Radical Cystectomy (ERAS) Pathway

Site Applicability

PHC Cerner

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 or paper chart as per policy
3

Pathway Patient Goals

1.1. Acute care Length of Stay (LOS) within target 7 days
1.2. Patients are prepared for surgery
1.3. Patients have pain management to a level acceptable to the patient.
1.4. Patients are free of nausea/vomiting on post-op day 1 (POD1)
1.5. Patients are aware of and understand discharge criteria.

- Able to independently perform all ADLs as required unless unable preoperatively
- Pain managed with oral analgesics
- Tolerating regular diet – eat at least 1 solid meal without nausea, vomiting, bloating or increased abdominal pain
- Passing flatus or stool
- Clinical exam and lab tests show no evidence of complications or untreated medical complication
- Able to care for ostomy or catheterize pouch independently

Inclusion Criteria

All patients having Radical Cystectomy including:

1.1 Cystectomy with formation of Ileal Conduit
1.2 Cystectomy with formation of Studer Neo-bladder
1.3 Cystectomy with formation of Indiana Pouch

Pathway

Pre-Surgery (Pre-admission Clinic Visit or Pre-op on ward (if applicable)	
Care Category	**Expected Outcomes**
Cognition	• Delirium Risk factors assessed and baseline CAM score recorded • Alert and Oriented x 3 • Mini Cognitive Assessment for patients 70 years or older (PHC)
Assessment	• Admission head to toe assessment and vital signs recorded • Baseline Admission Screening /Risk Assessments completed: o Violence risk o Delirium risk o Alcohol/Drug Screen o Smoking o Dysphagia o Falls o Advance care planning
Pain Management	• Acceptable comfort pain level (as stated by patient) documented (__/10) • Review pain control principles and encourage the reporting of any side effects of analgesics • Assess for any significant pain history
Elimination	• Patient's regular bowel pattern documented • If applicable, bowel preparation explained and bowel Prep administered as ordered • **Ostomy site marked by ET/WOCN if applicable**
Nutrition / Hydration Height: _____ cm Weight: _____ kg	• Risk factors for post op nausea/vomiting (PONV) assessed o Female, non-smoker, history of motion sickness, previous history PONV (**0 / 1 / 2 / 3 / 4)** • Patient understands pre-op fasting and carbohydrate loading requirements • Height and weight
Skin/Dressings/Drains	• Patient understands pre-op skin prep shower/bath procedure • Patient is aware of incision(s) and post-op dressings
Diagnostics	Ordered preoperative investigations are completed and results available (e.g. Lab work, radiology)

Fall Risk/Mobility	• Falls preventions strategies in place: **"SAFE STEP"** • **Stop** – scan for safety (clutter, spills etc.) • **Think toileting** – remind patient to ask for help; regular toileting prevents falls • **Equipment** – chair, commode, aids close to patient with brakes on • **Patient** – non-slip footwear, frequently used items close by, visual & hearing aids in place, educate to ask for help and wait 20 seconds before standing *Reference: Falls Injury Prevention and Management – Interdisciplinary Guideline* • Functional mobility assessment completed and documented. • Timed Up and Go test (TUG) completed for patients 65 and older, or with mobility problems
Medications	• Best possible medication history obtained and recorded • Preoperative medication instructions available for patient
Teaching & Discharge Planning	• Review with patient. o Clinical pathway o Discharge criteria and expected LOS • Ensure a discharge destination is planned • Confirm patient has identified support person for assistance at home following discharge • Review transportation needs for discharge • Teach patient to perform deep breathing and ankle/leg exercises every hour • Receives and reviews relevant patient teaching materials: o Preparing for Surgery o Bladder Removal: Cystectomy. Your Guide to Recovery o Spinal or Epidural Anesthesia (if appropriate o Patient Controlled Analgesia (if appropriate) o Nutritional information o Pre-operative video • Review unit/hospital routines • Pain management expectations re epidural. Usually removed approximately 24 to 48 hours post-op • For patients receiving neomycin: Review allergy status and using Lexicomp, check for pharmaceutical and therapeutic suitability that includes assessing drug interactions and contraindications. Contact physician/pharmacist when needing clarification Tour of Surgical Daycare and inpatient unit as required Teaching materials provided and reviewed

