

Drains, tubes and catheters — decision card

If you cannot write the removal trigger, do not insert the tube.

Every tube is a tether. Tethered patients do not mobilise.

Device	Default in ERAS	Legitimate indication	Removal trigger — write this down
Prophylactic abdominal drain	NOT placed	A specific question requiring monitored output — not 'a difficult dissection' and not habit	Remove early . Prolonged drainage increases intra-abdominal infection rather than preventing it.
Nasogastric tube	NOT left in situ	Intraoperative decompression only, or established mechanical obstruction	Remove before leaving theatre or in recovery. Not 'when flatus passes'.
Urinary catheter	Placed for the operation, removed early	Operative requirement; accurate output monitoring in the unstable patient; epidural per local protocol	≤24 h after colonic MIS. ≤48 h after rectal MIS. Longer only with a documented reason.
Peripheral IV cannula	Removed once oral intake is adequate	IV drugs due, or inadequate oral intake	Remove once drinking freely and no IV drugs are due. The drip stand itself blocks mobilisation.
Feeding tube (NJ / jejunostomy)	NOT routine	Anticipated prolonged inability to meet needs orally — an upper GI or major HPB decision	Remove once oral intake meets requirements. Review the plan daily, not weekly.

Insertion record — complete BOTH columns or do not insert

Device	Indication (why this patient, today)	Removal trigger	Inserted by	Removed (date/time)

The three reasons drains actually get inserted — routinely after every anastomosis, 'just in case' after a difficult dissection, and because the consultant always places one — are not indications. Routine prophylactic drainage after colorectal resection does not reduce anastomotic leak, reintervention or mortality.