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| RSUP Dr. Sardjito | CLINICAL PATHWAYAbses Leher Dalam(ICD X: J 39.0; J 36.0; K 12.2) |
|  |
|  | No. RM : ………………………………… |

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| Nama Pasien |  | BB | Kg |
| Jenis kelamin |  | TB | Cm |
| Tanggal Lahir |  | Tgl. Masuk | Jam :  |
| Diagnosa Masuk RS |  | Tgl. Keluar  | Jam : |
| Penyakit Utama |  | Kode ICD :Lama Rawat | Hari |
| Penyakit penyerta |  | Kode ICD :Rencana Rawat |  |
| Komplikasi |  | Kode ICD :R. Rawat/Klas | / |
| Tindakan |  | Kode ICD :Rujukan | Ya/Tidak |
| Dietary Counseling and Surveilance Kode ICD : Z71.3 |

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| **KEGIATAN** | **URAIAN KEGIATAN** | **HARI PENYAKIT** | **KETERANGAN** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| **HARI PERAWAT** |
| 1 pre-op | 2 op | 3 post-op | 4 post-op | 5 post-op | 6 post-op | 7 post-op | 8 post-op | 9 post-op | 10 post-op | 11 post-op | 12 post-op | 13 post-op | 14 post-op |
| 1. | Assesmen Awal |
|  |  |
|  | Assesmen Awal Medis | Dokter IGD |  |  |  |  |  |  |  |  |  |  |  |  |  |  | masuk melalui IGD |
| Dokter Spesialis |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Masuk melalui IRJ |
| Assemen Awal Keperawatan | Melakukan assesmen sesuai format asesmen keperawatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. | Laboratorium | Darah lengkap |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Darah lengkap dilakukan per3 hari |
| PT dan APTT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| SGPT/SGPT |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ureum Kreatinin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Albumin |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Glukosa darah sewaktu |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HbSAg |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kultur resistensi pus |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Varian |
| 3. | Radiologi/ Imaging | Ro Thorax PA |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CT Scan servical dengan kontras |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| CT Scan servical extended toracal dengan kontras |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. | Penunjang Lain | EKG |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. | Konsultasi | Konsul Bedah Mulut |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Konsul UPD |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Konsul Anestesi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. | Asesmen Lanjutan |
| A. Asesmen Medis | Dokter DPJP |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Visite harian/ Follow up |
| Dokter Non DPJP / dr ruangan |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Atas Indikasi/ Emergency |
| B. Asesmen Keperawatan | Perawat |  |  |  |  |  |  |  |  |  |  |  |  |  |  | dilakukan dalam 3 shift |
| C. Asesmen Gizi | Tenaga Gizi (Nutrisionis/ Dietisen) |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Lihat risiko malnutrisi melalui skrining gizi dan mengkaji data antropometri, biokimia, fisik/ klinis, riwayat makan termasuk alergi makanan serta riwayat personal |
| D. Asesmen Farmasi | Telaah resep |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Dilanjutkan dengan intervensi farmasi yang sesuai |
| Rekonsiliasi Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. | Diagnosis |
| A. Diagnisis Medis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Diagnosis Keperawatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Diagnosis Gizi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8.  | Discharge Planning | Identifikasi Kebutuhan Edukasi dan Latihan Selama Perwatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Program pendidikan pasien dan keluarga |
| Identifikasi kebutuhan di rumah |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hand Hygiene |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. | Edukasi Terintegrasi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A. Edukasi/ Informasi Medis | Penjelasan Diagnosis |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Oleh semua pemberi asuhan berdasarkan kebutuhan dan juga berdasarkan Discharge PlanningPengisian formulir informasi dan edukasi terintegrasiDi TTD Keluarga Pasien |
| Rencana Terapi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Informed Consent |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| B. Edukasi & Konseling Gizi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| C. Edukasi Keperawatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| D. Edukasi Farmasi | Informasi Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Konseling Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pengisian Formulir Informasi Dan Edukasi Terintegrasi | Lembar Edukasi Terintegrasi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. | Terapi Medika Mentosa |
| a. Injeksi | Ceftriaxon 1gr/12jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Jenis antibiotik disesuaikan setelah hasil kultur pus dan sensitivitas sudah keluar atau dipertimbangkan/ disesuaikan bila ada advice lain dari TS UPD  |
| Metronidazol 500mg/8jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Antibiotik Definitif sesuai hasil kultur pus dan sensitivitas |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ketorolac 30mg/8jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Ketorolac 30mg ekstra |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Diberikan secara situasional saat dressing abses |
| Paracetamol 500mg/8jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Diberikan saat suhu pasien >37,5 derajat celcius dan diberikan sebagai analgetik pengganti ketorolac setelah h2 post operasi |
| Metilprednisolon 125mg/12jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Tapering off per3 hari |
| Pemeberian PPI atau H2-blocker atau sucralfat |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Dosis disesuaikan  |
| Asam Tranexamat 500mg/8jam |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. Cairan Infus |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Jenis cairan ringer lactat namun bisa berubah tergantung advice dari TS UPD |
| c. Obat Oral | Kalium/ Natrium Diclofenac |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Antibiotik sesuai kultur Sensitivitas |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. | Tatalaksana/Intervensi (TLI) |
| a. TLI Medis | Eksplorasi multiple abses |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tonsilektomi |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Bila terindikasi |
| Trakeostomi |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Bila terindikasi |
|  | Dressing abses |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. TLI Keperawatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. TLI Gizi | Manajemen nyeri  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manajemen Cairan  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Kontrol Infeksi  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manajemen Pengobatan  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monitoring tanda vital  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Latihan mobilisasi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d. TLI Farmasi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. | Monitoring & Evaluasi (Monitor Perkembangan Pasien) |
|  | a. Dokter DPJP |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. Keperawatan | (mengacu ke TLI) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. Gizi | Monitoring Asupan makan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monitoring Antropometri |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monitoring Biokimia |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monitoring Fisik/Klinis terkait gizi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d. Farmasi | Monitoring Interaksi Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Monitoring Efek Samping Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Pemantauan Terapi Obat |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. | Mobilisasi/rehabilitasi |
|  | a. Medis |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Tahapan mobilisasi sesuai kondisi pasien |
| b. Keperawatan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. Fisioterapi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. | Outcome/hasil  |
|  | a. Medis | Produksi pus <5cc |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b. Keperawatan | Nyeri terkontrol  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Tanda vital dalam batas normal |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobilisasi hingga berjalan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Balance cairan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c. Gizi | Tidak terjadi penurunan status gizi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| d. Farmasi | Terapi rasional |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. | Kriteria Pulang | Umum: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Tanda vital normal |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Khusus: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. produk pus <5cc |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. mobilisasi hingga berjalan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Asupan nutrisi tercukupi |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. | Rencana Pulang/Edukasi Pelayanan Lanjutan | Penjelasan mengenai perkembangan penyakit berkaitan terapi dan tindakan yang mudah dilakukan |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Penjelasan mengenai diet yang diberikan sesuai dengan keadaan umum pasien |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surat pengantar kontrol |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Dokter Penanggung Jawab Pelayanan( …………………………………….. ) | Perawat Penanggung Jawab( ……………………………………. ) | Pelaksana Verifikasi( ……………………………………. ) |
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Keterangan :

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|  | Yang harus dilakukan |
|  | Bisa atau Tidak |
| **√** | Bila sudah dilakukan |