

Paper Session 1a: Surgery/Management

1a1 Ambulatory emergency care in general surgery: a scoping review

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Abstract

Introduction: Ambulatory emergency care (AEC) can include diagnosis, treatment and follow-up delivered outside standard inpatient admission. It has become well-established in medicine within the UK but not yet within surgery. The aim of this review is to map the available evidence for the use of AEC in general surgery and describe what outcomes have been used to assess methods of delivering this care.

Methods: A systematic search of Pubmed and CINAHL databases was conducted using terms including “ambulatory surgery” and “abdominal emergency”. All studies published in the English language describing a method of AEC (including ambulatory assessment and day case emergency surgery) were included.

Results: Of 620 records identified, 34 studies were eligible for inclusion into the review. These comprised 3 review articles and 31 studies describing original research. A range of methods of AEC were found including ambulatory assessment and day case emergency surgery (mainly appendicectomy) which could be delivered within existing inpatient areas or dedicated day case units with definitions used including <12hr stay, no overnight stay and <24hr stay. Clinical outcome measures commonly used include length of stay, success of ambulatory care and morbidity. There were little qualitative or economic outcome data available.

Conclusions: Research in this area is still aiming to establish feasibility. Only a small number of studies have used measures other than basic clinical outcomes. There is a need for further studies to elucidate the benefits from AEC and the best way to implement or expand these services.

1a2 Improvement of the delivery of day case breast surgery- a closed loop audit

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Abstract

Introduction: Breast cancer surgery is increasingly undertaken as day case procedure. The British Association of Day Surgery recommends that 95% of Wide Local Excisions(WLE) and 50% of mastectomies are performed as zero-night-stay cases. Many hospitals struggle to achieve the Gold Standard. This audit aimed to assess our unit's performance before and after the introduction of improved education.

Methods: Retrospective data for 982 patients undergoing breast surgery over a 3-year period before, and 128 patients over 3 months after the introduction of internal education, was captured. The Education Programme targeted medical staff, nursing staff and most importantly patients. We organised meeting-discussions, designed patient information leaflets with safety-netting and drain management advice; contact details for the breast team. GraphPad-v7.04 was used for data analysis.

Results: Between March 2014 and April 2017, the identified zero-night-stay rates for WLE and Mastectomies were 67% and 9%, respectively. Following the implementation of internal education our unit's performance has significantly improved. We have achieved same-day-discharge rates of 88%(51/58)($p < 0.05$) for WLE, and 19%(4/21)($p = 0.06$) for Mastectomy, between April and June 2018. There was no increase in re-admissions/complication rates. The improvement resulted in larger profit for the Trust equivalent to £40, 000 per year. We now compare favourably to other trusts being in the top25% of hospitals in the country, but not yet achieved top5% status.

Conclusions: The introduction of improved education has led to improved utilisation of day case breast surgery at our Centre, with maintained high levels of patient satisfaction.

1a3 Audiovisual technology to improve informed consent for laparoscopic cholecystectomy

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Abstract

Introduction: Despite laparoscopic cholecystectomy being a major operative procedure to remove the gallbladder, the general impression is that it is a common procedure with early recovery. We all know complications, though not common, can be quite severe like bile duct injury. Improving the understanding of the anatomy and the risks should help in reducing the 'on the day' anxiety of consenting. We aim to provide all common procedures with comprehensive audiovisual advice in clinic .

Methods: We audited the individual perceptions of the standard consenting in clinic and on the day of the procedure. This included paper consent and then literature for reading at home. We asked them if they wanted audiovisual information to help with understanding the anatomy and the risks. We got excellent feedback from 50 patients. A video was made with the help of a film company (funded by the author).

General advice was received by showing all doctors in our audit meeting . We closed the loop of our audit by using the video in our clinics to consent people. A consent form was signed and literature was provided to take home.

Results: Excellent feedback from patients was received. Very good understanding of the risks was obvious by the questionnaires signed by the individuals.

Conclusion: Consenting can be improved by using audiovisual aids. This can be uplodaed on to a website for perusal at home as well.

1a4 A Cost-effective and Safe Way to Alleviate the Soaring Medical Demands in China: A Case Study

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Abstract

The objective of this case study is to analyze the leading success, existing barriers and future planning of day surgery, which also can prove it is a cost-effective and safe way to alleviate soaring medical demands in China. Firstly, this case briefly introduces current healthcare status and medical problems in China, then lies on the case study hospital, West China Hospital, Sichuan University. We found that the success of West China Hospital on day surgery is the lack of payment obstacles and winning highly patient acceptance, utilize different processes to manage. Especially under the background of promoting day surgery by the government which makes it take great leap forward. As one of the earliest central health organizations that started day surgery service in mainland China, West China Hospital, Sichuan University has conducted approximate 140 thousands day surgery cases in the past decade, the case number keep increasing each year, but, the patient satisfaction rate remains a high level, no day surgery or anesthesia related death and severe complication. This is also message for the world that is in southwest China, Chengdu, there are a bunch of young enthusiasts and health professionals who are trying to devote their careers to promote day surgery which could provide high quality and cost-effective medical care for patients.

1a5 Improving quality of operation notes in day case surgery

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Abstract

AIM: Good operation notes are a key component of “Good Surgical Practice” where specificity can help future treating clinicians and in medico-legal cases. This audit aimed to improve the quality of operation notes in an urban acute hospital against standards set by the Royal College of Surgeons (RCS).

METHOD: Retrospective review of 20 case notes in a day case procedure unit dealing with local anaesthetic excisions, primarily of the head and neck. Change of practice was achieved by dissemination of preliminary audit results, introduction of a checklist at the point of operation note completion and simplification of the operation note proforma itself. The audit was repeated following intervention.

RESULTS: Recording of procedure time rose from 0% to 100%, logging of operative findings and operative diagnosis improved from 80% to 100% and a detailed note on postoperative instructions arose from 60% to 75%.

CONCLUSION: Proforma redesign along with necessary education and efficient recording prompts lead to improvement over time in operation notes, in accordance with best practice. Simplification of historically cluttered forms led to a good response from clinicians.

1a6

Factors Contributing to Readmission After Elective Day-Case Surgery in a dedicated Day Surgery Unit

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Abstract

Introduction: Readmission following elective day-case surgery remains an ongoing issue in the NHS. The aim of this study is to determine what factors are associated with an increased likelihood of readmission following elective day-case surgery

Methods: All patients undergoing elective day-case surgery under General Anaesthetic across all surgical specialties at our institution over a 2-year period were included in this study. Data on gender, age, ASA grade, smoking status and BMI were analysed.

Results: A total of 4,254 patients with the relevant data were identified, of whom 37% (n=1,589) were Male. The vast majority of patients (68.9%, n= 2,930/5,254) had a BMI over 25. Nearly a third (32.3%, n= 1,375) were classified as obese with a BMI over 30. The overall readmission rate was 8.9% (n=379). There was a significant difference between smokers and non-smokers in terms of readmission rates (Smokers: 9.4%, Non-Smokers: 7.0%, p=0.022) as well as increasing age (>75 years: 13.0%, 15-25 years old: 6.0%, p<0.001). ASA was also associated with a higher readmission rate (ASA 1: 7.0%, ASA>1: 10.1%, p<0.001) however obesity was not (BMI >30: 9.7%, BMI 20-25: 7.9%, p=0.231). There was also no difference in readmission rates based on gender (Male: 9.8% vs Female: 8.4%, p=0.109).

Conclusions: Increasing age, ASA grade and current smoking are factors associated with a higher readmission rate, obesity itself however is not. Concerns over obese patients undergoing day-case surgery appear to be unjustified as they did not experience a higher rate of admission than the non-obese population.

Paper Session 1b: Anaesthetics

1b1 Re-audit of local fasting policy “Sip until we send”

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Abstract

Introduction: Following previous audit showing prolonged fasting times for fluids and a patient satisfaction survey revealing thirst as the most complained about symptom post surgery we introduced “sip until we send” in January 2018. Patients are allowed to drink water freely on the ward pre-operatively until they leave to come to theatre. This re-audit was to assess the impact of the new policy.

Method: Prospective audit of elective surgery patients over 2 weeks. Audit forms comprised tick box for ward staff to describe the volume of water consumed and further questionnaire to be completed in the anaesthetic room.

Results: 138 forms completed. Mean fasting time for fluid (excluding water as part of “sip until we send”) was 6 hours 22 minutes. However, 89% had been drinking water on the ward, with an average consumption of just over 1 cup of water. 51% of patients reported no thirst at the time of induction. Of those who did report thirst, 76% had consumed less than 1 cup of water.

Conclusions: Since the introduction of “sip until we send” we have had no incident forms completed related to aspiration. This re-audit shows that the majority of patients are taking water on the ward and that this has contributed to reduction in complaints of thirst. The use of the word “sip” may have caused some confusion as to the volume of water which patients are allowed, and further education is planned.

1b2 Influence of catastrophism on the quality of recovery after orthopedic and gynecologic one day surgery

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Abstract

Introduction: The assessment of postoperative recovery should consider pain, nausea, vomiting but also quality of recovery (QoR). The Pain Catastrophizing scale (PCS) is an efficient tool to predict postoperative pain. Our aim was to determine the influence of catastrophism and its three subscores (rumination, helplessness and amplification) on QoR after orthopedic and gynecologic one day surgery.

