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Preoperative education: making every contact count

Patient education is an important part of obtaining informed consent, but can also be used to educate patients about how to prepare for surgery and help them take responsibility for improving their own health to reduce their risk of perioperative complications.

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Background

Patient education is an essential prerequisite to surgery, leading to informed consent. A well-prepared patient is also likely to be less anxious, have less pain and recover more quickly (Kruzik, 2009). Traditionally, education is undertaken in outpatient settings by the surgeon, anaesthetist and preassessment nurse. Following the launch of enhanced recovery after surgery a decade ago, group preoperative education sessions ('surgery schools') have become popular and are often a mandatory part of the preoperative pathway. Patients are taught what to expect, what to do to recover more quickly and are shown some rehabilitation exercises (DeLano, 2017).

Education and prehabilitation

Perioperative medicine pathways provide further opportunities for patient education, as a result of the additional patient contact during episodes such as cardiopulmonary exercise testing and shared decision-making clinics. The concept of prehabilitation, which addresses preoperative physical activity, nutrition and emotional wellbeing, is also becoming a recognised notion with growing evidence to support its impact on patient outcomes (Scheede-Bergdahl et al, 2019). To date, without NHS commissioned prehabilitation services, educating patients about how to prepare for surgery remains the responsibility of perioperative clinicians and research teams. Preoperative education is no longer purely about telling patients about what is going to happen to them, but empowering them to take responsibility for improving their own health to help with their recovery and reduce their risk of perioperative complications.

The role of the perioperative team in patient education

As the list of everything we need to teach patients before surgery grows, it raises the question of when and how should this education take place? Some centres have evolved their surgery schools to include aspects of perioperative medicine, such as screening for malnutrition and anaemia, as well as encouraging and supporting patients to make lifestyle changes (Fecher-Jones et al, 2021). Although this is an effective use of resources in providing education to a group rather than one-to-one, and there is some indication that patients find these sessions useful, there is no evidence that alone they have any impact on patient outcomes following surgery.

Whether in a group setting or one-to-one, providing education and then supporting patients to set their own goals for lifestyle change is known to be effective (National Institute for Health and Care Excellence, 2019). These interactions, known as 'healthy conversations', use a technique known as SMART planning (Dewhirst and Speller, 2015). These personalised plans can be undertaken with the patient in as little as 10 minutes, and are the responsibility of all members of the multidisciplinary team. Provided the message is consistent, they can be started by the surgeon and carried on through the perioperative pathway.

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Challenges

As with any new initiative there are challenges. Clinicians report a lack of time, confidence and resources to make the most of these opportunities within current clinic frameworks (Newman and McDowell, 2016). Making every contact count training can help with this and is freely available across the country to anyone working with patients.

Although group sessions have advantages, education and perioperative optimisation for higher risk patients requires a personalised approach, as one size does not fit all. However, personalised sessions are resource intensive, and a lack of clear consensus and guidelines for what should be taught leads to teams devising their own education packages which can result in mixed messages for patients.

Conclusions

Preoperative education is everyone's responsibility and has evolved from information giving to supporting and facilitating the patient to prepare themselves physically and emotionally for surgery. Every contact with the patient is an opportunity for this to happen. Clinician training is useful in increasing confidence and effectiveness of teaching. More work is needed to define parameters and guidelines on what should be taught and which formats are most effective.

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