Richmond Hospital
part of the Vancouver Coastal Health Authority

PCIS LABEL

ENHANCED RECOVERY AFTER SURGERY (ERAS)CLINICAL PATHWAY FOR ENDOVASCULAR ABDOMINAL AORTIC ANEURYSM REPAIR

DOCUMENTATION GUIDE
Circle either **Yes, No or NA**
Required Further Documentation when **No** is circled

DAY OF SURGERY - OR DAY **Arrival on WARD at _____ hrs**		**DATE:**	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Safety	Bedside safety check completed	Yes / No	Yes / No
	Bed/Chair alarm in use and set	Yes / No / NA	Yes / No / NA
	Increased observations required	Yes / No	Yes / No
Fall Risk/Care Plan	Not at risk: reviewed and no concerns	Yes / No	Yes / No
	Fall protocol in place: reviewed & no changes	Yes / No / NA	Yes / No / NA
	Risk assessed & **new** fall care plan completed	Yes / No / NA	Yes / No / NA
Teaching & Discharge Planning	Patient has the ERAS booklet at bedside	Yes / No	Yes / No
	Patient is aware of daily goals on ERAS booklet	Yes / No	Yes / No
	Patient received teaching re: importance of pain management	Yes / No	Yes / No
Neuro/ Cognition	Alert and orientated x 3, speech clear, appropriate to situation, intact protective reflexes	Yes / No	Yes / No
	Calm and cooperative with care, free from delirium	Yes / No	Yes / No
	Anxiety level acceptable to patient	Yes / No	Yes / No
Pain Management	Pain assessment completed as per protocol	Yes / No	Yes / No
	Pain level ≤ 4 or acceptable to patient	Yes / No	Yes / No
CVS VTE	Vital signs completed as per protocol and within patient's normal limits. Heart rate regular, capillary refill ≤ 3 seconds, peripheral pulses present, no pitting edema, no calf tenderness & normal skin turgor	Yes / No	Yes / No
	Bilateral pedal pulses and neurovascular assessment to lower extremity completed as per order and within normal limits	Yes / No	Yes / No
	IV site (s) assessed & satisfactory	Yes / No	Yes / No
	Sequential Compression Device (SCD) removed no longer than 30 min/shift to assess & perform skin care as per protocol	Yes / No / NA	Yes / No / NA
Respiratory	Chest sounds clear, respirations easy and regular, no cough or cyanosis	Yes / No	Yes / No
	Oxygen titrated to keep SpO_2 ≥ 92% or ≥ baseline as needed	Yes / No	Yes / No
Infection	Temperature within normal limits. Notify MD if ≥ 38.5˚C	Yes / No	Yes / No
	WBC within normal limits	Yes / No	Yes / No
	NO signs and symptoms of infection (e.g. UTI, pneumonia, surgical site)	Yes / No	Yes / No
	Pneumonia Prevention initiated (ICOUGH)		
	• **I**n: breath in and hold for 3 seconds 3 times every 30 min	Yes / No	Yes / No
	• **C**oughing with deep breathing: 5 times every hour	Yes / No	Yes / No
	• **O**ral care provided: ☐ morning ☐ noon ☐ evening	Yes / No	Yes / No
	• **U**p: **Please check & follow Doctor's order**: HOB flat for_____hours, then maximum 30° for _____hours	Yes / No	Yes / No
	• **G**et up & get moving: see mobility/activity section below for details	Yes / No	Yes / No
	• **H**ave a conversation: pt is aware of pneumonia prevention strategies	Yes / No	Yes / No
Gastro-Intestinal	Patient tolerated ≥ 75% of Regular/Diabetic Diet	Yes / No	Yes / No
	Abdomen soft, not distended, bowel sounds present	Yes / No	Yes / No
	Gum chewing (15 min TID)	Yes / No	Yes / No
	Nausea controlled	Yes / No	Yes / No
	Patient did **NOT** vomit during shift	Yes / No	Yes / No
	Nurse Initials		

