SITE: VCH Coastal Cerner Sites

UROL – BLADDER REPAIR CLINICAL PATHWAY

Instructions:

I. Review once per shift for patient care guideline only. Do not record patient care on this document.
II. Document all tasks completed and any problems, interventions, and evaluations in CERNER EHR.
III. Review previous shift documentation - unless documenting on outcomes for the first time.
IV. **Bolded Items are desired patient outcomes/required Interventions**

Within Defined Limits (WDL)

VS	VS as ordered.
Laboratory	Blood work as ordered. Notify physician if hemoglobin <90 or call stat if symptomatic and/or hemoglobin <80.
Vaginal Bleeding	Light to moderate sanguineous discharge, decreasing with each post op day.
Voiding	Notify Treating Provider if urine output is less than 60 mL for two consecutive hours. Urine output clear, no foul odour. Pt. voiding independently when foley discontinued.
Post Void Residual (PVR)	In and Out Catheterization if PVR greater than 150mL, PRN

Patient Resource Materials:

1.	FP.600.B569	Bladder Repair Surgery/Anterior/Posterior Repair or Burch Repair
2.	FN.200.P74	Preventing Pneumonia: ICOUGH

UROL – BLADDER REPAIR CLINICAL PATHWAY			
Date	**PAC**	**SSCU**	**OR day**
NEURO Delirium			Assess/address risk factors: pain, retention, restraint, sensory impairment, lytes, alcohol, meds, hypoxia, nutrition. **No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP Respiratory impairment	iCOUGH Protocol if applicable		iCOUGH Protocol if applicable **Chest clear**
CVS Hypovolemia DVT/PE		May receive antibiotics if ordered	**VS WDL**
Hematology Anemia	HGB, Cross Match		
GI Nausea/vomiting, constipation	Na Citrate if ordered Enema in evening if ordered	Confirm NPO Status	Sips to DAT **No nausea and/or vomiting**
GU Urine output, PV loss			**Vaginal Bleeding WDL** **Remove Foley Catheter at 0600 if ordered** **Voiding WDL**
Pain	PCA pamphlet if appropriate		**Pain level <4 on pain scale or level acceptable to patient**
MUSC/SKEL Mobility	Leg exercises		**Leg exercises** **Dangle**
Psychosocial Fear and anxiety			Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Pain control, complications, hygiene, activity, constipation prevention	Shower and Chlorhexidine cloth wash morning of surgery. Review current medications and ask re: 7 days before surgery stop taking ASA, NSAIDs, vitamins/herbal preparations. Take regular medications pre-op with a sip of water, unless otherwise ordered. Arrange transport home. Discuss length of stay. Review Pamphlet "Bladder Repair Surgery - (Anterior/Posterior Repair or Burch Repair) - #FP.600.B569 Pre-op Video	Chlorhexidine cloth wash completed on morning of surgery. Confirm regular medications taken pre-op. Reinforce pre-op teaching. Ensure transport arrangements have been made. **Patient has a primary support person available**	Orient to unit and hospital routine Reinforce pre-op teaching Review pain scale/management Review purpose of lines, tubes, (PCA, drain, foley cath). **Patient and family understands outcome of surgery**

UROL – BLADDER REPAIR CLINICAL PATHWAY			
Date	**POD 1**	**POD 2**	**POD 3**
NEURO -Delirium	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**	**No evidence of delirium, e.g. confusion, agitation, anxiety**
RESP Respiratory impairment	**Chest clear**	**Chest clear**	**Chest clear**
CVS Hypovolemia DVT/PE	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** DVT prophylaxis **No evidence DVT/PE**	**VS WDL** DVT prophylaxis **No evidence DVT/PE**
Hematology Anemia,		**Hemoglobin WDL**	
GI Nausea/vomiting, constipation	DAT **DC IV if tolerating fluids** **No nausea and/or vomiting**	DAT **No nausea and/or vomiting**	DAT **No nausea and/or vomiting**
GU Urine output, PV loss	**Vaginal Bleeding WDL** **Remove Foley catheter at 0600 if ordered** **PVR WDL** **Voiding WDL**	**Vaginal Bleeding WDL** **PVR WDL** **Voiding WDL**	**Vaginal Bleeding WDL** **Voiding WDL**
Pain	**Pain level < 4 on pain scale or level acceptable to patient**	**Pain level < 4 on pain scale or level acceptable to patient**	**Pain level < 4 on pain scale or level acceptable to patient**
MUSC/SKEL Mobility	Wash at sink **Walking in room/hall**	**Up to Bathroom** **Mobilizing independently**	 **Mobilizing independently**
Psychosocial Fear and anxiety	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**	Nurse will discuss pt's concerns and fears related to surgery and diagnosis **Pt describes anxiety as acceptable**
Patient Teaching/ Discharge Planning Pain control, complications, hygiene, activity, constipation prevention	**Begin discharge teaching and sign discharge outcomes** Review pamphlet "Bladder Repair Surgery (Anterior/Posterior Repair or Burch Repair). Patient information" #FP.600.B569.	**Review and sign discharge outcomes and teaching** Review pamphlet "Bladder Repair Surgery (Anterior/Posterior Repair or Burch Repair). Patient information" #FP.600.B569. **Discharge home by 10 a.m. if outcomes met**	Complete discharge teaching: Bowel Care Pain management including gas pain Personal hygiene Post-op complications (DVT/PE, infections, anemia.) Activity Review pamphlet "Bladder Repair Surgery (Anterior/Posterior Repair or Burch Repair) – Patient information" #FP.600.B569. Discharge home by 10 a.m. if outcomes met

DISCHARGE OUTCOMES

Record: Discharge Time, Destination, Accompanied by, Mode

Patient must:

Have effective pain control on oral analgesics

Scant vaginal bleeding

Bowel sounds, and/or passing flatus, abdominal distention within normal limits

Ambulate independently or a pre-op functional level

A suitable discharge plan is in place

Be voiding adequately

Teaching: document variances according to instructions on Page 1
Patients or caregivers must demonstrate awareness of:

- Activity restriction in relation to lifting, driving, household activities, returning to work and sexual intercourse
- Patient will state the signs and symptoms of common potential complications and appropriate action to be taken (e.g. wound/urinary/vaginal infections/DVT/pulmonary embolus)
- Pain management – patients understands the importance of taking analgesics and reporting severe pain to physician
- Medications on discharge
- Methods to promote bowel functions and prevent constipation
- Follow-up appointment with surgeon
- Personal hygiene recommendations (e.g. avoid tampon use and douching)