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Opinion

Enhanced recovery after surgery (ERAS®): Barriers and solutions for nurses

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Enhanced recovery after surgery, or ERAS®, has evolved from 'fast-track surgery' which was initially developed in colonic surgery by Henrik Kehlet in the 1990s.[1] The fundamental, evidence-based principles of ERAS® are applicable to all surgical pathways and have been shown to improve patient outcomes. Patients benefit as they return to their functional baseline more quickly with fewer complications and hospitals see cost savings through decreased lengths of stay and avoidance of complications. Many of the elements of ERAS® relate to nursing roles such as preoperative education and postoperative mobilisation, nutrition and pain relief. Twenty-five years on, we are still seeing barriers within ERAS® pathways. In this opinion article we discuss barriers and recommend some possible solutions. Barriers include poor nursing leadership, lack of engagement, poor communication, and lack of resources. Solutions include more structured communication and robust auditing. Many hospitals have found that the introduction of an ERAS® coordinator, often a nurse, is beneficial for the implementation and sustainability of ERAS® pathways.

Nursing leadership

Nurses are essential in all ERAS® pathways and when applied correctly, ERAS® should empower nurses. Not only do nurses have a responsibility in the day to day bedside care of patients, but also a responsibility in the areas of education and scientific research in an ever changing healthcare environment.[2] ERAS® can be described as a complex process and as such, can be challenging. It calls for nursing leadership: with nurses being best placed to identify problems and solve them together with other professionals. Strong leadership is needed to encourage, motivate and empower colleagues, other professions as well as patients. This is where some of the difficulties lie: traditionally, nurses have been viewed as 'care givers' rather than empowered clinicians that can make autonomous decisions about patient care. This perception may be perpetuated by nurses themselves, as they do not always see themselves as leaders within the multidisciplinary team. Changing this outdated, and often detrimental mind-set must be prioritised and supported by higher management and clinical colleagues. Over the last few years we have seen nurses take on more leadership roles and ERAS® is a perfect example of this. Many nurses have repeatedly demonstrated leadership acumen and have taken more control in the development and implementation of ERAS® pathways. This gives us confidence that nurses will continue to take ERAS® forward now and in the future and apply the principles to more and more specialties, across multiple disciplines in elective and emergency settings, provided they have the appropriate support from managers and the wider clinical team.

Buy-in and engagement

A lack of uniform engagement with different elements of the ERAS® pathway can lead to inconsistencies and uncertainty amongst nursing teams. There can be a lack of belief or gaps in knowledge with certain elements of ERAS® within the multidisciplinary team.[3] For example, surgeons may disagree with early feeding, nurses may disagree with early catheter removal, and patients may disagree with early mobilisation. Nurses sometimes fear reprisals for following ERAS® and can feel uncertain about whether they can progress patients along the ERAS® pathway autonomously or whether they still require clinician 'permission'. Sadly, this is still the case despite the extensive evidence-base supporting ERAS® pathways. Ongoing staff engagement, education, and support are essential to a successful ERAS® pathway.

Communication

Conflicting approaches to patient care between various members of the clinical team can lead to uncertainty, further confounded by poor communication. In order to address inconsistencies in daily clinical practice, there needs to be better communication between all healthcare

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professionals. It is important to challenge traditional practices and beliefs[3] through open discussion and education so that our nursing colleagues can fully understand the relevant evidence behind the various ERAS® elements. Nurses need to be encouraged to speak up, voice concerns and advocate for their patients whilst ensuring that they are adhering to best practice and have confidence progressing patients along the ERAS® pathway.

Consistent and open communication with the wider management and multidisciplinary team can be provided through regular reports that document aspects of the ERAS® process using data collected; highlighting successes as well as areas for improvement. Structured meetings can include daily patient reviews and nursing huddles, where the clinical team meets to briefly discuss, formulate and update patient care plans.

Communication with patients is also key to a successful ERAS® program. A lack of continuity and conflicting information can result in confusion. In this era of person-centred care, providing patients with conflicting information and advice is no longer acceptable. One of the key strengths of an ERAS® program is that it helps patients have a greater understanding of what is to be expected before, during and after surgery. By having an agreed pathway, we can confidently inform our patients about the key components of their recovery. Preoperative coaching ensures patients have realistic expectations and can fully participate in the pathway. Patients should be given this information in a manner that works for them; using appropriate language and tools such as apps, websites, and patient diaries to assist with their education, engagement, and participation.

Resources and work load

Limited resources can be a barrier to ERAS®. Although some published evidence demonstrates that ERAS® pathways effectively reduce nurses' workload,[4] this may not be easily perceived by staff at the bedside. Nurses are responsible for patient education and progression of patients from their operation to postoperative care, ensuring that they meet the milestones necessary for discharge home. In busy clinical areas, staff may become frustrated by the lack of time to follow ERAS® guidelines and address any common compliance concerns. Also, we know that nurses are increasingly leaving the bedside and the profession, victims of stress, burnout, exhausting work conditions, and often inadequate payment. There has long been a recognised nursing shortage, but the COVID-19 pandemic has elevated this situation to crisis proportions. It has been highlighted in recent publications that there has never been a more important time to implement ERAS® as it will increase efficiency in already stretched healthcare settings. By introducing a more structured perioperative pathway, this will lead to more efficient use of nursing time and resources and hopefully a more rewarding, less stressful working environment. Recognising the need for investment and provision of resources to support nurses is crucial to ensure the enduring success of ERAS® programs.

One solution to mitigate some of the barriers highlighted has been the introduction of the ERAS® coordinator, most commonly a specialist nurse.[5] The ERAS® coordinator focusses on successful ERAS® implementation and sustainability. This role includes continuous staff education, data management and care pathway development. By providing ERAS® education and real-time auditing, the coordinator maintains engagement and keeps ERAS® visible to the entire team. It is important that this person has effective leadership skills and knowledge as well as a level of seniority and trust within their department.

Data can be a powerful tool, showing in real-time what is being done well and what needs further improvement. Despite the additional time required to collect, input and analyse ERAS® data, it is truly necessary to provide evidence, highlight compliance and demonstrate improved clinical outcomes. This data should be shared with all members of the team, particularly the nurses who will benefit from understanding that their endeavours are making a difference. Data can also support requests for additional resources where needed.

Conclusions

To summarise, barriers to ERAS® can include ineffective leadership, poor engagement and poor communication. These barriers can lead to clinical variation and create confusion resulting in the potential failure of ERAS®. This uncertainty will have a negative impact on nurses. To avoid this, the pathway or protocol must include contributions by all stakeholders to ensure buy-in and support from inception to implementation and ultimately, sustainability. When implementing ERAS® at hospital level, continuous open communication is essential to ensure consensus across the multi-disciplinary team. There needs to be clear leadership and ownership of the program: one option is the deployment of an ERAS® coordinator. Data should be used to demonstrate improvements in clinical outcomes and adherence thereby strengthening support for ERAS® within the department.

Nurses are the driving force behind a successful ERAS® program and ERAS® should empower nurses to deliver the best evidence-based care for patients. It therefore stands to reason that ERAS® cannot exist without nurses. ERAS® should provide a framework to allow nurses to be more autonomous and confident therefore nurses must be supported during the transition from current, more traditional nursing roles to strong leadership roles advocating the use of evidence-based practice such as ERAS®.

Declaration of competing interest

Angie Balfour - ERAS® Coach, Encare®. Co-Director of The Enhanced Recovery after Surgery Society (UK) C.I.C. (not-for-profit organization—Company No. 10932208). No relevant conflict of interest related to this work.

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