**0268: EMERGENCY AND ESSENTIAL SURGERY AND ANAESTHESIA (EESA) AS A COMPONENT OF UNIVERSAL HEALTHCARE COVERAGE; WHAT IS NEEDED TO ACHIEVE THIS IN MALAWI?**

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**Aim**: The 68th World Health Assembly (May 2015) will consider a proposal for all member states to provide EESA as part of universal healthcare. We sought to assess the requirements for EESA in Malawi, a country in sub-Saharan Africa, population 16.8M, ranking 174/187 in the World Bank Human Development Index.

**Methods**: Lifebox aims to improve the safety of surgery in low- and middle-income countries (www.lifesbox.org). A needs assessment for EESA was conducted during a Lifebox training programme in Blantyre in August 2014. Exemption from ethics approval was granted.

**Results**: 88 anaesthesia providers attended from 27 hospitals in the south/central region (69 operating rooms, median 20 (7–110) cases/week). 100% attendees completed the questionnaire. Surgery performed (% hospitals) included caesarean section (100%), fracture reduction (85%) and emergency laparotomy (78%). Mains electricity was always available in 52% hospitals, sterile gloves in 85%, opioids in 59%, haemoglobin measurement in 22% and a staffed recovery room in 3% hospitals. 14 hospitals had a pulse oximeter in every theatre (in recovery in 2, emergency room in 4 hospitals). 100 oximeters were donated after training.

**Conclusion**: Deficits in basic infrastructure and supplies need to be addressed before universal access to EESA can be achieved in Malawi.

**0291: COMPULSORY COMPLETION OF VENOUS THROMBOEMBOLISM PROPHYLAXIS TOOL FAILS TO ENSURE GOOD PRACTICE**


**Aim**: Annually 25,000 potentially avoidable deaths from hospital-acquired venous thromboembolism (VTE) occur in England. Preventative measures include: mechanical and pharmaceutical (typically low molecular weight heparin (LMWH)) prophylaxis. Our hospital launched a VTE assessment tool in November 2011; all patients must undergo evaluation at admission. This study assesses the compliance of all hospital admissions against the standards: 1) completion of VTE proforma and 2) prescription of LMWH when indicated.

**Methods**: A prospective analysis of the electronic medical records of all consecutive hospital admissions for 7 days in November 2014 was performed. Compliance with VTE proforma completion and LMWH prescription standards were assessed. The timing of each was evaluated.

**Results**: 659 patients were admitted (199 elective, 460 emergency). 492 patients (74.7%) were VTE risk assessed. LMWH was indicated in 328 cases but only prescribed in 269 (82%). Of these 328 patients, 161 missed at least the first dose due to delayed assessment (45.7%) or delayed prescribing (3.4%). 49 admissions (7.4%) received LMWH without assessment. 81 (12.3%) were retrospectively assessed after LMWH prescription.

**Conclusion**: VTE risk assessment is not being appropriately performed on admission and LMWH prescription in response to evaluation is poor. Only 21.5% of admissions had appropriate VTE assessment and risk management.

**0299: IMPLEMENTING THE WORLD HEALTH ORGANISATION, SURGICAL SAFETY CHECKLIST**

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**Aim**: To introduce the World Health Organisation (WHO), Surgical Safety Checklist in a charitable hospital in India; and analyse uptake and efficacy.

**Methods**: The WHO checklist was adapted and used for one month in two operating theatres (OT). 24 “checklist” cases were compared with “current-practice” cases selected from the same date, and where possible, same OT. Any checklist steps carried out, were documented. A peri-operative record was created for detailing intra-operative and post-operative complications: data was collected retrospectively after discharge using paper records. A staff feedback survey was distributed at the end. Based on findings and opinions, a modified checklist was proposed for formal implementation.

**Results**: Of the 14 steps prior to anaesthesia induction, an average 73.9% were recorded; of the 11 steps before incision, 42.8%; and of the 6 steps before patient leaves OT, 60.4%. Despite variable uptake, feedback showed 93.3% believed a checklist was very/extremely important; 86.7% thought it was easy/easy to use; and 100% felt it should be implemented long-term. Intra- and post-operative complication rates in both groups were 11–17%.

**Conclusion**: A formalised surgical safety checklist should become part of standard protocol. The dataset was not large enough to adequately compare peri-operative morbidity and mortality in both groups.

**0300: ACHIEVING AN EFFECTIVE HANDOVER IS THE DUTY OF EVERY DOCTOR – IS GENERAL SURGICAL HANDOVER IN A DISTRICT GENERAL HOSPITAL COMPLIANT WITH THE ROYAL COLLEGE OF SURGEONS OF ENGLAND GUIDELINES?**

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**Aim**: “The transfer of a patient to the care of the oncoming team is point at which the patient is most vulnerable on their journey through the healthcare system. Poor or incomplete information is often handed over with potentially disastrous consequences. Achieving an effective handover is the duty of every doctor.” Our aim was to assess the compliance of general surgical handover in a district general hospital with the Royal College of Surgeons of England guidelines.

**Methods**: Handover documentation over a two week snap-shot was reviewed. Data was collected using an electronic pro-forma.

**Results**: 174 patients admitted over a 2 week period were included. No patients had complete documentation in-line with RCS guidelines. Only 41% patients had blood test results documented at handover. 41% of patients had no documented diagnosis at handover. 0 patients had resuscitation status or high-risk status documented at handover. The responsible consultant was documented in only 72% of patients.

**Conclusion**: Current handover documentation is incomplete and does not meet RCS guidelines. The electronic handover proforma needs redesigning to ensure all items from RCS guidelines are included, staff need to be educated on the importance of including such information and regular audit to ensure improved compliance.

**0366: EFFICACY OF AN ABSCESS PATHWAY**

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**Aim**: Conventionally, patients with abscess were operated according to the availability of emergency operation theatres.

**Methods**: An abscess pathway where patients were assessed and admitted the next morning for Incision and Drainage (I & D) and discharged from theatre recovery. Case load database was extracted through clinical coding.

**Results**: A retrospective review of a six month case load in a University Hospital of 152 cases. Male ratio was 55%. General anaesthetic in 148/152 (97%) versus Local 4/152 (3%), of which 145 (95.3%) discharge from recovery whilst 7 required overnight observation or further management. 99/152 (65%) were ASA 1, 47/152 (31%) were ASA 2 and 9/152 (6%) ASA 3. Theatre slots was planned for the morning session to prevent prolonged fasting, hence 96/152 (63%) were induced before midday, 56/152 (37%) were induced before 17:00. Procedures were mainly performed by registrars. On average waiting times ranged between 1–14 hours (mean = 3.743 hours). Average length of stay of 152 was 3.743 h, 100% had the procedure done on the day of admission.

**Conclusion**: Abscess pathway decreased the hospital stay of medically fit patients after I&D, improving efficiency and cutting costs. This generally on average saved our trust (152 x 350 = £53,200) in 6 months.