Enhanced Recovery after Surgery: Implementation Strategies

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Introduction

Enhanced Recovery after Surgery (ERAS) refers to a patient-centered, evidence-based, interdisciplinary team developed pathway for a surgical specialty. The care pathway limits variability from before admission to after discharge to reduce the stress response, optimize physiologic function, and facilitate recovery.[1] The key elements of ERAS include patient/family education and engagement; patient optimization prior to admission; minimal fasting that optimally includes a carbohydrate beverage and, at a minimum, clear fluids up until two hours before anesthesia; goal directed fluid therapy, when appropriate; multimodal analgesia with appropriate use of opioids; return to normal diet and activities within 24 hours of surgery; and return home in an expedited time frame.[2-4] Research has consistently shown that adoption of ERAS pathways leads to significant improvements in patient satisfaction,[5] outcomes,[6,7] and reduction in cost of care.[2,8,9]

Successful ERAS implementation depends on many factors, including patient and staff education, engagement, collaborative leadership culture between the facility and interdisciplinary team, and use of outcome data to continuously improve elements of the pathway.[5,10,11] Certified Registered Nurse Anesthetists (CRNAs) are well positioned as champion leaders and active members of the patient-centered team for ERAS excellence, not only within the intraoperative phase of care but throughout the continuum of care of the surgical patient. In this article, we discuss the steps for a successful transition to ERAS in your practice. To read AANA's complete *Enhanced Recovery after Surgery, Considerations for Pathway Development and Implementation*, visit www.aana.com/ERAS.

The Enhanced Recovery after Surgery Implementation Process

Successful change management and ERAS implementation occurs as a process that evolves from creation of an engaging story, leadership, a climate supportive of the change initiative, implementation or trial of the pathway in one surgical specialty, and sustained change with continued improvement.[10] Despite the proven successes of ERAS, implementation challenges exist due to long held team member and patient opinion of how things should be done. There are some who believe that traditional care works just fine. These beliefs include antiquated views on fasting, unimodal pain management, and mobilization.[12] Also, staff who are already overwhelmed with workload and time constraints may feel that the ERAS program will add additional strain and complexity to their day.[12] Actively addressing these concerns and other pathway barriers through the use of data and communication is critical prior to implementing the ERAS program.

Selecting and using a change management process, such as Kotter's 8-Step Change Model, Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) and/or Comprehensive Unit-based Safety Program (CUSP) facilitate preparation, planning and execution to successfully navigate change.[13] These models offer valuable insights for teams dealing with change.[13]

In March 2017, the Agency for Healthcare Research and Quality (AHRQ) Safety Program for ERAS launched an initiative to increase implementation of ERAS pathways in U.S. hospitals through the use of AHRQ's CUSP.[14] The CUSP multifaceted approach facilitates front line teams to more rapidly adopt evidence-based practices. The CUSP Toolkit supports Kotter's 8-Step Change Model and is compatible with TeamSTEPPS®, an evidence-based framework to support and optimize team performance.[15] For more information on AHRQ Safety Program for Improving Surgical Care and Recovery: A Collaborative Program to Enhance the Recovery of Surgical Patients, visit https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/enhanced-recovery/index.html.

Creating a Climate for Change

Many initiatives fade away or struggle because team members either adopt quickly far ahead of their peers, while others lack interest in the proposed change, and others are skeptical or resist change all together. In the first stage, leaders use encouragement and discussion to help team members understand what project involves and how to best contribute. The elements of a change management process are not sequential, but instead occur again as needed to support the evolving project. Specific considerations include:[13]

***Step 1.** Create a Sense of Urgency*[13]

Considerations:

- Does the team have the desire or compelling need to improve the current program? What are the main areas of improvement needed in the current program? Is perioperative care rooted in current, evidence-based practices?
- Are patients and families satisfied with the current program?
- What are the facilitators and barriers to ERAS implementation?

In Practice:

- A member of the interdisciplinary team returns from an educational meeting inspired to implement an ERAS program. After an assessment of current care practices and analysis of outcome data, it is determined that several surgical specialties will benefit from development of an evidence-based ERAS pathway. A team is identified as the pilot team to develop the project plan. Initial small-group, informational meetings are held to raise awareness and generate excitement for potential early adopters to develop and lead the initiative.

***Step 2.** Create a Guiding Coalition*[10,13,16,17]

Considerations:

- Who are the high performing team and "champions" (e.g., nurses, anesthesia professionals, surgeon) to lead and facilitate the development and implementation of the ERAS program?
- Who will be the patient's voice and advocate on the leadership team?

In Practice:

- Identify and create a small interdisciplinary ERAS team for early success and long-term sustainability. Seek out early adopters, as well as team members who are slower to adopt to offer valuable perspective to engage the broader interdisciplinary team in the initiative over time.

***Steps 3 & 4.** Create and Communicate a Vision for Change*[13,18,19]

Considerations:

- How can current facility and benchmark data and insight be best utilized to create and then engage others in the vision for change?
- What is the compelling story?
- Does everyone on the team share the vision and have "buy-in" for the initiative?
- Does your practice/facility partner with community leaders (e.g., leaders in community-based organizations, coalitions, policy)/pre- and post-care support services to increase safety, satisfaction, and outcomes?