Methods: Adults programmed for orthopedic and gynecologic one day surgery were prospectively recruited during five months. The PCS was completed during the preoperative anesthesia consultation. Patients were asked to complete the Quality of Recovery-9 questionnaire on postoperative day (POD) 1, 3 and 7 and about the intensity of pain, nausea and vomiting during that period.

Results: The median (IQR) PCS, rumination, magnification and helplessness scores were respectively 25 (0-46), 8 (0-16), 6 (0-11), 10 (0-24). PCS and its subscores did not influence postoperative pain, nausea and vomiting. For the gynecologic population, on POD 1 and 3, patients with high rumination score (≥ 8) had a poorer QoR-9 score than patients with low rumination (< 8), $p=0,02$, and on POD 7, the 3 subscores of the PCS influenced the QoR significantly.

Conclusion: For the gynecologic population, the QoR was influenced by the rumination subscore on POD 1 and on POD 3 and by the three subscores on POD 7. The PCS and its three subscores did not influence QoR in the orthopedic population. 61,9 % of those patients had locoregional anesthesia.

1b3 The highs and lows of day case surgery

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Abstract

Introduction: Diabetic patients attending hospital for elective day case surgery can have difficulties with fasting and altered medication regimes leading to hypo/hyper glycaemia. As a result it was found that patients were having procedures cancelled on the day due to staff in a district general hospital day case unit struggling with knowing how to manage patients' blood sugars prior and post procedure.

Methods: Meetings with staff working in the day case unit and the endocrinology team were held to see what issues were being faced and how these could be best addressed.

Using the Association of Anaesthetists guidelines, the local hospital guidelines and recommendations from National Confidential Enquiry into Patient Outcome and Death a tool was created that would gather the information and provide support for managing these patients safely.

Results: A new document, to be incorporated into the hospital surgical day case pathway, that helps to manage diabetic patients had been implemented. The document gathers information regarding last meal, blood sugar monitoring whilst in hospital and provides a step-by-step flow chart to support nursing staff in what to do should they encounter a patient who is hyper/hypo glycaemic prior or post procedure.

Conclusion: This simple document provides all medical staff with a simple flow chart allowing them to safely manage a diabetic patient with abnormal sugars whilst collating all blood sugar recordings so trends can be monitored and acted upon. This along with a teaching program for staff aims to help reduce the number of cancelled procedures.

1b4 Post-operative Day Surgery Carers' Service Evaluation

Aaqid Akram, Simon Hennigan, Kim Russon

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Abstract

Introduction: The Association of Anaesthetists (AAGBI) recommend that “Following most procedures under general anaesthesia, a responsible adult provide support for the first 24 hours” (1). The aim of this service evaluation was to ascertain how long carers were present post-operatively, explore if patients felt this was enough time and identify any procedures where patients felt that a carer for 24 hours may be unnecessary.

Method: All adult patients attending the Rotherham NHS Foundation Trust (RFT) Day Surgery Unit, during November/December 2018, were invited to participate. A telephone questionnaire on a standardised data collection sheet was conducted 2 to 28 days post-procedure.

Results: 99 patients provided responses with 100% confirming overnight carer presence. 73 patients had a carer present for 48 hours or less. No procedures were identified with universally low requirements for post-operative care. Some patients felt they needed better access to post-operative healthcare for pain relief or longer carer support. Patients with non-relative carers felt they had less carer support than desired.

Conclusions: RFT patients were conforming to AAGBI recommendations regarding minimum duration of carer presence. Patients undergoing Laparoscopic cholecystectomy & shoulder arthroscopy reported the longest times to regaining independence.

RFT patient information leaflets require revision to enable realistic expectations of the duration of carer presence.

Further data collection on targeted procedures is needed to assess if less than 24 hours carer support is feasible.

Reference

1. AAGBI & BADS. Day case and short stay surgery: 2. *Anaesthesia*. 2011 May;66(5):417-34.

1b5 Marginal Adjustments for Maximal Gains in Vascular Day Case Anaesthesia

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Abstract

Background: Arterio-venous fistula (AVF) formation is a common surgical procedure, which is associated with low rates of post-operative complications and is performed as a day case (DC) procedure in many institutions. We identified that patients undergoing AVF surgery were frequently admitted to hospital the night before surgery and being kept as in-patients post-operatively.

Methods: We performed retrospective analysis of the AVF formation procedures performed at our centre over a 2 year period, with data collected for 12 months either side of a change in our practice. We made changes to the management of AVF patients, aiming to reduce in-patient length of stay (LOS) and increase the number of day case procedures. Changes implemented included the introduction of a regional anaesthesia service for the list, altering the method of listing patients for surgery, streamlining the discharge process with checklists, introducing patient information leaflets and education of the multi-disciplinary team.

Results: Records of 183 patients were examined in total; 74 before change of practice and 109 afterwards. We demonstrated a reduction in patients' mean LOS from 3.95 days to 1.54 days. DC rate improved from 14% to 43%. Patients discharged within 24 hours of surgery increased from 62% to 84%.

Conclusion: Reduction in LOS and increasing DC rates has many potential benefits including reduced strain on hospital beds (and less procedure cancellation), cost reduction by reducing bed days, improved patient satisfaction, reduced risk of nosocomial infection, better throughput of patients, reduced anaesthetic time/overall theatre time and reduced waiting times for surgery.

1b6 Plastic recycling and beyond

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Abstract

Objective: In one of our audit meetings it was brought to light that:

- A large amount of plastic waste was being produced by our day surgery unit.
- Hand scrub bottles in theatre had a high residual scrub volume.
- Large amount of Balanced Salt Solution (BSS), containing a very minute quantity of adrenaline, had to be disposed as pharmaceutical waste because of added adrenaline.

Method: We ran three parallel projects at our unit.

- We identified the waste that should and shouldn't go into each bin and educated the staff via posters, corridor conversations and staff news.
- Hand scrub bottles were fitted with new pumps so that we could use all the liquid and then recycle the empty bottles.
- We contacted our local water authority and got approval to dispose of the BSS with adrenaline through our sluice.

Results:

- We have substantially reduced the amount of plastic waste entering our general and medical waste streams.
- Fitting new hand pumps resulted in a saving of £1600pa.
- Eye theatre pharmaceutical waste bins now no longer reach capacity or weight limit. 25 litre bins now take in excess of three months to fill as opposed to 2-3 weeks before we started our project.

Conclusion: We could implement this project successfully as we educated and engaged the staff right from the start. We have managed to streamline our waste so that significant amount of it can be recycled. Lots of new ideas are pouring in and we continue to introduce these in our daily practice.

Paper Session 2a: Surgery/Management

2a1 Retrospective Audit Examining On-The-Day Theatre Cancellations

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Abstract

INTRODUCTION: The aim of this audit is to evaluate on-the-day (OTD) theatre cancellations at Milton Keynes University Hospital (MKUH) and to identify the reasons behind these cancellations.

METHOD: All elective patients undergoing surgery in the General, Colorectal and Breast specialties over a 6-month period were included. 195 patients were identified. The reasons behind these cancellations were then ascertained using the electronic patient record system. Cancellations were defined as either avoidable: insufficient time, medication issues, not fasted; or unavoidable: bed availability, did not attend (DNA), unwell, surgical cancellation, self-cancellation.

RESULTS: 40% of cancellations were OTD cancellations (78/195). Of these, 89.7% (70/78) were considered to be unavoidable: the most common reasons being bed availability (27/70) and DNAs (14/70). 10.3% (8/78) of OTD cancellations were deemed to be avoidable.

CONCLUSION: OTD theatre cancellations account for significant financial burden across healthcare systems worldwide. Their unpredictable nature exacerbates wasted time of theatre staff and resources. The implementation of measures to reduce OTD cancellations, especially avoidable ones, would lead to increased efficiency and cost-effectiveness. Certain unavoidable OTD cancellations, such as bed availability and DNAs, are also areas worth targeting.

2a2 Reasons for same-day cancellation in a dedicated Day Surgery Hospital: A two year prospective study

Alan Askari, Nuha Ahmed, Ratna Makker, Amjid Riaz

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Abstract

Introduction: Thousands of elective day-case procedures are cancelled in the NHS annually on the day of surgery resulting in significant financial and strategic loss. The aim of this study is to determine the rate of cancellations and identify contributing factors in order to minimise these rates.

Methods: Hospital data was collated on patients undergoing elective-day case surgery across all surgical specialties at our institution over a 2-year period from 1/9/2015 to 31/08/2017. Reasons for cancellation were categorised as due to patient factors, hospital, administration/organisational factors. The data was collected prospectively.

