Retropubic Radical Prostatectomy Clinical Pathway

Site Applicability

Vancouver General Hospital

UBC Hospital

Pathway Patient Goals

Eligible for discharge when diamond (◆) outcomes met. Consult with surgeon.
Bolded items are desired outcomes.

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 (0)	
Core Issues	**Expected Outcomes**
Cardiopulmonary	• Encourage 10 deep breaths/hour and coughing while awake • Chest auscultation q 12 h • Chest physiotherapy • **Breath sounds clear in all lung fields ◆** • **O2 sat at or above 92% or acceptable range for patient** • **Vital signs within acceptable range ◆**
Pain	• Review pain management, modalities (PCA/Ketorolac infusion) and side effects • Assess pain q 1 h until controlled, then q 4 h and prn. • If unable to control pain, notify POPS or surgeon if not on PCA • **Pain rating at 4 or below or at level acceptable to patient ◆**
Elimination	• Monitor urine output q 2h overnight • Notify surgeon if urinary output below 60mls for 2 hours • Foley catheter to straight drainage. • Catheter care q 12 h and prn • **Urinary output at or above 60 mls/2 hours** • **Meatus clean, skin intact, foreskin not retracted, catheter clean and securely taped**
Bleeding **Dressing** **Drain**	• Review estimated blood loss and replacement given intra-op • Review Hgb results from PACU and pre-admission • Assess dressing q 4 h and reinforce prn • Assess if drain insitu • Empty and record drain output q 12h • Notify surgeon if drain output greater than 100 mls/hr and is sanguineous. • Change dressing daily and PRN • **Hgb within acceptable range, not symptomatic ◆ (dizziness, fatigue, orthostatichypotension, weak/rapid pulse)** • **Drainage from dressing within normal limits** • **Drain in situ, patent, volume and colour within normal limits ◆**
PONV **Fluids/lytes** **Nutrition**	• Assess PONV q 1 h until controlled • Assess for abdominal distention and firmness q 12 h. • Sips to clear fluids today • **Patient states nausea is under control ◆** • **Tolerating clear fluids ◆** • **Abdomen soft and minimal distension ◆** • **Electrolytes are within normal range ◆** • **IVCVC clean/intact no excessive redness/drainage**
Infection	• Notify surgeon of temperature over 38.5 • **Temperature within normal limits ◆**
Mobility **PR/DVT**	• If OR was in AM today, stand at bedside or walk a few steps today with assistance • Reposition q 2-4 h overnight • **Sequential Calf Compressors**

Anxiety	• Anticipate and discuss patient's concerns/fears related to surgery • **Patient describes anxiety as acceptable**
Teaching/Discharge Planning	• Reinforce expected length of stay (2 days) • Teach patient how to move in bed, leg exercises, splint wound and catheter comfort

Day of Surgery – Post-op Day 1	
Core Issues	**Expected Outcomes**
Cardiopulmonary	• Encourage 10 deep breaths/hour and coughing while awake • Chest auscultation q 12 h • Chest physiotherapy • **Breath sounds clear in all lung fields ◆** • **O2 sat at or above 92% or acceptable range for patient ◆** • **Vital signs within acceptable range ◆** • **Lab values within normal limits ◆**
Pain	• Review pain management. If on PCA, wean off today / importance of requesting analgesics PRN • Assess pain q 1 h until controlled, then q 4 h and prn. • If unable to control pain, notify POPS or surgeon if not on PCA • **Pain rating at 4 or below or at level acceptable to patient ◆**
Elimination	• Notify surgeon if urinary output below 60mls for 2 hours • Foley catheter to straight drainage. • Secure catheter with catheter secure tape today. Alternate cath secure tape from leg to leg for comfort • Note if patient passing flatus; note if bowel movement today (laxative use PRN). Patient to avoid straining (vasovagal risk) • Start leg bag teaching with return demonstration today • **Urinary output at or above 60 mls/2 hours ◆** • **Meatus clean, skin intact, foreskin not retracted, catheter clean and securely taped**
Bleeding **Dressing** **Drain**	• Assess dressing daily and change prn • Empty and record drain output q 12h and PRN • Notify surgeon if drain output greater than 100 mls/hr and is sanguineous. • Change dressing daily and PRN • **Hgb within acceptable range, not symptomatic ◆** (dizziness, fatigue, orthostatic hypotension, weak/rapid pulse) • **Drainage from dressing within normal limits** • **Incisions well approximated, free or redness, swelling and bruising; staples intact ◆** • **Drain in situ, patent, volume and colour within normal limits**
PONV **Fluids/lytes** **Nutrition**	• Assess PONV q 1 h until controlled • Assess for abdominal distention and firmness q 12 h and PRN • Clear to full fluids today • **Patient states nausea is under control ◆** • **Tolerating clear fluids ◆** • **Abdomen soft and minimal distension ◆** • **Electrolytes are within normal range ◆** • **IV/CVC clean/intact no excessive redness/drainage**
Infection	• Notify surgeon of temperature over 38.5 • **Temperature within normal limits ◆**
Mobility	• Assist to walk and up to chair today

