

Enhanced Recovery after Surgery

ERAS – Vom Detail zum Gesamtkonzept
Herbstsymposium Anästhesiepflege 2026

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Viszeralchirurgie USB/Clarunis
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Marathon

Eine Operation ist wie ein Marathon, aber die meisten Menschen starten untrainiert.





Was wäre, wenn Menschen sich auf eine Operation vorbereiten würden, so wie wir für einen Marathon trainieren

Marathonläufer

Vergleich zu Marathonbelastung

Marathonlauf verursacht ebenfalls vorübergehende Organ-Biomarker-Anstiege, Entzündung, hormonelle Veränderungen und akutes Überlastungsrisiko, die meist innerhalb einer Woche abklingen. **BRASCHLER2025** Abdominalchirurgie erzeugt jedoch eine gezielte Gewebetraumatisierung, breit angelegte Stoffwechselstörung und immunologische Aktivierung, die besonders bei unfitten oder älteren Patienten eine höhere Komplikationsgefahr bedeutet. **SEYMOUR2024ROXBURGH2022**

Fazit

Für den einzelnen Patienten ist eine große Bauchoperation ein tiefer Eingriff in Stoffwechsel, Hormonsystem und Entzündung, vergleichbar mit einer extremen sportlichen Belastung, aber mit gezieltem Gewebetrauma. Wie gut diese Belastung verkraftet wird, hängt stark von Ausgangsfitness, psychischem Stress, Prähabilitation und der Qualität von Anästhesie, Analgesie und Pflege ab. Moderne, multimodale Konzepte können die Stressreaktion deutlich reduzieren und die Erholung beschleunigen.

Von welchen Operationen sprechen wir?

- → Oft maligne Erkrankungen
- → Ältere, multimorbide Patienten

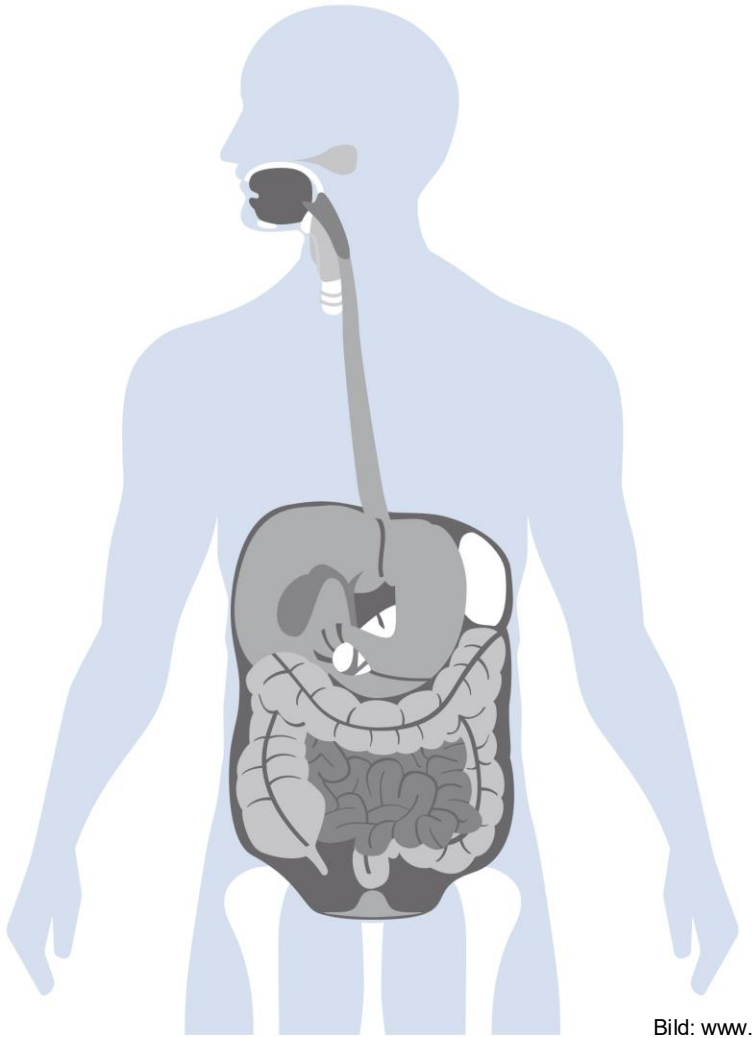


Bild: www.clarunis.ch

Was ist Enhanced Recovery after Surgery (ERAS®)



ERAS® ist ein multidisziplinäres, evidenzbasiertes Behandlungskonzept, das den Patienten **optimal** auf die Operation **vorbereitet**, den operativen **Stress reduziert** und dadurch eine rasche Erholung ermöglicht.

- Henrik Kehlet

Entwicklung von ERAS®

Geschichtlicher Hintergrund



- 1999: Henrik Kehlet: erste „Fast-track“ Konzepte in der kolorektalen Chirurgie

- 2001: ERAS® Study Group: Mission zur Entwicklung perioperativer Versorgung und Verbesserung evidenzbasierter Praktiken

- 2010: ERAS® Society: Gemeinnützige medizinische Gesellschaft als Schirmherrschaft und Garant zur Aufrechterhaltung Behandlungskonzept ERAS®
  - ➢ Wichtigster Endpunkt: Qualität der Erholung (nicht Geschwindigkeit)
  - ➢ Multidisziplinäres Team: multimodal, Evidenz-basiert, kontinuierliches Audit

- Plan: Paradigmenwechsel

➢ Eminenzbasierte Medizin	→	Evidenzbasierter Therapie
➢ Messung, Kontrolle, Regulation	→	Autonomie, Homöostaseerhalt, Autoregulation
➢ Patient: passives Behandlungsobjekt	→	Aktiver Partner im Genesungsprozess
➢ Individueller Heilversuch	→	Konsequent durchgeführter Behandlungsplan

Ziel des perioperativen multimodalen Managements

- Schmerzkontrolle
- Homöostase
- Ileus-Prävention
- Patientenkomfort
- Morbidität/Mortalität senken
- Schnellere Erholung
- Steigern Lebensqualität
- Besseres Überleben (DFS, OS)
- Kosten sparen

} Volumenmanagement

ERAS® Behandlungsaspekte und die wichtigsten Ziele



Erfolg:

1. Komplikationen Reduktion
2. LoS
3. Delay of Treatment
4. Quality of Life für Patienten
5. Kosten

Eigene Abbildung

Protokoll und Guidelines ERAS®

Perioperative Care in Elective Colorectal Surgery
Enhanced Recovery After Surgery ERAS® Society
Recommendations 2025



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Best in Surgery

Guidelines for perioperative care in elective colorectal surgery: Enhanced Recovery After Surgery (**ERAS**) Society recommendations 2025

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ARTICLE INFO

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Table IV
Comparison of the preoperative, intraoperative, and postoperative ERAS items between the 2018 and 2025 guidelines*

Item	Recommendation 2025	Change versus 2018
Preoperative		
1. Preadmission information	Information is strongly recommended for all patients before surgery, with moderate evidence supporting reduced anxiety but low evidence for improving quality of life or LOS	No changes
2. Preoperative optimization		
A. Identification of high-risk patients	Predictive tools are strongly recommended for identifying high-risk patients before colorectal surgery, despite very low evidence for reducing mortality and complications	Added details on specific tools
B. Management of comorbidities	Optimizing comorbidities before surgery is strongly recommended, despite low evidence for reducing mortality, complications, and length of stay	Added details on optimizing specific comorbidities
C. Alcohol cessation	Patients with high alcohol consumption are advised to stop drinking 4 weeks before surgery, though the recommendation is weak due to low evidence for reducing mortality, complications, and length of stay	Changed from strong to weak recommendation
D. Smoking cessation	Smokers should quit and undergo behavioral intervention with nicotine replacement at least 4 weeks before surgery to reduce mortality and complications, based on moderate evidence	No changes
E. Prehabilitation	No specific prehabilitation regimen can be recommended before surgery due to moderate to low evidence with conflicting results on functional capacity, complications, and length of stay	From weak recommendation to currently no recommendation for a specific regimen
F. Anemia treatment	Routine screening and correction of anemia before surgery is strongly recommended to improve long-term survival and decrease perioperative transfusions. Preoperative IV iron supplementation and high-dose erythropoietin (EPO) are weakly recommended for anemia correction	Use of EPO added in the current guidelines
3. Preoperative nutrition	Routine nutritional screening is strongly recommended for colorectal surgery patients, whereas nutritional supplementation and oral immunonutrition may be considered for malnourished patients, though evidence is that moderate and recommendations are weak	Immunonutrition added as recommendation in the current guidelines
4. PONV prophylaxis	PONV prophylaxis with medications such as aprepitant, ramosetron, granisetron, dexamethasone, and ondansetron is strongly recommended based on high-quality evidence	New optimal formulae in the current guidelines
5. Preanesthetic sedation/anxiolytics	Moderate quality of evidence showing no benefit	No change
6. Thromboprophylaxis	Patients should receive multimodal thromboembolism prevention, including mechanical and pharmacological measures. Intraoperative intermittent pneumatic compression (IPC) and extended prophylaxis for at-risk patients. Strong recommendation	Intraoperative IPC and more liberal timing of medication in the current guidelines
7. Mechanical bowel preparation (MBP)	MBP should not be used routinely in colonic surgery but may be considered in rectal surgery with diverting stomas. If MBP is used, adding oral antibiotics is recommended	Recommendation grade regarding avoidance of MBP alone have changed from strong to weak in the current guidelines
8. Fasting and carbohydrate load	Short preoperative fasting is strongly recommended in colorectal surgery to improve insulin sensitivity and reduce PONV. Preoperative carbohydrate loading may improve insulin sensitivity but offers no clinical advantages over standard short fasting protocols	Recommendation of preoperative carbohydrate loading changed from strong to weak
9. Antibiotics and skin preparation	IV antibiotics within 60 minutes before incision, repeat for prolonged surgery or blood loss. Oral antibiotics for MBP patients. Chlorhexidine-alcohol–based preparations for skin disinfection. Insufficient evidence for antiseptic showering or shaving	High-quality evidence in favor addition of oral antibiotic decontamination with MBP in the current guidelines
10. Preoperative fluids	Patients should be encouraged to stay well-hydrated with clear fluids up to 2 hours before surgery, and any fluid or electrolyte imbalances should be corrected, based on strong evidence	No changes
Intraoperative		
11. Anesthetic protocol	Use short-acting agents, cerebral monitoring, and antiadrenergic and anti-inflammatory strategies to minimize surgical stress and enhance recovery. Avoid hypotension, use protective ventilation, and ensure complete neuromuscular block reversal with TOF monitoring	No changes
12. Normothermia	Active body surface warming is strongly recommended during surgery as it reduces surgical site infections, decreases the need for blood transfusions, and improves patient satisfaction	The evidence levels for various warming methods have been incorporated into the current guidelines
13. Intraoperative fluids	A slightly positive fluid balance on the day of surgery is weakly recommended based on moderate-quality evidence	Shift from near-zero fluid balance to slightly positive fluid balance
14. Surgical approach	Minimally invasive surgery (MIS) should be routinely performed for CRC patients and combined with ERAS protocols to reduce length of stay. Strong recommendations based on high-quality evidence	Minimal invasive surgery: standard of care

Table IV (*continued*)

Item	Recommendation 2025	Change versus 2018
15. Abdominal drainage	Routine abdominal drainage is not recommended after colonic or rectal resection, with strong support for colonic resection and weaker support for rectal resection based on moderate to low-quality evidence	Weaker evidence for avoiding rectal drain in the current guidelines
Postoperative		
16. Nasogastric tube (NGT)	Prophylactic NGT may be used during colorectal surgery but is not recommended postoperatively	Quality of evidence changed from high to moderate
17. Normoglycemia	Intraoperative and postoperative hyper- and hypoglycemia should be avoided through glycemic control, with strict monitoring in patients with elevated preoperative HbA1c	Preoperative HbA1c and specified postoperative blood glucose levels have been included
18. Postoperative fluids	Maintain a slightly positive postoperative fluid balance with weight gain limited to 1–2.5 kg, using balanced crystalloid solutions. Varying evidence quality and strength of recommendation	Shift from near-zero fluid balance to slightly positive fluid balance
19. Urinary drainage	Urinary catheters should be removed within 24 hours after uncomplicated minimal-invasive colonic surgery, within 48 hours after uncomplicated minimal-invasive rectal surgery	Specified interventions included in the recommendations
20. Prevention of ileus	A multimodal approach should be undertaken to minimize the development of postoperative ileus	Extensive evaluation included, return of chewing gum as recommendation
21. Postoperative analgesia	A multimodal analgesia strategy, including acetaminophen, TAP blocks, NSAIDs for colonic surgery, and intrathecal morphine, should be used after both open and MIS colorectal surgery	Use alternative analgesic's (versus epidurals) also in open surgery
22. Postoperative nutritional care	Early gut feeding within 24 hours after surgery, resumption of oral intake, and the use of oral nutritional supplements are recommended to improve recovery	Detailed evidence evaluation included. Immunonutrition added as a recommendation
23. Mobilization	Early postoperative mobilization should begin on the day of surgery, with at least 3 hours of mobilization per day from POD 1 to discharge, supported by strong recommendations despite limited evidence	Detailed evidence evaluation included. From POD 1 to discharge: 3 hours/d

CRC, colorectal cancer; *ERAS*, Enhanced Recovery After Surgery; *HbA1c*, hemoglobin A1c; *IV*, intravenous; *LOS*, length of stay; *POD*, postoperative day; *PONV*, postoperative nausea and vomiting; *TOF*, train of 4.

