A UMC Health System Performance Improvement Initiative for use in all units where surgical patients receive care in support of Surgical Care Improvement Program (SCIP).

*Denotes guideline requirement for Core Measures

**Antibiotic administered in the OR at: ______________**

Procedure Date: _______________  Procedure: Laser Transurethral Resection of Prostate or Transurethral Resection of Prostate

Admitting Diagnosis: Benign Prostatic Hypertrophy Status Post Laser Transurethral Resection of Prostate OR Transurethral Resection of Prostate

1. Attending Physician: ___________________________  Resident/Fellow: ___________________________
2. Notify PCP of admission
3. Consult: ______________________________________
4. Admit:  ☐ Outpatient  ☐ In-Patient _____________
5. Code Status:  ☐ Full Code  ☐ DNR  ☐ Comfort Care  ☐ Other: ___________________________
6. Co-Morbidities: ______________________________
7. Condition:  ☐ Stable  ☐ Fair  ☐ Serious  ☐ Critical
8. Allergies:  ☐ NKDA Allergic to: ___________________________
9. NURSING:

**Vital Signs:**  ☐ Routine post op VS  ☐ every 4 hours  ☐ Call for Unstable Vital Signs

**Intake and output:**  ☐ Hourly  ☐ Every Shift  ☐ Other: ___________________________

**Foley Care:**  ☐ Daily  ☐ Ok to irrigate as needed  ☐ Notify MD for urine output < 120 mL in 4 hours

☐ Foley to bedside drainage unit irrigate as needed with ___________________________

☐ Continuous bladder irrigation with Normal Saline: titrate to keep urine pink to clear

☐ Discontinue Bladder Irrigation ONE hour prior to discharge home

☐ Discontinue irrigation at 0600 if patient admitted

☐ If urine remains clear to blush after One hour of Continuous Bladder Irrigation being off, discharge home with Foley

Make sure the irrigation port is plugged prior to discharge home with the out flow port to Closed Drainage Unit

Send home with Leg bag and closed drainage unit

☐ Encourage Fluids by mouth for the next TWO weeks

☐ Other: ___________________________

**Diet:**  ☐ As tolerated  ☐ other________________________________________

**Activity:**  ☐ As tolerated

**NOTIFICATION OF PHYSICIAN FOR:**

☐ Temp > __________ degrees

☐ HR/Pulse < __________ bpm  > __________ bpm

☐ SBP < __________ > __________

☐ DBP < __________ > __________

☐ Respiratory Rate:  < __________ > __________

☐ Excessive bleeding

☐ TO  ☐ Read back

Order taken by Signature: ___________________________  Date/Time ___________________________

Physician Signature ___________________________  Date/Time ___________________________

Page 1 of 5 – In-Patient Laser TURP Post-op Plan  05/14/2012 (#1006 R-5)
12. **IV:**
- Continuous IV fluids: Ringers Lactate to run at ___________ml/hr
- Convert IV to INT at 0600. Post op: When tolerating PO Day 1 Day 2 Day 3
- Maintain saline lock INT for blood draws. Flush with NS q 4 hours and prn
- Discontinue INT: Post op: Day 1 Day 2 Day 3

13. **MEDICATIONS:** (Refer also to Admission Medication Reconciliation Form and Discomfort Orders)

* Prophylactic Antibiotic Therapy: *DC 24 hours post Anesthesia end time

(Select one of the following if desired)
- Ciprofloxacin (Cipro) 400 mg IVPB every ______ hours X’s ______ doses.
- Levofloxacin (Levaquin) 500 mg IVPB every ______ hours X’s ______ doses.

Therapeutic Antibiotic – Antibiotic coverage ordered for greater than 24 hours post op, requires documentation of indication.

- Therapeutic Antibiotic: ________________________________________________________________________

Reason antibiotic was continued or added greater than 24 hours post-operatively (48 hours for Coronary Artery Bypass Graft [CABG]): Must be documented by physician / advance practice nurse / physician assistant within 2 days (3 days for CABG or other cardiac surgery) following the principle procedure with the day of surgery being Day Zero.

