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FOCUS ON: ENHANCED RECOVERY

Ten top tips on designing, developing & implementing an enhanced surgical treatment & recovery programme (ESTReP)

P.M. Meale [a,*], Joanne Cushion [b]

[a] Institute of Human Health & Performance, University College London, 1st Floor Charterhouse, Archway Campus Highgate Hill, N19 5LW London, UK
[b] Whittington Hospital, Magdala Avenue, N19 5NF London, UK

Keyword:
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SUMMARY

Enhanced Recovery Programmes have been demonstrated to improve short-term outcomes after major abdominal surgery, and are considered best practice.

The aim of this work is to share the experience and outline the process of the design; development; & implementation of an Enhanced Surgical Treatment & Recovery Programme (ESTReP), and also to provide recommendations for ongoing programme maintenance and improvement.

1. Introduction

In March 2008, following a review of literature on the subject of ESTReP, enhanced recovery was adopted at our District General Hospital, for patients undergoing major intra-cavity surgery. Subsequently, this led to a significant reduction in postoperative length of stay.

We hope that our recommendations will avoid reinvention of the wheel, streamline the process and dramatically reduce the run-in time for others considering adopting such a programme, in the United Kingdom (UK). In our experience a more formalised adoption process would have aided implementation, for example by being explicit about expectations; clearly defining individual roles & responsibilities and having clear-cut deadlines.

In order to succeed, it is essential that key stakeholders and programme users are consulted for collective decision-making i.e. the agreement of pathway goals. Their contribution to the programme development will reduce resistance to change and increase ownership. Understanding the official channels will facilitate the implementation time lines and prevent unnecessary delay.

Designated leadership, communication and education are critical to sustaining programme focus, enthusiasm and compliance. Whilst ESTReP documentation provides a visual flag and facilitates audit process.

2. The ten top tips

1. Set up a development group with project stakeholders i.e. anyone with an interest in the project

   At the initial meeting:
   - Nominate the project lead, this should be someone with the time and commitment to driving and implementing the programme in a timely manner
   - Identify the roles & responsibilities of each member
   - Set dates & times for subsequent meetings, no more than 2 weekly & no less than once monthly
   - Set time line for consensus to be reached, this should be no longer than two months

2. Conduct a literature search of current evidence and liaise with Trusts running similar care packages, the latter can save the reinvention of the wheel and unnecessary repetition of work

3. Over a series of meetings discuss & review the clinical evidence and decide the programme goals
   Other factors to assess:
   - Local Surgical Outcomes data e.g. current length of stay (LOS)/annual throughput
   - Simple financial analysis of approximate financial savings based on bed reduction e.g.
     - Current LOS 20 days minus anticipated LOS of 5 days = 15 bed days saved, at £200/per day = a minimum of £3000/patient
     - Approximate throughput of 100 patients per year = £300 000 or 1500 extra bed days available which could be used for 300 more 5 day cases or 1500 day cases, thus generating more income per bed
     - Minus the cost of an Enhanced Recovery Nurse approximately £50 000 (with on costs)

* Corresponding author. Tel.: +44 2072883887.
E-mail address: rmhapmm@ucl.ac.uk (P.M. Meale).

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4. Perform a stakeholder analysis, to identifying those who will be affected by the project, this can be broken down into: Diagram 1, Table 1

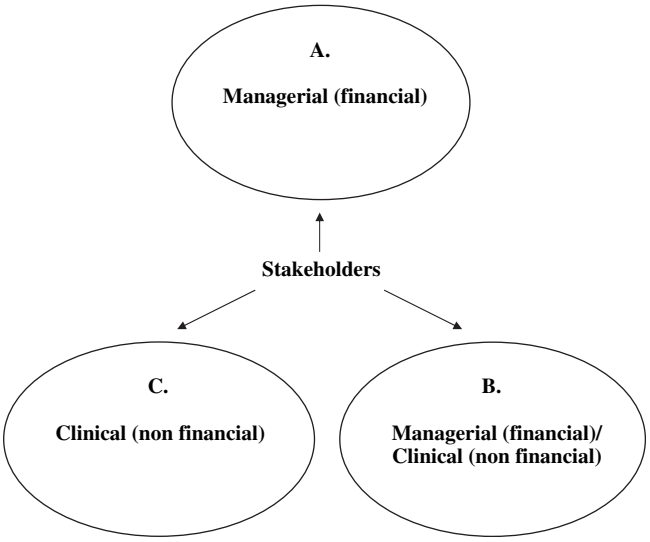

Diagram 1. Stakeholder breakdown.

