0540: A DESIGNATED ERAS NURSE CONSISTENTLY ACHIEVES ERAS GOALS WITH SIGNIFICANT COST REDUCTIONS FOR THE NHS

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Aim: Enhanced recovery after surgery (ERAS) optimises patient outcomes after elective surgery. The role of designated ERAS nurse has rarely been assessed with limited information on any potential cost savings.

Methods: 3 separate time periods were compared: n = 36, group 1 (ERAS established, no designated nurse, 3 months duration); n = 64, group 2 (5 month introductory period for ERAS Nurse) and group 3, n = 204 (12 months following introductory period) Total numbers of patients; length of hospital stay (LOS); re-admission rates were calculated with daily patient costs estimated using £541 / surgical ward.

Results: LOS reduced in group 2 and further reduced in group 3: 9 (3–36) vs 8 (3–15) vs 7 (3–68) [Groups 1, 2 and 3 respectively]. The re-admission rate reduced: 8% vs 4.7% vs 5.4%; length of re-admission stay shorter: 4.5 days vs 1.7 vs 1.7. The two-day LOS reduction saved 408 bed days: potential cost reduction of £1082/patient/ hospital stay or alternatively, allowed extra 58 patients to have surgery.

Conclusion: A designated ERAS Nurse has substantially increased the number of patients undergoing surgery, with further reductions in hospital stay and re-admission rates; a designated ERAS Nurse has vital and cost-effective role in current surgical practice.

0557: QUALITY IMPROVEMENT AUDIT: GENERAL PRACTICE GENERAL SURGICAL REFERRALS

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Aim: To evaluate the quality of general practice (GP) referral documentation to the general surgical unit at Southport and Ormskirk Hospital NHS Trust.

Methods: Prospective data collection of all GP patients referred to general surgery during a 5 week period.

Results: A total of 110 referrals were identified; 42 out of normal working hours, 65.5% female; 34.5% male; age range of 16–95years. Of those identified 61.8% arrived with a covering letter; 45.6% handwritten, 54.4% typed. 3 patients (2.6%) had no accompanying documentation, 2 previous operation notes (1.8%), and 1 last clinic letter (0.9%). 67.3% of patients attended with consultation and medical background printout. 93.3% of referral documentation included date; 46.2% time. 73.1% had a medication history, 29.8% covering social history, 12.5% of patients had a full set of observations recorded; 42.1% included no observations.

Conclusion: Clear referral documentation, including thorough past medical history, medication and social history is essential in the acute surgical setting for patient assessment. Observations recorded in the initial review of a patient are vital for appropriate departmental allocation and clinical prioritisation for the on call team. The development of guidelines for GP referrals regarding documentation is key prior to completion of the audit cycle in 12months time.

0572: AUDIT COMPLETION IN SURGERY

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Aim: A completed audit requires measurement against set standards, reporting of results, implementation of change and re-audit (HQUIP audit definition). Despite being a key requirement of training and revalidation, the overall rate of audit completion is unknown. We sought to examine audit activity and establish completion rates, and reasons underpinning failure to complete.

Methods: A standard audit proforma and methodology was established and the project registered across three hospitals. Records were searched for audits registered between 1/4/2011 and 31/3/2012. Audit department data was reviewed to establish validity and progress of audit. Audit teams were contacted to establish true progress and reasons for failure of completion.

Results: 39 Audits were registered within the General Surgery Directorate. Only 7 completed the audit with recommendation and re-audit according to HQUIP guidelines (18%). Commonest reasons given for failure to complete audit were gaining a required presentation/publication (no on-going desire) and results felt not to be of value to further investigate.

Conclusion: Audit completion rates are low. Our data suggests that audits are often performed to meet training/career progression needs rather than directly to improve patient care. To maximise the efficacy of clinical audit in surgery structured methods are needed to improve completion rates.

0573: IMPROVING THE DETAIL OF POST-OPERATIVE PLANS IN GENERAL SURGICAL PATIENTS


Aim: To assess the detail of postoperative plans and compare them to standards outlined by the Royal College of Surgeons.

Methods: Twenty general surgical post-operative notes were randomly chosen over a 3 week period. We analysed each plan looking at whether it was electronic or hand written, and if the following 6 parameters were documented: Analgesia plan, thromboprophylaxis, mobilisation, nutrition/feeding, details of drains, and post-operative antibiotics. Initial data was presented at our departmental meeting, followed by the implementation of a poster in each theatre emphasising the inclusion of the above 6 points.

