ORAL ABSTRACTS

A day surgery pathway for emergency surgery at Torbay Hospital, Devon

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Introduction A significant proportion of emergency surgical cases require minor or intermediate procedures. These lower priority patients occupy hospital beds and their surgery is frequently delayed. This impacts patient flow and satisfaction. We implemented a novel cost-neutral pathway, selecting appropriate cases for ambulatory same-day emergency surgery.

Methods Scheduling meetings identified vacant but staffed day surgery lists one week ahead. The emergency surgical teams were informed of these. Only patients fulfilling ambulatory surgery criteria were considered. Patients were admitted to and had their surgery performed in the Day Surgery Unit by the appropriate surgical specialty team. After surgery, patients followed usual well-established discharge protocols.

Results Over a 10-month period, 185 patients (169 adults and 16 children) had their emergency surgery via the ambulatory pathway.

218 hours 21 minutes of in-patient emergency theatre operating time was saved with estimated costs savings of £117,000.

127 (68.65%) patients were discharged the same day. 77 patients avoided a pre-operative overnight hospital admission. Overall 204 bed days were saved at an estimated £45,300.

Operations performed pushed the boundaries of our usual same day discharges and included emergency general and gynaecological diagnostic laparoscopies and laparoscopic cholecystectomies.

Patients were followed up via telephone the next day with 88.89% reporting feeling “good” or “very good” and 100% reporting feeling “satisfied” or “very satisfied.”

Conclusions Our innovative cost neutral pathway allows selected emergency patients to have their journey streamlined. Results clearly demonstrate substantial savings in cost, emergency theatre time, and improved patient and staff experience.

Day Case Shoulder replacement: Myth or Reality

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Background and Aims
Shoulder surgery is recognised as painful requiring patients treated generally as inpatients
Barlborough NHS Treatment Centre (BTC) has introduced a new pathway for patients requiring total shoulder replacement, who meet predefined physical and social criteria, as day cases
BTC decision making focuses on the safety of the patients whilst embracing new and innovative practices
Methods

- Patients predefined physical and social criteria
- The pre, peri and post-operative pathway is explained to the patient to meet patient expectations
- Physiotherapists teach patient's their post-operative exercises pre-operatively
- Interscalene block with analgesia lasting up to 22 hours, no GA
- The scheduling of the surgery is timed
- The surgical technique has been enhanced to minimise operating time and to reduce blood loss.
- Patients are given the consultants on call telephone number for their post-operative night
- A post discharge call by a registered nurse or the operating surgeon is made on the day of discharge
- A 1 day post-operation telephone call by the anaesthetist who performed the block and also a registered nurse
- Physiotherapy review within a week

Results
BTC is unaware of any other hospital in the UK who is able to offer this pathway. To date we have successfully treated thirteen patients. Clinical outcomes and patient satisfaction are to date excellent.

Conclusions
Staff and patients at BTC are excited by the success of this new and innovative pathway but will continue to monitor patient outcomes and listen to patient feedback to help ensure care is tailored to meet patient needs.

Major Ear Surgery – are we meeting expectations?

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Introduction

The British Association of Day Surgery (BADS) has national recommendations for the percentage of operations which could be daycase. Over the last 10 years the recommended rates for major ear surgery have increased. In 2007 suggested day surgery rate for mastoid surgery was 0% this is now 70%1. We audited our day surgery rates for major ear operations against current recommendations and assessed outcomes including post-operative pain, nausea scores, unplanned admissions and patient satisfaction.

Method

Using electronic record systems we identified all patients who had primary tympanic, stapes and mastoid surgeries between January 2013 and July 2017.

Results

202 patients underwent major ear surgery. We have been above the BADS recommendation in all groups since 2014. There were 2 unplanned admissions, for pain and dizziness. Reports of mild post-operative pain were comparable across all procedures and years. Most patients had no post-operative nausea or dizziness. 6% of patients complained of mild post-operative nausea and only one patient reported moderate dizziness. All patients would recommend our unit, being satisfied or very satisfied with their experience.

Conclusion

We need to continue to ensure that we meet the BADS criteria whilst delivery a safe effective pathway for our patients.

Reference

1. British Association of Day Surgery (BADS) Directory of Procedures 5th Edition. Published June 2016.

Analysis of Care Efficiency for patients with Acute Appendicitis suggests potential for Ambulatory Management

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Introduction

Emergency Surgery Ambulatory Clinic could provide an alternative to assessment and management of patients with acute appendicitis. This work aims to assess the efficiency of care offered to inpatients with acute appendicitis, looking specifically at the amount of time during an inpatient stay in which no intervention occurs.

Methods

A retrospective analysis of patient records was performed. Events over the course of an admission were analysed and total time divided into 'red hours' (no intervention occurs) and 'green hours' (Intervention to move management forward). All patients with a coded diagnosis of 'Appendicitis' over a one-month period in 2016 were included in the dataset.

Results

A total of 21 patient records were reviewed during the first round of data collection. Average length of stay was 78 hours 27 minutes. Average time from admission to surgery was 24 hours 14 minutes, and from senior review (registrar and above) to surgery, average time was 9 hours 20 minutes. Average number of green hours was 4 hours 5 minutes, and average red hours were 22 hours 18 minutes.

Conclusions

Data collected shows that patients with acute appendicitis are not managed in an efficient way as an inpatient, with access to diagnostics and theatre availability being main resources which impede flow. Managing patients via a dedicated Emergency Surgical Ambulatory Clinic service run by a consultant, with access to same-same day imaging and dedicated theatre list, is a safe alternative, with potential for real and positive impact on both patient experience and hospital flow.

Reducing antibiotic prophylaxis for TRUS biopsy

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Introduction

Antibiotic prophylaxis for transrectal ultrasound biopsy of the prostate (TRUS) is well established. Our local protocol previously consisted of ciprofloxacin 2-hours pre-biopsy, and post-biopsy metronidazole PR and 5-days of ciprofloxacin. Quinolones are used in many regimes, but resistance is emerging. Single dose quinolone prophylaxis has been shown to be safe and effective. We audited the post TRUS sepsis rate before and after introducing a single dose quinolone regime, screening patients for prior ciprofloxacin resistance and use of alternative agents if known to be resistant.

Patients & Methods

We retrospectively reviewed 160 consecutive patients undergoing TRUS biopsy from Nov16-Feb17. Positive blood & urine cultures were recorded. In conjunction with our microbiology department, a new antibiotic protocol was introduced consisting of a single, pre-procedure dose of ciprofloxacin 750mg. A re-audit was undertaken from Sept-Dec2017 consisting of 118 consecutive biopsies.

Results

The first audit showed that 2 patients (1.25%, n=2/160) had positive cultures and admissions with urosepsis. Both grew E. Coli, one resistant to ciprofloxacin, neither sensitive to metronidazole.
Following introduction of the new protocol, 2 patients (1.69%, n=2/118) had positive cultures and admissions with urosepsis. Microorganisms were - E. Coli resistant to ciprofloxacin and Acinetobacter. There was no significant difference between the groups ($p<0.76$, $X2$ test).

Conclusion

A reduced and simplified antibiotic protocol does not increase the risk of sepsis after TRUS biopsy. The risk of sepsis is increased by atypical or ciprofloxacin resistant organisms. Reducing antibiotic usage could reduce cost, side effects and antibiotic resistance.

Marker Sutures: Are We Doing It Right?

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Introduction

The majority of skin cancer surgery is carried out on a day case basis. The use of marker sutures in the orientation of skin cancer specimens for histological examination is well established. However there are currently no guidelines for their deployment. This study aims to understand current practices and studied various suture types for appropriateness as a marker. We propose changes in practice, improving both efficiency and making potential cost savings for a day case surgical unit.

Method

The study had two arms one a survey and the second experimental. Plastic surgeons from multiple centers answered a questionnaire on current practice. The experimental arm tested the appropriateness of various sutures for use as a marker in realistic reproducible conditions.

Results

A response rate of sixty three per cent gave a credible insight into current practices relating to markers across a range of scenarios. In addition the experiments on the durability of marker sutures identified that only the finer gauge rapidly absorbable sutures were not suitable.

Conclusion

Using our data we draw a number of conclusions allowing us to form guidelines for marker usage. We found that if one of our suggestions was adopted an annual saving of over twelve thousand pounds could be achieved in a single unit alone.
Our marker suture guidelines have the potential to make time and financial savings without compromising good practice across all specialities involved in day case skin cancer surgery.

Water Intoxication after a day case surgery

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Introduction

Hospital acquired Hyponatremia is not as uncommon, yet probably overlooked in terms of its potential associated complications and mortality. Drop in sodium can lead to cerebral oedema as a result of electrolyte-free water moving into the brain cells. The early signs of acute hyponatremia and rising intracranial pressure are often nonspecific and hence often missed.

Case Report

32 year old female patient was admitted for a day case – hysteroscopy for primary infertility. After an uneventful procedure the patient was transferred to Day Case recovery area and she became drowsy. Investigation revealed a sodium level of 117. She was monitored in recovery area and soon she developed generalised seizures and got transferred to HDU for Observation. Slow sodium correction improved her condition within 18 hours and went home next day.

Once back to herself, it was to everyone's surprise to hear to the following statement: "I was asked to drink a lot of water so that I can pass urine [which was a criterion for discharge from a day care surgery, so I drank around 3 litres of water".

The National Patient Safety Agency in the UK has identified hospital-acquired hyponatremia in children and adult as a major patient safety issue. Appropriate monitoring and early intervention remains the key to avoid potentially deadly complications.

Current Operative Practice for Day Case Minor Operations in Plastic Surgery

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Introduction

The aim was to identify current practice regarding minor operations amongst Plastic Surgery Units within the United Kingdom. Specifically, facilities in which procedures are undertaken, sterility precautions employed and personal protective equipment worn.

Method

All Plastic Surgery Units in the United Kingdom were identified through the British Association of Plastic Surgeons website. Units were contacted to complete Telephone questionnaires.

Results

32 units out of 57 units contacted completed the questionnaire (56.1%). 8/32 (25%) of units performed minor operations in an outpatient clinic room setting, 21/32 (65.6%) performed minor operations in a dedicated minor operating theatre, 25/32 (78.1%) did such operations in main theatre.
Procedures performed in an outpatient clinic setting included skin biopsies and exploration of traumatic wounds. 75% do not change into scrubs and 87.5% do not wear a theatre gown.
A variety of procedures were performed in dedicated minor operation theatres with 61.9% performing carpal tunnel releases and 47.6% performing extensor tendon repairs. There is a variation in patient preparation and personal protective equipment between different units.

Conclusion

This study demonstrates a wide variation in current practice in Plastic Surgery across the United Kingdom. Further studies are needed to see if extra precautions affect patient outcomes for minor operations.

The one year outcomes of a pilot study to assess the feasibility of same day discharge following knee arthroplasty

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Introduction

To assess the feasibility of same day discharge for appropriate patients we developed a pilot quality improvement project to facilitate safe same day discharge.

Method

A multi-disciplinary team re-defined and streamlined the patient pathway (pre-operative assessment, admission, post-operative care and discharge) for a narrow subgroup of primary hip and knee arthroplasty patients.
All patients were discharged when mobilising independently with walking aids, stable observations, minimal wound leakage and controlled pain. A physiotherapist attended the patient at home at day one and three, with a nurse if required.
Prospective outcome measures included Oxford scores, timed-get-up-and-go scores, length of stay and 30 day readmission.
The experience, satisfaction and feedback of the patient and multi-disciplinary team members were used to continually modify the pathway according to the plan-do-study-act method of quality improvement.

Results

11 patients were entered into this pilot. Of these, eight went home on the day of surgery and three were discharged the following day. Reasons for an overnight stay were bleeding, nausea and vomiting and poor control of pain. There were two readmissions (one possible wound infection and one Guillain Barre syndrome).
By the time of the meeting our one year outcomes will be available. We will also present our current position and pathway.

Conclusions

Safe same day discharge is achievable for carefully selected knee arthroplasty patients with the support of a committed multi-disciplinary team. Our project has potentially far reaching cost and health benefits for patients.

Use of SurgiAssist-Laparoscopic Camera Holder for Cholecystectomy

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Introduction

Laparoscopic cholecystectomy requires good views for which the surgeon is dependent on the camera person whose experience is variable. Staff shortages mean that a camera person may not be available. We overcame such issues by using the SurgiAssist laparoscopic camera holder. We describe our early experience.

Methods

We used SurgiAssist mechanical camera holder to perform a total of 7 day case laparoscopic cholecystectomy. 6 were performed by a single consultant and 1 by a trainee surgeon under direct supervision. The laparoscopic camera holder was used in unselected day cases when no surgical assistant was available.

Results

All cases were performed without any increase in operating time. No complications were noted in these patients.

