

Urology Surgery: Enhanced Recovery After Surgery (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

Pathway Patient Goals

- 1.1. Acute care Length of Stay (LOS) within target 1-5 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
 - Exam and lab tests show no evidence of complications or untreated medical complication

Inclusion Criteria

All patients having Urology Surgery including:

- 1.1. Laparoscopic pyeloplasty
- 1.2. TURP
- 1.3. Radical prostatectomy
- 1.4. Laparoscopic nephrectomy
- 1.5. Laparoscopic partial nephrectomy
- 1.6. Laparoscopic nephron-ureterectomy
- 1.7. Open partial nephrectomy, open radical nephrectomy, and open nephron-ureterectomy

Exclusion Criteria

All patients having Radical Cystectomy including:

- 1.8. Cystectomy with formation of Ileal Conduit
- 1.9. Cystectomy with formation of Studer Neo-bladder
- 1.10. Cystectomy with formation of Indiana Pouch

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Pathway

Pre-Surgery (Pre-admission Clinic Visit or Pre-op on ward (if applicable))	
Care Category	Expected Outcomes
Cognition	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Admission head to toe assessment and vital signs recorded Baseline Admission Screening /Risk Assessments completed: <ul style="list-style-type: none"> Violence risk Delirium risk Alcohol/Drug Screen Smoking Dysphagia Falls Advance care planning
Pain Management	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Patient's regular bowel pattern documented If applicable, bowel preparation explained and bowel Prep administered as ordered Patient is aware their urinary elimination will be altered post op Patient is aware they <i>may</i> have an indwelling Foley catheter that would be expected to be removed on PODO, 1 or 2
Nutrition / Hydration Height: _____ cm Weight: _____ kg	<ul style="list-style-type: none"> Risk factors for post op nausea/vomiting (PONV) assessed <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)

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Fall Risk/Mobility	<ul style="list-style-type: none"> 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 <p><i>Reference: Falls Injury Prevention and Management – Interdisciplinary Guideline</i></p> <ul style="list-style-type: none"> Functional mobility assessment completed and documented. Timed Up and Go test (TUG) completed for patients 65 and older, or with mobility problems
Medications	<p>Best possible medication history obtained and recorded</p> <p>Preoperative medication instructions available for patient</p>
Teaching & Discharge Planning	<ul style="list-style-type: none"> Review with patient. <ul style="list-style-type: none"> Clinical pathway 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: <ul style="list-style-type: none"> Preparing for Surgery Urology Surgery, Your Guide to Recovery You have a urinary catheter Spinal or Epidural Anesthesia (if appropriate) Patient Controlled Analgesia (if appropriate) Nutritional information Review unit/hospital routines Pain management expectations re epidural. Usually removed approximately 24 to 48 hours post-op <p>Tour of Surgical Daycare and inpatient unit as required Teaching materials provided and reviewed</p>

Day of Surgery POD0	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> Universal Fall Prevention strategies are in place (SAFE Step) Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Assess urine and hourly output. Notify Dr. if output is less than 60 mL over a 2 hour period If Foley insitu, pericare once per shift Assess and record urine characteristics 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 Assess site of suprapubic catheter if present and perform care.
Continuous Bladder Irrigation (CBI)	<ul style="list-style-type: none"> CBI drainage free of bleeding and clots CBI drainage assessed and documented on admission and then every 30 to 60 minutes CBI rate adjusted as per TUPR post-op orders (increase rate if CBI drainage becomes sanguineous and decrease if becomes clear) Document time when CBI drainage <ul style="list-style-type: none"> changed from sanguineous to moderate sanguineous Time: _____hrs changed from moderate sang to light sang to clear documented Time: _____hrs Document when CBI stopped Time: _____hrs
Nutrition / Hydration	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Ensure all routine lab work is ordered, performed and results are available.

Activity	<p><i>If continuous bladder irrigation (CBI), BED REST</i></p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Review with patient. <ul style="list-style-type: none"> ○ Orientation to room/environment ○ Unit and hospital routine ○ Any specific restrictions or precautions reviewed • Review progress and daily goals on pathway <p>If applicable (i.e. same day discharge post TUPR procedure) review with patient the importance of drinking 8 to 10 glasses of clear fluids</p>

Post-Operative Day 1 (POD1)	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> • Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> Assess urine output & record urine characteristics If Foley insitu, pericare once per shift (unless otherwise ordered, the goal of pathway is to remove Foley POD 1 at 06:00 am) 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 Assess site of suprapubic catheter if present and perform care.
Continuous Bladder Irrigation (CBI)	<p>If applicable, post CBI</p> <ul style="list-style-type: none"> Record time catheter was removed Record time of first void and assess for colour, blood and clots Urine remains light sang to clear following patient mobilization (if not, record a variance and contact physician to re-insert catheter)
Nutrition / Hydration	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Dressings dry and intact, including suprapubic if applicable 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 Assess IV/CVC site and record (refer to IV intervention sheet) Post op wash given
Diagnostics	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • Routine activities include minimum of: <ul style="list-style-type: none"> ○ Up in chair for all meals and ○ Walk 60 meters in hallway with assistance three times and ○ 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) <p><i>Bed rest , If continuous bladder irrigation (CBI)</i></p>
Teaching & Discharge Planning	<ul style="list-style-type: none"> • 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. <p>If discharge criteria are met:</p> <ul style="list-style-type: none"> • Discharge teaching is complete, patient has necessary equipment, appropriate home support, and follow up appointment