Results: A total 1,692 cases were cancelled on the day of surgery (8%). The majority were Orthopaedic (32.1%, n=543/1,692), Ophthalmology (26.4%, n=446/1,692) and General Surgery cases (14.9%, n=252/1,692). The median number of cancellations were 75 per month. Cancellations were lower in the summer months of July and August (112 and 134 respectively, P=0.03). The majority of patients were cancelled due to patient reasons (65.2%, n= 1,104/1,692); either patient did not attend/ changed their mind on day, acute infection/poor diabetic control, blood pressure control (26.3%, n=445/1,692). Approximately 34.8% (n=588/1,692) were cancelled due to hospital/administrative factors such as non-functioning equipment, lack of bed/staff and medical issues which were previously known about and should have been resolved at pre-assessment.

Conclusions: Approximately a third of cancellations of elective day-case procedure on the day of planned surgery are due to hospital factors, which are avoidable. Better communication between pre-operative assessment clinics, patients and theatre staff, is vital in reducing this.

2a3

Service evaluation of parent bleep for children having day surgery at Rotherham Foundation Trust Hospital

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Abstract

Introduction: The purpose of this evaluation was to obtain feedback from parents using this service. The accompanying parent is given the bleep upon leaving their anaesthetised child. Recovery staff bleep it when their child can return to the ward. Bleeps were initially introduced to day surgery theatres to improve efficiency of recovery and improve patient, parent and staff experiences. Having the bleep means: Parents don't need to remain on the ward awaiting a call from theatres, Recovery staff do not have to wait for the ward to answer the telephone, Ward staff had fewer phone calls and don't have to find parents when their child is ready.

Methods: Parents given a theatre bleep were given a questionnaire to be returned on discharge.

Results: The bleeps were used 201 times 1/11/18-28/2/19 for the following theatres: Emergency(23%); Trauma/Orthopaedics(25%), Maxillo-facial/ENT(23%), Day surgery(21%), other(8%).

26% of questionnaires were returned. 100% parents reported they felt that they could have left the ward if they had wanted to whilst their child was in theatre (57% did leave the ward). All parents reported feeling reassured that they could be contacted using the bleep (91% very reassured). 91% of parents felt the time they waited outside theatre after the bleep had sounded was reasonable; 9% thought it was too long. 98% of parents reported that the instructions given with the bleep were easily understandable.

Conclusions: This evaluation shows good use of the bleeps with positive experience reported by parents.

2a4

Unplanned admissions following day case laparoscopic cholecystectomy

Kelly-Anne Ide, David Bunting, David Sanders

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Abstract

Introduction: Day case laparoscopic cholecystectomy accounts for a significant proportion of the general surgical workload. It was noted that an unexpectedly large number of patients were being admitted following cholecystectomy in North Devon District Hospital so an audit was conducted to discover the reasons for the unplanned admissions and to identify any preventable factors. The British Association of Day Surgery and Royal College of Anaesthetists suggest a target rate of 2% for unexpected overnight stays after laparoscopic cholecystectomy.

Methods: A data collection tool was designed and placed in the Day Surgery Unit. Any unplanned admission following laparoscopic cholecystectomy and the reason for admission was recorded. from 01/02/2018 to 31/10/2018.

Results: 180 day case laparoscopic cholecystectomies were performed, with 26 (14.4%) unplanned admissions. 24 (92.3%) of these were acute cholecystectomies. Reasons for admission were:

- Co-morbidities – 1 (3.8%)
- Pain – 3 (11.5%)
- Active infection found intra-operatively – 3 (11.5%)
- Converted to open procedure – 5 (19.2%)
- Complexity of surgery – 6 (23.1%)
- Drain in situ – 8 (30.8%)

Conclusions: On review of the reasons for admission the majority of cases were deemed clinically appropriate and non-preventable. Post-operative pain and co-morbidities were identified as potentially preventable reasons for admission. These factors were responsible for unplanned admissions in 4 (2.2%) of the 180 cholecystectomies performed which is in line with current targets. It is, however, acknowledged that we perform a large number of acute cholecystectomies and as such a higher admission rate may be expected.

2a5

Day Case Laparoscopic Cholecystectomy in East Africa

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Abstract

Introduction: Northumbria Healthcare has fostered a 20 year relationship with Kilimanjaro Christian Medical Centre (KCMC) in Tanzania allowing KCMC to provide expert laparoscopic surgery since 2005. In 2017, a day case laparoscopic cholecystectomy (LC) service for KCMC patients was established. The aim of this research is to evaluate the service and investigate the barriers to its implementation.

Methods: Firstly, all patients who underwent LC's in KCMC since 2017 were identified. The demographics, day case rate, complications and conversions to open were recorded. The second part involved a patient telephone questionnaire to gain insight into patient perspective of day case service. Finally, KCMC staff interviews were conducted to determine their opinions on barriers to providing a day case service at KCMC.

Results: Of the notes analysed thus far, 82 patients were planned for day case and 55 (67%) were discharged as day case. For 16 (59%), no reason was identified for cancellation of planned day case, 6 (22%) were due to intra-operative complications or conversions and 5 (19%) were due to post-operative symptoms. Of the successful day cases, 3(5%) developed complications with one readmission. Of the 26 patients interviewed so far, 24 (92%) were 'Extremely Satisfied' with the service and 26 (100%) would recommend it to their relatives. All data collection will be complete by 28th May.

Conclusions: Day surgery is safe, achievable and beneficial in low resource hospitals such as KCMC. Working with developing countries to understand the barriers preventing day surgery is key in overcoming such obstacles.

2a6 Management of postoperative urinary retention in day surgery utilising the international prostate scoring system

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Abstract

Introduction: We initiated a quality improvement project where we improved upon our existing bladder management pathway with the addition of the International Prostate Symptom Score (IPSS) for selected male high-risk patients, a novel approach that has not been done before.

Methods: Plan: In 2013 we identified our existing bladder management pathway left a group of high-risk patients in need of either a prolonged stay until discharge and/or 48 hour catheterisation.

Do: In 2014 we implemented the IPSS bladder pathway and conducted an IPSS on high-risk patients who had a residual bladder volume of <400ml. An IPSS >17 led to 48 hours catheterisation. IPSS less than <17 led to discharge without catheterisation.

Study: We prospectively collected data on all patients who were managed using this system.

Act: We found that the service improvement was a positive success and have continued with the service, continually adding and improving upon it.

Results: After initiation of the service in 2014 we analysed the case records of 148 male patients. We prevented 46 patients from having a 48-hour catheter and expedited the discharge of 102 patients.

Conclusions: We have presented a summary of a 5-year quality improvement project that follows a continuous Plan Do Study Act loop. This pathway is the first that we are aware of that incorporates the IPSS.

Limitations of this project include the obvious gender gap that exists and we are looking at adopting a female modification to IPSS.

Paper Session 2b: Anaesthetics

2b1

Is day case total hip replacement feasible, safe and acceptable? Experience of a pilot project.

Anne-Marie Bougeard, Michael Kent, Claire Blandford, Alexandra Alen, Mary Stocker

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Abstract

Introduction: Over 105000 elective total hip replacements (THR) were performed in England and Wales in 2018¹, a year when NHS England suspended much of non-urgent elective orthopaedic surgery due to capacity pressures². Our unit has had a day surgery pathway for unicondylar knee replacement³ since 2011, and we wished to apply the same principles of safety, feasibility and acceptability to selected THR patients.

Methods: We process mapped our inpatient pathway, including audit of ward interventions within the first 24 hours. We adapted our current anaesthesia and analgesia protocols. Inclusion criteria included: ASA 1-3, BMI <30kg/m², age <75. They were consented for and underwent a planned day case procedure. Our orthopaedic outreach team followed patients up on days 1, 2, and 7 or 10. We collected satisfaction scores and qualitative data on experience.

Results: We have performed 12 planned day case THRs, with no failed discharges, readmissions or complications. Patients were all ambulant by the early afternoon and discharged home before 1900hrs. Satisfaction scores were high and pain was mild or moderate only.

Conclusion: This pilot study shows day case THR to be a feasible, safe and effective option for selected patients. We have demonstrated high levels of patient satisfaction, 100% successful discharge rate and no readmissions or complications. We plan to use this pathway to increase our day case THR rates as well as improve our inpatient processes to benefit our patients and the organisation.

2b2 Same day discharge for “hot” laparoscopic cholecystectomies

William Hare, Theresa Hinde, Kirk Bowling, Mary Stocker

Torbay Hospital, Torquay, United Kingdom

Abstract

Introduction: Urgent laparoscopic cholecystectomies constitute a significant proportion of emergency work at our trust. Evidence in recent literature demonstrates improved patient outcomes and organisational financial benefits in operating on the initial admission. Our unit has incorporated suitable ‘hot’ cases into an existing emergency ambulatory surgery pathway.

Methods: Patients identified as surgically and socially suitable were operated on in the day surgery unit via our recently established emergency ambulatory pathway, aiming for same day discharge.

A database search, and, where necessary, a review of clinical notes of a 22 month period was performed to evaluate caseload and factors enabling successful management as a day case.

Results: We undertook 67 emergency ambulatory laparoscopic cholecystectomies over 22 months. 29 (43%) of these were successfully discharged on the same day. This generated potential cost savings of at least £23,200 in overnight admission costs (£400 per night) and £120,540 in saved emergency theatre time (£15 per minute)

Factors that impacted positively on discharge rates were origin of admission (direct to DSU from home), operation timing (morning cases) and duration of surgery.