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DAY OF SURGERY - OR DAY		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Gastro-Intestinal	Flatus passed	Yes / No	Yes / No
	Date of last BM: _____		
	Capillary Blood Glucose (CBG) taken (TID + HS for **ALL** patients) and values were between 4-8 mmol/L	Yes / No	Yes / No
Genito-Urinary	If foley insitu, output more than 120ml in 4 consecutive hours	Yes / No / NA	Yes / No / NA
	Catheter secured and catheter care completed Q shift	Yes / No / NA	Yes / No / NA
	If **NO** foley, output more than 360ml / 12 hours	Yes / No / NA	Yes / No / NA
	Pericare completed Q shift	Yes / No	Yes / No
	Urine clear and amber	Yes / No	Yes / No
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas, as per CSAE: Pressure Injury Prevention). Mucous membranes pink and moist	Yes / No	Yes / No
	Dressings dry and intact (Do not change drsg until POD #2, unless saturated, otherwise outline drainage with a pen and reinforce PRN)	Yes / No	Yes / No
Mobility /Activity	As per order, HOB flat for _____ hours, then maximum 30° for _____hours	Yes / No	Yes / No
	As per order, bedrest for _____ hours, then activity as tolerated	Yes / No	Yes / No
	Nurse Initials		

INTERDISCIPLINARY PROGRESS NOTES / VARIANCE TRACKING RECORD

DATE dd/mmm/yyyy TIME (hhhh)	DISCIPLINE	FOCUS (Keyword)	DAR	PROGRESS D=DATA A=ACTION R=RESPONSE

Richmond Hospital
part of the Vancouver Coastal Health Authority

ENHANCED RECOVERY AFTER SURGERY (ERAS)CLINICAL PATHWAY FOR ENDOVASCULAR ABDOMINAL AORTIC ANEURYSM REPAIR

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DOCUMENTATION GUIDE
Circle either **Yes, No or NA**
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POST-OP DAY 1		**DATE:**	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Safety	Bedside safety check completed	Yes / No	Yes / No
	Bed/Chair alarm in use and set	Yes / No / NA	Yes / No / NA
	Increased observations required	Yes / No	Yes / No
Fall Risk/Care Plan	Not at risk: reviewed and no concerns	Yes / No	Yes / No
	Fall protocol in place: reviewed & no changes	Yes / No / NA	Yes / No / NA
	Risk assessed & **new** fall care plan completed	Yes / No / NA	Yes / No / NA
Teaching & Discharge Planning	Patient has the ERAS booklet at bedside	Yes / No	Yes / No
	Patient is aware of daily goals on ERAS booklet	Yes / No	Yes / No
	Patient received teaching re: importance of pain management	Yes / No	Yes / No
	Patient aware of discharge criteria	Yes / No	Yes / No
	Patient has met the following discharge criteria:		
	• independent with ADLs	Yes / No	Yes / No
	• pain managed on oral analgesics	Yes / No	Yes / No
	• tolerating regular diet	Yes / No	Yes / No
	• passing gas **OR** has had a bowel movement	Yes / No	Yes / No
	• up to bathroom to void	Yes / No / NA	Yes / No / NA
	Patient has arranged a support person at home for 72 hours post discharge Destination post discharge: _____	Yes / No	Yes / No
Neuro/ Cognition	Alert and orientated x 3, speech clear, appropriate to situation, intact protective reflexes	Yes / No	Yes / No
	Calm and cooperative with care, free from delirium	Yes / No	Yes / No
	Anxiety level acceptable to patient	Yes / No	Yes / No
	Sleep/wake cycle normal, minimum 4-6 hrs of uninterrupted sleep	NA	Yes / No
Pain Management	Pain assessment completed as per protocol	Yes / No	Yes / No
	Pain level ≤ 4 or acceptable to patient	Yes / No	Yes / No
CVS VTE	Vital signs completed as per protocol and within patient's normal limits. Heart rate regular, capillary refill ≤ 3 seconds, peripheral pulses present, no pitting edema, no calf tenderness & normal skin turgor	Yes / No	Yes / No
	Bilateral pedal pulses and neurovascular assessment to lower extremity completed as per order and within normal limits	Yes / No	Yes / No
	IV site (s) assessed & satisfactory	Yes / No	Yes / No
	IV saline locked @: _____	Yes / No	Yes / No
	Sequential Compression Device (SCD) removed no longer than 30 min/shift to assess & perform skin care as per protocol	Yes / No / NA	Yes / No / NA
	SCD D/C @ _____ , pt ambulating well	Yes / No / NA	Yes / No / NA
Respiratory	Chest sounds clear, respirations easy and regular, no cough or cyanosis	Yes / No	Yes / No
	Oxygen titrated to keep SpO_2 ≥ 92% or ≥ baseline as needed	Yes / No / NA	Yes / No / NA
Infection	Temperature within normal limits. Notify MD if ≥ 38.5˚C	Yes / No	Yes / No
	WBC within normal limits	Yes / No	Yes / No
	NO signs and symptoms of infection (e.g. UTI, pneumonia, surgical site)	Yes / No	Yes / No
	Pneumonia Prevention initiated (ICOUGH)		
	• **I**n: breath in and hold for 3 seconds 3 times every 30 min	Yes / No	Yes / No
	• **C**oughing with deep breathing: 5 times every hour	Yes / No	Yes / No
	Nurse Initials		

