Module 7: ERAS Pathways and Multimodal Analgesia

Welcome to Compass SHARP in Practice, a quick high-yield learning session made for busy healthcare professionals like you. In each episode, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, we hope to sharpen your skills and build knowledge that helps you better care for your patients.

A Patient Case

A 40-year-old man undergoes an elective colectomy for ulcerative colitis. He receives intraoperative opioids followed by a PCA and routine oxycodone as needed after surgery. No acetaminophen or NSAIDs are scheduled, and there is no preoperative patient education, early mobilization plan, or nutrition strategy—none of it.

By post-operative day two, he reports severe pain, delayed ambulation, and nausea from opioids. This case highlights the missed opportunities when ERAS principles are not applied. Without a multimodal foundation, patients often experience higher opioid use, slower recovery, and longer hospital stays.

Goal

Our goal in this module is to integrate ERAS and multimodal analgesia principles to enhance recovery, reduce opioid exposure, and improve the patient experience.

First, optimize multimodal analgesia across the care continuum from pre-op to discharge. Use complementary non-opioid medications such as acetaminophen, NSAIDs, and gabapentinoids, along with regional techniques when appropriate, to target pain through multiple pathways. This approach decreases opioid requirements and side effects while improving comfort and mobility.

Second, engage nursing and quality teams in ERAS adherence. Successful ERAS implementation depends on team coordination, not just protocols. Nurses reinforce key elements such as early ambulation, diet advancement, and patient education on realistic pain goals. Quality teams monitor compliance metrics like early mobility and multimodal analgesia use to sustain progress over time.

Third, embed opioid stewardship into ERAS pathways. Link every ERAS order set to standardized, right-sized opioid prescribing at discharge. This ensures that the opioid-sparing approach initiated in the hospital continues at home, maintaining continuity of care and patient safety.

Back to the Case

Let's revisit our colectomy patient.

This time, he is cared for under an ERAS pathway. He receives preoperative acetaminophen and an NSAID, multimodal intraoperative anesthesia, and scheduled non-opioids after surgery. He is awake within hours, tolerating oral intake, and using minimal opioids.
By the time of discharge, his pain is well controlled, and he requires only five tablets of oxycodone at home. His recovery is smoother, shorter, more satisfying, and overall much better. This demonstrates the power of team-based, multimodal care—evidence put into daily practice.

Takeaways

- Ensure ERAS order sets include scheduled non-opioid medications and functional pain goals.
- Encourage nursing documentation of key outcomes, such as early mobility, diet progression, and opioid use, as quality measures.
- Track opioid consumption and recovery time as dual outcomes to monitor safe and effective care.
- Engage ERAS champions from nursing, surgery, and anesthesia to keep protocols active, updated, and relevant.

Thank You

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Thank you for all you do caring for your patients.