

Experiences of enhanced recovery after surgery in general gynaecology patients: An interpretative phenomenological analysis

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Abstract

There is little qualitative research exploring non-cancer gynaecology patients' experiences of enhanced recovery after surgery (ERAS) protocols. Seven women participated in audio-recorded interviews, discussing their experiences of enhanced recovery after surgery for gynaecological surgery. Data were transcribed and analysed using interpretative phenomenological analysis. Three themes were identified: meeting informational needs, taking control of pain, and mobilising when feeling fragile. Control emerged as a key element throughout the themes and was supported by provision of factual information. While participants were generally satisfied with their experience, topics such as concerns about analgesic use, the informal role of staff in mobilisation, and the expressed desire for more experiential information for participants require further research.

Keywords

enhanced recovery after surgery, fast track recovery, health experiences, interpretative phenomenological analysis, qualitative, women's health

Introduction

In the past decade, National Health Service (NHS) initiatives have investigated innovative approaches to improve care and save money (Department of Health, 2010). Attention has turned to implementing effective innovations more widely, and the recent report 'Against The Odds' recommended better understanding aspects that enable scaling of these programmes with more qualitative research that encapsulates patient experience. Experiential research helps meet patient needs and provides evidence to 'capture the hearts and minds of stakeholders' (Innovation Unit and The Health Foundation, 2018: 2) and encourage programme adoption.

One innovative programme is enhanced recovery after surgery (ERAS), which aims to improve clinical outcomes and quality of care post surgery and is being implemented widely across the United Kingdom (Knott et al., 2012). ERAS programmes were pioneered for colorectal surgery (e.g. Bardram et al., 1995), but have spread to other areas,

including orthopaedics, gynaecology and urology (Paton et al., 2014). ERAS protocols aim to replace 'traditional surgical paradigms' (Nelson et al., 2014: 587) with evidence-based strategies to improve patient recovery. These involve a range of practices pre-, intra- and postoperatively, including replacing preoperative fasting with carbohydrate and fluid loading, making greater use of short-acting anaesthetics, reducing drain use during surgery, and encouraging early mobilisation and oral nutrition post surgery (Varadhan et al., 2010). Implementation of these protocols has been

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shown to reduce the length of in-patient stays and readmission rates (Paton et al., 2014) and decrease complication rates (Nelson et al., 2016a, 2016b). With medical outcomes established, attention has turned to investigating patient experiences (Miller and Mythen, 2014; Sibbern et al., 2017), of the type encouraged by the recent report (Innovation Unit and The Health Foundation, 2018).

Previous qualitative ERAS research has focused on colorectal patients (e.g. Bernard and Foss, 2014; Fecher-Jones and Taylor, 2015; Gillis et al., 2017; Norlyk and Harder, 2009; Short et al., 2016), with the small remaining literature covering liver resection (Vandrevala et al., 2016), hip/knee replacement (Høvik et al., 2017; Hunt et al., 2009; Specht et al., 2016) and general and oncological gynaecology (Archer et al., 2014; Wagner et al., 2004, 2005). There is little research on gynaecological patients' experiences (Paton et al., 2014), although around 55,000 women undergo hysterectomies in the United Kingdom annually and about one in five women will have a hysterectomy (The Hysterectomy Association, n.d.). This topic is ripe for additional study.

Most qualitative ERAS research has investigated general patient experiences, identifying the importance of consistent and relevant information (e.g. Fecher-Jones and Taylor, 2015; Gillis et al., 2017; Short et al., 2016), the value of the structure and expectations provided by ERAS programmes (Archer et al., 2014; Bernard and Foss, 2014; Fecher-Jones and Taylor, 2015; Vandrevala et al., 2016) and the benefits of recovering at home (e.g. Archer et al., 2014; Bernard and Foss, 2014; Høvik et al., 2017; Short et al., 2016; Vandrevala et al., 2016) with appropriate social support and medical backup (e.g. Fecher-Jones and Taylor, 2015; Hunt et al., 2009; Sibbern et al., 2017). To make specific recommendations for expanding ERAS, research should focus on details of the protocol, including the preoperative interview (Aasa et al., 2013), nutrition (Short et al., 2016) and postoperative pain and rehabilitation (Sjøveian and Leegaard, 2017). This allows better understanding of patients' perceptions and how these influence adherence to the protocol. Key elements of the protocol from a patient's perspective incorporate presurgical counselling and information, carb/fluid loading, early mobilisation and oral nutrition post surgery and optimal pain management (Varadhan et al., 2010). In addition, it would identify additional patient needs that should be met as the programme is implemented more widely. As such, the aim of this study was to explore the experiences of women who had undergone general gynaecological surgery, focusing on their experiences of the ERAS pathway, to identify factors to address when scaling these programmes.