* Some of the previous preadmission items have been reorganized into a preoperative optimization bundle. One of these items, prehabilitation, can no longer be recommended based on current evidence. Although immunonutrition has been incorporated into the current guidelines, no specific formula can be recommended. Several items have undergone content changes, as noted under the "Change" heading. For example, because of insufficient evidence on the optimal duration of mobilization, the recommended time for postsurgery mobilization has been reduced from 6 hours per day to 3 hours per day to comply with the protocol. Recommendations from the ERAS Society for standards for the development of enhanced recovery after surgery guidelines were fully followed for 21 of 23 ERAS items. The exceptions to the grading process were the anesthetic protocol and preoperative optimization of coexisting comorbidity (2A and 2B).

Smoking cessation before surgery. A total of 57 studies were identified through the literature search, with 18 considered robust enough to be included in the evidence grading. Behavioral interventions for smoking cessation, particularly when intensive and combined with nicotine replacement therapy, are effective in promoting smoking cessation and reducing morbidity and mortality.[25] Smoking cessation less than 4 weeks before surgery however showed no difference in complications.[26] However, RCTs on smoking cessation often suffer from insufficient statistical power and participant heterogeneity.

Quality of evidence and recommendations.

Recommendation: Cigarette smokers should stop smoking and undergo behavioral intervention, with nicotine replacement, at least 4 weeks before surgery.

Quality of Evidence: Smoking cessation before surgery.

Mortality: Moderate.

Complications: Moderate.

Recommendation grade: Strong.

Prehabilitation. Prehabilitation has gained prominence over the past decade, highlighting the need for an evidence-based approach to its implementation. However, inconsistent definitions across studies complicate evaluation. It may involve physical exercise alone or in combination with nutritional, psychological, or general optimization (multimodal) interventions. Many studies also include noncolorectal surgeries and often lack sufficient statistical power.

The literature search identified 253 prehabilitation studies, with 20 deemed robust for assessment.[27] Study designs varied: 15 focused on multimodal interventions and 5 on physical exercise. Two meta-analyses[28] found no significant impact on functional capacity, complications, or hospital LOS. One RCT[29] reported a 50% reduction in complications but no functional capacity improvement, whereas another[30] indicated better walking capacity at 4 and 8 weeks postoperatively.

Furthermore, 4 studies showed significantly improved physical capacity,[31–34] but others showed no benefit. Five studies reported reduced complications,[32,34–37] whereas 5 found none.[28,30,32,38,39] Only 2 of 6 studies on LOS[31,40] reported significant improvement.

Quality of evidence and recommendations.

Recommendation: No recommendation can be made for a specific prehabilitation regimen.

Quality of evidence: Prehabilitation before surgery.

Functional capacity: Moderate evidence demonstrating conflicting results.

Complications: Low evidence demonstrating conflicting results.

Length of stay: Low evidence demonstrating conflicting results.

Anemia treatment. Anemia affects 30%–67% of colorectal surgery patients and is linked to worse overall survival (hazard ratio: 1.56; 95% confidence interval [CI]: 1.30–1.88; $P < .001$) and disease-free survival. Although its role as a cause or marker of advanced disease remains unclear, its negative impact is evident. Transfusions further worsen tumor outcomes, underscoring the importance of preoperative anemia correction.[41] Evidence supporting iron correction includes RCTs, meta-analyses, and a population-based cohort study.

RCTs, meta-analyses, and a cohort study support iron correction. The IVICA trial[42] found intravenous (IV) iron more effective than

Guidelines ERAS Society Recommendations 2025

Items zur Compliance Behandlungskonzept ERAS®



Pflege

Anästhesie

Chirurgie

Universitätsspital Basel

Professionen zur Compliance Behandlungskonzept ERAS®



Pflege

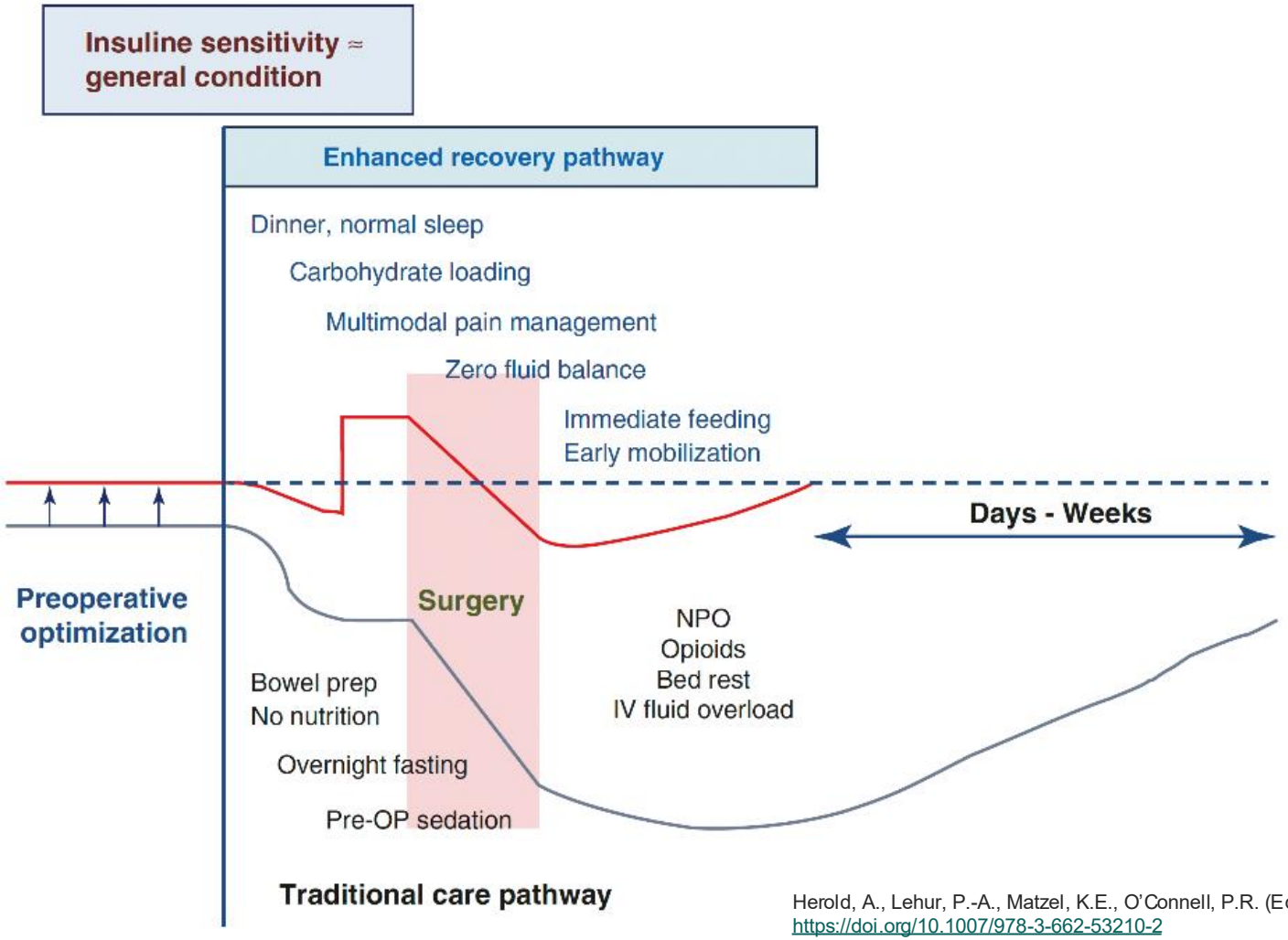
Anästhesie

Chirurgie

Spezialisten/innen
Pain Service
Stoma / ERB / DFS

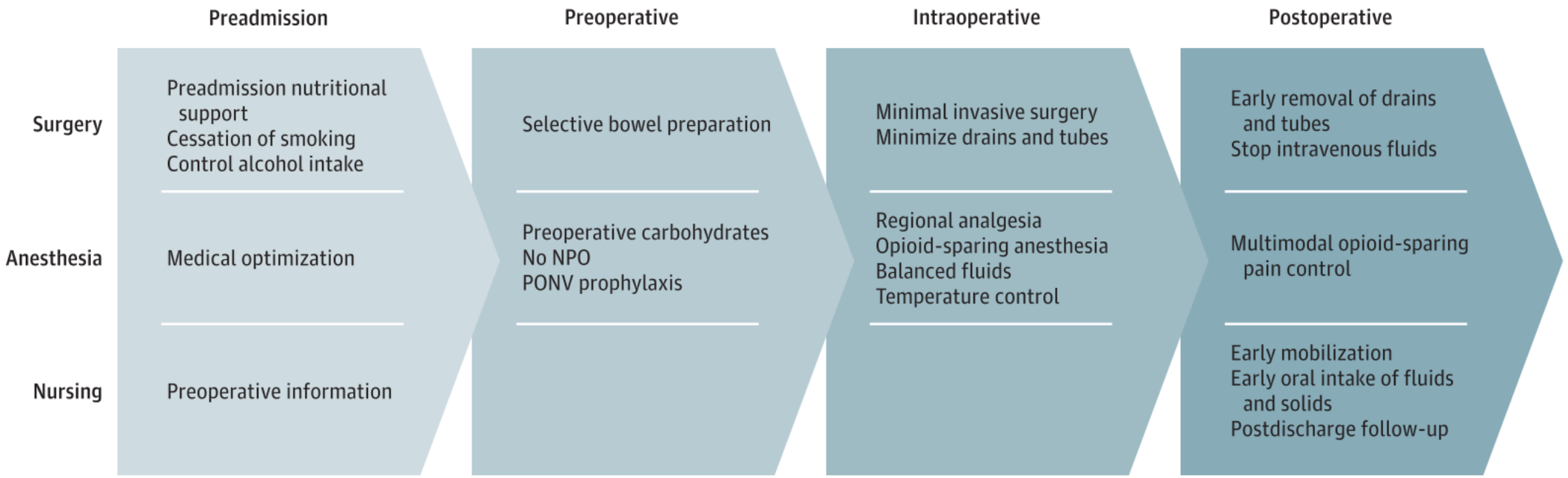
Universitätsspital Basel

Traditioneller Pat.-Behandlungsweg vs. ERAS® Behandlungspfad



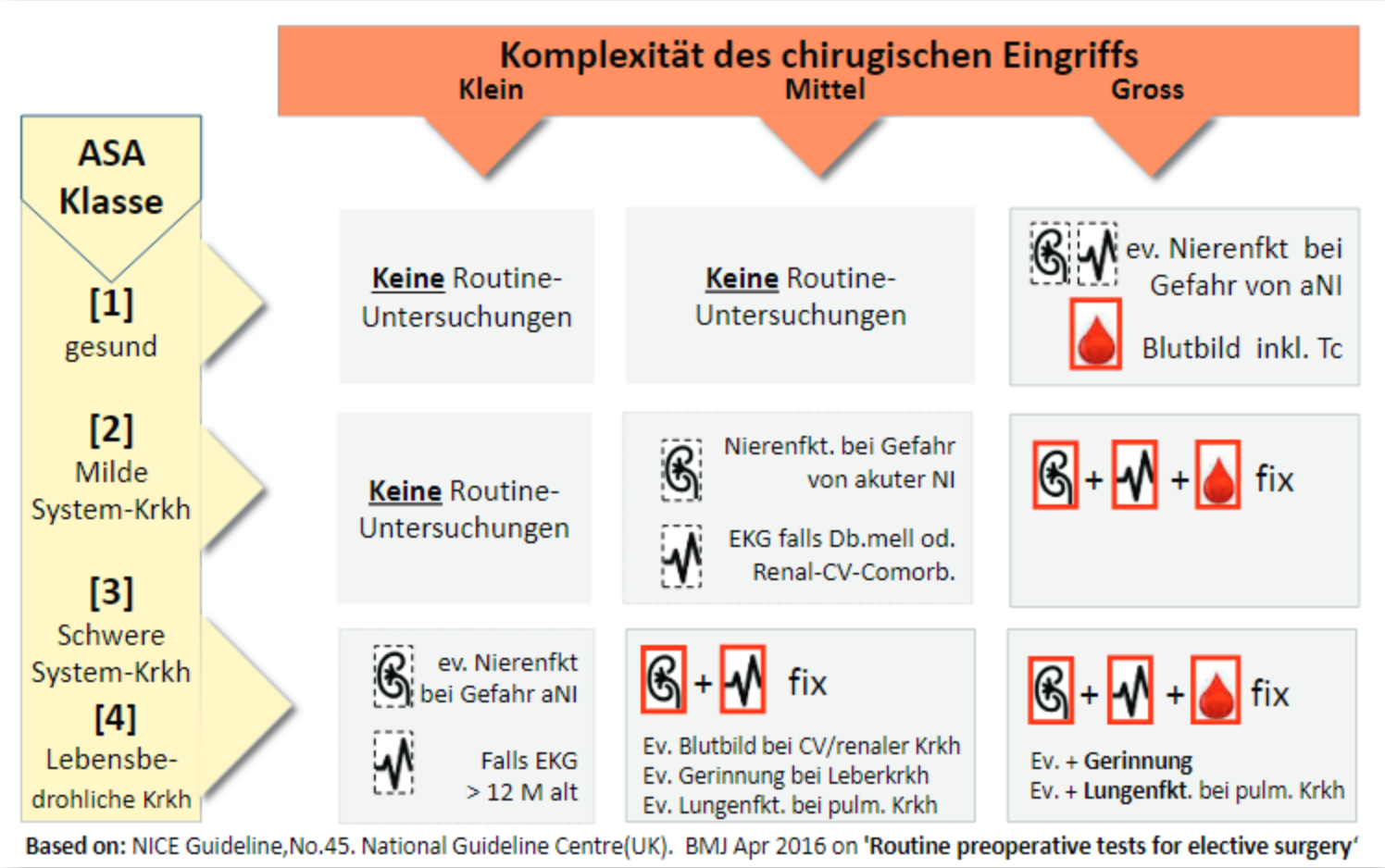
Herold, A., Lehur, P.-A., Matzel, K.E., O'Connell, P.R. (Eds.), 2017. Coloproctology. Springer Berlin Heidelberg, Berlin, Heidelberg. https://doi.org/10.1007/978-3-662-53210-2