Discussion

SurgiAssist is reusable camera holder with metallic arms secured to the operating table on which the laparoscopic telescope is mounted. SurgiAssist requires no sterilization; sterile disposable covers are used to ensure asepsis. Once set, the SurgiAssist maintains a static view, however, the surgeon has full access to adjust the length of the telescope insertion and telescope head's zoom and focus controls.

Conclusion

SurgiAssist is a potentially cost-effective solution to address the variable experience and the shortage of camera holding assistants in day surgeries for laparoscopic cholecystectomy.

Keywords: Laparoscopy; laparoscopic camera holder, cholecystectomy

Reference

Aiono S, Gilbert JM, Soin B, Finlay PA, Gordon A. Controlled trial of the introduction of a robotic camera assistant (EndoAssist) for laparoscopic cholecystectomy. Surg Endosc 2002; 16: 1267–70

Preoperative pain planning and management: A critical ethnographic examination and exploration of day surgery practices

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Introduction

As postoperative pain is predictable, individualised analgesic requirements should be explored preoperatively. However, while there is an abundance of literature examining pain planning for inpatients, there is limited research investigating whether pain planning is adequate and comprehensive for day surgery patients.

Methods

To examine how culture influences pain planning practices; a critical ethnographic methodological approach was adopted, utilising quantitative and qualitative methods of data collection. Data were analysed using reconstructive analysis and triangulated with the numerical data that was statistically analysed.

Results

Over eight months, 130 hours of practice were observed, incorporating 100 preoperative anaesthetic visits, 24 nurse-led preoperative assessments and in addition, 20 staff interviews were conducted. Four central themes emerged from the data: 'patient safety', 'surgical productivity', 'power and paternalism', and 'unconscious bias'. Within the culture of the perioperative department, safety was frequently prioritised over holistic pain planning and management. High levels of productivity negatively impacted on the quality of preoperative interactions. Power within interactions was unequal and paternalistic practices limited nursing staff autonomy and patient empowerment. Decisions about pain management were sometimes influenced by healthcare professionals' negative unconscious biases towards specific surgical specialities and patient gender.

Conclusions

Cultural work-based practices are varied, particularly regarding the length of time spent discussing pain, the language used during pain discussions and the depth and quality of the pain interactions. Healthcare professionals, therefore, need to be cognisant of how these varied cultural practices impact on their interactions and pain planning and management decisions to ensure pain is treated holistically.

A successful revolution in day case breast surgery

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Introduction

The British Association of Day Surgery (BADS) recommends that 95% of conservative breast cancer surgery and 50% of mastectomies for breast cancer are performed as day case. Despite Torbay Hospital being one of the top performers in the country for day case rates for most procedures, in January 2015 we were ranked in the lowest quartile nationally for day case rates for breast cancer surgery.
We present our strategy for revolutionising our day case breast surgery service

Methodology

A multidisciplinary team developed day case pathways for patients undergoing breast cancer surgery. In January 2015 the pathway for conservative surgery was introduced. The pathway for mastectomies was introduced in January 2017

Results

Between 1st January 2015 and 30th September 2017, the day case rates for conservative surgery improved from 16.5% to 97.8%. During the same time frame, the rates for mastectomies improved from 0% to 85.7%.
Between 1st October 2015 and 30th September 2017, 356 procedures were successfully performed as a day case. Follow up data exists for 288 (81%) of these patients; 100% of these patients were satisfied with the day surgery service provided.
National benchmarking for day case rates now rank us as 14th for mastectomy, 3rd for wide local excision of breast tissue and 2nd for sentinel lymph node biopsy

Conclusion

By introducing these pathways, we have revolutionised our service, achieved the BADS day case targets and are now one of the top performers nationally.

Introduction and development of Sheffield hot laparoscopic cholecystectomy pathway: improving patient's journey

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Introduction

There is increasing evidence for laparoscopic cholecystectomy (LC) to be performed at index admission. However this is difficult to implement due to challenges related to availability of theatre lists and experienced surgeons.LC attracts best practice tariff only if performed as a day-case. Our unit developed a Hot LC pathway where patients are discharged after index admission to come in within a week of discharge for a day-case LC performed on dedicated theatre lists. This study evaluates efficiency of our pathway.

Methods

Consecutive patients referred to the Hot LC pathway were studied. Referral criteria included fit patients with biliary colic, cholecystitis (<10 days duration) or pancreatitis. Postoperative length of stay, readmissions, total inpatient stay (index + LC), conversion rate and complications were analysed.

Results

Hot LC was performed in 368 patients over a three year period with a conversion to open rate of 2%. Significant complications were bile leak in 2(0.54%) and haemorrhage in 1(0.27%). There were no bile duct injuries. Length of stay for hot LC was zero days in 48%; one day in 33% and >1 day in 19% patients. Readmission rate after Hot LC was 4.9%. Hot LC reduced mean total inpatient stay to 4 bed-days compared to 8 bed-days (historical controls). The minimum in-patient bed cost saved through this pathway was £800/patient.

Conclusion

Development of a Hot LC pathway has allowed us to offer LC in the acute setting safely and efficiently with no excess complications and with reduction in total stay.

Is a Group and Save Sample Necessary for Elective Laparoscopic Cholecystectomy?

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Introduction

Laparoscopic cholecystectomies are one of the most common elective operations performed, with minimal blood loss anticipated. At our department, theatre lists were delayed due to problems obtaining a second group and save sample for patients prior to their operation. Obtaining and processing potentially unnecessary blood samples has implications for patients and cost.

Methods

All elective patients who underwent a laparoscopic cholecystectomy under the care of the Upper Gastrointestinal surgical team were identified from theatre lists between May and November 2017. Data on whether these patients needed blood transfusion was collected from the lab database and our electronic patient record system.

Results

114 patients underwent an elective laparoscopic cholecystectomy between May and November 2017. No patients required blood transfusion in the aforementioned period. Over a period of 2 years, between 2014 and 216, only 1 out of 421 patients required blood transfusion. The cost of processing one blood sample at our lab is £8-10.

Conclusions

We conclude that it is safe to omit the second group and save sample for our group of patients. We have continued to take a first sample at pre-operative assessment and a second sample taken for any patient who is deemed high risk of requiring blood. In future we propose that one sample could be taken with O negative blood given if required, or to omit group and save samples altogether, which could save our trust upwards of £2000 a year.

A review of pre-operative anticoagulant and antiplatelet prescribing in a plastic surgery outpatient local anaesthetic clinic

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Introduction

Anticoagulant (AC) and antiplatelet (AP) medications can cause haematoma formation, which for patients undergoing operations can lead to poor wound-healing and ultimately a poor outcome. However, by stopping these medications pre-operatively, surgeons run the risk of their patients developing thrombotic complications. Pre-operative prescribing of AC/AP in an outpatient local anaesthetic (OPLA) clinic was reviewed to evaluate if this practice adhered to Cambridge University Hospital (CUH) guidelines.

Method

The CUH computerised patient record system (EPIC), identified OPLA patients that were prescribed an AC/AP. The number of days their AC/AP was withheld (as stated in the pre-operative clinic letter), was compared to CUH trust guideline recommendations. The initial data collected from Sept-Dec 2016 was presented to CUH plastic surgery department doctors, at this time they were also familiarised with trust guidelines and posters highlighting these principles were displayed in pre-assessment clinics for guidance. The second cycle of data collection was performed from Dec. 2017-Jan. 2018.

Results

157 patients were included in data collection. The audit's second cycle of data collection demonstrated a 27% improvement in adherence to CUH pre-operative AC/AP prescribing guidelines. Warfarin was found to be prescribed incorrectly most frequently.

Conclusion

A clear improvement was demonstrated in pre-operative AC/AP prescribing following departmental teaching and the displaying of posters. However, adherence to trust guidelines can still be developed. According to trust guidelines, AC/AP should not be stopped pre-operatively for procedures considered to have a low-bleeding risk and this should encompass all OPLA cases.

Older age, prognosis and complexity of non-reconstructive procedure should not influence patient selection for day case breast cancer surgery

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Introduction

Although many breast procedures can be delivered as a day case safely, rates vary nationally, usually due to professional uncertainty about patient selection and outcome. Audit of the first 10 years of a day surgery pathway at King's Breast Care was undertaken to challenge these perceptions.

Methods

Demographic, histological and admission data was collected on all non-reconstructive breast cancer surgery from March 2006 until the end of February 2016. Use of drains and routine seroma aspiration had been stopped prior to 2006.Breast cancer prognosis was estimated using The Nottingham Prognostic Index (based on tumour size, grade, lymph node status), which defines five groups (excellent prognostic group, EPG: good prognostic group GPG: moderate prognostic group1, MPG1: moderate prognostic group2, MPG2; poor prognostic group, PPG).

Results

1586 women underwent 1892 surgical procedures. Between 2006 to 2016, irrespective of surgical complexity, day case admissions increased from 56% to 97%. Eighty-three per cent of bilateral surgeries were discharged the same day. The proportion having day surgery was not influenced by age (< 40 years 85%, > 80 years 84%) or prognostic group (EPG 89%; GPG 94%; MPG1 87%; MPG2 88%; PPG 84%).The median annual unplanned admission rate was 1.7% (range 0% to 5.2%); in-patient re-admission within 30 days was 0.6%, with a median duration of stay of 5 (range 2 to 11) days.

Conclusions

Use of established pre-operative eligibility criteria are safe when designing a breast day surgery pathway. Re-admission rates are not increased if drains and routine seroma aspiration are omitted.

Day case surgery and surgical training

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Introduction

Recent advances means that booking patients for day surgery has become the default for many elective surgeries. Guidance suggests day case surgery should be performed consultants due to the increasingly complex nature of these patients. This could affect training in general surgery. Few studies have assessed the general surgical trainee experience of day surgery.

Methods

The logbooks of 5 core surgical trainees (CSTs) were examined over a three month period (07/12/2017 – 06/03/2018). Statistical analysis was performed using Fisher exact test to identify factors affecting trainee involvement in surgical cases.

Results

A total of 281 procedures were recorded of which the majority were planned day case procedures (n=165).
Trainees were exposed to a mean of 33 day case procedures compared to 19 emergency cases each. Trainees recorded 39.5% of day case procedures as performed by them compared to 0% of elective procedures requiring planned admission (p=0.0001).
Day surgery case mix included 60 abdominal wall hernia repairs, 40 laparoscopic cholecystectomies, 34 simple skin biopsy / excisions and 31 other.
Trainees were more likely to perform a procedure when attending a day case list with the consultant only (p=0.0004).

Conclusions

Day surgery provides good training to general surgical trainees compared to emergency theatre and other elective surgery. Trainees are exposed to a reasonable case mix, performing a high percentage of cases. This is particularly the case when supervised by a consultant. Further research should be undertaken to assess the benefits of day surgery and how to formally incorporate this into surgical training.

A prospective service evaluation of a tertiary centre following the introduction of a new day case procedure: urolift®

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Background

The prostatic urethral lift (PUL) is a novel day case technique that has demonstrated successful sustainable results, for up to 5 years, for the management of benign prostatic obstruction secondary to BPH. In 2016 EAU included PUL into its guidelines for the management of LUTS. Here we review our centre's experience with Urolift®.

Methods

Prospective service evaluation of all patients who have undergone a Urolift® procedure from its introduction to our services in July 2017.

Results

A total of 74 patients have undergone a Urolift® procedure. Indications include; BPH (61%) retention (30%), HPCR (5%) and prostate cancer (4%). Average age was 69 years (range 48-87), average Qmax 8ml/s (3-15.9ml/s) and the average PVR 270mls (10-4000mls). Prostate size was large (53%), moderate (22%) and small (25%). 11% were re-admitted within 30 days for Clavien-Dindo I complications. 43% have had successful results and been discharged. 32% are awaiting follow-up. 25% require further management including; 8% ISC, all of which had pre-operative catheters for retention (n=4) or HPCR (n=2). 7% require a TURP/HoLEP. All of these patients had large prostates bar 1 who is under active surveillance for prostate cancer. 6% are awaiting urodynamics for OAB symptoms, and 3% are undergoing intravesical Botox.

Conclusion

Urolift has been extended within our practice to include patients' with retention and prostate cancer. There are overall low complication rates and although 25% require further management these patients all have significant BPH, OAB or prostate cancer.

Combining robotically-assisted surgery and enhanced recovery pathways in radical prostatectomy – delivering rapid recovery and ambulatory (day case) surgery

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Introduction
To describe the implementation of a robotically-assisted radical prostatectomy (RALP) programme in a UK cancer centre within an established enhanced recovery programme (ERP), including the impact on length of stay (LOS). We also describe our experience of providing RALP as ambulatory (daycase) surgery. The Exeter ERP has been described previously and has been in place at our institution for cystectomy and open radical prostatectomy since 2008.

Methods
972 consecutive patients underwent RALP between January 2013 and August 2017, by 6 consultant surgeons. All patients were entered into an ERP. Data were collected prospectively on the British Association of Urological Surgeons (BAUS) audit and data platform, and downloaded to an Excel spread sheet for analysis. Data were supplemented as required by review of electronic patient records.

