Prior to DOS
- Implement Strong for Surgery pre-hospital clinical interventions
- Clinic Staff Discuss Care Map with Patients & Set Expectations
- MRSA/ MSSA screen

If MRSA positive, Intranasal Mupirocin for 5 days prior
- Impact drink, 6 days prior (optional)
- Patient drinks 8 oz of apple juice b/f midnight, 1 day prior
- No food after midnight; Clear liquids as instructed

Day 0: Pre-Op
8oz of apple juice 2 hours b/f surgery
- Check Glucose: If > 100, recheck 30-60 min after incision. If > 140, start insulin GTT
- For patients needing Vancomycin, should be administered 60 min prior to operation
- For Bowel Resection ONLY (5% of cases): Minimum of 30 min prior: Alvimopan 12 mg po q12h until first B.M. or discharge*
- Portable SDCs in Pre-Op

Day 0: Intra-Op in OR
- Fluids: If IV in place, LR at 50 ml/hr
- Pain: 1000 mg Acetaminophen po (then po or IV q6h until discharge)
- Pain: Gabapentin 300 mg po (continue tid once tolerating pills again)
- Pain: Thoracic Epidural for ALL pathway patients: aimed at upper level of incision (tested with 3 ml 1.5% Lidocaine w/ Epi 1:200K)
- Blood Loss – Replace with colloid (5% Albumin) ml for ml
- For patients not receiving Vancomycin, initiate IV Abx in OR
- Glucose management

Day 0: PACU
- Fluid: LR at 1 ml/kg/hr
- Target urine output of 0.3-0.5 ml/kg/hr
- Pain: Changed to PCEA with 6 ml/hr infusion

Breakthrough Pain: Epidural Fentanyl (25-50 micrograms) (followed by 3 cc NS) and infusion increased, by 2ml/hr - followed by increased Bupivicaine concentration (1/10% then 1/8%) if BP okay. **

~ This pathway applies to all Ventral and Incisional Hernia Repairs where patients get admitted to the hospital, whether Open or Laparoscopic.
~ **Excluded patients:** Patients on daily pre-op opiates for >2 months; Abnormal LFTs; Abnormal coags; Abnormal Creatinine
* Unless chronic opioid user (on narcotics within 1 week of surgery)
** If BP low or marginal or pressors ongoing talk with surgeons about ketorolac (vs. bleeding vs. nephrotoxic risks vs. anastomotic risk). If BP unable to be controlled with low dose pressors or fluid bolus (500 cc) “split” epidural (take fentanyl out of epidural infusion and add IV opiate PCA) in preparation for, or as start of, stopping epidural.

UW Medicine
TRANSFORMATION OF CARE
### Target LOS = 3 to 4 days

<table>
<thead>
<tr>
<th>Day 0</th>
<th>Mobility: Edge of bed after last set of post-op VS (usually 6 hours) with orthostatic VS</th>
<th>Diet: Ice chips &amp; sips of clears</th>
<th>Incentive Spirometer 10x/hr while awake until discharge</th>
<th>Sequential Compression Device on, unless ambulating, until discharge</th>
<th>Heparin 5000 units SQ Q8h</th>
<th>Glucose Mgmt</th>
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</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>PT visit on Day 1, latest Mobility: OOB for all meals. Walk 3-4 times in the hall – Goal 9 laps. OOB 6hr/day</td>
<td>Diet: Advance diet as tolerated. General Diet, if patient has no nausea, no distention, no belching/hiccups</td>
<td>DC Foley (just pull)</td>
<td>Labs Days 1-4, as clinically indicated</td>
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<tr>
<td>Day 2</td>
<td>Mobility: OOB for all meals. Walk 3-4 times in the hall – Goal 18 laps. OOB 6hrs/day until discharge</td>
<td>Pain: Epidural stopped and oxycodone started after breakfast tolerated (epidural pulled 4 hours later).</td>
<td>JP Drain Teaching</td>
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<tr>
<td>Day 3, 4</td>
<td>Stool Softener docusate 100mg PO BID (NOT Senna)</td>
<td>DC Alvimopan (if bowel movement)</td>
<td>Med Rec on Day before Discharge</td>
<td>Pain: Gabapentin discontinued on Day 3.</td>
<td>Pain: Acetaminophen and ibuprofen continued at discharge.*</td>
<td></td>
</tr>
</tbody>
</table>

* Patients should be advised to stop Ibuprofen when oxycodone no longer needed more frequently than q6h.