 

ERAS Colorectal Surgery, Adult – Inpatient Post-Op Order Set

|  |  |
| --- | --- |
| McAlister | |
| Dorel | |
| PHN 123456789 | MRN |
| Birthdate *(01 / 02/ 1939* | Physician James |

Select orders by placing a () in the associated box

For more information, see Clinical Knowledge Topic ***ERAS Colorectal Surgery, Adult – Inpatient***

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| **Admit, Transfer, Discharge** | | |
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| **Patient Care** | | |
| *Discuss Goals of Care with patient / Alternate Decision-Maker and update Goals of Care Designation, if applicable (#103547).*   * Sequential compression device (SCD): discontinue when ambulating well | | |
| **Monitoring** | | |
| * Vital Signs: assess as per local institutional practices * Opioid Monitoring: monitor as per local institutional practices * Pain Score and Nausea Score: assess at least every 4 hours x 3 days **and then** every 8 hours * Blood Glucose Monitoring Point of Care Testing (POCT): QID * Other Monitoring: | | |
| **Activity** | | |
| * Activity as tolerated   + POD 0: stand at bedside, up in chair, walk to doorway and back; activity goal is 2 hours   + POD 1: up in chair each meal, ambulate at least 3 times daily; activity goal is 4 hours   + POD 2 until discharge: up in chair each meal, ambulate at least 3 times daily; activity goal is 6 hours * Notify physiotherapist if pre-operative mobility concerns or if patient requires more than one-person assist | | |
| **Intake and Output** | | |
| * Intake and Output: assess every 8 hours x 4 days, include strict oral intake   *Choose ONE:*   * Indwelling Urinary Catheter: remove on POD 1 in AM   √ Indwelling Urinary Catheter: remove on POD 2 in AM for low anterior resection and abdominoperineal resection   * In and Out Urinary Catheter: insert PRN for urinary retention once indwelling urinary catheter removed * Indwelling Urinary Catheter: insert if in and out urinary catheter is required twice. Notify most responsible health practitioner * Weight: assess daily x 3 days, start on POD 1 * Active Suction Drain(s): reprime every 8 hours and PRN, record output * Other Intake and Output: | | |
| **Diet/Nutrition** | | |
| * Clinical Communication: offer patient oral fluids; intake goal 500 mL on POD 0 * Post-Surgical Transition Diet: start on POD 0 * Regular Diet: start on POD 2 * Regular Diabetic – Adult Diet: start on POD 2 * Low Fiber Diet: start on POD 2 * Low Fiber Diabetic – Adult Diet: start on POD 2 * Other Diet/Nutrition: | | |
| Prescriber Signature *TJames MD* | Date*2 days ago* | Time *1320* |