The most common reasons for admission were surgical complication and late finish. 84% of respondents reported general feeling of ‘good’ or ‘very good’ when managed through the DSU.

Conclusions: We have demonstrated that management of emergency laparoscopic cholecystectomies via our ambulatory pathway, although challenging, is possible and can result in excellent patient experience with financial benefits to the organisation. We intend to use our experience to improve discharge rates.

2b3 'Here today, gone today' - evaluating an emergency ambulatory pathway

Ciska Uys, Hare William , Hinde Theresa , Mary Stocker

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Abstract

Introduction: Minor or intermediate surgical procedures account for a significant proportion of booked emergency cases. Implementing a novel day surgery pathway for appropriately selected cases has improved patient flow and experience, saved theatre time and decreased bed occupancy.

Methods: Vacant but staffed day surgery lists were highlighted to emergency teams in advance. At daily handovers teams identified patients fulfilling emergency ambulatory surgery criteria. Stable patients were sent home and instructed to return to the day surgery unit (DSU) for their surgery. The aim was surgery and discharge via the DSU pathway. Some patients underwent surgery in main theatres, but same day discharge via DSU.

Results: Over 22 months 442 patients (18 children, 424 adults) underwent emergency surgery via the ambulatory pathway. This freed 386 hours of emergency theatre time, saving around £347,280.

370 patients (83.7%) were successfully discharged same day. 301 patients (68.1%) avoided a pre-operative night stay. This saved 671 bed days with estimated cost of £268,400.

Next day, 90% of 257 patients (58.1%) followed up by telephone reported feeling 'good' or 'very good'.

Conclusions: Streamlining our ambulatory pathway for emergency patients has reduced cost, saved emergency theatre time and maintained patient satisfaction. The pathway's success is enjoyed by surgical, anaesthetic, theatre and recovery teams. Theatre culture has changed to expect ambulatory list availability and the pathway is used when elective list capacity allows for ad hoc emergencies. With growing confidence in the process, more complex procedures (gynaecological laparoscopies, laparoscopic appendicectomies/ 'hot' cholecystectomies) are undertaken as ambulatory cases.

2b4 Developing a teaching module for day surgery Preoperative Assessment staff

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Abstract

Introduction: BADS ratifies specifically trained preoperative (POA) staff working within daycase areas for best day surgery outcomes. New staff or those covering absence are commonplace. We postulated a specific daycase training module for these staff would retain day surgery success rates especially for complex patients.

Methods: A working party updated POA guidelines at Derby. Guidelines specific to day surgery were identified and linked to the aims set for daycase POA. All POA nurses listed topics they wanted addressing. Dedicated teaching time was identified for maximum attendance with end of course feedback.

All POA staff had access to the course.

Results: Topics identified were ; complex patients and daycase suitability (using anaesthetic led clinics). obstructive sleep apnoea, high body mass index, difficult airways, diabetes, cardiac failure management, chronic obstructive pulmonary disease. ischaemic heart disease, pacemakers, paraumbilical hernias, renal access, urology patients, chronic pain, cirrhosis, antihypertensives and anticoagulants, neuromuscular/multisystem disorders

30 minute interactive teaching sessions from a consultant anaesthetist were developed and implemented

Conclusion: Topics were devised by POA nurses to cover areas of need. Input from experienced day surgery POA staff delineated differences between day surgery and inpatient POA with emphasis on sending patients home safely post operatively

Teaching was implemented by a consultant anaesthetist interested in day surgery POA.

Teaching is currently ongoing and review of the process should allow revision and improvement to maintain expertise in day surgery POA.

2b5 A comparison of day case pathways demonstrates the benefits of a dedicated day surgery unit

Alexandra Humphreys, Gregory Warren, Jonathan Carter, Mary Stocker

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Abstract

Introduction: Patients undergoing day case operations in our trust are managed via one of two pathways:

- Admission, surgical procedure, recovery and discharge all in dedicated Day Surgery Unit (DSU)
- Admission, surgical procedure and first stage recovery via main inpatient theatres (IT), then transfer to DSU for second stage recovery and discharge.

We aimed to establish the difference in time taken for patients to undergo the same operation via each of the two pathways.

Methods: Three routine elective operations were monitored: laparoscopic cholecystectomy (LC), laparoscopic hysterectomy (LH), and open repair of inguinal hernia (IH).

The entire patient journey was observed. The time that each patient spent at each stage, and any delaying factors, were noted. Surgical procedural time was excluded. 18 patient journeys were monitored.

Results: The mean time taken for every step of the pathway was shorter in the patients on the DSU pathway.

From sending to arrival in second stage recovery, the mean duration for patients on the DSU pathway was less by:

- LC – 50 minutes
- LH – 32 minutes
- IH – 24 minutes

Combined, 9 patients undergoing their procedure via DSU saved a total of 5 hours and 19 minutes of direct clinical care.

Conclusions: Managing patients in a dedicated DSU results in less time taken for direct clinical care, which has associated financial savings for the trust. The increased turnover should enable more patients to be managed on an individual list.

2b6 Chest Wall Blocks - Still a Luxury in Day-Case Breast Surgery?

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Abstract

Introduction: The benefit of regional anaesthesia in day case and breast surgery is well documented. For mastectomies, current recommendation from The British Association of Day Surgery (BADs) Directory of Procedures sets a standard of 15% day-case rate and 70% single-night stay. The audit aim was to identify the proportion of patients receiving regional anaesthesia for mastectomy at our institute and establish whether this had an impact on perioperative opioid requirements and total length of hospital stay.

Methods: Retrospective data was collected for consecutive patients having mastectomies over a 12-month period at Frimley Park Hospital, UK. Electronic anaesthetic notes and drug charts were reviewed for data collection.

Results: 52 mastectomies were performed during the audit period. 27% of these patients had a regional anaesthetic technique as part of their intraoperative care with paravertebral and erector spinae blocks being the most commonly performed (36%). Time to first post-operative opioid administration was longer in the regional group, with total 24-hour opioid consumption being equivalent in both groups. At our institute the proportion of patients being discharged within 23 hours was 6%, and 62% of patients had a single-night stay. The regional group had a shorter average hospital stay.

Conclusion: With the introduction of a new enhanced recovery mastectomy protocol incorporating regional anaesthesia as a standard of care, we aim to improve patients' perioperative experience and increase the percentage of 23 hour ambulatory non-reconstructive breast cancer surgery. This pilot audit will act as a baseline for further comparative audits and improvement in perioperative care.

Posters

P1 The Scope for Emergency Day Surgery in the Surgical Management of Abscesses

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Abstract

Aim: We aim to implement a long-term, sustainable, ambulatory surgical abscess pathway that utilises pre-existing day surgery ward infrastructure. In doing so, we hope to provide a shorter stay for patients thus reducing inpatient bed usage. Previous studies indicate there is no significant difference in clinical outcomes between inpatient and ambulatory care.

Methods: Patients were identified by surveying admissions lists from a single surgical admissions unit. Data were collected prior to the introduction of ambulatory care (October 2017-April 2018) and seven months after the change (April 2018-November 2018).

Results: Prior to the introduction of the pathway, all patients requiring incision and drainage received standard inpatient care. Since the introduction of the new pathway, 43 of 163 patients (26%) have been treated within a true ambulatory setting. The mean length-of-stay for true ambulatory patients was 10.0hrs (SD±5.1) whereas for inpatients it was 23.4hrs (SD±17.5). Unpaired t-test analysis demonstrated a significant reduction in length-of-stay for an ambulatory patient compared to an inpatient (n=149 p<0.000001).

Conclusion: Our results indicate that it is feasible to use the new ambulatory pathway for a significant proportion of emergency abscess patients, using the strong platform we have to assess the success of further interventions.

P2 Day-Case Mastectomy Target- Achievable and Sustainable for the Future of the NHS

Claudia Wilson, Gwen Bromley, Annie Chan, Mujahid Pervaz

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Abstract

INTRODUCTION: Mastectomy remains a commonly used surgery in the management of breast cancer. National guidelines now recommend that we aim to carry out 50% of mastectomy procedures as day-cases. This project assesses how achievable the recommended day-case mastectomy (DCM) rates are within our trust, how DCM rates can be improved and whether this can be applied to other trusts.

METHODS: All mastectomy cases were evaluated from February to August 2018 at a district general hospital following an initial audit in 2017 identifying DCM rates much lower than the national 50% target. We undertook retrospective analysis of electronic records of all patients who underwent mastectomies.

RESULTS: 82 patients were included for analysis and the average age was 58. Overall 54.9% had their mastectomies as day cases, including patients with immediate reconstruction and all nodal procedures. 62% of patients who underwent simple mastectomies had their procedures done as day-cases compared to 35% of patients in 2017. Mean length of stay decreased for all types of mastectomies over this period compared to the previously audited period.

CONCLUSION: The rate of day-case mastectomies has improved significantly from 2017 to 2018. This has been attributed mainly to a drive to adjust patient expectations. This has had huge financial implications in the trust. Further work should be done nationally with patients and clinicians to make day-case mastectomies a part of routine surgical practice.

