

**Integrated Care Pathway**

**Trans Urethral Resection of the Prostate**

**(TURP /GYRUS/HOLAP/HOLEP)**

 Use this pathway for all patients requiring planned surgery for TURP



Patient name / Label

DOB:

Hospital Number

Consultant:

**How to use the pathway:**

1. The pathway should be used from being seen in pre admission
2. The document forms a single , multidisciplinary record and should be used
   * 1. by all staff in place of separate unidisciplinary notes (history sheets, nursing kardex etc)
3. All staff must complete the signature sheet on page 2
4. The pathway is a prompt only, any deviations from the pathway, must be written in the variance column along with any action taken and the results of the action. The variance must also be signed. This process enables the practitioner to use their clinical judgement and also enables the pathway to be audited more easily
5. It is a legal document, therefore all entries on the pathway, **must** be signed for.
6. Where possible the pathway has been based on clinical evidence. Where no evidence is available, a decision has been made to use best clinical practise.
7. The pathway follows the patient throughout their stay in hospital and includes discharge planning.
8. To use the pathway, just follow the prompts, fill in the relevant spaces, add any variances and then sign in the relevant area. If there are any changes and there is no room on the page, write in the variance column.
9. If patients’ condition requires lots of free text, extra sheets of clinical record can be added on a daily basis until the condition becomes stable. Deviation from the pathway should be avoided if possible. If the patient is removed from the pathway **or** extra clinical sheets are added this **must** be added to the variance page.

Abbreviations used:

BM = Blood Glucose Monitoring MSW = Medical Social Worker

BP = Blood Pressure MRSA = Methicillin Resistant Staphlococcus Aureus

D.O.B. = Date of Birth N = No

Dr = Doctor NA = Not applicable

FU = Follow Up 02 = Oxygen

GP = General Practioner. PU = Passing Urine

Hum = Humidifed PAC = Pressure Area Care

Hrly = hourly Pt = Patient

Min = Minute TEDS = anti –embolic stockings

MSU = Mid Stream Urine Y = Yes

**If you have any problems with this pathway. Please contact the**

**Urology Specialist Nurses on ext 4866**

**Integrated Care Pathway**

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

Attach Patient Label Here

Name:…..……………………………………….…….………

Address:..…………………………………………………….…

…………………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….

**SIGNATURE SHEET**

Please give your full name, designation, initials and full signature below, if you write in this pathway. This is for legal purposes.

|  |  |  |  |
| --- | --- | --- | --- |
| FULL NAME | DESIGNATION | FULL SIGNATURE | INITIALS |
| Alister Campbell | Consultant Urologist |  |  |
| Melissa Davies | Consultant Urologist |  |  |
| Mohammed Saghir | Consultant Urologist |  |  |
| James Brewin | Consultant Urologist |  |  |
| Vaselios Sakalis | Locum Consultant Urologist |  |  |
| Daphne Philips | CNS 7 |  |  |
| Kate Chadwick | CNS 6 |  |  |
|  |  |  |  |
|  | Clinical Fellow |  |  |
|  | Sp/R |  |  |
|  | CT |  |  |
|  | F1 |  |  |
|  | F1 |  |  |
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**Variance Sheet**

|  |  |  |  |
| --- | --- | --- | --- |
| Date & Time | Variance Number / Reason | Action Taken and result from action | Sign |
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**Patient name………………………………………………….Hospital number………………………….**

Date Date of Operation

**Urological assessment**



Frequency: Nocturia: Haematuria: Urgency Hesitancy

Stream Incontinence

Urinalysis: Blood Protein Leucocytes Nitrites MSU Yes / No Copy to GP Yes / No Medication:



Flow Studies



Maximum urinary flow (Qmax):………………………………ml/sec Average flow (Qave):………………………………………….ml / sec Voided volume:………………………………………………...ml Residual volume……………………………………………….ml