Methods

Design

ERAS patients participated in semi-structured interviews, exploring experiences of an ERAS programme at a

teaching hospital based in the East Midlands. The data were analysed using interpretative phenomenological analysis (IPA; Smith et al., 2009). IPA is popular within health psychology (Brocki and Wearden, 2006) as it uses small, homogeneous groups of participants to draw conclusions about a group of participants with specific characteristics (Smith, 2004). It is an inductive method of analysis in which a double hermeneutic is applied: the analyst interprets the participants' interpretation of their lived experience. A level of homogeneity (here demonstrated through recruiting patients who had all participated in ERAS after hysterectomy) is important in order to ensure access to a comparable experience across the group as a whole, while the idiographic focus of IPA acknowledges individual experiential aspects within each interaction.

Participants and recruitment

Seven women participated in the study; all were unknown to the researchers prior to the interview and were identified by the lead nurse for the ERAS programme as having undergone elective open surgery (hysterectomy) in line with the ERAS protocol. Patients identified as being eligible were contacted by letter and asked to complete a reply slip indicating that they would like to take part in the research. In total, 52 patients were invited to take part in the study; 17 patients did not respond to the invite. Of the 35 who did respond, 21 patients wished to participate; 14 patients had been diagnosed with gynaecological cancer (and are subsequently discussed in a separate paper, i.e. Archer et al., 2014) and 7 had not been diagnosed with gynaecological cancer. Patients were all living in the East Midlands at the time of the operation and spoke fluent English. The mean age of women at the time of surgery was 66 with ages ranging from 48 to 77. Patients were either retired ($n=3$), described themselves as 'housewives' ($n=2$) or were in full-time employment ($n=2$) at the point of interview. Women had undergone surgery at least 3 months previously and all identified themselves as being 'recovered'.

The study followed British Psychological Society (BPS; 2009) ethical guidelines and was approved by the University of Derby Psychology Research Ethics Committee. The study was approved as service evaluation by the Derby Teaching Hospitals NHS Foundation Trust.

Data collection

Interviews were conducted by a female researcher (S.A.). Participants attended a face-to-face interview ($n=5$) or spoke from home via telephone calls initiated by S.A. ($n=2$). The interview used open-ended questions, such as 'tell me about your experience of the enhanced recovery programme'. If patients needed further prompts, these encouraged participants to relate their experiences to each stage of the ERAS

Table 1. Themes and subthemes.

Theme	Subthemes
Meeting informational needs	Feeling well informed about the process Different types of information Unanswered questions and concerns
Taking control of pain	Evaluating pain experiences Uncertainties in self-management of pain
Mobilising when feeling fragile	Being encouraged by others Feeling constrained and limited

programme, including diagnosis, preparation for surgery, surgery, recovery, discharge, and follow-up (e.g. ‘tell me more about your pre-operative appointment?’). Interviews lasted between 25 and 54 minutes. Interviews were audio-recorded and were transcribed verbatim.

Analytic strategy

The analytic strategy followed IPA guidelines (Smith et al., 2009). Coding was conducted using QSR NVivo (version 11.4.0) to review the data and organise themes. The transcripts were analysed in turn and in detail. Each interview transcript was read and re-read, and initial codes were created to identify notable aspects of participants’ experiences, aiming to code all data. The initial coding and theme generation was conducted by E.P. The developing themes were discussed by E.P. and S.A. and revised. E.P., S.A. and J.M. reviewed relevant quotes to reach agreement on which were the most relevant and informative. There was a cyclical process of reviewing data, creating codes and writing. Data were initially coded by considering how participants viewed all aspects of their hospitalisation and surgical experiences. Theme selection was guided by the aims of the project, which were to better understand factors influencing adherence to the ERAS protocols and to add information about the experiences of people who had actually undergone these protocols.

Analysis

Three themes are presented here, representing aspects of participants’ experiences related to the ERAS protocol and most important to them in their interviews: *meeting informational needs*, *taking control of pain* and *mobilising when feeling fragile*. The analysis identifies participants’ experiences, and their meaning and significance. Quotes are labelled with participants’ pseudonyms. The themes and their main aspects are presented in Table 1.