P3 “Dying of thirst?” Perioperative fasting in adult patients undergoing day case surgery

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Abstract

Introduction: To reduce the risk of aspiration of gastric contents, patients have traditionally been denied food and clear fluids for 6 and 2 hours respectively prior to general anaesthesia. Much attention has been paid to reducing fasting times in children, who are more susceptible to dehydration and hypoglycaemia. Children are now encouraged to drink clear fluids until 1 hour prior to elective anaesthesia. As well as reducing patient discomfort, relaxing fluid fasting in adults may reduce pre-operative anxiety and post-operative nausea and vomiting. The aim of this study was to identify current fasting practice for adult patients undergoing day case surgery.

Methods: Data was collected prospectively over a 4-week period. Patient reported fasting times for solids and liquids and time of anaesthetic induction were recorded.

Results: A broad case-mix of 45 surgical patients was studied. Fasting times for clear fluids ranged from 3 hours and 5 minutes to 17 hours and 40 minutes (median time 11 hours and 20 minutes). Fasting times for solids ranged from 7 hours and 5 minutes to 22 hours and 40 minutes (median time 15 hours and 5 minutes).

Conclusions: Our study demonstrates that adult patients are being subjected to unnecessarily prolonged fasting times. This is likely to result in patient discomfort, increase the risk of nausea and vomiting and even perioperative renal dysfunction. There is scope to improve current practice through patient and staff education, updating current local policy and highlighting patients who can safely drink at the daily morning team brief.

P4 Managing patients with challenging behaviour for day surgery; use of a Vanguard mobile theatre.

Anna Lipp

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Abstract

Patients with challenging behaviour which may present a risk to staff and other patients pose a variety of issues when they need surgical procedures. We have recently managed 3 admissions for such patients and wish to share the learning from our experiences.

Planning for the admissions focussed on reducing triggers for the patient's behaviour and ensuring safety for the patient, staff and hospital users. Prior to admission the patient's carers visited the hospital to walk through the pathway. The identified triggers for challenging behaviour in each case were

- Waiting
- Unfamiliar environments
- Unfamiliar people
- Close contact and interventions

To minimise risks of waiting and contact with unfamiliar people we used the Vanguard mobile theatre which has direct vehicle access with a short walk up the ramp to the anaesthetic room. The area can be easily overseen by security staff and is separate from other patient areas.

A plan for management was agreed with the patient's carers for each admission and staff rehearsed the key steps. Photographs of the area and staff were used to familiarise the patients in advance. For 2 admissions it was recommended that anaesthetic induction and recovery should take place on the floor where the patient felt secure. A scoop stretcher was used for lifting the first time and "Hoverjack air patient lift" on second occasion and this was rehearsed with manual handling team.

Each admission proceeded uneventfully, and carers were grateful for the planning and use of a suitable environment for the procedures.

P5

Gynaecology Day Case Surgery Pathway in Northumbria Healthcare Trust

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Abstract

INTRODUCTION: The day-case enhanced recovery pathway has been developed to streamline the patients journey from their initial referral to their recovery from elective day case surgery. This aims to facilitate a more rapid recovery, shortened length of stay and return to normal activity. It will also reduce the trust's unplanned admission rate for day-case surgery, to alleviate inpatient bed pressures and improve patient satisfaction.

METHODS: The trust have developed a pathway for all day case surgeries which includes criteria for patient selection, patient counselling & consenting , optimisation and Pre-assessment. Following the Royal College of Obstetricians and Gynaecologists Enhanced Recovery Pathway and Patient Reported Outcome Measures.

RESULTS: Out of 2422 day case surgeries performed in 2018,113 required stay overnight (4.7%). Example of patient feedback "All positive following the operation, my lifestyle has improved dramatically. I would like to thank the NHS for making a huge difference to my life."

CONCLUSION: Increased successful planned day case surgeries . High-quality patient care with excellent patient satisfaction. Day surgery is the standard pathway of care for many complex patients and procedures traditionally treated through inpatient pathways.

P6 The use of botulinum toxin in keloid management: A literature review

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Abstract

INTRODUCTION: Keloids represent a challenging clinical entity resulting from pathophysiological processes such as fibroblastic hyperactivity. Despite the presence of various management strategies including intralesional/extralesional excision and corticosteroid injection, however, the ideal therapeutic approach has yet to be reached. To address this, botulinum toxin (BXT) has emerged as a promising approach to managing keloids owing to its ability to reduce the intensity of tensile forces caused by muscle pull during the wound healing process, and of its ability to modulate the cell-cycle distribution of fibroblasts derived from human hypertrophic scars.

METHODS: 87 total articles were identified following a literature search of PubMed Medline, Embase, and Web of Science with appropriate search terms. 11 studies were included for analysis and classified according to the Joanna Briggs Institute Levels of evidence.

RESULTS: Various level 2 studies confirm the additive and statistically significant value of BXT in alleviating pain and itch when compared to intralesional steroids alone. Two level 2 studies appraise the value of BXT as a post-operative keloid management adjunct. A notable advantage of BXT as a primary agent is of the lack of significant side-effects when compared against local intralesional steroid.

CONCLUSIONS: The adoption of BXT in keloid scar management has a number of potential advantages by virtue of its ability to confer chemoimmobilisation to the underlying tissue musculature. Having displayed good therapeutic outcomes and superior symptomatic benefit when compared to steroids, however, further high-quality studies are awaited to delineate the long-term role of BXT in keloid management protocols.

P7 Retrospective Audit Assessing the Completion Rate of the World Health Organisation Surgical Safety Checklist

Sanjeev Kotecha, Achal Khanna

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Abstract

INTRODUCTION: The World Health Organisation (WHO) Surgical Safety Checklist was developed in order to enhance surgical outcomes. Milton Keynes University Hospital (MKUH) has developed its own modified version. The purpose of this audit is to determine the extent to which this checklist is being completed.

METHOD: Patients undergoing procedures by the General Surgery Department over a 2-month period were included. The electronic patient record system was used to analyse each individual's checklist. MKUH's version comprises 30 distinct components that are categorised into one of the 3 primary categories: Sign In; Time Out; Sign Out. The number of incomplete components for each patient was then calculated.

RESULTS: 84 patients' checklists were assessed. Only 33.3% (28/84) of checklists were fully completed i.e. two-thirds of checklists were incomplete. In the remaining 56 checklists, there were a total of 156 missing components: an average of 2.79 per checklist. 2 particular checklists were missing as many as 10 components.

CONCLUSION: Given that the WHO Surgical Safety Checklist was designed in an attempt to improve patient safety by maximising consistency across all surgical procedures, it would be sensible to attempt to improve MKUH's checklist completion rate by implementing relevant changes and re-auditing.

P8 Should we be performing Day Case Laparoscopic Cholecystectomy after 3pm?

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Abstract

Introduction: Laparoscopic cholecystectomy (LC) is a common daycase procedure. The British Association of Day Surgery (BADs) Procedure Directory[i] sets out national performance targets for the number of LCs treated as day cases. We aimed to assess if operation time predicted unplanned inpatient admission.

Methods: An anonymised retrospective review of all patients undergoing LC was undertaken over a 6-month period. Data was obtained from multiple sources: discharge letters and the theatre data manager.

Results: 113 LCs were performed over a 6-month period, 5 (4%) were planned admissions. The zero night stay for Day Case Laparoscopic Cholecystectomy (DCLC) was 56%, which lies within the top 50% of current national performance but is below the BADs target of 75%. Of the planned DCLC there were 47 (42%) unexpected admissions. The unexpected admission and zero stay groups were matched in age and gender. Average age 54 (22 to 87) with 76% female in the zero stay group compared to 51 (18 to 81), with 77% female in the unplanned admission group. In the day zero stay group. 3 (10.4%) patients underwent operations between the hours of 15:00 to 18:00 compared to 14 (32.5%) in the unplanned admission group (P=0.0069).

Conclusion: The timing of operation of DCLC predicts inpatient admission; our data suggests that DCLC should not take place after 3pm. A small proportion of patients were planned admissions suggesting that there is a default for clinicians to book patients undergoing LC as DCLC, which may be inappropriate.

Reference

[i] *BADS Directory of Procedures 5th Edition*

P9 Re-audit of Unplanned Admissions following Day Surgery at the Norfolk and Norwich University Hospital

Elizabeth Herbert, Rachel Morris, Samuel Fletcher

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Abstract

Introduction: Unplanned admissions (UA) following day surgery (DS) represent a costly dilemma. They reduce the availability of acute hospital beds and negatively impact the lives of patients. UA rates are used as performance indicators for DS and the Royal College of Anaesthetists (RCOA) advises they should be <2% overall.

Method: We performed a retrospective study and re-audited UA following DS and recovery at the Norfolk and Norwich University Hospital's Day Procedure Unit (DPU) in August 2018. Data was collected from paper bed request forms and electronic discharge summaries.

Results: In August 2018, 1372 DS patients were recovered in DPU. There were 57 UA, which equates to 4.15% (vs 1.1% 2017).

Urology had the highest percentage of UA (35% vs 30% 2017), followed by general surgery (15.8% vs 32% 2017) and gynaecology (12.3% vs 6% 2017).