PE/DVT	• Sequential Calf Compressors on while in bed until mobilizing well (walking in hallway TID) • **Patient able to mobilize with assistance ◆** • **Patient understands the importance of mobility and the potential vasovagal risk when walking**
Anxiety	• Anticipate and discuss patient's concerns/fears related to surgery • **Patient describes anxiety as acceptable ◆**
Teaching/Discharge Planning	• Review expected length of stay with patient (2 days). PCC to be notified if concerns about discharge • PT: review incentive spirometer and safe mobilization • **Home support person available for discharge ◆** • **Refer to Discharge Teaching Checklist and begin discharge teaching today. Sign off each item** • **Patient understands progression of activity, diet, catheter care and catheter drainage system**

Day of Surgery – Post-op Day 2	
Core Issues	**Expected Outcomes**
Cardiopulmonary	• Encourage 10 deep breaths/hour and coughing while awake • Chest auscultation q 12 h • Chest physiotherapy • **Breath sounds clear in all lung fields ◆** • **O2 sat at or above 92% or acceptable range for patient ◆** • **Vital signs within acceptable range ◆** • **Lab values within normal limits ◆**
Pain	• Review importance of requesting analgesics prn • Assess pain q 1 h until controlled, then q 4 h and prn. • If unable to control pain, call surgeon • **Pain rating at 4 or below or at level acceptable to patient ◆**
Elimination	• Notify surgeon if urinary output below 60mls for 2 hours • Foley catheter to straight drainage. • Catheter care q 12 h and PRN. Alternate catheter secure tape from leg to leg for comfort • Note if patient passing flatus; note if bowel movement today (laxative use PRN). Patient to avoid straining (vasovagal risk) • **Able to demonstrate emptying & exchanging catheter/leg bag & describe bag/tubing cleaning** • **Urinary output at or above 60 mls/2 hours ◆** • **Meatus clean, skin intact, foreskin not retracted, catheter clean and securely taped**
Bleeding **Dressing** **Drain**	• Assess dressing daily and change prn • Empty and record drain output q 6 h • Notify surgeon if drain output greater than 100 mls/hr and is sanguineous. • Change dressing daily • **Hgb within acceptable range, not symptomatic ◆** (dizziness, fatigue, orthostatichypotension, weak/rapid pulse) • **Incisions well approximated, free or redness, swelling and bruising; staples intact ◆** • **Drain in situ, patent, volume and colour within normal limits**
PONV **Fluids/lytes** **Nutrition**	• Assess PONV q 1 h until controlled • Assess for abdominal distention and firmness q 12 h and PRN • Full fluids to DAT • Monitor intake • **Patient states nausea is under control ◆** • **Tolerating clear to full fluids ◆** • **Abdomen soft and minimal distension ◆** • **Electrolytes are within normal range ◆** • **IV/CVC clean/intact no excessive redness/drainage**
Infection	• Notify surgeon of temperature over 38.5 • **Temperature within normal limits ◆**
Mobility	• Up independently. Short walks x 3 today.

PR/DVT	• Sit on cushion. • Sequential Calf Compressors on while in bed until mobilizing well (walking in hallway TID) • **Patient able to mobilize independently ◆**
Anxiety	• Anticipate and discuss patient's concerns/fears related to surgery • **Patient describes anxiety as acceptable ◆**
Teaching/Discharge Planning	• PCC notified if concerns about discharge • PT: review incentive spirometer and safe mobilization • **Home support person available for discharge ◆** • **Patient understands discharge teaching ◆** • **Go to Discharge Teaching Checklist and continue discharge teaching. Sign off when items complete** • **Patient understands progression of activity, diet, catheter care and catheter drainage system**

