

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.

Methods: We retrospectively reviewed all the patients admitted to the RBH with a diagnosis of gallstone pancreatitis between June and December 2013.

Results: Thirty patients met with the inclusion criteria but five were excluded - two were unfit for any definitive intervention, one declined it, one died prior to discharge and one was referred to a specialist paediatric unit. 0/25(0%) patients underwent laparoscopic cholecystectomy with operative cholangiography and imaging of the bile ducts within the stated time-frame. 7/25(28%) underwent laparoscopic cholecystectomy within the stated time-frame, but without undergoing operative cholangiography. 2/25(8%) patients were considered unfit for surgery, but underwent ERCP plus sphincterotomy within the two-week time frame. In-hospital mortality rate was 1/30(6.6%) and the death resulted from complications secondary to pancreatitis. No patients died following surgical intervention.

Conclusion: 70% of patients with gallstone pancreatitis did not undergo definitive treatment within the recommended timeframe. Imaging of the bile ducts, with either intra-operative cholangiography, ERCP or MRCP was not routinely performed.

0232: UNRESECTABLE PANCREATIC CANCER: WHAT IS OUR BYPASS RATE AND HOW COULD THIS BE IMPROVED?

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Aim: Five-year pancreatic cancer survival remains at around 5% and the only significant chance of prolonging survival is complete surgical resection (R0). Only 20% of cases are deemed operable at presentation and many found to be unresectable at subsequent laparotomy. We undertook this study to clarify our rate of palliative bypass surgery (Roux-en-Y hepatico-jejunostomy/gastro-jejunostomy) for patients with 'resectable' pancreatic cancer, and the reasons for non-resection.

Methods: We reviewed our cases of pancreatic and peri-ampullary cancer operated on with curative intent from April 2009-14 and identified all who were unresectable at laparotomy.

Results: Of 245 patients undergoing laparotomy with the intent of pancreatic resection 44 patients (18%) had unresectable disease, and 41 (16.7%) underwent palliative bypass. The reasons for non-resection were vessel involvement (40.5%), liver metastases (35.7%), distant lymph node involvement (26.2%), intra-peritoneal deposits (16.6%) or local organ involvement (14.3%). Pre-operative laparoscopy was performed selectively (high serum Ca 19-9) in 19% of patients bypassed. The median time from staging CT to operation was 56 days (1-131).

Conclusion: Surgeons wish to avoid non-resectability at planned resection. Our rates are comparable to those in the literature but we wish to explore changes in practice that would decrease these rates in the future.

0234: SIZE OF COMMON BILE DUCT STONES ON MRCP PREDICTS LIKELIHOOD OF POSITIVE FINDINGS AT ERCP

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Aim: To determine if the size of common bile duct stones (CBD) measured on magnetic resonance cholangio-pancreatography (MRCP) can be used to predict the likelihood of a positive endoscopic retrograde cholangio-pancreatography (ERCP) result.

Methods: We analyzed the records of 1812 patients undergoing MRCP between November 2009 and November 2014 at the Victoria Infirmary. A CBD stone was present in 383 patients. 293 successfully underwent ERCP. **Results:** 221 patients (75%) had stones on ERCP. A receiver operating curve (ROC) was plotted correlating size with the likelihood of a positive ERCP result. A cut off of >4mm as an indication for ERCP gives the mathematical best-fit with sensitivity of 82.8% (95% CI 77.3 - 87.6) and specificity of 65.71% (95% CI 53.4 - 76.7).

Conclusion: Currently, all patients with stones on MRCP are considered for ERCP. Our results support the hypothesis that as size decreases the likelihood of stone passage increases. Although the threshold of mathematical best compromise is >4mm, we would suggest a lower threshold of 2mm above which ERCP is performed to minimise missed stones (sensitivity

98.65, 95% CI 96.1-99.7, sensitivity 25.71%, CI 16.0-37.6). For patients with stones measuring 2mm or less, early operative intervention with intra-operative cholangiography to confirm duct clearance could be an alternative.

0309: IMPROVING PATIENT CARE IN OUR CURRENT PRACTICE; MANAGING ACUTE PANCREATITIS WITH BRITISH SOCIETY OF GASTROENTEROLOGY (BSG) GUIDELINES

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Aim: BSG guidelines state that severity stratification should be made in all patients within 48-hours of diagnosis of acute pancreatitis (A.P) and severe cases should be managed in ITU/HDU. Aim of this audit is to compare management of A.P in our hospital with the BSG guidelines.

Methods: A retrospective analysis included patients diagnosed with A.P admitted from January 2012 till April 2014. Assessing the Glasgow score on admission and within 48-hours, length of hospital stay and whether ITU/HDU involvement was provided for high-risk patients. Patients with chronic pancreatitis or without a recorded amylase level were excluded.

Results: 79 patients were included. The primary cause was cholelithiasis (50%) while 8% were diagnosed as idiopathic in nature. 57% patients had incomplete documentation of Glasgow scoring in notes within 48-hours. Only 40% of patients with severe score received ITU input. Positive correlation was found between severity score and length of hospital stay ($r=0.52925$).

Conclusion: Recommendations were designing a scoring proforma with clear parameters; educating that better scoring would improve patient care. In a prospective study of 50 patients, 95% had a proforma in medical notes that led to a 69% increase in ITU/HDU involvement.

0312: MANAGEMENT OF GALLBLADDER STONES – ARE WE DELAYING THE INEVITABLE?

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Aim: Audit on management of symptomatic gallbladder stones, as compared to national guidelines, at Dumfries and Galloway Royal Infirmary. This showed that delaying laparoscopic cholecystectomy resulted in an increased readmission rate whilst increasing risk of postoperative complications.

Methods: Medical records of patients who underwent laparoscopic cholecystectomy between October 2013 and September 2014 were audited. PACS imaging software was used to identify patients with US-confirmed gallbladder stones. The period of time between diagnosis and operation was calculated and the readmission rate in the intervening period was measured. The rate of postoperative complications was then recorded as a function of time elapsed between diagnosis and operation.

Results: 55 patients with US-confirmed symptomatic gallbladder stones were included in the study (n=55). 48 patients had laparoscopic cholecystectomy as a day case procedure. The mean waiting time between diagnosis and operation was 124 days. 10 patients (18%) had to be readmitted with gallstone complications in this intervening period. 8 patients (15%) suffered postoperative complications, namely, conversion to open procedure and sepsis.

Conclusion: The waiting time between US confirmation and operation is prolonged resulting in a significant readmission rate. This increased waiting time is also statistically significant in terms of increased risk for postoperative complications.

0350: EMERGENCY LAPAROSCOPIC CHOLECYSTECTOMIES CAN BE DONE ON ELECTIVE LISTS TO IMPROVE PATIENT OUTCOMES AND COST EFFECTIVENESS IN THE NHS – A FEASIBILITY STUDY FOR WIDER IMPLEMENTATION

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