Day of Surgery POD 0	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess for delirium using CAM • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, abnormal lab values, alcohol, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• Perform routine vitals per protocol (on arrival to ward then Q4H), more frequently if unstable • If present, assess equipment in use and confirm settings • Hourly rounds for 5 P's (pain, position, personal needs, patient safety, plan of care) • Head to toe assessment Q shift within patient's normal limits • Assess for signs and symptoms of anemia/bleeding (weakness, pallor, blood loss, etc.) • Patient admission assessment and nursing care plan must be completed within 48 hours of admission
Pain Management	• Review pain control principles and encourage the reporting of any side effects of analgesics • Encourage patient to use subjective analog pain score (0 to10) • Pain assessment completed and documented on unit admission and at least Q4H • Assess level of pain at rest and with activity • Evaluate and record the effectiveness of pain control measures taken • All patients with PCA or epidurals are followed by Acute Pain Services (APS). If problems call APS or Clinical Nurse Specialist for Pain PRN • Patient receives regular around the clock acetaminophen unless contraindicated

Elimination	• Assess urine and hourly output. Notify Dr. if output is less than 60 mL over a 2 hour period • Assess and record urine characteristics • Depending on the surgical procedure, ureteral may be present • Depending on the surgical procedure, ureteral stent may be present • Check for flatus or BM. Refer to date of last BM • Assess abdomen is soft, non-tender and not distended • Refer to Wound and Ostomy Services for all new stoma • If present, assess and document stoma as per guidelines
Nutrition / Hydration	• No nausea/vomiting • Antiemetics given as per orders and response to antiemetic is recorded • Dysphagia screening completed before patient takes anything orally • Fluids/diet as per orders tolerated • Boost 1.5 240 mL once • Encourage gum chewing 15 minutes TID
Skin/Dressings/Drains	• Refer to patient's pre-op skin integrity. Head to toe skin assessment. Complete Braden Scale and implement appropriate nursing interventions • Assess dressing and/or incision. Re-inforce dressings and/or change as ordered. Check previous shift/day's wound care • Assess IV/CVC site and record (refer to IV assessment/intervention documentation) • Assess for all drainage tubes and record per protocol • Assess drain(s) for patency. Refer to previous shift/day's output • Consult Wound and Ostomy Service PRN for wound concerns • Post op wash night of surgery
Diagnostics	• Ensure all routine lab work is ordered, performed and results are available.
Activity	• Dangle (with supervision) at bedside or sit up in chair x 15 minutes • Encourage patient to perform deep breathing and coughing exercises every hour (10 deep breaths per hour. Cough if secretions present) • Encourage ankle/leg exercises • Assist to turn every 2 hours in bed as needed until patient able to do on their own • Completes personal care with assistance • Thromboprophylaxis given or applied

Teaching & Discharge Planning	• Review with patient. o Orientation to room/environment o Unit and hospital routine o Any specific restrictions or precautions reviewed • Review progress and daily goals on pathway

Post-Operative Day 1 (POD1)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Alert and Oriented x 3 (person, place, time), no evidence of new confusion, agitation, anxiety and CAM Screen Negative • Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, lab values, alcohol, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• VS within patient's normal limits Q4hours and prn • Assess for signs and symptoms of anemia (weakness, pallor, blood loss, etc.) • Patient Admission History & Screening reviewed/completed by day shift POD1 • Head to Toe assessment within patient's normal limits
Pain Management	• Pain assessment minimum Q4H, baseline recorded including patient goal comfort level • Review importance of pain control, modalities and encourage the reporting of any side effects of analgesics • Administer around the clock acetaminophen as ordered • If present, epidural site free of edema and redness. Assess for continued need for PCA or Epidural (plan should be to discontinue PCA / epidural by day 2 if able)
Elimination	• Assess urine output & record urine characteristics • Monitor and record urine output. Notify MD if output less than 60 mL for 2 hour period • Check for flatus or BM. Refer to date of last BM • Be aware of patient's normal bowel pattern • Assess abdomen is soft and not distended or bloated; Report any abdominal pain • If present, assess and document stoma as per guidelines • Instruct patient how to drain pouch

