

Enhanced Recovery After Surgery (ERAS) for Radical Cystectomy Pathway

Site Applicability

Vancouver General Hospital
UBC Hospital
Lions Gate Hospital (LGH)

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

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Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
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)
	Capillary Blood Glucose (CBG) taken as per protocol
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pain assessment completed as per protocol
	Epidural site satisfactory (if applicable)
	 Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Note date of last BM
Nutrition & Hydration	Sips of water/ice chips
•	Gum chewing (15 minutes TID) when awake
	Nausea controlled
	Patient did NOT vomit during shift
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Dressings dry and intact (do not change dressing until POD #3/as per
	order, unless saturated, otherwise outline drainage with a pen and
	reinforce as needed)
	 Sero-sanguineous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent
	Post-op wash completed (leave pink chlorhexidine preparation
	solution on for 6 hours post-op)
	 Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Turned Q2H until fully able to reposition on their own
	Ankle exercise every hour when in bed
	Sequential Compression Devices (SCD) applied unless
	contraindicated
	SCD removed no longer than 30 min/shift to assess & perform skin
	care as per protocol
	Patient sat at edge of bed or in chair x 15 minutes

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - Patient is aware of daily goals starting on page 55
 - Reviewed and reinforced pain management on page 43

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Bedside safety check	Day of Surgery – Post-Op Day 1	
Fall prevention care plan in place Risk assessed & new fall prevention care plan completed Not at risk: reviewed & no concerns Orginition Alert & Oriented x 3 (person, place, date)	Category	Expected Outcomes
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Not at risk: reviewed & no concerns	Fall Risk/Care Plan	Fall prevention care plan in place
Alert & Oriented x 3 (person, place, date) Assessment • Alert & Oriented x 3 (person, place, date) • Sand temp within patient's normal limits • Head to toe assessment (within patient's normal limits) • Capillary Blood Glucose (CBG) taken as per protocol • Anxiety level acceptable to patient • Pain level acceptable to patient • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable) • Rectus sheath site satisfactory (if applicable) • Note date of last BM • Abdomen soft, not distended • Note date of last BM • Abdomen soft, not distended • Water (Water AND Boost to a maximum total oral intake of 500 ml/12hr) • Boost 1.5 Tetra BID (Water AND Boost to a maximum total oral intake of 500 ml/12hr) • Gum chewing (15 minutes TID) when awake • Tolerating oral intake • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • If CVC in situ, obtain MD order to remove and insert peripheral IV • Braden Risk Assessment for skin integrity • Dressings, Drains • Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Sero-sanguinous dr		Risk assessed & new fall prevention care plan completed
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 SCD discontinued after first dose of anticoagulant, unless contraindicated 		
contraindicated		· · · · · · · · · · · · · · · · · · ·
 SCD removed no longer than 30 min/shift to assess & perform skin care as per protocol 		=
Walked in hallway x 2 (with assistance or independently)		

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• Up to bathroom (with assistance or independently)

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - Patient is aware of daily goals starting on page 57
 - o Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient received ostomy teaching by WOCN
- Patient received teaching re: self administration of LMWH
- Patient has a ride home on day of discharge

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Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
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)
	Capillary Blood Glucose (CBG) taken as per protocol
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pain assessment completed as per protocol
	Epidural site satisfactory (if applicable)
	Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
Nutrition & Hydration	Water (Water AND Boost to a maximum total oral intake of 500
	ml/12hr)
	Boost 1.5 Tetra BID (Water AND Boost to a maximum total oral
	intake of 500 ml/12hr)
	Gum chewing (15 minutes TID) when awake
	Tolerating oral intake
	Nausea controlled
	Patient did NOT vomit during shift
	Oral intake recorded
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Dressings dry and intact (do not change dressing until POD #3/as per
	order, unless saturated, otherwise outline drainage with a pen and
	reinforce as needed)
	 Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent
	Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	Routine bloodwork within normal limits
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed (while awake)
	Up in chair for all meals (with assistance or independently)
	Walked in hallway x 2 (with assistance or independently)
	Up to bathroom (with assistance or independently)

