ERAS – The Journey Continues

Princess Alexandra Hospital

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HRT 1719 Surgical Journey Improvement Group

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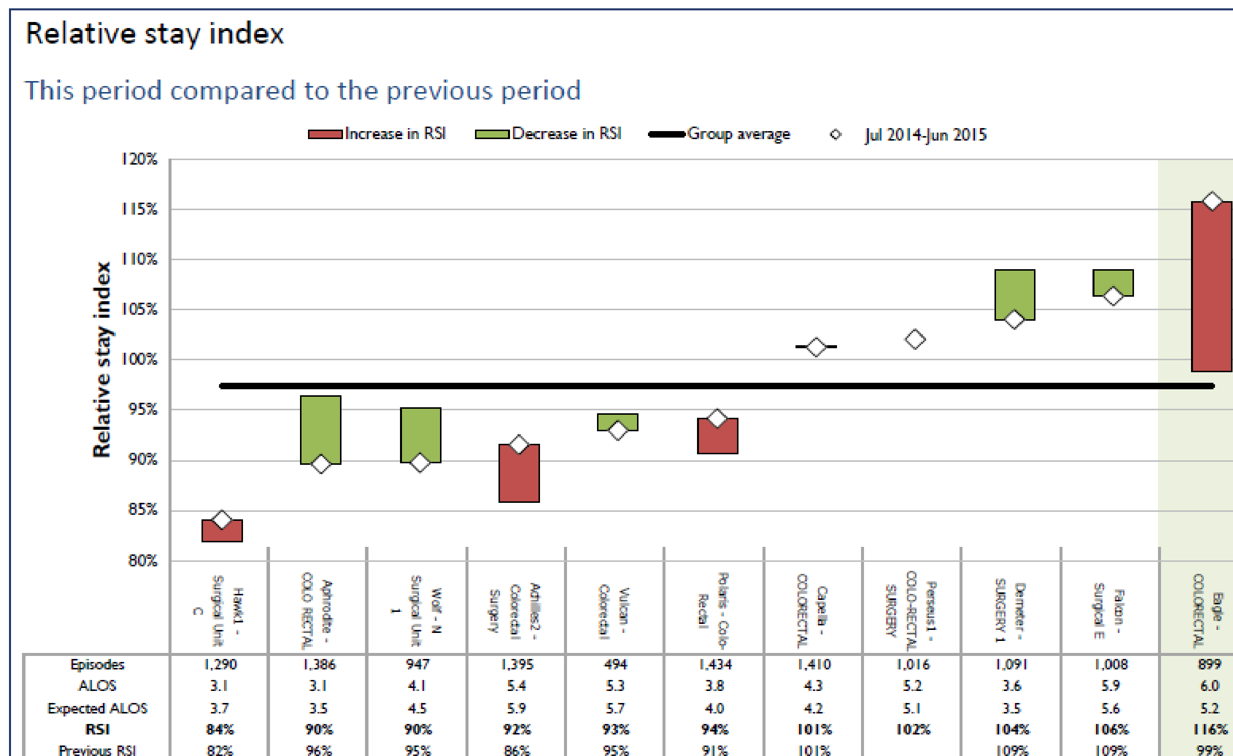
Brisbane

Key Problem

- In 2008 the Colorectal team implemented pre-op carbohydrate drinks for patients undergoing bowel surgery. Since then surgical practices have evolved to align with ERAS recommendations.
- Despite changing practice, a formal ERAS protocol has never been developed.
- As a result, we are unaware of how current practice complies with ERAS recommendations and hence, how we can better target ERAS recommendations to improve patient outcomes.
  - E.g. Health Round Table benchmarking for 2014-2015 showed increased LOS



	Hawk1 - Surgical Unit C	Aphrodite - COLO RECTAL	Wolf - N Surgical Unit 1	Achilles2 - Colorectal Surgery	Vulcan - Colorectal	Polaris - Colo-Rectal	Capella - COLORECTAL	Perseus1 - COLO-RECTAL SURGERY	Demeter - SURGERY 1	Falcon - Surgical E	Eagle - COLORECTAL
Episodes	1,290	1,386	947	1,395	494	1,434	1,410	1,016	1,091	1,008	899
ALOS	3.1	3.1	4.1	5.4	5.3	3.8	4.3	5.2	3.6	5.9	6.0
Expected ALOS	3.7	3.5	4.5	5.9	5.7	4.0	4.2	5.1	3.5	5.6	5.2
RSI	**84%**	**90%**	**90%**	**92%**	**93%**	**94%**	**101%**	**102%**	**104%**	**106%**	**116%**
Previous RSI	82%	96%	95%	86%	95%	91%	101%		109%	109%	99%

Aim of this innovation

1. To identify how current practice complies with ERAS recommendations
2. To develop and implement a formalised ERAS protocol for PAH Colorectal patients

Our ultimate outcomes through implementing an ERAS protocol include:

- Earlier post operative feeding
- Earlier mobilisation postoperatively
- Better outcomes for patients
- Earlier discharge dates
- Decreased complications

Baseline Data

What we know so far in colorectal surgery...

- PAH has limited baseline audit data

- The colorectal team have changed practice due to emerging evidence:
  - Limited use of nasogastric tubes and drains
  - Increased use of minimally invasive techniques vs. open procedures
  - Fluid management intra-operatively
  - ~90% of elective patients are given preoperative carbohydrate drinks (exclusion criteria: diabetics, reflux, BMI >35)

- Baseline audit: ***post-operative diet upgrades are inconsistent with ERAS recommendations*** of an unrestricted diet day 1 post-op
  - Free fluids diet day = 1 post-op
  - Full diet = day 4 post-op

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Key Changes Implemented

The Health Roundtable

We are currently focusing on improving early oral feeding...

- Many clinical practice guidelines recommend early oral feeding in the form of an unrestricted diet within 24 hours postoperatively
- Baseline audit: ***post-operative diet upgrades are inconsistent with ERAS recommendations*** of an unrestricted diet day 1 post-op
  - Free fluids diet day = 1 post-op
  - Full diet = day 4 post-op
- Conducted interviews with the colorectal team (surgeons and nursing staff) to identify barriers for successful implementation of early oral feeding in postoperative elective colorectal patients

ask us first

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Outcomes so far

We are currently focusing on improving early oral feeding...

- Interview outcomes:

1. Decision-makers use a pragmatic approach to diet upgrades
2. Disparities exist in diet upgrade practices
3. Limited understanding of different hospital diets

"I don't know whether there's just a bit of, sort of, hocus pocus… or whether there's really any difference with giving someone just clear fluids or free fluids." – Registrar

4. Diet upgrades are not systematically tracked and vulnerable to communication breakdown
5. An early oral feeding pathway with facility to 'opt-out' was widely accepted

"I think a pathway is a good idea, I think that is the way to do it" - Consultant

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Lessons Learnt

- The need for structure and frameworks to help plan implementation and evaluation to better execute effective change

- The need for multidisciplinary support and consensus to implement changes
  - Surgeons
  - Nursing
  - Dietetics
  - Anaesthetics
  - Physiotherapy

- Consideration of increased patient involvement (e.g. pre-op education, reviewing fact sheets/brochures)

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