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2023-04-13

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Recommended Citation

Roche, D., & Jones, A. (2023) 'A qualitative exploration of the strategies used by patients and nurses when navigating a standardised care programme', *Nursing Inquiry*, . Available at: <https://doi.org/10.1111/nin.12553>

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A qualitative exploration of the strategies used by patients and nurses when navigating a standardised care programme

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Funding information

National Institute for Social Care and Health Research

Abstract

The main aim of this paper is to explore and discuss the interesting juxtaposition of patient involvement within a standardised Enhanced Recovery After Surgery care programme (ERAS). We address our aim by examining the work and strategies of nursing staff caring for patients during postoperative recovery from surgery, exploring how these two potentially competing priorities might effectively co-exist within a hospital ward. This was a qualitative exploratory study, with data generated through 42 semi-structured interviews with patients and nurses who had taken part in an ERAS programme in one of three hospital wards in the United Kingdom, adopting a reflexive thematic approach to data analysis. We shine a light on the work undertaken by patients and nurses during the navigation of postoperative recovery, identifying strategies of collaboration and negotiation during this journey. Furthermore, we also identify and consider patients engaged in peer-peer support during postoperative recovery. This paper adds to the existing literature and current ways of thinking in relation to the quest for standardised, clinically effective care balanced with the aspirations for individualised, patient-centred care. This paper also helps inform thinking about the use of care pathways in relation to service delivery, considering how best to initiate and deploy best practice aimed at safe and effective postoperative recovery.

KEYWORDS

engagement, ERAS, nursing, patient involvement, peer support, surgical care

1 | INTRODUCTION

1.1 | Background

Recent evidence demonstrates there is an ongoing and progressive change in healthcare systems, with emphasis increasingly placed on involving patients in their care, with the recognition of meaningful partnership approaches between providers and patients as essential to improving the patient experience (Halabi et al., 2020; Ocloo et al.,

2020). This approach strives to rebalance traditional relationships between patients and professionals, by encouraging professionals to acknowledge and react to patients' individual experiences, experiential knowledge and the unique nature of individual patients (Halabi et al., 2020). Positive outcomes from adopting such an approach include better quality of care, improved treatments, better outcomes in terms of health and cost and also improved patient experience (Halabi et al., 2020). However, calls for more individualised, patient-centred services and associated opportunities for patient

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involvement should be considered in the context of the simultaneous drive for efficiencies in healthcare through standardisation of care and treatment.

1.2 | Enhanced Recovery after Surgery (ERAS)

ERAS programmes are characteristic of standardised approaches to care. The systematic implementation of these 'fast track' protocols seeks to reduce variation and improve patient outcomes through integrated care pathways and reduced length of hospital stay (Gustafsson et al., 2019). A range of ERAS protocols have been developed including, for example, urological, pancreatic, colorectal and orthopaedic surgery (Wainwright, 2020). There are several components to an ERAS programme, including preoperative information and education, preadmission patient optimising and preoperative carbohydrate loading. ERAS is also associated with developments in surgical techniques including minimal access techniques and improved anaesthetic management (Gustafsson et al., 2019; Refai et al., 2018; Wainwright, 2020). Another essential component of enhanced recovery programmes and the focus of this paper is early postoperative mobilisation for patients, which seeks to address a range of potential adverse events, including pulmonary and thromboembolic complications associated with prolonged bed rest (Gustafsson et al., 2019; Refai et al., 2018; Wainwright, 2020). Professionals and patients setting daily goals in relation to mobilisation is also an important aspect of ERAS, as is keeping patients informed of these goals so that expectations are effectively managed (Gustafsson et al., 2019; Wainwright, 2020). In this respect, standardised approaches such as ERAS can provide patients with an opportunity for some degree of involvement with their own healthcare at the direct level of care.

1.3 | Patient involvement and clinical care pathways

Given the importance of patient involvement to patient experiences and outcomes, Jerofke-Owen et al. (2023) call for further focus on the relationship and interactions between nurses and patients in attempts to establish and sustain opportunities for involvement. These nurse-patient relationships are seen to be essential in supporting effective, safe care and can also influence the experiences of both those receiving and providing nursing care (Manley et al., 2019; Pratt et al., 2021). Specifically in relation to pathways such as ERAS, nurses are in an ideal position to improve the communication of these standardised approaches in the peri-operative period (Sibbern et al., 2017). Indeed, nurses are observed to play a key role in surgical care and the success of enhanced recovery programmes (Hübner et al., 2015; Pache et al., 2021). However, the various interprofessional and patient-professional relationships and interdependencies which occur within care pathways has attracted little attention in the healthcare literature. Exceptions to

this include the conceptual framework of care trajectory management proposed by Allen (2019) and the recent work of Lydahl (2021). Allen (2019) recognises that the formal managerial approaches to care via pathways such as ERAS are important in coordinating and standardising healthcare, but also highlights the ongoing oversight and negotiations that take place in response to contingencies. Nursing staff have an important role in this process, carrying out what Allen (2014) conceptualises as 'organising work', which is care trajectory focused and related to the day-to-day elements of nursing practice involved with coordinating and organising patient care. Lydahl (2021) discusses that pathways such as ERAS can be viewed as tools to support partnership working between patients and providers. In this way, nurses and patients can work together to build a picture of informed and engaged patients. Both these approaches informed this paper, helping to look beyond the immediate care pathway and address some of the assumptions and relationships that support the use of pathways within the patient involvement literature.