Results
970 consecutive patients underwent robotically-assisted surgery, with the remainder converted to open. Median LOS was 1 day (mean 1.25 days), including 38 patients who underwent ambulatory surgery. The rate of Clavien Dindo ≥3 complications was 1.1% during the initial admission, with a 5.1% re-admission rate, the majority of which were for low grade complications.

Conclusions
RALP can be safely implemented within an established ERP, with an associated short LOS and a low complication rate. With careful patient selection and education, ambulatory surgery can also be offered.

Prediction of overnight admission for planned day-case urology sacral neuromodulation procedures

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Introduction

Sacral neuromodulation is a treatment which helps to restore normal bladder function by sending electrical signals to the nerves that control the bladder. It can be used for a variety of bladder conditions including urinary retention and over-active bladder.

Methods

In our institution, surgeon preference is to perform the procedure under general or regional anaesthetic. We audited admission rates, mode of anaesthesia, and drug related factors over a two year period (April 2016 – March 2018), to determine which patients were more likely require overnight admission.

Results

There were 97 patients in the two year period; 87 female, 10 male. The mean age was 46 years (range 19-78years). The overall admission rate was 15%. The length of stay for those admitted was between 1 and 7 days. Reasons for admission were unclear (5 patients), pain (3), possible infection (3), functional neurology (2), suicidal ideation (1) and drowsiness (1). Of the patients requiring overnight stay 87% were aged under 35, 73 % were on antidepressants, and 60% were on opioid medication.
Chance of admission if:

- under 35 years was 38%, versus 3% in over 35 years.
- taking an antidepressant was 26% versus 7% if not .
- taking a short-acting opioid was 28% versus 10% if not.
- taking a long-acting opioid was 47% versus 9% if not.

Conclusion

Risk of admission can be predicted using age and pre-operative medication, allowing better planning in our daycase unit. If aged under 35 and on opioid and antidepressant medication, the risk of overnight admission was 75%.

A survey of anaesthetic practice for patients with Obstructive Sleep Apnoea in a Day Case setting

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Introduction
Obstructive Sleep Apnoea (OSA) is a risk factor for adverse perioperative outcomes and is associated with increased all-cause mortality. Concerns arise when managing these patients in day case as there is currently a lack of guidance over which cohort can be managed safely in this setting.

Methods
The authors designed a qualitative survey based on 3 hypothetical scenarios of patients with OSA undergoing ambulatory surgery. The scenarios explored attitudes towards patients with: presumed OSA, poor CPAP compliance, poorly managed co-morbidities and patients undergoing urgent surgery and surgery requiring opiates. The survey focussed on the peri-operative plan and was distributed amongst Anaesthetists of all training grades over a 7 day period.

Results
Thirty-three responses were collected. For each of the 3 scenarios; 6%, 9% and 15% respectively continued with the case in an ambulatory setting, 40%, 67% and 30% chose to admit the patient to the ward post-operatively, whilst 24%, 21% and 3% preferred critical care admission and 30%, 3% and 52% chose to cancel the case. 33%,7% and 38% used Morphine as part of the intra-operative analgesia plan.

Discussion
The results demonstrated a wide variation in clinical practice. The authors felt all 3 vignettes were unsuitable for ambulatory care due to either non-compliance with CPAP, poorly controlled co-morbidities or need for opiates; all of which have been identified as risk factors for peri-operative adverse outcomes. Routine pre-operative screening and an algorithm to exclude patients with these risk factors from undergoing ambulatory surgery are potential solutions to standardise practice.

Checking our Local Anaesthetic patients are getting the service they deserve

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The Rotherham NHS Foundation Trust, Rotherham, United Kingdom

Introduction

As recommend by the Royal College of Anaesthetists, regular reviews of services should be undertaken. The focus of this service evaluation was patients having procedures under local anaesthetic (LA) in our day surgery unit (DSU).

Methods

Over a one-week period in March 2018, all patients undergoing LA procedures through our DSU had a retrospective, manual review of their notes. Data collected included premedication, specialty, surgery type and duration, local anaesthetic drug and dose, the need for intra and post-procedural anti-emetics and analgesia as well as length of stay (LOS).

Results

Nineteen LA cases were identified, 21% of the day cases undertaken that week. 79% of patients received a Paracetamol pre-med and one also received Ibuprofen SR 1600mg. 58% of patients were undergoing Orthopaedic procedures, with the remainder Maxillofacial or Dental 16%, Urology 11%, General Surgery 11% and ENT 5%. Procedures ranged in length from 10 minutes (shoulder joint injection) to 95 minutes (excision of a basal cell carcinoma), with an average length of 39 minutes. The average time to discharge from arrival onto the recovery ward was 57 minutes, with stays in recovery ranging from 25 minutes to 150 minutes. No patients required post-procedural anti-emetics or analgesia. No patients were converted to general anaesthesia, required sedation or needed admission to hospital.

Conclusions

Although documentation in some areas could be improved upon, it appears patients undergoing LA procedures have an efficient and comfortable course through our DSU with 71% being discharged within 1 hour of the completion of their procedure.

Introducing Uni-compartment knee replacement (UCKR) as a day case to Rotherham Foundation Trust Hospital

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Introduction

Knee replacements have become established as day surgery in some centres for many years. We wish to introduce this service to our hospital to improve patient experience and efficiency.

Method

This process was set up by a multidisciplinary team. Any patient listed for a Uni-Compartment Knee Replacement (UCKR) was eligible for the pathway. On the day of surgery the surgeon or anaesthetist could declare if the patients were unsuitable otherwise the nursing and physiotherapy teams on the Orthopaedic ward would aim to have the patient discharged by 19.30.

Results

Data collection commenced 1.09.17. There have been 20 patients listed for UCKR; 3 patients excluded from trial (2 had bilateral UCKR and 1 for comorbidities). 17 patients were considered for same day discharge (10 males and 7 females) with age range of 50-74 years. 8 had incomplete data. 5 (4 males and 1 female) out of 9 (6 males and 3 females) were successfully discharged home the same day with no readmissions. 1 patient reported mild pain at home while other 4 reported moderate to severe pain at home. Reasons for failed discharge included vomiting, wound leakage, dizziness, spinal anaesthesia not worn off and sever pain.

Conclusion

Although numbers have been small we have shown that we can successfully and safely send patients home the same day following UCKR. There are still some issues that need addressing before transferring this pathway to the Day Surgery Unit but we intend to do this in the future.

Developing a day case pathway for laparoscopic pyeloplasty

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Introduction

Laparoscopic pyeloplasty (LP) for pelvi-ureteric obstruction (PUJ) has been shown to be a safe and feasible procedure in the setting of daycase surgery1. In the UK, the vast majority of patients undergoing LP stay in hospital 1-2 days. We set out to challenge the prevailing surgical culture and introduce a paradigm shift within our organisation towards establishing daycase LP.

Methods

Since February 2018, we have implemented LP as a daycase procedure. This has been facilitated using the BAUS Enhanced Recovery Pathway2. All patients who fulfilled the criteria for daycase surgery were included. The aims were to provide successful surgery (improved symptoms and preserve renal function), minimise length of stay (same-day discharge) and achieve high levels of patient satisfaction (quality of recovery after anaesthesia (QOR))3.

Results

Seven patients (ASA 1-2) have undergone LP on the daycase unit. Five patients underwent same-day discharge; one patient was discharged after an overnight stay, at their request; and one patient stayed 4 days. There were no readmissions following discharge and no interim complications. Surgical outcomes from renograms are pending. QOR implies patients feeling well supported at home with good postoperative analgesia and minimal nausea/vomiting at 24 hours.

Conclusions

Early results demonstrate that LP can be undertaken safely, with self-reported patient satisfaction in the daycase setting. This paradigm shift in approach has the potential to offer patients a viable alternative to inpatient treatment, with conferred organisational benefits.

References

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Survey of practices and practicalities of day case spinal anaesthesia among British Association of Day Surgery (BADS) anaesthetists

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Introduction

With a wider range of patients and procedures now considered suitable for day surgery and newer local anaesthetics with quick onset of action and shorter duration of action available for spinal anaesthesia use, we wished to explore the practice and perceptions of spinal anaesthesia in day surgery.

Method

An online survey was sent out to all British Association of Day Surgery (BADS) members, with anaesthetists selected to complete the survey.

Results

The survey was sent to 292 members with 52 anaesthetists responding. All anaesthetised day case patients at least once a week, and all encountered patients where spinal anaesthesia would be appropriate. 44% performed day case spinals at least once a month, with 17% never doing any. The most common reason given for not doing day case spinals was patient choice (27%), with no stock of suitable short acting local anaesthetic the next. 17% felt resistance from surgeons and day surgery staff was the main reason for avoiding spinals in day case patients. Among those performing day case spinals less than once per month, the main reason for not doing a spinal when deemed appropriate was lack of suitable short acting LA (30%). 2% hyperbaric Prilocaine was the most common LA used (33/52) with only 6 anaesthetists using 1% 2-Chlorprocaine

Conclusions

The survey showed that access to short acting LA may be affecting the number of day case spinals done. There also seems to still be some resistance to day case spinals from patients and /or staff.

The Redundant Role of Preoperative 'Group and Save' for Laparoscopic Cholecystectomy

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Introduction

Historically, a 'Group and Save' (G&S) comprises one of the routine blood tests performed pre-operatively for patients undergoing laparoscopic cholecystectomy (LC). At some trusts, two separate group and save samples taken at different sites and at different times are mandated. It has been approximated that 0.9% of patients undergoing LC will require a blood transfusion. In patients requiring blood transfusion, the addition of a preoperative Group and Save may add little benefit.

Methods

The G&S is not included in guidance on preoperative investigations from NICE and British Association of Day Surgery. Various institutions have reported transfusion rates for LC, and these have been used as the standard in this audit. Retrospective data, including patient details, nature of procedure, requiring and timing for transfusion, was collected for all LCs over one year (n=493). Consequently, protocol was adjusted and the process re-audited and cost analysis performed.

Results

98% of patients undergoing LC had a preoperative G&S taken. A total of 883 group and saves were processed by the lab pertaining to laparoscopic cholecystectomy. Two patients required transfusion, both in the postoperative period. A preoperative G&S did not impact timing of transfusion in either case. Modification of the preoperative assessment protocol reduced G&S samples to 16% of patients.

Conclusion

A preoperative G&S did not impact management for any patient undergoing LC, and therefore should be removed from routine preoperative investigations. This will lead to a saving of £13,245 at our trust.

A qualitative Survey of Patient Experience and Outcomes after Prilocaine Spinal for Ano-rectal Surgery

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Introduction

A significant volume of anorectal surgery in our institution is performed as day case. Many of these cases are in the prone position for ease of surgical access. Previous work has demonstrated that short-acting spinal with prilocaine is effective in terms of analgesia and anaesthesia. We wanted to evaluate patient, surgeon and staff experience as well as time to discharge between patients having spinals and those having general anaesthetic (GA).

Methods

Patients received either GA or Spinal with prilocaine and target controlled sedation, according to choice, after informed consent. A questionnaire was completed by the surgeon, theatre team and patient at specific points through the patient pathway. 20 patients were included with equal numbers in each group.

Results

Duration of anaesthesia, operating time and length of stay were comparable between the groups. Patient satisfaction was high in both groups and the incidence of side effects was low. All of the spinal patients could self-position prone except one who was very frail. All patients could co-operate and the surgeon found it useful for them to be able to strain in 70% of cases. Surgeons and theatre staff showed a preference for spinal anaesthesia and free text comments reflected the surgical view that this technique is superior for day case anorectal surgery.

Conclusions

Short acting spinal anaesthesia is a well-tolerated alternative to GA for short anorectal procedures allowing safer positioning and better operating conditions with good patient experiences.

Formulation of an anaesthetic day surgery reference guide – a service improvement project

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Introduction

Nottingham City Hospital has a designated, separate two theatre Day Surgery Unit (DSU) incorporating various surgical specialities. A limited number of consultant/SAS anaesthetists cover the same lists weekly/fortnightly and are experienced in each list's issues. Staff occasionally observed a possible decrease in patient recovery parameters when anaesthetists less familiar with the list or DSU were covering.
We therefore created an anaesthetic reference guide, comprising a comprehensive collection of key anaesthetic approaches for each surgical list, analgesia and paperwork guidance. This should provide a useful tool for those unfamiliar with the DSU, so improving staff/patient satisfaction and safety.

Methods

Regular DSU consultants/SAS advised regarding the specific issues of their list: pain, positioning, patients, duration, surgeon foibles etc. The information was collated under relevant surgical specialities. Copies of the guide made available within the DSU clinic rooms and theatres.
Following its introduction, a snapshot survey of consultants and trainees was performed.

