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Anna Dunkley[1], Kim Russon[2], Helen Thornley[1]
[1]*Sheffield Teaching Hospitals, Sheffield, South Yorkshire, UK* [2]*Rotherham Hospital, Rotherham, South Yorkshire, UK*

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Medhat Hashem, Tony Collins, Jeevani Jayawardena, Nabil Abdul-Hamid, Ian Crate
North East London NHS Treatment Centre, Care UK, Ilford, UK

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Mark Abou-Samra, Katharine Stenlake
Musgrove Park Hospital, Taunton and Somerset NHS Trust, Taunton, UK

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Tracy Noble
Torbay Hospital, Torquay, UK

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C. Lalani[1], J Sweeney, D. Lawson, Dr M.L Wattie
Ashford and St Peters NHS Trust
[1]*Ashford and St Peters NHS Foundation Trust, Chertsey, UK*

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RJAH NHS Foundation Trust, Oswestry Shropshire, UK

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Worcestershire Royal Hospital, Worcestershire, UK

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Chesterfield Royal Hospital, Chesterfield, UK

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Lilian Loh, Monalisa Marbaniang, Indu Sivanandano
Leeds Teaching Hospitals NHS Trust, Leeds, UK

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Margaret Aslet1, Steven Wasawo
York Hospital NHSFT, York, UK

A2 Improving the rate of Paediatric Day Case Tonsillectomy

Nimisha Vallabh, James Morrison, Venkat Srinivasan
Arrowe Park Hospital, Wirral, Merseyside, UK

Objectives
Guidelines recommend that 70% of paediatric tonsillectomies should be carried out as day case procedures1. The Best Price Tariff is awarded to trusts meeting this target. Optimising the rate of paediatric day case tonsillectomy also ensures efficient use of available resources. However, recent HES data suggests a day case rate of 40%. The aim of this audit was to determine our paediatric day case tonsillectomy rate and how we can improve this.

Methods
Retrospective audit of all paediatric patients admitted for a tonsillectomy between June 2015 - May 2016 at a single centre.

Results
137 patients were identified. 71 female and 66 male, average age 7.1years. 71 patients were planned as day case but only 70% were discharged the same day. Reasons for unplanned overnight admission were: incorrectly listed as day case (6), vomiting (6), bleeding (2) and others (7). Of the 66 planned overnight stay patients, 8 were discharged the same day and a further 20 were suitable for day case.

Conclusions
Our current rate of day case tonsillectomy is 36% which falls below the guidelines. We are increasing the proportion of morning lists and ensuring accurate documentation and correct listing of patients. The day case criteria at our centre are being reviewed to determine if a greater proportion of patients can safely be listed for day case procedures.

References
1. British Association of Day Surgery (2012) *BADS directory of procedures* (4th edition), London: BADS.

A3 Single Centre Analysis on the Management of Abscesses Using an Ambulatory Care "Abscess Pathway"

Katie Siggens, Alison Luther, Benjamin Stubbs
Dorset County Hospital, Dorchester, UK

Objectives
Abscesses are a common painful condition, often requiring surgical management. They are seldom life threatening, therefore delays to theatre are frequent, leading to patient frustration and wasted bed days. We assessed using an ambulatory surgical care "abscess pathway" to avoid unnecessary admission.

Method
All abscesses (excluding breast/limb) requiring surgery between September and November 2016 were included. All non-septic patients, without significant comorbidities, and where there was no theatre space, were considered for discharge and planned readmission.

Results
25 cases were identified (median age 26 years). 40% (n=10) were operated on the day of admission, with 60% (n=6) discharged that day. 36% (n=9) were assessed and brought back the following day for planned surgery (median age 23, median ASA I), saving 9 overnight stays. 78% (n=7) of these were done as day cases. 24% (n=6) (median age 48.5, median ASA II) were admitted overnight for surgery the following day however, 83% (n=5) of these had a significant co-morbidity.

Conclusion
This data demonstrates that it is feasible and safe to manage abscesses as part of an ambulatory surgical care pathway, resulting in saved bed days. We therefore plan to develop other ambulatory surgical care pathways to improve effective use of resources.

References
Baker J, Windsor J. Management of adult superficial acute abscesses in a tertiary hospital: time for incisive action., *NZMed J*. 2009 May 22;122(1295):37–46

A4 Implications of Unplanned Admissions Following Elective Day Case Surgery in a Stand Alone Unit

Priti Morzaria, Shilpa Pangam

West Suffolk Hospital, Bury St Edmunds, UK

Objectives

Unplanned admissions following elective day surgery procedures to the main hospital have an impact on the patients including their family and carers, but also increased pressure on acute hospital beds including cost implications. The aim of this audit was to analyse these unplanned admissions from a stand alone unit at the West Suffolk Hospital. We also wanted to evaluate compliance with current national guidance and reflect on reasons for admission allowing for service development. [1][2]

Methods

All the unplanned admissions that occurred from the day surgery unit to the main hospital in the year 2016 were reviewed. The information was gathered in paper form from the nursing staff on the day surgical ward.

Results

2824 operations under general anaesthesia were performed in the day surgical unit at West Suffolk Hospital in the year 2016. Out of these only 42 patients had unplanned hospital admissions and 1 patient had a procedure performed under local anaesthesia. 26/43 patients (60%) were admitted due to surgical reasons. 8/43 patients (18%) were admitted due to anaesthetic reasons. 6/43 patients (14%) were admitted due to medical reasons. 3/43 patients (7%) were admitted for other reasons.

