Enhanced Recovery After Surgery (ERAS) for Retroperitoneal Lymph Node Dissection 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) • Full night sleep achieved
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 • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Catheter secured Pericare/catheter care completed q shift • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra 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 #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed) • 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 • ICOUGH protocol followed • Turned Q2H until fully able to reposition on their own • Ankle exercise every hour when in bed • Sequential Compression Devices (SCD) applied unless contraindicated • SCD removed no longer than 30 min/shift to assess & perform skin care as per protocol • 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 starting on page 49
  ○ Reviewed and reinforced pain management on page 37	

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) • Full night sleep achieved
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 • Pain assessment completed as per protocol • Epidural site satisfactory (if applicable)
Bowel/Bladder	• Urine output more than 100ml in 4 consecutive hours • Catheter secured 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 POD 2, provide rationale • Flatus passed • Note date of last BM • Abdomen soft, not distended, non-tender
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Saline lock IV unless oral intake < 600ml/12hr • If CVC in situ , obtain MD order to remove and inset peripheral IV
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed)
Diagnostics	• CBC and Electrolytes complete
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Turned Q2H until fully able to reposition on their own • Ankle exercise every hour when in bed (while awake) • 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 • 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 starting on page 51
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• 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	

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 • 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 • Flatus passed • Note date of last BM • Abdomen soft, non-tender, not distended or bloated
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • IV site(s) assessment completed as per protocol
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressings dry and intact (do not change dressing until POD #3/as per order, unless saturated, otherwise outline drainage with a pen and reinforce as needed)
Diagnostics	• CBC and Electrolytes complete
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • 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 starting on page 53
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• 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:	

- Independent with ADLs
- Pain managed on oral analgesics
- Tolerating low fat diet
- Passing gas or has had bowel movement

- Discharge destination confirmed

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 • 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, non-tender, not distended or bloated • No evidence or urinary tract infection
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • IV site(s) assessment completed as per protocol
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Dressing changed • Incision dry and left open to air (no dressing) • Incision approximated (no sign of infection)
Diagnostics	• CBC and Electrolytes complete
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • Up in chair for all meals 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 starting on page 55
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• Patient self administering 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:
  - Independent with ADLs
  - Pain managed on oral analgesics
  - Tolerating low fat diet
  - Passing gas or has had bowel movement
- Discharge destination confirmed

Day of Surgery – Post-Op Day 4	
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 • 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, non-tender, not distended or bloated • No evidence or urinary tract infection
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Remove saline lock prior to discharge
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no sign of infection)
Diagnostics	• CBC and Electrolytes complete
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • 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 57
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• 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	

- Tolerating low fat diet
- Passing gas or has had bowel movement

- Discharge destination confirmed

Day of Surgery – Post-Op Day 5	
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 • 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, non-tender, not distended or bloated • No evidence or urinary tract infection
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Remove saline lock prior to discharge
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no sign of infection)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • 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 57-60
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• 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
  ○ Tolerating low fat diet
  ○ Passing gas or has had bowel movement	

- Discharge destination confirmed

Day of Surgery – Post-Op Day 6 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 • 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, non-tender, not distended or bloated • No evidence or urinary tract infection
Nutrition & Hydration	• Low fat diet • Dietitian to provide low fat diet education prior to discharge • Patient tolerating Boost Fruit Beverage Tetra BID • Gum chewing (15 minutes TID) • Nausea controlled • Patient did NOT vomit during shift • Oral intake recorded • Remove saline lock prior to discharge
Skin, Dressings, Drains	• Braden Risk Assessment for skin integrity • Incision approximated (no sign of infection)
Functional Mobility	• HOB elevated 30 degrees when in bed, unless contraindicated • ICOUGH protocol followed • Ankle exercise every hour when in bed (while awake) • 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 57-60
  ○ Reviewed and reinforced pain management on page 37
  ○ Patient is aware of discharge criteria on page 59
• 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
  ○ Tolerating low fat diet	

- Passing gas or has had bowel movement
- Discharge destination confirmed

Day of Discharge	
Category	**Expected Outcomes**
Discharge	• Discharged, accompanied by support person • Has discharge prescriptions • Has sharps container & appropriate LMWH teaching sheet • Has received low fat diet education from dietitian • Has "My Discharge Plan" sheet • Has follow up information • Has all belongings • Understands when to seek medical attention for complications • Arrangements made for staple removal • Discharge destination confirmed

Developed By

Effective Date:	
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	Endorsed By: **Final Sign Off:**
Owners:	VCH
	Developer Lead(s): • Clinical Nurse Educator, Transplant, Urology, Gynecology, Plastics, VGH