The reasons for UA were manifold. The most common were that the surgery was more extensive than planned (15.8%) (no definitive 2017 data), bleeding (10.5% vs 5% 2017) and urinary retention (10.5% vs 11% 2017).

Conclusions: Our August 2018 DPU UA rate was double the RCOA's recommended <2% and four times the 2017 rate of 1.1%. However, not all DS cases are processed by DPU. The fact that the highest percentage of UA were due to surgical reasons may reflect the evolving nature and increasing complexity of DS. We plan to extend our study over a six-month period, to more reliably establish UA rates and patterns, with the aim to design targeted perioperative protocols.

P10 Unplanned Day Case Surgery Admissions from 2008 – 2018 in Rotherham Foundation Trust Hospital

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²Rotherham Foundation Trust, Rotherham, United Kingdom

Abstract

Introduction: In-line with NHS Improvements national drive, the proportion of elective surgical procedures performed as day-cases is continually increasing. However, as the complexity procedures performed as day-cases and patients' comorbidities increases so too does the risk of unplanned admissions. Unplanned admissions are inconvenient for patients and their carers, additionally it places increased pressure on hospitals (higher costs, loss of acute beds and best-practice tariffs). Therefore, at Rotherham Foundation Trust (RFT) we regularly audit the number and causes of unplanned admissions in order to reduce the rate of unplanned admissions and improve the quality of care delivered to day-case patients.

Methods: The time, procedure and cause of every patient unexpectedly admitted after a day-case procedure was prospectively recorded from 2008-2018, based on the Royal College of Anaesthetists audit compendium.

Results: Since 2008, RFT has performed 4460-6413 day-case surgical procedures annually. The rate of unplanned admission across the years ranges from 2.9%-1.5%. Some common reasons for unplanned admissions include pain, late leaving theatre, bleeding and post-operative nausea and vomiting. Regular auditing identified factors causing admission which targeted departmental education leading to improved practices. For example, the introduction of departmental guidelines and spinal-anaesthetic recipes reduced the rate of urinary retention and prolonged block admissions.

Conclusions: The increasing complexity of day-case patients and procedures increases the risk of unplanned admissions. Indeed, the continual pushing of boundaries may necessitate accepting a higher transfer from day-case pathway to inpatient. This highlights the importance of regularly auditing the rate and reason for admissions to actively manage root-causes.

P11 Why don't we ask patients to supply their own post-op analgesia - A matter of perspective?

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²The Medical Specialist Group, Guernsey, Guernsey, Guernsey

Abstract

Introduction: We investigated the process of patients acquiring analgesia following day surgery.

Methods: Interviews were conducted with staff and patients involved in prescribing, dispensing and receiving analgesia following day surgery.

Results: *Surgeons:* Frequently employ local anaesthetic intra-operatively. They do not routinely prescribe discharge analgesia leaving the task to anaesthetists.

Anaesthetists: Prescribe analgesia routinely - paracetamol, ibuprofen and codeine. They are concerned patients cannot be relied on to purchase their own supplies.

Day Ward Nurses: Label and dispense all drugs ordered by anaesthetists.

Pharmacists: Supply pre packed analgesia to the day unit.

Patients: Paracetamol and ibuprofen are commonly taken, codeine rarely. Most are familiar with these analgesics and have supplies at home. They would purchase drugs if instructed.

Conclusions: The aim of post-operative pain management is to ensure patient comfort, enable early restoration to normal activity, minimize side effects associated with analgesia, allow effective self-management of pain at home, and ensure safe, cost-effective use of analgesia¹.

If patients acquired their own post-operative analgesia further supplies from the hospital would be unnecessary. Nurses and pharmacists would be relieved of unnecessary work.

Dispensing excess quantities of analgesics, particularly codeine, would be avoided with less waste.

Reference

- 1 *Day Case Surgery*. Ed. I Smith, D McWhinnie, I Jackson. Oxford University Press. 2012.

P12 Short stay and day case Hysterectomy patient outcomes when receiving anaesthetic service from a Physician' Assistant in (Anaesthesia)

Howard Cox

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Abstract

Physician' Assistant in (Anaesthesia) [PA-(A)] have worked in a qualified capacity for the National Health Service (NHS) since 2007.

It is widely recognised that with robust local governance frameworks PA-(A)'s perform extended anaesthetic roles such as Regional Anaesthesia and providing anaesthetic services to patient undergoing major abdominal cavity surgery.

Despite these advance in the PA-(A) practice, there has been no evaluation of patient outcomes with extended role. There equally has been no evaluation of working in a 2 to 1 capacity in major abdominal surgery when the PA-(A) has been the primary anaesthetic provider. This study focuses over a two your period on the work carried out by PA-(A) specifically focussing on patient having elective hysterectomy.

The study elevated Length of Patient Stay (LOS) and post operative complication, be those of an anaesthetic or surgical nature.

The Study recruited 103 cases or which 82 could be successfully use within the study .

It demonstrated there was no adverse outcome in LOS with Laparoscopic Hysterectomy patients mean LOS been 28 hours and open Hysterectomy cases having a mean of 48 hours. This is within keeping in current NHS LOS for Hysterectomy patients.

The spinal anaesthetics undertaken by the PA-(A) in these two group which amounted to 56 patients had a100% success rate and there was only one complication relating to the anaesthesia which was post operative nausea and vomiting.

This study give a useful insight into PA-(A) extended roles and evolving scope of Practice.

P13 Improvement of analgesia prescribing in day surgery patients

Owen Thomas, Katharine Stenlake

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Abstract

Introduction: The number and complexity of cases performed in our unit has increased, but so have the numbers of patients requiring rescue analgesia from GPs postoperatively. Our prescription guidance was reviewed.

Methods: Day surgery cases (adults) were classified into 4 categories based on expected post-op pain. These were: none, mild, moderate and severe. An analgesic regime was recommended for each, and this categorization was circulated to senior anaesthetists and surgeons for comment before being widely distributed.

An audit of routine analgesia prescribing was conducted before and after implementation, and GPs contacted for any noticeable change in 'rescue' prescriptions required.

Results: The majority of patients purchase the recommended simple analgesia prior to surgery, but additional post-operative analgesic prescribing by clinicians is variable. 87% of patients had none and 40% did not have the recommended analgesia prescribed.

Reasons included clinicians unclear about their responsibility for prescribing, and the complex process of obtaining additional TTOs. Prescription rates were higher for procedures with clear guidance already in place e.g. tonsillectomy.

Post implementation anecdotal evidence suggests an improvement in rates of analgesia prescribing. (Data is still being collected)

Conclusions: A significant percentage of patients having surgery with potential post-op opioid analgesia requirements did not have adequate prescriptions. The introduction of a clear analgesic protocol improved prescription rates for specified operations.

Categorizing operations based on expected analgesia requirements should have a beneficial effect on individual patient's experience of their day surgery and reduce the burden on local GPs.

P14 Reducing Overnight Admissions Following Planned Day Case Surgery

Sally Dunlop

Airedale General Hospital, Keighley, United Kingdom

Abstract

Introduction: Avoidable admissions following day surgery can cause distress to patients, increase risk of hospital acquired infection and venous thromboembolism. They have a negative financial impact on the hospital due to cost of overnight stay and loss of best practice tariff, along with reduction in bed availability for acute admissions

Method: In summer 2017 our admission rate was unacceptably high at 12%. A thorough review of all admissions over a 3 month period was carried out by a team of medical and senior nursing staff to look for common themes.

Common reasons for admission included

- insufficient time for recovery due to late out of theatre
- not having passed urine
- patient too drowsy / nauseous / in pain

Results: Based on these results, we have implemented numerous work streams, including

- education surrounding criteria not time based discharge
- post operative urinary retention policy allowing discharge home without having passed urine
- “sip until we send” fasting policy to encourage hydration and reduce post operative nausea
- list planning review to achieve day case work earlier in the day
- introduction of fentanyl in place of morphine for rescue analgesia in theatre recovery (recent change effect yet to be analysed)

Our admission rate has reduced to 7% following some of these changes.

Conclusion: A through and ongoing review of reasons for admission is necessary to understand the issue. We continue to attempt to implement flexible opening hours for our day ward and for nurse led discharge into the evening from our inpatient wards.

P15 An observational study to analyse the potential effect of infusion dead space in the surgical and critical care setting

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Abstract

Introduction: This study observed current clinical practice to analyse the potential effect of infusion dead space. The importance of this study revolves around the potential for patients to receive suboptimal dosage of prescribed drugs or blood products.

Methods: We conducted a 6 – question survey of nursing staff across two intensive care units (ICUs), four surgical wards, postoperative recovery area and a Postoperative Care Unit (PACU).