Conclusion

The majority of unplanned admissions were due to surgical reasons primarily for post-operative bleeding and where further observations were required. The procedure with the highest admission rate was laparoscopic cholecystectomies. The data also highlighted some avoidable admissions and developing the service could ensure fewer unplanned admissions.

References

1. Quemby D, and Stocker M. (2014). Day surgery development and practice: key factors for a successful pathway. *Continuing Education in Anaesthesia, Critical Care & Pain*, 14 (6), 256–261.
2. Verma R, Alladi R, Jackson I, et al. (2011) *D , Anaesthesia*. 66, 417–434.

A5 Re-audit of Unplanned Admissions from Norfolk and Norwich Day Procedure Unit

Kin So, Anna Lipp

Norfolk and Norwich University Hospital, Norwich, UK

Introduction

Unplanned admissions are an inconvenience to both patients and hospitals. In 2012, our initial audit demonstrated an unplanned admissions rate from the Day Procedure Unit (DPU) at the Norfolk and Norwich University Hospital (NNUH) of 1.46%. The aim of this re-audit was to identify admission rates since the implementation of changes and to guide future protocol and practice.

Method

A retrospective review of all planned day case procedures to be discharged from DPU over a six month period from October 2016 to March 2017. Data was collected from paper records. Variables included: ASA grade, age, speciality, operation, pre/post-operative medications, body mass index, reason for admission and length of hospital stay.

Results

During this period of data collection, 83 patients were identified. 9714 procedures were performed in a six-month period. The most frequent reasons for admission were post operative nausea and vomiting (PONV). Among patients admitted, laparoscopic surgery was the most common procedure carried out.

Conclusion

Since the initial audit, changes implemented includes a more relaxed policy on selected patients going home without carer resident overnight (procedure dependent). Extended opening hours to 22:00. More major procedures undertaken e.g. laparoscopic hysterectomy and Holmium Laser Enucleation of the Prostate (HOLEP).

This re-audit demonstrated the NNUH DPU overall unplanned admission rate to be less than 1%, below RCOA set standard of 2%. However, PONV continues to be a common reason for unplanned hospitalisation. We recommend a review of analgesia and antiemetic practices in day surgery cases.

Reference

http://www.rcoa.ac.uk/document-store/audit-recipe-book- section-5-day-surgery-services-2012 accessed 15/03/2013

A6 Pre-operative Assessment. The role in diagnosing new serious co-morbidities pre-operatively

Rachel Tibble

Royal Derby Hospital, Derbyshire, UK

Objectives

Pre-operative assessment in day surgery has an important role in deciding suitability for day surgery and optimisation of pre-existing conditions to allow safe surgery. Another less recognised role in the discovery of previously undiagnosed conditions that could lead to a critical event during surgery and anaesthesia. We wanted to qualify this by auditing our pre-operative combined anaesthetic and nurse clinics to discover the number of patients with a potentially life threatening co-morbidity diagnosed at pre-operative assessment.

Methods

One year of data from the clinic was studied and patients identified where a new diagnosis was made which led to a change in management for their surgery. This was compared to the total number of patients having a day surgery procedure in our unit.

Results

47 patients were found to have severe previously unknown conditions. 17 were cardiac, including Hypertrophic cardiomyopathy, moderate to severe aortic stenosis, mitral regurgitation needing valve replacement and pericardial effusion. 15 were respiratory which included moderate or severe obstructive sleep apnoea, severe airflow obstruction and a pulmonary embolus. Other were hepatic - haemochromatosis and cirrhosis or haematological disorders such as severe anaemia or thrombocytopenia requiring treatment. One patient required surgery for a parathyroid adenoma first. 10 patients were found where known disease had progressed to a new severity where they could only be offered a local anaesthetic.

Conclusions

Pre-operative assessment has an important role in discovering new co-morbidities of a severity enough to necessitate a change in management for the patients prior to surgery. Our audit found 57 patients in total equating to 1.45% of all patients done in our unit in 1 year. It is worthwhile to promote excellent pre-operative assessment to allow the more complex patients to have a safe journey on their day surgery pathway.

A7 Day case TURP: Safety, cost benefit and patient satisfaction

Fahd Khan[2], Uwais Mufti[1], L Siriwardena[1], B Spencer-Lane[1], Jonathan Gill[1]

[1]*Harrogate & District NHS Foundation Trust, Harrogate, UK* [2]*St James' Hospital, Leeds teaching Hospitals NHS Trust, Leeds, UK*

Objectives

TURP has traditionally been an inpatient procedure [1], although the majority usually require minimal intervention for mild haematuria. We investigate the safety, cost benefit and patient satisfaction of day case TURP at our institution.

Method

In January 2016, day case TURP was introduced at our institution. Data was collected prospectively for all day case and inpatient TURPs from January to October 2016, comparing with retrospective data collection for 2015. Day case patient selection was based on patient preference along with medical and social suitability for day surgery. Patients were invited to complete a satisfaction questionnaire post-operatively.

Results

A 100% response rate for a post-operative questionnaire was obtained. Overall patient satisfaction with day case TURP was high.