1.4 | Factors influencing patient involvement at a micro level

When considering patient or public involvement in health care it is important to acknowledge that individuals often enact a diversity of roles as patients, carers or citizens. Individuals are also involved in different aspects of healthcare at a macro, meso or micro level, for example through involvement in service redesign or improvement, research, or during care and treatment. As patient involvement during hospital care at the micro level is the focus of our paper, we will briefly explore the evidence relating to this aspect of healthcare involvement. The reviews undertaken by Carman et al. (2013) and Snyder and Engström (2016) identified broad categories of micro-level patient involvement, which can be summarised as activities relating to prevention, diagnosis and treatment. The treatment aspect is particularly salient to our research aim. Both reviews make it clear that the degree of involvement should be viewed as a continuum ranging between passive and active, from patients simply receiving treatment information to being directly and actively involved in their care, setting treatment goals and managing their own health (Carman et al., 2013; Snyder & Engström, 2016). However, this does not suggest that the goal for all patients at all times is to be at the active end of this continuum. Rather, the level of involvement is best determined by the topic or issue in hand in consultation with the individual patient, meaning that a patient may occupy different positions on this continuum, even during a single episode of care.

When contemplating patient involvement in direct care, there are also a range of barriers and enablers to consider which can impact on patients' willingness and ability for involvement. A key barrier noted is patients' health status, in which patients may be affected by a range of factors such as illness, fatigue and the effects of analgesia and anaesthesia (Hall et al., 2010; Vaismoradi et al., 2015). On the other hand, clarity of roles and expectations, and clear

communication and information provision have been positively associated with patient involvement in their care. This can be through encouraging patients to ask questions, actively listening to patients, and providing positive encouragement and support to patients in involvement activities and behaviour (Doherty & Stavropoulou, 2012; Vaismoradi et al., 2015). In these cases, patients should be supported to ensure their safe treatment and recovery, adopting a level of involvement appropriate for their own individual circumstances.

To be active partners in care, patients also need power to influence decision making (Ocloo et al., 2020). However, at a fundamental level some inequity in the patient and healthcare provider relationship is unavoidable, for example, where patient illness may restrict certain abilities. It is also the case that the push for patient involvement has not always translated into patient experience (Ocloo et al., 2021) and the prevailing discourse still considers patients as passive and professionals as authoritarian, which can delimit patient involvement. In this respect, Hor et al. (2013) describe how power cannot simply be summarily removed from relationships between patients and healthcare professionals. Instead, they argue that power inequalities can be disrupted and managed through attending to the dynamics of these relationships at a local level. This argument is supported by the findings of a recent wide-ranging systematic review of reviews undertaken by Ocloo et al. (2021), which explores theories, barriers and enablers to patient and public involvement across health and social care. The review indicates the need for involvement to be considered and conducted as part of a 'whole systems' approach, including actions at the individual, team and organisation levels and also identifies the need for healthcare providers to recognise and acknowledge patients as experts in their own care, thus furthering the move from paternalism to partnership (Ocloo et al., 2021).

As previously noted, patient experience will be influenced by the quality of interactions with healthcare professionals who have an important role to play in ERAS in supporting and encouraging patient involvement. Evidence suggests that patients will become more involved in their care if the context and nature of this relationship is appropriate, the necessary support is provided to patients and the expectations of the nature of the behaviour or activity is clearly and mutually understood (Halabi et al., 2020; Ocloo et al., 2020). It is also essential that patients' willingness and ability to take part in ERAS requirements is explored and considered and, as discussed, there are a variety of factors that can influence this including the varied characteristics of each patient's physical state and wellness. It is also of relevance what type of task or activity patients are expected to carry out.

When discussing postoperative recovery, it should be noted that from a patient's perspective recovery is not complete until they have fully achieved their optimum state of health and activity, usually sometime after they have left hospital (Feldman et al., 2015). Postoperative recovery should be considered as a multidimensional concept that follows a specific trajectory from the abrupt deterioration of baseline functions in the immediate postoperative period, with a gradual rehabilitation back to an individual's optimal functioning (Feldman et al., 2015). This trajectory is, however, graduated; less

invasive procedures are associated with lesser deterioration and faster rehabilitation, whereas more invasive procedures result in a greater decline and lengthier period of recovery (Feldman et al., 2015).

1.5 | Aim

The main aim of this paper is to explore the interesting juxtaposition of patient involvement within a standardised ERAS care programme. We address this aim by examining the work and strategies of nursing staff caring for patients during postoperative recovery from surgery, exploring how these two potentially competing priorities might effectively co-exist within hospital wards. In addition to exploring the role of nurses working with patients during postoperative care, we also shine a light on the work undertaken by patients to navigate their postoperative recovery, including strategies of collaboration, negotiation and peer-peer support.