Umsetzung Behandlungsaspekte ERAS® und Guidelines



Ljungqvist et al. JAMA Surgery 2017

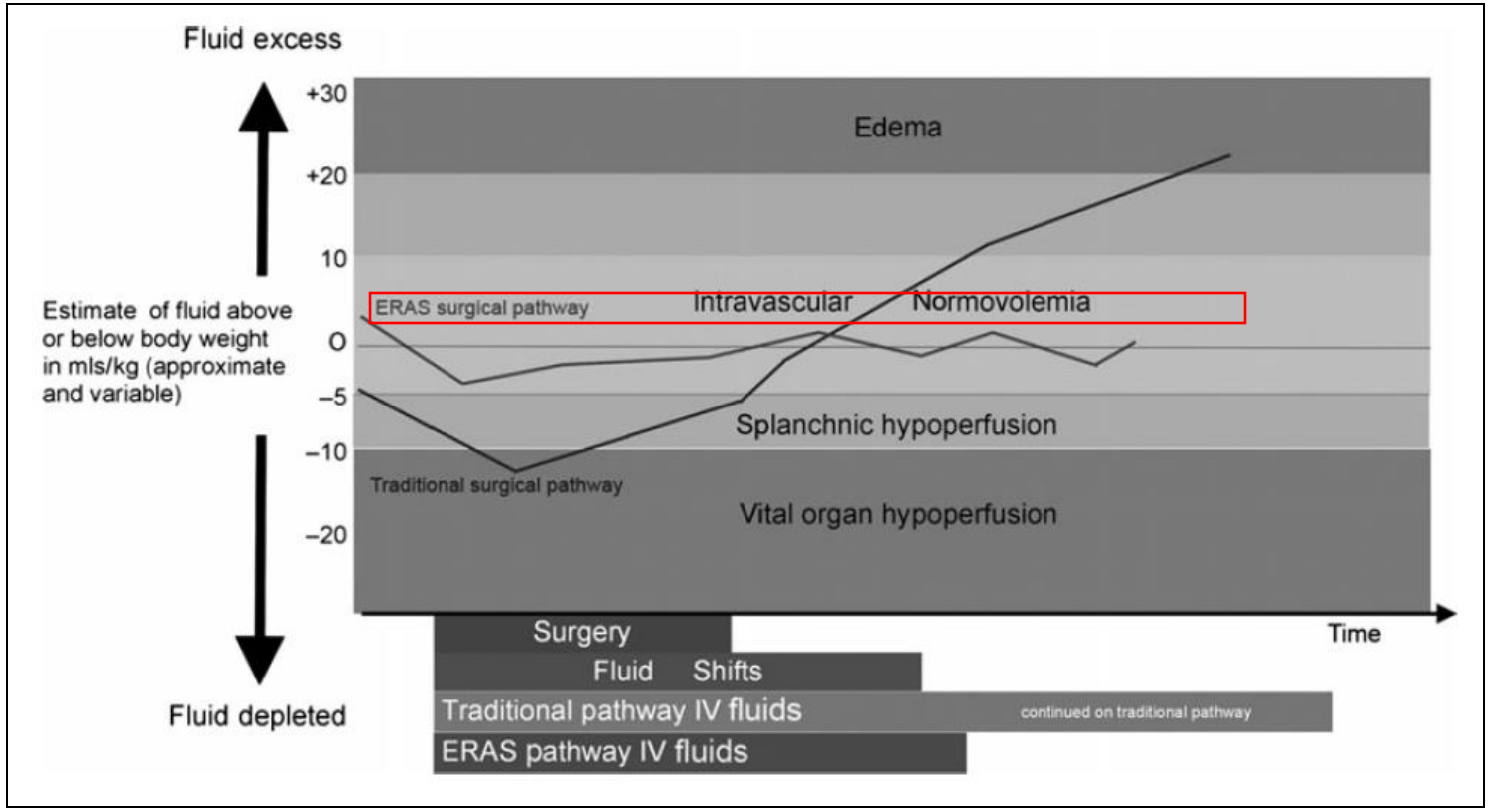
Präoperative Abklärungen



Therapeutische Umschau. 2017;74(7):345-350

Erwartung ERAS® Behandlungsaspekt intra- & postoperativ

Volumenmanagement u. Normovolämie



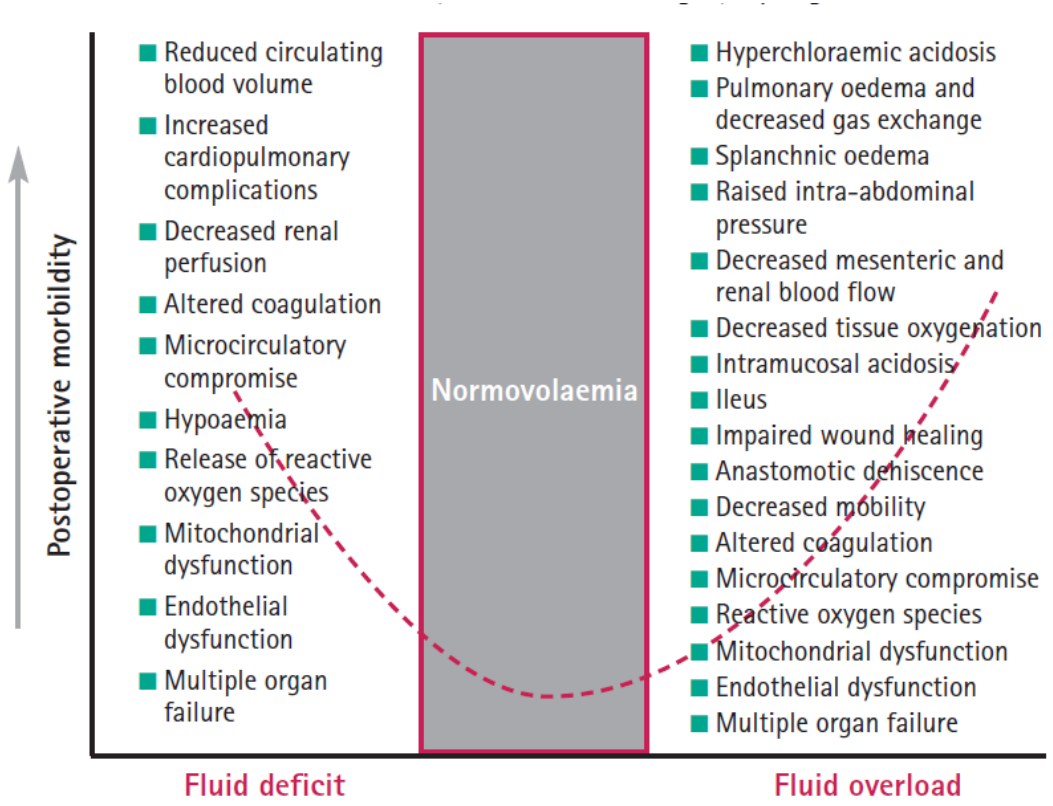
Minto et al. 2015

Universitätsspital Basel

ERAS® Ziel Normovolämie und Komplikationen Reduktion

Probleme bei zu wenig Volumen

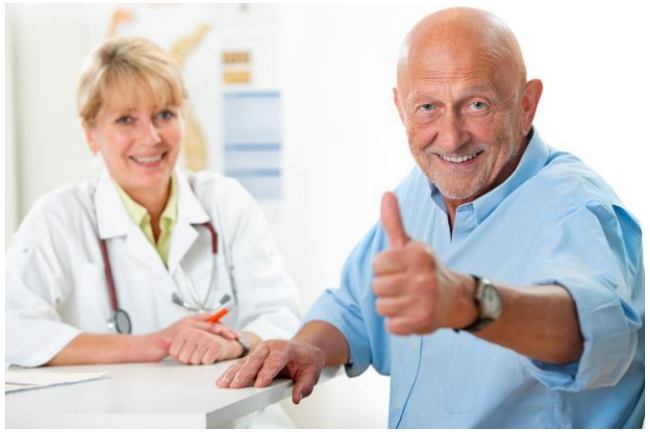
Probleme bei zu viel Volumen



Francis et al. 2012

Erwartung an das ERAS® Behandlungskonzept

Zufriedene Patienten



Zufriedenes Behandlungsteam

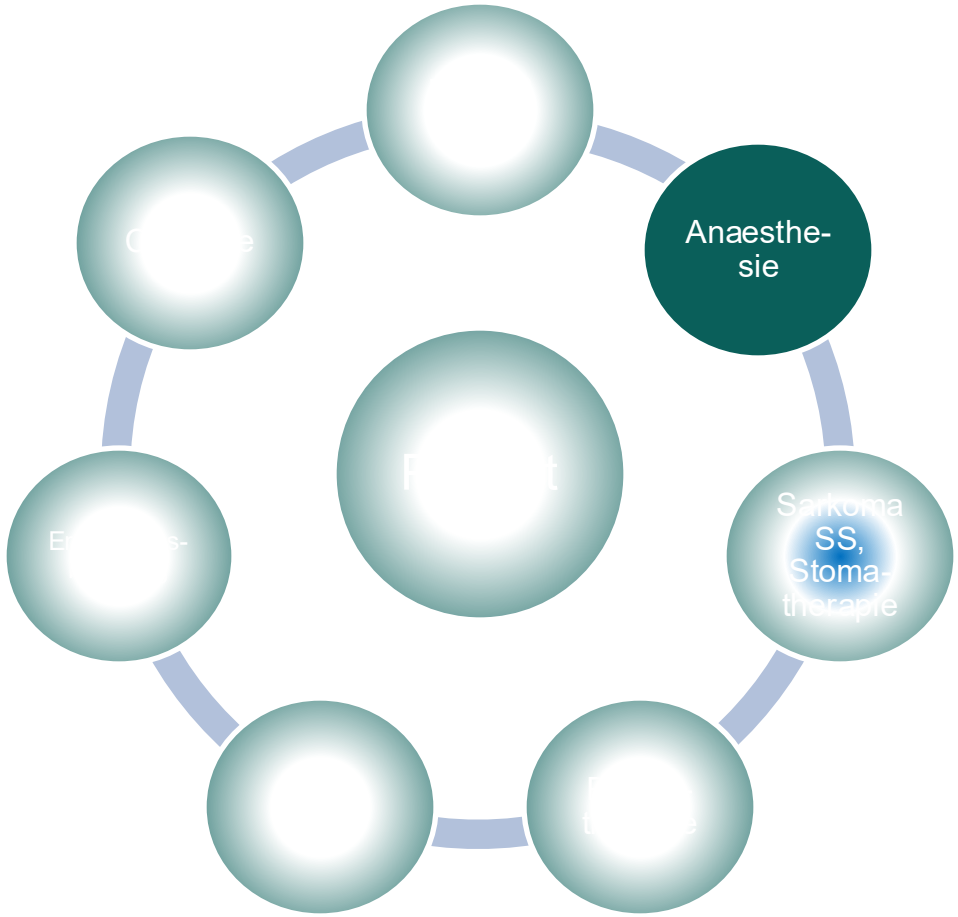


Zufriedene Klinikmanager



ERAS® ein personenzentriertes Behandlungskonzept am USB

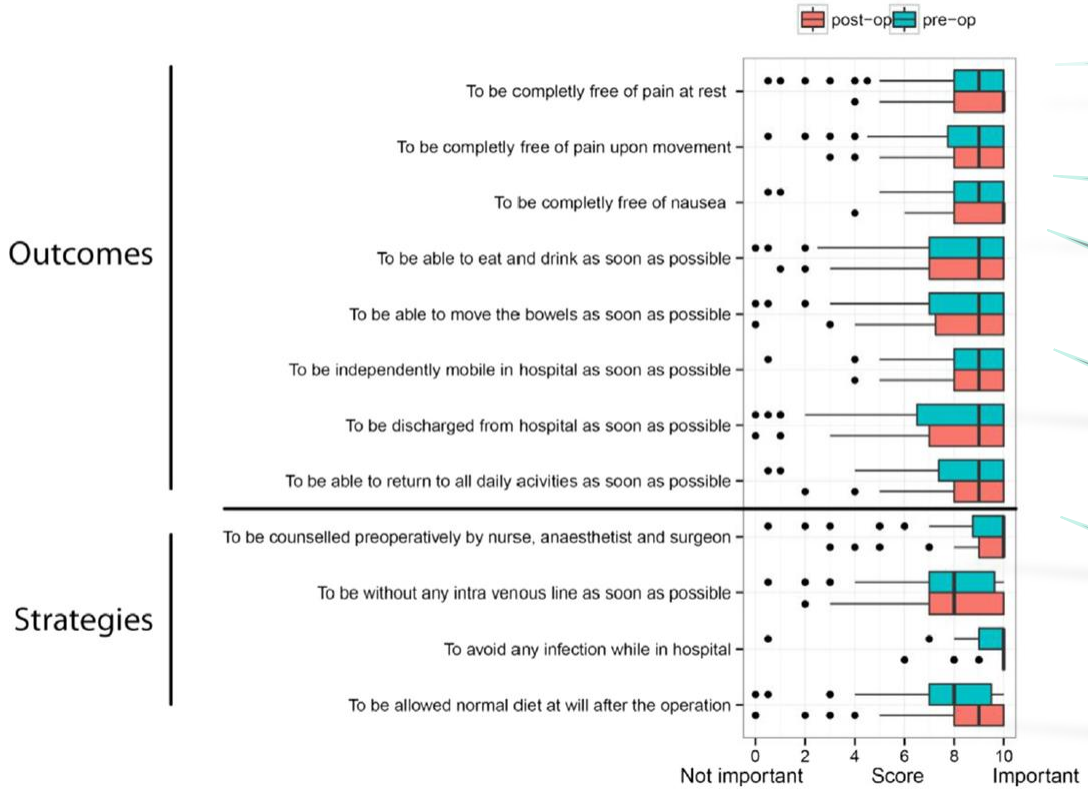
Multidisziplinäres Team



Eigene Abbildung

- Compliance ERAS®
- The Patient Activation through Community Empowerment/Engagement (PACE)

