Enhanced Recovery After Surgery (ERAS) for Radical Cystectomy Pathway

Site Applicability

Vancouver General Hospital

UBC Hospital

Lions Gate Hospital (LGH)

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 • Head to toe assessment (within patient's normal limits) • Capillary Blood Glucose (CBG) taken as per protocol • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable) • Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Note date of last BM
Nutrition & Hydration	• Sips of water/ice chips • Gum chewing (15 minutes TID) when awake • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed) • Sero-sanguineous draining < 100 ml/hr in HMV (if applicable) • Stents are patent • Post-op wash completed (leave pink chlorhexidine preparation solution on for 6 hours post-op) • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Turned Q2H until fully able to reposition on their own • Ankle exercise every hour when in bed • Sequential Compression Devices (SCD) applied unless contraindicated • SCD removed no longer than 30 min/shift to assess & perform skin care as per protocol • Patient sat at edge of bed or in chair x 15 minutes

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 55
  ○ Reviewed and reinforced pain management on page 43	

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 • Head to toe assessment (within patient's normal limits) • Capillary Blood Glucose (CBG) taken as per protocol • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable) • Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended
Nutrition & Hydration	• Water (Water **AND** Boost to a maximum total oral intake of 500 ml/12hr) • Boost 1.5 Tetra BID (Water **AND** Boost to a maximum total oral intake of 500 ml/12hr) • Gum chewing (15 minutes TID) when awake • Tolerating oral intake • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • If CVC in situ , obtain MD order to remove and insert peripheral IV
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent • Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	• Routine bloodwork within normal limits
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • SCD discontinued after first dose of anticoagulant, unless contraindicated • SCD removed no longer than 30 min/shift to assess & perform skin care as per protocol • Walked in hallway x 2 (with assistance or independently)

	• Up to bathroom (with assistance or independently)

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 57
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient received ostomy teaching by WOCN
• Patient received teaching re: self administration of LMWH
• Patient has a ride home on day of discharge	

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) • Capillary Blood Glucose (CBG) taken as per protocol • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable) • Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended
Nutrition & Hydration	• Water (Water **AND** Boost to a maximum total oral intake of 500 ml/12hr) • Boost 1.5 Tetra BID (Water **AND** Boost to a maximum total oral intake of 500 ml/12hr) • Gum chewing (15 minutes TID) when awake • Tolerating oral intake • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent • Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	• Routine bloodwork within normal limits
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • Up in chair for all meals (with assistance or independently) • Walked in hallway x 2 (with assistance or independently) • Up to bathroom (with assistance or independently)
Teaching & Discharge Planning • Patient is oriented to room/environment • ERAS booklet: Patient has booklet at bedside	

  - Patient is aware of daily goals starting on page 59
  - Reviewed and reinforced pain management on page 43
  - Patient is aware of discharge criteria on page 67
- Patient received ostomy teaching by WOCN
- Patient received teaching re: pouch irrigation
- Patient received teaching re: self administration of LMWH
- Patient has arranged for support person at home post 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 a bowel movement
  - Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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) • Capillary Blood Glucose (CBG) taken as per protocol • Anxiety level acceptable to patient
Pain Management	• Pain level acceptable to patient • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable) • Rectus sheath site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Full fluid as tolerated • Boost 1.5 Tetra BID • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressing changed • Incision dry and left open to air (no dressing) • Incision approximated (no signs of infection) • Sero-sanguineous draining < 100 ml/hr in HMV (if applicable) • Stents are patent • Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	• Routine bloodwork within normal limits
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • Up in chair for all meals independently • Walked in hallway x 2 (with assistance or independently) • Up to bathroom (with assistance or independently)

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 61
  ○ Reviewed and reinforced pain management on page 43	

- Patient is aware of discharge criteria on page 67
- Patient able to assist with ostomy care and management
- Patient received teaching re: pouch irrigation
- Patient self-administering LMWH
- Patient has arranged for support person at home post 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 a bowel movement
  - Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Full fluid as tolerated • Boost 1.5 Tetra BID • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift • Saline lock IV unless oral intake < 600 ml/12hr
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (when awake) • Up in chair for all meals independently • Walked in hallway x 2 independently • Up to bathroom independently