2 | METHODS

2.1 | Design

This was a qualitative exploratory study (Mason, 2002), using semi-structured interviews as a data generation method and employing a reflexive thematic approach to analysis.

2.2 | Participants and recruitment

There were 42 participants in total representing nurses ($n = 21$) and patients ($n = 21$) across three hospital wards in the UK, specialising respectively in upper gastrointestinal (UGI), colorectal (CR), and orthopaedic (OT) surgery. Members of the nursing team on the respective wards acted as intermediaries in the recruitment of patients, informing potential participants of the study. In addition, in each ward a senior nurse acted as gatekeeper for potential nurse participants, informing nurses about the study. Those patients and nurses who expressed an interest were put in contact with the first author and provided with participant information and the opportunity to ask questions. All participants met the inclusion criteria that they were or had been involved in an ERAS programme as a patient or nurse, aged 18 or above and able to provide informed consent. All patients and nurses who took part were self-selecting and gave written informed consent.

2.3 | Data collection

Interviews with nurses took place in private spaces on the respective wards, all patient interviews took place at their normal place of residence. Semi-structured interviews were chosen as the data

collection method as this was considered congruent with the study aims and is a widely used qualitative method that enabled the interviewer to identify and pursue topics of interest, while also allowing for discussion guided by participants responses (Hammersley & Atkinson, 2007; Silverman, 2016). All interviews were undertaken by the first author, recorded on a digital device and transcribed verbatim.

2.4 | Data analysis

A reflexive thematic analysis of the data was undertaken, using a classic iterative approach guided by the six-step process discussed by Braun and Clarke (2006, 2022). This entailed familiarisation of the data transcripts by the first author, through reading and rereading. The first author then systematically coded the individual nurse and patient interview transcripts at a granular level. This original coding was then reviewed by both authors to identify shared patterns in the data and work together to develop initial themes. At this stage, we also used data triangulation to support the analysis, involving a process of bringing together the different nurse and patient data sets to utilise multiple perceptions and help clarify meaning. Specifically, we compared data relating to the same phenomena, but derived from the account of different participants to help verify the repeatability of an interpretation. Ongoing discussion between the two authors resulted in further development and refinement of our thematic map and subsequent naming of themes.

The data quotes included in the findings section have been selected as we believe them to be representative of the sample population in relation to the themes and associated narrative presented. This process was also guided by Braun and Clarke's (2006, 2022) work, where we have striven to provide illustrative examples of the issues identified. The data extracts have been labelled according to whether the participant was a patient (PT) or a registered nurse (RN), and the relevant surgical area, (UGI, CR and OT). Table 1 provides further detail of participants.

2.5 | Ethics

Potential participants were provided with written information about the study before agreeing to take part. Assurances were provided to all participants about the protection of confidentiality and anonymity and all participants provided informed consent. Ethical approval for this study was granted by the Southeast Wales Research Ethics Committee (Reference: 12/WA/0192).

3 | FINDINGS

Based on our analysis of the data, we present three main findings themes. The first theme considers '*flexibility when using the ERAS pathway*', focusing on how nurses and patients use the ERAS pathway

to plan and negotiate aspects of postoperative care. The second is structured as two sub-themes focusing on '*patients with different levels of engagement*'; firstly, those patients who nurses perceive to need 'extra encouragement' and the potential consequences of this, and second those patients who demonstrate autonomy in post-operative rehabilitation. The third and final theme addresses '*patient to patient engagement and peer support*', looking at ways in which patients can support each other during postoperative hospital care.

3.1 | 'It's there as a guide, it's not there to be rigid': Flexibility when using the ERAS pathway

The use of the ERAS pathway in guiding postoperative care was seen to have benefits in relation to organising the delivery of nursing care, providing prompts and structure to ensure appropriate care and interventions were carried out. ERAS was also associated with 'best practice', as demonstrated in the following extract in which a nurse comments that not only does this approach to care assure nurses about their practice but can also increase patients' confidence due to the consistency of approach ('*everyone doing the same thing*').

RN5 (UGI): *the thing that ERAS brings is that the patient gets the care that the patient should have. [...] So I think it's good because it, it gives the patients confidence because they know that everybody's doing the same thing. [...] I think that that degree of certainty...is better for patients. [...] to know that you're following best practice*

While acknowledging the utility of a standardised approach, nurses were also aware of the need for flexibility in requirements with some nurses discussing how they were alert to the unpredictable and individual nature of patients' postoperative recovery. The pathway was seen as helpful, but some nurses commented that clinical judgement and patient-centredness were still vital aspects of care, and to achieve this would sometimes require deviation from the set goals associated with ERAS.

