GENSURG - COLON RESECTION PATHWAY
ENHANCED RECOVERY AFTER SURGERY (ERAS)

Site: VCH Coastal Cerner Sites

Instructions:

I. Review once per shift for patient care guideline only. Do not record patient care on this document.
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III. Review previous shift documentation - unless documenting on outcomes for the first time.

PRE-SURGERY	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
	Anesthesia consult completed
Pain Management	Pain level acceptable to patient
Bowel/Bladder	Urine output more than 360ml/12 hours
	Pericare completed Q shift
	Confirm Date of last BM
	Abdomen soft, not distended, non-tender
	Bowel prep given as per ERAS pre op PPO
Nutrition & Hydration	Diet as per ERAS pre op PPO
	Nausea controlled
	Absence of vomiting
	Patient drank 2 glasses (500ml or 16oz) of clear juice on evening prior to surgery
	Patient drank 1 glass of clear juice 3 hours prior to slated OR time, then NPO
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas)
	Ostomy Nurse to assess (for stoma marking)
	Chlorhexidine wipes completed on evening prior to surgery
	Chlorhexidine wipes completed on day of surgery
Functional Mobility	Independent with ADLs as per pre op status
Teaching & Discharge Planning	Patient and/or family received and reviewed ERAS Teaching Booklet
	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient received and reviewed Pain management pamphlet with nurses
Treatment	Provide forced air warmer.
	Administer Heparin 5000 unit subcutaneous pre-op, after cleared by Anesthesiologist

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Day of Surgery	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Glucometer < 8.1 mmol per 12 hours
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 60mL per 2 consecutive hours
	Catheter secured and pericare/catheter care completed Q shift
	In and Out Catheterization if PVR greater than 500mL, PRN
	Confirm Date of last BM
	Abdomen soft, not distended, non-tender
Nutrition & Hydration	Full fluids
	Gum chewing (15 minutes TID)
	Nausea controlled for 48 hrs, unless directed,
	Absence of vomiting
	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Saline lock IV when drinking ≥ 600 mL/12 hr
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas)
	Dressings dry and intact (Do not change dressing until POD # 3, unless directed.) Otherwise outline drainage with a pen and reinforce as needed.
	Monitor tube/drain output q6h
	Absence of sanginuous/bilious drainage in HMV (if applicable)
	Strip HMV Q1H for 4 hrs, then 6H PRN. (if applicable)
	Post-op wash completed (Leave pink chlorhexidine skin preparation solution on for 6 hours post op)
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
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 degree when in bed
	ICOUGH protocol followed
	Full night sleep achieved
	SCD applied
Teaching & Discharge Planning	Patient is orientated to room/environment
	Patient is aware of daily goals on ERAS Teaching Booklet
	Review & reinforce Pain management pamphlet
	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist

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POST-OP DAY 1	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Glucometer < 8.1 mmol per 12 hours
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Foley Catheter removed **(Except for rectal surgery patients)**
	Urine output more than 60mL per 2 consecutive hours
	Catheter secured and pericare/catheter care completed Q shift
	In and Out Catheterization if PVR greater than 500mL, PRN
	Flatus passed
	Confirm Date of last BM
	Abdomen soft, not distended, non-tender
Nutrition & Hydration	Full fluid (FF) to Post-surgical Transition Diet (PSTD) to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Tolerated oral intake
	Nausea controlled
	Absence of vomiting
	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Saline lock IV when drinking well ≥ 600 mL/12 hr
	If CVC insitu, when drinking ≥ 600 mL/12 hr, remove and insert saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure areas)
	Dressings dry and intact (Do not change dressing until POD # 3, unless directed). Otherwise outline drainage with a pen and reinforce as needed.
	Monitor tube/drain output q6h
	Absence of sanginuous/bilious drainage in HMV (if applicable)
	Strip HMV Q6H PRN (if applicable)
	Ostomy rod insitu (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	Electrolytes balanced
Functional Mobility	HOB elevated 30 degree when in bed
	Ankle exercises 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
	SCD applied
Teaching & Discharge Planning	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient received teaching re: self administration of VTE prophylaxis
	Patient received ostomy teaching by WOCN
	Patient received colostomy diet handout

	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Review & reinforce Pain management pamphlet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient has arranged for support person at home for 72 hours post discharge
	Determine discharge destination.

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POST-OP DAY 2	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Urine output more than 60mL/2 consecutive hours or 360 mL/12 hours
	Catheter secured and pericare/catheter care completed Q shift
	Flatus passed
	Confirm date of last BM
	Abdomen soft, non-tender, not distended or bloated
Nutrition & Hydration	Full fluid (FF) to Post-surgical Transition Diet (PSTD) to DAT as tolerated
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Saline lock IV when drinking well $\geq$ 600 mL/12 hr
	If CVC in situ, when drinking well remove and insert an saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcers)
	Dressings dry and intact (Do not change dressing until POD # 3, unless directed.) Otherwise outline drainage with a pen and reinforce as needed.
	Monitor tube/drain output q6h
	Absence of sanginuous/bilious drainage in HMV (if applicable)
	Strip HMV Q6H PRN (if applicable)
	Discontinue drain if less than_____mL/24 hours.
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degree when in bed, unless contraindicated
	Ankle exercises 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
	SCD applied
Teaching & Discharge Planning	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient received teaching re: self administration of VTE prophylaxis
	Patient received ostomy teaching by WOCN
	Patient received colostomy diet handout
	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Review & reinforce Pain management pamphlet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient has arranged for support person at home for 72 hours post discharge
	Determine discharge destination