Nutrition / Hydration	• No nausea/vomiting. Antiemetics given as per orders • Diet as per orders. Assess tolerance of diet after intake • Patient chewed gum for 15 minutes 3 times per day (sugar-free preferred) • Assess tolerance of fluids after intake and record intake on chart. When oral intake is above 750 mL per shift, saline lock IV or TKVO if PCA in use • Takes oral nutritional supplement Boost 1.5 240 mL BID
Skin/Dressings/Drains	• Dressings dry and intact • If drain present, assess for patency and output. Refer to previous shift/day's output. Check Prescriber's order for when to discontinue drain • Refer to patient's pre-op skin integrity. Head to toe skin assessment. Refer to Braden Assessment tool for frequency of reassessment • Consult Wound and Ostomy Service PRN for wound concerns • Assess IV/CVC site and record (refer to IV intervention sheet) • Post op wash given
Diagnostics	• Ensure all routine lab work (CBC, electrolytes, urea, and creatinine) is ordered, performed and results are available • Assess and compare post-op hemoglobin with pre-op hemoglobin • Assess renal function from lab results (in light of NSAIDS)
Activity	• Routine activities include minimum of: o Up in chair for all meals **and** o Walk 60 meters in hallway with assistance three times **and** o Walk to bathroom with assistance • Encourage ADLs and assist as needed • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc) • Encourage ankle/leg exercises every waking hour when in bed • Encourage patient to perform deep breathing and coughing exercises (10 deep breaths per hour. Cough if secretions present)
Teaching & Discharge Planning	• Review and re-enforce the discharge criteria • Review progress on pathway • Confirm a discharge destination is planned • Confirm that patient has appropriate support at home if necessary • If applicable, start LMWH (Dalteparin / Enoxaparin) teaching. Review medication & indications. Demonstrate injection technique on model.

Post-Operative Day 2 (POD2)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Alert and Oriented x 3 (person, place, time), no evidence of new confusion, agitation, anxiety and CAM Screen Negative • Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, lab values, alcohol, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• VS within patient's normal limits Q4hours and more frequently if indicated • Assess for signs and symptoms of anemia (weakness, pallor, blood loss, etc.) • Head to Toe assessment completed Q shift and within patient's normal limits
Pain Management	• Assess and document level of pain and the effectiveness of pain control (minimum of Q4H) • Review importance of pain control, modalities and encourage the reporting of any side effects of analgesics • Administer around the clock acetaminophen as ordered • If present, epidural site free of edema and redness. Assess for continued need for PCA or Epidural (plan should be to discontinue PCA / epidural by day 2 if able)

Elimination	• Assess urine output. Record urine characteristics. Monitor for signs and symptoms of UTI • Check for flatus or BM. Refer to date of last BM. Be aware of patient's normal bowel pattern. Consider stimulant (e.g. dulcolax or lactulose) • Assess abdomen is soft and not distended; Report any abdominal pain, distention or bloating • If present, assess and document stoma as per guidelines • Able to drain pouch and disconnect from night drainage bag with assistance/ supervision
Nutrition / Hydration	• Assess nausea and administer antiemetic PRN • Tolerates solid diet • Patient chewed gum for 15 minutes 3 times per day (sugar-free preferred) • Takes and tolerates oral nutritional supplement Boost 1.5 240 mL BID • Assess tolerance of fluids after intake and record intake on chart until oral intake is at least 1200 mL per day
Skin/Dressings/Drains	• If drain present, assess for patency and output. Refer to previous shift/day's output. Check Prescriber's order for when to discontinue drain (usually discontinue drain if less than 100mL/24hours) • Refer to patient's pre-op skin integrity. Head to toe skin assessment. Refer to Braden Assessment tool for frequency of reassessment • Assess IV/CVC site and record (refer to IV intervention sheet) • Post op wash given
Diagnostics	• No routine diagnostics on POD2
Activity	• Up in chair for all meals independently • Walks 120 meters (1 lap) in hallway three times with standby assistance • Walk to bathroom with standby assistance • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.) • Encourage patient to perform deep breathing and coughing exercises (10 deep breaths per hour. Cough if secretions present) • Encourage ankle/leg exercises every waking hour when in bed • Encourage independence with ADLs and assist as needed.
Teaching & Discharge Planning	• If applicable, continue LMWH (Dalteparin / Enoxaparin) teaching. Review injection technique. Supervise patient self-administration if patient able. • Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home if necessary • Confirm patient has follow up appointments and transportation to attend • Confirm a discharge destination is planned: Home

