

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

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Day of Surgery – OR Day	
Category	Expected Outcomes
Safety	Beside safety check
Fall Risk/Care Plan	Not at risk: reviewed & no concerns
	Fall prevention care plan in place: 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

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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
 - o Reviewed and reinforced pain management on page 39

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Day of Surgery – Post-Op Day 1 Category Expected Outcomes		
Safety	Beside safety check	
Fall Risk/Care Plan	Not at risk: reviewed & no concerns	
Tall Kisky care Flair	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	
Dain Managara	Anxiety level acceptable to patient	
Pain Management	Pain level acceptable to patient	
	Pain assessment completed as per protocol	
- 1/51 11	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 0000 POD 3 as par PayerPlan	
	tube at 0600 POD 2 as per PowerPlanFlatus passed	
	Note date of last BM	
	Abdomen soft, not distended, non-tender	
Nutrition & Hydration		
Nutrition & Hydration	Distal Pancreatectomy: Advance to Diet as Tolerated Dietal Pancreatectomy: Patient teleproting Pancre 1.5 Tetra PID	
	 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	
Skiii, Bressiiigs, Braiiis	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	

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_	Malked v 1 in room (Minimum F meters) (with assistance or
•	Walked x 1 in room (Minimum 5 meters) (with assistance or
	independently)
	Up to bathroom (with assistance or independently)

- Up to bathroom (with assistance or independently)
- SCD applied, discontinued after first dose of anticoagulant. Unless contraindicated

Up in chair for minimum x 2 (with assistance or independently)

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

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Day of Surgery – Post-Op Day 2 Category Expected Outcomes		
Category Safety	-	
Fall Risk/Care Plan	Deside surety offent	
raii Risk/Care Plan	Not at risk: reviewed & no concerns - Fall grounding core plan in places, reviewed and no changes.	
	Fall prevention care plan in place: reviewed and no changes Pick accessed 8 may fall prevention acres plan accordance.	
Comition	Risk assessed & new fall prevention care plan completed About 9 Option to do 2 (name of plan and	
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)	

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- 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
 - o Reviewed and reinforced pain management on page 39
 - Patient is aware of discharge criteria on page 61
- Patient received teaching re: self administration of LMWH
- Patient 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

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Category	Expected Outcomes
Safety	Beside safety check
Fall Risk/Care Plan	Not at risk: reviewed & no concerns
	Fall prevention care plan in place: 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
Assessment	Head to toe assessment (within patient's normal limits)
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
r an management	Pain assessment completed as per protocol
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 360 ml/12 hours.
bowel/ blaudel	·
	If Foley in situ provide rationaleIf NG still in situ, MD to reassess removal
	Flatus passed
	Note date of last BM
Nutrition 9 Undration	 No evidence of urinary tract infection Distal Pancreatectomy: Diet as Tolerated
Nutrition & Hydration	•
	Total Pancreatectomy & Whipple: Advance diet to Full Fluids Deticat teleprating Paget 1 F Tetra PID
	Patient tolerating Boost 1.5 Tetra BID Gura abouting (15 minutes TIP)
	Gum chewing (15 minutes TID) Sala dalad On the partner A map DO (NY OOLL + 12 decree (an area and the salad).
	Scheduled Ondansetron 4 mg PO/IV Q8H x 12 doses (ensure each dose is purposiselly lab all ad)
	dose is numerically labelled)
	Nausea controlled Datient did NOT consist during a hift
	Patient did NOT vomit during shift OG in its dispositions and start a sciel and NY access.
	If CVC insitu, discontinue and start peripheral IV access
di b i b i	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

• **ERAS Booklet**: patient has booklet at bedside

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

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Day of Surgery – Post-Op Day 4	
Category	Expected Outcomes
Safety	Beside safety check
Fall Risk/Care Plan	Not at risk: reviewed & no concerns
	Fall prevention care plan in place: 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
 - o Patient is aware of daily goals starting on page 59
 - Reviewed and reinforced pain management on page 39

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- 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
 - o Independent with ADLs
 - o Pain managed on oral analgesics
 - Tolerating regular diet
 - Passing gas or has had a bowel movement
- Discharge destination confirmed

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Day of Surgery – Post-Op Day	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
Tooching & Discharge Blanning	

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

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- 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

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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
 - o 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

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- Patient met the following discharge criteria
 - $\circ \quad \text{Independent with ADLs}$
 - o Pain managed on oral analgesics
 - o Tolerating regular diet
 - o Passing gas or has had a bowel movement
- Discharge destination confirmed

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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
 - o Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - o Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient 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

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- Patient met the following discharge criteria
 - $\circ \quad \text{Independent with ADLs}$
 - o Pain managed on oral analgesics
 - o Tolerating regular diet
 - o Passing gas or has had a bowel movement
- Discharge destination confirmed

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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
 - o Patient reviewed daily goals and discharge information on page 59-64
 - o Reviewed and reinforced pain management on page 39
 - o Patient is aware of discharge criteria on page 61
- Patient self-administering LMWH
- Patient 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

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- Patient met the following discharge criteria
 - $\circ \quad \text{Independent with ADLs}$
 - o Pain managed on oral analgesics
 - o Tolerating regular diet
 - o Passing gas or has had a bowel movement
- Discharge destination confirmed

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Day of Surgery – Post-Op Da	
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
 - o Reviewed and reinforced pain management on page 39
 - o 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

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- o Independent with ADLs
- o Pain managed on oral analgesics
- Tolerating regular diet
- Passing gas or has had a bowel movement
- Discharge destination confirmed

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Day of Surgery – Post-Op Day 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
 - o Reviewed and reinforced pain management on page 39
 - o 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

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- Independent with ADLs
- o Pain managed on oral analgesics
- Tolerating regular diet
- Passing gas or has had a bowel movement
- Discharge destination confirmed

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Day of Surgery – Post-Op Day 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
 - o Reviewed and reinforced pain management on page 39
 - o 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

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- Independent with ADLs
- o Pain managed on oral analgesics
- Tolerating regular diet
- Passing gas or has had a bowel movement
- Discharge destination confirmed

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Day of Surgery – Post-Op Day 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
 - o Reviewed and reinforced pain management on page 39
 - o 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

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- Independent with ADLs
- o Pain managed on oral analgesics
- Tolerating regular diet
- Passing gas or has had a bowel movement
- Discharge destination confirmed

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

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Developed By

Effective Date:	
Posted Date:	
Last Revised:	
Last Reviewed:	
Approved By:	
	Endorsed By:
	Final Sign Off:
Owners:	VCH
	Developer Lead(s):
	 Clinical Nurse Educator, General/Vascular Surgery, OTL-HNS & GI Medicine, VGH

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