RN10 (CR): *We are flexible, yeah. [...] It's there as a guide, it's not there to be rigid. You will do this on this day. Because some people are quicker than the pathway would anticipate you going, and some are slower, and you just have to judge that on the patients recovery. [...] every situation is gonna be different even if they've had the same operations, you can't really just say...it's easy to have just tick boxes, but not everybody falls into those tick boxes. [...] I think you've still got to have that leeway for clinical judgement.*

These accounts illustrate the interesting counterpoints of rigidity and flexibility within clinical pathways and this was evident when patients were unable to engage with postoperative mobility requirements due to factors such as pain, illness or fatigue. In such cases, sometimes nurses encouraged patients to mobilise, while in other

TABLE 1 Participant details.

Upper GI	Position	AfC band*	Sex	Upper GI	Procedure	Age	Sex
RN1 (UGI)	Staff Nurse	5	M	PT1 (UGI)	UGI	65–70	M
RN2 (UGI)	Deputy Ward Manager	6	F	PT2 (UGI)	UGI	45–50	M
RN3 (UGI)	Ward Manager	7	F	PT3 (UGI)	UGI	50–55	M
RN4 (UGI)	Staff Nurse	5	F	PT4 (UGI)	UGI	55–60	M
RN5 (UGI)	Staff Nurse	6	F	PT5 (UGI)	UGI	65–70	M
RN6 (UGI)	Staff Nurse	5	F	PT6 (UGI)	UGI	45–50	M
RN7 (UGI)	Surgical Nurse Practitioner	7	F				
Colorectal	Position	AfC Band*	Sex	Colorectal	Procedure	Age	Sex
RN7 (CR)	Staff Nurse	6	M	PT7 (CR)	CR	60–65	M
RN8 (CR)	Health Care Support Worker	3	F	PT8 (CR)	CR	60–65	F
RN9 (CR)	Staff Nurse	5	F	PT9 (CR)	CR	65–70	F
RN10 (CR)	Deputy Ward Manager	6	F	PT10 (CR)	CR	60–65	F
RN11 (CR)	Staff Nurse	5	M	PT11 (CR)	CR	65–70	M
RN12 (CR)	Ward Manager	7	F	PT12 (CR)	CR	55–60	F
RN13 (CR)	Staff Nurse	6	F	PT13 (CR)	CR	55–60	F
				PT14 (CR)	CR	50–55	F
Orthopaedic	Position	AfC Band*	Sex	Orthopaedic	Procedure	Age	Sex
RN14 (OT)	Staff Nurse	5	F	PT15 (OT)	OT	50–55	M
RN15 (OT)	Staff Nurse	5	F	PT16 (OT)	OT	55–60	F
RN16 (OT)	Staff Nurse	5	F	PT17 (OT)	OT	45–50	F
RN17 (OT)	Staff Nurse	5	F	PT18 (OT)	OT	65–70	F
RN18 (OT)	Deputy Ward Manager	6	M	PT19 (OT)	OT	50–55	F
RN19 (OT)	Clinical Nurse Specialist	6	F	PT20 (OT)	OT	65–70	M
RN20 (OT)	Clinical Nurse Specialist	6	F	PT21 (OT)	OT	55–60	M

Abbreviations: CR, colorectal; OT, orthopaedic; PT, patient; RN, registered nurse; UGI, upper gastrointestinal.

*Agenda for change is the national pay system for all NHS staff, with the exception of doctors, dentists and most senior managers.

instances mobility would be paused until the patient was more willing and able to take part. Either way, the patients' best interests appeared to be foremost in the nurses' reckoning.

RN4 (UGI): *We just try and encourage them. Sometimes they just don't feel like doing that. [...] they're feeling a bit weak or in pain [...] Giving them the pain relief and just encourage them to do what they can, really. Cause people will recover at different rates. Some of them will do really well and others will take a bit longer maybe.*

Patients also welcomed being able to recover at their own rate, and 'overdoing' recovery was perceived by some as potentially jeopardising the success of their treatment.

PT3 (UGI): *[...] you've got to recover at your own rate, really, haven't you? You can help it along a little bit. And some people do recover better than others.*

PT11 (CR): *I do things to match with what I can do. I don't try and overdo it. I'm only thinking, I'm not going to overdo it cause I'm gonna undo the work that they've already, they've done. So, you've got to be sensible.*

In a further extension of flexibility that can occur with the care pathway, nurses factored the issue of individual patient's variability into their support during the recovery period and referred to the importance of working with patients to 'pace' and monitor postoperative rehabilitation to reduce the risk of any adverse events.

RN7 (CR): *We have got a few patients who are brilliant after their surgery, you know. No pain at all, no sickness or anything. So, they get on, they just push it so hard. "I'm gonna eat as much as I can, walk around". Which is not bad and then the day after that [...] everything wears off then and they start being sick, they start to be in pain, um, and then as an effect of that they don't want to walk around as much as they should be doing. But, you know, again you just pace it out, you just take it slow really. It's better to start slow and build it up rather than go big time straight away and then you eventually fall flat [...] you don't want to push patients too much then and they feel awful after.*

This variability in recovery is demonstrated in the following data extracts in which patients vividly described their experiences of illness, but also commented that these episodes only resulted in temporary delays and that staying in bed was a necessity rather than a choice. This illustrates the importance of nurses adopting a flexible and individualised approach to the pathway to mitigate any adverse outcomes for patients during recovery.