Post-Operative Day 3 (POD3)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, lab values, alcohol, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• VS within patient's normal limits Q8hours and more frequently if indicated • Assess for signs and symptoms of anemia (weakness, pallor, blood loss, etc.) • Head to Toe assessment completed Q shift and within patient's normal limits
Pain Management	• Assess pain routinely at rest and with activity • Assess and document level of pain and the effectiveness of pain control (minimum of Q4H) • Review importance of pain control, modalities and encourage the reporting of any side effects of analgesics • Administer around the clock acetaminophen as ordered
Elimination	• Assess urine output. Record urine characteristics. Monitor for signs and symptoms of UTI • Check for flatus or BM. Refer to date of last BM. Be aware of patient's normal bowel pattern (refer to bowel protocol if ordered) • Assess abdomen is soft and not distended; Report any abdominal pain, distention or bloating • If present, assess and document stoma as per guidelines • Patient able to assist with ostomy management and care, including emptying pouch • If not already done, first ostomy appliance change and full peristomal assessment done on POD 3

Nutrition / Hydration	• Assess nausea and administer antiemetic PRN • Tolerates solid diet • Patient chewed gum for 15 minutes 3 times per day (sugar-free preferred). No longer needed if patient eating well and passing flatus • Takes and tolerates oral nutritional supplement Boost 1.5 240 mL BID • Assess tolerance of fluids after intake and record intake on chart until oral intake is at least 1200 mL per day • Consider discontinuing saline lock if not needed
Skin/Dressings/Drains	• Refer to patient's pre-op skin integrity. Head to toe skin assessment. Refer to Braden Assessment tool for frequency of reassessment • Remove dressing unless ordered otherwise and leave exposed when appropriate (e.g. not weepy or open). • Assess incision (edges approximated, sutures/staples/steri-strips, drainage, and no evidence of surgical site infection) • Patient may shower if wound clean and edges approximated. Pat incision dry after shower • Assess IV/CVC site and record (refer to IV intervention sheet) • Assess for all drainage tubes and record per protocol • Assess drain for patency. Refer to previous shift/day's output. Discontinue drain if less than 100mL/24 hours as per orders • Consult Wound and Ostomy Services PRN
Diagnostics	• Ensure all routine lab work (CBC, electrolytes, urea, creatinine) is ordered, performed and results are available
Activity	• Up in chair for all meals independently • Walks 120 meters (1 lap) in hallway three times with standby assistance • Walk to bathroom with standby assistance • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.) • Encourage patient to perform deep breathing and coughing exercises (10 deep breaths per hour. Cough if secretions present) • Encourage ankle/leg exercises every waking hour when in bed • Encourage independence with ADLs and assist as needed.

Teaching & Discharge Planning	• If applicable, continue LMWH (Dalteparin / Enoxaparin) teaching. Review injection technique. Supervise patient self-administration if patient able. • Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home if necessary • Confirm patient has follow up appointments and transportation to attend • Confirm a discharge destination is planned: Home • Notify TST of pending discharge as needed • Patient receiving teaching from WOCN for ostomy management • Patient ostomy management and teaching reinforced by bedside staff

Post-Operative Day 4 (POD4)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Assess level of consciousness and orientation to person, place and time for post-op patients as per protocol, more frequently if indicated • Assess and address risk factors for delirium: pain, urinary retention, sensory impairment, lab values, alcohol, medication effects and side effects • Notify surgeon of any evidence of altered level of consciousness (e.g. delirium, confusion and agitation) • Assess and record level of sedation
Assessment	• VS within patient's normal limits Q8hours and more frequently if indicated • Head to Toe assessment completed Q shift and within patient's normal limits
Pain Management	• Assess and document level of pain and the effectiveness of pain control. Pain should be managed with PO analgesia • Administer around the clock acetaminophen as ordered
Elimination	• Assess urine output. Record urine characteristics. No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • Check for flatus or BM. Refer to date of last BM. Be aware of patient's normal bowel pattern, refer to bowel protocol as needed • Report any abdominal pain, distention or bloating • If present, assess and document stoma as per guidelines • Patient able to drain pouch and empty overnight bag independently • Able to change appliance with assistance / supervision
Nutrition / Hydration	• Assess nausea and administer antiemetic PRN • Tolerates solid diet • If not on IV fluids, remove saline lock • Takes and tolerates oral nutritional supplement Boost 1.5 240 mL BID • Patient chewed gum for 15 minutes 3 times per day. No longer needed if patient eating well and passing flatus.

