

Enhanced Recovery After Surgery (ERAS) for Gynecologic Oncology Pathway

Site Applicability

Vancouver General Hospital UBC 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	Bedside safety check	
Fall Risk/Care Plan	Fall prevention care plan in place	
	Risk assessed & new fall prevention care plan completed	
	Not at risk: reviewed & no concerns	
Cognition	Alert & Oriented x 3 (person, place, date)	
Assessment	VS 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	
	Pruritus controlled	
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours	
	Foley catheter secured and catheter care completed q shift	
	Pericare completed Q shift	
	Flatus passed	
	Note date of last BM	
Nutrition & Hydration	Full fluid diet to Post-surgical Transition Diet to DAT (early feeding)	
	Boost 1.5 Tetra 240 ml BID	
	Gum chewing (15 minutes TID)	
	Nausea controlled	
	Patient did NOT vomit during shift	
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity	
	 Dressings dry and intact (do not change dressing until POD #2, 	
	outline drainage with a pen and reinforce as needed)	
	Peripad checked with minimal drainage	
	Post-op wash completed (leave pink chlorhexidine preparation	
	solution on for 6 hours post-op)	
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated	
	Ankle exercise every hour when in bed	
	ICOUGH protocol followed	
	Full night sleep achieved	
	For laparoscopic cases:	
	Independent ADLs as per preop status	
	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)	
	For open cases:	
	Turned Q2 until fully able to reposition on their own	
	Patient sat at edge of bed or in chair x 15 minutes	

Teaching & Discharge Planning

- Patient is oriented to room/environment
- ERAS booklet: Patient has booklet at bedside
 - o Patient is aware of daily goals
 - o Reviewed and reinforced pain management
- Patient received teaching re: self-administration of VTE prophylaxis or medication teaching regarding Apixaban (if applicable)

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Day of Surgery – Post-Op Day 1	
Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Assessment	VS and temp within patient's normal limits
	 Head to toe assessment (within patient's normal limits)
	CBG taken as per protocol
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Foley catheter secured and catheter care completed q shift
	Pericare completed Q shift
	Foley catheter removed
	Post void residuals less than100 ml x 2
	Flatus passed
	Note date of last BM
	Abdomen soft, non-tender, non-distended or bloated
Nutrition & Hydration	Full fluid diet to Post-surgical Transition Diet to DAT
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Patient did NOT vomit during shift
	Saline lock IV when drinking well
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	 Dressings dry and intact (do not change dressing until POD #2,
	outline drainage with a pen and reinforce as needed)
	Peripad checked with minimal drainage
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	Ankle exercise every hour when in bed
	ICOUGH protocol followed
	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)

Teaching & Discharge Planning

- ERAS booklet: patient has booklet at bedside
 - o Patient is aware of daily goals
 - o Reviewed and reinforced pain management
 - o Patient is aware of discharge criteria
- Patient self-administering VTE prophylaxis) or medication teaching regarding Apixaban (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

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- 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
- Confirm discharge destination

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Day of Surgery – Post-Op Day 2	
Category	Expected Outcomes
Safety	Bedside safety check
Fall Risk/Care Plan	Fall prevention care plan in place
	Risk assessed & new fall prevention care plan completed
	Not at risk: reviewed & no concerns
Cognition	Alert & Oriented x 3 (person, place, date)
Assessment	VS 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
	Pruritus controlled
Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
	Foley catheter secured and catheter care completed q shift
	Pericare completed Q shift
	Foley catheter removed
	Post void residuals less than 100 ml x 2
	Flatus passed
	Note date of last BM
	Abdomen soft, non-tender, non-distended or bloated
Nutrition & Hydration	Full fluid diet to Post-surgical Transition Diet to DAT
	Boost 1.5 Tetra 240 ml BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Patient did NOT vomit during shift
	Oral intake recorded
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
	Dressing changed
	Incision approximated with no signs of infection
	Peripad checked with minimal drainage
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
	Ankle exercise every hour when in bed
	Independent with ADLs as per preop status
	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
 - o Patient is aware of daily goals
 - o Reviewed and reinforced pain management
 - o Patient is aware of discharge criteria
- Patient self-administering VTE prophylaxis or medication teaching regarding Apixaban (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:
 - o Independent with ADLs