Erwartungen der ERAS® Patienten



Keine Schmerzen

Keine Übelkeit

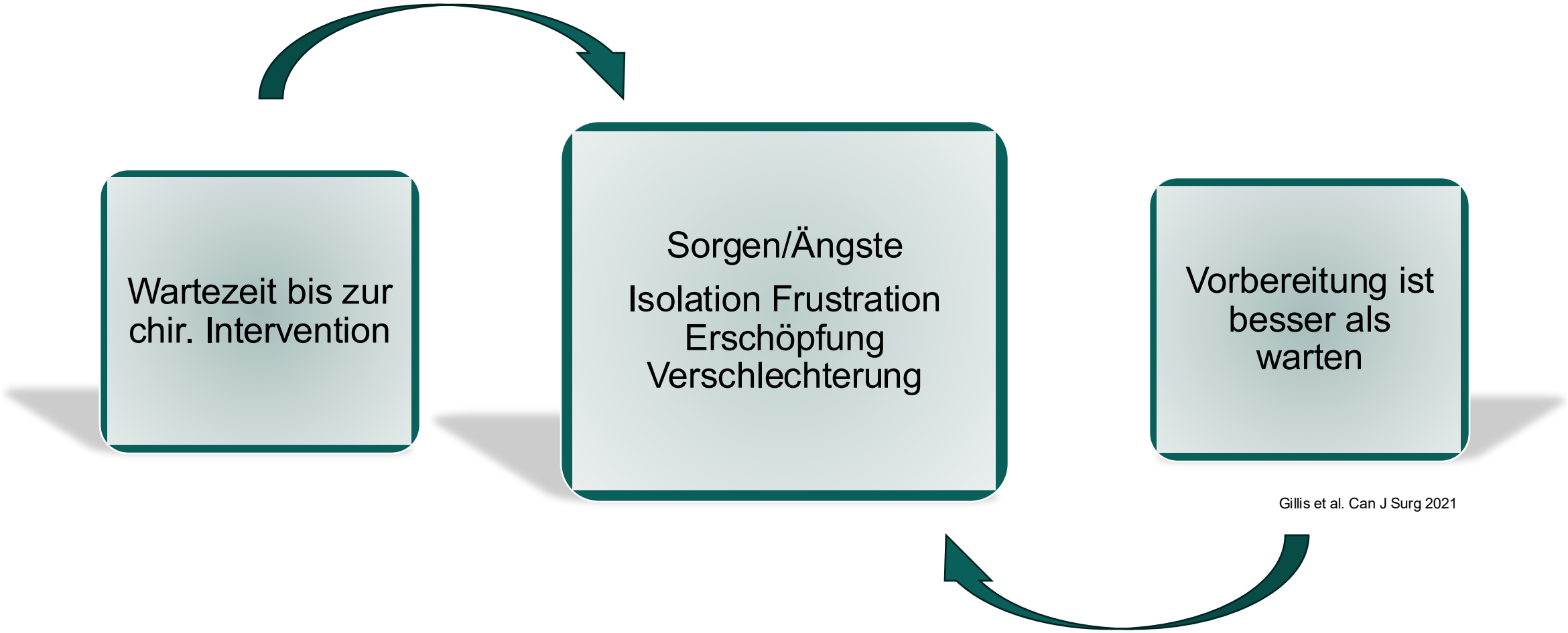
Normal Essen und Trinken

Mobilität

Informationen

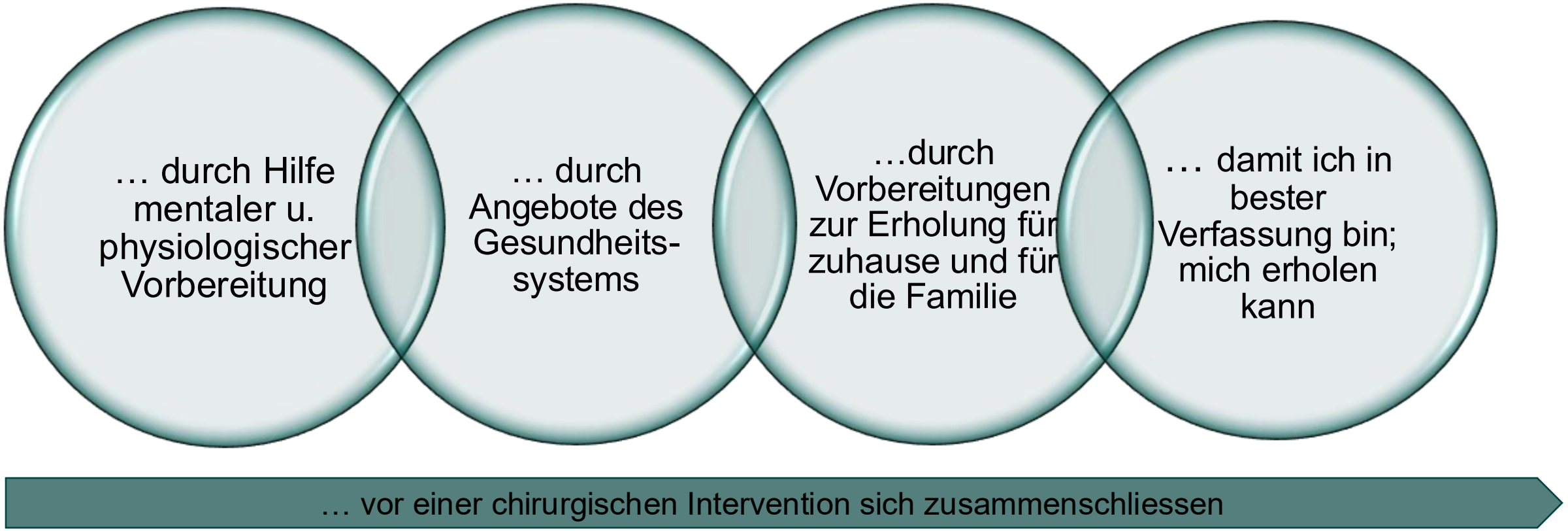
Hughes et al. J Surg Res. 2015

Psychologische Effekte der ERAS® Patienten



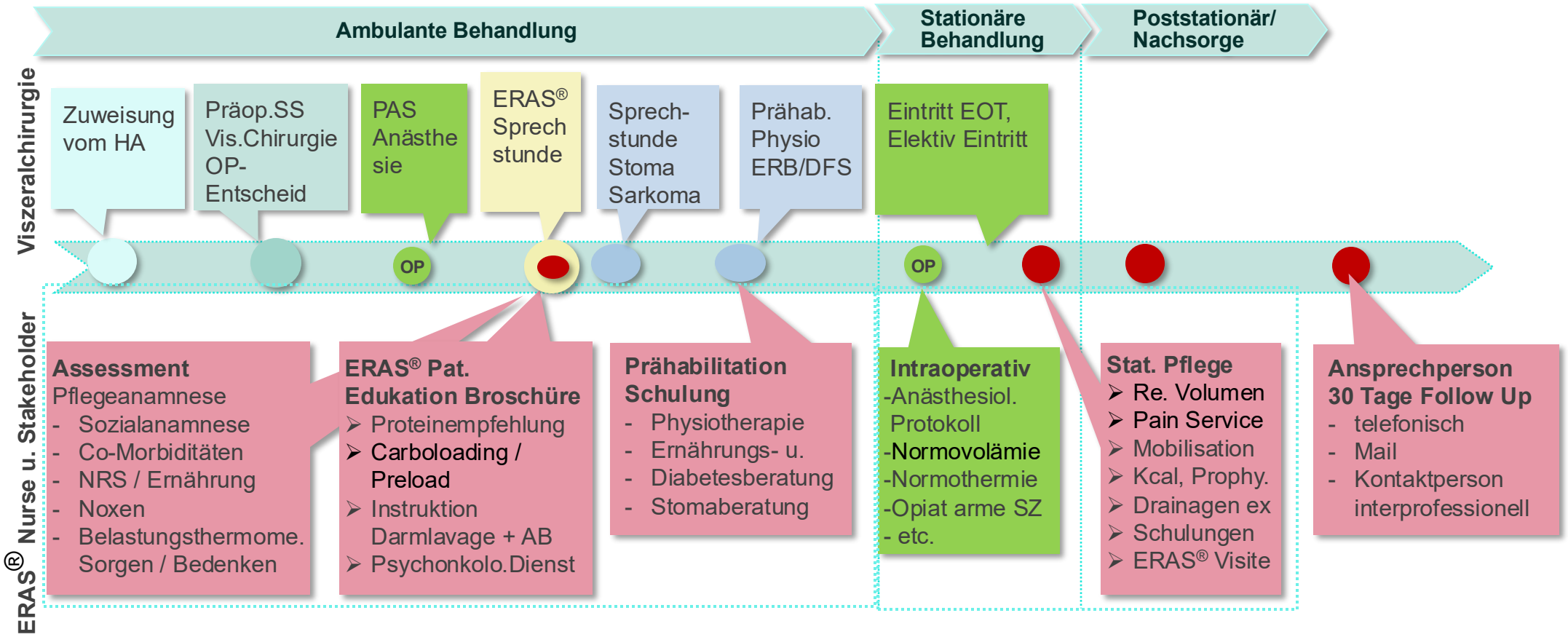
Gillis et al. Can J Surg 2021

Personenzentrierter Support an den ERAS® Patienten



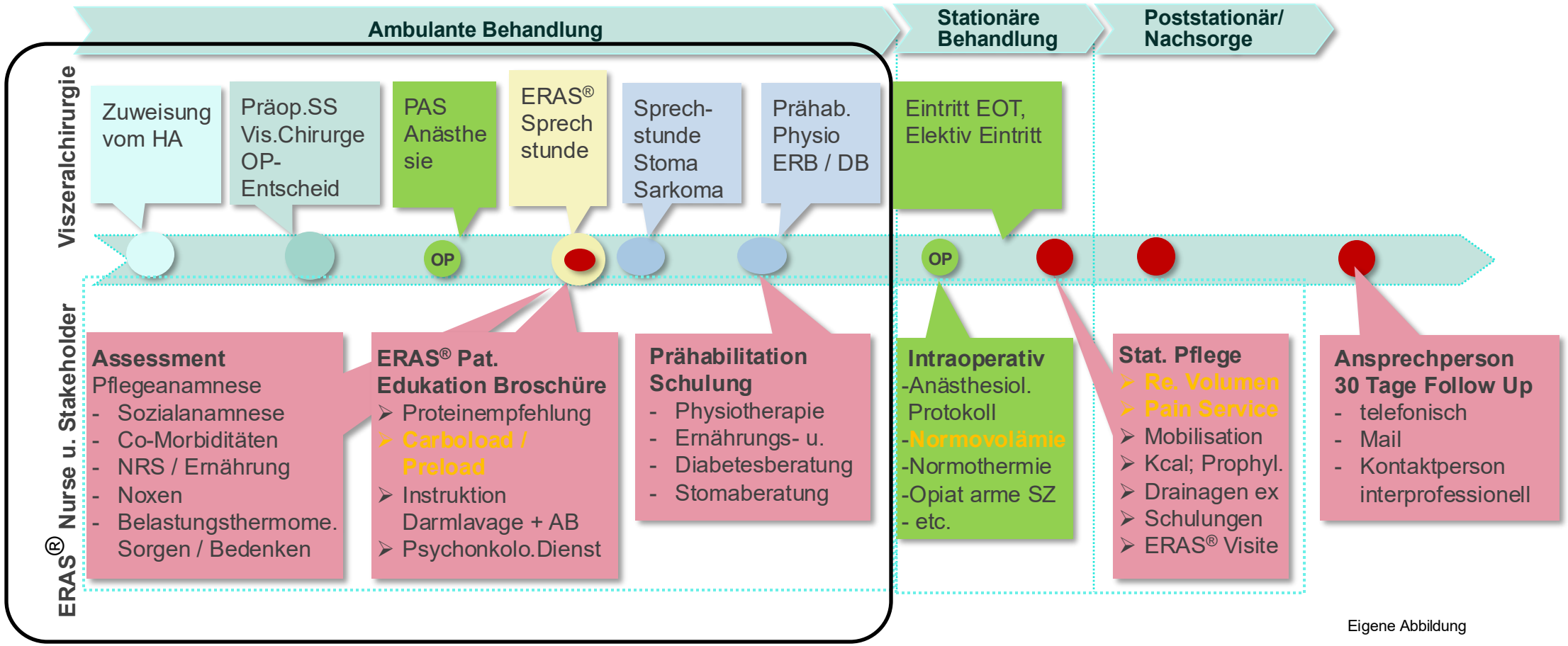
Gillis et al. Can J Surg 2021

Integration und Edukation ERAS® Patient im multidisziplinären Behandlungskonzept



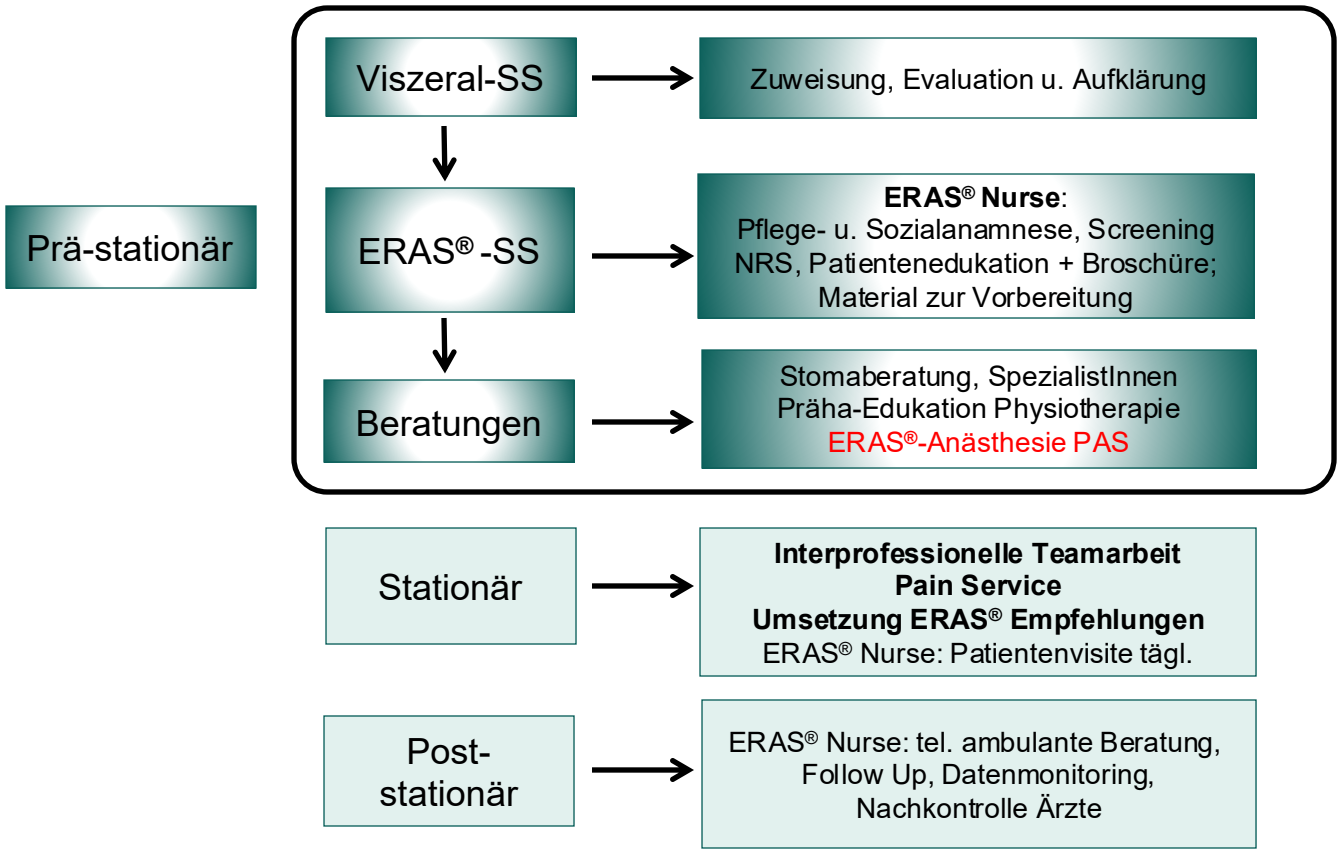
Eigene Abbildung

Integration und Edukation ERAS® Patient im multidisziplinären Behandlungskonzept



Eigene Abbildung

ERAS® Patient im Behandlungskonzept prä-stationär



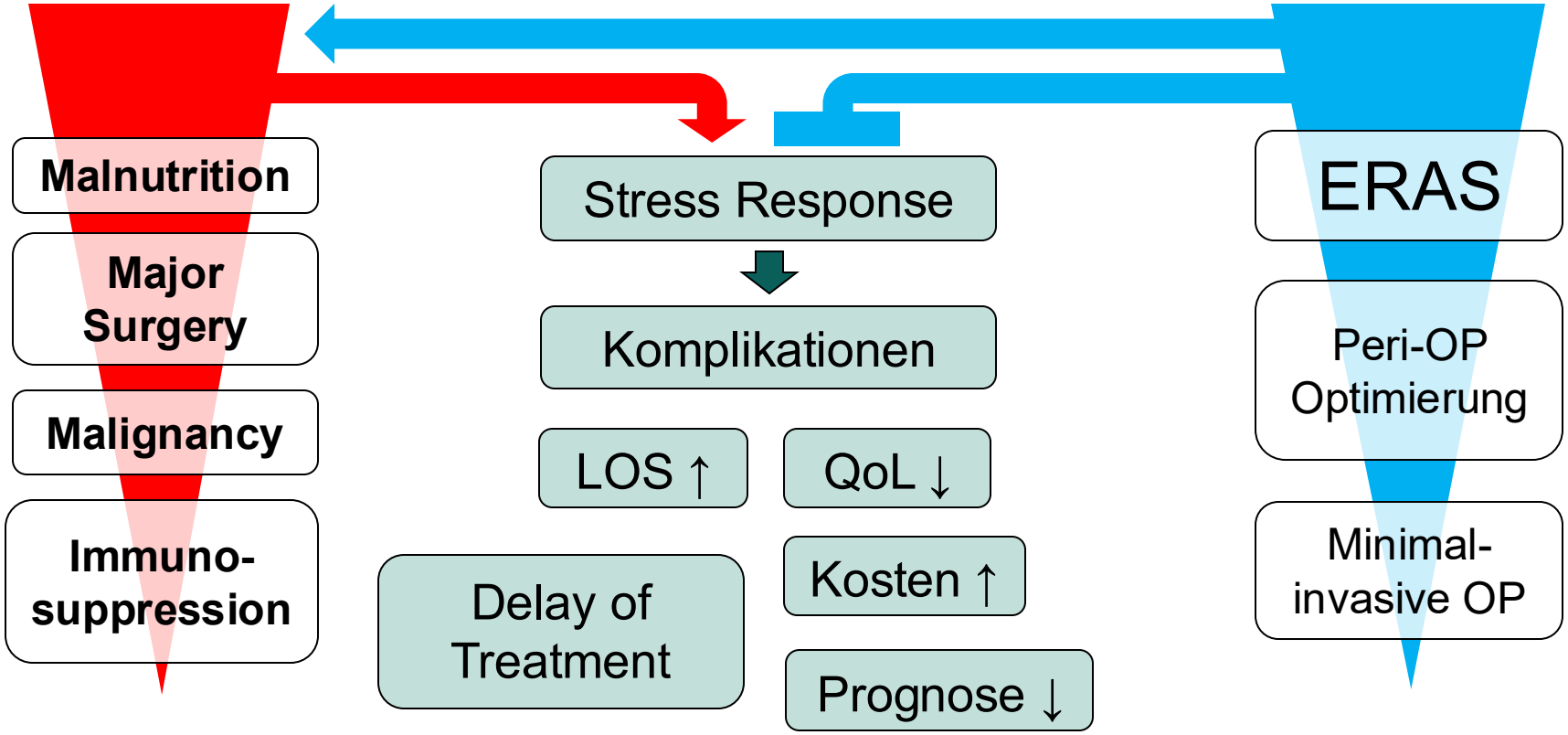




Vollständige Dokumentation

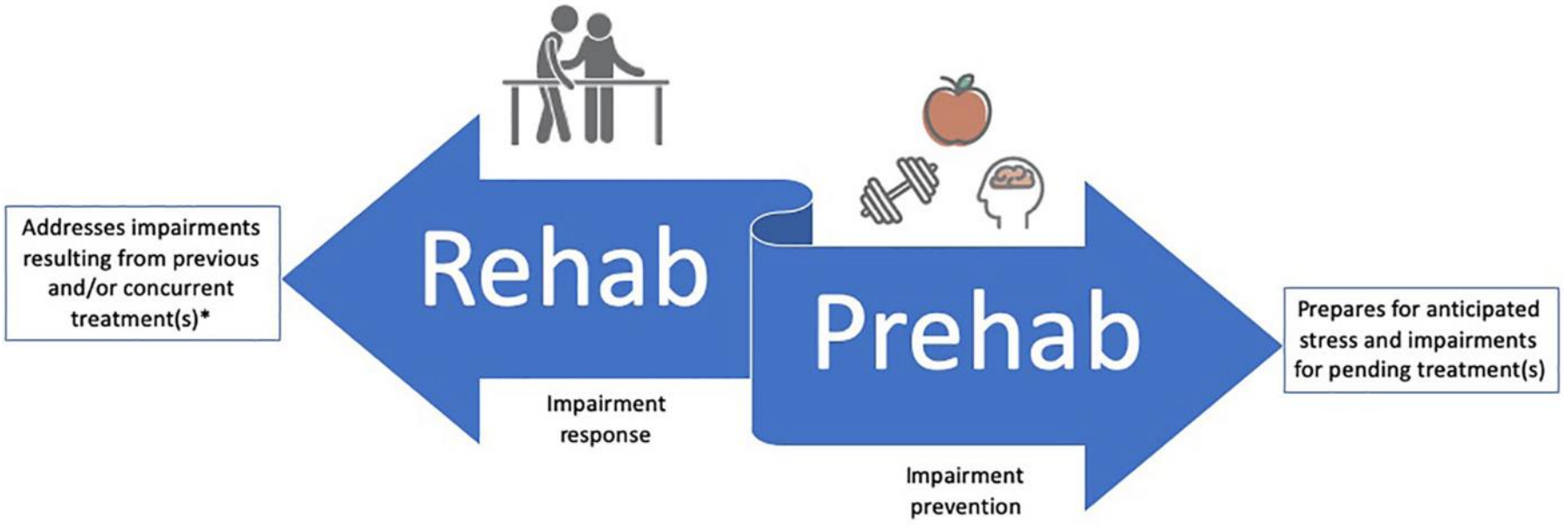
Eigene Abbildung

