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The patient voice in Enhanced Recovery After Surgery

An Edinburgh perspective

This article will explore the ERAS Programme and provide a unique insight into perspectives and realities of surgical recovery. It will highlight the current evidence versus patients' perceptions and expectations.

Background

The Enhanced Recovery After Surgery (ERAS) programme has been implemented in many surgical units around the world over the last two decades with varying degrees of success. This evidence-based multimodal programme is known to reduce length of hospital stay and reduce postoperative complications following elective surgery. This is clearly an attractive concept both for healthcare providers and for individual patients; however, despite the extensive evidence base, clinical variation still exists in surgical departments. Over the last several years, surgeons are performing more minimal access surgery, anaesthetists are prescribing and administering multimodal, opioid-sparing regimes, but has sufficient attention been given to patient preparation? And have the changes in surgical management been disseminated to the people that healthcare serves—the patients?

ERAS has its origins in colorectal surgery, and it is widely accepted that reduction of surgical stress, maintenance of physiological function and accomplishing early mobilisation are cornerstones of ERAS. Better compliance with these principles results in improved recovery and is reflected in shorter length of hospital stay and a reduction in complications (Gustafsson et al. 2013). In Edinburgh, Professor Ken Fearon was a key driver of ERAS and was one of the founding members of the ERAS® Society. The Western General Hospital in Edinburgh remains heavily involved in ongoing work to promote and progress ERAS principles both nationally and internationally.

A key aspect of the ERAS programme is the preoperative preparation and involvement of patients and their families. This should ideally lead to patients being more empowered and their expectations of surgical recovery being more realistic. However, this process can be challenging and requires a robust patient-centred approach to ensure that the *right* information is given to patients at the *right* time using the *right* format. In order to represent the patient voice and to highlight the realities of surgical recovery, a video interview was conducted between an ERAS nurse and a colorectal patient – Ruth.

Several topics were selected for discussion with Ruth during an informal, semi-structured interview to explore her experiences leading up to surgery and the recovery thereafter. Ruth is also a physiotherapist who works in the colorectal unit where she was unfortunately diagnosed with bowel cancer and required surgery. This gives her a unique perspective on both the importance of the ERAS programme from a healthcare professional point of view and from the patient perspective.

Interview

The interview was conducted using questions that were formulated from the experiences of several members of the local clinical team who had also had surgery recently. The key themes of these discussions were around preoperative preparation, being a patient, the discharge process and going home, and specific postoperative complications such as ileus. Other issues such as sleep deprivation and environmental realities of being in hospital were also raised.

The interview was an informal chat around these issues that was captured on video and then presented at the ERAS Congress in Lyon in May 2017. The patient voice is a crucial component of the ERAS programme that we were keen to highlight, because in some circumstances, despite the best intentions of the multidisciplinary team (MDT), delivery of the ERAS care pathway is challenging, particularly when issues such as pain or gut dysfunction hinder the patient's ability to adhere to all the aspects of ERAS. The key areas of the discussions are described under the following headings:

Preoperative preparation

It is often assumed that providing preoperative information is either simple or already embedded in standard practice. From the patient's perspective, being well prepared for surgery sets the expectations of how recovery should progress and will ultimately enhance the overall journey through the surgery, hospital stay and beyond. During the interview with Ruth, it was clear that certain parts of the preoperative information were appropriately delivered and well received by

her and her family and that they framed the forthcoming process succinctly. This information was delivered by the surgeon, who took into account that Ruth was a healthcare professional, but that he was going to give her, the same information as he would give any other patient. This was person-centred for her, and providing generic information was much appreciated and entirely appropriate in this case.

The information given following the initial consultation was felt to be heavily paper-based; Ruth admitted that she didn't read the majority of the booklets. We discussed this, and concluded that there may be better ways of delivering preoperative information. An app, access to video information or perhaps a face-to-face education class would be more appropriate for certain patients. We touched on whether being a healthcare professional altered the information she was given as there may have been pre-conceived ideas that she knew what was about to happen and so did not require the same level of information. This was not experienced until after her operation, where she almost felt 'reined in', as staff in the high dependency unit were obviously aware that she was a physiotherapist and were concerned that she may 'overdo' the mobilisation part of her recovery.

Hospital admission

In this case, there were obviously expectations of the ERAS process and Ruth had set herself goals around her recovery. There were understandable anxieties around changing roles from healthcare professional to patient—being treated by people she saw as peers and colleagues and potentially sharing ward space with ex-patients. This was alleviated somewhat by providing a single room in the ward area. During her hospital stay, there were key themes that were highlighted that she felt were difficult aspects of her recovery.