<table>
<thead>
<tr>
<th>Abscess</th>
<th>Necrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute abdomen</td>
<td>Necrotic/ischemic/infarcted bowel</td>
</tr>
<tr>
<td>Aspiration pneumonia</td>
<td>Osteomyelitis</td>
</tr>
<tr>
<td>Bloodstream infection</td>
<td>Other documented infection</td>
</tr>
<tr>
<td>Bone infection</td>
<td>Penetrating abdominal trauma</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Perforation of bowel</td>
</tr>
<tr>
<td>Endometritis</td>
<td>Pneumonia or other lung infection</td>
</tr>
<tr>
<td>Fecal Contamination</td>
<td>Purulence/pus</td>
</tr>
<tr>
<td>Free air in abdomen</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Gangrene</td>
<td>Surgical site or wound infection</td>
</tr>
<tr>
<td>H. pylori</td>
<td>Urinary tract infection (UTI)</td>
</tr>
</tbody>
</table>

- B&O Suppository 30 grain-One per rectum every 6 hours as needed for bladder spasms
- (*Required if home medication) Beta Blocker: ____________________________mg PO ________________

Unless contraindicated as listed here: ____________________________ (hold for SBP < 100 HR < 50)

14. **LABORATORY/DIAGNOSTICS:**
- CBC: Post op: Day 1 Day 2 Day 3 Notify Physician if: ____________________________
- Basic metabolic profile: Post op: Day 1 Day 2 Day 3 Notify Physician if: ____________________________
- Other: ____________________________
- X-Ray: ____________________________

☐ TO ☐ Read back
Order taken by Signature: ____________________________ Date/Time ____________________________

Physician Signature ____________________________ Date/Time ____________________________

Page 2 of 5 –In-Patient Laser TURP Post-op Plan 05/14/2012 (#1006 R-5)
15. **RESPIRATORY THERAPY:**

- O₂ @ ____ liters/minute via ____________________________
- SaO₂ Monitoring – every ________ hours
  - Discontinue oxygen therapy if SaO₂ consistently 92% or greater
  - O₂ saturations < 92% on room air; re check BID until > 92% on room air
  - Call physician if saturations continue at < 92% on room air
- Incentive spirometer x 10 over 30 minutes every _______ hours while awake, until discharge
- Other: ____________________

16. **PROPHYLAXIS:**

- VTE Prophylaxis: *Start within 24 hours of Anesthesia end time
  - *Start within 12 hrs. Post-operatively
  - *Start within 24 hrs. Post-operatively
    - SCDs  ☑ Plexi pulse (foot pumps)   ☑ ______ hours per day  ☑ While in bed
    - TED Hose (thigh high) ______ hours per day
    - Heparin 5000 units SQ  ☑ every 12 hours  ☑ every 8 hours
    - Warfarin (Coumadin) ______ PO every ______
    - Enoxaparin (Lovenox)  ☑ 30 mg SQ daily (Crcl < 30ml/min)  ☑ 40 mg SQ daily
    - Other: __________________________________________________________________________

**Reason for not administering venous thromboembolism prophylaxis:**

*Must be documented by physician / advance practice nurse / physician assistant within 24 hours of Anesthesia end time.*

<table>
<thead>
<tr>
<th>Bleeding risk</th>
<th>Gastrointestinal bleed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage</td>
<td>Patient refusal</td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>Excessive bleeding</td>
</tr>
<tr>
<td>Active bleeding (gastrointestinal bleeding, cerebral hemorrhage, retroperitoneal bleeding)</td>
<td></td>
</tr>
<tr>
<td>Patients on continuous IV Heparin therapy within 24 hours before or after surgery</td>
<td></td>
</tr>
</tbody>
</table>

**GI: (Please Select One)**

- Proton Pump Inhibitor: Esomeprazole (Nexium) 40 mg PO Daily
- H2 Blocker: Pepcid 20 mg PO BID

17. **PATIENT COUNSELING:**

- Post Op teaching
- Other: __________________________________________________________________________
Indicate desired medications by checking appropriate box. If more than one box is checked for an indication, then use the ordered medications in the descending order.

**PAIN MANAGEMENT:** *(TARGET MAXIMUM OF 3000 MG OF ACETAMINOPHEN PER 24 HOURS FROM ALL SOURCES)  (DO NOT EXCEED 4000MG OF ACETAMINOPHEN PER 24 HOURS)*

**MILD PAIN (Pain Scale 1-3):**
- Acetaminophen (Tylenol) 500–1000 mg PO every 4 hours PRN mild pain (Do not exceed 4,000 mg in 24 hours), *if NPO use:*
- Acetaminophen (Tylenol) 650 mg suppository PR every 4 hours PRN mild pain (Do not exceed 4,000 mg in 24 hours), *if acetaminophen is ineffective/contraindicated use:*
- Ibuprofen (Motrin) 400 mg PO every 6 hours PRN mild pain (Do not exceed 3,200 mg in 24 hours)
- Other

**MODERATE PAIN (Pain Scale 4-7):**
- Hydrocodone/acetaminophen (Lortab) 5/500 mg 1–2 tabs PO every 4 hours PRN moderate pain (Do not exceed 4 grams of acetaminophen in 24 hours), *if ineffective/contraindicated or NPO use:*
- Ketorolac (Toradol) 15–30 mg IV every 6 hours PRN moderate pain x 48 hours (May give IM if no IV access)
- Other