Other investigations / Advice

Follow up 3/12 – LUTS tel/OP LUTS/ Cons F/U

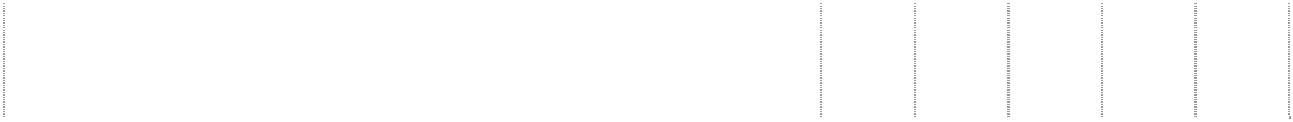
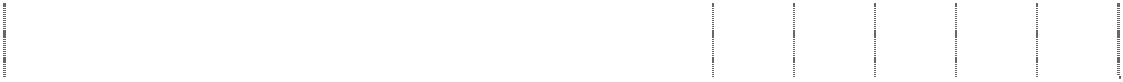
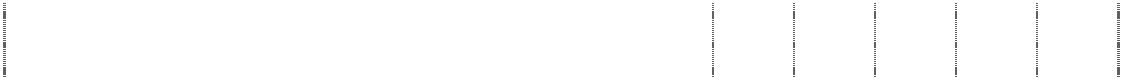
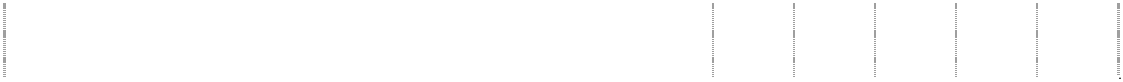
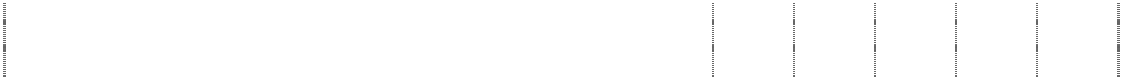
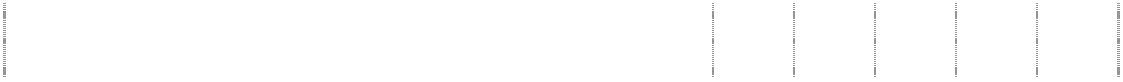
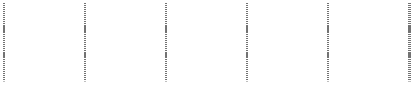




Print Name and

Signature: Date and Time Band

**IPSS Score**



1 **Incomplete emptying**

Not at all

Less than 1 time in

5

Less than half the time

About half the time

More than half the time

Almost

Always

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?

2 **Frequency**

Over the past month, how often have you had to urinate again in less than two hours after you finished urinating?

3 **Intermittency**

Over the past month, how often have you found you stopped and started again several times when you urinated?

4 **Urgency**

Over the past month, how often have your found it difficult to postpone urination?

5 **Weak Stream**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

Over the past month , how often have you had a weak urinary stream? **0 1 2 3 4 5**

6 **Straining**

Over the past month, how often have you had to push or strain to begin urination

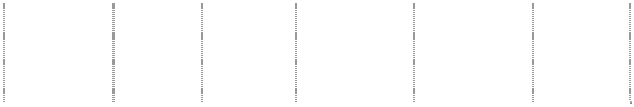
7 **Nocturia**

Over the past month, how many times did you most typically get up to urinate form the time you went to bed at night until the time you got up in the morning

**0 1 2 3 4 5**

**0 1 2 3 4 5**

Total I-PSS Score



**Quality of life due to urinary symptoms**

**Delighted Pleased Mostly satisfied**

**Mixed about equally satisfied & dissatisfied**

**Most dissatisfied**

**Unhappy Terrible**

**If you were to spend the rest of your life with your urinary condition just the way it is now, how would your feel about that?**

**0 1 2 3 4 5 6**

**Integrated Care Pathway**

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

Attach Patient Label Here

Name:…..……………………………………….…….………

Address:..…………………………………………………….…

…………………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….