Sleep deprivation

Sleep is challenging in a hospital environment and is perhaps mismanaged in some instances. Ruth was able to highlight how she didn't fully appreciate how profound an effect this would have on her recovery. She commented that in hindsight it would have been better to have this highlighted earlier in her preoperative preparation and mentioned that although her pain was managed very well, she used analgesia knowing that it would result in a period of sleep and alleviate her nausea. We discussed the need to highlight this as an issue and perhaps recommend that patients are supplied with simple strategies such as eye masks and earplugs and that they discuss any sleep issues with staff.

"requires a robust patient-centred approach to ensure that the *right* information is given to patients at the *right* time using the *right* format"

Mobility and Restricted Independence

Because Ruth is a physiotherapist, she was all too aware of the importance of mobilisation and ERAS targets. However, she described how she would have preferred to walk as opposed to sitting in a chair for a set period of time. It is perhaps the case that walking is not offered to patients for a variety of reasons, and sometimes the desire for staff may be to follow the ERAS pathway, which contains certain compliance measures such as being up to sit for 4 hours on post-op day one. Ruth felt that some of the ERAS processes are a bit too prescriptive and suggested that a more person-centred approach should be offered. Being aware of each patient's capabilities is crucial and the sheer exhaustion following surgery means that it may not be appropriate to meet the targets with that particular patient on that particular day. Ruth described this sensation of fatigue as "*walking in glue*".

Ruth also commented:

"…..I think any element of normality that was added in during my stay in hospital always felt good. I think any patient would probably feel that way……putting on your own clothes, being able to get up and walk to the toilet on your own. All these things are hugely important to how you feel and then you're not the vulnerable person, getting stuff done to you—you regain your independence"

This sentiment that Ruth wished to regain normality is very powerful and really important. However, it is not always possible due to other circumstances such as intravenous fluids left up and catheters not being removed when appropriate.

Diet and associated challenges

This issue was by far the most challenging aspect of Ruth's recovery (including her chemotherapy treatment) as she developed a postoperative ileus.

She recognised the need to eat and drink soon after surgery in order to minimise gut dysfunction so she ate soon after surgery, but within 48 hours she began to vomit, and despite her best intentions, she was no longer able to eat or drink, so had a nasogastric tube inserted and IV fluids recommenced which was the main reason for her immobility. She described her experience as:

"…the time that I felt physically the worst, mentally the worst—it was terrible!! Unrelenting nausea, sickness, being limited in what I could do because of various attachments that came along with having an ileus. Knowing what I should be doing and not being able to do it. Knowing that I should be eating and being constrained. I can't even describe how awful it feels … it's just unrelenting is really the only way I can describe it."

She describes how she felt throughout this time and the relief when it finally came to an end:

"…I think it's just all-encompassing. Usually with pain, there's something you can take or there's a position you can get yourself into to relieve it. There's no relief from that feeling of nausea and then when it stopped, it was like a switch was flipped and I just felt better. I opened my eyes and I felt better. It was an incredible feeling and I think passing this on to anybody else, that they know it will end. I've seen people with postop ileus in a professional capacity so I knew even though in the moments of it, I just thought when, when is it going to finish?"

During this time when Ruth was unable to eat, she became increasingly fatigued and lost a significant amount of weight, which for a fit and healthy girl was a rather shocking sight for her family and friends (and her!!) to witness. The message emphasised here is that gut dysfunction is a significant barrier to recovery, and ultimately for Ruth led to a longer stay in hospital and delayed her overall recovery. We discussed whether this potential complication should be emphasised more at the preoperative stage, but Ruth felt that no-one could have described or made her understand just how unwell she would feel, and knowing more would not have helped her cope with this complication.

Going Home

The interview concluded by asking Ruth how she felt when she was given the green light to go home. Unsurprisingly, she felt that going home was when her real recovery began. She acknowledged that being able to eat what she wanted, sleep normally and go out for a walk, which may seem like simple tasks, all added to regaining a sense of normality.

Conclusion and recommendations

Although the purpose of this video was for presentation at the ERAS 2017 congress, it has been an excellent resource to increase staff awareness about the realities surrounding hospital admission, the patient experience and the often unrealistic expectations of clinical staff, patients and the wider population.

The ERAS programme is widely recognised as evidence-based healthcare; however, it must be targeted appropriately and the individual needs and capabilities of each patient should be considered as opposed to a protocolised 'tick-box' process.

Recommendations highlighted during this process include considering alternative methods such as preoperative classes to deliver patient information, methods to reduce sleep-related difficulties and consideration around individualising patient care within an ERAS programme. ■

References and Further Reading

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