Skin/Dressings/Drains	• Refer to patient's pre-op skin integrity. Head to toe skin assessment. Refer to Braden Assessment tool for frequency of reassessment • Assess incision (edges approximated, sutures/staples/steri-strips, drainage, and no evidence of surgical site infection) • No evidence of surgical site infection • Assess IV/CVC site and record (refer to IV intervention sheet) • Assess for all drainage tubes and record per protocol • Assess drain for patency. Refer to previous shift/day's output. Discontinue drain if less than 100 mL/24 hours as per orders • Consult Wound and Ostomy Services PRN
Diagnostics	• No routine diagnostics on POD4
Activity	• Up in chair for all meals independently • Walks 120 meters (1 lap) in hallway three times independently or at level of baseline • Walk to bathroom independently or at level of baseline • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.) • Independent with ADLs or at the level of baseline
Teaching & Discharge Planning	• Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home if necessary • Assess the patient's education about the drugs, dosage, duration, etc. If appropriate, patient able to self-administer LMWH. Re-enforce teaching PRN • Confirm that patient has completed all ostomy teaching, has supplies • Confirm patient has follow up appointments and transportation to attend • Confirm a discharge destination is planned: Home • Patient knows who to contact for assistance if needed • Confirm TST arrangement are made if needed **Provide and review with patient** • Bladder Removal: Cystectomy Your Guide to Recovery

Post-operative Day 5 (POD5) if needed	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Patient is alert and oriented x 3 (person, place, date) or back to baseline • No evidence of delirium
Assessment	• Perform routine vitals Q8H per protocol, more frequently if indicated • Head to toe assessment completed Q 12 hour shift and within patient's normal limits
Pain Management	• Pain level acceptable to patient • Pain is managed on **oral analgesia**
Elimination	• Has had BM or passing flatus • Report any abdominal pain, distention or bloating • No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • If present, assess and document stoma as per guidelines • Patient able to drain pouch and disconnect from overnight bad independently • Able to change appliance with assistance / supervision
Nutrition / Hydration	• **Ensure patient tolerates solid diet more than 75% of meal trays** • Dietary education completed as required
Skin/Dressings/Drains	• Ensure skin integrity is intact, no evidence of pressure areas. Refer to Braden Assessment tool for frequency of reassessment. • **Ensure incision is approximated with no signs of surgical site infection** • Consult Wound and Ostomy Services PRN • No evidence of surgical site infection
Diagnostics	• Ensure routine lab results are within acceptable limits
Activity	• Safely independent for transfers, ambulation and ADLs • Walks 120 meters (1 lap) three times independently or at level of baseline • Confirm that patient has purchased, borrowed or rented the necessary equipment for discharge. • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.)

Teaching & Discharge Planning	• Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home • Review with patient "Bladder Removal: Cystectomy Your Guide to Recovery" booklet • Understands potential post-operative complications and when to seek medical attention • Has completed LMWH (Dalteparin / Enoxaparin) teaching, if applicable • Confirm TST arrangements complete (as needed) • Confirm patient has follow up appointment for 2 weeks post-discharge (unless otherwise ordered) and transportation to attend

Post-operative Day 6 (if needed)	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Patient is alert and oriented x 3 (person, place, date) or back to baseline • No evidence of delirium
Assessment	• Perform routine vitals Q8H per protocol, more frequently if indicated • Head to toe assessment completed Q 12 hour shift and within patient's normal limits
Pain Management	• Pain level acceptable to patient • Pain is managed on **oral analgesia**
Elimination	• Has had BM or passing flatus • Report any abdominal pain, distention or bloating • No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • If present, assess and document stoma as per guidelines • Patient able to drain pouch and disconnect from overnight bad independently • Able to change appliance with assistance / supervision
Nutrition / Hydration	• **Ensure patient tolerates solid diet more than 75% of meal trays** • Dietary education completed as required
Skin/Dressings/Drains	• Ensure skin integrity is intact, no evidence of pressure areas. Refer to Braden Assessment tool for frequency of reassessment. • **Ensure incision is approximated with no signs of surgical site infection** • Consult Wound and Ostomy Services PRN • No evidence of surgical site infection
Diagnostics	• No routine diagnostic POD6
Activity	• Safely independent for transfers, ambulation and ADLs • Walks 120 meters (1 lap) three times independently or at level of baseline • Confirm that patient has purchased, borrowed or rented the necessary equipment for discharge. • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.)

