iERAS Pathway

Best Practice in General Surgery

Clinic

Physician

- Complete preadmission package including consent and pre-op orders
- Introduction of ERAS program

Clinic Nurse / Admin. Assistant*

- “My Surgery" binder
- PEP
- ERAS booklet
- Letter about the program
- LEARNS program implementation
- "Going Home After Surgery" guide
- Patient Education Prescription
- Flagging ERAS patients (assign in the ERAS binder, ERAS stickers in the chart, Care Map, e-form)

Clinical Research Coordinator / Nurse Champion

- ERAS consent form

ET Nurse

- Ostomy teaching

*Administrative support from volunteers

Preadmission Clinic

Nurse

- Patient education
  - Stop solid food at midnight
  - Stop clear fluids 2h before surgery
  - Clear fluids day before surgery with bowel preparation
  - Pain management
  - Activities
  - Gum
  - Nutrition
  - Confirm preoperative pain management order set with anaesthesia
  - Initiate preadmission alert if necessary

Anesthesiologist

- Finalise preoperative pain management order set
- Celecoxib will be only prescribed after discussion with surgery
- Celecoxib will be infrequently ordered at our sites given the concern over anastomotic break-down and patient renal dysfunction

Nurse Champion

- Confirm that the ERAS patient is on the OR list
- Communicate via email day before surgery to anaesthesia team and nursing leadership

POCU

Nurse

- Identify patient on the OR list as the ERAS patient
- Gabapentin 300mg PO 1 h pre-op (If not pre-ordered, anaesthesia to be paged)
- Celecoxib 200-400mg PO 1h pre-op (If not pre-ordered, anaesthesia to be paged)
- DVT prophylaxis
- Antibiotics prophylaxis

Operating Room

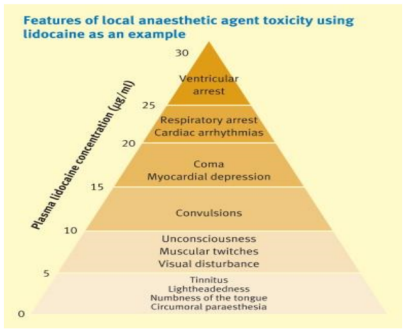
Anaesthesia

- **Restrict fluid** to 1-2 ml/kg/hr in the OR giving fluid boluses in responsive to hemodynamic or a reduction in urine output (i.e. < 0.5 ml/kg/h), using balanced salt solutions in preference to N/Saline.
- **Cardiac output** monitor to optimise intraoperative fluid therapy, for example esophageal Doppler, flotrac etc.
- **IV Lidocaine bolus** 1.5 mg/kg (pre-incision) + infusion 1-2 mg/kg/hr until PACU. *Severe liver disease*, administer bolus dose + infuse 0.5-1 mg/kg/hr.
- **PAIN-Laparoscopic**: Postop IV PCA + acetaminophen 1000 mg 6hrly for 3-4 days +/- consider Celecoxib 200 mg bd for 7 days if no medical contraindication. Consider thoracic epidural or other regional, for example intrathecal LA/opioid.
- **PAIN-Open:** Consider Thoracic (T6-9) Epidural with LA/opioid 48-72 hrs followed by oral opioid + acetaminophen 1000 mg 6hrly for 4 days. If epidural contraindicated, please use intraop IV lidocaine bolus + infusion followed by post op PCA

PACU

Nurse

- ERAS patients will commonly have an epidural or PCA ordered, APS to follow
- Intraop Lidocaine infusion will be run until end of case to optimize patient analgesia.The infusion regime is low dose and unlikely to cause adverse events within PACU. However, side effects to be aware off are allergic reaction, local anaesthesia toxicity, which is dependent on the plasma concentration, see fig below



Inpatient Unit

Clerical Team*

- Flagging patients on the white board, *Volunteer* forms

Medical team

- Implementation of ERAS guidelines, bullet rounds report, initiated discharge process

Nurses*

- *ERAS Care Map* + *Standard Ostomy Pathway* implementation, PEP, data collection daily/on discharge "*My Activity Log*", communication to interprofessional team (APS, PT, OT, ET)

Physiotherapist / OT*

- Mobility / Activity

Nurse Navigator / CCAC

- Provide patient with discharge information and arrangement of home care

Clinical Research Coordinator / Nurse Champion*

- Implementation of the ERAS protocols, data collection

*Administrative support from volunteers

Post Discharge

Nurse Navigator

- Post discharge follow up
- Readmission data collection

Clinical Research Coordinator

- 30 days post discharge follow up