RESEARCH PAPER.

JOHA
Journal Of Health Academics

ENHANCED RECOVERY PATHWAY IN GYNAECOLOGICAL SURGERIES: ARE WE PRACTISING IT IN OUR LOCAL SETTING?

Weerasinghe,AM[1], Herath,CMB[1], Mohamed ALS[1],Kariyawasam,UG[1]

[1]Castle Street Hospital for Women, Colombo, Ministry of Health Sri Lanka,

Corresponding Author: Weerasinghe A.M email: madushansinghe@gmail.com

INTRODUCTION

Enhanced recovery after surgery (ERAS) pathway is an established evidence-based standard practice. It reduces physiological stress and organ dysfunction associated with elective surgeries, and also reduces the hospital stay, surgical complications and health care expenditure. Many hospitals throughout the country follow some of its elements, but not as a hospital protocol. Regular auditing to see the adherence to ERAS pathway is essential to ensure the efficacy of the health system and patients' safety.

OBJECTIVE

To assess the adherence of Enhanced Recovery After Surgery pathway in a local setting

METHOD

A prospective audit was performed using the data in the bedhead tickets, and direct observation of those who underwent major gynaecological surgeries in ward 4, Castle street Hospital for women in September. Type of surgery, duration of hospital stay, six pre operative and six post operative elements in ERAS were assessed. Data was analyzed to get percentage values.

RESULTS

Twenty-three patients were analyzed. Twelve abdominal surgeries, six laparoscopy surgeries and five vaginal surgeries were carried out.

Average length of stay is 4.16 days, the stay from admission to surgery is 1.7days and surgery to discharge 2.5 days. High level of compliance was observed in pre operative optimization of haemoglobin and informed consent which was 100%. The least adherence was noted in admission on the same day of surgery (4.6%) followed by the ERAS element of discharged planned date agreed with the patient (36%). Prolonged starvation before surgery observed in 31.8%. Pre-existing cormobidities were not managed prior to admission in 22.7%. Compliance with post operative ERAS elements was good. Planned mobilization, early catheter removal and regular oral analgesia prescription were 72.7%. Early nourishment was started in 86.4% patients. Only 22.7% need drains. Avoidance of systemic opiates was 59.1%.

CONCLUSION AND DISCUSSION

This audit implies the necessity of pre-admission clinic for managing co-morbidities, admission on the same day and patient educations on pain management and preoperative preparation. Admission on the same day of the surgery was not observed due to logistic reasons inherent in our health system. ERAS involve patients in their own care in every step. Therefore patients' education is fundamental to facilitate this change. All health team members need to understand their vital role to make it a success. Continuing training, evaluation, feedback is important to demonstrate the progress of implementing ERAS as it offers a cost effective, quality of care pathway on patients` outcome.

Key words: Surgery, Gynaecology, Morbidities

