



# Podcast Transcript

## The ERAS Protocol: Faster, Safer Surgical Recovery

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#### Guest: Joanna Grayson, RN, BSN

Joanna Grayson is an experienced nurse educator specializing in evidence-based protocols like Enhanced Recovery After Surgery (ERAS). With a background in clinical nursing, curriculum development, and healthcare communications, she provides clear, practical education to improve surgical outcomes and patient care. A BSN-prepared nurse with additional training in pediatric and school health, Joanna has developed content for healthcare professionals across clinical and academic settings. Her academic credentials include degrees from Baylor University and Emory University, along with advanced coursework in health education and communication. Joanna is known for making complex topics accessible and actionable for both providers and patients.

#### Host: Candace Pierce: DNP, MSN, RN, CNE

Dr. Candace Pierce is a nurse leader committed to ensuring nurses are well prepared and offered abundant opportunities and resources to enhance their skills acquisition and confidence at the bedside. With 15 years in nursing, she has worked at the bedside, in management, and in nursing education. She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education, and collaborative efforts within and outside of healthcare. Scholarship endeavors include funded grants, publications, and presentations. As a leader, Dr. PIERCE: strives to empower others to create and deploy ideas and embrace their professional roles as leaders, change agents, and problem solvers. In her position as the Sr. Course Development Manager for Elite, she works as a project engineer with subject matter experts to develop evidence-based best practices in continuing education for nurses and other healthcare professionals.

### Transcript

Candace Pierce: Hello. I am Dr. Candace Pierce with Elite Learning by Colibri Healthcare, and you are listening to our Elite Learning podcast where we share the most up-to-date education for healthcare professionals. Welcome to our podcast, *Understanding the ERAS Protocol: Enhanced Recovery After Surgery*. It's also known by that acronym ERAS, which is how it got its name, ERAS, and it's an approach to perioperative care that really aims to optimize patient recovery and outcomes. There are strategies that range across perioperative, intraoperative, and postoperative phases. And in each phase, the goal is really to reduce complications. Joining me for this discussion is Joanna Grayson. Joanna, thank you for being here for this discussion. Can you give us a little bit about your background?

Joanna Grayson: Thank you very much for having me. Sure. So I'm a registered nurse and I currently work in the education field. And in terms of clinical background, I've worked in everything from Med-Surg to elementary schools.

PIERCE: That's a diverse range. Elementary school to the operating room. Med-Surg, what about OB, Peds?

GRAYSON: I have done that as well, yes.

PIERCE: Wow, that's a very, I have not gone to that floor. That is a floor I'd like to stay off of is OB and Peds. But yes. Now I want to really start off with the ERAS protocol. You know, where did the ERAS Protocol come from? How old is it? What is it?

GRAYSON: Sure. So, as you mentioned, the ERAS protocol stands for Enhanced Recovery After Surgery. And it is a protocol or a set pathway of evidence-based clinical guidelines that clinicians can use to promote faster recovery in post-surgical patients. It is known for reducing hospital stays, surgical complications, and readmissions, which, of course, means reducing costs for the facility.

PIERCE: What are the primary objectives within the ERAS protocol? Well, I will say I thought I read that the ERAS protocol actually came from Denmark.

GRAYSON: It did, it did. It came from a Danish physician, Dr. Kehlet, from the University of Copenhagen, and he implemented ERAS in 1997 during colorectal surgery. And it has expanded from there to most industrialized nations and then used for all different kinds of surgeries. Everything from breast reconstruction to bariatric to hepatic, gynecological, urological, rectal, and so on.

PIERCE: How come it's, I have not heard of this? You say, you know, it started in 1997, but I still, in the hospital setting, have not heard of the ERAS protocol. Is it not as popular, or is it just becoming popular?

GRAYSON: No, it has been around. I think there have been some issues with compliance with it. And like any protocol, clinicians have to use it consistently for it to be effective. And this, of course, falls on the shoulders of nurses because nurses are the team members who are with patients throughout the whole surgical process. And so nurses have had some barriers to adapting to ERAS.

So, yeah. No, that's okay. Some other history about the ERAS protocol is that when it was first introduced in the orthopedic setting, it was used for total hip arthroplasty and total knee arthroplasty surgeries, because those are high-volume surgeries that tend to be very costly and that also equate to longer hospital stays. ERAS has seen a lot of success in the orthopedic field.

