to 37.5º C		
Respiratory System ▪ Wean from O2 and maintain SpO2 above 93% ▪ Deep breathing and coughing exercises ▪ Monitor CT drainage with vital signs ▪ D/C chest tubes as per MD/NP order	▪ Lung sounds within normal parameters for a post-op patient ▪ No signs of respiratory complications ▪ If chest tube drainage > 200 ml/hr, inform MD/NP ▪ Chest tubes removed without complication if ordered		
Gastrointestinal System ▪ Diet as ordered ▪ Insulin sliding scale as ordered ▪ If no BM x 24 hours, follow protocol	▪ Tolerating oral medication ▪ Tolerating prescribed diet ▪ No nausea & vomiting ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily ▪ Remove catheter as per MD/NP order	▪ Urine output is between 0.5 to 1 ml/kg/h (minimum 30 cc/h) ▪ Foley catheter removed if ordered		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Dressing(s) dry and intact		
Mobility & Exercise ▪ Sternal precautions ▪ Activity per Physiotherapist	▪ Pain level allows effective deep breathing & coughing ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ The discussion of these topics took place		

SURGERY POST-OP DAY 2

DATE: _____

CARE CATEGORIES DAILY TASKS AND ACTIVITIES	EXPECTED OUTCOMES	DAYS	NIGHTS
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation as needed	▪ Physician and/or NP are aware of abnormal results ▪ Target INR established and anticoagulation ordered as needed		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain SBP & HR as per physician orders ▪ ECG strips Q4H or with a change in rhythm ▪ Temporary pacing as per MD/NP order or unit standard	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Temp 36º to 37.5º C		
Respiratory System ▪ Wean from O2 and maintain SpO2 above 93% ▪ Deep breathing and coughing exercises ▪ Monitor CT drainage with vital signs ▪ D/C chest tubes as per MD/NP order	▪ Lung sounds within normal parameters for patient ▪ No signs of respiratory complications ▪ If chest tube drainage > 200 ml/hr, inform MD/NP ▪ Chest tubes removed without complication if ordered		
Gastrointestinal System ▪ Diet as ordered ▪ Insulin sliding scale as ordered ▪ If no BM x 24 hours, follow protocol	▪ Tolerating oral medication ▪ Tolerating prescribed diet ▪ No nausea & vomiting ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily ▪ Remove catheter as per NP/MD order	▪ Foley removed without complications if ordered ▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Dressing(s) dry and intact		
Mobility & Exercise ▪ Sternal precautions ▪ Activity per Physiotherapist	▪ Pain level allows effective deep breathing & coughing ▪ Sternal precautions maintained ▪ Patient ambulating independently as tolerated		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ The discussion of these topics took place		

SURGERY POST-OP DAY 3		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation	▪ Physician and/or NP are aware of abnormal results ▪ Target INR established and anticoagulation ordered as needed		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain SBP & HR as per physician orders ▪ ECG strips Q4H or with a change in rhythm ▪ Temporary pacing as per MD/NP order or unit standard	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Temp 36º to 37.5º C ▪ If chest tube drainage > 200 ml/hr, inform MD/NP		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises ▪ D/C chest tubes as per MD/NP order ▪ Monitor CT drainage with vital signs	▪ Lung sounds within normal parameters for post-op patient ▪ No signs of respiratory complications ▪ Chest tubes removed without complication if ordered		
Gastrointestinal System ▪ Diet as ordered ▪ If no BM x 48 hours, follow protocol and notify MD/NP	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Dressing(s) removed, incision cleaned, well approximated, dry and intact, incision left exposed to air		
Mobility & Exercise ▪ Sternal precautions	▪ Up to chair for meals ▪ Ambulated in hallway 3-6 times/day ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ The discussion of these topics took place		

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CARDIAC SURGERY
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SURGERY POST-OP DAY 4		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation	▪ Physician and/or NP are aware of abnormal results ▪ Target INR established and anticoagulation ordered as needed		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ Maintain SBP&HR as per physician orders ▪ ECG strips Q4H or with a change in rhythm ▪ D/C temporary wires as per MD/NP order	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Temp 36º to 37.5º C ▪ Epicardial wires removed without complications if ordered		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises	▪ Lung sounds within normal parameters for patient ▪ No signs of respiratory complications		
Gastrointestinal System ▪ Diet as ordered ▪ If no BM x 72 hours, follow protocol and notify MD/NP	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Incision well approximately, dry and intact		
Mobility & Exercise ▪ Sternal precautions	▪ Up to chair for meals ▪ Ambulated in hallway 3-6 times/day ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ The discussion of these topics took place ▪ Discharge booklet started and information gathered		