**Date:**

**Operation Note**

**Surgeon:…………………………………….. Anaesthetist:……………………………………**

Assistant:…………………………………… Anaesthetic : General / Spinal

Calf compression : Yes / no

**TRANS-URETHRAL RESECTION (Diathermy) / TRANS-URETHRAL RESECTION (GYRUS)/**

**HOLMIUM ABLATION (HOLAP)/ HOLMIUM ENUCLEATION (HOLEP)**

**ANY ADDITIONAL PROCEDURES:**

**Assessment:**

Pre-op checklist with patient □ consent process completed □

**EUA**: Benign / Malignant

Clinical Stage…………….

**CYSTOSCOPY**

**Interventions**

Urethrotomy performed Yes / No

PRE-SURGERY POST-SURGERY

Resectoscope sheath size ……………….French

Weight resected………………..grams

Haemostasis………………………… Perforations Yes / No

Three Way Catheter ……………………..FG volume of water in balloon…………mls

Antibiotic given Yes / No

Gentamicin Yes / No Dose…………………… Other

**Post Operation instructions:**

**See over for photographs**



**CONSULTANT / SURGEON SIGNATURE NAME DATE & TIME**

**Pre Op**

**Post Op**

**Photographs** / **Stickers**(Prosthesis/Equipment/ sutures etc)

**Integrated Care Pathway**

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

Attach Patient Label Here Name:…..……………………………………….…….……… Address:..…………………………………………………….……………

………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….





To be completed by medical & nursing staff

**Date and time Clinical Record – legible signature & grade MANDATORY for each entry**

**Post OP**

|  |  |
| --- | --- |
| Operation / Current diagnosis  Active problem  Progress – improving / stable / unstable | **Name Date** Hb WBC Plat Neut |
| INR APTT |
| Na K Urea  eGFR Creat CRP TP ALB Glo  Bil ALT ALP GGT Amy |
|  | |

**If required, extra clinical sheets can be added per day…document use on variance sheet on page 3**



**Post Operation on Return to ward – Nursing notes (all fields are mandatory)**

**Respiratory System Cardiovascular System**

O2 Saturations = BP &TPR – frequency – 1\*/2\*/4\*/QDS/TDS/BD/OD

Supplementary O2 = Nasal specs. / O2 mask /

Change to frequency

Hum O2 If yes, action: Chest Physiotherapy Y / N

**GenitoUrinary System** TEDS Y / N

Catheter in situ Yes / No Catheter volumes - 6hrly/2 hrly/1 hrly Bladder irrigation in progress Yes □ No □

Removed for 30mins daily Y / N

Change every 3 days for clean pair – due ………

**Comments & action Wound**

Any existing wounds?

Catheter removal plan:**( MSU copy to GP Y/N)**

Adequate urine output - Yes □ No □ Dressing details;

Catheter care given Yes / No / N.A Dressing form Y / N

**Comments & actions**

**Skin**

**Braden score =**

**Gastro-intestinal system** Assessment of broken areas

Tolerating – normal diet □ Light diet □: Fluids □:

**Nutritional assessment score =**

BM monitoring – frequency ………… **Mobility**

Pressure area care (as per policy) □

**Pain and Nausea** Frequency of PAC Control method – Oral State patient mobility

Control adequate (pain score <4) - Yes □ No □. If no, action

Cot side assessment form completed Y / N

**Personal hygiene/ mouth care** **Manual Handling assessment**

Please free text what care you gave Score:

Action & comments:

**Infection: Communication**

Any signs of infection Yes / No MRSA pathway in use Yes/No Additional notes

Relatives / Drs/ MSW

**Discharge Planning**

Pu’ing good volumes Yes / No Urine clear or clot free Yes /No Good bladder control Yes / No

Pt discharged with catheter Yes / No / NA Community team informed Yes / No / NA

Pt informed of FU plan Yes / No

Print name / Band ………………………………. Signature Date + time



Print name / Band ………………………………. Signature Date + time

Print name / Band ………………………………. Signature Date + time

**Document and check for variance on page 3**

**Integrated Care Pathway**

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

l Attach Patient Label Here Name:…..……………………………………….…….……… Address:..…………………………………………………….……………

………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….