PIERCE: Okay, what are those primary objectives that he was trying to hit when he developed this protocol?

GRAYSON: Sure. So what makes ERAS different from the traditional perioperative models is that with ERAS, patients receive a lot of education and counseling in the preadmission phase and in the preoperative phase. And of course, when patients receive that level of education and counseling, it

empowers them, and it empowers them to take care of their health. The other thing that makes ERAS different from the traditional protocol is that it uses multimodal analgesia, which we can get into in a few minutes. And then it also encourages early mobilization right after surgery.

And the difference, how that differs from the traditional perioperative model, is that the traditional perioperative model really did not educate and empower patients about their procedure. So of course, in turn, patients had a lot of anxiety, particularly a lot of anxiety about the pain that they were going to face after surgery. And so when patients have that level of anxiety and distress going into a surgery and after a surgery, there's a higher risk for complications and slower healing.

Also, the traditional perioperative model really relied heavily on opioids as the main pain medication. And ERAS is a little bit different from that, which we can get into. And then also, the traditional perioperative model relied on surgical tourniquets and drains, which are not used as much anymore. Research has indicated that those strategies are not very effective for most surgeries.

And then, of course, the traditional perioperative model emphasized bed rest. So after surgery, patients were told to stay in bed and rest. And what we know now is that bed rest leads to respiratory complications, wound healing issues, thromboembolism, blood clots, those sorts of things. So one of the main goals of ERAS is to get the patient up and out of bed as soon as possible after surgery.

PIERCE: So just listening to you describe all of these things, and I know we talked about nurses playing a major role in this protocol, and that's probably why we don't see it adopted as much as we would like, but listening to some of the things you're saying makes me think physicians also would be hesitant. Especially those who say, "Wait, I can't have my drains? I can't have my tubes?" That's different. So what are you seeing there with physicians?

GRAYSON: So the issue with any new protocol that's being used is that it is based in evidence-based research, which is going to be newer information. Most clinicians tend to do things how they were taught in school, and they tend to hold on to those practices throughout their career.

And so, essentially, it's harder to teach an older dog new tricks. When we learn something in school and we've implemented that for X number of years in our practice, and then new research comes around and says, "Hey, actually, what you've been doing for 10, 15, 20 years has been found to not be as effective as this other way of doing things," then we see where clinicians kind of dig their heels in and are not willing to accept the new practices. So that's one of the barriers with ERAS. Clinicians, whether it's physicians, nurses, anesthesiologists, techs, it doesn't matter. A lot of them want to hold on to the ways that they were taught, and they're slow to adopt new practices.

PIERCE: Which could mean why we're slow to adopt the ERAS protocol in some areas more readily. What I did see is we were talking about that this was developed, I think you said 1997. So I did see that there is, so that's roughly what, two decades of clinical research. And what I saw was that it showed reductions in complications, reduction in length of stay, and reduction in overall healthcare costs. It's just, I'm curious. Other than just us not wanting to go away from what we were taught; it seems like the evidence is there.

GRAYSON: It is. And in terms of cost, which, as we know, the healthcare system is always concerned about cost of care. Some research has come out about how the ERAS protocol translates to saving money. Essentially, research has found that ERAS can reduce hospital stays, surgical complications, and readmissions by as much as 50%, which is tremendous. It also saves about seven thousand dollars per patient compared to standard care.

At the University of Virginia Healthcare System, they found that they were able to save seven hundred seventy-eight thousand dollars within the first six months of launching their protocol. They also found that their patients' opioid use fell by 80% and that their patient satisfaction rate doubled. In St. Mary's Hospital in Waterbury, Connecticut, they had an increased revenue of about \$750,000.

PIERCE: That's huge. That's huge too, because it's not just about the money.

GRAYSON: And then they also studied how using the protocol impacted rates of surgical infections in patients. They found that surgical site infections, which are very costly to treat. When they implemented the protocol, they were actually able to save twenty-eight thousand dollars per infection. That equated to one and a half million dollars in savings for them. So the research is there that ERAS does work, and it is effective. But like any protocol, it has to be used consistently. And of course, there are those barriers that we talked about.