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POST-OP DAY 1		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Infection	• **O**ral care provided: ☐ morning ☐ noon ☐ evening	Yes / No	Yes / No
	• **U**p: Head of bed up/elevated at 30-45˚while in bed	Yes / No	Yes / No
	• **G**et up & get moving: see mobility/activity section below for details	Yes / No	Yes / No
	• **H**ave a conversation: pt is aware of pneumonia prevention strategies	Yes / No	Yes / No
Gastro-Intestinal	Patient tolerated ≥ 75% of Regular/Diabetic Diet	Yes / No	Yes / No
	Abdomen soft, not distended, bowel sounds present	Yes / No	Yes / No
	Gum chewing (15 min TID)	Yes / No	Yes / No
	Nausea controlled	Yes / No	Yes / No
	Patient did **NOT** vomit during shift	Yes / No	Yes / No
	Flatus passed	Yes / No	Yes / No
	Date of last BM: _____		
	Capillary Blood Glucose (CBG) taken (TID + HS for **ALL** patients) & values were between 4-8 mmol/L **EXCEPT:** If patient is non-diabetic and **ALL** glucometer readings are less than 8.1 mmol/L for 24 hrs, discontinue CBG	Yes / No	Yes / No / NA
Genito-Urinary	**Foley Catheter D/C @** _____	Yes / No / NA	Yes / No / NA
	If foley insitu, output more than 120ml in 4 consecutive hours	Yes / No / NA	Yes / No / NA
	Catheter secured and catheter care completed Q shift	Yes / No / NA	Yes / No / NA
	If **NO** foley, output more than 360ml / 12 hours	Yes / No / NA	Yes / No / NA
	Pericare completed Q shift	Yes / No	Yes / No
	Urine clear and amber	Yes / No	Yes / No
Diagnostics	CBC within normal limits	Yes / No	Yes / No
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas, as per CSAE: Pressure Injury Prevention). Mucous membranes pink and moist	Yes / No	Yes / No
	Dressings dry and intact (Do not change drsg until POD #2, unless saturated, otherwise outline drainage with a pen and reinforce PRN)	Yes / No	Yes / No
Mobility /Activity	Patient able to reposition **independently** (if No, assist Q2H)	Yes / No	Yes / No
	Leg exercises every hour when in bed	Yes / No	Yes / No
	Mobility goals achieved as per pathway		
	• Up in chair for all meals	Yes / No	Yes / No
	• Walked in hallway x 2 ☐ with assistance ☐ independently	Yes / No	Yes / No
	• Up to bathroom ☐ with assistance ☐ independently	Yes / No	Yes / No
	Nurse Initials		