**SEVERE PAIN (Pain Scale 8-10):**
- Morphine 2–4 mg slow IV push every 4 hours PRN severe pain, *if ineffective/contraindicated use:*
- Hydromorphone (Dilaudid) 1 mg slow IV push every 4 hours PRN severe pain
- Other

**NAUSEA/VOMITING:**
- Promethazine (Phenergan) 25 mg PO every 4 hours PRN nausea/vomiting, *if ineffective/contraindicated or NPO use:*
- Ondansetron (Zofran) 4 mg IV every 8 hours PRN nausea/vomiting
- Other

**BOWEL MANAGEMENT:**
- Docusate (Colace) 100 mg PO at bedtime PRN for constipation, *if contraindicated or ineffective after 12 hours use:*
- Bisacodyl (Dulcolax) 10 mg suppository PR daily PRN constipation, *if contraindicated or ineffective after 6 hours use:*
- Sodium phosphate enema (Fleet enema) PR daily PRN constipation (Do not use in renal patients)
- Other

**INDIGESTION/GAS:**
- Aluminum hydroxide/magnesium hydroxide (Maalox) 30 ml PO every 4 hours PRN indigestion
- Simethicone (Mylicon) 80–160 mg PO every 4 hours PRN gas/bloating
- Other

**DIARRHEA:**
- Loperamide (Imodium) 4 mg PO initially then 2 mg PO with each loose stool (Max 16 mg hours)
- Other

☐ TO  ☐ Read back
Order taken by Signature: ___________________________________________ Date/Time __________________________
Physician Signature ___________________________________________ Date/Time __________________________
Indicate desired medications by checking appropriate box. *If more than one box is checked for an indication, then use the ordered medications in the descending order.*

**ANXIETY:**
- ☐ Alprazolam (Xanax) 0.25 mg PO three times a day PRN anxiety. *If ineffective/contraindicated or NPO use:*
- ☐ Lorazepam (Ativan) 0.5 – 1 mg IV every 6 hours PRN anxiety
- ☐ Other___________________________

**SLEEPLESSNESS:**
- ☐ Zolpidem (Ambien) 5 mg PO at bedtime PRN sleeplessness, *may repeat x 1 in one hour if ineffective*
- ☐ Other___________________________

**ALLERGIC REACTIONS:**
- ☐ Diphenhydramine (Benadryl) 25 mg PO every 4 hours PRN itching, *if ineffective or NPO use:*
- ☐ Diphenhydramine (Benadryl) 25 mg IV every 4 hours PRN itching
- ☐ Other___________________________

**COUGH / SORE THROAT:**
- ☐ Phenol-menthol (Cepastat) 1 lozenge PO PRN sore throat (Do not exceed 6 lozenges in 24 hours)
- ☐ Guaifenesin/dextromethorphan (Robitussin DM) 10 ml PO every 4 hours PRN cough
- ☐ Other___________________________

**TEMPERATURE:**
- ☐ Acetaminophen (Tylenol) 500–1000 mg PO every 4 hours PRN fever (Do not exceed 4,000 mg in 24 hours), *if ineffective/contraindicated use:*
- ☐ Ibuprofen (Motrin) 200–400 mg PO every 4 hours PRN fever (Do not exceed 3,200 mg in 24 hours)
- ☐ Other___________________________

**HEMORRHOIDS:**
- ☐ Witch hazel/glycerin (Tucks) pads at bedside *wipe affected area* as PRN, *if ineffective use:*
- ☐ Mineral oil/petrolatum/phenylephrine (Preparation H) ointment *apply to affected area* every 6 hours PRN. *If ineffective/contraindicated use:*
- ☐ Pramoxine/hydrocortisone (Proctofoam HC) at bedside *apply to affected area* every 8 hours PRN

**MUCOSITIS:**
- ☐ Dexamethasone/diphenhydramine/nystatin/NS (Fred’s Brew) 15 ml *swish and spit* every 2 hours while awake PRN mucositis. *If ineffective/contraindicated use:*
- ☐ Viscous lidocaine (Xylocaine) 15 ml *swish and spit* every 4 hours PRN mucositis

**BLADDER SCAN:**
- ☐ Bladder scan as needed for patients complaining of urinary discomfort and/or bladder distention present OR 6 hours post-Foley removal and patient has not voided. If bladder scan volume is >250 ml please notify the physician.

**OTHER:**
______________________________________________________________
______________________________________________________________

☐ TO ☐ Read back
Order taken by Signature: ____________________________ Date/Time ____________________________
Physician Signature ____________________________ Date/Time ____________________________