In Practice:

- Human factors and change management principles are valuable tools for successful ERAS implementation. Engaging the team by sharing achievements and data from established ERAS programs may garner interest and motivation for changing personal and team practice. Sharing your own data for the team to improve the ERAS pathway and care delivery is a powerful influencer. Appealing to the different attitudes and personalities to link all areas of care promotes "buy-in" from each stakeholder. Ownership is a powerful motivator for change. A cohesive vision and clear goals guide the team over many hours, days, months, and years for continued improvement and engagement with the pathway.

Introducing New Practice

In the second stage, each leader's role is to provide the team with the knowledge and training which will make them familiar with the elements of their new roles and how they are part of a larger vision. It is also important that the leaders acknowledge and celebrate team members for their active contribution for continued motivation and commitment. Specific considerations include:[13]

***Step 5.** Empower Broad-based Action, Remove Obstacles*[10,13]

Considerations:

- Which surgeon and surgical specialty is interested in developing and piloting an ERAS pathway?
- What educational and training resources exist or need to be created to support the team?
- What patient feedback can be utilized to develop the care pathways?
- What resources are available/needed in your practice for implementation success (e.g., clinical and leadership staff, equipment, medications, policy and procedure, staff and patient education, information technology, documentation and data capture)?

In Practice:

- Choosing the initial ERAS pathway is a frequent obstacle to getting started. Many facilities begin with a colorectal pathway due to the amount of literature supporting this specialty. However, the decision for an initial pathway should be facility dependent. A service line with high volumes, an enthusiastic surgeon lead, and/or the potential for the largest, quickest

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gains is a favorable starting point. Once a pathway is chosen, the development of provider education material is crucial to implementation, compliance, and long-term success. Education materials should be current and utilized to refresh current staff and to onboard new employees.

- Data is helpful to identify possible barriers. A detailed step-by-step process for auditing is necessary. Metrics include outcomes, process compliance, patient surveys, and patient reported outcomes. Collection of too many data points can be overwhelming and less meaningful. Keep it simple, and define the points that will have the greatest impact.
- Data may be obtained through the electronic medical record (EMR) or data analytic apps. When resources are limited, use free software or simple spreadsheets for data compilation. If there are issues with EMR integration, collaborate with a clinical effectiveness nurse who may already be mining and analyzing data points for other quality measures or non-ERAS service lines.

Maintaining the Momentum

In the last phase, continue to build on gains until the change becomes the new norm.[13]

***Step 6.** Generate Short-term Wins*[13,18]

- What are the data points from an EMR report that can track progress and identify opportunities for improvement?
- How are initial, new, and sustained successes celebrated?
- How are staff and patients recognized for their excellence?

In Practice:

- Short-term wins generate enthusiasm for the program and begin to hard wire the processes into the culture of the team and facility. Frequent sharing of outcome data should extend to all who are involved in the ERAS initiative. The teams may be engaged in executing the pathway, but if they are not aware of the impact of practice changes, traditional practices will return, and compliance can wane.
- Development of an internal and external marketing campaign is useful at this step. Materials that highlight improved care and outcomes can be used as direct marketing tools to increase revenue for the facility. Working with a local newspaper, internet-based news outlet, or the facility's social media platforms are low-cost options for patient outreach. Marketing within the facility is equally important. Celebrate wins with promotional items, food, thank you note, or certificate—simple things mean a lot.

***Step 7.** Consolidate and Build on Change*[13,20]

- Are there outcome and process measures to track quality?
- Are all steps audited for compliance, review, and process?
- Is there an opportunity to receive and offer feedback to improve staff, patient, and family experience?
- Is there a way to address less than satisfactory experiences?

In Practice:

- A program's success can be proven with accurate, up-to-date data, and analysis of not only outcomes, but also compliance and patient-reported experiences. Dynamic feedback loops with providers and patients are used to assess program effectiveness and guide adjustments of the pathway throughout implementation.

***Step 8.** Anchor ERAS Pathway Changes into the Organization and Team Culture*[13,20]

- Is ERAS viewed on a continuum and not a final destination?
- Does the facility encourage and facilitate leadership presence, participation, and ongoing support?
- Are initial and ongoing staff education and training supported?
- Are frequent updates provided on the successes, challenges, and solutions?
- Do the patient and the community receive continuous education on the significance and importance of ERAS?
- Are short-term wins continuously celebrated?

In Practice:

- After analyzing the data to identify the difference in ERAS vs. non-ERAS patients, ERAS teams soon realize:
  - Development of a pathway specific for the surgical specialty, patient populations, and facility may or may not include all the elements of an ERAS pathway.
  - ERAS encompasses a change in practice from when the surgery is scheduled to 30-to-90 days post discharge. Comprehensive, patient-lead perioperative care soon becomes the norm.
- Utilizing change management principles will support long-term compliance and success.
  - Enthusiasm and compliance for ERAS may decrease over time. Maintaining communication and constant feedback loops with providers, administration, and patients will support a more consistent program.
  - The multidisciplinary team continues to work together to monitor pathway compliance and contribute ongoing administrative support for evolving needs.

Conclusion

Introducing an ERAS program in practice requires careful planning, a strategic interdisciplinary approach that includes ongoing assessment for improvement, continuous education, and training.[10] Recognizing challenges early on in the program and effectively addressing them over time may be helpful for the long-term success of an ERAS program.[20] CRNAs are encouraged to be part of the ERAS change leadership team within their facilities, not only within the anesthesia realm but throughout the continuum of perioperative management and care of the surgical patient. For additional ERAS resources, including links to sample protocols, visit www.aana.com/EnhancedRecovery, or contact the AANA Professional Practice Division at practice@aana.com.

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