LONDON CANCER ALLIANCE

Colorectal Enhanced Recovery Checklist

July 2015 V2.0

Contents

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1 Introduction

Enhanced recovery is a tried and tested approach with elective surgery that enables a reduction in the length of stay by ensuring that patients are in the optimal condition for treatment, have different care during their operation, and experience optimal pre- and post-operative rehabilitation. Because of these benefits, enhanced recovery was also a key recommendation in the Model of Care in 2010, which states that enhanced recovery after surgery programmes should be adopted by all surgical and anaesthetic teams treating patients with colorectal cancer.

2 Colorectal Enhanced Recovery Checklist

In response to the Model of Care recommendation, the LCA Colorectal Pathway Group developed a standardised colorectal enhanced recovery checklist. In developing the checklist there was LCA-wide consultation with colorectal clinical, nursing and managerial stakeholders, both at the 4 March 2015 LCA enhanced recovery workshop and 14 July colorectal clinical forum.

2.1 Implementation

In 2013 an LCA baseline audit of colorectal services reported that all Trusts had an enhanced recovery pathway in place; however there was variation against the tasks within the pathway which impact on clinical outcomes and patient experience.

Implementation of the standardised colorectal enhanced recovery checklist (Appendix 1) will require an integrated rehabilitation approach as well as the professional belief of nurses in the clinical management process offered by enhanced recovery. Our aim in its implementation is to address variation and ultimately improve patient outcomes and experience.

2.2 Trust audit against the colorectal enhanced recovery checklist

Audit against the colorectal enhanced recovery pathway will provide compliance evidence for the intended standards, processes and outcomes within the enhanced recovery pathway, as well as where service improvements may be required. Trusts should therefore set up an annual audit plan which includes the audit items listed in segments 1 though to 6 in Appendix 2. Trusts may increase the audit frequency of individual segments depending on the service improvements being undertaken.

2.1 Compliance and performance measure

There is collective agreement for all Trusts to achieve these standards within the 2015/16 financial year and performance will be measured using national data where available, audit data and the colorectal accreditation scheme once this is formally in place. The colorectal enhanced recovery checklist will also form part of the LCA Colorectal Cancer Clinical Guidelines and their compliance.

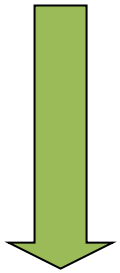
Trusts should put in place a work programme to ensure compliance against the colorectal enhanced recovery checklist and the audit requirements listed in Appendix 2.

Appendix 1 Colorectal Enhanced Recovery Checklist

PRIMARY CARE

The primary care elements are outside of LCA control, but are included for information

Who/When	What	How
GP (In primary care)	Ensure patient fitness for referral by optimising health prior to admission.	Encourage weight loss (or weight gain) as appropriate; provide appropriate dietetic advice; manage hypertension; correct anaemia; manage diabetes; smoking cessation; stabilise asthma/COPD.



SECONDARY CARE

1. Nurse Led Pre-assessment

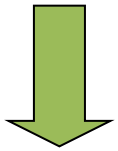
Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
CNS (in pre-assessment clinic)	Assess patient fitness for surgery and provide appropriate patient information	a. Pre-operative assessment tests as appropriate (e.g. cardio, pulmonary, bloods, including group and save)		
		b. Management of co-morbidities: e.g. hypertension, asthma, COPD, diabetes		
		c. Information exchange about consent process		
		d. Access to smoking cessation		
		e. Access to anaesthetics at pre-assessment		
		f. Access to nutritional assessment and dietetics advice as required		
		g. Discuss surgical procedure and enhanced recovery pathway and expected discharge date. Aim for 4 days after colonic resection and 6 days after rectal resection		
		h. Provide appropriate patient information including who will take care of the follow-up arrangements, e.g. enhanced recovery protocol, information on surgery, coming to hospital		
		i. Plan discharge (with all relevant clinicians and AHPs)		
		j. Discuss likely time-frames for return to living activities and work		
		k. Carbohydrate pre-loading		
		l. Discuss plan for family support post discharge		
		m. Pre-op stoma therapy tuition if necessary		

