Journal of Visceral Surgery (2016) 153, S33—S39

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REVIEW

How to introduce a program of Enhanced Recovery after Surgery? The experience of the CAPIO group

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Available online 16 November 2016

KEYWORDS
Rapid Recovery after Surgery (RRAS);
Enhanced Recovery after Surgery (ERAS);
Enhanced Recovery Program (ERP);
Rapid recovery program;
Transforming healthcare;
Multidisciplinary team;
Pre-operative education;
Peri-operative care;
Telemedicine

Summary The traditional model of hospital care has been challenged by the development of a care-management process that allows early patient autonomy (outpatient surgery, Enhanced Recovery after Surgery). Hospitalization has been transformed in response to this development, based on innovative medical and organizational strategies. Within a surgical service, the deployment of these processes requires the creation of a support structure, with re-organization of existing structures, analysis of potential obstacles, implementation of management tools, and ongoing follow-up of organizational function, clinical results, organizational and patient satisfaction. These will ultimately assess adaptation of structures within these new organizations. In this article, we share our insights based on experience gained over the past six years by surgical teams of the CAPIO group.
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Introduction

Since the original publications by Henrik Kehlet [1], the principles of rapid rehabilitation after surgery have spread to involve most surgical specialties under the leadership of national programs, including the United Kingdom (National Health Service) and the Netherlands. Nevertheless, despite their known benefits, these programs have still not been universally adopted [2], and the expected results have not always lived up to expectations.

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http://dx.doi.org/10.1016/j.jviscsurg.2016.10.001
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This highlights the need to standardize the implementation of the process and to organize monitoring, to reform our organizations and structures and to ensure greater consistency and efficiency of the care chain.

CAPIO: a European health care group

The Capio Group is positioning itself as a pan-European health care provider for both public (contracted management) and private patients. It is located mainly in Sweden and France, but also in Germany, Norway and the United Kingdom. In 2015, 4.6 million European patients underwent treatment in CAPIO facilities (inpatient and outpatient). In France, CAPIO manages 22 establishments providing medical, surgical, and/or obstetrical care. It follows a policy of hospital restructuring that incorporates solutions based on innovative care strategies to provide quality care and economic productivity. It thus provides an original answer to the needed adaptation of European care systems to their socio-economic environment.

Transforming care

Why?

The positioning of the CAPIO Company in territories with great variation in structures and medical care organization (Sweden, France) has allowed us to clearly analyze our operations and to make two major observations involving innovative thinking about our organizations.

The first is based on the analysis of hospital capacity that demonstrates overcapacity of beds per capita in France, double that in Sweden, with no corresponding improvement in international indicators of quality of care according to an Organization for Economic Cooperation and Development (OECD) report. This overcapacity is directly related to our structural organizations and their upstream and downstream articulations.

The second is based on the observation that our surgical activity is predominantly ambulatory and increasingly so from year to year (57% of all surgical activity was outpatient in 2015), suggesting the need for organizational change toward a single model, structured and clear for hospital professionals and accessible for all patients.

How?

This assessment has defined the medical strategy of the group: to transform and improve our care process through the development of Enhanced Recovery after Surgery Programs (ERP).

These combine clinical ERP with a fundamental re-design of organizations. The aim is to optimize early return to normal function after any surgical or interventional procedure, and to produce the best possible medical care through reliance on factual indicators of quality and safety of care. The program involves all health professionals involved in the care process and is the primary axis of medical policy of the institution.

Length of stay, which has often been advanced as the only medico-economic objective, cannot be the only inspiration for improving the health care process. Indeed, much more is expected including further improvement in clinical and functional outcomes, quality of life and patient satisfaction, not only in the short term but also in the medium and long term. It is therefore necessary to reposition length of stay in the dashboard of results of process indicators.

The main principles

The commitment of medico-surgical teams

This is the essential entry point of the program. The private practice of hospital medicine involves the health care facility with medical-surgical participants. Building an effective organization depends on close collaboration between clinical administrators and private practitioners. The effectiveness of the multidisciplinary team and its ability to modify the care process depend on the level of integration of these various components.

The organization of medical and surgical teams also determines the success of this collaboration. Teams organized as large associations in a particular specialty and surgical hyperspecialization facilitate the construction and implementation of the program.

The ERP referee

The ERP referee, usually from the nursing service, is a key player and should receive useful support from a high-quality institution in the first weeks of taking up this post. The choice of this professional will have a major influence on the successful implementation of the ERP program in cooperation with the anesthesiologist and surgeon team. They both participate in the investment and the implications of the multidisciplinary ERP team.

Two main criteria arise in the choice of this professional:

- the esteem and confidence of responsible practitioners and care units;
- strong motivation and commitment to the process.

Among the desired skills are:

- competence in team leadership and project management;
- good quality of communication: being able to listen but also to be firm once a course has been set;
- the ability to train medical staff;
- business competence, including expertise, knowledge of the terrain, understanding of the problems raised by every aspect of the surgical and interventional treatment.

All tasks must be clearly defined, and the support of the quality manager can assist in project formulation at the beginning of the experience. The role of the referee is to build, in cooperation with the multidisciplinary care team, the new clinical pathways and the therapeutic protocols with leading practitioners, and the documentation provided to the patient. The referee is responsible for the collection of monitoring data to measure adherence to the program, and for mapping out the ERP structure of the institution. The referee oversees the ERP program and assures that it is properly conducted in each relevant care unit, but is not directly involved in patient care. The referee runs regular ERP training programs for caregivers including all shifts, and also for the administrative and medical secretariats. The referee regularly communicates to the steering committee all advances, obstacles and needs related to the program.

The time required by the ERP referee to launch the program may amount to a half-time job equivalent and may

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