	Daycase TURP 2016	Inpatient TURP 2016	Inpatient TURP 2015
No. Patients	17	52	133
Day 0 discharge	14	N/A	N/A
Mean Age (range)	73.3 (60-83)	73.5 (53-88)	73.3 (47-92)
Mean Length of Stay	0.61 (0-6)	1.3 (0-7)	2.2 (1-10)
Days (range)			
Mean Resection weight (g)	16.3	13.8	15.9
Reason for failed day	2 haematuria (irrigation)	N/A	N/A
0 discharge	1 social reasons		

Conclusion

This study confirms the safety and positive patient experience of day case TURP in selected patients. The estimated cost saving per case is £1368.

References

1. Kirollos MM. Length of postoperative hospital stay after Transurethral resection of prostate. *Ann R Coll Surg Engl* 1997; 79: 284–288.

A9 The implementation of a protocol led anaesthetic approach to reduce daycase gynaecological surgery failure rate in an NHS trust

David Hay, Michael Blundell

Northumbria NHS Trust, Northumbria, UK

Objectives

The objectives of this project were to ascertain the incidence of failed gynaecological daycases in our trust, and to identify common factors in failures, which could be addressed through a protocol led anaesthetic approach based on best practice guidelines and evidence (1).

Methods

A list of failed gynaecological daycases from July 2015 to June 2016 was obtained to identify procedures with highest incidence of admission. We obtained patient notes and anaesthetic charts for samples of 10 of each procedure to identify admission indications and common anaesthetic factors. This information was used to formulate a perioperative management protocol including multimodal pre-operative and intra-operative analgesia and anti-emesis, and guidelines on management of post-operative pain, nausea and vomiting (PONV).

Results

Two procedural groups accounted for the majority of failed daycases; laparoscopic hysterectomies (failure rate 51.1%, n=117) and other laparoscopic upper genital tract procedures (failure rate 24.8 % n=145). On analysis of a sample of these cases (n=20) the most common admission indications were surgical factors (40%), pain (25%) and PONV (20%). Use of volatile anaesthesia and intravenous morphine was highly prevalent among admissions for pain and PONV. We have introduced a protocol based approach to anaesthesia utilising multi-modal analgesia and anti-emesis, including use of total intravenous anaesthesia, and adjuvant analgesics such as magnesium (2).

Conclusions

Gynaecological procedures leading most commonly to daycase failure in our trust are laparoscopic surgeries. A heterogenous approach to anaesthesia for these cases may underlie a relatively high admission rate. We introduced an evidence based anaesthetic protocol and will evaluate this approach over the period March to April 2017.

References

1 Campbell N, Hindley J, *Journal of One-Day Surgery*, 2013 Vol 23 No.1 14–15.

2 Sousa et al,Magnesium sulfate improves postoperative analgesia in laparoscopic gynaecologic surgeries. *J Clinical Anaesthesia* 2016 Vol 34 379–84.

A10 Hand and Wrist Day Surgery – Dream or Disaster?

Daniel Morell[1], Chrishan Mariathas[1], Matthew Jones[1,2], Jeremy Stanton[1], Meg Birks[1]

[1]*Northern General Hospital, Sheffield, UK* [2]*University Hospital Coventry and Warwick, Coventry, UK*

Objectives

Simple surgical procedures performed on the hand and wrist have relatively low morbidity and therefore can be performed in the day-case setting. There has been a progressive move to performing more complex procedures as a day-case to avoid costly hospital overnight stay. The rate of re-admission and unplanned overnight stay was investigated before and after a simple intervention at our hand unit.

Methods

All patients readmitted within 48 hours or with unplanned hospital stay following day-case hand and wrist surgery, between April 2012-March 2014 were investigated. Both patient and surgical factors were recorded and data analysed. Following a prospective analgesic intervention combined with patient education at the point of discharge, data was then re-collected retrospectively between March–June 2016.

Results

There were 1709 operations between April 2012-March 2014. Of these, 43 patients were re-admitted or had unplanned overnight stays (2.52%). Patient factors resulting in readmission were pain (67.5%), nausea (10%) and frailty (5%). Of those patients readmitted due to pain 87.1% had a regional block. It was hypothesised that patients were not taking or being given adequate analgesia prior to regional block cessation and therefore were in intolerable levels of pain. For the period March-June 2016 all patients were given simple analgesia and written patient information on when to dose. There were 316 operations in this period and only 1 re-admission (0.32%).

Conclusion

Re-admission and unplanned hospital stay results in a large financial loss for the trust. In our initial investigation the main reason for readmission was due to pain especially in those who had a regional block. Following our intervention of simple analgesia and patient education there was a significant reduction in the rate of re-admission (2.2%).

References

Verma R, Alladi R, Jackson I, et al. Day case and short stay surgery: 2, *Anaesthesia* 2011;66:417–434.

A11 Unplanned admissions on a split site trust: The difference a day surgery unit makes

Moira Wattie

Ashford and St Peters NHS Foundation Trust, Chertsey, UK

Objective

To audit the number of unplanned admissions on both the hot and cold site of our trust and establish the reasons why they occurred and if they can be reduced. The Royal college of anaesthetists audit standard is unplanned admissions should be <2% of all day surgery. [1]

Methods

We audited 7 months of patients, looking at total numbers and percentage of unplanned admissions on each site. The type of operation was ranked as to occurrence of unplanned admissions and the reasons why.

Results

Over the 7 month audited period Ashford hospital [cold site] admitted overnight 93 day surgery patients equating to 159 patients per year 1.9% of all day surgery on that site

St Peters hospital [hot site] admitted overnight 232 day surgery patients equating to 397 patients per year 4.5 % of all day surgery on that site.