Day of Surgery – Post-op Day 3 and Onward	
Core Issues	**Expected Outcomes**
Cardiopulmonary	• Encourage deep breathing and coughing while awake • Chest auscultation q 12 h • Chest physiotherapy • **Breath sounds clear in all lung fields ◆** • **O2 sat at or above 92% or acceptable range for patient ◆** • **Vital signs within acceptable range ◆** • **Lab values within normal limits ◆**
Pain	• Review importance of requesting analgesics PRN • Assess pain q 1 h until controlled, then q 4 h and prn. • If unable to control pain, call surgeon • **Pain rating at 4 or below or at level acceptable to patient ◆**
Elimination	• Notify surgeon if urinary output below 60mls for 2 hours • Foley catheter to straight drainage. • Catheter care q 12 h and PRN. Alternate catheter secure tape from leg to leg for comfort • Ureteral external stent to straight drainage. Measure and record drainage q 12 h and PRN • Note if patient passing flatus; note if bowel movement today • **Able to demonstrate emptying & exchanging catheter/leg bag & describe bag/tubing cleaning** • **Urinary output at or above 60 mls/2 hours ◆** • **Meatus clean, skin intact, foreskin not retracted, catheter clean and securely taped**
Bleeding **Dressing** **Drain**	• Assess dressing daily and change prn • Empty and record drain output q 12 h and PRN • Notify surgeon if drain output greater than 100 mls/hr and is sanguineous. • Change dressing daily • **Hgb within acceptable range, not symptomatic ◆** (dizziness, fatigue, orthostatic hypotension, weak/rapid pulse) • **Incisions well approximated, free or redness, swelling and bruising; staples intact ◆** • **Drain in situ, patent, volume and colour within normal limits**
PONV **Fluids/lytes** **Nutrition**	• Assess PONV q 1 h until controlled • Assess for abdominal distention and firmness q 12 h and PRN • Tolerating full fluids to DAT • **Patient states nausea is under control** • **Tolerating clear to full fluids ◆** • **Abdomen soft and minimal distension ◆** • **Electrolytes are within normal range ◆** • **IV/CVC clean/intact no excessive redness/drainage**
Infection	• Notify surgeon of temperature over 38.5 • **Temperature within normal limits ◆**
Mobility	• Up independently. Frequent short walks, at least x 3. Up in chair.

PR/DVT	• **Continuous night sleep for at least 4 hours** • **Patient able to mobilize independently ◆**
Anxiety	• Anticipate and discuss patient's concerns/fears related to surgery • **Patient describes anxiety as acceptable ◆**
Teaching/Discharge Planning	• PCC notified if concerns about discharge • PT: review safe mobilization • **Home support person available for discharge ◆** • **Patient understands discharge teaching ◆** • **Go to Discharge Teaching Checklist and continue discharge teaching. Sign when items complete** • **Patient understands progression of activity, diet, catheter care and catheter drainage system**

Discharge Teaching Checklist – Radical Retropubic Prostatectomy
Patient has discharge teaching booklet - If no booklet, provide booklet to patient.

Follow-up appointments

- Appointment with surgeon scheduled
- Cystogram appointment arranged or radiology will call patient
- Appoint with GP for staple removal or staple remover provided
- Prescription provided
- Patient/family counselling at BCCA if required

Pain

- If pain interferes with activity or sleep/rest, need to take pain medication more frequently.

Activity – take pain med 30 minutes prior to activity

- Exercise- avoid strenuous exercise /lifting for 4-6 weeks. Walk short distances to start, then increase as able
- Rest/sleep- take pain meds before bed at night
- Driving – avoid for 2-3 weeks
- Back to work – usually 6-8 weeks
- **Emotions during recovery**: Range of emotions. Recovery is individual, no right or wrong way to cope. Share worries/feelings with family/friends. Contact BCCA if not improving.

Incision:

- **Signs of incision infection**
- **Dressing**
- **Shower**: Shower 24 hours after drain is removed
- Support of incision
- **Signs of bladder infection** – Fever, chills, dull pain lower back area, no urine from catheter, excessive drainage around catheter, blood clots, bright red urine or increasedmucous in urine, bladder spasms not relieved with treatment , burning or foul smelling urine once catheter removed

Food and fluids

- Volume of fluid –drink 1-2 litres of non-caffeinated, non-alcoholic fluid daily
- Constipation: Keep bowels regular. Do not strain. High fibre/fresh fruit/vegetables. Use stool softener

Catheter – in place for 1 to 3 weeks.

- Emptying drainage bag/leg bag.
- Return demonstration
- Cleaning bags and tubing
- Leakage around the catheter- spasms, kinked tubing, constipation
- Bladder spasms- antispasmodic or may be bladder infection
- Blood clots- increase fluid intake and lie down. Contact MD if continues
- Penis/meatus discomfort – wear fitted underwear/incontinent product, ensure catheter is securely taped
- Reducing risk of bladder infection. Drink fluids, wash hands, keep catheter/penis clean
- Confirm when catheter is to be removed following discharge
    - Provided syringe if patient is required to remove catheter

Urinary elimination/Incontinence- sufficient bladder control within a few months

- Empty bladder q 2-4 hours. Learn to control urge to void
- Management – pelvic floor exercises, reduce caffeine, drink fluids, maintain weight
- Incontinence products – incontinent pads ensure patient has pads for catheter removal
- Physiotherapist/NCA at the Bladder Care Centre
- **Pelvic floor muscle exercises -** start after catheter is removed. Provide patient with kegal exercise pamphlet
- **Sexual activity –** return of ability to have an erection is individual and dependent on nerve damage to penis. Need to discuss this with surgeon.

Complications

- **DVT/PE**
- Walk short distances at least once an hour. While seated or in bed, twirl ankles and do footpumps.

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