Enhanced Recovery After Surgery (ERAS) for Metoidioplasty

Site Applicability

Vancouver General Hospital

UBC Hospital

Pathway Patient Goals

Inclusion Criteria

Home Discharge Criteria

Instructions

1. Review pathway once per shift for patient care goals and expected outcomes
2. Do not document on this pathway, complete documentation in the Electronic Health Record (Cerner) or paper chart as per policy

Day of Surgery - OR Day	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • Risk assessed & new fall prevention care plan completed
Gender Care Plan	• Preferred name confirmed and highlighted on name band & in Kardex if different from BC Care Card • Preferred pronouns confirmed & documents in Kardex • Gender-specific belongings obtained for patient
Cognition	• Alert & Oriented x 3 (person, place, date)
Assessment	• VS and temp within patient's normal limits • Head to toe assessment (within patient's normal limits) • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Bladder spasms controlled • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Suprapubic catheter to straight drainage • Suprapubic catheter secured and catheter care completed qshift • Urethral catheter in situ as stent • Urethral catheter (stent) secured as per orders under mesh underwear with no tension • **Catheter(s) to remain in situ and only to be removed by surgeon** • Abdomen soft, not distended, non-tender • Flatus passed • Note date of last BM
Nutrition & Hydration	• Full fluids to Post-Surgical Transition to DAT (early feeding) • Boost 1.5 Tetra 240ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Absence of vomiting
Skin, Dressings, Drains	• Incisions assessed q4h & prn • Incisions intact • No evidence of hematoma • Minimal edema to surgical areas • Peripad with minimal drainage • Ointment applied to phallus incisions as ordered • Post-op wash completed (leave pink chlorhexidine preparation solution on for 6 hours post-op) • Groin penrose intact • Hemovac or JP drain stripped • Hemovac or JP drain emptied & recorded q6h • Buccal (inner cheek) graft site minimal bleeding
Functional Mobility	• HOB elevated 30 degrees or greater while in bed • Ankle exercises every hour when in bed (while awake)

	• Sit/stand at edge of bed • ICOUGH protocol followed • Full night sleep achieved • Turned q2h until fully able to reposition on own
Teaching & Discharge Planning • Patient is oriented to room/environment • Patient is aware of daily goals on clinical pathway • Review & reinforce Pain management pamphlet • Patient reviewed ERAS teaching booklet	

Day of Surgery – Post-Op Day 1	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • Risk assessed & new fall prevention care plan completed
Cognition	• Alert & Oriented x 3 (person, place, date)
Assessment	• Vital signs and temp (within patient's normal limits) • Head to toe assessment (within patient's normal limits) • Anxiety level acceptable to patient • Lab values with normal limits
Pain Management	• Pain level acceptable to patient • Bladder spasms controlled • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Suprapubic catheter to straight drainage • Suprapubic catheter secured and catheter care completed qshift • Urethral catheter in situ as stent • Urethral catheter (stent) secured as per orders under mesh underwear with no tension • **Catheter(s) to remain in situ and only to be removed by surgeon** • Abdomen soft, not distended, non-tender • Flatus passed • Note date of last BM
Nutrition & Hydration	• Full fluids to Post-Surgical Transition to DAT (early feeding) • Boost 1.5 Tetra 240ml BID • Gum chewing (15 minutes TID) • Tolerated oral intake • Nausea controlled • Absence of vomiting • Saline lock IV when drinking 600ml or more in 12 hours
Skin, Dressings, Drains	• Incisions assessed q4h & prn • Incisions intact • No evidence of hematoma • Minimal edema to surgical areas • Peripad with minimal drainage • Ointment applied to phallus incisions as ordered • Groin penrose intact • Hemovac or JP drain stripped • Hemovac or JP drain emptied & recorded q6h • Buccal (inner check) graft site minimal bleeding
Functional Mobility	• HOB elevated 30 degrees or greater while in bed • Ankle exercises every hour when in bed (while awake) • ICOUGH protocol followed • Up in chair for all meals (may sit on pillow for comfort) with assistance or independently

	• Walked in hallway x 2 with assistance or independently • Full night sleep achieved
Teaching & Discharge Planning • Patient is oriented to room/environment • Patient is aware of daily goals on clinical pathway • Review & reinforce Pain management pamphlet • Patient reviewed ERAS teaching booklet • Patient education done regarding suprapubic catheter care, leg bag/night bag • Patient is aware of discharge criteria • Patient has arranged transportation for discharge • Patient has arranged for support person at home for 72 hours post discharge • Discharge destination confirmed	