Results

Of the 18 respondents, 72% did not have regular exposure to lists within the DSU. Overall over 80% stated they would find the guide helpful; 67% rating it as very or extremely useful. This seemed particularly relevant to trainees, as reflected in the open comments section. Only one third of respondents were aware of the availability of the guide.

Conclusion

Positive feedback suggests this guide may be a helpful tool for trainees and consultants. However wider promotion of the guide is needed, for example at new trainee's induction, and via the local on-line anaesthetic site.

Does high body mass index impact surgical outcomes and hospital cost for day case laparoscopic cholecystectomy?

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Introduction

Obesity is a known risk factor for the formation of gallstones and has a prevalence of 27% in the UK. High body mass index (BMI) has been associated with poorer perioperative outcomes such as increased operative time and a higher incidence of conversion to open surgery though this risk may be an overestimation. The purpose of this study is to evaluate the outcomes and costs associated with day case laparoscopic cholecystectomy (DCLC) in morbidly obese patients.

Methods

A retrospective analysis of patients who underwent DCLC between December 2015 and November 2017 was performed. Anaesthetic and operating times, pre-operative complications, 28-day readmissions and average costs were compared among WHO classifications for BMI.

Results

There were 332 patients who were listed for DCLC. Morbidly obese patients had a longer anaesthetic and operative time of 4 and 8 minutes respectively compared to healthy patients (24 vs. 20, $p<0.005$; 60 vs. 52 $p<0.001$) There was no significant difference in postoperative complications (2 vs. 1, $p=0.392$) cost (£161.96 vs. £162.40 $p=0.364$) or readmissions (8 vs. 2, $p=0.149$) between morbidly obese and healthy patients. There was no difference in length of stay postoperative (0 vs. 0, $p=0.371$) or proportion of successful DCLC (66 vs. 62%, $p=0.655$).

Conclusions

With rising prevalence of obesity in the UK and chronic bed shortages, indications for inpatient admissions in under scrutiny. This study has shown that morbid obesity is not a contraindication to DCLC and is neither associated with worse outcomes or higher costs.

POSTER ABSTRACTS

Tonsillectomy: Reducing Length of Stay and Increasing Day Surgery Rate

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Aims
85% of tonsillectomies should be completed as day-case operations. This rate was 33% in the University Hospital of South Manchester (UHSM) in April 2015.This study will focus on identifying factors that could be contributing to this low rate, in order to decrease length of stay following tonsillectomy.

Methods
Tonsillectomies were accessed from April 2015, October 2014 and April 2014, with patient details recorded. The case notes were then requested and a pro forma made to include a variety of information regarding the patient and operation.

Results
A total of 62 patients had tonsillectomies done across the 3 months of the study. 8 were not included. The day-case rate was 31% in April 2015, 50% in October 2014, and 65% in April 2014. In total, 27 patients were managed as day cases (50%).
Patients under the age of 6 had a low day-case rate of 29%. 68% of bilateral tonsillectomies were completed as day cases, in contrast to 21% of adenotonsillectomies.
64% of operations done in the morning were completed as day cases, in comparison to 22% performed in the afternoon. Operations done as day-case averaged 25.6 minutes, while overnight stay averaged 31.4 minutes. 10% of patients with sleep apnoea, and 20% of patients with complications, were managed as day cases.

Conclusion
The day-case rate of tonsillectomies performed at UHSM are significantly below the required standards of 85%. Several contributing factors were identified: younger patients, afternoon operations, type of procedure (adenotonsillectomy), prolonged duration of surgery, sleep apnoea, and complications.

The introduction of day case Transurethral Resection of the Prostate at a District General Hospital in the South of England

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Introduction

Approximately 25,000 transurethral resections of the prostate (TURP) are completed per year in the UK, with a total cost of £53 million. The British Association of Day Surgery has recommended that 15% of TURPs should be completed as day surgery.

Methods

We aimed to establish day case TURP at the Royal Hampshire County Hospital, a District General Hospital in the South of England. We analysed our current data as a baseline, and to understand which patients would be suitable for day case TURP. We put in place the necessary clinical, administrative and managerial structures to allow the hospital to run a day case TURP service, and present a framework for doing so.

We are currently completing the first Plan, Do, Study, Act Cycle as recommended by NHS Improvement. Our primary outcome measures are: percentage of planned day case conversion to inpatient stay; readmission rate; and patient feedback, to be analysed using qualitative thematic content analysis. Our secondary outcome measures will also analyse: complications related to readmission using the Clavien-Dindo classification; length of stay; financial impact of change in length of stay; percentage trial without catheter success rate; and prostatic resection weight.

We aim to complete multiple PDSA cycles to ultimately meet the 15% British Association of Day Surgery target.

Spinal vs. General Anaesthesia for Laparoscopic Cholecystectomy: A Review of Current Literature

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Introduction

Laparoscopic cholecystectomy (LC) has become a gold standard intervention with reduced post-operative pain and length of hospital stay. A practicable, safe anaesthetic approach conferring similar benefit would improve post-operative recovery. Studies have shown promise for the use of spinal instead of general anaesthesia.

Methods

Aim: compare the effects of LC under spinal anaesthesia with LC under general anaesthesia, looking primarily at post-operative pain scores (using median Visual Analogue Score [VAS] pain scores at 4, 8 and 24 hours post-op) but also with regards to length of stay, cost and patient satisfaction. Initially 40 trials were identified via computerised searches of Cochrane Central Register of Controlled Trials (CENTRAL), PubMed and MEDLINE (all up to December 2017). Selection criteria (using PRISMA) narrowed this to 8. Statistical comparisons were done using RevMan v5.3.

Results

Eight trials with 501 participants were included in the review. Results show with regards to:

Primary outcome:

VAS pain scores were significantly reduced in spinal anaesthesia patient group compared to general anaesthesia patient group at 4 hour (SMD -0.45, 95% CI -0.68 to -0.23), 8 hour (SMD -0.23, 95% CI -0.46 to -0.01) and 24 hour (SMD -0.16, 95% CI -0.37 to -0.04) intervals.

Secondary outcomes:

2/4 trials reported significantly reduced length of stay with spinal,
4/4 trials reported significantly reduced cost with spinal.

Conclusions

Spinal anaesthesia for laparoscopic cholecystectomy results in reduced pain at all stages of a typical post-operative period compared to general, with a reduced length of stay and improved feasibility from reduced cost.

Can patients be pain free following hand surgery for 24hours with Axillary Brachial Plexus Blocks + Peripheral Blocks?

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Introduction

At Sheffield Teaching Hospitals (STH) we perform over 3000 operations on hands and wrists each year, 90% of these patients are anaesthetised by the Physicians Assistants Anaesthesia (PAAs). Nearly all patients elected to undergo Regional Anaesthesia (RA) for their surgery.

Methods

Consent was obtained from the patient for a follow up telephone call the day following surgery. Data collected showed the type of surgery, duration and the type and volume of local anaesthetic used, and was recorded on the day. The follow up call captured data relating to the time the patient experienced the return of motor function, the time the patient experienced pain over the operative site and what (if any) oral analgesics they self-administered. This was categorised according to when they took said analgesics, and whether or not the ABPB was supplemented with peripheral nerve blocks.

Results

We captured 72 patients who had received an ABPB. Quantitative and qualitative data was captured. The results showed the patient group who had peripheral nerve blocks in addition to ABPB was lower than the group undergoing ABPB alone, also a reduction in mean pain scores in the group who self-administered oral analgesics while the block was still working compared to those where the block was wearing off and after the onset of pain.

Conclusion

The service evaluation concludes that the addition of peripheral nerve blocks as a strategy for post-operative relief positively impacted the patient's experience, as did specific advice regarding the timing of oral analgesics.

Day case emergencies – the challenge of surgical management of miscarriage (SMM)

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Introduction

Miscarriage is common, occurring in about 20% of pregnancies. Experiencing a miscarriage is incredibly distressing for both the patient and their family. Management of miscarriage can either be medical or surgical. Surgical management of miscarriage (SMM) is a common day-case emergency procedure, but there is no consensus on where these patients should be cared for perioperatively. NICE recommends tailoring healthcare services for each patient. We look at how the hospitals in our region care for these vulnerable patients.

Methods

We conducted a regional survey across the South West to investigate how these patients are managed, receiving a 70% response rate. Using the results, we targeted a variety of stake-holders to make some changes, both within our trust and across the region.

Results

Hospitals manage up to 40 SMM patients a month. 43% of patients have procedures in maternity theatre (alongside elective deliveries), 57% in gynaecology or general emergency theatres. 72% of clinicians feel these patients are not receiving care in an optimal environment, and no clinician believes these patients should be managed in maternity theatre. There is room for improvement!

Conclusions

The majority of SMM patients in the South West are managed in maternity theatres, where they are surrounded by audible and visual reminders of new-born babies. Our work demonstrates that clinicians feel this should change. We share the strategies we are currently using to improve this service including the challenges of change in a large teaching hospital that involves colleagues from a variety of different disciplines.

A review of day case hysterectomies in a district general hospital day surgery unit

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Introduction

Hysterectomies are common procedures usually performed via an inpatient pathway. However, there is evidence that day-case surgery is safe and has a high level of patient satisfaction for a variety of gynaecological procedures, as well as providing a cost-effective, bed-saving service. This audit provides a review of patient outcomes and satisfaction following hysterectomy in our day surgery unit.

Methods

The routinely collected dataset for patients undergoing hysterectomies over a 24 month period was reviewed; fields of interest included admission rates, reason for admission and patient satisfaction.

Results

354 hysterectomies were performed of which 169 (48%) were via a day case pathway. 70 of 105 (75%) vaginal hysterectomies and 90 of 202 (45%) laparoscopic hysterectomies were planned as day case procedures.
44 (26%) day case patients required admission. The most common reasons for admission were pain and surgical complications. Of those who were discharged, 100% were satisfied or very satisfied with their experience.

Discussion

This audit has demonstrated that day-case hysterectomies can be successfully performed with an acceptable admission rate, minimal post-op morbidity and excellent patient satisfaction. Changes in anaesthetic technique and post-operative pain management could help reduce the admission rate and improve this service further.

An audit of cancellations on the Day Procedure Unit at the Norfolk and Norwich University Hospital

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Introduction

Performing operations as a day case can minimise morbidity, reduce waiting lists and improve patient satisfaction. Cancelling operations, particularly on the day of surgery, can reduce theatre utilisation, impact on waiting lists and decrease patient satisfaction. We have reviewed the cancellation of operations in our Day Procedure Unit (DPU)

Methods

We retrospectively reviewed data from our hospital computer database on cancelled day case operations over a 4 month period. We recorded specialty, operation, number of days before surgery that the operation was cancelled and reason for cancellation (pre-set options).

Results

724 operations were cancelled, 38.3% of these occurred on the day of the planned operation. Analysing initial data identified 2 specialties (urology and pain management) which accounted for the highest proportions of cancellations. A high number of on the day cancellations occurring within urology are entered as 'patient unfit, cancelled by hospital', additional comments show just over half of these are due to the detection of a urinary tract infection (UTI) on arrival for surgery. We are reviewing our current processes and re-auditing a pre-assessment pathway that identifies UTIs in certain elective urological surgical patients. Did not attend (DNA) and operation not needed are the commonest reasons for on the day cancellations for pain management.

Conclusions

A reduction in the number of cancelled operations would improve theatre utilisation and patient satisfaction and reduce waiting lists. We have focussed on 2 specialties that contribute the highest proportion of cancellations and have identified areas where an intervention may reduce this number.

Improving Consent in Laparoscopic Cholecystectomy

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Introduction

General guidance from RCSE states that consent should be taken as early as possible to allow patients time to reflect prior to surgery. In cases of acute cholecystitis/pancreatitis requiring urgent laparoscopic cholecystectomy, patients are often listed on a semi-emergency basis for theatre straight from acute admission and therefore miss an opportunity for consent discussions prior to day of surgery (DOS). We aim to improve the quality of this process in our unit.

Methods

A retrospective audit of all semi-emergency laparoscopic cholecystectomies at a single centre was undertaken October to December 2017, using individual paper and electronic records. Date of listing for theatre, date of operation and of consent was collected along with evidence of documented discussion of procedural risks, if done, prior to DOS.

Results

26 patients underwent semi-emergency laparoscopic cholecystectomy, all coordinated via the Emergency Surgery Department. The median time from listing to DOS was 28 days. 17 were listed straight from acute admission, 9 via interim Emergency Consultant clinic. 92% of patients were formally consented on DOS. 23% of patients had evidence of discussion of risks and complications documented prior to the DOS, all of whom were seen in clinic.

Conclusion

The majority of patients that undergo semi-emergency laparoscopic cholecystectomy are still consented on the DOS. The quality of our consent process should improve with planned inclusion of unit complication rates in a specific information leaflet. This will be given out to every patient on their index admission prior to discharge and documented in the notes.

Green Light Prostatectomy as Day case: A single centre experience (Mid Yorkshire NHS Trust)

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Introduction

We present our experience of day surgery GreenLight XPS prostatectomy. Since 2013, there was a gradual reconfiguration of our service in order to enable this operation to be performed as day case.