Theme 1 – ‘you’ve got all the factual stuff’ (Laurie): meeting informational needs

Generally, participants felt well informed about expectations and requirements for their hospital stay and that they

were provided with ample information to refer to later, which was helpful. Most described the staff they interacted with as caring, understanding and informative; these characteristics aided the women’s ability to absorb the content of the information provided. Despite this, participants expressed that there were missed opportunities for understanding the rationale for what they were asked to do, obtaining answers to difficult or embarrassing topics, or for receiving more experiential information from other patients about how they could expect to feel.

The written information was valuable for later reference and participants used to it to ensure that they complied with instructions:

Connie: As you can see I’ve ticked all my little boxes because I’m that sort of person. And I drank the drink, so yeah, for me the programme was really really good.

Connie saw herself as the type of person who would comply and, here, evaluated the programme based on her ability to do so. Her overall positive evaluation, with the repetition of ‘really’ was despite her expressed dissatisfaction with one of the occupational health personnel, who she described as insensitive when delivering information.

While participants were well informed and desired to meet the requirements, they acknowledged that these could be challenging. For example, consuming the preoperative drinks was frequently mentioned as difficult, both in the quantity and meeting the time frame. Women often expressed as a lack of understanding of their purpose, which might have exacerbated this:

Delia: Ummm. [clicks her tongue] You see, the drinks, I don’t quite know what they do, to you. Are they full of proteins?

Other participants asked if they contained nutrients, vitamins or minerals. While all the women described consuming the drinks, they were often unsure about why this was important. While this group was perhaps more inclined to ‘do as you’re told’ (Delia), lack of clarity about purpose and rationale might reduce urgency to comply in other populations.

In addition, patients may forget to adhere to the instructions they are given, which could cause distress (perhaps due to overall inclinations to follow instructions):

Ruth: I had visitors and then lunch came, and I had some lunch and then after I had some lunch I remembered that one of the things I was told by the physio is to start off with water and liquids and I didn’t. I had lunch. So I knew at that point I was in, you know, that I’d done something wrong, if you see what I mean. So I started to have some pain.

While Ruth may have been distracted by her visitors, the complexity and quantity of information may inhibit patients' ability to recall instructions or make it difficult to prioritise the information they are given. Ruth linked her later pain to this error. Ensuring that participants understand the purpose of their instructions might help ensure adherence and promote self-efficacy for their postsurgical care by explaining how these steps enhance recovery.

Several participants mentioned wanting to know what to expect and knowing what others had experienced:

Laurie: You sort of don't really know umm how you should be, how you should feel. Is this alright, you know? That. You've got all the, you've got all the factual stuff, yeah you do, you've got all that, but you thi-you tended to think, you know should I be doing this by now? Or should I not or should I be able to do this? I think that, but there again I suppose that varies with individuals, obviously.

Laurie distinguishes between factual and experiential knowledge. She wanted to know what to expect physically, although she acknowledged that individual experiences vary. While some participants expressed a willingness to share their own knowledge to encourage others, some personal experiences were negative, and the influence of those on others' expectations could be meaningful:

Penny: I just felt really sick, but I did say to them [hospital staff] that whenever I've had an anaesthetic, except for when I had breast cancer, if it's been lower waist that I've had an operation, I've always been sick after. But they were giving me anti-sickness, but I felt sick. I wasn't sick, but I just felt sick.

Penny's previous experiences of surgery influenced her expectations and experiences; women without this experience felt that they would have benefitted from more experiential information so to better set their expectations.

The participants described various unanswered questions. Some were worried about future cancer, others felt that their specific health concerns were not addressed, and one participant wondered about how her internal organs appeared post hysterectomy:

Julie: You know what I would like to know, it sounds stupid really. I'm mentioning it to you cos you're kind of an anonymous person to me. I just wonder what I'm like inside.

This is one example of questions that patients felt less comfortable asking; Julie described this as a 'stupid'

question, even though it related to her surgery, ongoing recovery and return to a normal sex life. This emphasises a need for patients to be offered the opportunity to ask questions in a non-embarrassing, accessible way.