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside

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- Patient is aware of daily goals starting on page 59
- Reviewed and reinforced pain management on page 43
- Patient is aware of discharge criteria on page 67
- Patient received ostomy teaching by WOCN
- Patient received teaching re: pouch irrigation
- Patient received teaching re: self administration of LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - o Independent with ADLs
 - Pain managed on oral analgesics
 - o Tolerating regular diet
 - Passing gas or has had a bowel movement
 - Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Day of Surgery – Post-Op Day 3	
Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
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)
	Capillary Blood Glucose (CBG) taken as per protocol
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pain assessment completed as per protocol
	Epidural site satisfactory (if applicable)
	Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
	Full fluid as tolerated
	Boost 1.5 Tetra BID
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	Dressing changed
	Incision dry and left open to air (no dressing)
	Incision approximated (no signs of infection)
	• Sero-sanguineous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent
	Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	Routine bloodwork within normal limits
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed (while awake)
	Up in chair for all meals independently
	Walked in hallway x 2 (with assistance or independently)
	Up to bathroom (with assistance or independently)

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - Patient is aware of daily goals starting on page 61
 - o Reviewed and reinforced pain management on page 43

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- o Patient is aware of discharge criteria on page 67
- Patient able to assist with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - O Pain managed on oral analgesics
 - o Tolerating regular diet
 - Passing gas or has had a bowel movement
 - Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
· an mony care i ian	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
	Full fluid as tolerated
	Boost 1.5 Tetra BID
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock IV unless oral intake < 600 ml/12hr
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Incision approximated (no signs of infection)
	 Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed (when awake)
	Up in chair for all meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient is aware of daily goals starting on page 63
 - Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient independent with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - Pain managed on oral analgesics
 - Tolerating regular diet

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- Passing gas or has had a bowel movement
- Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
an many care rian	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
Journal, Diadae.	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
Tutilion a riyaration	Post Surgical Transition Diet (PSTD)
	Boost 1.5 Tetra daily
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock removed
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
,	Incision approximated (no signs of infection)
	Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent/removed by urology on POD5
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
,,	ICOUGH protocol followed
	Ankle exercise every hour when in bed
	Up in chair for all meals independently
	Walked in hallway x 2 independently

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient is aware of daily goals starting on page 65
 - Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient independent with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - Pain managed on oral analgesics
 - Tolerating regular diet

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- O Passing gas or has had a bowel movement
- Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
ran Kisky care i lan	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
•	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
-	Post Surgical Transition Diet (PSTD) to DAT
	Boost 1.5 Tetra daily
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock removed
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Incision approximated (no signs of infection)
	Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	Stents are patent/removed by urology if not done on POD5
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed (while awake)
	Up in chair for all meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient reviewed daily goals and discharge information on page 65-68
 - o Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient independent with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - Pain managed on oral analgesics
 - Tolerating regular diet

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- Passing gas or has had a bowel movement
- Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Day of Surgery – Post-Op Day 7	
Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
	Post Surgical Transition Diet (PSTD) to DAT
	Boost 1.5 Tetra daily
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock removed
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Incision approximated (no signs of infection)
	 Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	 Stents are patent/removed by urology if not done on POD5
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed (while awake)
	Up in chair for all meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient reviewed daily goals and discharge information on page 65-68
 - o Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient independent with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - Pain managed on oral analgesics

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- Tolerating regular diet
- Passing gas or has had a bowel movement
- O Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Day of Surgery – Post-Op Da Category	Expected Outcomes
Safety	
•	Bedside Sarety offens
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Bowel/Bladder	 Urine output more than 100ml in 4 consecutive hours
	Pericare/catheter care completed q shift
	Stoma is patent
	Flatus passed
	Note date of last BM
	Abdomen soft, not distended
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded
	Post Surgical Transition Diet (PSTD) to DAT
	Boost 1.5 Tetra daily
	Gum chewing (15 minutes TID), when awake
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock removed
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Incision approximated (no signs of infection)
	 Sero-sanguinous draining < 100 ml/hr in HMV (if applicable)
	 Stents are patent/removed by urology if not done on POD5
	 Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ICOUGH protocol followed
	Ankle exercise every hour when in bed
	Up in chair for all meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient reviewed daily goals and discharge information on page 65-68
 - o Reviewed and reinforced pain management on page 43
 - Patient is aware of discharge criteria on page 67
- Patient independent with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria:
 - Independent with ADLs
 - Pain managed on oral analgesics
 - Tolerating regular diet

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- O Passing gas or has had a bowel movement
- Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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Day of Discharge	
Category	Expected Outcomes
Discharge	Discharged, accompanied by support person
	Has discharge prescriptions
	Has sharps container & appropriate LMWH teaching sheet
	"My Discharge Plan" sheet updated with follow-up appointments
	and given to patient
	Has all personal belongings
	Understands when to seek medical attention for complications
	Discharge destination/accommodation confirmed
	Aware where to get extra supplies for ostomy care
	Arrangements made for staple removal

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, Transplant, Urology, Gynecology, Plastics, VGH

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