Fast-track or enhanced recovery after surgery (ERAS) pathways are evidence-based perioperative guides that promote stress reduction and earlier return to function following surgery. They emphasize preoperative counseling, nutrition optimization, analgesia standardization, fluid and electrolyte balance, minimally invasive approaches, and early ambulation. Although ERAS pathways were implemented in 2016 on a 43-bed postoperative colorectal medical–surgical unit, inpatient stays remained beyond the projected two-day length of stay (LOS). A quality improvement team was formed and an eight-week pilot project was initiated in 2018. The project included the implementation of a laminated bedside goals-to-discharge checklist in the immediate postoperative period.

AT A GLANCE

- ERAS pathways are evidence-based guides and need to include a component of patient participation for self-management.
- Checklists are valuable tools that can ensure a structured approach to patient education and early discharge with or without an electronic health record.
- Quality improvement projects can be developed, evaluated, and adopted to optimize patient participation and organizational metrics.

KEYWORDS
colorectal cancer; length of stay; discharge; quality improvement; surgery

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Goals-to-Discharge Patient Checklist

Implementing a program to optimize recovery after surgery for patients with colorectal cancer

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Fast-track or enhanced recovery after surgery (ERAS) pathways are evidence-based, multimodal perioperative guides that focus on stress reduction and an earlier return to function following surgery (Patel et al., 2014). First introduced in 1997 by Henrik Kehlet, the ERAS approach was generated to improve surgical outcomes by decreasing length of stay (LOS) and complications, leading to early recovery and reduction of economic burdens (Kehlet, 1997; Taurchini et al., 2018). The pathways emphasize preoperative counseling, nutrition optimization, analgesia standardization, fluid and electrolyte balance, minimally invasive approaches, and early ambulation (Ljungqvist et al., 2017).

Within Memorial Sloan Kettering Cancer Center in New York, New York, the ERAS pathways for patients with colorectal cancer include the minimally invasive colon resection pathway (two-day LOS) and the open colon resection pathway (four-day LOS). Patients choosing the two-day pathway undergo minimally invasive surgery (MIS), such as a laparoscopic or robotic procedure, which may require creation of an ostomy. The four-day pathway includes patients who undergo an open procedure involving a large incision made by a scalpel; these patients may also require formation of an ostomy. However, simply establishing ERAS pathways may not be adequate to achieve sustainable improvement in the overall quality of patient care, including the discharge process (Taurchini et al., 2018).

Although ERAS pathways had been implemented since 2016 on the 43-bed postoperative colorectal medical–surgical unit, inpatient stays often exceeded the projected LOS. Delays in discharge translated into delayed access to care for patients awaiting admission. Because of inadequate patient preparation, delayed discharges led to inadequate numbers of inpatient beds and surgery cancellations. Unit discharge delays also resulted in adverse hospital bed turnover times and excessive LOS. A frontline oncology nurse practitioner proposed that patients might benefit from a step-by-step guide of milestones needed for individualized discharge planning. Early implementation of a goals-to-discharge checklist was envisioned to foster patient engagement, optimize time of discharge, and reduce LOS.

Goals-to-Discharge Checklist

A goals-to-discharge checklist was developed after reviewing the literature regarding discharge criteria following colorectal surgery and the value of checklists. Clinical face validity was granted by the colorectal service surgical chief and colorectal surgery team before initiating a pilot project to assess the value of a checklist and discharge metrics for designated ERAS patients. The initial checklist was a laminated 12-by-18–inch poster placed at the patient's bedside (see Figure 1). Patients were instructed to note real-time progress on each discharge milestone with magnetic dry erase markers. Occasionally, family caregivers, nurses, and/or the surgical team offered input.