Day of Surgery – Post-Op Day 2	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • Risk assessed & new fall prevention care plan completed
Cognition	• Alert & Oriented x 3 (person, place, date)
Assessment	• Vital signs and temp (within patient's normal limits) • Head to toe assessment (within patient's normal limits) • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Bladder spasms controlled • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Suprapubic catheter to straight drainage • Suprapubic catheter secured and catheter care completed qshift • Urethral catheter in situ as stent • Urethral catheter (stent) secured as per orders under mesh underwear with no tension • **Catheter(s) to remain in situ and only to be removed by surgeon** • Abdomen soft, not distended, non-tender • Flatus passed • Note date of last BM
Nutrition & Hydration	• Full fluids to Post-Surgical Transition to DAT (early feeding) • Boost 1.5 Tetra 240ml BID • Gum chewing (15 minutes TID) • Tolerated oral intake • Nausea controlled • Absence of vomiting • Saline lock IV when drinking 600ml or more in 12 hours
Skin, Dressings, Drains	• Incisions assessed q4h & prn • Incisions intact • No evidence of hematoma • Minimal edema to surgical areas • Peripad with minimal drainage • Ointment applied to phallus incisions as ordered • Hemovac or JP drain emptied & recorded q6h • Hemovac or JP drain removed
Functional Mobility	• HOB elevated 30 degrees or greater while in bed • Ankle exercises every hour when in bed (while awake) • ICOUGH protocol followed • Independent with ADLs as per preop status • Up in chair for all meals (may sit on pillow for comfort) with assistance or independently • Walked in hallway x 2 with assistance or independently • Full night sleep achieved

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet
- Patient is aware of discharge criteria
- Patient has met the following discharge criteria:
    - Independent with ADLs
    - Pain managed on oral analgesics
    - Tolerating regular diet
    - Passing gas OR has had a bowel movement
    - Able to care for Suprapubic catheter independently
- Patient has arranged transportation for discharge
- Patient has arranged for support person at home for 72 hours post discharge
- Discharge destination confirmed

Supplemental	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • Risk assessed & new fall prevention care plan completed
Cognition	• Alert & Oriented x 3 (person, place, date
Assessment	• Vital signs and temp (within patient's normal limits) • Head to toe assessment (within patient's normal limits) • Anxiety level acceptable to patient • Lab values within normal limits
Pain Management	• Pain level acceptable to patient • Bladder spasms controlled • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Suprapubic catheter to straight drainage • Suprapubic catheter secured and catheter care completed qshift • Urethral catheter in situ as stent • Urethral catheter (stent) secured as per orders under mesh underwear with no tension • **Catheter(s) to remain in situ and only to be removed by surgeon** • Abdomen soft, not distended, non-tender • Flatus passed • Note date of last BM
Nutrition & Hydration	• DAT (early feeding) • Boost 1.5 Tetra 240ml BID • Gum chewing (15 minutes TID) • Tolerated oral intake • Nausea controlled • Absence of vomiting • Saline lock IV when drinking 600ml or more in 12 hours
Skin, Dressings, Drains	• Incisions assessed q4h & prn • Incisions intact • No evidence of hematoma • Minimal edema to surgical areas • Peripad with minimal drainage • Ointment applied to phallus incisions as ordered • Hemovac or JP drain emptied & recorded q6h • Hemovac or JP removed
Functional Mobility	• HOB elevated 30 degrees or greater while in bed • Ankle exercises every hour when in bed (while awake) • ICOUGH protocol followed • Independent with ADLs as per preop status • Up in chair for all meals (may sit on pillow for comfort) with assistance or independently • Walked in hallway x 2 with assistance or independently

	• Full night sleep achieved

Teaching & Discharge Planning
• Patient is oriented to room/environment
• Patient is aware of daily goals on clinical pathway
• Review & reinforce Pain management pamphlet
• Patient reviewed ERAS teaching booklet
• Patient is aware of discharge criteria
• Patient has met the following discharge criteria:
  ○ Independent with ADLS
  ○ Pain managed on oral analgesics
  ○ Tolerating regular diet
  ○ Passing gas OR has had a bowel movement
  ○ Able to care for Suprapubic catheter independently
• Patient has arranged transportation for discharge
• Patient has arranged for support person at home for 72 hours post discharge
• Discharge destination confirmed	

Day of Discharge	
Category	**Expected Outcomes**
Discharge	• Confirm discharge time • Has discharge prescriptions • Has post-op instruction sheet • Has Suprapubic catheter supplies • Has follow up information • Has all belongings • Understands when to seek medical attention for complications • Confirm discharge destination

Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, High Acuity Unit, UBC Hospital • Clinical Nurse Educator, Transplant, Urology, Gynecology, Plastics, VGH