To be completed by medical & nursing staff

**Date and time Clinical Record – legible signature & grade MANDATORY for each entry**

**Day 1**

|  |  |
| --- | --- |
| Operation / Current diagnosis  Active problem  Progress – improving / stable / unstable | **Name Date** Hb WBC Plat Neut |
| INR APTT |
| Na K Urea  eGFR Creat CRP TP ALB Glo  Bil ALT ALP GGT Amy |
|  | |

**If required, extra clinical sheets can be added per day…document use on variance sheet on page 3**



**Day 1- Nursing notes (all fields are mandatory)**

**Respiratory System Cardiovascular System**

O2 Saturations = BP &TPR – frequency – 1\*/2\*/4\*/QDS/TDS/BD/OD

Supplementary O2 = Nasal specs. / O2 mask /

Change to frequency

Hum O2 If yes, action: Chest Physiotherapy Y / N

**GenitoUrinary System** TEDS Y / N

Catheter in situ Yes / No Catheter volumes - 6hrly/2 hrly/1 hrly Bladder irrigation in progress Yes □ No □

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Change every 3 days for clean pair – due ………

**Comments & action Wound**

Any existing wounds?

Catheter removal plan**:( MSU copy to GP Y/N)**

Catheter removed as instruction Yes / No / N.A

Dressing details;

Catheter care given Yes / No / N.A Dressing form Y / N

Adequate urine output - Yes □ No □

**Comments & actions Skin**

**Braden score =**

Assessment of broken areas

**Gastro-intestinal system**

Tolerating – normal diet □ Light diet □: Fluids □:

**Nutritional assessment score = Mobility**

BM monitoring – frequency ………… Pressure area care (as per policy) □

Frequency of PAC

**Pain and nausea** State patient mobility

Control method – Oral Cot side assessment form completed Y / N Control adequate (pain score <4) -

Yes □ No □. If no, action

**Manual Handling assessment**

Score:

**Personal hygiene/ mouth care** Action & comments: Please free text what care you gave …

**Communication Infection:** Relatives / Drs/ MSW Any signs of infection Yes / No

MRSA pathway in use Yes/No Patient advised re catheter care & Plan Yes /No/NA

Additional notes

**Discharge Planning**

Pu’ing good volumes Yes / No

Urine clear or clot free Yes /No

Pt discharged with catheter Yes /No/NA Community team informed Yes /No/NA

Pt informed of follow up plan Yes

Print name / Band ………………………………. Signature Date + time



Print name / Band ………………………………. Signature Date + time

Print name / Band ………………………………. Signature Date + time

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**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

Address:..…………………………………………………….……………

………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….





To be completed by medical & nursing staff

**Date and time Clinical Record – legible signature & grade MANDATORY for each entry**

**Day 2**

|  |  |
| --- | --- |
| Operation / Current diagnosis  Active problem  Progress – improving / stable / unstable | **Name Date** Hb WBC Plat Neut |
| INR APTT |
| Na K Urea  eGFR Creat CRP TP ALB Glo  Bil ALT ALP GGT Amy |
|  | |

**If required, extra clinical sheets can be added per day…document use on variance sheet on page 3**



**Day 2- Nursing notes (all fields are mandatory)**

**Respiratory System Cardiovascular System**

O2 Saturations = BP &TPR – frequency – 1\*/2\*/4\*/QDS/TDS/BD/OD

Supplementary O2 = Nasal specs. / O2 mask /

Change to frequency

Hum O2 If yes, action: Chest Physiotherapy Y / N

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Adequate urine output - Yes □ No □