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 63
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient independent with ostomy care and management
• Patient received teaching re: pouch irrigation
• Patient self-administering LMWH
• Patient has arranged for support person at home post 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 a bowel movement
  - Able to self manage ostomy and irrigates pouch if required
- Discharge destination confirmed

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)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Post Surgical Transition Diet (PSTD) • Boost 1.5 Tetra daily • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift • Saline lock removed
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent/removed by urology on POD5 • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed • Up in chair for all meals independently • Walked in hallway x 2 independently • Up to bathroom independently

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 65
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient independent with ostomy care and management
• Patient received teaching re: pouch irrigation
• Patient self-administering LMWH
• Patient has arranged for support person at home post 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 a bowel movement
- Able to self manage ostomy and irrigates pouch if required

- Discharge destination confirmed

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)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Post Surgical Transition Diet (PSTD) to DAT • Boost 1.5 Tetra daily • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift • Saline lock removed
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent/removed by urology if not done on POD5 • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • Up in chair for all meals independently • Walked in hallway x 2 independently • Up to bathroom independently

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient reviewed daily goals and discharge information on page 65-68
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient independent with ostomy care and management
• Patient received teaching re: pouch irrigation
• Patient self-administering LMWH
• Patient has arranged for support person at home post 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 a bowel movement
- Able to self manage ostomy and irrigates pouch if required

- Discharge destination confirmed

Day of Surgery – Post-Op Day 7	
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)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Post Surgical Transition Diet (PSTD) to DAT • Boost 1.5 Tetra daily • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift • Saline lock removed
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent/removed by urology if not done on POD5 • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • Up in chair for all meals independently • Walked in hallway x 2 independently • Up to bathroom independently

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient reviewed daily goals and discharge information on page 65-68
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient independent with ostomy care and management
• Patient received teaching re: pouch irrigation
• Patient self-administering LMWH
• Patient has arranged for support person at home post 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 a bowel movement
- Able to self manage ostomy and irrigates pouch if required

- Discharge destination confirmed

Day of Surgery – Post-Op Day 8 and Onward	
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)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Pericare/catheter care completed q shift • Stoma is patent • Flatus passed • Note date of last BM • Abdomen soft, not distended • No evidence of urinary tract infection
Nutrition & Hydration	• Oral intake recorded • Post Surgical Transition Diet (PSTD) to DAT • Boost 1.5 Tetra daily • Gum chewing (15 minutes TID), when awake • Nausea controlled • Patient did NOT vomit during shift • Saline lock removed
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Sero-sanguinous draining < 100 ml/hr in HMV (if applicable) • Stents are patent/removed by urology if not done on POD5 • Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed • Up in chair for all meals independently • Walked in hallway x 2 independently • Up to bathroom independently

Teaching & Discharge Planning
• Patient is oriented to room/environment
• ERAS booklet: Patient has booklet at bedside
  ○ Patient reviewed daily goals and discharge information on page 65-68
  ○ Reviewed and reinforced pain management on page 43
  ○ Patient is aware of discharge criteria on page 67
• Patient independent with ostomy care and management
• Patient received teaching re: pouch irrigation
• Patient self-administering LMWH
• Patient has arranged for support person at home post 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 a bowel movement
- Able to self manage ostomy and irrigates pouch if required

- Discharge destination confirmed

Day of Discharge	
Category	**Expected Outcomes**
Discharge	• Discharged, accompanied by support person • Has discharge prescriptions • Has sharps container & appropriate LMWH teaching sheet • "My Discharge Plan" sheet updated with follow-up appointments and given to patient • Has all personal belongings • Understands when to seek medical attention for complications • Discharge destination/accommodation confirmed • Aware where to get extra supplies for ostomy care • Arrangements made for staple removal

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