Fokus ERAS®: Stress-Response und Prophylaxe



Hoffmann et al. 2018

Prähabilitation Behandlungskonzeptes ERAS®

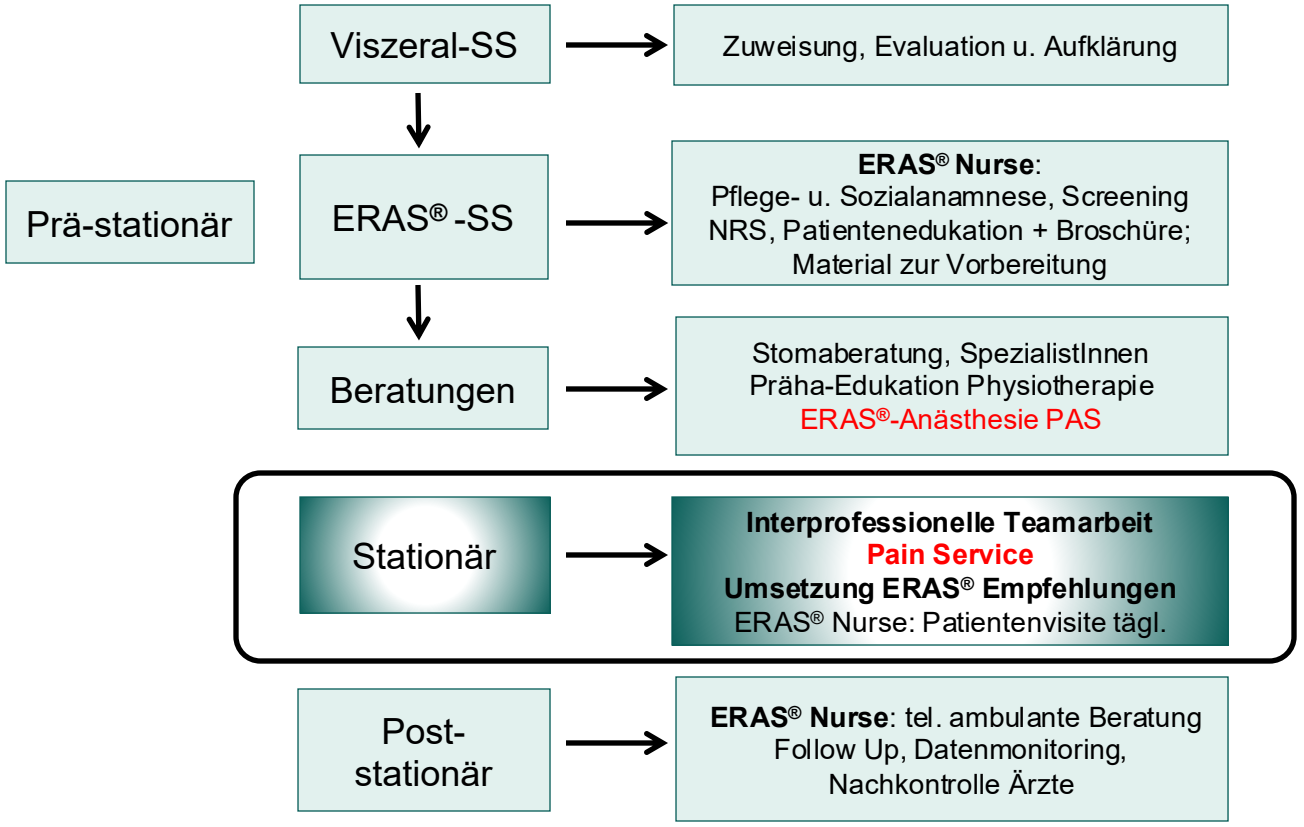


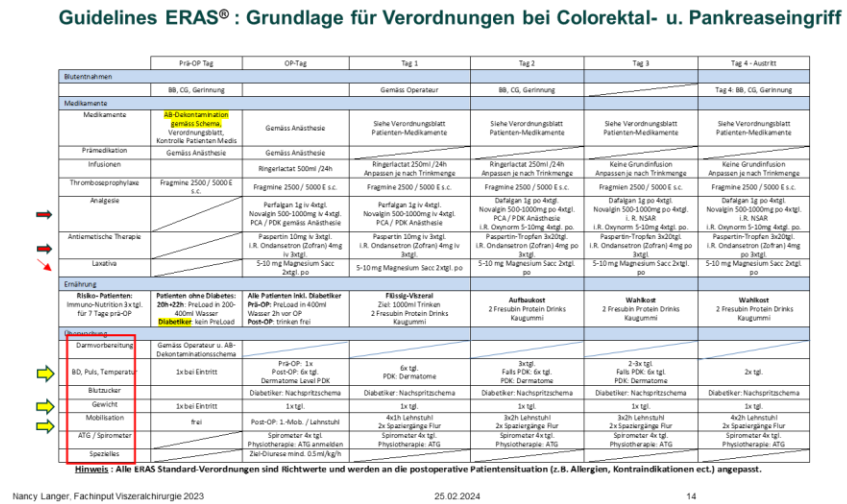
Front Oncol. 2021;10:598425 I World J Surg. 2023;47(1):86-102

Multimodale Prähabilitation
- Ernährungstherapie
- Bewegungstherapie
- Psychologische Unterstützung

- Verbessert präoperative funktionelle Kapazität
- Weniger postoperative Komplikationen (?)
- Keinen Einfluss auf Mortalität und Hospitalisationsdauer
- Evtl. bessere Lebensqualität

ERAS® Patient im Behandlungskonzept stationär




Guidelines ERAS® : Grundlage für Verordnungen bei Colorektal- u. Pankreaseingriff

Hinweis : Alle ERAS Standard-Verordnungen sind Richtwerte und werden an die postoperative Patientensituation (z.B. Allergien, Kontraindikationen ect.) angepasst.

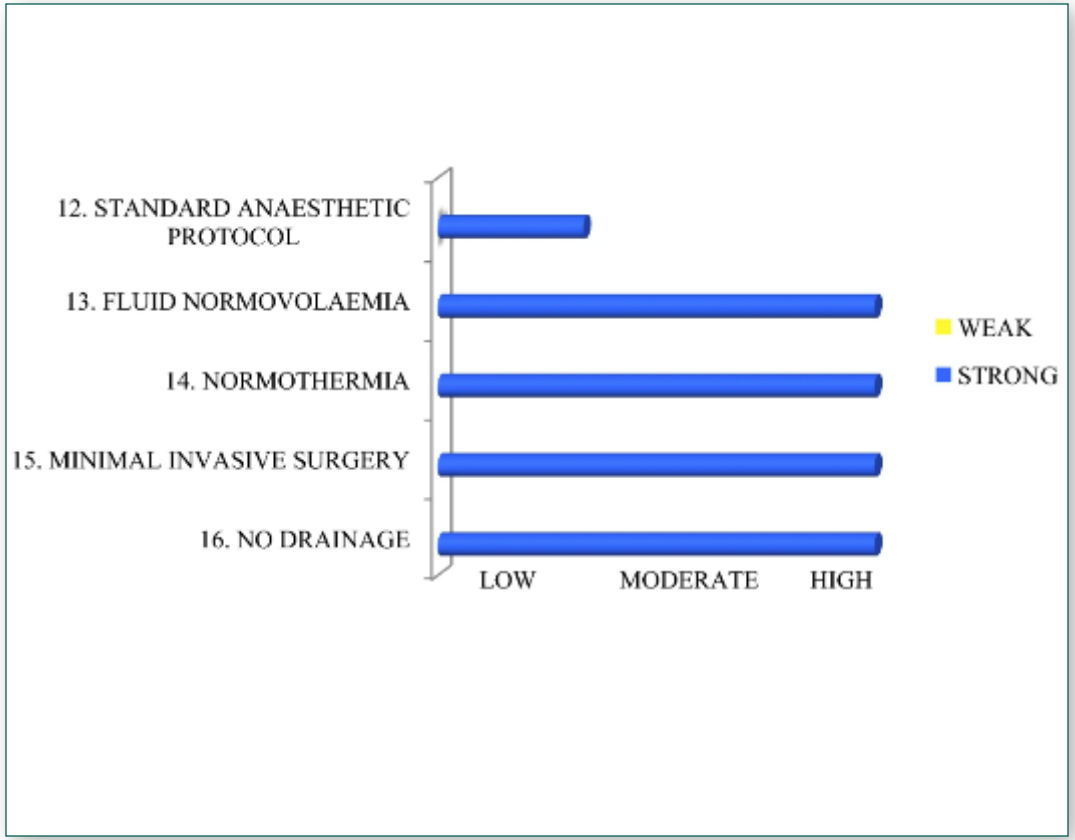
Nancy Langer, Fachinput Viszeralchirurgie 2023 25.02.2024 14