PIERCE: So if we go back to the ERAS protocol itself, what are the key components and how do they contribute to the patient outcomes, the improved patient outcomes that we're seeing?

GRAYSON: So there are four stages of the ERAS protocol. The first is the pre-admission stage. The second is the pre-operative stage. The third is the intraoperative stage. And then the fourth is the post-operative or discharge stage. During the pre-admission stage, there are two main goals. The first is to educate the patient. The second is to correct any underlying conditions that the patient may have that can lead to poor surgical outcomes. So, during the pre-admission stage, the clinical staff will educate the patients about their condition, about the procedure, offer emotional support, and also explain the healthcare team's expectations of the patient, particularly while they're hospitalized after the surgery and what that patient's role is in their own recovery process.

Then diagnostic tests, imaging, and a comprehensive patient history can detect any underlying conditions such as malnutrition, and those can get corrected before the surgery. If the patient smokes, then they are required to quit at least four weeks before their surgery because, as we know, smoking can delay wound healing.

A lot of surgeons today, if the patient is a smoker and is not willing to quit, will not do the surgery on that patient. So a lot of surgeons will not perform surgery on patients who are actively smoking because, as we know, smoking can delay wound healing and cause respiratory complications post-op. Surgeons today really just do not want the liability and to take chances with that. If the patient drinks alcohol, they are encouraged to stop drinking prior to the surgery because drinking alcohol can increase the risk of infection. It can increase respiratory complications, which of course increase hospital stays. Today, patients are encouraged to exercise as much as they are able to prior to the surgery, and they are encouraged to eat a healthy diet mostly comprised of high fats and proteins, which can help with wound healing.

So the next stage, the preoperative stage. In the past, the gold standard for patients was not to eat or drink anything past midnight the night before the surgery. That has changed. Today, patients can eat up to six hours before their surgical procedure. Yes, you can have supper. You can have supper. And again, the preferred diet is high-quality protein and fat. You can certainly have carbohydrates, and there's a little bit of a debate about the role of carbo loading prior to surgery.

PIERCE: Yes, I saw that. Yes. Please talk about that.

GRAYSON: It has been found to be effective in some surgeries and not recommended for others. For instance, in some orthopedic surgeries, they say that carbo loading is not productive. It does not enhance outcomes. Whereas in some gastric surgeries, the surgeons feel that the carbo loading does help prior to that surgery.

PIERCE: I think what I read was the debate was about carbohydrate loading and its ability to maintain your metabolic stability versus your insulin resistance. So to reduce that insulin resistance. So it's hard for me to understand, if I'm looking at it that way, why wouldn't it be beneficial in all surgeries? Of course, I don't understand. I'm not doing the research on that. But yes, that's an interesting debate. I don't know the answer to that.

GRAYSON: Well, I don't either, or that's actually why there's no specific recommendation regarding carbohydrates in the protocol. It's essential that patients are encouraged to eat a healthy high-protein, high-fat diet prior to and after surgery.

PIERCE: Right, which the high protein I know helps with healing and wound recovery. So that makes complete sense to me that you would say, yeah, eat a high-protein diet. Makes sense.

GRAYSON: Yeah, and that's also our benefit, you know, and that's so good for our skin, which also helps with the wound healing. To your point about insulin resistance, patients are not encouraged to fast before surgery because fasting creates a catabolic state, and that can actually cause insulin resistance. Some research studies have been done about that, and it's not encouraged.

In terms of liquids, patients can have fluids up to two hours before they receive anesthesia. Research studies have shown that liquids are safe up to two hours before induction of anesthesia because they don't increase gastric content, they don't reduce gastric fluid pH or increase complications. So, multimodal analgesia, which we touched on a little bit previously, is when different medications are given via different routes to help reduce pain at different points in the pain pathway. Multimodal analgesia is a big part of the ERAS pathway. Analgesics will be started during the pre-op phase, as well as any medications needed to help combat nausea and vomiting.

In terms of hair removal prior to surgery, that's to reduce surgical site infection, and it's actually not encouraged as much. If the hair can stay intact, then surgeons are asked to leave the patient's body hair, wherever it occurs in relation to the surgery, intact, and to use prophylactic antibiotics or a dilute betadine lavage instead of doing hair removal.

