Enhanced Recovery After Surgery (ERAS) for Vaginoplasty Pathway

Site Applicability

Vancouver General 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	• 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 (notify MD if > 38.5^{o}C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, non-distended, non-tender • Bowel protocol initiated
Nutrition & Hydration	• Tolerating full fluids, post-surgical transition diet, or DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Post-op wash completed (leave pink chlorhexidine preparation solution on for 6 hours post-op) • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • VAC dressing – note settings • VAC seal maintained. If not, reinforced with transparent drape (if unable to maintain seal, notify physician) • Pressure dressing to perineum dry and intact
Functional Mobility	• Bedrest as ordered • Ankle exercise every hour when in bed • ICOUGH protocol followed • Full night sleep achieved • Turned q2h until fully able to reposition on their own • Sequential Calf Compressors applied
Teaching & Discharge Planning • Patient is oriented to room/environment • ERAS booklet: patient has booklet at bedside • Patient is aware of daily goals • Reviewed and reinforced pain management	

Day of Surgery – Post-Op Day 1	
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 (notify MD if > 38.5^{o}C) • CBC, Electrolytes, Urea, Creatinine within patient's normal parameters. If not, inform physician. • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, non-distended, non-tender • Bowel protocol continued to maintain soft stool
Nutrition & Hydration	• Tolerating full fluids, post-surgical transition diet, or DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Saline lock IV if drinking more than 600 ml in 12 hours
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • VAC dressing – note settings • VAC seal maintained. If not, reinforced with transparent drape (if unable to maintain seal, notify physician) • Pressure dressing to perineum dry and intact
Functional Mobility	• Bedrest or activity as ordered • Ankle exercise every hour when in bed • ICOUGH protocol followed • Full night sleep achieved • Turned q2h until fully able to reposition on their own • HOB elevated 30 degrees when in bed, unless contraindicated • Dangle at bedside • Sequential Calf Compressors in situ
Teaching & Discharge Planning • Patient is oriented to room/environment • ERAS booklet: patient has booklet at bedside • Patient is aware of daily goals starting	

- Reviewed and reinforced pain management
- Patient is aware of discharge criteria
- Patient has arranged for support person at home post discharge
- Patient has home equipment prepared for 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
    - Passing gas or has had BM
- Confirm discharge destination

Day of Surgery – Post-Op Day 2	
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 (notify MD if > 38.5°C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, non-distended, non-tender • Bowel protocol continued
Nutrition & Hydration	• Tolerating full fluids, post-surgical transition diet, or DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Saline lock IV if drinking more than 600 ml in 12 hours
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • VAC dressing – note settings • VAC seal maintained. If not, reinforced with transparent drape (if unable to maintain seal, notify physician) • Pressure dressing to perineum dry and intact
Functional Mobility	• Activity as ordered • Ankle exercise every hour when in bed • ICOUGH protocol followed • HOB elevated 30 degrees when in bed, unless contraindicated • Independent with ADLs as per pre-op status • Up in chair • Walked in hallway • Full night sleep achieved • Dangle at bedside • Sequential Calf Compressors in situ
Teaching & Discharge Planning • ERAS booklet: patient has booklet at bedside • Patient is aware of daily goals starting • Reviewed and reinforced pain management	

- Patient is aware of discharge criteria
- Patient has arranged for support person at home post discharge
- Patient has home equipment prepared for 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
    - Passing gas or has had BM
- Confirm discharge destination

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 (notify MD if > 38.5^{o}C) • CBC, Electrolytes, Urea, Creatinine within patient's normal parameters. If not, inform physician. • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, non-distended, non-tender • Bowel protocol continued
Nutrition & Hydration	• DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • VAC dressing – note settings • VAC seal maintained. If not, reinforced with transparent drape (if unable to maintain seal, notify physician) • Pressure dressing to perineum dry and intact
Functional Mobility	• Activity as ordered • Ankle exercise every hour when in bed • ICOUGH protocol followed • HOB elevated 30 degrees when in bed, unless contraindicated • Independent with ADLs as per pre-op status • Up in chair • Dangle at bedside • Walked in hallway • Sequential Calf Compressors in situ
Teaching & Discharge Planning • ERAS booklet: patient reviewed daily goals and discharge information on page • Patient is aware of daily goals starting on page • Reviewed and reinforced pain management on page	

- Patient is aware of discharge criteria on page
- Patient has arranged for support person at home post discharge
- Patient has home equipment prepared for 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
    - Passing gas or has had BM
- Confirm discharge destination