Results: Experimental work using administration sets (B Braun Intrafix® SafeSet) found the infusion dead space on average to be 18ml (filling chamber 50% full). 102 surveys were given to nursing staff over a 4 day period with an 81% response rate. Following administration of IV Metronidazole (500mg/100ml) 67% of respondents would not flush the administration set, resulting in the patient not receiving 18% (90mg) of the infusion. Following administration of IV Paracetamol (1g/100ml) 71% of respondents would not flush the administration set, resulting in the patient not receiving 18% (180mg) of the infusion. Following administration of one unit of Packed Red Cells (average 250ml) 48% would not flush the administration set, resulting in the patient not receiving 7% of the infusion. Following administration of IV Omeprazole (40mg/100ml) 75% would not flush the administration set, resulting in the patient not receiving 18% (7.2mg) of the infusion.

Conclusions: Based on the study results, potentially subtherapeutic treatment could lead to longer, more complicated patient recovery postoperatively and adverse patient outcomes. There is a need for robust national guidelines and increased awareness of intravenous infusion sets' dead space.

P16 Reducing Perioperative Fasting at The Rotherham Foundation Trust – A completed Quality Improvement Cycle

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²Sheffield Teaching Hospitals, Sheffield, United Kingdom

Abstract

Introduction: A service evaluation in our department in 2017 demonstrated excessive fasting times. Despite local guidance in keeping with the Association of Anaesthetists' of 2hours for clear fluids 26% of patients had clear fluid fasting time exceeding 6hours.

Prolonged fasting can be detrimental to patients' experience and health including causing headaches, nausea, increased insulin resistance and an altered acute phase response to surgery.

Studies demonstrate that stomach emptying follows an exponential course, with a half-time($T_{1/2}$) for water approximating 15minutes.

In November 2018, guidelines were introduced to try and reduce excessive pre-operative fasting. Our written patient information was amended to encourage drinking clear fluid until 2hours before. The pre-operative assessment nurses were asked to tell patients that they should actively try and drink water up until 2hours preoperatively. Patients are offered a small glass of water on admission to Theatres admission unit.

We aimed to determine whether there had been a reduction in clear fluid fasting times following this change.

Methods: Clear fluid fasting times for all adult elective surgery cases (including day surgery) was collected over five consecutive days in February 2019.

Results: Data from 117 patients was collected. 15% of patients had clear fluid fasting time >6hours, a 42% reduction from our previous service evaluation. 33% of patients received water on admission. 66% had received clear fluids <4hours before arrival to Theatre. There were no cases of postoperative pulmonary complications.

Conclusions: Our intervention has resulted in a reduction in prolonged fasting. There is still room for further improvement.

P17

Pre-operative waiting, a timely solution

Katharine Hannon, Christopher Roberts

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Abstract

Introduction: The Royal Free Day Surgery unit has been operating since the early 1990s. Typically the unit sees 50-70 patients per day. Day surgery historically involves long waiting times and, although there is no specific guidance on how long patients should wait pre-operatively, we are aware that prolonged waiting times increase patient dissatisfaction and anxiety. With patient satisfaction a key performance indicator of the trust we chose to audit pre-operative waiting times.

Methods: Over the course of two weeks the nurses recorded the time patients arrived in the department, when they saw a nurse, anaesthetist and surgeon and the time they went to theatre using a table the patients kept with them. We cross referenced the patients to the surgical speciality to see areas needing improvement or areas of excellence.

Results: We surveyed 86 patients in a 2 week period, focusing on the elective lists only. The results showed an average waiting time of 3 hours 58 minutes; with patients seen by a nurse within 35 minutes and by a surgeon within 1 hour 11 minutes. The longest waiting time was 9 hours the shortest 1 hour.

Conclusion: Day surgery procedures can involve long waiting times leading to a decrease in patient satisfaction. The plastic speciality had the shortest waiting times, mainly due to the effective staggering of lists, and breast surgery had the longest waiting time. We can use the results to make a case for change and replicate the plastics model across other specialities.

P18 “Routine Preoperative Tests for Elective Surgery” – Audit and Education of Guidelines can Cut the Costs Associated with Unnecessary Tests

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Abstract

Introduction: Patients undergoing elective operations frequently attend a pre-operative assessment, where a series of tests are performed, each with an associated cost. Guidelines exist to guide the tests required for each grade of surgical severity in patients of all ASA Grades. We performed an audit to evaluate knowledge of and adherence to these guidelines. An educational poster was made and a re-audit performed to see if education helped improve adherence to these guidelines, and assess any cost implications.

Method: Inclusion criteria included patients over 16 attending pre-assessment for elective surgery in Pilgrim Hospital, Boston. A random selection of case notes covering a range of Surgical Specialties were reviewed to see what tests were ordered, whether they were advised under NICE guidelines and what the associated costs were. A poster of the guidelines was subsequently made available in the pre-assessment clinic and the amount of tests ordered and their cost was compared between cycles.

Results: The first audit cycle of 50 patients over 1 month highlighted 44 tests not required under guidelines, with a cost of £632.24, correlating to £75,868.80/year when extrapolated to the number of patients operated on per year in Pilgrim Hospital and £189,672 across the Trust. The second cycle of 100 patients over 8 weeks highlighted 121 unnecessary tests, equating to £372.28 - £22,336.80/year in Pilgrim and £55,469.72 across the Trust. The saving was £53,532/year in Pilgrim, and £134,202/year across the Trust.

Conclusion: Knowledge and adherence to existing guidelines regarding pre-assessment tests has significant cost implications for the NHS.

P19 What are the barriers to daycase TURBT?

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Abstract

Introduction: Transurethral resection of bladder tumour (TURBT) is integral for the diagnosis, grading and treatment of bladder cancer. There has been an increasing drive for day surgery to optimise inpatient capacity, and current policy is to plan patients for daycase TURBT where feasible. This is a re-audit of TURBTs in a district general hospital where previous audit demonstrated 43% discharge rate within 24 hours.

Methods: Retrospective data was collected on all TURBTs from January-December 2018 utilising the hospital's database. Demographic data included age at operation, American Society of Anaesthesiologists (ASA) grade, tumour size, resection mass and histology, as well as length of stay (LOS).

Results: There were 104 resections including 13 re-resections in 94 patients, with a mean age of 76. 12 underwent an additional procedure at time of surgery. Male to female ratio was 3:1. 50% of patients were ASA 1-2 and 50% ASA 3-4. 79% had a new tumour diagnosis and 16% were undertaken for recurrence. 3.8% were booked as daycases. At re-audit, 9.6% were discharged within 24 hours, increasing to 62.5% at 48 hours with mean LOS 44.4 hours. 57 tumours were solitary and 32 multifocal. Spread of histological grading was 8.2% G1, 38% G2 and 54% G3 respectively.

Conclusions: The previous daycase discharge rate has not been replicated at re-audit. This may be due to booking as inpatient rather than daycase procedures, increased rate of G2/3 tumours, and higher ASA grades. Better implementation of the pre-existing pathway, and further audit, is required.

P20 Operation note documentation in laparoscopic cholecystectomies in a District General Hospital.

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Abstract

Introduction: The Royal College of Surgeons of England (RCSE) published “Good Surgical Practice” in 2014. This publication includes a recommended minimum data set to be recorded in operation notes. We set out to quantify and improve adherence to these guidelines.

Methods: Operation notes (op. notes) were obtained for all patients undergoing Laparoscopic Cholecystectomies (lap. Chole.) between 1/11/2017 and 31/11/2017 and compliance to the guideline was assessed.

Findings were presented at a local meeting attended by surgical staff.

Recommendations included: typing operation notes where possible, familiarization with the guidelines and display of the guideline in areas where operation notes are produced.

Finally the same data was collected from the op notes of all patients undergoing lap chole between 1/11/18 and 31/11/18. Compliance with the same set of guidance was assessed and comparisons made.

Results: Initially, 28 surgeries were carried out and the majority (24) of operation notes were hand written. Many criteria such as date, incision and operative findings were recorded in 100% of cases. Others, including time of surgery, DVT prophylaxis and name of anaesthetist, were less consistently recorded.

At re-audit, 32 surgeries were performed. More operation notes were typed and legibility was improved. Compliance was improved in typed operation notes. In particular, time of surgery, elective/emergency status, and theatre anaesthetist. In contrast, hand written operation notes demonstrated similar recording of the recommended data.

Conclusions: Adherence to this guidance was improved following intervention. Amount of typed op notes also increased. This may reflect use of typed, prepopulated operation notes.

P21 How to Improve the Experience of Day Surgery Patients

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Abstract

Introduction: This quality improvement project had two aims:

1. Identify factors that influence the experience of elective surgery patients
2. Improve that experience.

Methods: We conducted repeated snapshot surveys on our on-the-day surgical admissions unit over a four year period. On a given day, all patients admitted to the Royal Free Hospital for elective surgery to completed a questionnaire about their experience and the factors that influenced it.

We conducted semi-structured interviews with our patients about their experience and the themes were identified. The iterative nature of this project allowed us to identify which interventions were effective and which were less so.

Results: The proportion of patients reporting their overall experience as “Excellent” or “Good” was 65% in 2015, it peaked at 96% in 2017 and was 82% in 2019.

Patients who had operations before 12:00 were significantly more likely to report a “Good” or “Excellent” experience compared to those whose operations were after 15:00 ($p < 0.05$).

The most common positive theme was the staff, who were described as friendly, helpful and caring. The most common negative factor theme was waiting before surgery.