PT5 (UGI): *I had one bad night. [...] Where my heart rate went through the bloody roof. And my, and I...it was a, I think they said it was an infection. [...] this was only two or three days after the operation. [...] but I got over that fairly quickly.*

PT17 (OT): *My blood pressure kept going down, so every time I got up, I had to get back down again. So obviously there was an issue there for a couple of days with my blood pressure. [...] it was a medical reason that I couldn't get out of bed really. Not so much, um, you know, not getting out of bed. It was more that I wasn't able to get out of bed.*

Overall, this theme shows that the ERAS pathway supports nurses in delivering a standardised, evidence-based approach to promote patient recovery. However, this theme also illuminates the significance of allowing for a flexible approach to patient care during the important recovery and rehabilitation period, with nurses (and patients) reacting to individual needs and variability.

3.2 | Patients with differing levels of engagement

We can see that the overall tenor of nurses' interactions with patients recovering from surgery was generally supportive and encouraging. However, our analysis also identified different approaches to recovery adopted by patients, which in turn required different approaches to nursing care and the management of postoperative recovery.

3.2.1 | 'I didn't need nagging': Patients feeling 'pressured' into postoperative mobility

In situations where, despite nurse prompting and encouragement, patients were still reluctant to engage with mobilisation, nurses reported adopting a more 'assertive' approach to encourage patient involvement. In contrast to the earlier accounts of nurses basing their practice on experiential or tacit knowledge, nurses also drew on evidence-based information when encouraging, or perhaps more accurately, incentivising patients to mobilise. The following quotes demonstrate that nurses would return to, and reinforce, earlier advice and offer further encouragement and reminders of the perils associated with prolonged bed rest.

RN1 (UGI): *But then we wouldn't be doing our jobs properly if, like or three or four days, if we didn't have ERAS and they were reluctant to be moved out of bed [...] Cause when there's no reason for them not to be completing the ERAS, there's no reason to leave them in bed. [...] sometimes you have to be assertive and say well, you know, out of bed now. Because they get chest, if you just lay down, you can end up with a chest infection, a pressure sore. And that soon gives them a bit of a motivation.*

RN16 (OT): *I think it's really important for them to know the risks cause you know, even if it's painful, if you tell them the risks. [...] the first thing we think of on this ward is like pain relief cause you're not going to be able to mobilise. And that's such an important part of getting better and out and reducing the risks of any clots or anything.*

Despite earlier evidence demonstrating that some patients who were not well enough to take part in mobilisation were afforded rest and recuperation by nursing staff, there were also examples of patients reporting they felt inappropriately pressured into continuing postoperative rehabilitation despite being unwell. This approach was considered unnecessary by some patients, demonstrating that although nurses can legitimately refer to the evidence base to encourage involvement, this can sometimes be misguided or misjudged.

PT14 (CR): *I told them, if I can manage to do it, I will do it. And, you know, I did. I think it was only one day that I only did three circuits instead of the four, when I was feeling so lousy. But um...yeah, I did feel that sort of pressure that I had to do it. [...] Still encouraging me to do it! Which I can understand because I think it's a great scheme. But I think, you know, it should be tailored to individuals rather than, "yes everybody will do this no matter how they're feeling". (laughs)*

This highlights some discrepancies with the earlier findings in which staff noted they were aware that some patients may experience 'blips' and would require a slower pace to their recovery. Not all staff were accommodating of this patient-led approach to rehabilitation, regarding patient protestations of feeling unwell as not 'serious' enough to warrant bedrest.

3.2.2 | "I started exercising as soon as I was conscious": Highly engaged patients

There were also patients that we categorise as demonstrating 'high' engagement. These patients followed nurse encouragement and evidence-based advice after initial prompting, and also described how they were then left to independently manage their own post-operative goals.

PT5 (UGI): *Well, I started exercising as soon as I was conscious. You know, I mean probably a day. A day and a half. And I used to exercise, do breathing exercises and all these things which they said I could do and, um, I said, well when do I get out of bed. And I wanted to do it. [...] must have been walking three hundred metres a day to start off with. Up and down the wards.*

This high level of engagement was also noted in relation to patients wanting to return home to complete rehabilitation, with the home environment presented as more conducive to recovery than a hospital ward. Some patients also identified where they believed healthcare professional input was no longer required to support their ongoing recovery.

PT1 (UGI): *[...] I said to the nurse in the morning, look, do you think you would ask if I could go home because we're at a stage now that I don't need any clinical...er, side of things. It's just recovery. [...] I would recover better in the house than what I would do in hospital. [...] Once the level of, er, cover, nursing cover then, is, has come to what I call an end. I think then it's time to leave. Cause your own care then can be done in the house.*

These highly engaged patients demonstrated independence and agency, in some cases pushing the boundaries of the ERAS pathway in terms of choosing to exceed the physical activities expected and also actively lobbying staff for discharge from hospital. Some other patients were comparatively passive and disinclined to engage in mobilisation evoking nurses to adopt strategies to encourage and motivate engagement. However, this was perceived by some patients as inappropriate and unnecessary. It should also be noted that other patients simply followed the pathway, which neither pushed boundaries, nor delayed progress.