Different procedures experienced different rates of unplanned admission.

Reasons for unplanned admission were only recorded on the cold site.

Reasons are charted and analysed

Conclusions

The absence of a dedicated day surgery unit on the hot site more than doubled the numbers of unplanned admissions.

If St Peters hospital was delivering a < 2% unplanned admission rate then that would save 203 excess unplanned admissions per year. Bed costs alone [based on £400 per night estimate] are £81000 per year.

Best practice tariffs would also be gained . Thus ASPH could earn an extra £60,900 as further income if the unplanned admission rate was reduced to <2%.

A conservative estimate would be that 240 unnecessary unplanned admissions per year could be avoided on the St Peters hot site if there was a dedicated day surgery discharge facility such as at Ashford cold site day surgery unit.

Reference

[1] RCOA audit compendium.

A12 An Audit of Unplanned Admissions Following Arthroscopic Shoulder Surgery

Maulik Gandhi, Tressa Amirthanayagam, Ruth Longfellow, Richard Potter

Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, Shropshire, UK

Objective: In our unit, the gold standard for arthroscopic shoulder surgery is for 100% of the planned day cases to be discharged on the day of surgery.

Method

A retrospective audit was performed looking at all planned day case shoulder arthroscopy cases for the five shoulder surgeons during October and November 2016. The admission and discharge date, patient demographics and comorbidities, type of anaesthetic, time of surgery and duration of surgery was noted.

Results

Of the 96 planned day cases 81 (84%) were discharged the same day and 15 (16%) had an overnight stay. The reasons for overnight stay varied from drowsiness, reaction to general anaesthetic, block complication, pain and shortness of breath to social reasons and distance from home. The mean age of the overnight group was 60.6 years (range 20 – 77) compared to 57.7 (22 – 82) in the daycase group. They had similar mean ASA grade of 1.9 for overnight and 1.8 for daycase and similar mean operation time of day (14:15 vs 12:38). The mean duration of surgery was longer in the overnight group at 112 (71 – 172) minutes compared to 85 (49 – 170) minutes in the daycase group. 95 of the 96 cases underwent an interscalene block either alone, with sedation or with a general anaesthetic. In the overnight group 12 of the 15 cases (80%) underwent a general anaesthetic whereas 50 of the 81 daycases (62%) had a general anaesthetic.

Conclusions

It appears that general anaesthetic and longer procedure duration are associated with an increased likelihood of overnight stay. We propose that longer cases are performed earlier in the day. Further work is required to look at underlying causality for length of stay differences between general anaesthetic and 'awake' arthroscopic shoulder surgery.

B1 Patient satisfaction with Physician' Assistants (Anaesthesia)

Howard Cox
Heart of England NHS Foundation Trust, Birmingham, UK

Objective

Physician' Assistants in (Anaesthesia) [P'A-(A)] have worked as qualified practitioners since January 2007 and within this, they have worked within in a two to one model of supervision, there has been no formal evaluation of patient satisfaction of anaesthetic outcome comparing to a Consultant only delivered anaesthetic.

Method

A patient questionnaire was developed using the Delphi principle, this study ran during November and December 2016. One hundred questionnaires were sent out; fifty to patients receiving Day Case anaesthetics from a Consultant only and fifty to those patients receiving an anaesthetic from a P'A-(A) with two to one anaesthetic Consultant supervision. The questionnaires were given to the patients prior to their discharge home. Neither the control nor study group were informed of the data collection been undertaken. A direct comparison of patient reactions to the anaesthetic service they received was elevated and the results for each of the questions were statically analysed using the Chi Square Test.

Results

Within the Consultant only group forty-nine of the fifty questionnaires were returned. Two were incorrectly completed so forty-seven were used in the analysis. Within the P'A-(A) group forty-eight were returned and two were incorrectly completed thus forty-six were used in the study. For each of the ten questions no statistical significance could be found between those patients who received an anaesthetic from a Consultant only and those who received an anaesthetic from a P'A-(A).

Conclusions

This study found no statistical difference in perceived patient outcome quality markers from those who received care from a Consultant in Anaesthetics and those who received care from a P'A-(A). Both groups identified high levels of patient satisfaction. The study offers a valuable snap shot of patient satisfaction with the P'A-(A) profession.

B2 Paediatric Urology Day Case Surgery: A 5 year closed loop audit of length of stay

Ruairidh Crawford, David Ellis, Charlotte Dunford, Sanjiv Agarwal
Imperial College Healthcare, London, UK

Objectives

The NHS Day Surgery strategy launched in 2002 outlined the need to deliver high quality surgery with same-day discharge. The British Association for Day Surgery (BADS) highlight overnight admissions of day-case patients as a key indicator of quality. This is particularly important in paediatric urology surgery, since overnight stays cause distress to children and their families. The aim of our audit was to to improve our practice and prevent all unplanned overnight admissions in paediatric urology.

Method

Retrospective analysis of all paediatric urology day-case elective surgery was performed January 2011-December 2013. An audit was carried out based on nationally recognised standards from current literature. Information regarding the operation type, case number, unplanned overnight admission rate and reasons were recorded. Recommendations were made including altering the intra-operative analgesia, adequately preparing parents by providing written information for post-operative care, and reinforcing timely nurse led discharge from the day surgery unit. We then re-audited in December 2014 and 2015, collecting 5 years of data in total.