INTERDISCIPLINARY PROGRESS NOTES / VARIANCE TRACKING RECORD

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DOCUMENTATION GUIDE
Circle either **Yes, No or NA**
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POST-OP DAY 2		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Safety	Bedside safety check completed	Yes / No	Yes / No
	Bed/Chair alarm in use and set	Yes / No / NA	Yes / No / NA
	Increased observations required	Yes / No	Yes / No
Fall Risk/Care Plan	Not at risk: reviewed and no concerns	Yes / No	Yes / No
	Fall protocol in place: reviewed & no changes	Yes / No / NA	Yes / No / NA
	Risk assessed & **new** fall care plan completed	Yes / No / NA	Yes / No / NA
Teaching & Discharge Planning	Patient has the ERAS booklet at bedside	Yes / No	Yes / No
	Patient is aware of daily goals on ERAS booklet	Yes / No	Yes / No
	Reviewed & reinforced teaching re: importance of pain management	Yes / No	Yes / No
	Patient aware of discharge criteria	Yes / No	Yes / No
	Patient has met the following discharge criteria:		
	• independent with ADLs	Yes / No	Yes / No
	• pain managed on oral analgesics	Yes / No	Yes / No
	• tolerating regular diet	Yes / No	Yes / No
	• passing gas **OR** has had a bowel movement	Yes / No	Yes / No
	• up to bathroom to void	Yes / No	Yes / No
	Patient has arranged a support person at home for 72 hours post discharge Destination post discharge: _____	Yes / No	Yes / No
Neuro/ Cognition	Alert and orientated x 3, speech clear, appropriate to situation, intact protective reflexes	Yes / No	Yes / No
	Calm and cooperative with care, free from delirium	Yes / No	Yes / No
	Anxiety level acceptable to patient	Yes / No	Yes / No
	Sleep/wake cycle normal, minimum 4-6 hrs of uninterrupted sleep	NA	Yes / No
Pain Management	Pain assessment completed as per protocol	Yes / No	Yes / No
	Pain level ≤ 4 or acceptable to patient	Yes / No	Yes / No
CVS VTE	Vital signs completed as per protocol and within patient's normal limits. Heart rate regular, capillary refill ≤ 3 seconds, peripheral pulses present, no pitting edema, no calf tenderness & normal skin turgor	Yes / No	Yes / No
	Bilateral pedal pulses and neurovascular assessment to lower extremity completed as per order and within normal limits	Yes / No	Yes / No
	IV site (s) assessed & satisfactory	Yes / No / NA	Yes / No / NA
	IV saline locked @: _____	Yes / No / NA	Yes / No / NA
Respiratory	Chest sounds clear, respirations easy and regular, no cough or cyanosis	Yes / No	Yes / No
	Oxygen titrated to keep SpO_2 ≥ 92% or ≥ baseline as needed	Yes / No / NA	Yes / No / NA
Infection	Temperature within normal limits. Notify MD if ≥ 38.5˚C	Yes / No	Yes / No
	WBC within normal limits	Yes / No	Yes / No
	NO signs and symptoms of infection (e.g. UTI, pneumonia, surgical site)	Yes / No	Yes / No
	Pneumonia Prevention initiated (ICOUGH)		
	• **I**n: breath in and hold for 3 seconds 3 times every 30 min	Yes / No	Yes / No
	• **C**oughing with deep breathing: 5 times every hour	Yes / No	Yes / No
	• **O**ral care provided: ☐ morning ☐ noon ☐ evening	Yes / No	Yes / No
	• **U**p: Head of bed up/elevated at 30-45˚while in bed	Yes / No	Yes / No
	• **G**et up & get moving: see mobility/activity section below for details	Yes / No	Yes / No
	Nurse Initials		