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POST-OP DAY 3	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Foley Catheter removed for **rectal surgery patient**
	Output more than 360 mL/12 hours
	Pericare completed Q shift
	Flatus passed
	Confirm date of last BM
	Abdomen soft, non-tender, not distended or bloated
	No evidence of urinary tract infection
Nutrition & Hydration	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Full fluid (FF) to Post-surgical Transition Diet (PSTD) to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcer)
	Incision approximated, edges approximated (no signs of infection)
	Dressing changed
	Monitor tube/drain output q6h
	Absence of sanginuous/bilious drainage in HMV (if applicable)
	Strip HMV Q6H PRN (if applicable)
	Discontinue drain if less than__mL/24 hours.
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Diagnostics	Electrolytes balanced
Functional Mobility	HOB elevated 30 degree when in bed
	Ankle exercises every hour when in bed
	Independent with ADLs
	Ambulate 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
	ICOUGH protocol followed
	SCD applied
Teaching & Discharge Planning	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient self administering dalteparin
	Patient able to assist with ostomy care and management
	Review & reinforce Pain management pamphlet
	Patient has home prepared & equipment in place for discharge
	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Patient has appropriate home support as needed
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Determine discharge destination

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POST-OP DAY 4	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Output more than 360 mL/12 hours
	Flatus passed
	Confirm date of last BM
	Abdomen soft, non-tender, not distended or bloated
	No evidence of urinary tract infection
	Pericare completed Q shift
Nutrition & Hydration	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Full fluid to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Remove saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcer)
	Incision approximated (no signs of infection)
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degree when in bed, unless contraindicated
	Ankle exercises every hour when in bed
	ICOUGH protocol followed
	Independent with ADLs
	Up in chair for meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently
	SCD applied
Teaching & Discharge Planning	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient self administering dalteparin
	Patient independent with ostomy care and management
	Patient has home prepared & equipment in place for discharge
	Patient has appropriate home support as needed
	Determine discharge destination.

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POST-OP DAY 5	**DATE:**
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Output more than 360 mL/12 hours
	Flatus passed
	Confirm date of last BM.
	Abdomen soft, non-tender, not distended or bloated
	No evidence of urinary tract infection
	Pericare completed Q shift
Nutrition & Hydration	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Full fluid to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Remove saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcer)
	Incision approximated (no signs of infection)
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degree when in bed, unless contraindicated
	Ankle exercises every hour when in bed
	ICOUGH protocol followed
	Independent with ADLs
	Up in chair for meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently
	SCD applied
Teaching & Discharge Planning	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient self administering dalteparin
	Patient independent with ostomy care and management
	Patient has home prepared & equipment in place for discharge
	Patient has appropriate home support as needed
	Determine discharge destination.

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POST-OP DAY 6	**DATE:**
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Output more than 360 mL/12 hours
	Flatus passed
	Confirm date of last BM.
	Abdomen soft, non-tender, not distended or bloated
	No evidence of urinary tract infection
	Pericare completed Q shift
Nutrition & Hydration	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Full fluid to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Remove saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcer)
	Incision approximated (no signs of infection)
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degree when in bed, unless contraindicated
	Ankle exercises every hour when in bed
	ICOUGH protocol followed
	Independent with ADLs
	Up in chair for meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently
	SCD applied
Teaching & Discharge Planning	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Patient is aware of daily goals on ERAS Teaching Booklet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient self administering dalteparin
	Patient independent with ostomy care and management
	Patient has home prepared & equipment in place for discharge
	Patient has appropriate home support as needed
	Determine discharge destination.

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POST-OP DAY _____	
CATEGORY	**EXPECTED OUTCOMES**
Safety	Bedside Safety Check
Fall Risk/Care Plan	Fall Risk Assessment completed
Cognition	Alert and orientated x 3 (person, place, date)
Assessment	Vital Signs as ordered (Notify Treating Physician for new fever >38.5 C)
	Head to toe assessment completed
	Anxiety level acceptable to patient
Pain Management	Pain level acceptable to patient
	Pruritis controlled
	Epidural site satisfactory (if applicable)
Bowel/Bladder	Output more than 360 mL/12 hours
	Flatus passed
	Confirm date of last BM
	Abdomen soft, non-tender, not distended or bloated
	No evidence of urinary tract infection
	Pericare completed Q shift
Nutrition & Hydration	Oral intake recorded in 24 Hour Fluid Balance Sheet
	Full fluid to DAT
	Boost 1.5 Tetra 240 mL BID
	Gum chewing (15 minutes TID)
	Nausea controlled
	Absence of vomiting
	Remove saline lock
Skin, Dressings, Drains	Skin integrity intact (no evidence of pressure ulcer)
	Incision approximated (no signs of infection)
	Ostomy rod in situ (if applicable)
	Ostomy bud is pink, warm, moist and raised (if applicable)
Functional Mobility	HOB elevated 30 degree when in bed, unless contraindicated
	Ankle exercises every hour when in bed
	ICOUGH protocol followed
	Independent with ADLs
	Up in chair for meals independently
	Walked in hallway x 2 independently
	Up to bathroom independently
	SCD applied
Teaching & Discharge Planning	Patient reviewed ERAS teaching booklet and filling out ERAS patient checklist
	Patient is aware of daily goals ERAS Teaching Booklet
	Patient is aware of discharge criteria
	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
	• Capable to self manage ostomy (if applicable)
	Patient self administering dalteparin
	Patient independent with ostomy care and management
	Patient has home prepared & equipment in place for discharge
	Patient has appropriate home support as needed
	Determine discharge destination.