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| **Diet/Nutrition, continued** | | |
| **Protein/ Calorie Dense Oral Nutritional Supplements**  *Appropriate when patient is on any type of oral diet including Gluten-free and Diabetic - Adult. Suitable for lactose intolerance but NOT appropriate for dairy allergy. Achieve a supplement intake of 300 kcal/day on POD 0 and 600 kcal/ day on POD 1 until discharge.*   * Ensure Protein Max: 90 mL PO 3 times daily, start on POD 0 **and then** 90 mL PO 5 times daily, start on POD 1 until discharge | | |
| **Wound Care** | | |
| * Surgical Incisions: assess every 8 hours and PRN   Wound Dressing Instructions: *change dressing post op day 3*   * Active Surgical Drain(s) Care: assess and change dressing daily and PRN | | |
| **Respiratory Care** | | |
| * Incentive Spirometry: perform every 1 hour while awake * Oxygen Therapy: titrate to saturation, maintain SpO2 greater than 92% * Head of Bed: elevate to at least 30 degrees while patient on opioids or epidural * Other Respiratory Care: | | |
| **Laboratory Investigations** | | |
| √Complete Blood Count (CBC) with differential on POD 1 in AM and POD 3 in AM  *If patient is receiving VTE prophylaxis choose repeat CBC with differential:*  √ Complete Blood Count (CBC) with differential, start on POD 1 in AM and repeat every 3 days x 5 times  √ Creatinine on POD 1 in AM and POD 3 in AM  √Electrolytes (Na, K, Cl, CO2) on POD 1 in AM and POD 3 in AM   * Magnesium (Mg) on POD 1 in AM and POD 3 in AM | | |
| **Intravenous Therapy** | | |
| * sodium chloride 0.9% lock when patient tolerating oral fluid intake * lactated Ringer’s infusion IV at 60 mL / hour if patient **not** tolerating oral fluid intake, lock when patient tolerating oral fluid intake * potassium chloride 20 mmol in dextrose 5% (D5W) – sodium chloride 0.45% infusion IV at 60 mL/hour if patient **not** tolerating oral fluid intake, lock when patient tolerating oral fluid intake * Other Intravenous Therapy: | | |
| **Medications** | | |
| **VTE Prophylaxis**  *Refer to AHS Provincial Clinical Knowledge Topic: VTE Prophylaxis, Adult – Inpatient. Refer to AHS VTE Weight-Band Table if patient has reduced renal function or is less than 40 kg or greater than 100 kg.*  *If patient is at increased risk of VTE (refer to AHS Venous Thromboembolism Prophylaxis Guideline) consider extended prophylaxis (up to 4 weeks post-discharge) with low molecular weight heparin (LMWH).*  *Choose ONE:*  √ tinzaparin 4500 units SUBCUTANEOUSLY once daily at 0900hours *(hh mm)*, start on POD zero until discharge   * tinzaparin 4500 units SUBCUTANEOUSLY once daily at hours *(hh mm)*, start on POD and extend therapy for 28 days   + Teach LMWH self-injection in preparation for discharge if patient on extended tinzaparin therapy * Other VTE Prophylaxis: | | |
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| **Medications, continued** | | |
| **Antiulcer Agents and Acid Suppressants**   * pantoprazole EC tab 40 mg PO daily before breakfast until discharge * raNITIdine 150 mg PO BID until discharge | | |
| **Bowel Stimulation**   * Chew gum 3 times daily (minimum 30 minutes each time), as tolerated   *Choose ONE:*  √ magnesium gluconate 1000 mg PO BID, start on POD 1 and discontinue after first bowel movement   * magnesium hydroxide 30 mL PO BID, start on POD 1 and discontinue after first bowel movement * Other Bowel Stimulation: | | |
| **Analgesics**  *Consider non-opioid analgesia or appropriate opioid-sparing multimodal analgesia. If needed, short acting opioids are recommended. Long acting opioids should be avoided.*  √Follow Anesthesia/Acute Pain Service orders for continuous regional epidural, nerve block therapy and/or patient controlled analgesia (PCA)   * Follow Surgery orders for patient controlled analgesia (PCA)   **Prophylaxis Analgesics**  *Consider dose reduction if patient is elderly.*   * acetaminophen 975 mg PO every 6 hours X 5 days. Maximum of 4000 mg acetaminophen in 24 hours from all sources   *Use caution if patient has renal impairment, is at high risk of acute kidney injury, or increased risk of anastomotic leak especially when low rectal anastomosis is anticipated.*  *Choose ONE:*   * ibuprofen 400 mg PO every 6 hours x 3 days.   *If eGFR is greater than 30 mL/minute and patient has no epidural choose celecoxib:*   * celecoxib 200 mg PO BID for 3 days   √ ketorolac 10 mg IV every 8 hours x 48 hours  *If patient had open surgery without an epidural, long acting opioids may assist with pain control. Consider using only short acting opioids or the lowest possible dose of long acting opioid if patient is elderly or opiate-naïve.*   * Other Prophylaxis Analgesics:   **PRN Oral Opioids** *(for pain not controlled by non-opioid analgesia) Consider dose reduction if patient is elderly or opiate-naïve.*   * oxyCODONE 5 mg PO every 4 hours PRN for pain not controlled by non-opioid analgesia | | |
| Prescriber Signature *T James* | Date *today* | Time 1310 |



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| **Medications, continued** | | |
| **PRN Parenteral Opioids** *(for pain not controlled by oral opioids, or oral analgesia is contraindicated) Consider dose reduction if patient is elderly or opiate-naïve.*  *Choose ONE:*   * morphine 2.5 to 5 mg IV/ SUBCUTANEOUSLY every 4 hours PRN for pain not controlled by oral opioids * HYDROmorphone 0.5 to 1 mg IV/ SUBCUTANEOUSLY every 4 hours PRN for pain not controlled by oral opioids * √Other Analgesics: See anesthesia pain management for epidural | | |
| **Antiemetics Prophylaxis Antiemetics**  *Consider dose reduction if patient is elderly or has reduced renal function.*  *Choose BOTH:*   * ondansetron 8 mg PO/ NG *(or ODT if difficulty swallowing or active vomiting with no IV access)*   every 8 hours x 48 hours **and then** ondansetron 4 mg PO/ NG every 8 hours PRN  √ ondansetron 4 mg IV every 8 hours x 48 hours **and then** ondansetron 4 mg IV every 8 hours PRN if oral dose is **not** tolerated  **PRN Antiemetics**  *Consider dose reduction if patient is elderly or has reduced renal function.*   * metoclopramide 10 mg PO/ NG/IV/ IM every 6 hours PRN * dimenhyDRINATE 25 to 50 mg PO/ IV/ IM every 4 hours PRN * Other Antiemetics: | | |
| **Glycemic Management Medications**  *Refer to AHS Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient Clinical Knowledge Topic.* | | |
| **Patient Teaching** | | |
| * Teach: ostomy self-management * Other Patient Teaching: | | |
| **Consults and Referrals** | | |
| * Nurse Specialized in Wound, Ostomy and Continence (NSWOC)   √ Physiotherapy   * Registered Dietitian * Social Work * Transition Services * Other Consults and Referrals: | | |
| **Other Orders** | | |
|  | | |
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