Methods

Retrospectively, relevant electronic medical entries for all the operations carried out between January 2013 and September 2016 were reviewed. We recorded the length of stay, readmission and complications rate, subdivided in yearly intervals. We also examined if the ASA score or preoperative retention had an effect on the length of stay. Finally, we looked at the rate of successful trials without catheter for each group.

Results

Between 2013 and 2016 we performed 448 GreenLight XPS prostatectomies. The average age was 73.7. There was a gradual improvement in the rate of procedures performed as day case. In 2013 the percentage was 19% while in 2016 we achieved a rate of 78%. The readmission rate at 30 days was 6.8% for the day cases and 10.5% for the patients with longer stays.
The risk factors that may lead to longer duration of stay we identified that overall there was statistical significance in patients with age >80, ASA > 3 and prior retention.
Finally from the 182 the " day case" patients 95% had a successful TWOC. This was 92% in the 238 patient that had a longer stay.

Conclusion

Our study concludes that GreenLight XPS prostatectomy is a procedure that can be safely performed as a day case for the majority of the patients with a low readmission risk.

Daycase Hernia Repair Retrospective Audit

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Introduction

Southport was identified as having a low rate of day cases for hernia repairs compared with other trusts in the area. We carried out a retrospective case note study using the British Association of Day Surgery (BADS) guidelines. The guidelines included that 75% of suitable elective cases should be booked as day cases, 80% of all day case patients should go home the same day and should be performed at a dedicated day case centre (Ormskirk hospital). Regional blocks and prophylactic oral analgesia should be given to all patients and patients who do not go home should have a reason documented.

Methods

Our inclusion criteria were notes which involved 'Hernia' in the primary diagnosis, done as elective cases. We excluded cases not booked as day cases.

Results

We completed three audit loops, collecting data for 3 month periods over 3 consecutive years. The first loop included 52 cases, 24 of which were performed at Ormskirk (47%) and 27 at Southport (53%). The mode length of stay was found to be 1 night (26 cases). Stricter adherence to BADS guidelines led to improvements in the second cycle with the mode length of stay being 0 nights for 34 out of 35 cases.

Conclusions

The third audit loop consolidated these findings with 94% of cases being discharged the same day. It also demonstrated that the use of regional blocks in conjunction to GA and the combined use of opioid and simple analgesia facilitated same day discharges.

Sick of patient scoring systems: Two interventions to raise awareness of a ready-made PONV risk score in day case anaesthesia

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Introduction

Post-operative nausea and vomiting (PONV) is a barrier to successful day case surgery. However, the risk of this must be balanced against potential side effects of anti-emetic use. The preoperative assessment service at Torbay hospital calculates a PONV risk score and gives a recommendation for perioperative antiemetic use based on the Apfel score. This is available to the Anaesthetist on the day of surgery.

Methods

The aim of this project was to raise awareness of the predetermined risk score using a department-wide survey and a presentation at a local governance meeting. Data collection after each of these interventions aimed to determine if Anaesthetists are following the risk score's recommendations and whether the interventions had an effect on anti-emetic strategy and incidence of PONV.

Results

A total of 135 patient records were analysed. Prior to any intervention, baseline data showed compliance with recommendations in less than 50% of low to medium risk patients. After the survey, compliance improved to 63%. The survey also elicited a range of views regarding intraoperative anti-emetic practice. After the clinical governance presentation compliance remained above baseline but dropped to 55%. In each data collection period, only 1 patient required an anti-emetic in recovery.

Conclusion

We conclude that a simple survey may have been effective in raising awareness of the PONV risk score and may have changed practice. We recommend that patients receiving Total Intravenous Anaesthesia with low and medium risk scores for PONV undergoing low risk procedures do not require intra-operative anti-emetics.

Are we starving patients too long? An evaluation of fasting times for elective surgery at Rotherham Hospital

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2 British Association of Day Surgery, United Kingdom
3 Sintetica Advisory Board, ., United Kingdom

Introduction

Undergoing general anaesthesia involves a risk of aspirating gastric contents. This can be reduced through adequate preoperative fasting. However, prolonged starvation can be detrimental to patients' health and experience. Therefore fasting times for patients presenting to Rotherham Hospital for elective surgery (including day surgery) were evaluated.

Method

Patients attending Rotherham Hospital Theatre Suite for elective surgery were asked when they had last 1 Eaten 2 Drank clear fluids. This was recorded with the time the patient arrived in theatre and the intended mode of anaesthesia. Data collection took place over one week in November 2017.

Results

- Fasting times for food: (131 patients), 17 local anaesthetic only (LA); 114 non LA techniques.
- Non LA patients: Starved 2-6hours-3%, 6-12hours -31%, 12-24hours -65%, > 24hours -2%.
- LA patients: Starved < 2hours-6%, 2-6hours-47%, 6-12hours-18%, 12-24hours-29%.
- Fasting times for clear fluids: (113 patients) 14 LA, 99 non LA techniques.
- Non LA patients: Fasted <2hours -13%, 2-6hours-58%, 6-12hours-21%, 12-24hours-8%.
- LA patients: Fasted <2hours 29%, 2-6hours - 64%, 6-12hours - 7%.

Conclusions

Many of our patients are undergoing prolonged starvation times. The reason for this is likely to be multifactorial but could influence patients' health and recovery. We intend to introduce strategies to reduce excessive starvation times which include patient education to actively encourage eating and drinking until fasting should begin; consider allowing small amounts of milk in drinks up to 2 hours prior to admission and offering water on arrival.

Developing a cost-neutral strategy to minimise theatre delay

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Introduction

Patients requiring procedures should have them completed within 18 weeks of referral. The 92% target has not been met since February 2016. Waiting times for elective surgery may jeopardise patient's safety due to likelihood of developing complications. Delays may be reduced by maximising theatre efficiency and minimising turnaround time with the view of expanding case lists.

Methods

This cross-sectional study looked at start and finish times of elective cases across all specialties during a working week period. The time of induction, knife to skin, closure and recovery were collected from the theatre database. The number, length and reasons for delay were identified. We subdivided into length of 'golden patient' delay and subsequent cases delay. Stages from patient's check-in to recovery were assessed for delays. Strategies were developed to target this.

Results

During a 5 day period, 173 elective cases were completed in 10 theatres across 6 specialities. Seventy-one cases (41%) were delayed. During this period, 38 cases (first on each list) were due to commence at 0900. All cases were delayed by an average of 30.0 minutes (range 3 to 131 minutes). The following cases on the lists (n=33) had a turnaround delay averaging 57.4 minutes (range 10 to 217 minutes).

Conclusions

The high number of delayed cases with prolonged turnaround time is detrimental to the safety and well-being of patients and theatre staff. A number of strategies have been developed to minimise delays. The effects of these will be analysed in 3 months' time.

Pain after paediatric tonsillectomy – SMS texting as a novel audit tool

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Introduction

Following our switch from codeine to oral morphine solution for rescue analgesia for tonsillectomy, we wished to assess pain control at home. We trialled text messaging (SMS) to gather daily post-discharge data.

Methods

We recruited patients undergoing tonsillectomy ± adenoidectomy, and recorded their age, weight, gender, diagnostic indication for surgery and surgical technique. Parents consented to be texted with a series of questions for 10 evenings postoperatively, starting the day following surgery. Questions included the maximum pain score (0-10), the analgesic drugs administered and any nausea or vomiting (PONV) experienced that day. Responses were stored in a secure database for analysis.

Results

Data was gathered from 32 patients. 27/32 (84%) parents responded to texts on ≥5 days. 2 patients with poor responses were excluded. Of the 30 studied, 50% were male, with ages 10 months to 15 years, and weights 6.6kg to 64kg. 21 patients had sleep-disordered breathing (SDB) and 14 patients had experienced recurrent tonsillitis, including 5 who also had SDB. The average pain score ranged from 4.0 on Day 1 to a peak of 5.5 on Day 6 to a minimum of 2 on Day 10. 69.2% parents gave their children morphine on one or more days in addition to simple analgesia. The rate of PONV was 30%, unrelated to morphine use.

Conclusion

SMS proved very successful for data collection. We showed that pain is a significant problem for up to 10 days post-tonsillectomy and confirmed the requirement for opioid rescue medication after discharge.

Improving Care in Anaesthetics: A Quality Improvement Project

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Introduction
We focused on pre-operative testing NICE guideline NG45 compliance at University Hospital Lewisham in elective surgery patients between October 2017 and February 2018. Aims included increasing the number of pre-operative tests performed appropriately, reducing the number of tests performed unnecessarily, and improving staff awareness of guidelines.

Methods
Data was collected from 100 randomly-selected patients before, and 93 patients after, an intervention (comprising a poster displaying guidelines in a clear, staff-focused format) was implemented. The intervention was identified through patient shadowing and root-cause analysis and improved through sequential Plan-Do-Study-Act cycles.

Results
Baseline data demonstrated 65.8% concordance. ECG concordance was greatest (73.0%) followed by U&Es (65.0%), clotting (64.0%) and FBC (61.0%). Post-intervention, overall concordance increased to 69.6%. ECG testing saw a 19.3% improvement (87.1%) whilst U&Es and FBC testing displayed reductions (62.3% and 60.2% respectively). Clotting increased to 68.8%. Concordance was greatest for major surgery (72.8%) and lowest for minor surgery (55.0%). ASA-3 grades showed notably high concordance (93.0%).

Conclusion
A 5.9% concordance increase was achieved. Concordance was greatest for high ASA or surgery grades as more tests are justified at greater risk levels. Where concordance was low, the cause was inappropriately completed tests indicating over-testing. This demonstrates an area of unnecessary financial expense and the patient experience could be improved by reducing excessive testing. Further work is needed to educate staff on minor surgery guidelines and emphasise the negative sequelae of over-testing. Clinicians should be encouraged to question why they are ordering tests and evaluate patient benefit.

Consent in Day Case Surgery - a single centre

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Introduction

Since the Montgomery law was passed in 2016 new guidance regarding consent in day surgery have been released by the Royal College of Surgeons and the GMC. These guidelines suggest that consent should be relevant to the individual, should commence well in advance of the treatment and the discussion should be documented in the notes. It is important to assess the impact that these guidelines have had on clinical practice.

Methods

A prospective audit was performed between the time period 21/09/2017 – 19/12/2017 to assess the consenting process in the day surgery unit of a single centre. This was then repeated over a 2 week period 26/02/2018 – 09/03/2018.

Results

The notes of 89 patients were reviewed in the initial audit cycle. Of these patients 81% were consented on the day of surgery.
During the second cycle the notes of 34 patients were reviewed. Of these patients 85% were consented on the day of surgery. There was no significant difference in the consent process between the two groups (p=0.79). However, 76% of patients had the discussion regarding consent documented in their clinical record prior to attending for day surgery.

Conclusions

Despite recent guidelines the consenting process in day surgery is still poor. Further work needs to be done to assess how to improve this to meet the standards of the latest guidance.

Ambulatory knee surgery at Nottingham city hospital – an audit of current anaesthetic practice

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Introduction

This audit aimed to review common anaesthetic strategies for day surgery knee arthroscopies, and to assess whether the different approaches to analgesia and anti-emesis influenced recovery time.

Methods

This retrospective audit looked at all patients admitted to the elective orthopaedic admissions lounge (THAL) for ambulatory knee arthroscopy +/- surgical intervention during a one month period in 2017.
Data collected included analgesia and anti-emetic administration – pre-operative and intra-operative strategies, and rescue requirements in recovery. Time in recovery was noted, prior to discharge back to THAL. Unplanned admissions were also noted.

Results

A total of 48 elective knee arthroscopies were performed, with 79% having arthroscopy with intervention. Multimodal analgesia was given in 100% cases (paracetamol, opioid, local anaesthetic infiltration by surgeons); 73% also received non-steroidal analgesia.
All but three patients received opioid analgesia intra-operatively – the vast majority receiving fentanyl, in the range of 50–300µg. 20% of patients were given intravenous morphine.
In recovery, rescue analgesia was needed in 35% cases – this rose to 58% in patients who received only 100µg fentanyl and who underwent arthroscopy and intervention. Intra-operative morphine appeared to reduce the need for rescue analgesia to 22%, with a slight reduction in time spent in recovery (96vs.103 minutes). Of those not given peri-operative anti-emetic(s), 75% needed rescue treatment.

Conclusion

For patients undergoing ambulatory knee surgery, use multimodal analgesia, and consider using morphine, or higher doses of intra-operative fentanyl in order to reduce the need for rescue analgesia in recovery. Use at least one anti-emetic for all patients.

Improving Day Case rate of Inguinal Hernia Repair

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Background
Compare the our trust day case rate for inguinal hernia repair and compare with national standard

Aim
What was the actual day case rate; Was coding accurate? ; Why were patients staying overnight? and Is there a need to extend Day Case unit opening hours?

