Enhanced Recovery After Surgery (ERAS) for Whipple/Pancreatectomy 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

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: reviewed and no changes • 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 (if applicable)
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	• Gum chewing (15 minutes TID) • **Distal Pancreatectomy:** Start first meal as Post Surgical Transition Diet • **Distal Pancreatectomy:** Patient tolerating Boost 1.5 Tetra BID • **Whipple and Total Pancreatectomy:** NPO (may have sips of water when NPO) • Scheduled Ondansetron 4 mg PO/IV Q8H x 12 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 (if applicable) • Pancreatic stent patent & secured with safety pin • Strip HMV Q1H for 4 hrs, then Q6H PRN (if applicable) • Nasogastric tube in situ & secured • 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
  ○ Patient is aware of daily goals starting on page 51
  ○ Reviewed and reinforced pain management on page 39	

Day of Surgery – Post-Op Day 1	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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 (if applicable)
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 • **Whipple and Total Pnacreatectomy**: Night shift to trial clamping NG tube at 0600 POD 2 as per PowerPlan • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender
Nutrition & Hydration	• **Distal Pancreatectomy:** Advance to Diet as Tolerated • **Distal Pancreatectomy:** Patient tolerating Boost 1.5 Tetra BID • **Whipple and Total Pancreatectomy**: NPO (may have sips of water when NPO) • Gum chewing (15 minutes TID) • tolerating oral intake • Scheduled Ondansetron 4 mg PO/IV Q8H x 12 doses (ensure each dose is numerically labelled) • Nausea controlled • Patient did NOT vomit during shift • Saline lock IV when tolerating ≥ 600 ml/12 hours
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 (if applicable) • Pancreatic stent patent & secure with safety pin • Strip HMV Q6H PRN (if applicable) • Nasogastric tube in situ & secured
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) • SCD applied, 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
  ○ 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 received teaching re: pancreatic stent and/or J tube (if applicable)
• Patient has arranged for support person at home post discharge
• Discharge destination confirmed	

Day of Surgery – Post-Op Day 2	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• No issue with first void post Foley removal • Urine output more than 360 ml/12 hours. • If Foley in situ, provide rationale • **Whipple and Total Pancreatectomy:** NG tube clamed x 6 hours, residual less than 200ml, NG tube removed • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender • No evidence of urinary tract infection
Nutrition & Hydration	• **Distal Pancreatectomy:** Diet as Tolerated • **Distal Pancreatectoy:** Patient tolerating Boost 1.5 Tetra BID • **Whipple and Total Pancreatectomy**: Post NG tube removal, start Clear Fluids • **Whipple and Total Pancreatectomy:** Patient tolerating Boost Fruit Beverage (Clear Fluid drink) TID • Gum chewing (15 minutes TID) • Scheduled Ondansetron 4 mg PO/IV Q8H x 12 doses (ensure each dose is numerically labelled) • 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 • 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 • Pancreatic stent patient & secured with safety pin • Strip HMV Q6H PRN (if applicable)
Diagnostics	• Bloodwork completed as per order
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • 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) • ICOUGH protocol followed

Teaching & Discharge Planning
• **ERAS Booklet**: patient has booklet at bedside
  ○ Patient is aware of daily goals starting on page 55
  ○ 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 received teaching re: pancreatic stent and/or J tube (if applicable)
• Patient has arranged for support person at home post discharge
• Patient has a ride home on day of discharge
• Discharge destination confirmed	

Day of Surgery – Post-Op Day 3	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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. • If Foley in situ provide rationale • If NG still in situ, MD to reassess removal • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender • No evidence of urinary tract infection
Nutrition & Hydration	• **Distal Pancreatectomy:** Diet as Tolerated • **Total Pancreatectomy & Whipple**: Advance diet to Full Fluids • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Scheduled Ondansetron 4 mg PO/IV Q8H x 12 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 • Pancreatic stent patient & secured with safety pin
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) • ICOUGH protocol followed
Teaching & Discharge Planning • **ERAS Booklet**: patient has booklet at bedside	

- Patient is aware of daily goals starting on page 57
- Reviewed and reinforced pain management on page 39
- Patient is aware of discharge criteria on page 61

- Patient self-administering LMWH
- Patient received teaching re: pancreatic stent and/or J tube (if applicable)
- 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
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Discharge destination confirmed

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: reviewed and no changes • 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. • If Foley in situ provide rationale • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender • No evidence of urinary tract infection
Nutrition & Hydration	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Advance to Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** 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 12 doses (ensure each dose is numerically labelled) • Nausea controlled • Patient did NOT vomit during shift • If CVC in situ, discontinue and start peripheral IV access • Saline lock IV when drinking ≥ 600 ml/12 hours
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 • Strip HMV Q6H PRN (if applicable) • Pancreatic stent patent & secured with safety pin
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 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 received teaching re: pancreatic stent and/or J tube (if applicable)
- 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
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Discharge destination confirmed

Day of Surgery – Post-Op Day 5	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple**: Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Saline lock IV when tolerating ≥ 600ml/12hr
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 • Pancreatic stent patent & secured with safety pin • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient received teaching re: pancreatic stent and/or J tube (if applicable)
• 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
    - Tolerating regular diet
    - Passing gas or has had a bowel movement
- Discharge destination confirmed

Day of Surgery – Post-Op Day 6	
Category	**Expected Outcomes**
Safety	• Beside safety check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
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 • Pancreatic stent patent & secured with safety pin • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient received teaching re: pancreatic stent and/or J tube (if applicable)
• 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
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Discharge destination confirmed

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: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
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 • Pancreatic stent patent & secured with safety pin • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Discharge destination confirmed

Day of Surgery – Post-Op Day 8	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Pancreatic stent patent & secured with safety pin • Remove abdominal staples and apply steri-strips as per MD orders • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Discharge destination confirmed

Day of Surgery – Post-Op Day 9	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Pancreatic stent patent & secured with safety pin • Remove abdominal staples and apply steri-strips as per MD orders • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
- Tolerating regular diet
- Passing gas or has had a bowel movement

- Discharge destination confirmed

Day of Surgery – Post-Op Day 10	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Pancreatic stent patent & secured with safety pin • Remove abdominal staples and apply steri-strips as per MD orders • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
- Tolerating regular diet
- Passing gas or has had a bowel movement

- Discharge destination confirmed

Day of Surgery – Post-Op Day 11	
Category	**Expected Outcomes**
Safety	• Bedside Safety Check
Fall Risk/Care Plan	• Not at risk: reviewed & no concerns • Fall prevention care plan in place: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Pancreatic stent patent & secured with safety pin • Remove abdominal staples and apply steri-strips as per MD orders • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
- Tolerating regular diet
- Passing gas or has had a bowel movement

- Discharge destination confirmed

Day of Surgery – Post-Op Day 12 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: reviewed and no changes • 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	• **Distal Pancreatectomy:** Diet as Tolerated • **Classic Whipple:** Post Gastric Surgical Diet • **Pylorus Sparing Whipple:** Post Surgical Transition Diet • Patient tolerating Boost 1.5 Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Remove saline lock when ordered
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no signs of infection) • Pancreatic stent patent & secured with safety pin • Remove abdominal staples and apply steri-strips as per MD orders • Strip HMV Q6H PRN
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
  ○ Reviewed and reinforced pain management on page 39
  ○ Patient is aware of discharge criteria on page 61
• Patient self-administering LMWH
• Patient is able to self manage pancreatic stent and/or J tube (if applicable)
• 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
- Tolerating regular diet
- Passing gas or has had a bowel movement

- Discharge destination confirmed

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