Then the intraoperative stage. This is where the surgical team will warm intravenous fluids, they'll use warming blankets, and they'll also warm and humidify any of the anesthetic gases that the patient is receiving. All of these help promote a normal body temperature and prevent

hypothermia. The goals of fluid management during this stage are to maintain the normal body fluid compartments, to facilitate waste excretion, and also to help the patient be able to return to their normal oral fluid intake as soon as possible after surgery. Urinary catheters are also an issue during surgery. ERAS protocol recommends that catheters be removed within twenty-four hours after the surgery to prevent complications like urinary tract infections. And then, of course, medications to prevent blood loss and decrease transfusion rates are also used.

PIERCE: Yes, it all sounds really good.

GRAYSON: And then the last stage, the post-operative stage. The main goal of the post-operative stage is to return the patient to a baseline state of health as close to their pre-surgical state as possible. One of the strategies is to allow the patient to eat a regular diet as soon as they're able to tolerate food after surgery, with an emphasis on healthy proteins, healthy fats, vitamins, minerals, probiotics, complex carbohydrates, and also for the patient to start drinking fluids, particularly water, to help prevent any blood clots. Ice, compression, and elevation therapy can be used to reduce any post-surgical swelling and pain and to improve the patient's range of motion.

The primary goal in the post-operative stage, in terms of returning the patient to optimal health, is to discharge them to home versus a rehab facility. So the main goal is to return the patient to health as much as possible so that they can go straight home and not have to go to a rehab facility.

PIERCE: It all makes sense. It all sounds great. It sounds like that's the care we should be giving our patients anyway when they're going through surgery. How do I keep their infection rates down? How do I get them mobile? How do I get them eating? Because they need the nutrition in order to heal their wounds that we've created in surgery. You know, we call them incisions, however we want to call them, but it's still a wound to the body. The body has to heal from it. But I see nurses playing a really big role in this, with the education that you're talking about, with the mobilization, with making sure that they adhere to their pre-op plans along with their post-op plans as well. That's a big role that nurses are playing.

Do you see other healthcare professionals? I mean, do we see physical therapists being utilized in the ERAS protocol to help with mobilization? Do we see nutritionists being pulled in to help? Do we see that, or does it really just typically fall on the nurse?

GRAYSON: No, and that's a great question. No, I mean, it falls on the shoulders of all of the clinicians. So physical therapy, occupational therapy, respiratory therapy, pharmacists, dietitians, nurses, surgeons, and so on. Everybody has their role, and everybody is included in the protocol. And sometimes one of the reasons why the protocol is not as effective as it could be is because those team members may not be communicating in the way that they should. One of the ways that clinicians can help improve that is to implement real-time documentation, keep their documentation up to date so that the other team members can log in, look at the patient healthcare record, and understand where the patient is in the process. Also, for the team members to just have a huddle and to make a point to update each other and include each other in the communication.

PIERCE: And then, of course, you have the time constraints with making sure that you have your documentation done in a timely manner. You know, like you were talking about earlier on, we were

talking about some of the challenges of this and how it is a lot that you're putting on a nurse as well. But then, you know, the time constraints that we have. I want to go back to when you were talking a little bit about the analgesia and how that plays a role in the ERAS protocol. And we mentioned the multimodal use of pain management. Can you talk a little bit about that and the benefits of that within the ERAS protocol?

GRAYSON: Sure. So the main goal of the ERAS protocol is to refrain from opioid use as much as possible, which is in direct conflict with what the old perioperative model was, which was to give opioids as pain medication. With the opioid crisis today and everything that we're seeing in relation to that, clinicians are really encouraged to use other medications for pain control, such as non-steroidal anti-inflammatories, COX-2 inhibitors, gabapentinoids, nerve blocks, skeletal muscle relaxants, and low-dose ketamine. In some ERAS protocols, opioids are used in the post-op period, but as sparingly as possible. Something else that the ERAS protocol does that is very different from the previous perioperative model is that the previous model really relied on patients having a PCA, or patient-controlled analgesia pump. The ERAS protocol strongly discourages the use of that.

And the reason is because that pump interferes with the patient's mobility and their ability to be independent. That is one of the main discharge criteria, the patient has to be independent, and they have to be able to mobilize. That pump gets in the way of that. Instead of the PCA pump, the protocol will use a controlled release. This has been found to actually be better tolerated than a patient-controlled pump, and it's associated with shorter hospital stays. Research has also shown where corticosteroids in combination with NSAIDs and pregabalin are effective at controlling pain without creating post-op wound complications.