Objectives
The aim of the audit was to see if we can improve a Day case rate for inguinal hernia

Method
Retrospective analysis for Day case inguinal hernia rates for our trust for the audit period 1-sep 2016 to 30th Sep 2017. Cases with day case intent was included and Cases done as emergency and Case with planned overnight stay/In patient stay was excluded

Results
We identified 366 patients who underwent inguinal hernia repair as a day case intent . however we excluded 13 patients who were wrongly coded as it was not meant for day case . thereby our cohort of patient dropped to 353 patients. Of these patients 327 patients went home same day (True day case rate 92.5%) target was 95%.

- 22 patients stayed overnight (6%)
- 4 patients stayed beyond overnight but less than 72 hours (1.1%)
- 0 patients stayed beyond 72 hours

We analysed the notes of patient who overstayed. The commonest reasons was acute urinary retention(n=10); social reasons(n=9); more complex surgery (n=4);concerns of bleeding(n=6)

Conclusion
In summary, clinical coding should be more accurate ; we are trying to develop a pathway for acute urinary retention who can be safely placed in that path.

Improving Cost Effectiveness and Patient-Centred Care in Mastectomies in Queen Elizabeth Hospital (QEH), Gateshead: A Retrospective Audit

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Introduction

Safe, cost effective and patient-centred care is essential in current financial climate. Day case procedures are more cost effective compared to inpatient stay while allowing patients to recover in the comfort of their home. Mastectomy is a common procedure in the treatment of breast cancer. British Association of Day Surgery (BADS) sets a target of 50% mastectomies to be day case procedures. If done as day case, mastectomy attracts £195 higher tariff while mastectomy with node procedure attracts £274 higher tariff. There is additional £306/day hospital bed cost saving. The aim was to ascertain the percentage of mastectomies done as day case and determine contributing/complicating factors for those Length of stay (LOS) >0.

Methods

Patients who underwent mastectomies at QEH, from 1/4/2017 to 31/10/2017, were identified retrospectively using theatre programme, operation notes and GP handover documents.

Results

106 mastectomies were done (age 28-88 and mean 61.76). Only 35% cases were done as day case (versus 50% BADS target). Reason for inpatient stay were not documented in 55% of in-patients. Other reasons include post-operative intravenous antibiotics and other complications. Nodal procedures did not affect LOS.

Conclusion

QEH did not achieve the BADS target. Only 35% of cases were done as day case.
Findings and importance of day case mastectomies were presented at surgical safecare meeting to ensure relevant staff promote and encourage patients for same day discharge, and if not possible, to documents reasons. A re-audit will be performed in 6 months' time.

Improving Day Case rate for umbilical hernia repair

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Background

Compare the our trust day case rate for Umbilical hernia repair and compare with national standard.

Aim

What was the actual day case rate; Was coding accurate?; Why were patients staying overnight? and Is there a need to extend Day Case unit opening hours?

Objectives

The aim of the audit was to see if we can improve a Day case rate for Umbilical hernia

Method

Retrospective analysis of day case umbilical hernia repair for our trust for the period 1st Sep 2016 to 30th Sep 2017. Cases with day case intent was included; Cases done as emergency and Case with planned overnight stay/In patient stay was excluded

Results

We identified 113 patients who underwent Umbilical hernia repair as a day case intent. However we excluded 4 patients who were wrongly coded as it was not meant for day case. Of these patients 109 patients; 96 patients went home same day (True day case rate 88%) target was 85%. 12 patients stayed overnight (11%); 0 patients stayed beyond overnight but less than 72 hours (0%); 1 patient stayed beyond 72 hours
We analysed the notes of patient who overstayed. The commonest reasons was acute urinary retention(n=3); social reasons(n=1); more complex surgery (n=1);concerns of bleeding(n=3);lack of interpreter (n=1);unclear documentation(n=3)

Conclusion

In summary, clinical coding should be more accurate ; we are trying to develop a pathway for acute urinary retention who can be safely placed in that path.

What factors influence day surgery unit length of stay: Can we do better?

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Introduction

Identifying factors that increase the length of stay (LOS) in day case operations can improve patient flow through the day case pathway and potentially increase patient throughput. We aimed to look at if anaesthetic technique, analgesic and anti-emetic management affected LOS on the day surgery unit (DSU).

Methods

A single centre, retrospective review of data collected on all planned adult general anaesthesia day case operations over 1 week. Data were collected by manual review of the anaesthetic chart and recovery notes.

Results

A total of 65 cases were recorded, 1 of these cases was abandoned after induction due to aspiration and so was excluded from analysis. A range of specialties were covered, general surgery (6, 9.2%), gynaecology (12, 18.5%), ENT (8, 12.3%) orthopaedics (16, 24.6%), dental (10, 15.4%), breast (3, 4.6%) and urology (10, 15.4%). Pre-operative paracetamol was given to all but 1 patient and 43 patients (66%) received modified release ibuprofen. Anaesthetic maintenance seemed to have some effect on mean LOS; Desflurane 136 minutes (4, 6.3%), Propofol 138 minutes (10, 15.6%), Sevoflurane 179 minutes (48, 75%), Isoflurane 238 minutes (2, 3.1%). The biggest factor seemed to be surgical procedure performed with surface and less invasive surgery generally spending less time on DSU and more invasive surgery such as laparoscopic abdominal surgery generally spending longer.

Conclusions

Maintenance with Isoflurane was associated with longer LOS but this may not be the only factor in these cases. Prolonged stay on DSU seemed to be mainly associated with the surgical procedure performed.

Case Report: An unusual presentation of a life threatening post-operative haemorrhage

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Introduction
Clinicians are taught to clinically assess patients, and combine this with the physiological parameters available to assess likely differential diagnoses. This is essentially pattern recognition which we build upon through clinical experience. So what happens when the cause does not fit the clinical picture?

Case report

Here we discuss the case of a healthy 57 year old male who had a significant intra-peritoneal haemorrhage following elective open inguino-scrotal hernia repair, yet did not display the typical signs or symptoms. The specific bleeding vessel and mechanism was likely to contribute to the unusual presentation.
The patient displayed no tachycardia, no abdominal pain, and there was no evidence of any haematoma in the abdomen, flanks or scrotum. His observations remained unremarkable except for intermittent episodes of hypotension that were responsive to minimal crystalloid resuscitation. Moreover, the patient himself felt well except for transient episodes of dizziness and nausea, caused by the hypotensive episodes. It was subsequently discovered that the patient was a regular marathon runner so his physiological reserve probably masked his signs.
At surgery the bleeding vessel was discovered to be the inferior epigastric artery which had bled directly into the abdominal cavity with no external signs. This was thought to be related to the complexity of the large hernia sack and subsequent dissection.

Conclusion

This demonstrates that life threatening haemorrhage can present in unusual ways, especially with patients who have altered physiology to begin with. The anatomy of the haemorrhage can also significantly affect the presentation and should be taken into consideration.

Laparoscopic Cholecystectomy in a District General Hospital – Are we achieving the best practice?

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Introduction

Laparoscopic cholecystectomy is regarded as the gold standard treatment for benign biliary pathology. It is estimated that 66,000 cholecystectomies are performed each year across the United Kingdom. Ample evidence exists in the literature that advocates that laparoscopic cholecystectomy is both safe and a suitable operation to be undertaken as a day case procedure. This audit reviewed our current practice and assessed whether the best standard of practice was being achieved for our patients that undergo laparoscopic cholecystectomy.

Methods

A retrospective case note review was conducted evaluating all elective laparoscopic cholecystectomies being performed in a district general hospital over a 6 month time period.

Results

193 laparoscopic cholecystectomies were performed during the 6 month time period. The gender split was 145 Females / 48 Males. The mean age was 54 (range18-86). 6 cases (3%) were converted to an open procedure. 106 patients (55%) were successfully discharged as a day case procedure. Only 7 patients had a documented reason for an overnight stay. There was a 4.7% complication rate observed, of which only 1 patient needed a return to theatre.

Conclusion

The data highlights a low conversion rate and a low post-operative complication rate. However only 55% of patients were successfully discharged as a day case. Further assessment is required to identify the specific causes for delayed discharges. Obtaining this information will enable a revision of the current day case pathway in order to achieve best standard of care.

An audit of the perioperative complications of intra-thecal baclofen and morphine pumps in Swansea (1998-2016) and a patient satisfaction survey

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Introduction/Background

Intrathecal baclofen (ITB) and morphine (ITM) pumps improve pain, spasticity and QoL. Pump explantations due to complications is more expensive and traumatic for patients. Determining complication rates is beneficial from a bio-psychosocial aspect.

Aims

Determine the perioperative complications post-primary pump implantation (1998-2016); perform a service evaluation.

Methods

A retrospective review of indications, dose changes over time, and the complications 14 days post-operatively.

Results

48 adult patients were included. The overall perioperative complications rate was 24%. 10% were pump related (4 catheter blocks, 1 pump failure), 14% non-pump related (1 CSF leak, 3 haematomas, 2 superficial infections). The mean initial and current ITM doses were 4.27mg/day and 10.4mg/day, and 120.61 mcg/day and 215mcg/day for ITB. Patients rated the service as excellent. 73.4% ranked their QoL improvement moderate (2-4/5) to excellent (5/5). Moderate symptoms control satisfaction (3.70/5 (ITB), 3.82/5 (ITM)).

Conclusion

These results are comparable to those from the NHNN and current literature (level III evidence). There is a deficiency between the incidence of patients eligible for pump implantation and procedures performed per annum. Reviews across the UK including patient surveys are required to set a standard of care and support adequate resource allocation for the continuation of this service.

Perforated duodenal ulcer presenting with left iliac fossa pain

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Introduction

Upper gastrointestinal ulceration has variable presentations. Although rare, perforated duodenal ulcers presenting with right iliac fossa pain due to fluid tracking the paracolic gutter, have been reported (Valentino's Syndrome). However there are few cases presenting with left-sided pain. This case highlights that a perforated upper gastrointestinal viscus should be considered in patients with acute left iliac fossa (LIF) pain and where stable, can be managed within the scope of day surgery.

Method

A 43 year old female was admitted to the Emergency Department with 24 hours of nausea and LIF pain. She was an ex-smoker and drank 12 units of alcohol/week. Temperature was 38.1°C and heart rate 112 beats per minute. On examination, there was localised LIF peritonism. White cell count was 14.3x109/L and C-reactive protein 137mg/L. CT scan suggested a perforated duodenal ulcer with pneumoperitoneum close to the pylorus and duodenum.

Results

The patient was managed conservatively with intravenous antibiotics, omeprazole and dietary rest. She was discharged with a follow up oesophago-gastroduodenoscopy (OGD).

Conclusion

1. Although uncommon, upper GI perforation should be considered in patients who present with LIF pain and a suggestive history.
2. Erect chest radiograph may not show pneumoperitoneum. CT scanning may be of diagnostic value to differentiate from diverticulitis and avoid unnecessary surgery.
3. Where an appendix appears macroscopically normal at laparoscopy, full intra-abdominal survey should be performed.
4. Stable patients with sealed perforated ulcers may be managed non-operatively. Laparoscopy, washout, oversew or drainage may be required. Follow up OGD is recommended.

An audit on Adherence Patient Operation Notes to Royal College of Surgeons in England Guidelines

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Introduction

All patients undergoing a surgical procedure in the UK should have documentation of the operative details in the medical notes. The Royal College of Surgeons of England (RCSEng) "Good Surgical Practice" document details 21 standards that should be met. This audit aimed to measure how accurately these guidelines are followed in our trust within a defined patient group.

Methods

We identified all patients undergoing day-case laparoscopic cholecystectomy between 1.11.2017 and 31.11.2017 from the electronic operative database 'Theatreman'. Operative records filed in the patient notes were analysed to see how many of the 21 criteria described in the 'Good Surgical Practice' document were adhered to. For each criterion, adherence was deemed good if met in >50% patients and was deemed poor if met in <50% patients.

Results

29 patients were identified. One set of notes could not be obtained, leaving 28 for the final analysis. One criterion was deemed not applicable in this patient group. 9 of the 20 remaining criteria had a 100% adherence rate. 6 of 20 criteria were deemed good and 5 were poor.

Conclusions

Standards for operative note documentation are not being consistently met. Results will be presented in a departmental clinical governance meeting. The authors recommend: 1. all notes should be typed on a pro forma that includes all RCSEng guidelines; 2. all surgeons should familiarise themselves with RCSEng guidelines and 3. a laminated copy of the guidelines should be displayed in every theatre. Following these interventions, re-audit will take place in 3 months' time.

Day surgery renal stone management: ureteroscopy and laser lithotripsy

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Introduction

Incidence of renal stones is increasing worldwide and varies from 58 to 900 per 100,000, whilst there is a 9% lifetime risk of having renal stone related symptoms. Increasingly ureteroscopy (URS) coupled with laser fragmentation is being used for ureteral and renal stone management, with associated high stone-free levels and patient satisfaction. However 5% of patients require an additional procedure for residual fragments and 25% readmission for pain management.