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POST-OP DAY 2		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Infection	• **H**ave a conversation: pt is aware of pneumonia prevention strategies	Yes / No	Yes / No
Gastro-Intestinal	Patient tolerated ≥ 75% of Regular/Diabetic Diet	Yes / No	Yes / No
	Abdomen soft, not distended, bowel sounds present	Yes / No	Yes / No
	Gum chewing (15 min TID)	Yes / No	Yes / No
	Nausea controlled	Yes / No	Yes / No
	Patient did **NOT** vomit during shift	Yes / No	Yes / No
	Flatus passed	Yes / No	Yes / No
	Date of last BM: _____		
Genito-Urinary	If foley insitu, output more than 120ml in 4 consecutive hours	Yes / No / NA	Yes / No / NA
	Catheter secured and catheter care completed Q shift	Yes / No / NA	Yes / No / NA
	If **NO** foley, output more than 360ml / 12 hours	Yes / No	Yes / No
	Pericare completed Q shift	Yes / No	Yes / No
	Urine clear and amber	Yes / No	Yes / No
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas, as per CSAE: Pressure Injury Prevention). Mucous membranes pink and moist	Yes / No	Yes / No
	Incision well-approximated, dry & intact, free from pain, redness and swelling	Yes / No	Yes / No
	Dressing Changed	Yes / No	Yes / No
Mobility /Activity	Patient able to reposition **independently** (if No, assist Q2H)	Yes / No	Yes / No
	Leg exercises every hour when in bed	Yes / No	Yes / No
	Mobility goals achieved as per pathway		
	• Up in chair for all meals	Yes / No	Yes / No
	• Walked in hallway x 2 ☐ with assistance ☐ **independently**	Yes / No	Yes / No
	• Up to bathroom ☐ with assistance ☐ **independently**	Yes / No	Yes / No
	Nurse Initials		

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Circle either **Yes, No or NA**
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POST-OP DAY 3		**DATE:**	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Safety	Bedside safety check completed	Yes / No	Yes / No
	Bed/Chair alarm in use and set	Yes / No / NA	Yes / No / NA
	Increased observations required	Yes / No	Yes / No
Fall Risk/Care Plan	Not at risk: reviewed and no concerns	Yes / No	Yes / No
	Fall protocol in place: reviewed & no changes	Yes / No / NA	Yes / No / NA
	Risk assessed & **new** fall care plan completed	Yes / No / NA	Yes / No / NA
Teaching & Discharge Planning	Patient has the ERAS booklet at bedside	Yes / No	Yes / No
	Patient is aware of daily goals on ERAS booklet	Yes / No	Yes / No
	Reviewed & reinforced teaching re: importance of pain management	Yes / No	Yes / No
	Patient has home prepared & equipment in place for discharge	Yes / No	Yes / No
	Patient aware of discharge criteria	Yes / No	Yes / No
	Patient has met the following discharge criteria:		
	• independent with ADLs	Yes / No	Yes / No
	• pain managed on oral analgesics	Yes / No	Yes / No
	• tolerating regular diet	Yes / No	Yes / No
	• passing gas **OR** has had a bowel movement	Yes / No	Yes / No
	• up to bathroom to void	Yes / No	Yes / No
	Patient has arranged a support person at home for 72 hours post discharge Destination post discharge: _____	Yes / No	Yes / No
Neuro/ Cognition	Alert and orientated x 3, speech clear, appropriate to situation, intact protective reflexes	Yes / No	Yes / No
	Calm and cooperative with care, free from delirium	Yes / No	Yes / No
	Anxiety level acceptable to patient	Yes / No	Yes / No
	Sleep/wake cycle normal, minimum 4-6 hrs of uninterrupted sleep	NA	Yes / No
Pain Management	Pain assessment completed as per protocol	Yes / No	Yes / No
	Pain level ≤ 4 or acceptable to patient	Yes / No	Yes / No
CVS VTE	Vital signs completed as per protocol and within patient's normal limits. Heart rate regular, capillary refill ≤ 3 seconds, peripheral pulses present, no pitting edema, no calf tenderness & normal skin turgor	Yes / No	Yes / No
	Bilateral pedal pulses and neurovascular assessment to lower extremity completed as per order and within normal limits	Yes / No	Yes / No
	IV site (s) assessed & satisfactory	Yes / No / NA	Yes / No / NA
	IV saline locked @: _____	Yes / No / NA	Yes / No / NA
Respiratory	Chest sounds clear, respirations easy and regular, no cough or cyanosis	Yes / No	Yes / No
	Oxygen titrated to keep SpO_2 ≥ 92% or ≥ baseline as needed	Yes / No / NA	Yes / No / NA
Infection	Temperature within normal limits. Notify MD if ≥ 38.5˚C	Yes / No	Yes / No
	WBC within normal limits	Yes / No	Yes / No
	NO signs and symptoms of infection (e.g. UTI, pneumonia, surgical site)	Yes / No	Yes / No
	Pneumonia Prevention initiated (ICOUGH)		
	• **I**n: breath in and hold for 3 seconds 3 times every 30 min	Yes / No	Yes / No
	• **C**oughing with deep breathing: 5 times every hour	Yes / No	Yes / No
	• **O**ral care provided: ☐ morning ☐ noon ☐ evening	Yes / No	Yes / No
	• **U**p: Head of bed up/elevated at 30-45˚while in bed	Yes / No	Yes / No
	Nurse Initials		