Post-Operative Day 2 (POD2)	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> Universal Fall Prevention strategies are in place (SAFE Step) Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Assess site of suprapubic catheter if present and perform care. Assess urine output. Record urine characteristics. Monitor for signs and symptoms of UTI If Foley insitu, pericare once per shift (unless otherwise ordered, the goal of pathway is to remove Foley POD 1 at 06:00 am) 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
Nutrition / Hydration	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> No routine diagnostics on POD2
Activity	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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 <p><i>If discharge criteria are met,</i> appropriate discharge pamphlets are provided and reviewed with the patient</p> <ul style="list-style-type: none"> ○ Urology Surgery, Your Guide to Recovery ○ “Going Home with a urinary Catheter”, if applicable ○ If applicable, reviewed with patients the importance of drinking 8 to 10 glasses of clear fluids per day at home post TUPR procedure ○ Patient knows who to contact for assistance if needed ○ Patient aware of date/time of follow up appointment
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Post-Operative Day 3 (POD3)	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> Universal Fall Prevention strategies are in place (SAFE Step) Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Assess site of suprapubic catheter if present and perform care. Assess urine output. Record urine characteristics. Monitor for signs and symptoms of UTI If Foley insitu, pericare once per shift (unless otherwise ordered, the goal of pathway is to remove Foley POD 1 at 06:00 am) 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

Nutrition / Hydration	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Ensure all routine lab work (CBC, electrolytes, urea, creatinine) is ordered, performed and results are available
Activity	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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 <p><i>If discharge criteria are met,</i> appropriate discharge pamphlets are provided and reviewed with the patient</p> <ul style="list-style-type: none"> • Urology Surgery, Your Guide to Recovery • “Going Home with a urinary Catheter”, if applicable • If applicable, reviewed with patients the importance of drinking 8 to 10 glasses of clear fluids per day at home post TUPR procedure • Patient knows who to contact for assistance if needed • Patient aware of date/time of follow up appointment
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Post-Operative Day 4 (POD4)	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> • Universal Fall Prevention strategies are in place (SAFE Step) • Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Assess site of suprapubic catheter if present and perform care. • Assess urine output. Record urine characteristics. No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine) • If Foley insitu, pericare once per shift (unless otherwise ordered, the goal of pathway is to remove Foley POD 1 at 06:00 am) • 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
Nutrition / Hydration	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 100mL/24 hours as per orders • Consult Wound and Ostomy Services PRN
Diagnostics	<ul style="list-style-type: none"> • No routine diagnostics on POD4
Activity	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 patient has follow up appointments and transportation to attend • Confirm a discharge destination is planned: Home • Confirm TST arrangement are made if needed <p>Provide and review with patient</p> <ul style="list-style-type: none"> • Urology Surgery, Your Guide to Recovery • "Going Home with a urinary Catheter", if applicable • If applicable, reviewed with patients the importance of drinking 8 to 10 glasses of clear fluids per day at home post TUPR procedure • Patient knows who to contact for assistance if needed • Patient aware of date/time of follow up appointment

Discharge Day-Post-op Day _____	
Tasks & Activities	Expected Outcomes
Safety/Risk Assessment	<ul style="list-style-type: none"> Universal Fall Prevention strategies are in place (SAFE Step) Fall risk care plan in place, if appropriate
Cognition	<ul style="list-style-type: none"> Patient is alert and oriented x 3 (person, place, date) or back to baseline No evidence of delirium
Assessment	<ul style="list-style-type: none"> Vital signs are stable and within patient's normal limits. Afebrile
Pain Management	<ul style="list-style-type: none"> Pain level acceptable to patient Pain is managed on oral analgesia
Elimination	<ul style="list-style-type: none"> Assess site of suprapubic catheter if present and perform care. Has had BM or passing flatus No evidence of UTI (burning, frequency, pain, cloudy or malodorous urine)
Nutrition / Hydration	<ul style="list-style-type: none"> Ensure patient tolerates solid diet more than 75% of meal trays Dietary education completed as required
Skin/Dressings/Drains	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Ensure routine lab results are within acceptable limits
Activity	<ul style="list-style-type: none"> 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	<p>Ensure patient:</p> <ul style="list-style-type: none"> • 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 • Review with patient “ Urology Surgery, Your Guide to Recovery” booklet • Understands potential post-operative complications and when to seek medical attention • Arrangements made for staple removal Day 7 to 10 with GP or clinic, if applicable • Has completed LMWH (Dalteparin / Enoxaparin) teaching, if applicable <p>Confirm TST arrangements complete (as needed)</p>
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Last Revised:	
Last Reviewed:	
Approved By:	PHC
	Professional Practice Standards Committee
Owners:	PHC
	Surgery