After 2 months 20 operation notes were randomly selected and compared to close the audit loop.

Results: Pre and post intervention, notes were electronic in 80% and 100% respectively. Post intervention the inclusion of the 6 parameters improved as shown in brackets. Analgesia 40% (95%), thromboprophylaxis 50% (100%), mobilisation 30% (80%), nutrition/feeding 95% (100%), details of drains 15% (70%), and post-operative antibiotics 35% (90%).

Conclusion: Post-operative plans are vital in providing clear instructions for the multi-disciplinary team. They remove uncertainty, which may lead to complications. Compliance with recommended guidelines prior to intervention was poor. A simple reminder in theatre significantly improved the detail of post-operative plans.

0580: AUDIT (CLOSED LOOP); DAILY REVIEWS: ARE WE SEEING OUR INPATIENTS ON A DAILY BASIS?

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Aim: Principles of best practice states “an organised and disciplined approach to ward rounds…improves patient safety and care”. With this in mind, and an awareness of changing working patterns for junior doctors; are patients still being seen on the Ward Round (WR) every day? The aim of this audit was to assess whether we are reviewing inpatients on a daily basis and on re-audit; have we improved?

Methods: Prospective audit of notes over one week. Review of patient notes on a daily basis after 1630hrs of all adult inpatients in the orthopaedic department Exclusion of patients under the care of orthogeriatricians.

Re-audit after a month.

Results: Cycle 1: Average 86% patients seen daily (range 83–92%); 98% seen in 48hours, only 24% patients seen at weekend.

Intervention: Departmental education and audit meeting presentation/discussion. New consensus that all patients should be seen during the weekend. Cycle 2: Average 92% patients seen daily (range 85–97%), 98% within 48hrs. 96% seen at weekend

Conclusion: Due to the constraints of working patterns and multiple handovers there is a risk of patients being missed during the daily WR. Having identified this issue within our department, changes were made to improve performance and hopefully patient care.

0621: IMPROVING STANDARDS IN RADIOLOGY REQUEST FORMS: A SCORING TOOL FOR CLINICAL AUDIT

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**Aim:** The aim of this study was to develop an audit tool, identify current standards and measure improvement of emergency CT request forms for patients admitted to our surgical unit.

**Methods:** A 16-point scoring tool was developed and a retrospective review of 200 consecutive inpatient CT requests was carried out. A point was allocated to each completed parameter and the overall score calculated. Results were presented to the surgical team and a prospective audit of 100 consecutive requests performed. Following the audit a questionnaire was disseminated to members of the surgical team to determine the level of individual change in clinical practice.

**Results:** The overall mean score for CT request form completion improved from 13.3 (83.1%) to 15.3 (95.6%). Previous surgery documentation (35% to 71%), reference to previous imaging (37.5% to 75%), documentation of clinical signs (67% to 97%) and contact details of requesting practitioner (79.5% to 98%) all showed improvement. 20 individuals completed a post-audit questionnaire with 95% finding the audit useful in their clinical practice and 100% recognising the audit’s educational merits for junior doctors in radiology request form completion.

**Conclusion:** This audit tool is a useful method of assessing and improving standards of radiology request forms.

**0627: IMPLEMENTING THE WHO SURGICAL CHECKLIST: AUDIT OF ENT PATIENTS**

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**Aim:** In 2009 the National Patient Safety Agency published a patient safety alert, aiming to implement the WHO Surgical Checklist in all surgical procedures. A previous study by Haynes et al. had demonstrated a significant reduction in morbidity and mortality in surgical patients when utilising a surgical checklist. Our aim was to determine the completion rate of the checklist within our department. A previous audit had shown only 14% of procedures had a fully completed checklist.

**Methods:** We undertook a retrospective re-audit of ENT patients undergoing elective or emergency procedures. Data were collected from 34 case notes using a pre-defined audit proforma tool.

**Results:** We found that only 19% of notes had a fully completed checklist (previously 14%). In 16% of cases the forms were blank, and 6% had no checklist within the notes. Regarding the sections of the checklist (sign in, time-out, sign-out), completion rates were 56%, 75% and 50% respectively (previously 86%, 48% and 19%).

**Conclusion:** The WHO Surgical Checklist is now an essential tool in surgical practice. However, both audit cycles have demonstrated a significant number of incomplete forms. All surgical teams should complete regular audits to ensure correct implementation of these guidelines.