Results

The total operative numbers were 545 from 2011-2015. Following the initial audit, all patients undergoing groin and hypospadias surgery received caudal nerve blocks. Parents were provided with verbal and written documentation regarding postoperative care at home. Nursing staff were empowered to lead in discharging patients in a timely manner. After implementation of changes, we re-audited and closed the cycle: the rate of unplanned overnight admissions decreased from 5.2% in 2011 to 0% in 2014 and 2015 demonstrating improved care.

Conclusions

Adequate communication with parents and an MDT approach involving the expertise of our anaesthetic and nursing colleagues has eradicated unplanned overnight admissions in paediatric urology day case surgery within our unit.

B3 Can Regional Anaesthesia facilitate day case Mastectomy surgery? A Quality improvement project

Amitabh Aggarwal[2,1], Mike Blundell[1], Seb Aspinall[1]

[1]*Northumbria Trust Hospitals, Northumberland, UK* [2]*Northern Deanery, North East, UK*

Introduction

Breast Surgery is one of the common surgeries performed worldwide with about 16,485 women undergoing mastectomy in 2008-2009. Regional Anaesthesia (RA) modalities have evolved with time with thoracic paravertebral block being the most widely used technique currently. New technique of Pectoral nerve (Pecs) block, developed recently, has been shown to be devoid of major adverse effects.

The aim of this Quality improvement project was to evaluate the effect of Pecs block on patients undergoing simple mastectomy surgery.

Methods

This was a prospective Quality improvement project looking at the usefulness of RA for simple mastectomy surgeries, especially after the introduction of the Pecs block. The primary outcomes evaluated were post-operative analgesia at 4 and 8 hours, opioid use, episodes of PONV and if RA facilitated performing mastectomies as a day case.

Results

Data was collected regarding 52 simple mastectomies, with 29 cases having no RA and 23 cases having Pecs block.

Patients receiving Pecs block had lower pain scores at 4 hours (Mean pain score 2.5 with RA vs 4.6 without RA) and 8 hours (Mean pain score 1.8 with RA vs 3.6 without RA) post mastectomy surgery

More patients having Pecs block were discharge as day case (82.6% vs 10.3%) and had a less incidence of PONV (8.7% vs 44.83%). The 24 hour opioid consumption was less when Pecs block was administered.

Conclusions

Taking active steps to facilitate mastectomy as day case is an important initiative. The encouraging results of the study make Pecs blocks an attractive option as part of multi-modal analgesia post mastectomy. Patients receiving Pecs block benefit by better overall patient satisfaction, lower postoperative pain, decreased opioid use, less incidence of PONV and earlier discharge to home. Better management of acute pain may decrease the incidence of chronic pain post mastectomy.

References

1. National Mastectomy and Breast Reconstruction Audit © 2011.

B4 Does Intra-operative Cholangiography reduce the 28 day readmission rate following Day Case Laparoscopic Cholecystectomy ?

Chaminda Sellahewa, Eranda Karunadasa, Sajith Ranatunga, Richard Evans, Sherif Abbas, Ravinath Gunasiri, Nuzair Nizam

Russells Hall Hospital, Dudley, West Midlands, UK

Objective

The role of Intra-operative Cholangiography(IOC) during day case laparoscopic cholecystectomy is widely debated. NICE emphasizes the need for large, high-quality trials to address clinical questions about the benefits of IOC. Our upper GI unit recently started intra-operative cholangiography in day case laparoscopic cholecystectomy(DCLC) and our objective is to find out whether IOC reduces the 28 day readmission rate.

Methodology

This retrospective study was done in the Upper GI firm of a District General Hospital in UK. Consecutive patients were included over the period of 2 years (2015-2016). Data were collected from the computer data base. Readmission is defined as patients getting admitted or visiting hospital within 28 post procedure days due to any procedure related complications. The comparison was made between IOC coded and IOC none coded elective day case laparoscopic cholecystectomy groups.

Results

Over the last 2 years total of 452 (221 in 2015 and 231 in 2016) patients underwent elective DCLCs. Out of which 135/452(29.8%) had IOCs {16/221(7.2%) in 2015 and 119/231(51.5%) in 2016}. Day case rate for IOC group was 102/135(75.5%) correspondingly for non IOC group this was 237/317(74.8%). However 28 day readmission rate for IOC group was 9/135(6.7%) whereas for the non IOC group this was 43/317 (13.6%). Consequently there is a statistically significant ($p<0.05$) reduction in 28 day readmission rate for the IOC group.

Conclusion

IOC reduces 28 day readmission rate after elective DCLCs and therefore we recommend carrying out IOC for all DCLCs.

References

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2. Minimally Invasive Surgery, Volume 2011 (2011), Article ID 564587, 5 pageshttp://dx.doi.org/10.1155/2011/564587,
3. The Royal College of Surgeons of England HPB SURGERY Ann R Coll Surg Engl 2009; 91: 583–590 doi 10.1308/003588409X432365, Introduction of a day-case laparoscopic cholecystectomy service in the UK

B5 Reconfiguration of Anaesthetic Services at a Short Stay Satellite Unit to support and help relieve Winter Pressures

Monalisa Marbaniang, Kumar Mekala, Moira O'Meara

Leeds Teaching Hospitals NHS Trust, Leeds, UK

Objectives

Reconfiguration of anaesthetic services to support conversion of a Short Stay Unit (SSU) to a 23-hour unit: Will it help relieve winter pressures in a large Teaching hospital with a significant number of acute admissions?