Method

Retrospective analysis of 57 patients admitted under Urology between November 2016 –17, undergoing URS guided laser fragmentation for ureteric and renal calculi. Compared against national intercollegiate guidelines

Results

Of 57 Patients, average patient age was 55 years old and a 38:19 male: female ratio. Of stones treated 71% were ureteric (73% upper, 8% middle and 19% distal ureter), and 29% renal (11% upper pole, 28% middle pole and 61% lower pole). Average stone size was 9.7mm, with 52% of stones ‹1cm, 43% 1-2cm and 5% › 2cm. Average stone burden treated was 10.9mm and an average 0.961 Watts of energy used. 89% of patients following URS guided stone fragmentation were stone-free, with a 7% additional procedure rate.

Conclusion

The increasing prevalence of renal stones globally, associated with factors such as dietary changes and global warming, emphasises the need to develop effective management strategies. A high level of patients can be made stone-free via URS guided stone fragmentation, which can be further enhanced with intraoperative retrieval of fragments › 2mm.

Leg weakness after hernia repair; a cautionary tale

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Case report

A patient fell in the toilet a couple of hours after a general anaesthetic hernia repair and fractured their ankle. They stated that their leg gave way. The surgeon had infiltrated wound with local anaesthetic(LA) but had not requested testing for leg weakness before mobilisation. The patient had been assisted to the toilet door but then left alone and had not expressed any concerns about leg weakness prior to their fall. Root Cause Analysis(RCA) of this fall highlighted the potential risk of leg weakness due to femoral nerve block after LA infiltration in groin . A large study demonstrating this complication and use of straight leg raise test to detect it, was carried out in our Day unit 20 years ago (1). Most of the day unit staff are familiar with the risks of LA infiltration in the groin and would routinely test for leg weakness before mobilising. However, many new staff had recently joined and not been made aware of this requirement.

Conclusion

The outcome of the RCA was production of a poster describing when leg weakness might occur post op and how to use a straight leg raise test. This is now displayed prominently in recovery and ward areas to remind staff to test for leg weakness before allowing patients to mobilise unaided.

References

1. Leg weakness is a complication of ilio-inguinal nerve block in children. A K Lipp, J Woodcock, B Hensman, K Wilkinson. British Journal of Anaesthesia, Volume 92, Issue 2, 1 February 2004, P 273

Implementing day case emergency cholecystectomies – a DGH's experience

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Aims

Our aim was to improve the care of patients with gallstones by providing emergency laparoscopic cholecystectomy within 14 days of presentation for suitable patients.

Methods

Patients were identified at diagnosis and entered onto our cholecystectomy pathway, and included patients with biliary colic, acute cholecystitis and gallstone pancreatitis. We obtained two theatre lists per week dedicated to emergency cholecystectomies giving us a capacity of 4 cases per week. Patients are assessed and, where possible, are discharged and return for day case surgery in order to reduced length of stay and associated costs. Patients are provided with a date of surgery prior to discharge and undergo a telephone pre-operative assessment.

Results

Over a 15 month period 216 patients presented with gallstone disease. 122 (56.4%) patients were fit for emergency surgery and 102 (83.6%) had this within 14 days of admission. 18% of these were patients with gallstone pancreatitis, the remaining 82% had biliary colic or acute cholecystitis. 43% were performed as a day case procedure.

Conclusions

Early laparoscopic cholecystectomy has been shown to be beneficial both for both patients and institutions. It reduces costs by removing the repeated admissions these patients often have whilst waiting for surgery, improves patient experience and has been shown in multiple studies to have no significant increase in complications. Through participating in this quality improvement project run by the RCS we have developed a pathway that enables us to achieve this efficiently and effectively and is being well received by patients and staff alike.

Feasibility of adding a day surgery abscess patient to an elective list: The experience of Rotherham Foundation Trust Hospital (RFT)

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Introduction

Patients with abscesses often wait many hours for surgery due to more urgent cases on the emergency list. This can result in blockage of inpatient beds and poor patient experience. Our surgeons suggested creating a slot at the beginning of their elective list to operate on these patients, similar to the existing priority slot on the emergency list for evacuation of retained products of conception patients.

Methods

Patients with a surgically appropriate abscess and who met local day surgery criteria were deemed suitable for this pathway. Phase 1 (July-Sep 2017) to establish any impact on the elective list - addition of suitable patients to general surgical list but via their inpatient surgical bed. Phase 2 (Nov-Jan 2018) pilot through DSU (Day Surgery Unit). Patients were discharged home, admitted to DSU the following day for their operation at the beginning of the elective operating list and discharged via DSU ward.

Results

Pre pathway
38 patients March to May 2017
Mean length of stay 44 hours

Phase 1
Six patients
Mean Length of stay 21 hours

Phase 2
Two patients
Mean length of stay on surgical day 5 hours

There were no late finishes or cancellations on the elective lists with an abscess patient added in either phase.

Conclusions

Although our numbers are small we have shown this pathway to be effective in reducing the time these patients wait and to free up inpatient beds without any negative impact to the elective list.

Improving rates of Laparoscopic Fundoplication performed as a day-case procedure in a national specialist centre

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Introduction

Research has shown that daycase laparoscopic fundoplication can be feasible and safe in carefully selected patients. Despite laparoscopic fundoplication being on the British Association of Day Surgery Directory of Procedures we found some resistance to this approach within our trust. Within a 4-year period we have successfully increased the rate of laparoscopic fundoplication being performed as a daycase procedure.

Methods

We retrospectively reviewed prospectively maintained data from all the fundoplications performed by a single surgeon from 2013 to 2017. Demographic details, length of stay, complications and re-admissions were obtained from trust electronic records. Data was analysed using Windows Excel.

Results

From 2013-2017 a total of 159 patients underwent laparoscopic fundoplication. 88 patients were female (55.3%) and 71 male (44.7%). Average age of patients was 49.4. Average length of stay was 1.8 days and 61 patients were discharged the same day (38.3%). The rate of successful daycase procedures increased across the 4-year period. In 2013 15.4% of patients (n=2) required no overnight stay post-op; in 2014 this was 25% (n=10), in 2015 32.5% (n=13), in 2016 45% (n=31), and in 2017 62.8% (n=22). Overall readmission rate was 12 patients (8.1%) within 90 days. The rate of readmissions for daycase patients was 4.9% (n=3) and for non- daycase patients was 10% (n=10).

Conclusion

Across a 4-year period we have been able to increase the number of laparoscopic fundoplications performed as daycase procedures. There was no increase in readmission rates for patients undergoing laparoscopic fundoplication as a daycase.

Improving Day Case Laparoscopic Hysterectomy Rates

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Introduction

A push towards day case surgery has been driven nationwide by fewer acute hospital beds, as well as improved patient recovery.
At Northumbria Healthcare NHS Foundation Trust an audit of day case total laparoscopic hysterectomy (DCTLH) outcomes and causes of unplanned admissions, showed a failure rate of 51% between July 2015 to June 2016. Following this, an anaesthetic protocol for DCTLH was introduced in January 2017. This audit looked at the compliance with the anaesthetic protocol and associated DCTLH failure rate.

Methods

A retrospective analysis of all DCTLH between March and August 2017, with 51 of the 58 notes available. A pro forma was used to collect data on admissions and compliance with DCTLH protocol.

Results

DCTLH failure rate was 37%, an improvement from 51% in 2016. Also, there were fewer admissions including pain (15.3% to 7.8%) and post-operative nausea and vomiting (20.3% to 2%) as factors. Of unplanned admission 75% had no recorded decision maker.
Compliance with individual items of the protocol varied from 100% to 29%.The use of magnesium intraoperatively having the lowest compliance. It was also found that the doses of magnesium and ketamine were largely sub-therapeutic.

Conclusions

There has been an increase in successful DCTLH since the protocol was introduced, with reduction in pain and PONV being a causal factor, however this protocol is not completely adhered to and better compliance could improve success further. Also there is ambiguity regarding the decision maker and reason for admitting failed DCTLH due to poor documentation.

Sim to Win: Building a stronger team in Day Surgery

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Our day surgery centre (DSC) has excellent staff who work hard in pressured times for the NHS. However, in spring 2017, staff turnover and study budget cuts had taken their toll on our team-working, skills and morale. Staff development and morale scored badly in a trust-wide staff survey, and our clinical service lead received feedback from some surgeons that they were reluctant to work in our unit.

Method

We instigated a program of simulation-based training, held in daycase theatres and recovery on surgical 'audit' mornings. The scenarios written were based on incident forms received from DSC as well as perceived training needs. Focus was on constructive feedback, examining our processes and maintaining a supportive learning environment.

Results

After initial concerns, staff became more relaxed about the process and engaged well. We found that it streamlined our processes, opened a dialogue about quality improvement and broke down the silo mentality between theatres, recovery and ward. Surgeons have noted improved team-working and feedback from staff has been positive.

Conclusion

We are instigating a series of brief in-situ simulations at the start of occasional operating lists to focus on potential complications and kit required for each speciality. We intend to run a whole unit simulation to include administration staff as well as clinical staff.

Pre-operative fasting compliance in day-case surgical patients

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Introduction

Historically, patients were fasted from eight to twelve hours prior to anaesthesia to reduce the risk of aspiration pneumonitis. More recently there has been evidence that shortened pre-operative fasting periods do not increase the risk of harmful events. Current guidelines recommend fasting for six and two hours for food and clear fluids respectively prior to anaesthesia. This audit aims to compare our patient's fasting times to the guideline.

Method

This was a prospective study of 51 day-case surgical patients. Patients attending for morning or afternoon theatre lists were selected at random from the waiting room prior to admission and given a questionnaire regarding pre-operative fasting to complete.

Results

Of the 51 patients, 19 had attended for the morning theatre list and 32 for the afternoon. All patients reported receiving an information leaflet on fasting. Overall 41/51 (80%) fasted from clear fluid for 2 hours. The remaining 10/51 (20%) had either started fasting too early (n=8), too late (n=1) or couldn't remember (n=1). 43/51 (84%) fasted from food for 6 hours while 8/51 (16%) either started fasting too early (n=6) or too late (n=2).

Conclusion

At COCH there was good overall adherence to current fasting guidelines. It was concerning that despite all the patients reporting to have received an information leaflet so many started fasting from either food or clear fluids too early. This can affect patient comfort and hydration. A targeted approach to these patients outlining the guidelines should be considered to prevent this.

Arthroscopic subacromial decompression surgery - acromioplasty and bursecomty versus bursecomty alone - does it matter?

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Introduction

Traditional surgical treatment for subacromial impingement is an arthroscopic subacromial decompression (ASD) with bursectomy and acromioplasty. Acromioplasty aims to reduce compression from the acromial arch and bursectomy removes inflammation from degenerative tendinopathy. Bursectomy alone may be sufficient treatment.

Method

This was a single centre, four-surgeon retrospective study of patients who underwent an ASD between 2013-2017 with an intact rotator cuff. All failed conservative management and underwent a bursecomty, or bursecomty with acromioplasty. Pre and post-operative Oxford Shoulder Scores (OSS) were analysed using t-tests and effect size. Minimum clinically important difference was set at 4.5 points5.

Results

17 underwent bursectomy alone and 20 underwent bursecomty with acromioplasty. The mean improvement in the bursectomy group was 15.53 (SD 9.3) ($p<0.005$, 95% CI -20.3 to -10.7) and 16.4 (SD 9.6) ($p<0.005$, 95% CI -20.9 to -11.9) in the bursectomy with acromioplasty group. The difference in the mean change score between the two treatments was 0.87 points ($p=0.3998$, 95% CI -9.7 to 3.9, effect size 0.0095). 88% achieved the minimum clinically important difference in the bursecomty group with 80% in the bursectomy with acromioplasty group.

Conclusion

Statically significant improvements were seen with both treatments, with less than a point difference in the mean change scores. There was no statistically significant difference between the two treatments with a small effect size, highlighting no superior treatment. Regardless of the treatment more than 80% achieved a good clinical outcome. No increased clinical benefit was seen with acromioplasty suggesting bursectomy alone may be sufficient.

Consent in Anaesthesia: A Service Evaluation

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Introduction

Consent in anaesthesia has become a topical issue following recent landmark legal rulings. In 2017 the Association of Anaesthetists of Great Britain and Ireland (AAGBI) updated their informed consent guidelines. We wished to evaluate how consent for anaesthesia is being undertaken in a major teaching hospital.

Methods

A service evaluation of documented consent on anaesthetic charts was undertaken. Data were collected across two sites, from anaesthetic charts, in the post-operative recovery room.