**0628: AN AUDIT TO ASSESS AND IMPROVE ADHERENCE TO ABBREVIATED MENTAL TEST SCORING IN EMERGENCY NECK OF FEMUR PATIENTS**

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**Aim:** An audit to evaluate as well as improve junior doctor adherence to the best practice tariff as set out by the national institute of clinical excellence (NICE) of completing an abbreviated mental test score (AMTS) on admission in all emergency fractured neck of femur (NOF) patients.

**Methods:** A retrospective observational audit of all junior doctor clerking’s of emergency NOF patients admitted into orthopaedics over a one-month period was completed. Junior doctors were educated upon NICE guidance of completing an AMTS on admission. A repeat audit cycle was completed over the following month to assess the efficacy of intervention.

**Results:** Data was collected from 36 patients over the first audit period. The audit demonstrated an overall adherence of 80.6% to NICE guidance. Following intervention data was collected from 31 patients, which demonstrated an improved adherence rate of 87.1%.

**Conclusion:** The audit demonstrated that there is currently a high level of adherence to NICE guidance. However, with education of junior doctors on the importance of AMTS on predicting patient recovery improved adherence. Further research is recommended with a larger patient population as well as a longer audit period to further evaluate the efficacy of intervention.

**0644: A PROSPECTIVE AUDIT OF THE WHO SURGICAL CHECKLIST USE IN A DISTRICT GENERAL HOSPITAL**

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**Aim:** We aim to identify how effectively the checklist is being used to capture both quantitative and qualitative information about the use of the WHO checklist using a predesigned proforma. Use of the WHO checklist in eight hospitals around the world was associated with a reduction in major complications from 11.0% before introduction of the checklist to 7.0% afterwards.

**Methods:** 32 Cases in General Surgery Theatres at Hillingdon Hospital in June 2013 were randomly chosen to cover general surgery, vascular surgery, paediatric surgery and Ophthalmology. Data was collected on 1) documentation of WHO checklist at the sign-in, time-out and sign-out phases. 2) Each phase was observed and a questionnaire to assess qualitative. Re-audit was performed after educational measures for all Operating Room staff.

**Results:** Documentation completions at the three phases were, 69%, 59% and 50% respectively. Re-audit showed improvement of sign-in and time-out to approximately 95% and 80% respectively. However sign-out results remained low at 50%. Qualitative improvement in sign-in phase was demonstrated after educational measure. There was no improvement in the execution of time-out and sign-out.

**Conclusion:** Checklist performance can be poor due to high turnover of elective cases, staff distractions and lack of respect for the procedure.

**0678: THE NATIONAL COMPLICATED ACUTE DIVERTICULITIS (CADS) AUDIT – A SNEAK PEAK**

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**Aim:** Acute complicated diverticulitis (ACD) is a common surgical emergency with significant implications for patients like major surgical intervention, intensive care support and life-long stoma. However, there is currently no standardisation of care or unified national guidelines. This audit aims to generate baseline data to inform future RCTs.

**Methods:** Protocol was developed and nationally peer-reviewed for a national audit with a pre-audit questionnaire exploring existing management policy for ACD, followed by 3-months of data-collection on patient demographics, admission details, surgical intervention, mortality/ morbidity. Finally, a one-off follow-up will be at 3-months from the date of admission to assess short-term outcome.

**Results:** The national CADS audit has successfully launched with 107-centres participating nationally. The data-collection phase is ongoing with nearly all participants having submitted the unit policy questionnaire and more than 1800 patient-records in the database so far. More results will be available at the conclusion of phase-1.

**Conclusion:** The audit has generated data on an unprecedented number of patients with diverticulitis. It is anticipated that these data may refine several pressing questions relating to management of ACD, like role of need for radiological and drainage of sepsis, major surgical resection with/ without primary anastomosis/stoma formation. This may enable development of robust RCTs with potential to generate level-1 evidence.

**0724: A CLOSED LOOP AUDIT OF PRE-OPTERATIVE MAINTENANCE FLUID PRESCRIPTIONS IN PATIENTS MADE NIL BY MOUTH PRIOR TO SURGERY**

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**Aim:** In December 2013, NICE published guidance entitled ‘Intravenous Fluid Therapy in Adults in Hospital’ [174] highlighting a weight-based approach to maintenance fluid prescribing suggesting patients require 25–30 ml/kg/day water, 1 mmol/kg/day Na/Cl/I/K, 50–100 g/day glucose.