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POST-OP DAY 3		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Infection	• **G**et up & get moving: see mobility/activity section below for details	Yes / No	Yes / No
	• **H**ave a conversation: pt is aware of pneumonia prevention strategies	Yes / No	Yes / No
Gastro-Intestinal	Patient tolerated ≥ 75% of Regular/Diabetic Diet	Yes / No	Yes / No
	Abdomen soft, not distended, bowel sounds present	Yes / No	Yes / No
	Gum chewing (15 min TID)	Yes / No	Yes / No
	Nausea controlled	Yes / No	Yes / No
	Patient did **NOT** vomit during shift	Yes / No	Yes / No
	Flatus passed	Yes / No	Yes / No
	Date of last BM: _____		
Genito-Urinary	If foley insitu, output more than 120ml in 4 consecutive hours	Yes / No / NA	Yes / No / NA
	Catheter secured and catheter care completed Q shift	Yes / No / NA	Yes / No / NA
	If **NO** foley, output more than 360ml / 12 hours	Yes / No	Yes / No
	Pericare completed Q shift	Yes / No	Yes / No
	Urine clear and amber	Yes / No	Yes / No
Diagnostics	BW within normal limits (if drawn today)	Yes / No / NA	Yes / No / NA
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas, as per CSAE: Pressure Injury Prevention). Mucous membranes pink and moist	Yes / No	Yes / No
	Incision well-approximated, dry & intact, free from pain, redness and swelling	Yes / No	Yes / No
	Dressing changed (if applicable)	Yes / No	Yes / No
Mobility /Activity	Patient able to reposition **independently** (if No, assist Q2H)	Yes / No	Yes / No
	Leg exercises every hour when in bed	Yes / No	Yes / No
	Independent with ADLs as per pre-op status	Yes / No	Yes / No
	Mobility goals achieved as per pathway		
	• Up in chair for all meals **independently**	Yes / No	Yes / No
	• Walked in hallway x 2	Yes / No	Yes / No
	• Up to bathroom	Yes / No	Yes / No
	Nurse Initials		