Eigene Abbildung

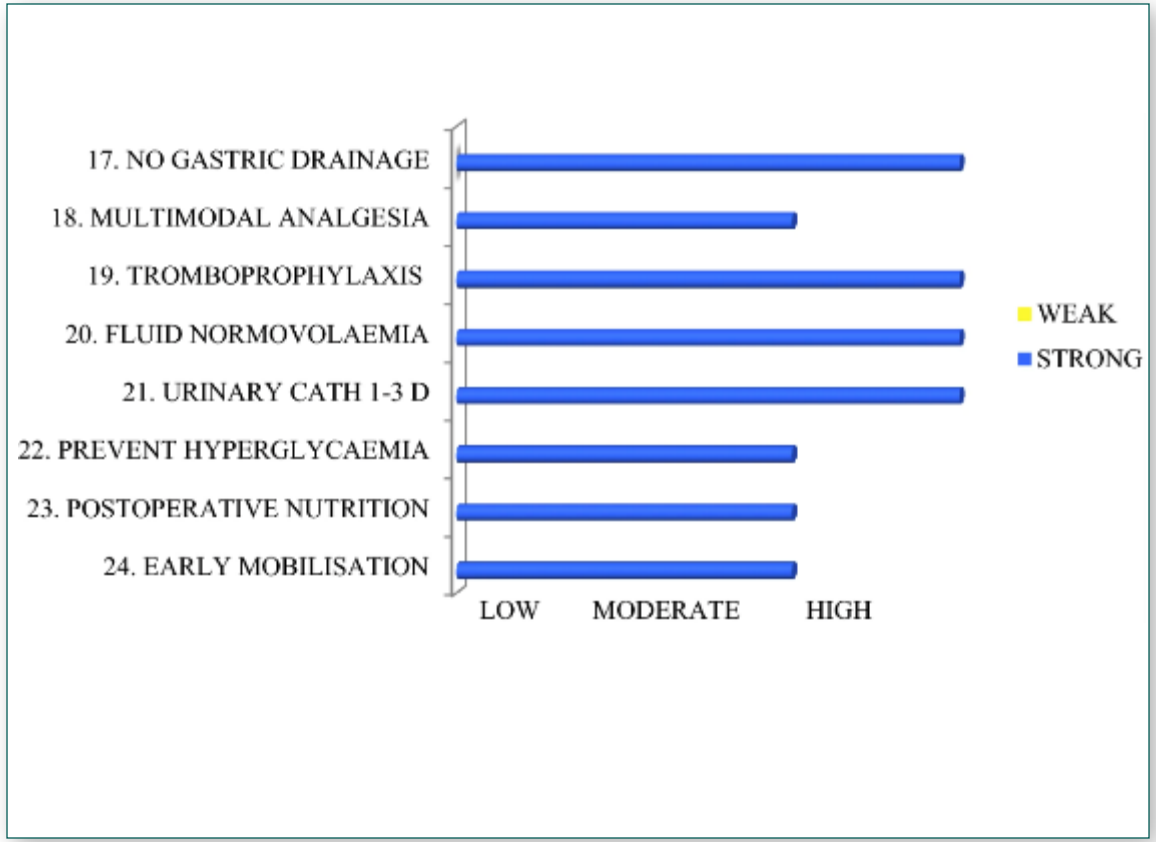
Universitätsspital Basel

ERAS® Empfehlungen im Behandlungskonzept intraoperativ

Intraoperativ

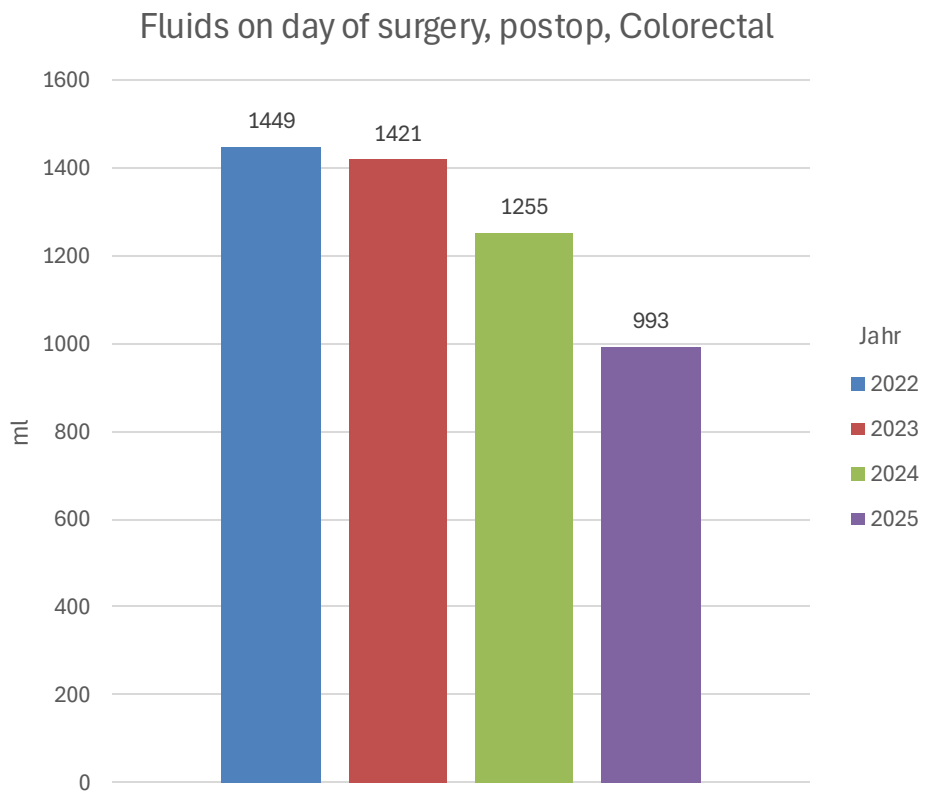


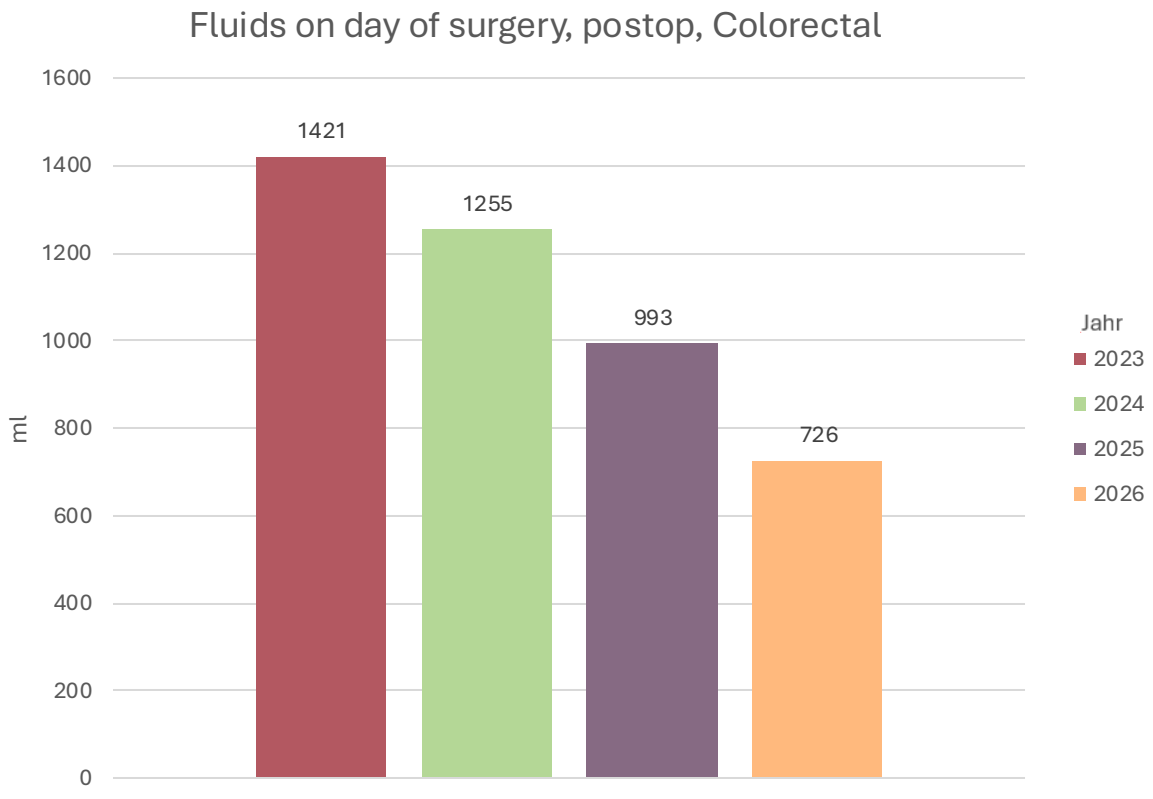
Postoperativ



World J Surg. 2019;43(3):659-695

ERAS® Monitoring Daten Flüssigkeitsmanagement intraop. bis 24h

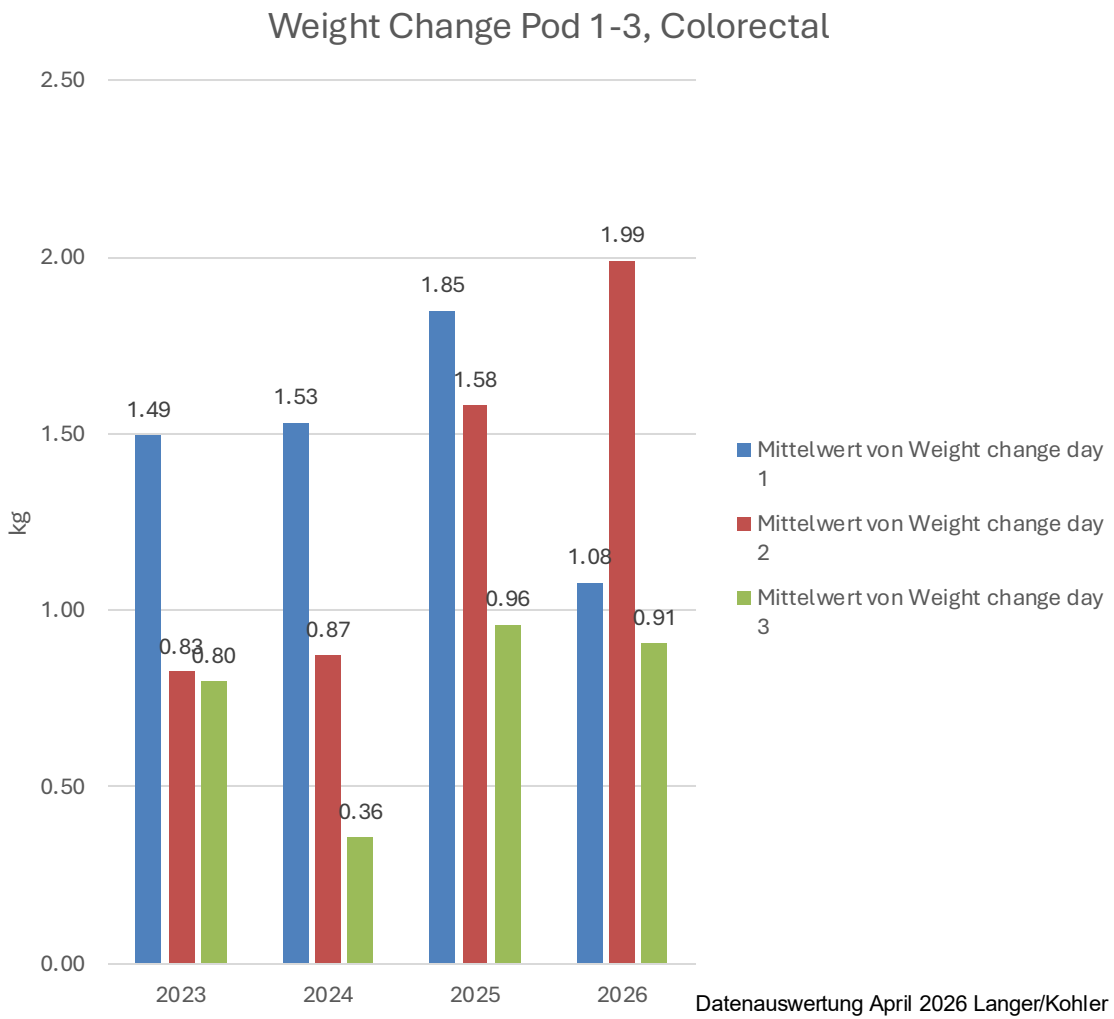




Datenauswertung April 2026 Langer/Kohler

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ERAS® Monitoring Flüssigkeitsmanagement u. Gewicht Tag1-3



