

Enhanced Recovery After Surgery (ERAS) for Liver Resection Clinical Pathway

Site Applicability

Vancouver General Hospital

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

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| Day of Surgery – OR Day | | |
|-------------------------|---|--|
| Category | Expected Outcomes | |
| Safety | Beside safety check | |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns | |
| | Fall prevention care plan in place | |
| | Risk assessed & new fall prevention care plan completed | |
| Cognition | Alert & Oriented x 3 (person, place, date) | |
| Assessment | Vital signs 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 | |
| Bowel/Bladder | Urine output more than 100 ml per 4 consecutive hours | |
| | Catheter secured and pericare/catheter care completed Q shift | |
| | Flatus passed | |
| | Note date of last BM | |
| | Abdomen soft, not distended, non-tender | |
| Nutrition & Hydration | Ice chips | |
| | Gum chewing (15 minutes TID) | |
| | • Scheduled Ondansetron 4 mg PO/IV Q8H x 9 doses; First dose | |
| | administered 8 hrs after intra-op dose (ensure each dose is | |
| | numerically labelled) | |
| | Nausea controlled | |
| | Patient did NOT vomit during shift | |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity | |
| | Dressing dry and intact (do not change dressing until POD #3, unless | |
| | saturated, otherwise outline drainage with a pen and reinforce as | |
| | needed) | |
| | Absence of sanguineous/bilious drainage in HMV | |
| | Strip HMV Q1H for 4 hrs, then Q6H PRN | |
| | Post-op wash completed (leave pink chlorhexidine skin preparation | |
| | solution on for 6 hours post-op) | |
| Functional Mobility | Turned Q2H until fully able to reposition on their own | |
| | Ankle exercises every hour when in bed | |
| | Patient sat at edge of bed or in chair x 15 minutes | |
| | HOB elevated 30 degrees when in bed | |
| | ICOUGH protocol followed | |
| | Full night sleep achieved | |
| | Sequential Compression Deice (SCD) applied | |
| | SCD removed no longer than 30 min/shift to assess & perform skin | |
| | care as per protocol | |

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS Booklet: patient has booklet at bedside
 - o Patient is aware of daily goals starting on page 51

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o Reviewed and reinforced pain management on page 39

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| Day of Surgery – Post-Op Day 1 Category Evpected Outcomes | | |
|---|---|--|
| Category Safety | Expected Outcomes • Reside safety check | |
| | Desired survey circuit | |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns | |
| | Fall prevention care plan in place | |
| | Risk assessed & new fall prevention care plan completed | |
| Cognition | Alert & Oriented x 3 (person, place, date) | |
| Assessment | Vital signs 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 | |
| Bowel/Bladder | Urine output more than 100 ml per 4 consecutive hours | |
| | Catheter secured and pericare/catheter care completed Q shift | |
| | Night shift to remove Foley catheter tomorrow am at 06:00hr on | |
| | POD 2 (even if epidural in situ). If Foley not removed at 0600 POD2, | |
| | provide rationale | |
| | Flatus passed | |
| | Note date of last BM | |
| | Abdomen soft, not distended, non-tender | |
| Nutrition & Hydration | MINOR Liver Resection: Start first meal as Post Surgical Transition | |
| | Diet | |
| | MAJOR Liver Resection: Start first meal as Full Fluids | |
| | Patient tolerating Boost 1.5 Tetra BID | |
| | Tolerating oral intake | |
| | Gum chewing (15 minutes TID) | |
| | Scheduled Ondansetron 4 mg PO/IV Q8H x 9 doses (ensure each | |
| | dose is numerically labelled) | |
| | Nausea controlled | |
| | Patient did NOT vomit during shift | |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity | |
| | Dressing dry and intact (do not change dressing until POD #3, unless | |
| | saturated, otherwise outline drainage with a pen and reinforce as | |
| | needed) | |
| | Absence of sanguineous/bilious drainage in HMV | |
| | Strip HMV Q6H PRN (if applicable) | |
| Diagnostics | Bloodwork completed as per order | |
| Functional Mobility | HOB elevated 30 degrees when in bed | |
| - - | Ankle exercises every hour when in bed | |
| | ICOUGH protocol followed | |
| | Up in chair for minimum x 2 (with assistance or independently) | |
| | Walked x 1 in room (Minimum 5 meters) (with assistance or | |
| | independently) | |
| | Up to bathroom (with assistance or independently) | |

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| • | 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 |

Teaching & Discharge Planning

- **ERAS Booklet**: patient has booklet at bedside
 - Patient is aware of daily goals starting on page 53
 - o Reviewed and reinforced pain management on page 39
 - o Patient is aware of discharge criteria on page 61
- Patient received teaching re: self administration of LMWH
- Patient has arranged for support person at home post discharge