**Comments & actions Skin**

**Braden score =**

Assessment of broken areas

**Gastro-intestinal system**

Tolerating – normal diet □ Light diet □: Fluids □:

**Nutritional assessment score = Mobility**

BM monitoring – frequency ………… Pressure area care (as per policy) □

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**Pain and nausea** State patient mobility

Control method – Oral Cot side assessment form completed Y / N Control adequate (pain score <4) -

Yes □ No □. If no, action

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Score:

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Additional notes

**Discharge Planning**

Pu’ing good volumes Yes / No

Urine clear or clot free Yes /No

Pt discharged with catheter Yes /No/NA Community team informed Yes /No/NA

Pt informed of follow up plan Yes

Print name / Band ………………………………. Signature Date + time



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**Integrated Care Pathway**

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Attach Patient Label Here

Name:…..……………………………………….…….………

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant\_ Ward…………………………..**

Address:..…………………………………………………….……………

………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….





To be completed by medical & nursing staff

**Date and time Clinical Record – legible signature & grade MANDATORY for each entry**

**Day 3**

|  |  |
| --- | --- |
| Operation / Current diagnosis  Active problem  Progress – improving / stable / unstable | **Name Date** Hb WBC Plat Neut |
| INR APTT |
| Na K Urea  eGFR Creat CRP TP ALB Glo  Bil ALT ALP GGT Amy |
|  | |

**If required, extra clinical sheets can be added per day…document use on variance sheet on page 3**



**Day 3- Nursing notes (all fields are mandatory)**

**Respiratory System Cardiovascular System**

O2 Saturations = BP &TPR – frequency – 1\*/2\*/4\*/QDS/TDS/BD/OD

Supplementary O2 = Nasal specs. / O2 mask /

Change to frequency

Hum O2 If yes, action: Chest Physiotherapy Y / N

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Change every 3 days for clean pair – due ………

**Comments & action Wound**

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Catheter removed as instruction Yes / No / N.A

Dressing details;

Catheter care given Yes / No / N.A Dressing form Y / N

Adequate urine output - Yes □ No □

**Comments & actions Skin**

**Braden score =**

Assessment of broken areas

**Gastro-intestinal system**

Tolerating – normal diet □ Light diet □: Fluids □:

**Nutritional assessment score = Mobility**

BM monitoring – frequency ………… Pressure area care (as per policy) □

Frequency of PAC

**Pain and nausea** State patient mobility

Control method – Oral Cot side assessment form completed Y / N Control adequate (pain score <4) -

Yes □ No □. If no, action

**Manual Handling assessment**

Score:

**Personal hygiene/ mouth care** Action & comments: Please free text what care you gave …

**Communication Infection:** Relatives / Drs/ MSW Any signs of infection Yes / No

MRSA pathway in use Yes/No Patient advised re catheter care & Plan Yes /No/NA

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**Discharge Planning**

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Pt informed of follow up plan Yes

Print name / Band ………………………………. Signature Date + time



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**Integrated Care Pathway**

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Attach Patient Label Here

Name:…..……………………………………….…….………

**(TURP/GYRUS/HOLAP/HOLEP)**

**Consultant Ward…………………………..**

Address:..…………………………………………………….……………

………………………………………………………...

Hospital Number……………………………………………….. Date of Birth…………………………………………………….

**3/12 Follow up appointment**

Date Date of Operation Consultant Surgeon Histology: Benign / Malignant Grams resected Patient informed of histology Yes / No



**Clinical Progress notes:**

Frequency: Nocturia: Haematuria: Urgency Hesitancy



Stream Incontinence

Urinalysis: Blood Protein Leucocytes Nitrites MSU Yes / No Copy to GP Yes / No Medication:

**IPSS Score on reverse of this sheet**

Total Symptom Score (Max 35) Quality of Life (Max 6) Symptoms = Quality of Life =

Flow Studies

Maximum urinary flow (Qmax):………………………………ml/sec Average flow (Qave):………………………………………….ml / sec Voided volume:………………………………………………...ml Residual volume……………………………………………….ml

Other investigations / Advice







Follow up: Signature:

1 **Incomplete emptying**

**IPSS Score**

Not at all

Less than 1 time in

5

Less than half the time

About half the time

More than half the time

Almost

Always

Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?

