Methods: Retrospective analysis of 50 cases where echo requests were made for preoperative general surgical patients after an incidental finding of a murmur, between April 2011-August 2012. Cases were analysed using the surgical and radiological databases in a single hospital.
Results: 7 (14%) of patients had a change of management as a direct result of the echo results. A further 34 (68%) were shown to have valvular disease but the surgical procedure occurred without change in management. The remaining 18% of patients had no valvular disease.
Key messages: These results suggest that a large number of patients (86%) have additional investigations that do not lead to a change in management. Issues with resource allocation and possible delays in surgery suggest a more targeted policy focused on those patients where a change in operative management is more likely.

0061: ASIT-PLG PATIENT SAFETY PRIZE WINNER: BLACK WEDNESDAY?

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Background: Audit is necessary to ensure assumptions about good clinical management do not lead to missed opportunities for its improvement. We audited the care of patients recovering from surgery on different days of the week. A common assumption is that weekend care is likely to be substandard: we found care on Wednesdays to present greater risks to patients. By completino of the audit cycle, we were able to identify the critical cause and so to implement changes, ensuring a measurable, cost-neutral improvement in outcome.
Methods: A comprehensive analysis interrogating results from patient questionnaires, documentation and accuracy of observations, doctor review times, critical care out-reach call and mortality data across the week.
Results: We discovered that Wednesday was the most dangerous day to be a general surgical in-patient. Further investigation suggested this was due to scheduling of the senior nurses' meeting, which left inexperienced nurses on the wards at this time. A structured handover and changes to the nursing time-table were implemented. Re-audit confirmed our hypothesis.
Conclusion: We should not presume that basic standards are best on weekdays. There is a need for structured handover meeting if patient safety is not to be compromised in shift-based patterns of work.

0107: ARE SURGICAL READMISSIONS PREVENTABLE?

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Introduction: Readmission to hospital within 30 days of discharge may impact on a patient's wellbeing, and increase the burden of resources, time, and cost. In order to preventing readmissions it is worthwhile investigating exactly why patients are readmitted and whether this is preventable.
Methods: We examined the records of surgical patients at a single NHS Trust who were readmitted to hospital within 30 days of their initial admission between April–July 2012. Reasons for admission and readmission were recorded. Patients were excluded if their readmission was for an unrelated pathology to initial presentation.
Results: There were 179 documented readmissions, with a mean age of 48. 57.5% were for the same pathology as initial presentation. Readmission was more likely if initial presentation was as an emergency ($p<0.001$). The causes for readmission were: inadequate symptomatic relief (37.5%); post-operative complications (21.9%); inadequate follow-up plan (12.5%); awaiting elective procedure (12.5%); inadequate initial procedure (10.4%); missed diagnosis (4.2%); and side effects of medicine (1%).
Conclusion: Most surgical readmissions within 30 days were preventable with no added resource requirements or cost. We recommend an emphasis amongst doctors on adequate initial treatment, symptomatic relief on discharge, and a comprehensive follow up plan, especially following emergency admission.

0109: CARBON DIOXIDE ABSORPTION DURING LAPAROSCOPIC INGUINAL HERNIA REPAIR: TEP VERSUS TAPP

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Introduction: The two most commonly used laparoscopic approaches for inguinal hernia repair are totally-extraperitoneal (TEP) and trans-abdominal pre-peritoneal (TAPP) repairs. During TEP, carbon dioxide is insufflated in the preperitoneal plane and, during TAPP repairs, into the intra-peritoneal cavity. The aim of this study was to demonstrate which laparoscopic approach is associated with a greater level of carbon dioxide absorption.
Methods: A retrospective case note analysis was performed for consecutive adult patients (ASA 1-2) undergoing laparoscopic repair of an inguinal hernia at a single centre over an 18 month period between January 2010 and July 2011. End-tidal carbon dioxide values were recorded directly from anaesthetic charts.
Results: Although TAPP procedures (n=23) were significantly longer operations than TEP Nn=24), (94.5 minutes vs. 41.0 minutes, $p<0.001$), the maximum end-tidal CO2 was found to be higher in the TEP group although this was not statistically significant (TAPP 5.1 versus TEP 5.4, $p=0.208$).
Conclusion: This study did not demonstrate any difference in carbon dioxide absorption between the TEP and TAPP approaches for laparoscopic inguinal hernia repair. Whilst the TEP plane may be susceptible to greater CO2 absorption, the overall effect may be negated by it being the shorter of the two procedures.