PIERCE: The education that I wanted to ask really quickly is, you know, early education was we're going to get you to a zero. Your pain is going to be a zero out of 10. So is there more education around the idea that you're going to have some pain when you have surgery versus "we're going to get your pain to just be completely gone, you're not going to have to worry about it"?

GRAYSON: No, and that's an excellent question. So in that pre-admission stage, patients are given a lot of information about pain, what type of medications they're going to receive during the procedure, after the procedure, which medications they're going to go home with, what the proper dosing is, what those medications are, the proper administration, and so on.

The less anxiety that patients have about pain, the better their outcome. So, of course, knowledge being power, patients need to understand. Patients naturally have a high amount of fear regarding the pain that they anticipate experiencing after surgery. That's one of the main concepts that all patients ask clinicians about: "How much pain am I going to have when I get home? Am I going to have access to pain medication?" and so on.

Some patients may request their preferred pain medication. When that happens, depending on what that preferred pain medication is, if it's something that clinicians can work with, they certainly will. But if it's something that they don't feel is in alignment with the protocol, then they will explain that to the patient and say, "Hey, look, I understand that that medication has worked for you in the past, but we're going to try something a little different for this surgery, and here's why." Yeah, no. So, of course, pain causes anxiety.

PIERCE: Great, that's good. Were there other things you wanted to go over when I interrupted you with my random question about pain?

GRAYSON: It used to be in the traditional perioperative model that patients would be given anxiolytics or anti-anxiety medications prior to surgery. That's not recommended in the protocol because research indicates that they actually are not effective, and they don't improve discharge criteria at all.

The other thing that patients are really taught a lot about before their procedure are the non-pharmacological ways that they can help control their pain, such as distraction techniques like listening to music, reading, and watching television. If they have a pet at home, you know, playing with their pets to help decrease their anxiety, and then using ice and anything else that helps them feel comfortable.

PIERCE: So looking at mobilization and nutrition, I know we talked about the nutrition and the different types of diets that they recommend, early mobilization and how important that is as well. Because that gets your stomach moving, gets your body ready to start eating. How well is that accepted? Because I've seen a lot of patients that are like, "I can't get out of bed. I'm in a lot of pain." So now we're using the ERAS protocol. Regimen is different, and now we're trying to get you out of bed. Now we're trying to get you to eat.

GRAYSON: So actually, most patients prefer, even if they're not hungry after surgery and they're not feeling well, they like the option of being able to eat those foods that they like to eat and that they're used to eating. Patients today, when they're in the hospital, are given a menu just like you are at some hotels, where you check off the menu to order your breakfast for room service. Patients are given the same thing in the hospital, with options that correlate with the meal plan that they're on. So they have choices. They can check a box and say they want toast, or oatmeal, or their eggs done this way or that way, or whatever. They like having those options because that feels like what they would do at home. They would wake up and say, "What do I want for breakfast this morning?" Instead of someone bringing in a tray with three things on it that they had no option to choose.

Now they can select, hopefully, foods that they like and that sound palatable to them. Also, the medical-surgical staff, when they're released from post-op and they're on the Med-Surg floor, that staff, the nurses and nursing assistants will accommodate them as much as they can. If the patient has an upset stomach and the nurse says, "We really want you to try to eat," and the patient says, "Well, I don't feel like having what I selected for dinner," the nurse will bring crackers or make toast, peanut butter toast, things like that that the patient can tolerate.

PIERCE: I think the ERAS protocol, again, as I said earlier, just makes sense as to how we should be practicing and taking care of our patients. But there are challenges to implementing something new, especially something like this. Can you walk us through those challenges? I know we've talked a little bit about some of them, but what are those challenges we're seeing in clinical practice, and how may be overcome those?

GRAYSON: Sure. Again, and I know we touched on this earlier, nurses are the team members who have the most contact with the patient. The specific challenges that nurses have with the ERAS

protocol is that there are not enough nurse leaders out there who really support the ERAS protocol. If you're a staff nurse and your superior is not encouraging you to use the protocol, then you're not going to use it. There are also the challenges we talked about previously, such as how some team members may not communicate effectively. The protocol works best when all team members communicate, document in a timely manner, and do so effectively.