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| Day of Surgery – Post-Op Day 2 lategory afety all Risk/Care Plan | Expected Outcomes Beside safety check |
|---|---|
| - | , |
| all Risk/Care Plan | |
| | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| ognition | Alert & Oriented x 3 (person, place, date) |
| ssessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| ain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| | Epidural site satisfactory (if applicable) |
| owel/Bladder | No issue with first void post Foley removal |
| | Urine output more than 360 ml/12 hours. If Foley in situ, provide |
| | rationale |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| lutrition & Hydration | MINOR Liver Resection: Advance diet to Diet as Tolerated |
| | MAJOR Liver Resection: Advance diet to Post Surgical Transition |
| | Diet |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Scheduled Ondansetron 4 mg PO/IV Q8H x 9 doses (ensure each |
| | dose is numerically labelled) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| | Saline lock IV when drinking ≥ 600 ml/12 hours |
| kin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Dressing dry and intact (do not change dressing until POD #3, unless |
| | saturated, otherwise outline drainage with a pen and reinforce as |
| | needed) • Absence of sanguineous/bilious drainage in HMV |
| | |
| | Strip HMV Q6H PRN (if applicable) Discontinue drain as per order ,based on drainage volume |
| Piagnostics | Bloodwork completed as per order |
| unctional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| undional Mobility | Ankle exercises every hour when in bed |
| | Up in chair for all meals (with assistance or independently) |
| | Walked in hallway x 2 (10 meters/walk) (with assistance or |
| | independently) |
| | Up to bathroom (with assistance or independently) |
| | SCD removed no longer than 30 min/shift to assess & perform skin |
| | care as per protocol |
| | ICOUGH protocol followed |
| eaching & Discharge Planning | 1 |

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- ERAS Booklet: patient has booklet at bedside
 - Patient is aware of daily goals starting on page 55
 - o Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- 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
 - o Independent with ADLs
 - o Pain managed on oral analgesics
 - o Tolerating regular diet
 - o Passing gas or has had a bowel movement
- Discharge destination confirmed

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| Category | Expected Outcomes |
|-------------------------------|--|
| Safety | Beside safety check |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| Assessment | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| r ann ivianagement | Pain assessment completed as per protocol |
| | |
| Bowel/Bladder | |
| bowel/ blaudel | Urine output more than 360 ml/12 hours. If Followin gith provide rationals. |
| | If Foley in situ provide rationaleFlatus passed |
| | · |
| | Note date of last BM Abdaman act, not distanted to an tonder. |
| | Abdomen soft, not distended, non-tender No suidense of winesy tractions |
| Nituitian O IIduatian | No evidence of urinary tract infection |
| Nutrition & Hydration | MINOR Liver Resection: Diet as Tolerated |
| | MAJOR Liver Resection: Advance diet to Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | • Gum chewing (15 minutes TID) |
| | Scheduled Ondansetron 4 mg PO/IV Q8H x 9 doses (ensure each |
| | dose is numerically labelled) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| | If CVC insitu, discontinue and start peripheral IV access |
| | Saline lock IV when drinking ≥ 600 ml/12 hours |
| 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) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| | Strip HMV Q6H PRN (if applicable) |
| | Absence of sanguineous/bilious drainage in HMV |
| Diagnostics | Bloodwork completed as per order |
| Functional Mobility | HOB elevated 30 degrees when in bed |
| • | Ankle exercises every hour when in bed |
| | 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) |
| | SCD removed no longer than 30 min/shift to assess & perform skin |
| | care as per protocol |
| | ICOUGH protocol followed |
| Teaching & Discharge Planning | COOGH protocorrollowed |

ERAS Booklet: patient has booklet at bedside

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- Patient is aware of daily goals starting on page 57
- Reviewed and reinforced pain management on page 39
- o Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - Independent with ADLs
 - Pain managed on oral analgesics
 - o Tolerating regular diet
 - Passing gas or has had a bowel movement
- Discharge destination confirmed

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| Day of Surgery – Post-Op Day 4 | |
|--------------------------------|--|
| Category | Expected Outcomes |
| Safety | Beside safety check |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| | Epidural site satisfactory (if applicable) |
| Bowel/Bladder | Urine output more than 360 ml/12 hours. |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| | No evidence of urinary tract infection |
| Nutrition & Hydration | Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| | Saline lock IV when drinking ≥ 600 ml/12 hours |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Incision approximated (no signs of infection) |
| | Strip HMV Q6H PRN (if applicable) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| Diagnostics | Bloodwork completed as per order |
| Functional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| | Ankle exercises every hour when in bed |
| | ICOUGH protocol followed |
| | Up in chair for all meals independently |
| | Walked in hallway x 2 independently |
| | Up to bathroom independently |

Teaching & Discharge Planning

- ERAS Booklet: patient has booklet at bedside
 - o Patient is aware of daily goals starting on page 59
 - Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - o Independent with ADLs
 - Pain managed on oral analgesics

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- Tolerating regular diet
- o Passing gas or has had a bowel movement
- Discharge destination confirmed