0115: CONSENT-RELATED LITIGATION CLAIMS IN GENERAL SURGERY: A RETROSPECTIVE ANALYSIS OF 16-YEARS OF NHS LITIGATION AUTHORITY MALPRACTICE CASES

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Aims: This study investigates malpractice claims regarding consent in General Surgery (GS) and establishes which procedures present the greatest consent-related risks to surgeons and patients.
Methods: Data regarding was obtained from the NHSLA relating to all consent-related malpractice claims in general surgery from 1995-2011 and corresponding national annual operative statistics from the Health Episode Statistics (HES) database.
Results: NHSLA supplied anonymous data of 223 claims for analysis with 63.2% classified successful. The highest annual damages occurred in 2001/02 with a steady decrease since. Colorectal surgery had the most claims, with a 74% success rate and average total costs of £109,803 per claim. Bowel damage was the injury with highest average damages per claim at £224,783. Colonic resection was the riskiest procedure with average damages per claim of £150,401. Fatality and nerve damage were the injuries with the highest proportion of successful claims (71.4%). Consent-related litigation cost the NHS £10,680,151 during this period.
Conclusions: Consent-related claims should be avoidable with education and training. There is greater tolerance from patients having emergency surgery compared to minor elective procedures. “Failure to warn” was the primary complaint in 86.1% of claims suggesting clinicians must improve their discussion with patients surrounding the risks of surgery.

0123: DAY CASE LAPAROSCOPIC CHOLECYSTECTOMY: A DGH EXPERIENCE, CAN A NATIONAL AVERAGE TARGET BE ACHIEVED?

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Aim: To evaluate our current practice of Cholecystectomy in terms of number of Day Case Cholecystectomies (DCLC) and re-admissions as compared to National Average, to improve the outcome.
Methods: A retrospective audit from 01/09/2010 to 31/08/2011. All patients who underwent cholecystectomy at DGH Macclesfield, were included in the study. Data was extracted from case notes and electronic discharge summaries, entered to a Performa and was analysed using Microsoft Excel. No exclusion criteria.
Results: Out of 194, 90.7% were operated laparoscopically, 36% as day case, 43% as 23 hour stay (total 79%)and 21% as inpatient. Average length of stay for all laparoscopic cholecystectomies was 1.21 days. Number of DCLCs varied from 14% to 55% among surgical teams. 10.3% of patients readmitted to the hospital within 29 days of index surgery with intra-abdominal collection, wound infection, pancreatitis and cholangitis in descending order.

Conclusion: The high performing team (in number) had highest number of DCLCs (55%). Our readmission rates were comparable to the National Average. National Average targets for DCLC can be achieved at relatively smaller organizations like DG Hospitals provided that Cholecystectomy is considered as a Day Case procedure by default and clear criteria for patient selection are established and implemented.

0134: A SURGICAL CLERKING PROFORMA: IMPACT ON QUALITY AND COMPLETENESS OF DOCUMENTATION FOR SURGICAL ADMISSIONS

Jasmine Ehsanullah Umar, N. Ahmad, Justin Healy, Naim Kadoglou. *Department of Surgery, Ealing Hospital, London, UK.*

Aims: Accurate and complete documentation on admission to hospital is vital for communicating acute clinical information and is essential medico-legally. Structured documentation has been shown to improve doctor performance and patient outcomes. We aimed to design a surgical clerking form and evaluate its impact on documentation during this critical period.

Methods: We designed and implemented a proforma for acute surgical admissions in a busy District General Hospital. Documentation was assessed based on 33 criteria from the Royal College of Surgeons guidelines 16 days before and after proforma introduction. Fisher's exact test was applied.

Results: 72 notes were assessed before and 96 after proforma introduction. Proforma uptake was 73%, leading to improved documentation of 28 criteria, 17 being statistically significant. These included past surgical history ($p<0.001$), medication history ($p=0.032$), blood pressure ($p=0.004$) and communication with the patient ($p=0.022$). 20 healthcare professionals were surveyed, with 89% preferring the proforma to freehand notes and 94% considering it valuable during post-take ward rounds.

Conclusion: Our clerking proforma lead to significant improvement in the quality of admissions documentation in our unit, and importantly was also preferred by the surgical team. This simple intervention could be replicated to improve the admissions process within other surgical units.

0192: AN AUDIT INVESTIGATING COGNITIVE ASSESSMENT OF EMERGENCY GENERAL SURGICAL ADMISSIONS IN ELDERLY PATIENTS IN SHEFFIELD, UK

Charlotte Dodd. *Sheffield Teaching Hospitals, Sheffield, UK.*

Aim: The NCEPOD published "An Age Old Problem" in 2010, raising concerns about surgical care of elderly patients. Cognitive dysfunction is associated with poorer surgical outcomes and the report recommends that hospitals should address the need for baseline mental capacity assessments for all elderly patients pre-operatively, to inform patient care and allow appropriate decision-making.