The women were satisfied with the information they received, though the delivery and demeanour of the staff sometimes overshadowed the informational content. While the people in this group were self-defined 'by the book' (Connie) patients, who were determined to comply with the guidelines, Ruth's experience highlights the impact of forgetting and the associated sense of losing control, with potential effects on patient anxiety, well-being and recovery. Participants desired more information about others' experiences. In addition, more opportunities to ask questions would be helpful. Some participants described a lack of access to this kind of support after discharge, sometimes because they were too embarrassed or unsure to ask, sometimes due to mobility issues, or not feeling able to bother staff.

Theme 2 – 'you get better quicker with pain relief (Delia): taking control of pain

Participants' experiences of pain were important in their accounts, and they expressed some uncertainty about their own ability to properly use the pain management they were given. Control played an important part in how pain was experienced, as did expectations of pain:

Connie: It [the information pack] sort of went day 1 and what to expect, day 2 and pain levels, sort of talking through pain from 1-5 what you might experience, when you're describing your pain try to describe it within these levels.

Connie's account shows that preoperative information given to patients provided a context and scale in which to position their experiences; in this case, practical information was helpful, linking back to the role of information described in the previous theme. Participants gave nuanced perceptions of pain and interpreted it through the perspective of others:

Laurie: Well, my husband was surprised when he came to visit in the afternoon. He said I expected you to be really, you know, obviously it is painful and it's discom-uncomfortable, really uncomfortable because you can't move around, properly as you'd want to, you know. But I wouldn't [have] said, no it was not really, really bad pain.

Laurie differentiated between pain and being uncomfortable. She described her experiences in terms of the impact on mobility and through her husband's eyes. It

appears that others' expectations or perspectives might influence pain perceptions. Preparation and information may enhance patients' ability to control their pain management too:

Jenny: I like to be aware, sort of aware and in control of my own pain, I know I was.

Awareness, skills for evaluation and knowledge of the interventions available helped give patients a sense of control enhanced by the information provided prior to surgery.

The most frequent sources of pain mentioned were the surgical site during mobilisation, trapped wind, or during the journey home. Participants described fluctuating levels of pain; for example, Delia mentioned 'horrible pain' immediately post surgery but less pain later. Pain was mostly described as well managed. Pain sometimes arose from other conditions; for example, Ruth attributed extreme pain to undiagnosed gallstones, triggered by her food selection post surgery:

Ruth: I can't move, well I'm in pain, I can't move because I've got this belly full of staples, ummm, I'm hormonal, I can't stop crying, I'm hormonal and I just feel really, really scared that I've just harmed myself because I've had a meal when I know I should have been started on water. So you put all that together and I star-I just started to panic.

Ruth described the most negative pain experience of any participant and felt that her need for pain relief was ignored, although she described the most analgesic use of any participant. It is possible that her panic about the effects of eating when she shouldn't have contributed to her experience, reinforcing the importance of patients knowing what is expected of them to create a sense of control. Her sense of being ignored by staff for 'kicking up a fuss' appeared to magnify her pain experience.

The other key aspect of pain management was participants' concerns about using pain medication correctly and not excessively. Most participants expressed a desire to use the minimum effective dose for the minimum time:

Delia: I only took them for about, a few days and I slowly weaned myself off. But they said you must take them because you get better quicker with pain relief. But, I just ended up taking a couple of paracetamol or something, because I don't have a lot of tablets.

Delia described the importance of pain relief to recovery, but there may be some tension for participants between a desire to minimise medication and the role of pain relief in the recovery process: in general, participants were cautious about morphine use post surgery:

Laurie: I did use it but not a lot.

Connie: Rightly or wrongly, I gave myself probably a clicker there at the time, thinking that that would see me through for when I wake up again.

Penny: I'm not very good with medicine at all.

While the ERAS protocol calls for minimal use of opioids, these quotes suggest that participants were uncertain and uncomfortable about their usage, although all suggested that their pain was well managed. It is unclear how Penny considered herself 'not very good' with medicine, but this underscores participants' discomfort with the unfamiliar medications to which they had access. It is not clear whether this caution reflected the information they were given, concerns about potential addiction, a desire to maintain control or stoicism. Julie was an exception, stating 'I had a lot of pain relief'.

Participants appeared more willing to use familiar medications if they saw this as meeting their needs:

Jenny: I wouldn't say that I was in pain really, so, I thought well if paracetamol and ibuprofen will do it then, yeah I was fine.

In general, the participants described their pain as being well controlled and were able to access adequate medication to maintain this. Presurgical discussions of pain evaluation and management emerged in descriptions and evaluations of pain levels and contributed to participants feeling in control of their pain relief. Lack of control (making 'mistakes' in recommended behaviour) caused anxiety and distress, and increased the experienced pain for one participant. Participants described their pain relief use in terms of their need but appeared reluctant to use stronger painkillers with which they were less familiar.

