PROTOCOL FOR: Bladder Reconstruction/Cystectomy: Care of the Perioperative Patient

DESIRED PATIENT OUTCOMES:

1. Patient will experience minimal/no complications related to bladder surgery or bladder diversion.

2. Patient and/or significant other will be prepared for independent management of ostomy.

CLINICAL ASSESSMENT/ AND CARE:

Pre-operative Care:

1. Assess patient's and/or significant other's understanding of planned surgical procedure and/or if applicable type of diversion.

2. Follow "Pre-operative Preparation Protocol" and MD orders to insure appropriate preparation of patient for surgical procedure.

3. If applicable, consult CNS, per MD order, to mark stoma at appropriate site.

4. If applicable, initiate "Teaching Plan: Ostomy Care", and follow interventions for pre-operative care.

Post-operative Care:

1. If ileal conduit performed, assess stoma every 4 hours for the first 24 hours, and then every 8 hours and prn. Assess whether stoma is pink/red and moist. Stoma may be edematous for several days post-op. The presence of stents should also be noted, and care of stents given per LIP order. Initiate to Ostomy Care protocol: Post-operative Care.

2. Assess and monitor drainage from urostomy and surgical drains every 4 hours and as ordered.

3. Assess bowel sounds every 4 hours x 24 hours then every 8 hours/prn.

4. Maintain NPO status as per MD order.

5. If applicable, maintain NGT per protocol.

6. Maintain IV fluids as per MD order.

7. Monitor I+O's every 4 hours x 24 hours then every 8 hours or more frequently per MD order.

8. Assess need for possible nutritional support.

9. Monitor lab values, especially electrolyte balance. Replace as ordered by MD.

10. Maintain activity as ordered.

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11. Encourage patient to turn, cough and deep breath and to use the incentive spirometer every 1 hour while awake.

12. Assess for S/S of pain using the 0-10 pain scale. The patients pain should be 5/10 or less or at a level acceptable to the patent. A pain level of 5/10 or greater or any level unacceptable to the patient requires further assessment and review. Initiate the appropriate Pain Protocol.

13. Discharge Planning needs:

    a. If patient is to be discharged with any drains, instruct regarding possible dressing changes, irrigation, and emptying of any drainage.
    b. Instruct patient to monitor for any S/S of infection: change in color of drainage, foul odor, and erythema.
    c. Contact case manager to assist in arranging home care services if necessary.
    d. Assist the patient with increasing their independence with ostomy care.

REPORTABLE CONDITIONS: Notify House Officer if:

1. Vital signs outside of MD parameters.
2. Urine output less than 30 cc/hr or as MD order.
3. Any S/S of infection around incision/drain sites.
4. Inadequate pain management.

PATIENT TEACHING:

1. Initiate Patient and Family Teaching Record Ostomy Care.
2. Assess patient's/significant other's ability to learn ostomy care.
3. Provide patient with referral for home care services/nursing support after discharge.
4. Provide patient with information about the United Ostomy Association.

DOCUMENTATION:

1. Document physical findings and interventions on the unit flow sheets, MAR and Infusion Record.
2. Document patient response to care in patient progress notes per Unit/Department Documentation Standards.

REFERENCES: Med-Surg Standards Review
ICU Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 5/93

REVISION DATES: 12/97, 5/03, 8/05