

Enhanced Recovery After Surgery (ERAS) for Phalloplasty 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

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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
Gender Care Plan	Preferred name confirmed and highlighted on name band & in
	Cerner if different from BC Care Card
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)
	Anxiety level acceptable to patient
Pain Management	Surgical pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Clear fluids (xanthine-free)
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
Flap	Warm room 27 to 30 degrees Celsius
	Air driven temperature management blanket
	Flap check q1h x 72 hours (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to Integra or skin
	graft (document accordingly)
	 Neurovascular checks to donor hand q4h (document accordingly)
	Free radial forearm donor site elevated
	Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Secondary dressing intact
Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact



Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated ERAS ankle and arm exercises
	ICOUGH protocol followed
	Full night sleep achieved
	Bedrest: turned q2h until fully able to reposition on their own
Teaching & Discharge Planning	

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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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)
	Anxiety level acceptable to patient
	Lab values within normal limits
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Full fluids to Post Surgical Transition to Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Saline lock IV if drinking 600 ml or more fluids in 12 hours
Flap	Warm room 27 to 30 degrees Celsius
•	Air driven temperature management blanket
	Flap check q1h x 72 hours (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to Integra or skin
Jones one	graft (document accordingly)
	Neurovascular checks to donor hand q4h (document accordingly)
	Free radial forearm donor site elevated (OT to make splint and splint)
	on)
	Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Secondary dressing removed to expose Xeroform
	Xeroform free from slime & excessive dried blood

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	Exudry placed under dependent areas
	Linens/gown free from site
Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ERAS ankle and arm exercises
	ICOUGH protocol followed
	Full night sleep achieved
	Bedrest: turned q2h until fully able to reposition on their own

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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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
	 Head to toe assessment (within patient's normal limits)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Full fluids to Post Surgical Transition to Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Saline lock IV if drinking 600 ml or more fluids in 12 hours
Flap	Warm room 27 to 30 degrees Celsius
	Air driven temperature management blanket
	Flap check q1h x 72 hours (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to Integra or skin
	graft (document accordingly)
	 Neurovascular checks to donor hand q4h (document accordingly)
	Free radial forearm donor site elevated (OT to make splint and splint)
	on)
	Skin graft donor site dressing (Transparent Drape/Transparent Drape with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed xeroform free from slime & excessive dried blood
	Linens/gown free from site

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Drains	 Hemovac drain stripped Hemovac drain emptied and recorded q6h Groin Penrose drain intact
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated ERAS ankle and arm exercises ICOUGH protocol followed Full night sleep achieved
	Bedrest: turned q2h until fully able to reposition on their own

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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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)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	 Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	• Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	 Full fluids to Post Surgical Transition to Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Saline lock IV if drinking 600 ml or more fluids in 12 hours
Flap	Warm room 27 to 30 degrees Celsius
	Air driven temperature management blanket
	• Flap check q1h x 72 hours, then transition to q2h x 48 hours
	(document accordingly)Absence of phallus edema
	Absence to blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	 Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	 VAC negative pressure wound therapy (NPWT) to Integra or skin
	graft (document accordingly)
	 Neurovascular checks to donor hand q4h (document accordingly)
	 Free radial forearm donor site elevated (OT to make splint and splint on)
	 Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed xeroform free from slime & excessive dried blood
	Exudry placed under dependent areas
	Linens/gown free from site

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Drains	 Hemovac drain stripped Hemovac drain emptied and recorded q6h Groin Penrose drain intact
Functional Mobility	 HOB elevated 30 degrees when in bed, unless contraindicated ERAS ankle and arm exercises ICOUGH protocol followed Full night sleep achieved Bedrest: turned q2h until fully able to reposition on their own

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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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
	 Head to toe assessment (within patient's normal limits)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Saline lock IV if drinking 600 ml or more fluids in 12 hours
Flap	Warm room 27 to 30 degrees Celsius
•	Air driven temperature management blanket
	Flap check q2h x 48 hours (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to Integra or skin
	graft (document accordingly)
	Neurovascular checks to donor hand q4h (document accordingly)
	Free radial forearm donor site elevated (OT to make splint and splint)
	on)
	Skin graft donor site dressing (Transparent Drape/Transparent Drape with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed xeroform free from slime & excessive dried blood
	Exposed xeroid in the front sinite & excessive direct blood Exudry placed under dependent areas
	Linens/gown free from site
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Drains	 Hemovac drain stripped Hemovac drain emptied and recorded q6h Groin Penrose drain intact
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated ERAS ankle and arm exercises ICOUGH protocol followed
	 Full night sleep achieved Bedrest: turned q2h until fully able to reposition on their own

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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Day of Surgery – Post-Op Day 5 Category Expected Outcomes	
Category Safety	
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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)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Regular diet (xanthine-free)
, , , , , , , , , , , , , , , , , , ,	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Saline lock IV if drinking 600 ml or more fluids in 12 hours
Flap	Warm room 27 to 30 degrees Celsius
гар	
	Air driven temperature management blanket Flan check 52b y 48 beyes, then transition to 54b y 48 beyes.
	• Flap check q2h x 48 hours, then transition to q4h x 48 hours
	(document accordingly)
	Absence of phallus edema Absence of blisters on phallus
	Absence of blisters on phallus
	No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision Ointroopt to phallus incisions RID as ordered.
Doman Cita	Ointment to phallus incisions BID as ordered VAC a particular and the argument of the property (NDMT) to interest and the property of th
Donor Site	VAC negative pressure wound therapy (NPWT) to integra or skin State of the support of Mound flower act).
	graft (document on Wound flowsheet)
	• ½ slab cast removed
	If Integra, VAC reapplied
	If skin graft, protective dressing to tissue donor site when
	ambulating or while asleep
	Neurovascular checks to donor hand q4h
	Free radial forearm donor site elevated, splint on
	Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Agaucel/Xeroform)