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POST-OP DAY ____		**DATE:**	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Safety	Bedside safety check completed	Yes / No	Yes / No
	Bed/Chair alarm in use and set	Yes / No / NA	Yes / No / NA
	Increased observations required	Yes / No	Yes / No
Fall Risk/Care Plan	Not at risk: reviewed and no concerns	Yes / No	Yes / No
	Fall protocol in place: reviewed & no changes	Yes / No / NA	Yes / No / NA
	Risk assessed & **new** fall care plan completed	Yes / No / NA	Yes / No / NA
Teaching & Discharge Planning	Patient has the ERAS booklet at bedside	Yes / No	Yes / No
	Patient is aware of daily goals on ERAS booklet	Yes / No	Yes / No
	Reviewed & reinforced teaching re: importance of pain management	Yes / No	Yes / No
	Patient has home prepared & equipment in place for discharge	Yes / No	Yes / No
	Patient aware of discharge criteria	Yes / No	Yes / No
	Patient has met the following discharge criteria:		
	• independent with ADLs	Yes / No	Yes / No
	• pain managed on oral analgesics	Yes / No	Yes / No
	• tolerating regular diet	Yes / No	Yes / No
	• passing gas **OR** has had a bowel movement	Yes / No	Yes / No
	• up to bathroom to void	Yes / No	Yes / No
	Patient has arranged a support person at home for 72 hours post discharge Destination post discharge: _____	Yes / No	Yes / No
Neuro/ Cognition	Alert and orientated x 3, speech clear, appropriate to situation, intact protective reflexes	Yes / No	Yes / No
	Calm and cooperative with care, free from delirium	Yes / No	Yes / No
	Anxiety level acceptable to patient	Yes / No	Yes / No
	Sleep/wake cycle normal, minimum 4-6 hrs of uninterrupted sleep	NA	Yes / No
Pain Management	Pain assessment completed as per protocol	Yes / No	Yes / No
	Pain level ≤ 4 or acceptable to patient	Yes / No	Yes / No
CVS VTE	Vital signs completed as per protocol and within patient's normal limits. Heart rate regular, capillary refill ≤ 3 seconds, peripheral pulses present, no pitting edema, no calf tenderness & normal skin turgor	Yes / No	Yes / No
	Bilateral pedal pulses and neurovascular assessment to lower extremity completed as per order and within normal limits	Yes / No	Yes / No
	IV site (s) assessed & satisfactory	Yes / No / NA	Yes / No / NA
Respiratory	Chest sounds clear, respirations easy and regular, no cough or cyanosis	Yes / No	Yes / No
	Oxygen titrated to keep SpO_2 ≥ 92% or ≥ baseline as needed	Yes / No / NA	Yes / No / NA
Infection	Temperature within normal limits. Notify MD if ≥ 38.5˚C	Yes / No	Yes / No
	WBC within normal limits	Yes / No	Yes / No
	NO signs and symptoms of infection (e.g. UTI, pneumonia, surgical site)	Yes / No	Yes / No
	Pneumonia Prevention initiated (ICOUGH)		
	• **I**n: breath in and hold for 3 seconds 3 times every 30 min	Yes / No	Yes / No
	• **C**oughing with deep breathing: 5 times every hour	Yes / No	Yes / No
	• **O**ral care provided: ☐ morning ☐ noon ☐ evening	Yes / No	Yes / No
	• **U**p: Head of bed up/elevated at 30-45˚while in bed	Yes / No	Yes / No
	Nurse Initials		

