37% of the patients had hypertension, which if well controlled did not affect the suitability of patients for streamlined direct referral and day case surgery. 7% of patients required overnight admission following the procedure which was unpredictable. An initial consultant led clinic appointment did not affect the overall outcome. Patient with MC score ≤3 are suitable for the streamlined assessment pathway.

**Conclusions:** This audit has demonstrated a direct referral pathway for suitable patients with groin hernia straight to pre-operative assessment can help deliver cost effective and efficient care. This has the potential to reduce waiting times and help re-allocate clinic for patients with complex needs.

**0990: AN AUDIT OF THE MANAGEMENT OF PATIENTS WITH ACUTE PANCREATITIS AT AN EAST LONDON DGH**

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**Introduction:** To audit the management of patients with acute pancreatitis, at a busy east London DGH, against the national standards of practice in the British Society of Gastroenterology guidelines.

**Methods:** A retrospective audit of 70 consecutive patients with acute pancreatitis was undertaken. Standards audited were correct diagnosis and severity stratification within 48hrs, aetiology determined in more than 80%, definitive management of gallstone pancreatitis within 2 weeks, overall mortality below 10 per cent and correct documentation of fluid balance status.

**Results:** The audit showed that severity stratification was documented in 41% of patients, while definitive management of gallstone pancreatitis within 2 weeks was undertaken in only 17% of patients. Correct fluid balance was documented in 27% of patients. Other standards were in keeping with the national guidelines. A clerking proforma was developed, distributed and an education programme undertaken. The audit was repeated after 6 months.

**Conclusions:** Improvement was shown in severity stratification (54% vs 41%) and correct fluid balance documentation (92% vs 27%). Delay to management of gallstone pancreatitis is a trust wide concern, which is being reviewed imminently. The clerking proforma is currently used within the surgical department, while implementation of an electronic proforma in A&E, is currently being considered.

**1211: COMPARING SURROGATE MARKERS OF SURGICAL SITE INFECTION BETWEEN TWO DIFFERENT ANTIBiotic PROPHYLAXIS REGIMES IN TOTAL JOINT REPLACEMENT PATIENTS: A PROSPECTIVE STUDY**

Punit Makwana, Satish Babu, William Harvey Hospital, East Kent NHS Trust, Ashford, Kent, UK.

**Introduction:** Antibiotic prophylaxis decreases surgical site infection (SSI) after total joint replacement (TJR) (relative risk reduction up to 81%). The ideal antibiotic(s) are internationally debated with choice dependant on surgeon, cost and availability. We aimed to study surrogate markers of SSI in patients receiving Teicoplanin and Gentamicin and compare this to a previous study of Cefuroxime efficacy.

**Methods:** Patients admitted for TJR between 20/12/11 and 15/3/12 at William Harvey Hospital were given standardised questionnaires to complete 30 days postoperatively. Wound healing duration, postoperative antibiotic use and wound microbiology were assessed. We compared our results to the previous study (n=147).

**Results:** 71% of participants responded (n=149). 53% reported wound healing in <14 days (46% in previous study), 37% recorded 15-21 days (38% before) and 3% of wounds had not healed at 30 days (4% previously). 0.09% of subjects received postoperative antibiotics vs. 0.02% formerly. Both studies yielded 0 positive wound cultures.

**Conclusion:** We found no clinically significant difference in wound healing, postoperative antibiotic prescription and positive microbiology between regimes. We postulate Teicoplanin and Gentamicin is not superior to Cefuroxime. However the incidence of SSI after TJR is low. Therefore large-scale trials are required to evaluate statistically significant differences between antibiotics.

**1309: OPERATION NOTES AUDIT CYCLE: ASSESSMENT OF COMPLIANCE WITH RCS GUIDELINES AT SOUTHDPORT DGH**

Abhishek Kalia, Andrew McIvor, Richard Steven, Frank Mason, David Jones. Southport DGH, Southport, UK.

**Introduction:** The culture of medical litigation in the UK is ever increasing. Good documentation of operation notes is therefore highly important. Furthermore, accurate documentation helps to maintain patient safety. The Royal College of Surgeons (RCS) has set out guidelines on what should be documented in operation notes. We aimed to assess compliance with these guidelines at Southport DGH, implement change to improve standards and then re-audit current practice.

**Methods:** In the initial audit, 100 operation notes were prospectively analysed by a single observer. The standards were the 14 points in the RCS guidelines. Changes were made to improve current practice including delivering a lecture on current practice, education of surgeons and installation of reminder notices of the guidelines in theatres. Practice was re-audited 1 year later.

**Results:** All 14 standards were met in 2% (1%) of operation notes. Greater than 90% compliance was achieved in 9 standards (10). Compliance with documentation of signature was 80% (67%); tissue samples obtained 97% (83%); time 35% (41%); elective or emergency 4% (7%).

**Conclusions:** Improvements were made in documentation of signatures and tissue samples obtained. Time and whether a procedure is elective or emergency are poorly documented. Overall compliance with RCS guidelines remains poor.

**1323: DOES A WARD ROUND CHECKLIST IMPROVE DOCUMENTATION AND PATIENT CARE?**


**Introduction:** To assess the current quality of documentation of post-take ward rounds after the introduction of the ward round checklist.

**Method:** A retrospective audit of 50 patients from November 2013. Data was collected from post-take ward round case notes, drug charts, operation notes and the checklist and compared to the first cycle audit undertaken in September 2013.

**Results:** In 100% of patients a ward round leader was identified on a standard history sheet with the date and time recorded. A named consultant was recorded in 11% of the first cycle to 96% currently. Blood results recording improved from 9% to 88%, VTE prophylaxis improved from 4% to 100%. Review of antibiotics, analgesia and nutrition improved from 50% to 100%. Documentation of the patients progress and examination improved from 85% to 100%. Average patient stay reduced from 3 days to 2 days (p=0.048)

**Conclusions:** On a busy surgical ward round it is easy to miss, or fail to document certain aspects of patient-care. This checklist has shown significant improvements in documentation which has translated into enhanced patient-care and reduced inpatient stay.

**1339: ARE PATIENTS ACTUALLY ATTENDING THE EMERGENCY DEPARTMENT BECAUSE THEY CAN'T GET APPOINTMENTS WITH THEIR GP? A SERVICE REVIEW AT THE ROYAL LIVERPOOL UNIVERSITY HOSPITAL**

Elizabeth Kane, Ryan Robinson, Alison Waghorn. Royal Liverpool University Hospital, Liverpool, Merseyside, UK.

**Introduction:** High volumes of attendances at emergency departments are a strain on current services. This review aimed to determine the reasons that patients are attending the emergency department (ED) rather than the GP.

**Methods:** Patients attending the ED over 3 days in October 2013 were interviewed at triage using a standardised questionnaire.

**Results:** 302 patients were interviewed; 122 of these presented following an injury. 14.2% of patients were admitted. 40.3% of patients had seen a doctor about the presenting problem; 37% were awaiting relevant investigations or outpatient appointments. 62.9% of patients didn't think their GP could help, and even if they could have had an appointment with their GP, 78.8% would still have attended the ED. 55.9% felt the hospital was the best place to be seen. 15.2% named a specialist, while 7% thought the GP. Reasons for differences in opinions included convenience, lack of confidence in the GP, 'cutting out the middle man', and desiring investigations.

**Conclusions:** Reasons for not wanting to see a GP were broad, deterring ease of classification. This review identifies that poor relationships in the community, lack of communication and understanding are key areas requiring intervention. Patients feel dissatisfied with care provision in the community.