

ERAS role cards

Who does what, in each phase. Print one per discipline and put it in the department folder.

SURGEON		
Before surgery	During surgery	After surgery
• Own the pathway clinically and defend it when it is inconvenient • Screen for anaemia, nutrition and glycaemia; act on every abnormal result • Do NOT order routine mechanical bowel prep; prescribe oral antibiotics where indicated • Take consent as a process, including what the ERAS pathway will ask of the patient	• Shortest adequate incision; gentle tissue handling; minimal bowel handling • Minimally invasive approach where available (standard of care, 2025) • No routine drain. If placed, write the indication AND the removal trigger • Infiltrate the wound with local anaesthetic before closure • State anticipated critical events at Time out	• Ward round using the six questions, every patient, every day • Remove tubes on schedule; do not let a tube outlive its purpose • Escalate failure to progress the SAME day — never blame ileus for a fever • Discharge on written criteria, not on the postoperative day number

ANAESTHETIST		
Before surgery	During surgery	After surgery
• Write fasting as 6 hours solids / 2 hours clear fluids, in those words • Prescribe carbohydrate loading; manage the diabetes exception explicitly • Score PONV risk (Apfel) and match the number of agents to the score • Score VTE risk and time prophylaxis around any neuraxial block • Avoid long-acting sedative premedication	• Short-acting agents; avoid unnecessarily deep anaesthesia; confirm full reversal • Regional technique wherever it fits — the biggest opioid-sparing lever • Goal-directed fluids to a slightly positive balance; balanced crystalloid • Normothermia $\geq 36^{\circ}\text{C}$ — measure at induction, mid-case and handover • Antibiotic within 60 minutes of incision	• State the FIVE-PART analgesia plan at Sign out and write it in the notes • Anticipate the block wearing off; have the next step written before it does • Review any patient needing repeated rescue doses • Support the ward in keeping the scheduled non-opioids scheduled

WARD NURSE		
Before surgery	During surgery	After surgery
• Confirm fasting times are correct and challenge them when they are not • Give the carbohydrate drink at the right time — this is the commonest orphaned task • Deliver the structured education session and use teach-back on three points • Issue the milestone card to the patient AND a family member	• (Theatre nurse) Run the checklist as a conversation; confirm antibiotic timing aloud • (Theatre nurse) Active warming in place; instruments ready to avoid delay • Prepare the ward to receive the patient with the plan already known	• Offer oral fluids day 0 and diet within 24 hours — treat nausea, do not stop food • Deliver and DOCUMENT ≥ 3 hours out of bed per day from POD 1 • Remove the catheter on schedule; stop the drip once they are drinking • Keep the scheduled non-opioid analgesia actually given, not written PRN • Complete the patient diary with them each day • Escalate failure to progress the same day — do not write 'refused'

MIDWIFE

Before surgery	During surgery	After surgery
• Deliver the whole ERAS pathway for caesarean delivery, antenatally and on admission • Antenatal education and expectation setting; anaemia screening and treatment • Fasting and carbohydrate loading for planned caesarean section	• Support the checklist; skin-to-skin contact as early as safely possible • Support intrathecal morphine / TAP block analgesia planning • Maintain maternal normothermia	• Early oral intake and early mobilisation after caesarean section • Early urinary catheter removal • Breastfeeding support integrated with the analgesia plan • Newborn care alongside maternal recovery milestones

PHYSIOTHERAPIST

Before surgery	During surgery	After surgery
• Prescribe prehabilitation IN WRITING with numbers — walking, sit-to-stand, breathing • Teach the breathing technique before surgery, not after • Baseline functional assessment	• (Usually no intraoperative role — use the time to prepare the ward plan)	• First mobilisation, safely, in the correct order • Train ward staff and family members to supervise mobilisation — this is how you scale with one physio • Assess discharge function against the patient's own baseline

DIETITIAN / NUTRITION FOCAL PERSON

Before surgery	During surgery	After surgery
• Screen with MUST or NRS-2002; identify malnutrition early • Prescribe high-protein oral supplements 5–7 days preoperatively • Sign off the local supplement recipe and write it into the unit protocol • Set the carbohydrate loading protocol, including the diabetes exception	• (No intraoperative role)	• Restart oral nutrition support once intake is established • Continue supplements after discharge in malnourished patients • Audit whether the supplements are actually being given

PHARMACIST

Before surgery	During surgery	After surgery
• Medicines reconciliation; stop what should be stopped • Check prophylactic antibiotic choice, dose and weight adjustment • Ensure essential ERAS drugs are on the hospital priority stock list	• Support correct antibiotic redosing in long cases	• Check the analgesia is written SCHEDULED, not PRN — the single commonest chart error • Check the opioid has a stated ceiling and a step-down plan • Check thromboprophylaxis duration, including extended prophylaxis • Flag stock-outs to the ERAS team BEFORE the pathway breaks

ERAS COORDINATOR

Before surgery	During surgery	After surgery
• Keep the protocol current and known; train every new starter • Own the elements that fall between people — write a NAME and a TIME against each	• Observe and report checklist utilisation and completeness	• Collect and report compliance data monthly, BY ELEMENT and BY WARD • Run the audit cycle and feed results back to the teams that generated them • Chair the ERAS meeting and the daily huddle • Notice when an element quietly stops happening — this is the whole job

HOSPITAL LEADERSHIP

Before surgery	During surgery	After surgery
• Issue a clear mandate: ERAS is hospital policy, not one enthusiast's project • Provide PROTECTED TIME for the coordinator and for training	• Ensure uninterrupted supply of analgesics, antiemetics, thromboprophylaxis, supplements	• Provide data systems that make audit possible without heroics • Support the pathway visibly when it is inconvenient — this is the real test • Include ERAS indicators in the hospital's own performance review

The tasks that fall between people are the ones that stop happening. Common orphans: the carbohydrate drink at 06:00 · the catheter that should have come out at 24 h · the paracetamol charted as required · the diary nobody filled in · the compliance data nobody extracted. For each element, write a NAME or a ROLE — never “the team” — and a TIME.