Methods

In Leeds Teaching Hospitals NHS Trust, winter pressures in 2016/17 caused 'congestive hospital failure' affecting patient care adversely. To relieve some of the pressure from surgical waiting list breaches, an innovative idea was introduced. Over a 6-week period a trial was undertaken, a Short Stay satellite day case unit was converted to a 23-hour unit. To facilitate the change, anaesthetic services underwent significant reconfiguration.

Patient selection at pre-assessment was revised, allowing higher medical, anaesthetic and surgical risk patients, to be operated upon in the SSU. Anaesthetic rotas were reconfigured introducing all day lists. Anaesthetic practitioners were utilised in a perioperative role enabling staggered arrival of patients, they also provided cover on the ward and recovery. Consultant anaesthetist out of hours' cover was provided.

Results

Availability of overnight stay enabled ASA 3, more complex surgical, higher BMI and patients with day case social issues to be operated upon at the SSU. In total 131 patients utilised the extended hours facility. Better patient care and satisfaction resulted. Lesser number of cancellations meant the Trust gained financially.

Conclusions

The trial was put together as a last minute winter pressure relieving measure. Planned well in advance it will work better, supporting the Trust during periods of winter pressures each year.

References

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2. BMA Briefing paper: Beating the effects of winter pressures https://www.bma.org.uk/media/winter%20pressures/winterpressuresreport2013.

Public Health England. Cold Weather Plan for England: Protecting health and reducing harm from cold weather. https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

B6 The Effect of Pre-Operative Pain on Day Surgery Outcomes

Navreen Chima, Jane Montgomery

Torbay Hospital, Torbay and South Devon NHS Foundation Trust, Devon, UK

Objectives

Increasing numbers of patients are living with chronic pain conditions and are utilising opioid based analgesics regularly. These patients have been identified as at risk of severe post-operative pain. It is not clear if these risk factors bear any validity in the ambulatory setting. We have reviewed the effect of pre-operative pain on progression through a day case surgery pathway.

Methods

We conducted a one year retrospective analysis of all patients treated through our day surgery unit. 12 620 patient records were reviewed and 84 were deemed to be high risk of peri-operative pain based on a four question screening tool, previously validated for patients undergoing inpatient surgical procedures3.

Results

All patients completed the day case pathway as planned and there were no unplanned admissions. Six had a numerical pain score greater than zero upon discharge from primary recovery, and had all undergone orthopaedic procedures. Two patients had severe pain at 24 hours and required further medical input. The cohort of patients had both variable anaesthetist and anaesthetic technique (Table 1).

Conclusions

This strongly suggests that chronic pain should not be a barrier to day case surgery and that input from pain management services are unlikely to be required in the ambulatory setting.

References

1Magides, A., Carter, S., Day, R., Natusch, D., Do pre-operative screening questions on pain predict a worse post-operative pain experience? An exploratory audit, British Journal of Pain; (2013); 7(2 Suppl):5-76

ANAESTHETIC TYPE

Anaesthetic Type	Number of Cases
LA	7
REGIONAL BLOCK	4
SEDATION	1
TIVA & IPPV & ETT	14
TIVA & IPPV & LMA	3
TIVA & SR	13
TIVA & SR & ETT	2
TIVA & SR & LMA	33
VOLATILE ANAESTHESIA & IPPV & ETT	6
VOLATILE ANAESTHESIA & IPPV & LMA	1
VOLATILE ANAESTHESIA & SR & LMA	1

P1 Laparoscopic Cholecystectomy – A review of surgical outcomes in a tertiary hospital

JIE LIM, Christopher Ray, Paul Glen

Queen Elizabeth University Hospital, Glasgow, UK

Objectives

Laparoscopic cholecystectomy(LC) is the most commonly performed abdominal surgery in the Western world. It has been established as a day surgery operation with recommendations that 60% of it being carried out as day surgery in specialist units. We aim to assess the outcomes of LC after the amalgamation of four hospitals and reorganization of surgical services in Glasgow.

Methods

Patients who had LC from May 2015 to February 2016 were retrospectively identified from theatre database. Their demographics, intra and post-operative details were examined. Chi square and Mann-Whitney U test were employed for statistical analysis.

Results

321 patients' records were analysed. Median age of patients was 52. The female to male ratio was 2.87: 1, but sex of patients did not significantly affect outcome of surgery. Elective LC outnumbered urgent cases by a ratio of 3:1. Average age of patients who had elective surgery was higher than urgent cases (52.3 years vs 46.9 years [p<0.0001]). Urgent surgery was found to consume more operative time (98 minutes vs 88 minutes [p<0.0001]). Urgent LC also predisposed patients to higher risks of conversion to open surgery. (Overall conversion rate:5.3%; Urgent LC:8.6%; Elective LC:4.2% [p=0.12]). Urgent LC, longer duration of surgery and conversion to open surgery correlates to longer hospital stay (p=0.0048, p=0.00132 and p=0.0027 respectively). We observed 10 patients who were readmitted with complications, where five had intraabdominal collections, four had bile leak and one had bile duct injury. No significant difference in complication rates exist between elective and urgent procedures.

Conclusions

LC is a relatively safe surgery, and when planned carefully as an elective procedure, dangerous complications are potentially avoidable.