Continues on next page →→→

POST-OP DAY 3		DATE:	
CATEGORY	**EXPECTED OUTCOMES**	**DAY**	**NIGHT**
Infection	• **G**et up & get moving: see mobility/activity section below for details	Yes / No	Yes / No
	• **H**ave a conversation: pt is aware of pneumonia prevention strategies	Yes / No	Yes / No
Gastro-Intestinal	Patient tolerated ≥ 75% of Regular/Diabetic Diet	Yes / No	Yes / No
	Abdomen soft, not distended, bowel sounds present	Yes / No	Yes / No
	Gum chewing (15 min TID)	Yes / No	Yes / No
	Nausea controlled	Yes / No	Yes / No
	Patient did **NOT** vomit during shift	Yes / No	Yes / No
	Flatus passed	Yes / No	Yes / No
	Date of last BM: _____		
Genito-Urinary	If foley insitu, output more than 120ml in 4 consecutive hours	Yes / No / NA	Yes / No / NA
	Catheter secured and catheter care completed Q shift	Yes / No / NA	Yes / No / NA
	If **NO** foley, output more than 360ml / 12 hours	Yes / No	Yes / No
	Pericare completed Q shift	Yes / No	Yes / No
	Urine clear and amber	Yes / No	Yes / No
Diagnostics	BW within normal limits (if drawn today)	Yes / No / NA	Yes / No / NA
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas, as per CSAE: Pressure Injury Prevention). Mucous membranes pink and moist	Yes / No	Yes / No
	Incision well-approximated, dry & intact, free from pain, redness and swelling	Yes / No	Yes / No
	Dressing Changed	Yes / No	Yes / No
Mobility /Activity	Patient able to reposition **independently** (if No, assist Q2H)	Yes / No	Yes / No
	Leg exercises every hour when in bed	Yes / No	Yes / No
	Independent with ADLs as per pre-op status	Yes / No	Yes / No
	Mobility goals achieved as per pathway		
	• Up in chair for all meals **independently**	Yes / No	Yes / No
	• Walked in hallway x 2	Yes / No	Yes / No
	• Up to bathroom	Yes / No	Yes / No
	Nurse Initials		

INTERDISCIPLINARY PROGRESS NOTES / VARIANCE TRACKING RECORD

DATE dd/mmm/yyyy TIME (hhhh)	DISCIPLINE	FOCUS (Keyword)	DAR	PROGRESS D=DATA A=ACTION R=RESPONSE

Richmond Hospital
part of the Vancouver Coastal Health Authority

ENHANCED RECOVERY AFTER SURGERY (ERAS)CLINICAL PATHWAY FOR ENDOVASCULAR ABDOMINAL AORTIC ANEURYSM REPAIR

PCIS LABEL

INTERDISCIPLINARY PROGRESS NOTES / VARIANCE TRACKING RECORD

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DOCUMENTATION GUIDE
Circle either **Yes, No or NA**
Required Further Documentation when **No** is circled

DISCHARGE CHECKLIST (To be completed day of discharge)	**DATE:**	
EXPECTED OUTCOMES	**DAY**	**NIGHT**
Patient has met the following discharge criteria:		
• independent with ADLs	Yes / No	Yes / No
• pain managed on oral analgesics	Yes / No	Yes / No
• tolerating regular diet	Yes / No	Yes / No
• passing gas **OR** has had a bowel movement	Yes / No	Yes / No
• up to bathroom to void	Yes / No	Yes / No
Patient has home prepared & equipment in place for discharge	Yes / No	Yes / No
Patient has arranged a support person at home for 72 hours post discharge Destination post discharge: _____	Yes / No	Yes / No
Patient has all belongings with them	Yes / No	Yes / No
Patient has all post-op prescriptions	Yes / No / NA	Yes / No / NA
Patient has all post-op instruction sheet	Yes / No / NA	Yes / No / NA
Patient aware of follow up appointment with surgeon	Yes / No / NA	Yes / No / NA
Patient able to self-administer dalteparin/enoxaparin & Special authority form faxed to BC Pharmacare	Yes / No / NA	Yes / No / NA
Patient has appropriate LMWH teaching sheet	Yes / No / NA	Yes / No / NA
Arrangements made for staple removal on post-op day _____	Yes / No / NA	Yes / No / NA
Patient understands when to seek medical attention for complications	Yes / No	Yes / No
Patient discharged home @ _____ , accompanied by:_____		
Nurse Initials		

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