	Pooling fluid under dressing aspirated prn
	Exposed Xeroform free from slime & excessive dried blood
	Exudry placed under dependent areas
	Linens/gown free from site
Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ERAS ankle and arm exercises
	ICOUGH protocol followed
	Full night sleep achieved
	Full flight sleep achieved

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet

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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	
Assessment	 VS and temp within patient's normal limits Head to toe assessment (within patient's normal limits)
	Anxiety level acceptable to patient
Dain Managament	
Pain Management	Pain level acceptable to patient Pledder grasses controlled.
	Bladder spasms controlled Branches a sector lead
D 1/Dl - d d	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	IV Saline locked
Flap	Air driven temperature management blanket
	 Flap check q4h x 48 hours (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to integra or skin
	graft (document accordingly)
	• ½ slab cast removed
	If Integra, VAC reapplied
	If skin graft, protective dressing to tissue donor site when
	ambulating or while asleep
	Neurovascular checks to donor hand q4h
	Free radial forearm donor site elevated, splint on
	Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed Xeroform free from slime & excessive dried blood
	- LAPOSEG AETOTOTTI HEE HOTH SITTLE & EXCESSIVE GHEG DIOOG



	Exudry placed under dependent areas
	Linens/gown free from site
Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact
	Penrose drain removed
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ERAS ankle and arm exercises
	ICOUGH protocol followed
	Ambulate (standing/walking) with phallus protected and pointing
	upwards (mesh pants); with assistance or independently
	Independent with ADLs as per pre-op status
	Full night sleep achieved

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet
- Urinary catheter teaching for home
- Patient has arranged transportation for discharge
- Patient has arranged for support person at home for 72 hours post discharge
- Discharge destination confirmed

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Day of Surgery – Post-Op Da Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
Thony 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)
Assessment	VS and temp within patient's normal limits
	Head to toe assessment (within patient's normal limits)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
5	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
•	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	
Nutrition & riguration	
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	IV Saline locked
Flap	Air driven temperature management blanket
	Flap check q4h x 48 hours, then transition to q6h until discharge
	(document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	VAC negative pressure wound therapy (NPWT) to integra, reapply
	VAC (if not done)
	If skin graft, protective dressing to tissue donor site when
	ambulating or while asleep
	Neurovascular checks to appropriate hand q4h
	Free radial forearm donor site elevated, splint on
	Skin graft donor site dressing (Transparent Drape/Transparent Drape
	with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed Xeroform free from slime & excessive dried blood
	Exudry placed under dependent areas



	Linens/gown free from site
Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact
	Penrose drain removed
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ERAS ankle and arm exercises
	ICOUGH protocol followed
	Ambulate (standing/walking) with phallus protected and pointing
	upwards (mesh pants); with assistance or independently
	 Independent with ADLs as per pre-op status
	Full night sleep achieved

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet
- Urinary catheter teaching for home
- Patient has arranged transportation for discharge
- Patient has arranged for support person at home for 72 hours post discharge
- Discharge destination confirmed

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Day of Surgery – Post-Op Da Category	Expected Outcomes
Safety	Bedside safety check
-	·
Fall Risk/Care Plan	Tan prevention care plan in place
	Risk assessed & new fall prevention care plan completed
C!#!	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)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Bladder spasms controlled
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Suprapubic indwelling catheter to straight drainage
	Urethral catheter (as stent)
	 Catheter(s) to remain in situ and only to be removed by surgeon
	Suprapubic catheter secured and catheter care completed q shift
	Abdomen soft, not distended, non-tender
	Flatus passed
	Note date of last BM
Nutrition & Hydration	Regular diet (xanthine-free)
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	IV Saline locked
Flap	Air driven temperature management blanket
	 Flap check q6h until discharge (document accordingly)
	Absence of phallus edema
	Absence of blisters on phallus
	 No constriction at pedicle/anastomosis location (no tight dressings,
	external pressure)
	Phallus in cradle pointed upward and away from thigh incision
	Ointment to phallus incisions BID as ordered
Donor Site	 VAC negative pressure wound therapy (NPWT) to integra (reapply VAC if not done)
	If skin graft, protective dressing to tissue donor site when
	ambulating or while asleep
	Neurovascular checks to appropriate hand q4h
	Free radial forearm donor site elevated, splint on
	 Skin graft donor site dressing (Transparent Drape/Transparent Drape with Aqaucel/Xeroform)
	Pooling fluid under dressing aspirated prn
	Exposed Xeroform free from slime & excessive dried blood
	Exudry placed under dependent areas
	Linens/gown free from site



Drains	Hemovac drain stripped
	Hemovac drain emptied and recorded q6h
	Groin Penrose drain intact
	Penrose drain removed
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	ERAS ankle and arm exercises
	ICOUGH protocol followed
	 Ambulate (standing/walking) with phallus protected and pointing upwards (mesh pants); with assistance or independently
	Independent with ADLs as per pre-op status
	Full night sleep achieved

Teaching & Discharge Planning

- Patient is oriented to room/environment
- Patient is aware of daily goals on clinical pathway
- Review & reinforce Pain management pamphlet
- Patient reviewed ERAS teaching booklet
- Patient has arranged transportation for discharge
- Patient has arranged for support person at home for 72 hours post discharge
- Discharge destination confirmed
- Urinary catheter teaching for home

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Day of Discharge	
Category	Expected Outcomes
Discharge	Discharged, accompanied
	 Physician has removed implanted Doppler and staple
	Understands urinary catheter care
	Has urinary catheter care equipment
	Has discharge prescriptions
	Has post-op instruction 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, Transplant, Urology, Gynecology, Plastics, VGH