P2 Solving the Consent Problem: A Cross-Specialty Approach

Dafydd Loughran[1], Imran Haq[2], Jade Harrison[5], Jason O'Neill[4], Ben Sharif[4], Andrew Beamish[3]

[1]*Surgical Consent, Cardiff, UK* [2]*Oxford Deanery, Oxford, UK* [3]*Gothenburg University, Gothenburg, Sweden* [4]*Wales Deanery, Cardiff, UK, 5Cardiff & Vale UHB, Cardiff, UK*

Objectives

The 'Montgomery Judgment' has changed the landscape for informed consent, both for patient & surgeon. This change, as warned in recent RCS England guidance, is expected to lead to a significant increase in litigation if the profession do not change practice.

Our initial aim is to develop a resource that allows clinicians to provide comprehensive procedure specific complication and outcome data. Subsequently, integrating this resource, a platform that facilitates shared decision making will be developed, improving patient engagement, experience and ultimately outcomes.

Methods

Extensive cross-specialty analysis of published procedural complications & outcomes undertaken by a team of 43 UK consultant & SPR specialty advisors, leading to development of a comprehensive procedure specific consent resource to be used in conjunction with clinical acumen.

Results

Following previous published work demonstrating significant national variation and deficiencies in consent practice this work demonstrates a concerted approach to solving a clinical problem.

Conclusions

Project shows the potential of the systematic synthesis of available surgical outcome data to develop useful applications for clinicians and patients.

Team are proceeding to implementation of the resource into clinical practice, using Quality Improvement and Lean methodology, and the subsequent development of a 'Consent Clinic' shared decision making electronic platform.

P3 Adequacy of post-operative pain relief after discharge: A comparison of college proposed targets with a Welsh District General Hospital Day Surgery Department

Gianluca Trisolini Longobardi, Doddamanegowda Chethan

Prince Charles Hospital, Merthyr Tydfil Anaesthetics Department, Merthry Tydfil, UK

Objectives

How does Prince Charles Hospital, Merthyr Tydfil compare with the proposed targets set out by The Royal College of Anaesthetists (RCoA) Audit Recipe Book1;

- <5% reporting "severe" pain on verbal pain score in the first 48 hours after discharge
- >85% reporting "none" or "mild" pain after discharge

Method

Data was collected in accordance to the RCOA Audit Recipe Book1. This involved the use of the Theatre Management System (TMS) and a post-operative telephone proforma which qualified verbal pain scores. The data collection period lasted from 25/01/2017 to 26/02/2017.

Results

A total of 83 operations which involved anaesthetics were carried out. Of these cases;

- 3.6% (3/83) reported "severe" pain at the post-operative phone call
- 66% (55/83) reported "none" or "mild" pain at the postoperative phone call
- 18% (15/83) did not answer the post-operative phone on two separate occasions

Furthermore 69% (9/13) who reported "moderate" or "severe" pain post-operatively were gynaecological cases including laparoscopic techniques and endometrial ablations.

Conclusions

We are delighted to see the number of "severe" pain scores better the suggested target. That said, we will look to improve the "none" or "mild" scores to achieve the proposed targets by the next audit.

Consequent changes to practice have already been discussed including;

- The encouraged use of morphine for gynaecological and laparoscopic procedures
- Active control of pain in recovery with appropriate analgesics
- Liaise with the pharmacy department regarding the role of stronger opiates such as oramorph to be given as take home medication

References

1. The Royal College of Anaesthetists. *Audit Recipe Book: Section 5, Day surgery services* (2012). http://www.rcoa.ac.uk/document-store/audit-recipe-book-section-5-day-surgery-services-2012 (accessed 26/03/2017).

P4 Audit of the Recording of Hba1c, Blood Pressure and BMI in Elective Surgical Referrals From Primary Care

Nazrul Islam[2], Thazin Wynn[2], Joseph Pease[2], Anna Lipp[1,2]

[1]*Norfolk and Norwich University Hospitals NHS Foundation Trust, Norwich, UK* [2]*Norwich Medical School, Norwich, UK*

Objectives

Updated guidelines for the peri-operative management of patients with diabetes and hypertension were recently published, and suggest primary care referrals to surgery should include information regarding patients' diabetic control (HbA1c) and blood pressure (1,2) This allows optimisation of glycaemic control and BP before surgery to reduce the risk of complications, prolonged hospital stay and procedure cancellation; which impacts the patient's physical and mental health, and has significant financial implications. This audit aims to assess whether surgical referrals from primary care are including this information, and to identify if certain referral formats include them more consistently.

Method

Data including diabetic status, HbA1c and BP readings were collected from routine referrals between January-February 2017; encompassing 200 adult patients from breast, urology, general and vascular surgery. The number of referrals including this information was calculated, as well as whether they were within guideline limits.

Results

185 referrals contained information on comorbidities, of these – 19 patients had diabetes, 3 of which had accompanying HbA1c levels. Of the 57 patients with hypertension: 49 referrals included a BP measurement and 6 were above the advised range.

Conclusions

Few referral letters provided sufficient information recommended by guidelines. Better reporting of HbA1c levels is necessary. BP, BMI and smoking status was reported more often, however not consistently. Electronic summaries, e.g. SYSTMONE, were most likely to contain the necessary information. A standardised proforma for elective referrals may be useful in ensuring that relevant information is included. It may be the case that the new guidelines are not yet fully integrated within primary care.

