

were identified. Pathology results were reviewed to identify if they had a glandular fever screen on admission or on a second venepuncture sample. After highlighting the importance amongst Otolaryngology and Emergency medicine colleagues, a further eight-week period was audited.

Results: Screening on admission for glandular fever increased from 76% in cycle one to 97% in cycle two. Those patients identified as having glandular fever did not have prolonged hospital admissions and all were adequately counselled of the potential risks and complications.

Conclusion: Glandular fever screening is a simple investigation that can contribute to patient safety. Patients with active infection need adequate advice; especially the risks of trauma to the spleen and failure to discuss these risks may have medico-legal implications.

0999: ARE WE POSITIONING PATIENTS APPROPRIATELY FOR DIRECT LARYNGOSCOPY? A NATIONAL SURVEY OF UK ENT CONSULTANTS

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Aim: Although the “sniffing” position is widely accepted as providing optimal views of the larynx when carrying out Direct Laryngoscopy, a questionnaire-based study of UK ENT specialty trainees suggested no general consensus in positioning patients for microlaryngoscopy. Our aim was to explore the positions used for direct laryngoscopy amongst UK ENT consultants.

Methods: A structured questionnaire was sent to 580 UK ENT consultants. This addressed the initial position preferred for direct laryngoscopy, the techniques used to achieve these positions, and whether any additional manoeuvres were employed in the case of a difficult airway.

Results: 320 responses were received (response rate 55.2%) of which 287 were analysed. 156 (54.4%) surgeons reported that they used the sniffing position, however only 33.1% used an aid to elevate the head in order to allow this position to be attained. Only 48.4% of surgeons applied additional cervical flexion in the case of a difficult airway. (It is only this manoeuvre that can technically exaggerate the sniffing position).

Conclusion: This study has identified significant variation amongst ENT consultant surgeons when positioning patients for this very common ENT procedure. This variation amongst consultants may not only affect patient care but can also have an impact on training.

1006: IMPROVING PATIENT SAFETY IN ENT

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Aim: Approximately 200 operations per month are performed in the ENT department across Brighton and Sussex University Hospitals. The WHO surgical checklist and RCS-Good Surgical Practice (RCSGSP) are paramount to patient safety.

Methods: Two audits have been performed: 1) to assess the completeness of operation notes against the RCSGSP and 2) to analyse the errors on theatre lists. A prospective audit was undertaken over a 4-week period and ENT operation notes were analysed against the RCSGSP parameters. A retrospective audit was performed and theatre lists were analysed for differences between the intended operation and the coded operation.

Results: 208 ENT operations were performed within the 4-week period. Only one parameter, signature of surgeon, had a 100% compliance rate. The time of operation was recorded in 11% of operation notes and intra-operative diagnosis was documented in 76%.

43% of theatre lists showed a mismatch between the intended operation and coded operation. In 9% of cases, the wrong operation and site were coded for on theatre lists.

Conclusion: Incompleteness of operation notes and errors on theatre lists are a major concern for patient safety. An operation note template has been implemented and the coded operation has been removed from theatre lists. Re-audits are currently being undertaken.

Posters: Hepatopacreatobiliary

0056: INTRA-ABDOMINAL DRAINAGE POST LAPAROSCOPIC CHOLECYSTECTOMY: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Aim: To assess the effectiveness of intra-abdominal drain (IAD) post laparoscopic cholecystectomy (LC).

Methods: Main electronic databases [MEDLINE via Pubmed, EMBASE, Scopus, Web of Knowledge, Cochrane Central Register of Controlled Trials (CENTRAL) and the Cochrane Library, and clinical trial registry (Clinical-Trial.gov)] were searched for randomised controlled trial (RCT) reporting outcomes of IAD. The systematic review was conducted in accordance with the PRISMA guidelines and meta-analysis was analysed using fixed and random-effects models.

Results: Twelve RCTs involving 1763 patients were included in the final pooled analysis. IAD did not reduce the overall incidence of nausea and vomiting (RR 1.10, 95% CI 0.90, 1.36), shoulder tip pain (RR 0.99, 95% CI 0.69, 1.40) and length of hospital stay (MD 0.22 day, 95% CI -0.51, 0.95). Negative effects of drain include higher pain scores (measured by visual analogue scale) (MD 10.08, 95% CI 5.24, 14.92) and longer operative time (MD 4.93 min, 95% CI 3.40, 6.47) were statistically significant. Wound infection was not significantly higher in the drain group (RR 1.84, 95% CI 0.91, 3.71).

Conclusion: There is no significant advantage of IAD placement. The routine use of abdominal drain seems to have unfavourable clinical outcome and the practice should be carefully re-considered.

0129: A CLOSED-LOOP AUDIT OF HANDOVER PRACTICE IN GENERAL SURGERY: HOW DOES IT COMPARE TO THE STANDARDS SET BY THE ROYAL COLLEGE OF SURGEONS OF ENGLAND?

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Aim: Inadequate handover can lead to adverse events and compromised patient safety. We present a closed-loop audit of handover in a tertiary General Surgery department.

Methods: The RCS “Safe Handover” 2007 publication outlines the minimum information required in patient handover. We analysed handover of new admissions to the department over a one-month period (n=202 patients) against this standard. Findings were presented to the department. The action plan consisted of: a) handover proforma modification to better reflect the standard and b) securing a private handover location. Re-audit was undertaken three months later (n=204 patients).

Results: Full adherence was seen in documentation of patient name and responsible surgeon in both audit loops. Improvements were seen in: admission date (57% to 100%, p<0.001); clinical presentation (82% to 99%, p<0.001); diagnosis (83% to 98%, p<0.001); management plan (92% to 98%, p=0.010); investigations (63% to 91%, p<0.001); patient stability (4% to 15%, p<0.001). Documentation of patient location decreased following reaudit (20% to 16%, p=0.302).

Conclusion: Following re-audit accordance with the standard was over 90% for all items except patient location and patient stability. To address this we are developing an electronic handover platform onto the Electronic Patient Record that auto-populates these handover items.

0190: AUDIT ON TIMING OF CHOLECYSTECTOMY FOLLOWING GALLSTONE PANCREATITIS

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Aim: To assess the compliance with the national guidelines on management of acute biliary pancreatitis, which recommend definitive treatment of the gallstone disease on the index admission or within two-weeks of discharge. Definitive treatment includes cholecystectomy with operative cholangiography or endoscopic sphincterotomy for unfit patients.