Teaching & Discharge Planning	• Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home • Review with patient "Bladder Removal: Cystectomy Your Guide to Recovery" booklet • Understands potential post-operative complications and when to seek medical attention • Has completed LMWH (Dalteparin / Enoxaparin) teaching, if applicable • Confirm TST arrangements complete (as needed) • Confirm patient has follow up appointment for 2 weeks post-discharge (unless otherwise ordered) and transportation to attend

Post-operative Day 7 (POD7) if needed	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Patient is alert and oriented x 3 (person, place, date) or back to baseline • No evidence of delirium
Assessment	• Perform routine vitals Q8H per protocol, more frequently if indicated • Head to toe assessment completed Q 12 hour shift and within patient's normal limits
Pain Management	• Pain level acceptable to patient • Pain is managed on **oral analgesia**
Elimination	• Has had BM or passing flatus • Report any abdominal pain, distention or bloating • No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • If present, assess and document stoma as per guidelines • Patient able to drain pouch and disconnect from overnight bad independently • Able to change appliance with assistance / supervision
Nutrition / Hydration	• **Ensure patient tolerates solid diet more than 75% of meal trays** • Dietary education completed as required
Skin/Dressings/Drains	• Ensure skin integrity is intact, no evidence of pressure areas. Refer to Braden Assessment tool for frequency of reassessment. • **Ensure incision is approximated with no signs of surgical site infection** • Consult Wound and Ostomy Services PRN • No evidence of surgical site infection
Diagnostics	• Ensure routine lab results are within acceptable limits
Activity	• Safely independent for transfers, ambulation and ADLs • Walks 120 meters (1 lap) three times independently or at level of baseline • Confirm that patient has purchased, borrowed or rented the necessary equipment for discharge. • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.)

Teaching & Discharge Planning	• Confirm that patient has the necessary equipment for discharge and home is prepared. If barriers identified, refer to OT, PT, SW as indicated • Confirm that patient has appropriate support at home • Review with patient "Bladder Removal: Cystectomy Your Guide to Recovery" booklet • Understands potential post-operative complications and when to seek medical attention • Has completed LMWH (Dalteparin / Enoxaparin) teaching, if applicable • Confirm TST arrangements complete (as needed) • Confirm patient has follow up appointment for 2 weeks post-discharge (unless otherwise ordered) and transportation to attend

Discharge Day-Post Operative Day _____	
Tasks & Activities	**Expected Outcomes**
Safety/Risk Assessment	• Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	• Patient is alert and oriented x 3 (person, place, date) or back to baseline • No evidence of delirium
Assessment	• **Vital signs are stable and within patient's normal limits. Afebrile**
Pain Management	• Pain level acceptable to patient • Pain is managed on **oral analgesia**
Elimination	• Has had BM or passing flatus • No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • Ostomy functioning appropriately and patient independent with care
Nutrition / Hydration	• **Ensure patient tolerates solid diet more than 75% of meal trays** • Dietary education completed as required
Skin/Dressings/Drains	• Ensure skin integrity is intact, no evidence of pressure areas. Refer to Braden Assessment tool for frequency of reassessment. • **Ensure incision is approximated with no signs of surgical site infection**
Diagnostics	• Ensure routine lab results are within acceptable limits
Activity	• Safely independent for transfers, ambulation and ADLs • Review with patient any activity restrictions required for specific surgery • Confirm that patient has purchased, borrowed or rented the necessary equipment for discharge. • Chart reason if patient is unable to meet the expected outcome for pathway activity (e.g. pain, delirium, patient refusal, etc.)

Teaching & Discharge Planning	Ensure patient: • Is ready for discharge by 10:00 am • Has prescriptions and is able to get them filled/brought home • Has follow-up appointments for 2 weeks post-discharge (unless otherwise ordered) and transportation to attend • Has all personal belongings • Has appropriate support at home if necessary • Has home prepared • Understands potential post-operative complications and when to seek medical attention • Arrangements made for staple removal Day 7 to 10 with GP or clinic • Has completed Dalteparin / Enoxaparin teaching • Confirm TST arrangements complete (as needed) • Has all educational materials

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