Impactful interventions were staggering lists (reducing waiting times) and updating patients about their operation time. Ineffective interventions were; having a single telephone number for calls from theatre and the ward and altering the letters sent to patients.

Discussion: Our study demonstrates the importance of patient engagement in quality improvement projects. By speaking to our patients directly, we were able to make focused and effective changes to our processes.

Prize Papers

Prize 1 Major ambulatory surgery in a freestanding, bedless facility?

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Abstract

Introduction: In 2007, our local public hospital faced saturation and needed expansion while ambulatory surgery suffered from poor quality and bad cost-coverage. With this in mind, we reconsidered our organization and set up a dedicated, freestanding ambulatory surgery center (ASC).

We now perform more than 3800 increasingly invasive surgical procedures in a wide range of surgical specialties, without beds.

Methods: 9 years later we assessed the relevance of the freestanding option by using the SWOT tool and put some of our practical results in perspective with other studies, OECD data and recommendations.

Results:

- The freestanding, single level design facilitates setting up specific clinical pathways maximizing the quality and thereby improving cost-effectiveness.
- The compact and open architectural design of the recovery room and the operating theater provides a safe and reassuring overview while preserving patient privacy.
- The “bedless” concept helps optimizing patient circulation, increases the safety and turns out to be a real space saver.
- The appropriate level of cooperation with the main hospital, an important key factor to success, has yet to be found and challenges us to find a different corporate structure.

Conclusions: Ambulatory surgery is about innovation of care, it's not about improving hospitals. Architecture is an important key factor as it enables the blossoming of an adjusted culture to make it as simple and safe as possible.

The challenge of a successful integration of freestanding ASC's in local healthcare systems might not to be underestimated.

Prize 2 Patient-centred hernia surgery in a Primary Care Setting: optimising quality

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Abstract

Introduction: Stresses on the NHS and specifically secondary care has meant that some surgical services are increasingly difficult to provide in hospital environments. Long waits and difficult access requires strategies to change methods of provision that bring the patients needs into focus.

Method: We describe the provision of a day case local anaesthetic hernia service in a primary care setting instigated in 2015.

Results: The service was started in 2015. To August 2018 a total of 324 patients have undergone Consultant lead hernia surgery after 692 were seen in a dedicated hernia clinic. Surgery and clinics were done in an easily accessible primary care setting with a dedicated operating theatre and staff. The service required a standardised approach with Consultant Surgeon and Anaesthetist, a day 5 wound assessment, a standard post-operative analgesia protocol and pre and post patient information literature. There were two post operative admissions to secondary care (one at day 2 with pain, one at day 5 with a haematoma). One patient developed recurrence and two patients developed chronic groin pain.

National PROMs results showed an improvement of 54.4% by EQ5D and 57% by VAS (national results 51.3 and 39.2 respectively).

Patient satisfaction survey demonstrated a 92% excellent service response, 8% good service response and 92% would recommend the service to others.

Conclusion: Moving hernia surgery to primary care setting provides good results and excellent patient feedback. This model of Primary Care-based Consultant Lead Service may be the future way forward for hernia repair in the UK

Prize 3 Breaking the conventional -hip replacement as day surgery

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Abstract

Background and aims: Longer life expectancy, obesity, changes in lifestyle have increased the prevalence of osteoarthritis therefore the demand for total hip arthroplasty in the forthcoming years is predicted to rise (over 90000 in 2017). It is well known that higher morbidity and mortality is associated with prolonged hospital stay after total joint arthroplasty. The current situation generates multiple problems for our healthcare system, principally an unsustainable high cost.

In order to reduce costs, 'fast-track' or 'enhanced recovery' protocols were introduced and found to be successful to reduce the length of stay compared with conventional pathways. While this led to a reduction in the LOS in our hospital from 4 to 1- 2.2 days, day-case arthroplasty is still relatively uncommon worldwide.

Our experience aims to define the safety and effectiveness of day-case arthroplasty

Methods: 25 patients scheduled for hip arthroplasty were included into the pilot study. Patients included were ASA 1 to ASA 2, BMI < 40, age was not an exclusion criteria. The anaesthetic protocol and fluid management were standardised.

Results: Of the 25 patients scheduled, 21 went home on the same day. Average length of surgery was 55 minutes, average blood loss 277ml. Patients were discharged between 4 and 6 Pm. There were no readmissions. None of the patients used rescue analgesia at home

Conclusion: Outpatient hip arthroplasty is a good option for selected patients. Costs are reduced, safety (complications rate) and effectiveness (patient satisfaction and functionality) seem to not be compromised compared with conventional pathways for hip arthroplasty

Prize 4 Improving fluid fasting times and postoperative nausea rates after introducing a liberal preoperative fluid policy for patients undergoing elective surgery

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Abstract

Introduction: In 2018, Northumbria NHS Trust implemented a Liberal Preoperative Fluid Policy (LPFP) for patients undergoing elective surgery. Patients can now drink water freely until being transferred to theatres. Previously, drinking was prohibited in the two hours before general anaesthesia. However, previous audits had demonstrated that the Average Fluid Fast Time (AFFT) greatly exceeded the two-hour cut-off (5.7 Hours).

Fluid fasting is an unpleasant patient experience, linked to several adverse pre/postoperative consequences.

This re-audit aimed to review the current AFFT, since the introduction of the LPFP.

Methods: Questionnaires were distributed to the recovery units of four hospitals within the trust. Recovery nurses questioned all patients who had undergone elective surgery. The time of their last drink and arrival time to theatres was noted and used to deduce the AFFT. Nurses also recorded patients' sensation of preoperative thirst and postoperative nausea & vomiting (PONV).

The re-audit ran between the 28th Jan – 8th Feb 2019.

Results:

- 219 questionnaires were completed, 188 included enough information to calculate the AFFT.
- Our results demonstrated an AFFT of 2.1 Hours, an improvement of 63% compared to previous audit cycles.
- 75% reported drinking water in the three hours preceding general anaesthesia.
- Seven patients experienced PONV giving an incidence of 3.2%, previously recorded at 5.7%, a 43% decrease.
- Pre-operative thirst reduced by 20%

Conclusion: A LPFP has resulted in a 63% decrease in the AFFT before elective surgery. Preoperative thirst rates have improved, with our results also suggesting that PONV has reduced since the implementation of the LPFP.

Prize 5 Upper limb day case arthroplasty – Developing a pathway

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Abstract

Introduction: There is a drive towards shortening length of stay for elective surgery. Whilst reducing hospital costs and bed pressures, it improves patient satisfaction and has proven possible in lower limb arthroplasty. A retrospective audit of upper limb arthroplasty (approx. 150 cases) showed a mean length of stay of 2.9 days.

Our aim was to develop and introduce a pathway for upper limb arthroplasty day-cases in our trust.

Methods: A clearly defined pathway was devised in collaboration with a multidisciplinary team. This involved identifying suitable patients and educating them in the process. Anaesthetic, physiotherapy and occupational therapy evaluation were carried out to identify obstacles to discharge. Patients were placed first on morning lists and planned for regional analgesia, with a general anaesthetic or sedation. Ward contact details were given on discharge along with pain diaries and rescue analgesia.

Results: Of 21 suitable cases since introduction of the pathway, 16 successful day-cases have been managed across two sites within the trust. Failed discharges were on one of the two sites. Patient feedback is positive and we have had no readmissions or complications relating to early discharge. The success of our pathway on mainly one site suggests logistical issues and lack of engagement in the pathway may be a factor.

Conclusion: Day-case arthroplasty may be beneficial and is possible, but patient selection and education of all team members is key. We hope the formation of a clear pathway and multidisciplinary collaboration has potential to establish this as standard practice in the trust.

Prize 6 Total Ankle Replacement – Walking the Path to Day Case Surgery

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Abstract

Introduction: Day Case Surgery is a priority within the National Health Service and has been shown to provide beneficial outcomes for patients and hospitals. We report our experience developing a Day Case Programme for Total Ankle Replacement (TAR).

Methods: Prior to the introduction of a Day Case Programme, average length of stay following TAR in our unit was 3.5 days. Stakeholders were consulted about ways in which same day discharge could be facilitated. Patients' post-operative pain charts were reviewed prior to the introduction of this programme. Inclusion criteria included non-complex surgery, friend or relative support and pre-operative walking-aid assessment. An enhanced recovery protocol included long-acting popliteal block and dexamethasone. Patients were discharged with opiate analgesia and written pain instructions. Patients were asked to complete a pain and satisfaction questionnaire. Patient Reported Outcome Measures (PROMs) were recorded.

Results: From September 2017 to April 2019 21 of 70 patients underwent TAR as a Day Case. Mean age was 67 years (43–85 years). Complications included one superficial infection and one readmission on day three with urinary retention. No patients reported post-operative nausea or vomiting, half did not use Oramorph at home. Average Visual Analogue Score for pain was 21 on day one and day three post-operatively. PROMs at 12 months showed a trend improvement compared to standard inpatient care.

Conclusions: Early results suggest that Day Case Total Ankle Replacements are safe. Appropriate patient selection is necessary. Day Case Surgery relies on support and communication between multiple teams to organise and run effectively.