Theme 3 – 'I've got to move' (Jenny): mobilising when feeling fragile

While prompt mobilisation is a core component of ERAS, participants expressed few strong issues or concerns about it. What appeared key was the role of others in helping participants actually mobilise when they felt constrained by their fragility and physical limitations. Participants did not necessarily want to get out of bed and walk but did so with encouragement. Having advance knowledge of this expectation provided motivation, again showing the important role of prior information in structuring participants' experiences:

Jenny: Yeah, I think a lot of it though is mental, in your own mind, that right, I'm going to do this. I mean the forms, that you read obviously what was expected of you, that helped, but I still think it's a mental thing, to think right, I'm going to do this, and I've got to do that.

Information and support from a physiotherapist alongside concrete goals of distances helped participants' mental preparation to mobilise. Empathic, considerate encouragement was important and its absence was noted:

Connie: I met the occupational therapist who sort of got me out of bed, took the um catheter and marched me down the corridor and I'm going 'wait for me, I'm attached to that!' There's men walking past and I'm thinking this is so (.) nice <laughs>.

Participants needed to overcome their reluctance to move and physical barriers to mobilisation were mentioned most often: the presence of the catheter, as in the last quote, and consciousness of the surgical site, as mentioned by Ruth describing her 'belly full of staples'. For Ruth, pain and awareness of physical wound were an impediment to moving. Others described more a general feeling of weakness:

Laurie: As I say, you, I think you're just more fragile than anything. Because, obviously, it is uncomfortable it's not, you can't move about freely.

Several participants mentioned feeling 'fragile' and an empathic other helped overcome those physical limitations. For example, informal activities helped the women mobilise, with staff playing a role in encouraging activity:

Julie: You know it was a success to sort of go to the toilet, but I had a catheter in for a day, I seem to remember [Consultant] stressing that. So once that was out I did go to the loo and that was good. You know you felt you'd achieved something.

Gentle, yet firm, encouragement aided mobilisation, and opportunities to undertake normal tasks were a valuable addition to structured activity. While preoperative information informed patients about the expectations of mobilisation, actual mobilisation created positive beliefs about their ability to manage at home. One participant mentioned the need to be able to climb stairs, which her physiotherapist addressed, raising her confidence in her ability to go home. One participant, Ruth (whose experience of unmanaged pain was discussed earlier), felt as though her needs were not taken into account. She had no perception of mutual decision making, or accounting for her needs, and saw the intervention and actions of the staff as unhelpful.

The car journey home was a major hurdle, both painful and uncomfortable:

Jenny: Yeah, I mean on the Saturday when they said, well if you're still not feeling very good then

come back to the gynae outpatients. And I thought there's no way I'm getting in that car and going all the way back there, forget that one.

Desire to avoid another car journey discouraged some women from seeking follow-up care that might have needed additional journeys in the car.

Some women mentioned perceived benefits of mobilising, for example, that walking 'massaged the stomach' (Connie) and relieved pain there, but participants did not linger on this aspect. Most described their pain in relation to being fragile; and both formal guidelines and informal encouragement from staff were helpful in supporting successful mobilisation. Some benefits emerged from their accounts, such as increased confidence in being mobile and identifying needs to be addressed with physiotherapy. This contrasts with the concerns expressed about pain relief, perhaps reflecting that moving shows a return to normal, where medication does not.

Discussion

The accounts of seven women who had undergone hysterectomy were analysed using IPA. The three themes represent components of the ERAS protocol (Nelson et al., 2016a, 2016b) that were prevalent through participants' accounts (Smith, 2011): *meeting informational needs*, *taking control of pain* and *mobilising when feeling fragile*. Some similarities with themes identified in gynaecological oncology patients emerged (Archer et al., 2014), for example, the importance of patients' knowledge and its contribution to feelings of control. Control emerged as a key factor in women having more positive experiences and being able to adhere to the protocols. However, mobilisation was much less problematic for the present sample than for the gynaecological oncology sample. When scaling protocols like ERAS, this does highlight the importance of noting differences between populations.