Datenauswertung April 2026 Langer/Kohler

Reduktion Infusionsmenge i.v.

Per os Flüssigkeitsaufnahme

Mobilisation

Gute Schmerztherapie (Pain Service) !

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Pflegerische ERAS® Items prä- und postoperativ

Physiologische Stressreduktion



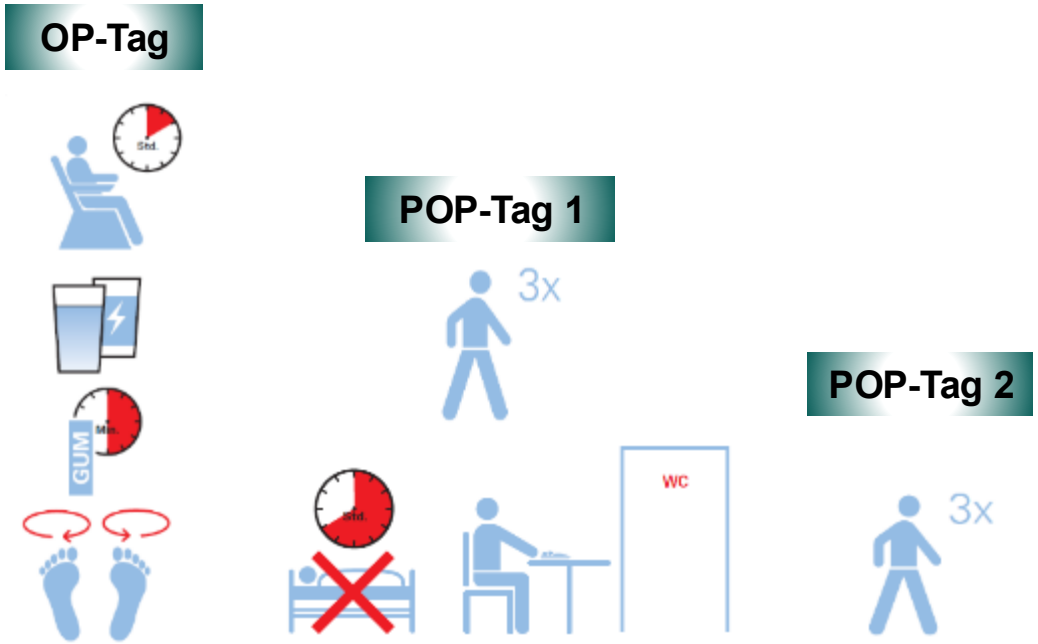
Proteine u. Nährstoffe
Cave NRS > 5
Immunonutrition

Preload

Carboloading mit Preload alle Patienten (cave Diabetiker)

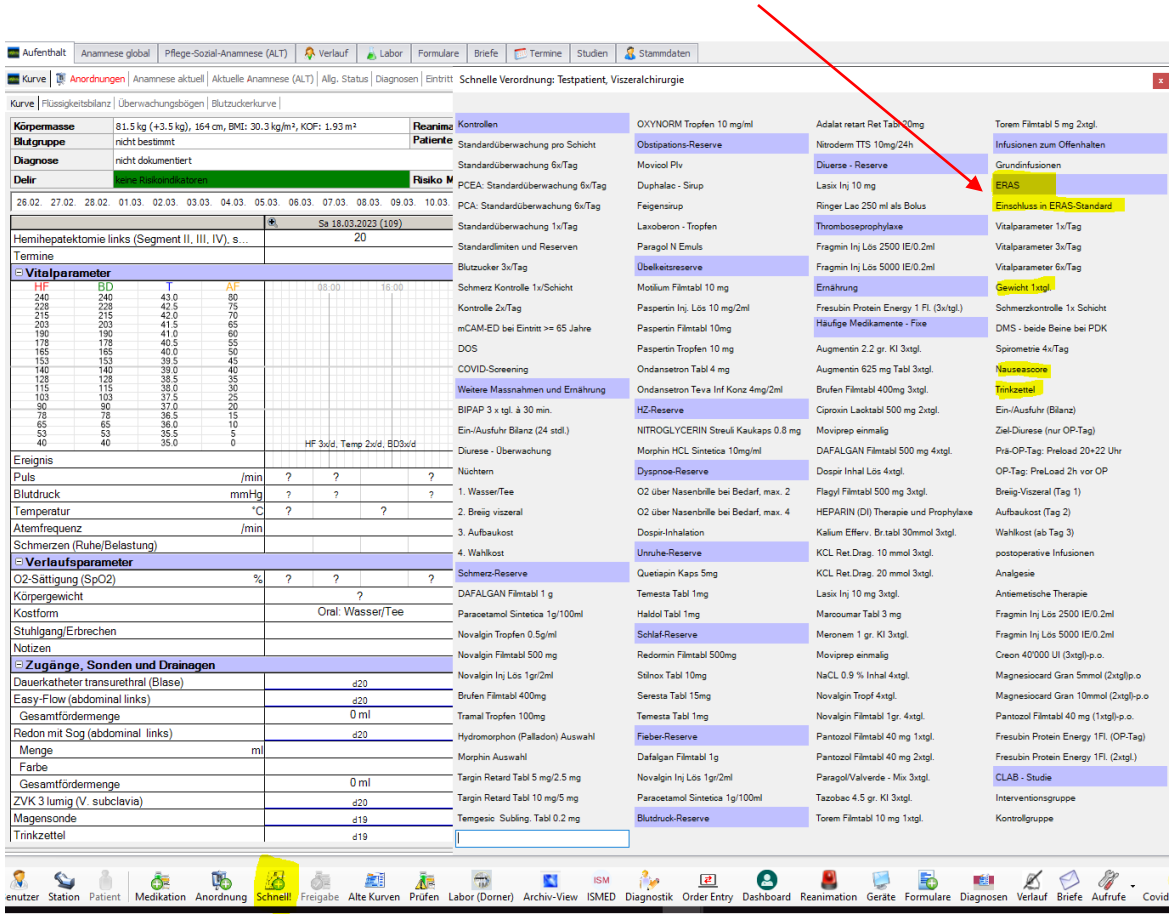
Effekte früher Mobilisation[1,2]