SURGERY POST-OP DAY 5

DATE: _____

CARE CATEGORIES DAILY TASKS AND ACTIVITIES	EXPECTED OUTCOMES	DAYS	NIGHTS
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation if needed	▪ Physician and/or NP are aware of abnormal results ▪ INR at target if on anticoagulation		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ ECG strips Q4H or with a change in rhythm ▪ D/C temporary wires as per MD/NP order	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable ▪ Epicardial wires removed without complications if ordered		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises	▪ No signs of respiratory complications		
Gastrointestinal System ▪ Diet as ordered	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Incision well approximately, dry and intact		
Mobility & Exercise ▪ Independent personal care	▪ Patient independent with personal care am ambulating as tolerated ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ Discharge teaching done ▪ Discharge documentation provided ▪ Staple removal kit and/or dressings provided as needed on discharge		

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CLINICAL PATHWAY
CARDIAC SURGERY
ACTIVITIES & OUTCOMES

ADDITIONAL SURGERY POST OP DAY ____		DATE:	
CARE CATEGORIES DAILY TASKS AND ACTIVITIES	**EXPECTED OUTCOMES**	**DAYS**	**NIGHTS**
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation if needed	▪ Physician and/or NP are aware of abnormal results ▪ INR at target if on anticoagulation		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ ECG strips Q4H or with a change in rhythm	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises	▪ No signs of respiratory complications		
Gastrointestinal System ▪ Diet as ordered	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Incision well approximately, dry and intact		
Mobility & Exercise ▪ Independent personal care	▪ Patient independent with personal care am ambulating as tolerated ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ Discharge teaching done ▪ Discharge documentation provided ▪ Staple removal kit and/or dressings provided as needed on discharge		

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CLINICAL PATHWAY
CARDIAC SURGERY
ACTIVITIES & OUTCOMES

ADDITIONAL SURGERY POST OP DAY ___

DATE: _____

CARE CATEGORIES DAILY TASKS AND ACTIVITIES	EXPECTED OUTCOMES	DAYS	NIGHTS
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation if needed	▪ Physician and/or NP are aware of abnormal results ▪ INR at target if on anticoagulation		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ ECG strips Q4H or with a change in rhythm	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises	▪ No signs of respiratory complications		
Gastrointestinal System ▪ Diet as ordered	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Incision well approximately, dry and intact		
Mobility & Exercise ▪ Independent personal care	▪ Patient independent with personal care am ambulating as tolerated ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ Discharge teaching done ▪ Discharge documentation provided ▪ Staple removal kit and/or dressings provided as needed on discharge		

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CLINICAL PATHWAY
CARDIAC SURGERY
ACTIVITIES & OUTCOMES

ADDITIONAL SURGERY POST OP DAY ___

DATE: _____

CARE CATEGORIES DAILY TASKS AND ACTIVITIES	EXPECTED OUTCOMES	DAYS	NIGHTS
		INITIAL OR *	
Key Diagnostics & Other Assessments ▪ Blood work and diagnostics as ordered ▪ Glucose monitoring as per PPOs ▪ MD or Pharmacist to determine target INR and required anticoagulation if needed	▪ Physician and/or NP are aware of abnormal results ▪ INR at target if on anticoagulation		
Central Nervous System ▪ Analgesics administered as ordered ▪ CAM as per nursing standard	▪ CAM negative ▪ Patient reports pain control as adequate		
Cardiovascular System ▪ Nursing assessment and vital signs frequency as per nursing standard ▪ ECG strips Q4H or with a change in rhythm	▪ Patient in stable cardiac rhythm ▪ Hemodynamically stable		
Respiratory System ▪ Maintain SpO2 above 93% on room air ▪ Deep breathing and coughing exercises	▪ No signs of respiratory complications		
Gastrointestinal System ▪ Diet as ordered	▪ Tolerating prescribed diet ▪ Bowel movement daily or as per patient normal		
Genitourinary System ▪ Dry weight daily	▪ Voiding without difficulty		
Skin ▪ Braden scale risk assessment ▪ Incision assessment and care daily	▪ Braden scale risk assessment complete ▪ Incision well approximately, dry and intact		
Mobility & Exercise ▪ Independent personal care	▪ Patient independent with personal care am ambulating as tolerated ▪ Sternal precautions maintained		
Consults ▪ As needed: Psychiatry, Endocrine, Social Work, Nephrology, other	▪ New consults initiated or patient seen by consultant as ordered		
Patient & Family Teaching ▪ Oriented to plan of care ▪ Pain scale and use of analgesics ▪ Sternal precautions ▪ Deep breathing & coughing ▪ Incision care	▪ Patient & family understand plan of care, pain control, sternal precautions, importance of deep breathing & coughing, and incision care		
Discharge Planning ▪ Discuss length of stay, goals, social support	▪ Discharge teaching done ▪ Discharge documentation provided ▪ Staple removal kit and/or dressings provided as needed on discharge		