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

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
  ○ Patient is aware of daily goals
  ○ Reviewed and reinforced pain management
• Patient received teaching re: self-administration of VTE prophylaxis or medication teaching regarding Apixaban (if applicable)	

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
  ○ 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:
  - Independent with ADLs
  - Pain managed on oral analgesics
  - Tolerating regular diet
  - Passing gas or has had a bowel movement
- Confirm discharge destination

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
  ○ 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:
  ○ Independent with ADLs	

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

Day of Surgery – Post-Op Day 3	
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 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) • 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
  ○ 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:
  ○ Independent with ADLs
  ○ Pain managed on oral analgesics	

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

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
  ○ 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:
  ○ Independent with ADLs
  ○ Pain managed on oral analgesics	

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

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

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, High Acuity Unit, UBCH • Clinical Nurse Educator, Transplant, Urology, Gynecology, Plastics, VGH