3.3 | 'We're all in it together': Patient-patient engagement and peer support

Further to the nurse-patient interactions described thus far, some patient participants also discussed how they engaged with other patients during their hospital stay. This served as mutual reassurance about recovery, as well as acting as a source of motivation, encouraging and moderating each other with postoperative mobility rehabilitation.

PT16 (OT): *Well, I think, you chat to each other, you're encouraging each other to sort of like move and do your little walking bits and your exercises and, you know, just generally on a social level as well. You find out about each other's lives and you know, you're sort of just chatting through the day.*

PT6 (UGI): *I think there was four people on the same thing as me. 'Get up early'. (ERAS) And they all said, I hope I can get up and do what you done. [...] this 'Bob', I had to say, you take it easy. Don't let them rush you. You know what I mean. Cause you were up and down, you know. And then they said, I hope I can do that. [...] We were all in it together, though.*

PT18 (OT): *Yes. As I say, the lady opposite, in that corner. She'd had the knee operation. [...] Yes, we used to try to encourage each other. [...] when we're doing the exercises, you know, and stuff like that, we was trying to encourage each other on and, you know.*

Patients described how it was not just the periods of activity that were important, but also the time in-between where patients may engage and socialise, helping build a spirit of camaraderie. This shows patients becoming actively involved in their intertwined recovery journey. The standardised approach of ERAS may have contributed to these opportunities for shared experiences and sense making, as demonstrated in the quotes above. This shared experience was also observed by a nurse respondent as a type of benchmark around which patients could encourage each other and compare progress.

RN13 (CR): *[...] it is competitive, but in a good way. Because they do see, they might have spoken to somebody in the four bedder who's had an operation the same day, came in the same day. They're doing more walks than them! That's not fair, they wanna do the same. You know, it is competitive but it's not a negative, it's a good, it's a positive for them.*

Patients reported how friendships and reciprocity emerged from their shared experiences of hospitalisation, and this was identified by some as a support mechanism for recovery being both reassuring and beneficial to individuals' sense of wellbeing. This was also viewed as a

means of distraction from the issues at hand in terms of illness and recovery.

PT10 (CR): *When I first went on the ward, I was sort of saying hello and we were introducing ourselves and I went and spoke to the old lady and she told me all about her family. And she thanked me for going across and speaking to her. [...] And yeah, you could see how people were sort of interacting and bouncing off.*

PT9 (CR): *And then also a lady came in and she was so nervous about her op. She was so not looking forward to having the operation at all. And it was nice to be able just to chat to her about other things. Not, you know, I couldn't advise her what was, I didn't take on that role. But just to distract her. And that distracted me.*

It should be noted this shared experience was not welcomed by all patients, as demonstrated in the following respondent's comments.

PT8 (CR): *I think it's private. And maybe we each had a different problem [...] And I think we were not particularly chatty people. You know, you're not going to shout across the ward. [...] We didn't go and sit by each other's bed. Maybe other people do. But it didn't happen when I was there.*

4 | DISCUSSION

4.1 | Tensions between standardised and individualised care

Our findings show that the use of an ERAS pathway can provide standardisation and consistency to guide nursing practice in postoperative care and rehabilitation. Existing literature similarly identifies that a useful function of care pathways is to remind staff of their practice requirements (Alawadi et al., 2016) which may also benefit the quality of patient care by standardising working practices (Cohen & Gooberman-Hill, 2019). Our findings also show that patient involvement in ERAS postoperative rehabilitation is not necessarily subject to a 'one size fits all' or static concept of patient recovery. Instead, patients respond in different ways to the opportunities to take part in their recovery from surgery. Some may be reluctant (or refuse), whereas others may be highly engaged, exceeding what is required or expected of them. In response, some nurses in our study frequently counter-balanced their approach between the 'best practice' structure of the pathway and a more individualised approach. This was derived from nurses' experiences of providing care and support for patients during the early stages of postoperative recovery, empowering nurses to modify or pause the requirements and demonstrate awareness of patients inability to engage with, or fit

within, the postoperative expectations. Other studies have noted the similar adoptions of a flexible approach to pathway related goals such as those found in the ERAS programme, highlighting the potential struggle between following standardised care, while also providing individualised patient care (Cohen & Gooberman-Hill, 2019; Herbert et al., 2017). This is further supported by the findings of Gillis et al. (2017) where patients reported enjoying being treated as an individual receiving personalised care rather than just being told what to do, which encouraged patients to invest more effort into their postoperative recovery.