Table 1
Stakeholders by group.

A. Director of Operations & General Manager, Division of Surgery.
B. Critical Care Matron; Medical Director; Surgical Director; Surgical Matron; Theatre Matron.
C. Anaesthetists; Colorectal Nurse specialist; Colorectal Ward Charge Nurse; Critical Care Outreach Team; Dietician; Intensivists; Pain Team (medical & nursing); Pharmacist; Physiotherapist; Preoperative assessment team; Stoma Nurse; Service user i.e. patient[a]; Surgeons.

[a] Optional.

5. Arrange for the development group lead to present at a meeting with high level of attendance, such as a joint surgical/anaesthetic or morbidity & mortality meeting.
   Who should attend the meeting?
   - All development group members should attend the meeting, in order that they are available to answer questions relating to their particular area of expertise
   - All influential stakeholders should be invited to the meeting i.e. those listed in group A & B
   - Anaesthetists & surgeons working with patient cohort

   What should the presentation include?
   - Historical Surgical Outcomes for the Trust, on relevant patient cohort i.e.
     - Current morbidity and mortality
     - Average length of hospital stay
     - Evidence for a multimodal care package
     - Anticipated length of stay with the introduction of a multimodal package
     - Anticipated benefits for the patient i.e. improving the quality of patient care and reduction of morbidity, (based on other Trust's data)
     - Anticipated financial impact for the trust
     - Necessity of an Enhanced Recovery Nurse (ERN) to ensure programme success, include examples of failings in Trusts that do not have enhanced recovery champion

   The aim of the meeting:
   - To promote discussion around the subject matter
   - Achieve a consensus amongst the influential stakeholders
   - To gain permission to implement & role out the programme
   - Find out which committee the programme will need to be approved by i.e. Clinical Guidelines Committee and committee dates

6. Set up a implementation group, this should largely comprise of representatives of the stakeholders listed in group C, in addition to the Matrons from group B
   At the initial meeting:
   - Nominate the project lead, this will ideally be the same person from the development group
   - Introduce the evidence for a multimodal care package and perceived patient/Trust benefits
   - Identify the roles & responsibilities of each member:
     - Who will develop the ESTReP pathway document for publication, this should be the person who will facilitate the implementation at the earliest opportunity
     - Who will write associated guidelines/patient information literature, this should be person(s) from relevant specialties'
     - Who will approach Trust management and write business case for ERN funding
     - Who will manage staff education
     - Time lines for project launch, be ambitious and don't allow apathy, aim for two months
     - Highlight the importance of cascading information from the meetings back to own clinical area/disciplines, in order that the programme is topical and expected
   - Set dates & times for subsequent meetings, no less than 2 weekly initially, to enable troubleshooting and discuss progress

7. Developing the ESTReP pathway document
   - Wherever possible the new document should be merged with current documentation for familiarity
   - The document should however comprise of:
     - The ESTReP goals
     - Comprehensive nursing documentation in the form of closed questions, as quality reporting relies upon accurate patient data
     - Information to facilitate surgical outcome & compliance monitoring as this is paramount to reporting programme success i.e. benefits to the patient & Trust
     - Ideally the data should provide information required for validated outcomes tools such as the 'POSSUM' (morbidity/mortality prediction tool) and 'POMS' (observed morbidity tool)
     - Additional data such as ITU & ward bed usage, reoperation rates & mortality data should be included
   - The users of the document should be involved at each stage of the process, in order that they contribute to the content and format of the document

8. Managing resistance to change
   Unfortunately, even the best planned and designed programme will encounter opposition. This can manifest itself in lack of attendance or disruption of meetings; failure to engage or facilitate in the change process; actively working against the process i.e. refusal to provide information or tools or giving ambiguous information.
   To try and avoid this:
   - Engage the programme users at all stages of the process
   - Actively seek out their thoughts and reactions to the proposed changes
   - Listen to their needs & concerns and address them
   - Only change what is necessary, 'If it isn't broken don't fix it'