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| Day of Surgery – Post-Op Day Category | Expected Outcomes |
|---------------------------------------|---|
| Safety | · |
| | Desired surery critical |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| | Epidural site satisfactory (if applicable) |
| Bowel/Bladder | Urine output more than 360 ml/12 hours. |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| | No evidence of urinary tract infection |
| Nutrition & Hydration | Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Incision approximated (no signs of infection) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| Diagnostics | Bloodwork completed as per order |
| Functional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| • | Ankle exercises every hour when in bed |
| | ICOUGH protocol followed |
| | Up in chair for all meals independently |
| | Walked in hallway x 2 independently |
| | |
| Tanahina & Disaharan Diannina | Up to bathroom independently |

Teaching & Discharge Planning

- **ERAS Booklet**: patient has booklet at bedside
 - o Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - o Independent with ADLs
 - Pain managed on oral analgesics
 - Tolerating regular diet
 - Passing gas or has had a bowel movement

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Discharge destination confirmed

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| Day of Surgery – Post-Op Da | |
|-----------------------------|---|
| Category | Expected Outcomes |
| Safety | Beside safety check |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| Bowel/Bladder | Urine output more than 360 ml/12 hours. |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| | No evidence of urinary tract infection |
| Nutrition & Hydration | Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Incision approximated (no signs of infection) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| Diagnostics | Bloodwork completed as per order |
| Functional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| | Ankle exercises every hour when in bed |
| | ICOUGH protocol followed |
| | Up in chair for all meals independently |
| | Walked in hallway x 2 independently |
| | Up to bathroom independently |

Teaching & Discharge Planning

- **ERAS Booklet**: patient has booklet at bedside
 - Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - o Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - o Independent with ADLs
 - o Pain managed on oral analgesics
 - Tolerating regular diet
 - Passing gas or has had a bowel movement
- Discharge destination confirmed

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| Day of Surgery – Post-Op Day 7 | |
|--------------------------------|---|
| Category | Expected Outcomes |
| Safety | Beside safety check |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| Bowel/Bladder | Urine output more than 360 ml/12 hours. |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| | No evidence of urinary tract infection |
| Nutrition & Hydration | Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Incision approximated (no signs of infection) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| Diagnostics | Bloodwork completed as per order |
| Functional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| | Ankle exercises every hour when in bed |
| | ICOUGH protocol followed |
| | Up in chair for all meals independently |
| | Walked in hallway x 2 independently |
| | Up to bathroom independently |

Teaching & Discharge Planning

- **ERAS Booklet**: patient has booklet at bedside
 - Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - o Independent with ADLs
 - o Pain managed on oral analgesics
 - Tolerating regular diet
 - Passing gas or has had a bowel movement

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Discharge destination confirmed

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| Day of Surgery – Post-Op Day 8 and Onward | |
|---|--|
| Category | Expected Outcomes |
| Safety | Bedside Safety Check |
| Fall Risk/Care Plan | Not at risk: reviewed & no concerns |
| | Fall prevention care plan in place |
| | Risk assessed & new fall prevention care plan completed |
| Cognition | Alert & Oriented x 3 (person, place, date) |
| Assessment | Vital signs and temp within patient's normal limits |
| | Head to toe assessment (within patient's normal limits) |
| | Anxiety level acceptable to patient |
| Pain Management | Pain level acceptable to patient |
| | Pain assessment completed as per protocol |
| Bowel/Bladder | Urine output more than 360 ml/12 hours. |
| | Flatus passed |
| | Note date of last BM |
| | Abdomen soft, not distended, non-tender |
| | No evidence of urinary tract infection |
| Nutrition & Hydration | Diet as Tolerated |
| | Patient tolerating Boost 1.5 Tetra BID |
| | Gum chewing (15 minutes TID) |
| | Nausea controlled |
| | Patient did NOT vomit during shift |
| Skin, Dressings, Drains | Braden Risk Assessment for skin integrity |
| | Incision approximated (no signs of infection) |
| | Remove abdominal staples and apply steri-strips as per MD orders |
| Functional Mobility | HOB elevated 30 degrees when in bed, unless contraindicated |
| | Ankle exercises every hour when in bed |
| | ICOUGH protocol followed |
| | Up in chair for all meals independently |
| | Walked in hallway x 2 independently |
| | Up to bathroom independently |

Teaching & Discharge Planning

- **ERAS Booklet**: patient has booklet at bedside
 - o Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient has arranged for support person at home post discharge
- Patient has home & equipment prepared for discharge
- Patient has a ride home on day of discharge
- Patient met the following discharge criteria
 - o Independent with ADLs
 - o Pain managed on oral analgesics
 - Tolerating regular diet
 - Passing gas or has had a bowel movement
- Discharge destination confirmed

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| Day of Discharge | |
|------------------|--|
| Category | Expected Outcomes |
| Discharge | Discharged, accompanied |
| | Has discharge prescriptions |
| | If script for proton pump inhibitor, RN to review medication in ERAS |
| | booklet with patient prior to discharge |
| | Has sharps container & appropriate LMWH teaching sheet |
| | Has post-op instruction sheet |
| | Has follow up information |
| | Has all belongings |
| | Understands when to seek medical attention for complications |
| | Arrangements made for staple removal at post-op day 7 to 10 if |
| | applicable |
| | Discharge destination confirmed |

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, General/Vascular Surgery, OTL-HNS & GI Medicine, VGH |

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