Having a strong nurse leader who believes in the ERAS protocol is really important not just to the nursing staff, but to all of the clinicians involved. A strong nurse leader empowers nurses, other multidisciplinary team members, as well as patients and families. Nurses traditionally are viewed as caregivers and not as empowered, autonomous leaders. Since nurses have not typically been thrust into leadership roles, they don't view themselves as leaders, and other members of the interdisciplinary team often don't either.

That's a significant barrier because nurses may not feel like they have the power to progress their patient along the ERAS pathway. If they hit a stumbling block, such as a post-op patient not ambulating as soon as they should be or as was anticipated prior to the surgery, the nurse may feel stuck in terms of what to do next to help that patient. The nurse may feel like they have to defer to other team members, when in reality, the pathway is designed so that each interdisciplinary team member can be independent in their decision-making. Nurses have the autonomy and the power to progress the patient along the ERAS pathway, but they just don't feel like they do. So they may call upon the physician or someone else to ask permission to do certain things for the patient. That is one of the major stumbling blocks. Nurses also perceive the ERAS pathway as being something that takes more time because it is a set protocol. They may feel that implementing it means spending time they don't actually have when they enter the patient's room. However, research shows that is not actually the case. It decreases the nurse's workload and gives them more time. If nurses could shift their perspective and say, "Maybe for pre-op, I have to go in and spend 15 minutes talking with the patient, providing all of this education," yes, that's 15 minutes, which is a big chunk of time for a nurse. But if they see it as something preemptive, it can improve patient outcomes. More education means fewer complications, such as infections or uncontrolled pain. Infections lead to more time spent at the bedside giving IV medications, changing wound dressings, and so on. A shift in perspective is needed. And then in healthcare overall, but especially in nursing, we have seen a tremendous exodus from the profession. We've had a nursing shortage for decades, and COVID certainly did not help the situation. Many nurses have left the profession, which negatively impacts ERAS implementation. Facilities now rely on temporary nurses, agency nurses, or travel nurses who are not full-time employees. Those nurses are less likely to adopt protocols they don't view as personally relevant or useful.

PIERCE: One of the things I was thinking about as you've been walking through this is something that stood out to me: data and metrics. Okay, you have things that you're going to measure, but like you mentioned earlier, what if you have a patient that doesn't eat or a patient that you can't get up in the time that is set aside when you're supposed to be getting up?

Then the question becomes, are we being tracked and measured? Is our performance as an employee of that facility, as a nurse, being tracked and measured by the fact that I can't get my patient to get up, even though I've done everything I possibly can? That patient still has free will. I can't force them. So that was a question that came to my mind and could be a barrier. And then the other thing I was thinking about is the fact that we are short-staffed in so many places. Number

one, a lot of times contractors don't necessarily invest in the facility and the team. I mean, a lot of them do, but a lot of them do not. Plus, now you have nurses who are already short-staffed, already feeling the burden of all the hats they are wearing. And now I'm saying, "No, you've got to add this on, and you've got to add that on," rather than seeing how we can fit it into what we're already doing. Maybe it's overwhelming because now all I hear is, "I have to do this now." Those were two things that stood out to me while you were going through. I know you want to talk a little bit about that.

GRAYSON: Sure, and those are very pertinent observations. In terms of tracking the success of a protocol, that's where auditing comes into play. Auditing any sort of protocol is very important for the facility so they can track whether the protocol is successful. Is it really helping patients? Is it reducing burden on clinicians? Is it saving the facility money?

Facilities can implement real-time checklists. They can track things such as multimodal analgesia. For instance, in patients who have had a hip replacement or knee replacement, what type of pain medications are proving to be more effective? That means tracking data, recording the type and length of surgical procedure, the skin prep used, and whether that skin prep was effective or if there's been an increase in surgical site infections. Using daily team huddles can improve communication and remind team members: "Let's be compliant with this protocol. Let's follow the steps and calculate the outcomes for our patients." Implementing real-time chart audits, rather than waiting until the patient is discharged and at home, is much better. The goal is to review and collect that data while the patient is still in the hospital. Clinicians and administrators can compile reports. They can create daily, monthly, and annual ERAS reports and then compare them month to month, year to year, to evaluate the success of their ERAS protocol.