2. Surgical Admissions (on day of operation)

Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
Surgical admissions (on day of operation)	a. Involve patient in care pathway b. Continue health optimisation c. Prepare for discharge	a. Discharge date		
		b. Reduce starvation (6 hours fasting for solids and fat containing liquids only)		
		c. Continue clear oral fluids until 2 hours prior to surgery, provided gastric emptying normal		
		d. Carbohydrate loading (as appropriate)		
		e. Manage diabetes/co-morbidities		
		f. No routine oral bowel prep is recommended as per national guidance, (unless Trust audited evidence proves otherwise) except patients having rectal surgery with a defunctioning stoma		
		g. Pre-operative tests		
		h. DVT prophylaxis/compression stockings		
		i. Ensure second group and save is completed		

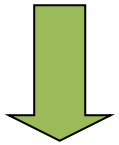
3. Anaesthetic and Surgical Team

Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
Anaesthetic and surgical team (during surgery)	1. Optimise fluid balance and cardiac function 2. Manage pain control 3. Minimise post-op nausea and vomiting 4. Minimise infection risk 5. Maintain optimum room temperature	a. Active monitoring of IV fluid intake and euvolaemic fluid replacement(ensuring sodium load does not exceed 1mmol/kg/day^{-1})		
		b. Regional, spinal, local block analgesia (where appropriate)		
		c. Minimally invasive surgery		
		d. Prophylactic anti-emetics and antibiotics		
		e. Intra-operative temperature control to avoid hypothermia		
		f. Avoid drains if possible		
		g. Remove nasogastric tube at the end of the operation		



4. Ward Staff Post Op

Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
Ward staff (post-operative)	1. Involve patient in care plan 2. Minimise starvation 3. Minimise disability 4. Manage pain pro-actively 5. Prepare meds to take home before estimated discharge date	a. Patient care plan +/- diary		Physiotherapy and exercise guidance
		b. Confirm estimated discharge date		
		c. Oral fluid and nutrition on day 0 (as tolerated)		
		d. Stop intravenous fluids as early as possible and within 2 days		
		e. Planned early mobilisation day 0 with walking goals		
		f. If epidural in situ aim to remove within 48 - 72 hours		
		g. Aim to remove urinary catheter within 48 hours except rectal surgery which is 72 hours		
		h. Avoid systemic opiates where possible and discontinue early when possible		
		i. Regular multi–model analgesia including paracetamol		
		j. Oxygen supplementation for 6-12 hours only. Remove as soon as saturation is normal for the patient		



5. Ward Staff and Consultant Prep for Discharge

Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
Ward staff and consultant (prep for discharge)	1. Appropriate communication with primary care and community team 2. Criteria based discharge	a. Confirm -support needed post discharge e.g. stoma care, OT, physiotherapy, district nurse, practice nurse and GP		
		b. Confirm expected discharge date		
		c. Consider nurse-led discharge (if appropriate protocols in place)		
		d. Written patient discharge information includes warning signs/symptoms to report, follow-up arrangements and and DVT prophylaxis (28 days from surgery). Exercise and diet information		
		e. Discharge medications (ready 24 hours prior to discharge)		
	3.	f. Ensure 24 hour telephone helpline available for first 14 days after discharge		
	4.	g. Ensure that the discharge criteria are met		
	5.	h. Start recovery package		

6. CNS and Consultant Follow Up

Who/When	What	How	Currently in place? Yes or no?	GENERAL COMMENTS
CNS or consultant follow-up	1. Telephone follow-up or open access 2. Care plan includes information on likely time to return to activity for daily living/work	a. Stratified follow up. Use checklist with prompts to visits/reviews if needed		http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/risk-stratification/
		b. Have telephone patient access and telephone follow up at earliest opportunity		
		c. Patient reported outcome measures review		
		d. Patient experience review		

Appendix 2 Trust Audit Plan

	Enhanced Recovery Segment	Audit Items	Completed
1	Pre-assessment	• Access to appropriate clinics and specialists • Patient information • Discharge planning	
2	Pre-operative	• Minimise starvation • Carbohydrate loading • Bowel preparation • VTE prophylaxis	
3	Intra-operative	• Fluid monitoring • Drains and NG • Laparoscopic rate	
4	Post-operative	• Patient care plan • Discharge date planning • Mobilisation	
5	Discharge	• Necessary support available • Patient information • VTE prophylaxis	
6	Follow-up	• Telephone access • Patient reported outcome measures • Patient experience	

Published by the London Cancer Alliance

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