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- o Pain managed on oral analgesics
- o Tolerating regular diet
- o Passing gas or has had a bowel movement
- Confirm discharge destination

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Safety Bedside safety check Fall Risk/Care Plan Fall Risk/Care Plan Fall prevention care plan in place Risk assessed & new fall prevention care plan completed Not at risk: reviewed & no concerns Cognition Alert & Oriented x 3 (person, place, date) Assessment VS and temp within patient's normal limits Head to toe assessment (within patient's normal limits) Anxiety level acceptable to patient Print to patient Pruritus controlled Urine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Flats hassessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage	Day of Surgery – Post-Op Day 3	
Fall Risk/Care Plan Fall prevention care plan in place Risk assessed & new fall prevention care plan completed Not at risk: reviewed & no concerns Alert & Oriented x 3 (person, place, date) Assessment VS 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 Pruritus controlled Purine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Pericare completed Q shift Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Parade Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Category	Expected Outcomes
Risk assessed & new fall prevention care plan completed Not at risk: reviewed & no concerns Alert & Oriented x 3 (person, place, date) Assessment VS 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 Pruritus controlled Bowel/Bladder Urine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Functional Mobility Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Safety	Bedside safety check
• Not at risk: reviewed & no concerns Cognition • Alert & Oriented x 3 (person, place, date) Assessment • VS and temp within patient's normal limits • Head to toe assessment (within patient's normal limits) • Anxiety level acceptable to patient Pain level acceptable to patient • Pruritus controlled Bowel/Bladder • Urine output more than 100ml in 4 consecutive hours • Foley catheter secured and catheter care completed q shift • Pericare completed Q shift • Foley catheter removed • Post void residuals less than100 ml x 2 • Flatus passed • Note date of last BM • Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration • Full fluid diet to Post-surgical Transition Diet to DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded Skin, Dressings, Drains • Braden Risk Assessment for skin integrity • Incision approximated with no signs of infection • Peripad checked with minimal drainage HOB elevated 30 degrees when in bed • Independent with ADLs as per preop status • Up in chair for all meals (with assistance or independently)	Fall Risk/Care Plan	Fall prevention care plan in place
Assessment Anxiety level acceptable to patient Pain level acceptable to patient Pruritus controlled Bowel/Bladder Dirine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Risk assessed & new fall prevention care plan completed
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Head to toe assessment (within patient's normal limits) Anxiety level acceptable to patient Pain Management Pain level acceptable to patient Pruritus controlled Urine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Cognition	Alert & Oriented x 3 (person, place, date)
Pain Management Pain I level acceptable to patient Pruritus controlled Bowel/Bladder Urine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Assessment	VS and temp within patient's normal limits
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Pruritus controlled Ourine output more than 100ml in 4 consecutive hours Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Functional Mobility Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Anxiety level acceptable to patient
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Foley catheter secured and catheter care completed q shift Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Pruritus controlled
Pericare completed Q shift Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Bowel/Bladder	Urine output more than 100ml in 4 consecutive hours
Foley catheter removed Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Foley catheter secured and catheter care completed q shift
Post void residuals less than100 ml x 2 Flatus passed Note date of last BM Abdomen soft, non-tender, non-distended or bloated Nutrition & Hydration Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Pericare completed Q shift
• Flatus passed • Note date of last BM • Abdomen soft, non-tender, non-distended or bloated • Full fluid diet to Post-surgical Transition Diet to DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Braden Risk Assessment for skin integrity • Incision approximated with no signs of infection • Peripad checked with minimal drainage • HOB elevated 30 degrees when in bed, unless contraindicated • Ankle exercise every hour when in bed • Independent with ADLs as per preop status • Up in chair for all meals (with assistance or independently)		Foley catheter removed
Note date of last BM Abdomen soft, non-tender, non-distended or bloated Pull fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Post void residuals less than100 ml x 2
Abdomen soft, non-tender, non-distended or bloated Full fluid diet to Post-surgical Transition Diet to DAT Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Flatus passed
Nutrition & Hydration • Full fluid diet to Post-surgical Transition Diet to DAT • Boost 1.5 Tetra 240 ml BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Braden Risk Assessment for skin integrity • Incision approximated with no signs of infection • Peripad checked with minimal drainage Functional Mobility • HOB elevated 30 degrees when in bed, unless contraindicated • Ankle exercise every hour when in bed • Independent with ADLs as per preop status • Up in chair for all meals (with assistance or independently)		Note date of last BM
Boost 1.5 Tetra 240 ml BID Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage Functional Mobility HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Abdomen soft, non-tender, non-distended or bloated
 Gum chewing (15 minutes TID) Nausea controlled Patient did NOT vomit during shift Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 	Nutrition & Hydration	Full fluid diet to Post-surgical Transition Diet to DAT
 Nausea controlled Patient did NOT vomit during shift Oral intake recorded Skin, Dressings, Drains Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 		Boost 1.5 Tetra 240 ml BID
 Patient did NOT vomit during shift Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 		Gum chewing (15 minutes TID)
Oral intake recorded Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Nausea controlled
Braden Risk Assessment for skin integrity Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)		Patient did NOT vomit during shift
 Incision approximated with no signs of infection Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 		Oral intake recorded
Peripad checked with minimal drainage HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently)	Skin, Dressings, Drains	Braden Risk Assessment for skin integrity
 HOB elevated 30 degrees when in bed, unless contraindicated Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 		Incision approximated with no signs of infection
 Ankle exercise every hour when in bed Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 		Peripad checked with minimal drainage
 Independent with ADLs as per preop status Up in chair for all meals (with assistance or independently) 	Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated
 Up in chair for all meals (with assistance or independently) 		Ankle exercise every hour when in bed
		Independent with ADLs as per preop status
 Walked in hallway x 2 (with assistance or independently) 		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) 		Up to bathroom (with assistance or independently)
ICOUGH protocol followed		ICOUGH protocol followed