Information and preparation helped participants understand (Fecher-Jones and Taylor, 2015) and feel in control of their pain (Gillis et al., 2017), as established by previous work (Ridgeway and Mathews, 1982). Two new aspects emerged. Participants were cautious in their analgesic use, describing their discomfort with unfamiliar medications and concern about excessive use, perhaps reflecting perceptions of a lack of control. The second issue, which arose for one participant, was believing she had failed to comply with requirements placed on her, and the impact this appeared to have on her interpretation of pain and her ability to manage it. Other accounts suggested an important role for expectation and interpretation from significant others, and this could be a useful avenue for further research to understand how best to manage postoperative pain through a variety of strategies. The importance of control here suggests this element as a key mediator in participants' adherence to ERAS protocols.

As other qualitative research has indicated, staff play a key role in encouraging mobilisation (Archer et al., 2014; Wagner et al., 2005); pain, or a patient's concern about pain, is a barrier (Fecher-Jones and Taylor, 2015; Sibbern et al., 2017). While the formal, outlined requirements of mobilisation were mentioned, participants often referred to informal suggestions from nursing staff that helped them mobilise. When scaling interventions like ERAS, greater staff awareness of their role is essential, particularly in supporting patients' sense of being in control of their recovery. The journey home was challenging, as identified in other ERAS populations (Hunt et al., 2009), with physical limitations hindering getting into/out of the car and the discomfort of the car ride. The pain experienced on the journey home discouraged participants from seeking additional care that involved travel, which could impede recovery. This contrasts with previous research that has found that concerns about identifying the correct individual to help them are a problem (Vandrevala et al., 2016). Identifying and resolving particular hurdles that individuals face at home can improve their confidence about being discharged, and strategies should be implemented to ensure that appropriate follow-up care is available, considering patient concerns, as ERAS is further implemented.

The women in this study felt well informed. They valued the written material for later reference and used the checklist to ensure that they were meeting the programme expectations. When requirements were difficult to comply with, for example, consuming the preoperative drinks, understanding the reasoning for this instruction may aid adherence. Short et al. (2016) found that patients were unclear on the purpose of this aspect, perhaps because it contradicts traditional understandings of presurgical behaviour (Archer et al., 2014). Participants desired more experiential information: they wanted to know what to expect to feel, and this should be included as these programmes are more widely adopted.

These participants were generally happy with their experience. However, the detailed, qualitative approach employed here identified areas of dissatisfaction or confusion such as insensitive interactions with some personnel and not understanding the purpose of instructions despite complying with them, which might not emerge in a more traditional quantitative survey. Studying participants with a range of outcomes, including those who required readmission to hospital, would be valuable. There is little research on general gynaecological patients (Wagner et al., 2004, 2005), and there is only one recent study in the United Kingdom, of gynaecological cancer patients (Archer et al., 2014). Additional research with gynaecological patients would enhance understanding of the range of experiences.

This study raises additional questions for future research. One relates to patients' understandings and perceptions of analgesic use. Gillis et al. (2017) noted addiction concerns of colorectal ERAS patients, and this issue needs investigation to ensure adherence to this aspect of the ERAS protocol.

While mobilisation was formally implemented as a physiotherapist-mediated activity, the nursing staff encouraged patients to engage in normal activities, with positive effects, which was not noted with gynaecological oncology patients (Archer et al., 2014). The informal contributions to mobilisation could be investigated to develop support for these opportunities and staff understanding of their contribution to successful ERAS programmes.

It would be useful to understand how the information provided preoperatively and the personal relationships established with staff contribute to patients' knowledge and perceptions of their experience. Alternative sources of information could be explored to address patients' concerns about returning to the hospital, asking embarrassing questions and wasting staff time. Further study might investigate whether avenues such as anonymous Internet chats might allow patients to receive appropriate, tailored informational support. It would be useful to investigate the opportunity for providing experiential information.

Conclusion

This research aimed to identify factors that should be considered when implementing ERAS programmes more widely, based on women's experiences of ERAS after general gynaecological surgery. While the participants in this programme were generally satisfied with their experience, areas for additional research were identified in this understudied group. When scaling ERAS, it is important to note differences between populations and to study these, as highlighted by differences between gynaecological oncology (Archer et al., 2014) and general gynaecological patients. A greater role for experiential information is required, and it is suggested that the impact of informal support of ERAS protocols be studied and communicated to staff. In addition, better understanding of patients' use of analgesia would underpin implementation of this aspect of the pathway. These findings highlight the benefits of qualitative research, particularly in the identification of specific areas of concern within general programme satisfaction.

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