Results

74 sets of patient notes were reviewed with a mean patient age of 52 and median American Society of Anaesthetists (ASA) grade of 2. There was evidence of anaesthetic consent for 63 of the 74 patients. Of those patients consented for general anaesthesia (n= 45), 84% were warned of sore throat, 78% of post-operative nausea and vomiting and 47% of dental damage. Discussion regarding death and cardiorespiratory complications appeared on one chart. 26 patients were consented for neuraxial anaesthesia, of which; 77% were warned of potential for nerve damage, 69% for failure to give complete analgesia, 65% for post-dural puncture headache and 54% for potential conversion to general anaesthesia.

Conclusions

The results show a large variation in consent for anaesthesia. 15% of patients had no evidence of documented anaesthetic consent and many common complications were not discussed prior to anaesthesia, contrary to AAGBI guidance. Documentation may not reflect verbal patient consent; however, failure to disclose and document material risk may be challenged legally. A difficult balance exists between legal-centred and patient-centred consent in anaesthesia.

Retrospective audit of complication rates following cholecystectomies in a District General Hospital

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Aims

We aimed to complete a local database of patients undergoing cholecystectomies, and compare complication data to those of the CholeS collaborative national study.

Methods

Retrospective study of consecutive patients undergoing cholecystectomies between July 2015 and June 2016 at local district general hospital. Discharge summaries, radiological investigations, and a subset of case notes were analysed to identify patients with postoperative complications and readmissions.

Results

239 patients underwent cholecystectomies in the time period analysed: 70% females with an average age of 54 years (21-89 years). Cases were almost equally divided into emergency (110) and elective (129). The majority of cases were laparoscopic (227, 95%), 6 were planned open cases, and 6 were converted to open (2.6%). The overall length of stay was 5 days, with 48% (63/129) of elective patients and 6%(7/110) of emergency patients discharged on day one postoperative. The majority of patients listed as day cases were discharged on the same day (19 out of 20, 95%), whilst 27% (30/110) of emergency patients stayed 10 days or more. In total 15 patients (6.3%) were readmitted within 30 days, with no statistically significant difference ($p = 0.4$) in the rate of readmission between emergency and elective cases. The most common readmission diagnosis was non-specific abdominal pain (10), and one recorded bile leak.

Conclusion

Our patient population and complication rates were comparable to the national CholeS data. We highlighted that bile leaks are under reported on electronic and paper documentation, and will organise a local intervention to improve this.

Manage pain or ring the Bed Manager!

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Introduction

We noted a spike in unplanned admissions in late 2017 and found that most were from patients undergoing Laparoscopic Cholecystectomy (LC). This combined with feedback from local General Practitioners about inadequate take home analgesia prompted us to improve our process.

Method

We retrospectively audited 3 months of LC procedures, analgesia received, timing of surgery and admission rates.
Based on our findings, we made 4 changes to our process: Guidelines for anaesthetists and ward staff on perioperative analgesic regimes, improved drug charts to enable timely intervention, continuity of usage of numerical pain rating scales throughout, improved written and verbal instructions (and take home medication chart) for patients to manage their own post-operative analgesia.

Results

Prior to intervention, patients weren't given adequate multimodal analgesia or 'rescue' medication post operatively. We weren't scoring and treating pain promptly, and patients weren't routinely given opiate analgesia to take home.
With small changes in all 4 areas in December, our admission rate fell back from a peak of 4.2% in September to 2.3% in February. This rate continues to fall, despite some resistance to change from staff.

Conclusion

Whilst we know that protocolizing anaesthetic management of LC improves outcome and multimodal analgesia delivers better results (1), the real challenge lies with change management and a slow cultural shift.

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Transanal Haemorrhoid Dearterialisation in Day Surgery. A review of the first year at Derby

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Introduction

Transanal Haemorrhoid Dearterialisation is a procedure recently introduced into the day surgery unit at Derby for treating haemorrhoids. Haemorrhoidectomy operations in day surgery have previously been noted to cause significant postoperative pain and delayed discharge in our unit. A comparison of the two procedures was useful to look at the impact of this new procedure on these critical factors for successful same day discharge.

Methods

One year of data for the first ten cases having Transanal Haemorrhoid Dearterialisation was reviewed and compared with data for 10 patients having standard haemorrhoidectomy in day surgery during that time.

Results

The standard haemorrhoidectomy group had one overnight unplanned stay, the ligation group nil. The standard group had longer times to discharge; 5 hours 12 minutes compared to 3 hours and 42 minutes on average in the ligation group. More patients required long acting opiates during their recovery post operatively with five out of ten in the standard haemorrhoidectomy group vs. three out of ten in the ligation group requiring oral morphine.

Conclusions

Although the groups have small numbers the new procedure showed fewer overnight admissions, a shorter time to discharge and a reduced need for long acting opiates after the operation too. These are all positive indicators that Transanal Haemorrhoid Dearterialisation is an advance for successful day surgery haemorrhoid treatment.

Is Primary Ureteroscopy for ureteric stones the 'new' gold standard?

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Introduction

Primary Ureteroscopy (PURS) is a recognised operation for removing ureteric stones in patients presenting with renal colic. It is however common practice for patients to undergo general anaesthesia and placement of a temporising ureteric stent to return at a later date for ureteroscopy and stone removal. This latter approach subjects the patient to delayed surgery, unwarranted additional operations and potential emergency admissions with stent related symptoms. This audit reviewed outcomes from patients undergoing PURS.

Methods

A retrospective analysis was performed over an 18-month period on all patients undergoing emergency ureteric stone operations at our institution. Patients were identified via electronic database and were grouped into those who had PURS or those who underwent temporising ureteric stent insertion only. Successful PURS was defined as being stone free at the end of surgery. Factors potentially influencing outcomes such as surgeon grade, stone size and location of the stone were recorded.

Results

38 PURS procedures were identified of which 31 were successful. Patients presenting with smaller distal ureteric stones and operated on by senior surgeons were more likely to have a successful outcome. Over the same time period, 210 patients had temporising ureteric stent placement which required further stone surgery at a later date.

Conclusion

PURS to remove ureteric stones is successful in the majority of patients where the procedure is undertaken, though parameters which may lead to an unfavourable outcome have been identified. This work has laid the foundation for algorithms for managing patients presenting as emergencies with ureteric stones.

Preoperative fluid policy: a thirst for change

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Objective

Understanding patient perspective on healthcare is central to the evaluation of quality. SANP-11 study showed thirst was one of the three areas where patient experienced severe discomfort in postoperative period.

Method

From October 2017 we began to offer 150 ml of water on arrival to the day surgery unit(DSU). A prospective patient survey was conducted specifically looking at postoperative thirst, sore throat and nausea vomiting in patients receiving water on arrival. Adult patients undergoing general anaesthesia in February 2018 in DSU filled in the questionnaire prior to their discharge.

Results

We analysed 99 out of 100 collected forms. 100% of our patients had read the information sheet given to them at pre-assessment. 82 patients drank water as per instruction and were subsequently offered it on arrival. Statistical analysis of these patients showed significant reduction in post-operative thirst compared to patient surveys conducted in 2016 (19.66%; 95% CI 6.04 - 32.02, p =0.005) and 2017 (16.71%, 95% CI 3.21 - 29.04, p=0.01). There was reduction in post-operative sore throat; 2016 (19.18%; 95% CI 7.55-29.27, p=0.002) and 2017 (11.05%, 95%CI -0.01 to 20.71, p=0.05).

Conclusion

We worked closely with our nursing staff to implement the change in our practice and it has shown to improve our patient experience. However we have identified that both patients and some staff are unsure of the new guidelines. We plan to discuss this further within the department.

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When to phone? Patient preferred timing of telephone review post laparoscopic cholecystectomy

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Introduction

The Mater Hospital Belfast performs approximately 300 cholecystectomies annually, with the majority undertaken as day cases. Our practice includes nurse-led telephone review one month following surgery, however with recent pressures and staff shortages this has become inconsistent. There is much debate over the optimum timing for telephone review, so our primary aim was to determine when patients felt they would have most appreciated a phone call.

Methods

A telephone questionnaire was constructed with ten questions regarding: information provided upon discharge; complications encountered; follow-up received; merits of telephone reviews, and optimal timing of calls. A final open ended question invited general feedback. All patients who underwent laparoscopic cholecystectomy between August and November 2017 were included.

Results

Of 71 eligible patients, 52 (73%) responded and participated. Median age was 50 (range 20-82) and 69% were female. Our day case rate was 86.5%. Eighteen patients (34.6%) sought advice regarding analgesia, gastrointestinal upset or wound problems, and three (5.7%) were readmitted to hospital. There were no biliary complications. Seven patients had been reviewed by telephone and two at clinic. Nine deemed telephone reviews unnecessary but 43 (82.6%) thought a call would have been useful. The most popular time suggested was one week (46%), with a further 30% suggesting follow-up within a month. General feedback was overwhelmingly positive, however two patients felt routine outpatient reviews should be offered.

Conclusion

Patients find telephone review an acceptable method of follow-up, and their preferred timing is one-week post discharge.

Patient Body temperature - Measuring, recording and taking action

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Introduction

NICE (National Institute for Health and Care Excellence) guideline 65 provides guidance on hypothermia prevention and management. We assessed compliance to this guideline at Nottingham University City Hospital's Day Surgery Unit.

Method

Retrospective data collection for all patients having day surgery in a one week period in January 2018. Data collected on pre, intra, post-operative body temperature and warming method.

Results

64 patients were identified. 38 (59%) had general anaesthesia and 26 (41%) had regional or local anaesthesia. 7 (11%) had their body temperature measured in the immediate one hour period prior to surgery. 30 (47%) had a pre-operative body temperature less than 36oC. Intra-operatively 9 (14%) were actively warmed. 32 (50%) were kept warm with a blanket or a pre-heated blanket. 11 (17%) were covered by surgical drapes. In 12 (19%) of cases documentation of the warming method was omitted. Of the patients having general anaesthesia 9 (24%) had an endotracheal tube and 26 (76%) had a supraglottic airway device. 4 (6%) of patients had their body temperature documented during their operation. 48 (75%) had temperature measured in recovery. 16 (25%) performed under local or regional anaesthetic did not have body temperature recordings. 27 (42%) had a temperature of 360C or greater

Conclusion

Missing or poorly completed data for example nonstandard responses limited the audit. Findings will be presented to all staff in day surgery theatres along with a poster highlighting the importance of using all possible warming methods and a re-audit performed in 6 months.

Colour-Edged Operation Note Paper: A Time Saver!

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Introduction

Finding a specific item in a patients' medical records often requires patience. Searching for an operation note can be very frustrating and time consuming. Colour coded paper has long been used for handwritten pro formas, but typed documents are often printed on plain white paper.
The hypothesis that colour-coded operation notes help identification and reduce the time to locate was explored to justify the money spent on paper bearing a pre-printed coloured edge.

Methods

Thirty health care professionals participated. Two sets of notes; 15cm and 2cm deep, each had a typed operation note with a coloured edge and one without, inserted into the notes. Each health care professional was timed to find each operation note in each set of notes.

Results

When comparing the 60 plain notes with the 60 coloured edge notes, a paired T test revealed statistical significance ($p=0.0001$). The mean time to find the plain note was 82 seconds, and the coloured-edge note 20 seconds. The mean difference was 62 seconds.
A paired T test revealed that there was no statistical difference between the size of the notes used for either finding either paper.

Conclusion

Identifiable paper saves time when searching through a set of notes. Using pre-printed coloured edge paper saves over 1-minute searching for the note. This has a real, yet small impact on the efficiency of all healthcare professionals looking after the patient. Although marginal, the potential gains to patient safety should not be overlooked.

Electronic Typed Operation Notes: An Obvious Patient Safety Manoeuvre for Day Case Surgery

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Introduction

Advances in patient record systems mean that typed, electronic operation notes are possible. The Royal College of Surgeons of England (RCS) suggests this as a preferred method incorporating a list of 18 minimum standards that should be present on each note to avoid compromising patient safety

Methods

A sample of 30 hand written notes was audited across a 1-week retrospective period.
A database was then created on Microsoft Access which linked patient administration system Medway to enable an operation note pre-populated with basic data such as patient details and date/time. The completed note was then automatically uploaded to Medway.
A second retrospective audit of 27 notes was conducted 3 months after the introduction of the "E-op Note Database"

Results

Of the first audit 1/10 notes were entirely illegible. Few notes were entirely legible. Overall compliance to mandatory details was 59%. Important details were surprisingly poorly recorded: Time (12%), Estimated blood loss (3%), Surgeon (82%), Venous-thromboembolism (57%), Further antibiotics (58%) to detail a few.
Post-intervention audit revealed that every electronic operation note was entirely legible. Overall compliance improved to 96%. Comparative important details had all improved to 100%. Average time to amend, upload and print a template compared favourably against handwriting, meaning this is an efficient solution between daycase

Conclusion

Electronic operation notes prove to be a quick, legible and consistently reliable. RCS 18 minimum details were radically improved due to prompting and easy selection of information using a template solution. Notes are instantly available when a patient re-attends.