Teaching & Discharge Planning

- ERAS booklet: patient has booklet at bedside
 - o Patient is aware of daily goals
 - Reviewed and reinforced pain management
 - o Patient is aware of discharge criteria
- Patient self-administering VTE prophylaxis or medication teaching regarding Apixaban (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
 - o Pain managed on oral analgesics

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- Tolerating regular diet
- o Passing gas or has had a bowel movement
- Confirm discharge destination

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Day of Surgery – Post-Op Day 4 and Onward		
Category	Expected Outcomes	
Safety	Bedside safety check	
Fall Risk/Care Plan	Fall prevention care plan in place	
	Risk assessed & new fall prevention care plan completed	
	Not at risk: reviewed & no concerns	
Cognition	Alert & Oriented x 3 (person, place, date)	
Assessment	VS 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	
	Pruritus controlled	
Bowel/Bladder	 Urine output more than 100ml in 4 consecutive hours 	
	Foley catheter secured and catheter care completed q shift	
	Pericare completed Q shift	
	Foley catheter removed	
	Post void residuals less than 100 ml x 2	
	Flatus passed	
	Note date of last BM	
	Abdomen soft, non-tender, non-distended or bloated	
Nutrition & Hydration	Full fluid diet to Post-surgical Transition Diet to DAT	
	Boost 1.5 Tetra 240 ml BID	
	Gum chewing (15 minutes TID)	
	Nausea controlled	
	Patient did NOT vomit during shift	
	Oral intake recorded	
Skin, Dressings, Drains	Braden Risk Assessment for skin integrity	
	 Incision approximated with no signs of infection 	
	Peripad checked with minimal drainage	
Functional Mobility	HOB elevated 30 degrees when in bed, unless contraindicated	
	Ankle exercise every hour when in bed	
	Independent with ADLs as per preop status	
	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
 - o Patient is aware of daily goals
 - Reviewed and reinforced pain management
 - Patient is aware of discharge criteria
- Patient self-administering VTE prophylaxis or medication teaching regarding Apixaban (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:
 - o Independent with ADLs
 - o Pain managed on oral analgesics

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- Tolerating regular diet
- o Passing gas or has had a bowel movement
- Confirm discharge destination

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Day of Discharge	
Category	Expected Outcomes
Discharge	Discharged, accompanied
	Has discharge prescriptions
	Has sharps container & appropriate VTE teaching sheet (if applicable)
	Has "Patient Discharge Handout" sheet
	Has follow up information
	Has all belongings
	 Understands when to seek medical attention for complications
	Discharge destination confirmed

Developed By

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