In addition to negotiating individual approaches to achieving recovery goals, our findings also identified nurses adopting different approaches to encouraging patients, depending on the extent to which patients were deemed to be engaging with rehabilitation. In particular, patients who were considered not to be engaging with the recovery programme received heightened levels of encouragement from nurses, which made some patients feel pressurised into rehabilitation activities despite communicating their reluctance to do so. This phenomenon is also reported in the wider literature, for example, in their review, Sibbern et al. (2017) identified that patients described experiences of healthcare workers exhibiting an authoritarian and top-down approach which inhibited some patients recovery and conflicted with their expectation of individualised care. Gillis et al. (2017) also report patients' experiences of nurses being overly focused on ERAS protocol requirements, without taking individual physical health into account, which caused anxiety for some patients. The importance of staff effectively setting and managing expectations through negotiation with patients and in doing so building a shared understanding of ERAS requirements is also emphasised by Cohen and Gooberman-Hill (2019). Further to this, Sibbern et al. (2017) identified personalised feedback and positive support from healthcare professionals as a motivator for patients in their ongoing engagement with postoperative aspects of ERAS.

Our findings data did not offer definitive insights into why some nurses were willing to individualise and suspend the recovery process requirements for some patients who were struggling to maintain the pace, whilst other patients in a similar situation were encouraged by nurses to persist with the programme's stipulated recovery process and were less likely to experience adaptations to their recovery programme. Suffice to say that some nurses' responses to patients depended on nurses' perceptions of patients' level of engagement.

4.2 | A continuum of care

The variability or 'spectrum' of nurse-patient interactions is an interesting point of discussion in relation to the involvement of patients in clinical pathways such as ERAS and the consequences of this for nursing work and the way this work is organised and deployed. We suggest, based on our findings, that to more effectively support the management of nurse-patient postoperative expectations and interactions, it may be helpful to categorise patients in the

postoperative rehabilitation process as existing somewhere along a low-medium-high engagement continuum. This aligns with the concept of patient agency as described by Street et al. (2009) in which they view patient agency as existing on a spectrum of involvement, focusing on the more active aspects such as involvement in medical encounters and self-care skills (such as those demonstrated in ERAS), to support individuals in managing their own health and healthcare-related activities. It is also helpful to consider our findings in the context of literature, which has identified a dynamic that patients traverse during recovery—a dynamic that nurses and other healthcare professionals are sometimes unsure how to deal with. For example, the systematic review reported by Murray et al. (2019) identified that as patients attempt to resolve health-related goals, they move through multiple states of involvement in response to their interactions with healthcare professionals. Murray et al. (2019) conclude that any intervention which seeks to involve patients should attempt to address these dynamic states of involvement. They also identified attempts by some patients to be more active often failed as healthcare professionals were unsure how to respond, resulting in patients moving between states of involvement (Murray et al., 2019).

Identifying and incorporating these dynamic states of involvement into patient postoperative care could support a more nuanced and rounded view of, and approach to, recovery for nurses. Rather than viewing patients as 'not involved' or ambivalent about recovery, a continuum approach would encourage nurses to recognise that states of recovery are labile rather than fixed. For example, even within the same day a patient appearing reluctant to mobilise in the morning, may well be walking laps of the ward by evening depending on, for example, a change in their mood, energy levels or reduced nausea. The obverse is also true, in which actively involved patients may move to a less active state as a result of fatigue or increased pain. Finally, some patients may be more 'fixed' than labile, remaining in a steady state of involvement (or not) throughout the course of their recovery. The salient point being that nursing work and interaction with patients recovering from surgery needs to be reactive to where patients are at any point in time on this perceived continuum, not fixed to where they expect or wish patients to be in their recovery. Pathways such as ERAS can raise the expectations of nurses and other healthcare professionals of a 'standardised' or linear recovery process, which on the basis of our findings is a rather reductive approach to a more complex and nuanced postoperative journey.

Building further on the notion of patient involvement in recovery as a continuum rather than fixed, our paper also helpfully demonstrates that at any given point in time, nurses and patients negotiate this continuum between, at one end, a patient-centred approach embracing patient involvement and choice, and at the other end decisions taken by professionals that are aligned to the expediency of processes related to the pathway and the wider organisation, rather than patient choice. Vogus et al. (2021) discuss the perceived tension between customisation and standardisation, which may be seen as contradictory. They argue that both are necessary to ensure efficient

high quality health care, with customisation required to increase healthcare providers understanding of patient needs, while standardisation is necessary to promote repeatability and reliability of healthcare interventions (Vogus et al., 2021). Returning to Lydahl's (2021) work on the use of healthcare protocols in person-centred care, we can see also that the actions of some of the nurses in our study were comparable in that they did not dogmatically follow a pre-determined 'script'. Instead, nurses used their skills, knowledge and experience to mediate and negotiate with patients to ensure appropriate use of the pathway to support patient-centred care—what Lydahl (2021) describes as 'making space' for the patient experience (notwithstanding that this was not always the case in our study).

What we can see is that as long as patients are perceived to be making progress in postoperative rehabilitation, then the care relationship with nurses progresses smoothly in a patient-centred way, with no obvious tension between patients' and nurses' expectations. However, when progress is delayed in the context of the stipulated requirements of the care pathway and associated organisational goals, this can create tension in nurse-patient relations and nurses are seen to deploy more direct instructions to patients. Perceived delays, where recovery does not align with nurses' expectations can limit patient choice, such as electing to stay in bed, and lead to patient decisions being scrutinised in more detail by nurses and sometimes directly challenged.