Day of Surgery – Post-Op Day 4	
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 (notify MD if > 38.5^{o}C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, non-distended, non-tender • Bowel protocol continued
Nutrition & Hydration	• DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • VAC dressing – note settings • VAC seal maintained. If not, reinforced with transparent drape (if unable to maintain seal, notify physician) • Pressure dressing to perineum dry and intact
Functional Mobility	• Activity as ordered • Ankle exercise every hour when in bed • ICOUGH protocol followed • HOB elevated 30 degrees when in bed, unless contraindicated • Independent with ADLs as per pre-op status • Up in chair • Dangle at bedside • Walked in hallway
Teaching & Discharge Planning • ERAS booklet: patient reviewed daily goals and discharge information on page • Patient is aware of daily goals starting on page • Reviewed and reinforced pain management on page • Patient is aware of discharge criteria on page • Patient has arranged for support person at home post discharge • Patient has home equipment prepared for 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
  - Passing gas or has had BM
- Confirm discharge destination

Day of Surgery – Post-Op Day 5	
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 (notify MD if > 38.5°C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Remove catheter once surgeon has removed VAC dressing. Post void residual < 100 ml x 2 • Pericare completed q shift • Flatus passed • Abdomen soft, non-distended, non-tender • Bowel protocol continued. If no BM by POD6, initiate advanced bowel protocol
Nutrition & Hydration	• DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • Obtain dilation set prior to dressing removal • VAC dressing – note settings. DO NOT REMOVE VAC; physician to remove • Turn VAC machine off in preparation for surgeon to remove dressing • Vaginal Dilation reviewed and practiced QID
Functional Mobility	• Ankle exercise every hour when in bed • ICOUGH protocol followed • Independent with ADLs as per pre-op status • Up in chair • Walked in hallway
Teaching & Discharge Planning • ERAS booklet: patient reviewed daily goals and discharge information on page • Patient is aware of daily goals starting on page • Reviewed and reinforced pain management on page • Patient is aware of discharge criteria on page • Patient has arranged for support person at home post discharge • Patient has home equipment prepared for discharge including dilators	

- 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
    - Passing gas or has had BM
    - Vaginal Dilation reviewed and practiced QID
- Confirm discharge destination

Day of Surgery – Post-Op Day 6	
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 (notify MD if > 38.5°C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Remove catheter once surgeon has removed VAC dressing. Post void residual < 100 ml x 2 • Voiding well. Contact physician if urinary output is less than 100 ml per 4 hours • Pericare completed q shift • Flatus passed • Abdomen soft, non-distended, non-tender • Bowel protocol continued. If no BM by POD6, initiate advanced bowel protocol
Nutrition & Hydration	• DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • Obtain dilation set prior to dressing removal • VAC dressing – note settings. DO NOT REMOVE VAC; physician to remove • Turn VAC machine off in preparation for surgeon to remove dressing • Vaginal Dilation reviewed and practiced QID
Functional Mobility	• Ankle exercise every hour when in bed • ICOUGH protocol followed • Independent with ADLs as per pre-op status • Up in chair • Walked in hallway • Up to bathroom
Teaching & Discharge Planning • ERAS booklet: patient reviewed daily goals and discharge information on page • Patient is aware of daily goals starting on page • Reviewed and reinforced pain management on page	

- Patient is aware of discharge criteria on page
- Patient has arranged for support person at home post discharge
- Patient has home equipment prepared for discharge including dilators
- 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
    - Passing gas or has had BM
    - Vaginal Dilation reviewed and practiced QID
- Confirm discharge destination

Day of Surgery – Post-Op Day 7 or greater	
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 (notify MD if > 38.5^{o}C) • Head to toe assessment (within patient's normal limits) • CBG taken as per protocol • Patient describes anxiety as acceptable
Pain Management	• Review pain management and importance of pain control • Pain level acceptable to patient • Pruritus controlled
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • If catheter discontinued, post void residual > 100 ml x 2 • Pericare completed q shift • Flatus passed • Abdomen soft, non-distended, non-tender • Bowel protocol continued. If no BM by POD7, initiate advanced bowel protocol
Nutrition & Hydration	• DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Drains emptied q6h. Dressing around drains dry and intact. Stripped if ordered • Vaginal Dilation reviewed and practiced QID • Incision approximated with no signs of infection
Functional Mobility	• Ankle exercise every hour when in bed • ICOUGH protocol followed • Independent with ADLs as per pre-op status • Up in chair • Walked in hallway • Up to bathroom
Teaching & Discharge Planning • ERAS booklet: patient reviewed daily goals and discharge information on page • Patient is aware of daily goals starting on page • Reviewed and reinforced pain management on page • Patient is aware of discharge criteria on page • Patient has arranged for support person at home post discharge • Patient has home equipment prepared for discharge including dilators • 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
- Passing gas or has had BM
- Vaginal Dilation reviewed and practiced QID

- Confirm discharge destination

Day of Discharge	
Category	**Expected Outcomes**
Discharge	• Discharged, accompanied • Has discharge prescriptions • Has dilator set and appropriate teaching sheet • Has "My Discharge Plan" sheet • Has follow up information • Has all belongings • Understands when to seek medical attention for complications • Discharge destination confirmed

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, UBCH • Clinical Nurse Educator, Transplant, Urology, Gynecology, Plastics, VGH