Facilities are also encouraged to implement their own randomized controlled studies and share findings with others. For example, a facility can create a randomized controlled study around the postoperative inflammatory response or pain reduction strategies they have found effective.

Clinicians should also be studying how the protocol works in different patient populations. How effective is the protocol in patients with mental health disorders? Is it just as effective, or does it need to be adjusted? What about patients with chronic renal failure, where medication adjustments are needed? Or patients with chronic sleep impairment: how do you need to modify the protocol for them? Providing ongoing support and education is very important. To circle back to the nursing issue, having an ERAS nurse coordinator who can help keep the other nurses on track is essential. That person can also help implement training and education for the facility.

PIERCE: Sounds like a champion. You need an ERAS champion on your unit to really champion the use of it, to help make sure that you're using it, and to support some of the data and metrics that you mentioned. It sounds like those studies would be happening in some of your larger hospitals and some of those university hospitals where they do a lot of research and they have the staff, time, and ability to do that research, since they have students coming in and out that can do research. But what about for just the smaller hospitals? We have the data and the metrics. How can that be monitored to really look at the effectiveness of what they're doing with the ERAS protocol and to continue to improve what they're doing?

GRAYSON: Even if it's a smaller facility and they don't have the resources that a larger facility has, they can still implement tracking. They can still do real-time chart audits. They can still appoint an ERAS coordinator to educate staff and so on. They may not be able to do it to the same extent as larger facilities, but every facility has the capability to track data.

PIERCE: What types of data would you encourage if it was limited to what they could actually track? What would you say, "Hey, let's start with tracking this"?

GRAYSON: Start by breaking down the steps of the protocol and tracking things such as patient satisfaction. That's something that, regardless of the size of the facility, every facility and healthcare system wants happy patients. They could implement questionnaires, pre- and post-interviews with patients, and those sorts of things to track what the patients are thinking about the care they received and how effective they feel it is. And then, as I mentioned previously, track things such as the types of multimodal analgesia used, what type of skin prep was used those sorts of things.

PIERCE: So how can healthcare professionals stay informed about the latest research and best practices that are coming out for the ERAS protocol?

GRAYSON: There are several platforms. There's the ERAS Society, which is a tremendous resource for everything related. Then there's the National Surgical Quality Improvement Program, and the Agency for Healthcare Research and Quality, specifically their "Improving Surgical Care and Recovery" initiative. There's also the ACS NSQIP platform and the ERAS Interactive Audit System, which are good resources. In terms of journals, any surgical journals are going to cover this, The American Journal of Surgery, the Journal of the American College of Surgeons. And then of course, any surgical-related professional associations. That includes the Association of peri-Operative Registered Nurses (AORN), the American Surgical Association, and the Association of Surgical Technologists.

PIERCE: Do you have any advice for anybody who maybe wants to start the ERAS protocol in their facility?

GRAYSON: I would say that one thing they may find very helpful is to collaborate with a facility that has already been using the protocol. Have those clinical administrators meet with the other facility and find out what they did to implement their ERAS program and what they felt the pitfalls were, so that the facility that wants to implement the program can hopefully avoid some of those barriers. So, reaching out to other facilities that have a protocol, connecting with the ERAS Society, and also having meetings with the surgical staff to find out what their experience has been with ERAS have they worked in other facilities that have used the protocol?

PIERCE: That is a good starting point. Those are really good. Well Joanna, we are at the end of our time for this podcast. So while we wrap up, is there anything that you want to emphasize or that you didn't get to talk about that you want to make sure you touch on?

GRAYSON: I don't think so. I think we covered everything.

PIERCE: Well, thank you so much for being here.

GRAYSON: My pleasure. Thank you for having me.

PIERCE: Yes. And now what I want to emphasize, which I think you've touched on all throughout this podcast, is that implementing the ERAS protocol can significantly improve patient outcomes, reduce hospital stays, and enhance overall patient satisfaction when it comes to surgical care. So I do think that if you are not already using this in your facility, it would be worth the time to investigate it and plan to try to implement this within your facility. To our listeners, thank you for joining us, and I encourage you to explore many of the courses we have available on www.EliteLearning.com to help you continue to grow in your careers and earn CEs.