4.3 | Patient-patient engagement and support

Our findings also introduce the seldom considered notion of patient-patient encouragement and motivation. Our data, for example, captured evidence of patients' supporting and motivating one another to move toward and accomplish postoperative mobility goals, as well as more broadly building a sense of camaraderie during the immediate postoperative recovery process. In this respect, our paper adds a further dimension to understanding recovery from surgery on hospital wards that goes beyond merely considering recovering as a function of the collaborative work of nurses, other healthcare professionals and patients. Our findings demonstrate that recovery is also a function of the social life of wards in a process facilitated by patient engagement and involvement with other patients; a process that is currently inadequately understood in the broader practices of clinical and research nurses.

To date, the patient involvement literature has mostly focused on understanding the relational dynamics occurring between patients and healthcare professionals, in terms of establishing a mutual relationship that enhances the organisation, delivery and quality of care (e.g., Snyder & Engström, 2016). Although Andersen et al. (2015) state the need for healthcare professionals to be alert to, and aware of, relationships and interactions between patients our findings are amongst a small number to offer insights into the potential positive impact of patient-patient interaction during immediate postoperative recovery on hospital wards. Analogous to our findings, Samuelsson

et al. (2018) described how older patients on ERAS programmes similarly expressed a need for existential reflections, with fellow patients being preferred to healthcare staff when discussing certain aspects of illness. More recently, Costa et al. (2022) described how patients on an acute stroke ward actively sought opportunities to socialise with other patients. However, they also noted that while socialising was seen to be helpful and enjoyable for patients, at other times patients were observed as being silent in the presence of one another. On a similar note, previous research (Borregaard & Ludvigsen, 2018; Laursen, 2016) reported patients as being ambiguous about relationships with fellow patients and whilst it was recognised that it can be useful for patients to have someone like-minded to talk with, patients may also feel anxious about entering into a relationship in which another's illness is something to have to cope with alongside one's own illness.

Our findings bring to the fore patients' active involvement with each other and identifies activities that take place when hospitalised patients are together in what is often unobserved and hidden peer support. Although under-researched in acute hospital care, peer support is a recognised strategy in mental health services (Bellamy et al., 2017) and this collective experience and support mechanism is something that could be better understood in other settings, such as those described in our study. However, this will require consideration of patients' preferences for this type of interaction and also how the hospital environment is designed. For example, current design of single rooms rather than wards may have unintended consequences for recovery. These issues are particularly relevant where the focus of recovery is physical and observable and open to shared experience, such as with ERAS postoperative mobility. Further consideration is needed in regard to patient-patient relationships and interactions in the context of existing theories and how this might be harnessed to support improved patient outcomes and experiences. This patient-patient involvement may have positive consequences for nursing work as patients support and encourage each other towards recovery, and patients may also act as a 'proxy' for each other with postoperative activities when nurses are not present or available (which may increasingly be the case with current staffing issues in the UK NHS).

5 | CONCLUSION

This paper adds to the existing literature and current ways of thinking in relation to the quest for standardised, clinically effective care, balanced with the aspirations for individualised, patient-centred care. This study has demonstrated that although clinical pathways are deployed in a standardised way, discretion and variation also exist against the background of this standardisation. For example, some nurses acknowledge the importance of flexibility when applying the ERAS pathway, whilst others do not. This paper also helps inform thinking about the use of care pathways such as ERAS in relation to service delivery by focusing on both nurse-patient relationships and patient-to-patient interactions, which can help lead to a better understanding that a sense of context beyond patient and healthcare

professional interactions is required. In this sense, much of the focus is on recovery being enhanced by nurses interactions with patients, but on occasion we have seen that patient-patient relationships can be an equally strong factor in hospital ward-based rehabilitation programmes. This paper has also considered the potentially dynamic state of patients during postoperative recovery, and how this aligns to notions of patients existing on a continuum that requires ongoing negotiation between patients and nurses. This approach embraces notions of what active patient involvement actually means, rather than more passive types of involvement focusing mostly on healthcare professionals facilitating involvement with a narrow, pre-determined scope. This is a different conceptual framing of the ERAS pathway, considering how to most effectively initiate and deploy best practice aimed at safe and effective postoperative recovery and rehabilitation which can also be reflected in other clinical pathways.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of Health and Care Research Wales, all those who participated in the doctoral study and Professor Davina Allen for her supervisory role during the main author's PhD candidature. The original doctoral study was funded by a studentship from National Institute of Health and Care Research Wales (NISCHR)* – reference HS-10-32 (*Now Health and Care Research Wales).

CONFLICTS OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions: The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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How to cite this article: Roche, D., & Jones, A. (2023). A qualitative exploration of the strategies used by patients and nurses when navigating a standardised care programme. *Nursing Inquiry*, e12553. <https://doi.org/10.1111/nin.12553>