2 **Frequency**

Over the past month, how often have you had to urinate again in less than two hours after you finished urinating?

3 **Intermittency**

Over the past month, how often have you found you stopped and started again several times when you urinated?

4 **Urgency**

Over the past month, how often have your found it difficult to postpone urination?

5 **Weak Stream**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

**0 1 2 3 4 5**

Over the past month , how often have you had a weak urinary stream? **0 1 2 3 4 5**

6 **Straining**

Over the past month, how often have you had to push or strain to begin urination

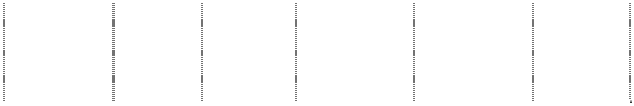
7 **Nocturia**

Over the past month, how many times did you most typically get up to urinate form the time you went to bed at night until the time you got up in the morning

**0 1 2 3 4 5**

**0 1 2 3 4 5**

Total I-PSS Score



**Quality of life due to urinary symptoms**

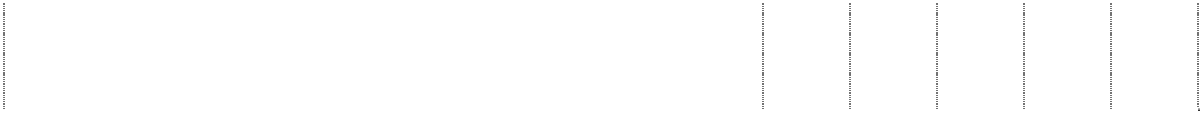
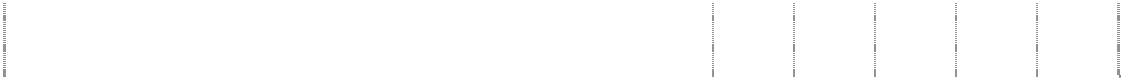
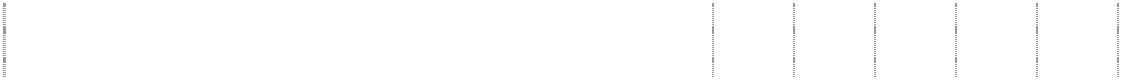
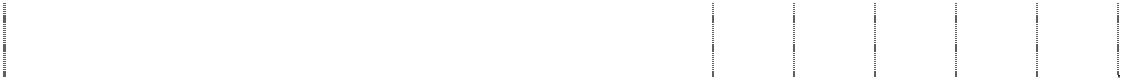
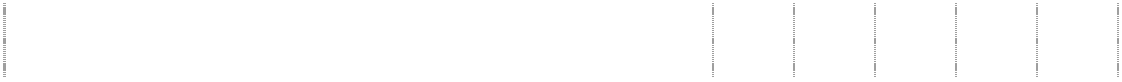
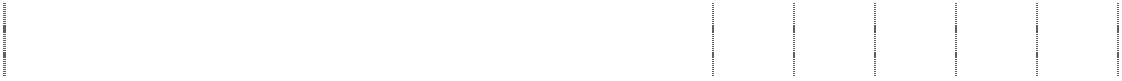
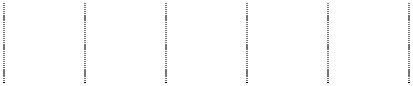
**Delighted Pleased Mostly satisfied**

**Mixed about equally satisfied & dissatisfied**

**Most dissatisfied**

**Unhappy Terrible**

**If you were to spend the rest of your life with your urinary condition just the way it is now, how would your feel about that?**



**0 1 2 3 4 5 6**