Methods: A preliminary audit reviewed thirty-six case notes of patients aged above 70 years admitted as emergencies to general surgery. Compliance of assessing cognitive function using a confusion assessment tool was 5.6% (2/36 admissions) with a target of 100%. Interventions initiated alongside the introduction of a Commissioning for Quality and Innovation (C-QUIN) approved cognitive screening tool, included enhanced education of staff by presentations, correspondence to all surgical admissions staff and erection of posters in surgical admission areas. This reiterated the NCEPOD report, preliminary results and standards expected.

Results: The re-audit reviewing forty-four case-notes after intervention, showed compliance had improved to 43.2% (19/44).

Conclusions: Some surgical departments are poor at assessing baseline cognitive function of elderly patients on acute admission. With relatively simple interventions, this care can be improved. Doctors should be aware of the importance of index assessment on admission in informing surgical decision-making.

0205: A DEDICATED PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) LINE SERVICE: 2 YEAR REVIEW

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Aim: Review the outcomes of a dedicated PICC service.

Method: Retrospective review of a prospectively maintained database. Catheter related blood stream infection (CRBSI) was defined as positive paired qualitative blood cultures from a peripheral vein and PICC.

Results: Between January 2010 and January 2012, 225 patients (115 male, 110 female) had 294 single lumen lines inserted. Median age was 69 years old (range 22-98). 43 had ≥ 1 sited and of these, 19 had synchronous lines. Indications for insertion: reliable peripheral access (149, 51%), parenteral nutrition (PN) (145, 49%) of which, fifty (34%) were for type II intestinal failure (i.e. $\geq$28 days). 283 (96.3%) were placed under ultrasound guidance. Total line days was 8063 (median 16 days, range 0-368). Complications: phlebitis (4, 1.4% or 0.5/1000 catheter days) and occlusion (16, 5.4% or 2.0/1000 catheter days). Line associated infection was suspected clinically in 14 patients (4.8% or 1.7/1000 catheter days), however only one had confirmed CRBSI (0.3% or 0.1/1000 catheter days).

Conclusion: Current published CRBSI are 2.1-2.2/1000 catheter days. With a dedicated team, CRBSIs are kept to a bare minimum. Furthermore, synchronous lines can be successfully used which includes use in the management of complex patients with type II intestinal failure.

0244: DO CLERKING PROFORMA'S IMPROVE MEDICAL RECORD KEEPING ON A SURGICAL ADMISSIONS UNIT: A RE-AUDIT FOLLOWING TRIAL

Scott Castell, Harriet Percival, Neeta Lakhani. *University Hospitals of Leicester, Leicester, Leicestershire, UK.*

An audit was carried out to determine if record keeping on an acute surgical admissions unit, could be improved with the use of a proforma. Key points that were missing on the admission clerking were identified and a clerking proforma was produced and trialled over the course of 2 weeks. This proforma contained 37 criteria deemed essential for admission clerking.

This study compared the number of criteria fulfilled before the use of the proforma and the number of criteria fulfilled after. The aim was to determine if the proforma improved the clerking data.

20 sets of notes were obtained from the trial period, 16 contained the clerking proforma.

The 37 essential criteria were compared and the results showed that each of the areas of identified weakness from the initial audit were significantly improved. Results showed a 70% to 100% completion in two criteria, from 35% to 100% in one criteria, and 40% to 100% and 50% to 100% in two other criteria.

In the identified areas of weakness the use of a clerking proforma showed a significant benefit over not using a proforma.

Overall 50% of the criteria showed a higher rate of completion after the use of the proforma.

0264: THE HEADACHE BEHIND HEAD INJURY MANAGEMENT

Mark Jones, Victoria Banwell, Fergal Monsell, Steve Mitchell. *University Hospitals Bristol, Bristol, UK.*

Aim: National Institute for Health and Clinical Excellence (NICE) 2007 guidance on the management of patients with a head injury sets out a 'gold standard' of care.

We aimed to assess current management of patients admitted under the care of an orthopaedic consultant with a head injury against NICE guidelines.

Method: Retrospective analysis of case notes was performed on all orthopaedic admissions with a head injury over a three month period.

Results: Twenty-six patients were admitted (mean age 45.5, range 18-88) with a median length of stay of two days (range 1-105). Compliance with triage guidelines in A&E was 46%, 50% and 0% for patients with a GCS of 15, 9-14 and <8 respectively. CT was performed appropriately in all cases; 32% were reported within an hour from request. All abnormal results were discussed with a neurosurgeon. No patient was admitted under the care of an appropriate consultant. 23% of neurological observations were performed correctly.

Conclusion: Poor compliance to NICE guidelines was illustrated, especially related to the admitting team. Given the result of this audit, change needs to be implemented in our institution so that potentially high risk patients are treated to the high standards as set out by NICE.

0266: ACTIVITY ANALYSIS OF SENTINEL NODE BIOPSY FOR CUTANEOUS MELANOMA IN ADULTS IN A DISTRICT GENERAL HOSPITAL

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