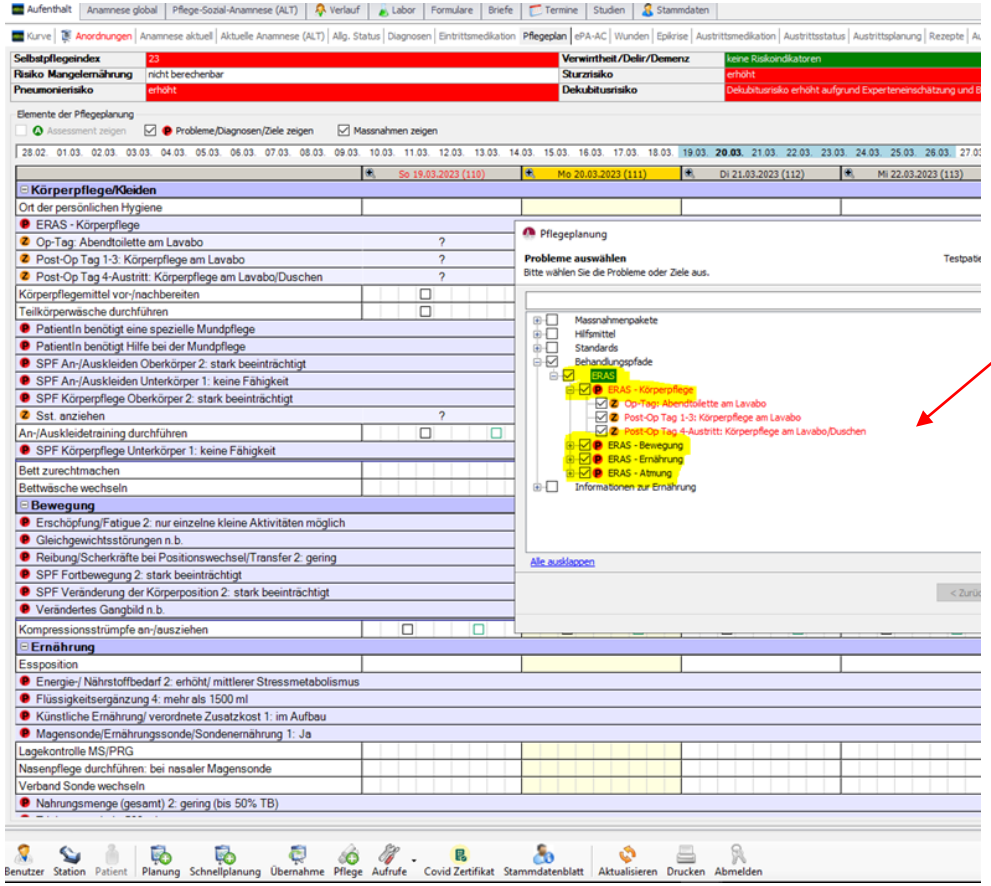
Reduktion Pneumonie
Reduktion TVT
Wundheilung
Stuhlregulierung



ERAS® Broschüre 1

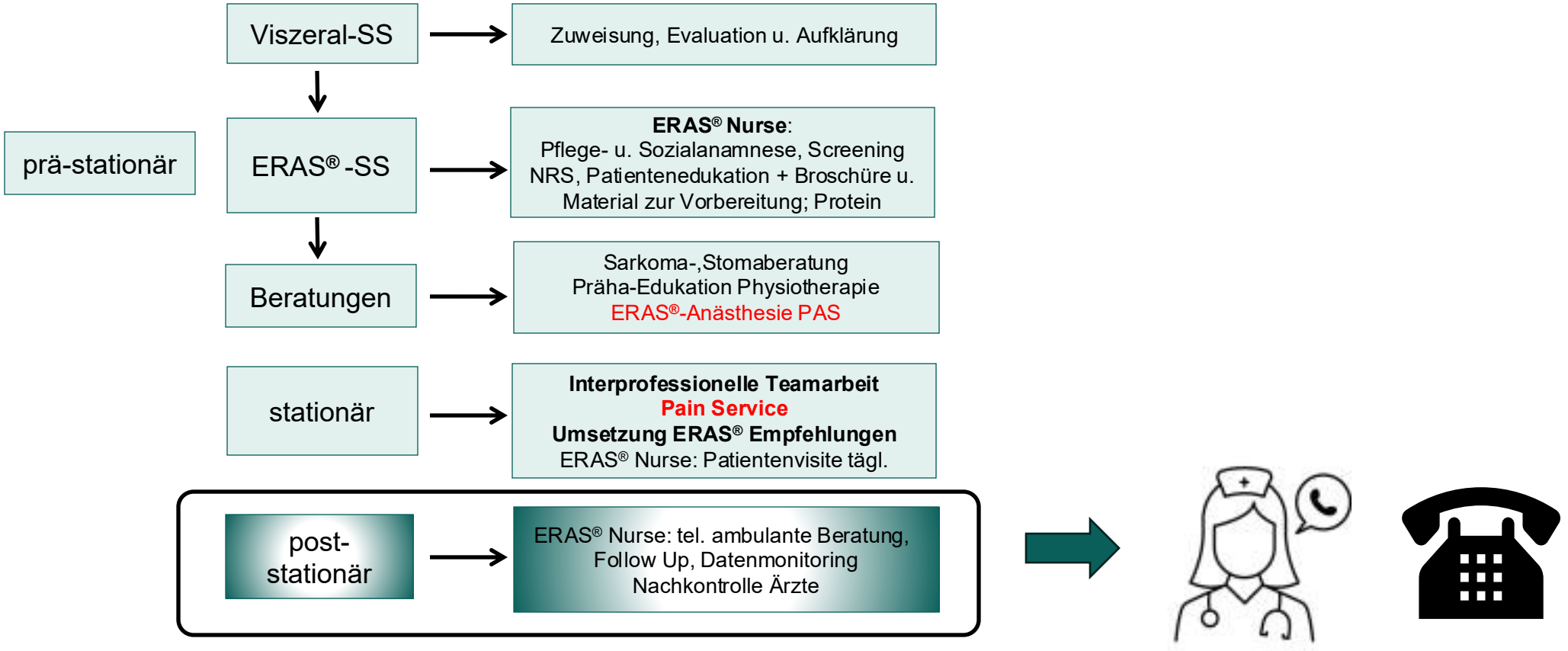
Dokumentation und Leistungserfassung ERAS®





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ERAS® Patient im Behandlungskonzept poststationär



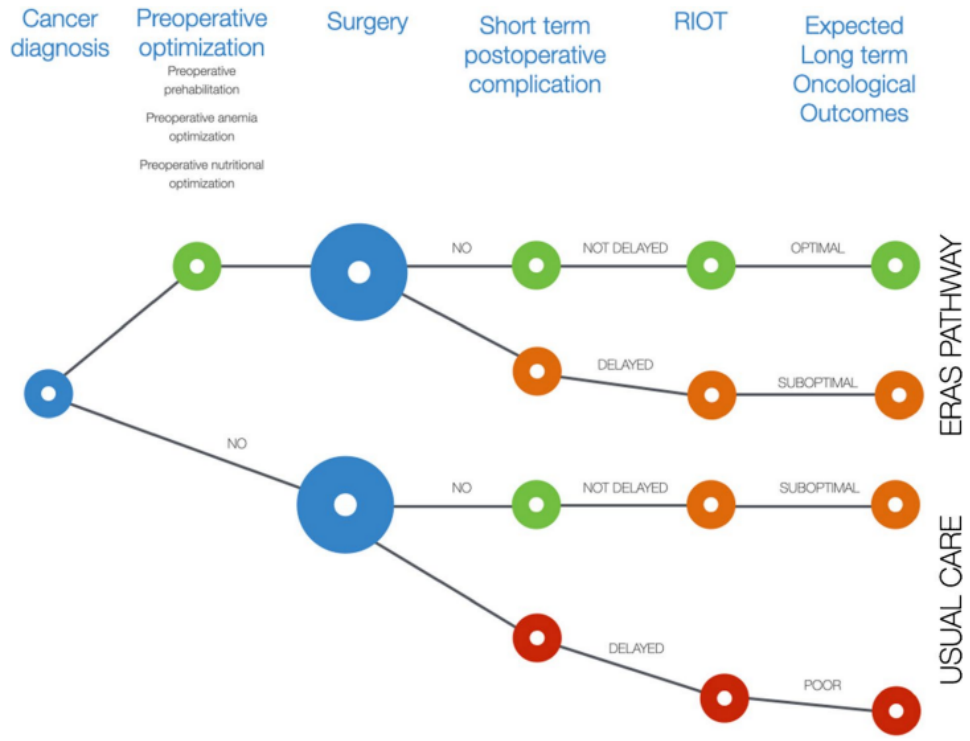
Eigene Abbildung

Effekt ERAS® auf die Quality of Life

Return to Intended Oncologic Treatment / RIOT (Rückkehr zur beabsichtigten onkol. Nachbehandlung)

Current Oncology Reports

Fig. 1 Possible scenarios and expected outcomes after the application of ERAS elements in cancer surgery



Optimaler Zeitverlauf

Zeitverlust Verspätung Folgetherapie

Javier Ripolles-Melchor, Current Oncology Reports published 11. April 2022

Effekt Kostenersparnis mit ERAS®

Economic Evaluation



RESEARCH • RECHERCHE

An economic evaluation of the Enhanced Recovery After Surgery (ERAS) multisite implementation program for colorectal surgery in Alberta

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DOI: 10.1503/cjs.006716

Background: In February 2013, Alberta Health Services established an Enhanced Recovery After Surgery (ERAS) implementation program for adopting the ERAS Society colorectal guidelines into 6 sites (initial phase) that perform more than 75% of all colorectal surgeries in the province. We conducted an economic evaluation of this initiative to not only determine its cost-effectiveness, but also to inform strategy for the spread and scale of ERAS to other surgical protocols and sites.

Methods: We assessed the impact of ERAS on patients' health services utilization (HSU; length of stay [LOS], readmissions, emergency department visits, general practitioner and specialist visits) within 30 days of discharge by comparing pre- and post-ERAS groups using multilevel negative binomial regressions. We estimated the net health care costs/savings and the return on investment (ROI) associated with those impacts for post-ERAS patients using a decision analytic modelling technique.

Results: We included 331 pre- and 1295 post-ERAS patients in our analyses. ERAS was associated with a reduction in all HSU outcomes except visits to specialists. However, only the reduction in primary LOS was significant. The net health system savings were estimated at $2 290 000 (range $1 191 000–$3 391 000), or $1768 (range $920–$2619) per patient. The probability for the program to be cost-saving was 73%–83%. In terms of ROI, every $1 invested in ERAS would bring $3.8 (range $2.4–$5.1) in return.

Conclusion: The initial phase of ERAS implementation for colorectal surgery in Alberta is cost-saving. The total savings has the potential to be more substantial when ERAS is spread for other surgical protocols and across additional sites.

Contexte : En février 2013, les Services de santé de l'Alberta ont mis en place le programme ERAS (Enhanced Recovery After Surgery — récupération postchirurgicale améliorée) dans le but de faire adopter les lignes directrices en matière d'interventions colorectales de la ERAS Society à 6 établissements (première phase) où sont pratiquées plus de 75 % des interventions chirurgicales colorectales de la province. Nous avons réalisé une évaluation économique du programme, non seulement pour en mesurer la rentabilité, mais aussi pour élaborer une stratégie visant à étendre le programme ERAS à d'autres protocoles chirurgicaux et services de chirurgie.



Langenbeck's Archives of Surgery (2024) 409:5
https://doi.org/10.1007/s00423-023-03195-7

RESEARCH

Enhanced recovery after surgery (ERAS) in colorectal surgery: implementation is still beneficial despite modern surgical and anesthetic care

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Abstract

Purpose Enhanced recovery after surgery (ERAS) protocols have shown beneficial outcomes in the last 20 years. Nevertheless, simultaneously implemented technical improvements such as minimally invasive access or modified anesthesia care may play a crucial role in optimizing patient outcome. The aim of the study was to investigate the effect of ERAS implementation in a highly specialized colorectal center.

Methods This is a propensity score matched single-center study comparing the short-term outcomes of patients undergoing elective colorectal surgery in a society-indepedent ERAS program from January 2021 to August 2022 to standard perioperative care from January 2019 to December 2020.

Results Four hundred fifty-six patients were included in the propensity score matched analysis with 228 patients per group (ERAS vs. standard care). Minimally invasive access was used in 80.2% vs. 77.6% ($p = 0.88$), and there were 16.6% vs. 18.8% ($p = 0.92$) rectal procedures in the ERAS and standard care group, respectively. Major complications occurred in 10.1% vs. 11.4% ($p = 0.65$) and anastomotic leakage demanding operative revision in 2.2% vs. 2.6% ($p = 0.68$) in the ERAS and standard care group, respectively. ERAS lead to a lower number of non-surgical complications compared to standard care (57 vs. 79; $p = 0.02$). Mean length of stay (LOS) and mean costs per case were lower in ERAS compared to standard care (9.2 ± 5.6 days vs. 12.7 ± 7.4 days, $p < 0.01$; costs 33,727 ± 15,883 USD vs. 40,309 ± 29,738 USD, $p < 0.01$).

Conclusion The implementation of an ERAS protocol may lead to a reduction of LOS, costs, and a lower number of non-surgical complications even in a highly specialized colorectal unit using modern surgical and anesthetic care. (ClinialTrials.gov number NCT05773248)

Herausforderungen und Schlüssel zum Erfolg

Herausforderungen

- Erkennen und Aufbrechen alter Routineprozesse in den Berufsgruppen
- Kontinuität
- interprofessionelle Zusammenarbeit
- Schnittstellenmanagement
- Strukturen

Schlüssel zum Erfolg

- Prästationäre Vorbereitung mit Screening und Optimierung
- Zeit für Patientenedukation
- Ressource ERAS® Nurse als Dreh- und Angelpunkt
- Intensive interdisziplinäre und interprofessionelle Zusammenarbeit, **d.h. gute Zusammenarbeit im multidisziplinäre ERAS®-Team u. den weiteren Stakeholder, insbesondere der Fachvertretung Pflege ERAS® Anästhesie**



Take Home Message



„Es ist doch an der Zeit, nicht ständig nach neuer Evidenz zu suchen, sondern die bekannte Evidenz erst einmal effizient umzusetzen!“

- Henrik Kehlet

Vielen Dank für Ihre Aufmerksamkeit

Kontakt

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Ihre Fragen…