References

1. Association of Anaesthetists of Great Britain and Ireland. Peri-operative management of the surgical patient with diabetes 2015. *Anaesthesia* 2015; 70: 1427–1440.
2. Hartle A et al. The measurement of adult blood pressure and management of hypertension before elective surgery. *Anaesthesia* 2016; 71:326–337.

P5 Developing a laparoscopic cholecystectomy "recipe"

Anna Dunkley[1], Kim Russon[2], Helen Thornley[1]

[1]*Sheffield Teaching Hospitals, Sheffield, South Yorkshire, UK* [2]*Rotherham Hospital, Rotherham, South Yorkshire, UK*

Objectives

AAGBI (1) recommended that protocols for anaesthetic management of laparoscopic cholecystectomy improves outcome. BADS directory (2) recommends a day case rate of 60%. This service review of all patients having laparoscopic cholecystectomy was undertaken with an aim to develop a "recipe" based on what works best for our patients and our anaesthetists to guide anaesthetic management of laparoscopic cholecystectomy.

Method

All patient notes (bar one) between February and July 2016 were reviewed in Rotherham Hospital, a district general hospital in South Yorkshire. A total of 152 cases were reviewed, 108 daycase, 22 inpatient and 22 hot. Data was collected retrospectively.

Results

10 patients planned as daycase were admitted, 9% admission rate, length of stay range 1-4 days, average = 1.9 days. Reasons included complex surgery with drain, bleeding of 500ml, urinary retention, pain and nausea.

Planned in-patient average stay 1.6 days, 1-6 days range

Hot lap chole average 1.7 days, 0 - 3 days range

Pre-medication given included paracetamol, NSAID, PPI/H2 antagonist, Domperidone, Acupin.

Intra-op analgesia included paracetamol, NSAID, Tramadol (50-200mg), Morphine (average 9.7mg, 5-20mg range), Diamorphine (average 8.7mg, 5-10mg range), Clonidine, Ketamine, Fentanyl and Alfentanil.

The mean total intra and post-op dose of morph/diamorphine was 12.2mg.

Total opiate requirement was increased if the patient received intra-operative remifentanil, ketamine, clonidine or tramadol.

All bar one case received anti-emetics either pre/intra/post operatively.

Time from arrival in 1st stage recovery to discharge home ranged from 2hrs 25mins to 8hrs 35 mins.

Conclusion

We have identified factors which have allowed us to develop a local "recipe" / guideline .

References

1 *Day Case and Short Stay surgery* The Association of Anaesthetists of Great Britain & Ireland, The British Association of Day Surgery, May 2011.

2 *Day Case Laparoscopic Cholecystectomy*, 2nd Edition, May 2010, British Association of Day Surgery.

P6 Impact of culture change on the rising trends of same day discharge following laparoscopic cholecystectomy

Medhat Hashem, Tony Collins, Jeevani Jayawardena, Nabil Abdul-Hamid, Ian Crate

North East London NHS Treatment Centre, Care UK, Ilford, UK

Objectives

North East London NHS Treatment Centre decided to promote day case discharge of patients undergoing laparoscopic cholecystectomy (LC) to 60% (1). The main obstacles of same day discharge include variation in surgical and anaesthetic techniques and cultural resistance. This abstract examines same day discharge rates for patients undergoing LC from 2010 to 2016.

Method

A project plan was devised by lead personnel who agree multidisciplinary perioperative protocols to minimize practice variability. The surgical protocol included pre-emptive local wound infiltration with L-Bupivacaine, intra-abdominal L-Bupivacaine prior to commencing dissection and proscription of routine drain placement. Anaesthetic protocol included perioperative multi-modal analgesia and full prophylaxis for post-operative nausea and vomiting. On the 4th of January 2011, we promoted patients' expectation, that they will be discharged on the same day following LC. Data were extracted from electronic patient records and included all patients admitted for LC including those admitted as planned inpatients for either social or clinical reasons and were those admitted for overnight stay from the day case pathway. All patients were ASA 3 or less with BMI less than 42.

Results

The percentage of day case LC increased from 14% in 2010 to 84% in 2016.

Conclusion

Our results showed that the introduction of standardised surgical and anaesthetic protocols will enable a unit to achieve the recommended BADS day case rate of 60% within one year. The results demonstrate that improvement continues to be seen over the whole six year period, although the protocols and techniques have not changed. This we believe is due to the slow but inexorable cultural change throughout all staff within the Treatment Centre, who now believe that LC "should be" done as a day case, rather than passively accepting that it "can be" done.

References

1. *BADS Procedure Directory* 4th Edition 2012. British Association of Day Surgery.

P7 Our patients are a fire hazard! Time for a culture shift in daycase fluid starvation?

Mark Abou-Samra, Katharine Stenlake

Musgrove Park Hospital, Taunton and Somerset NHS Trust, Taunton, UK

Objectives

To quantify pre-operative fluid restriction periods, how thirsty patients are at induction of anaesthesia and identify correlation between the two. In addition, understand why patients are not drinking fluids up to 2 hours prior to surgery.

Methods

Prospective data on time of last drink, thirst and type of surgery were collected in March 2017. Thirst scores were obtained using a visual analogue scale. Scores were grouped (1-5=mild, 5.1-10=moderate, 10.1-15= severe).

Results

Total of 53 patients surveyed.

11% of patients had no fluids for >11 hours, 38% for >6 hours and 69% for >4 hours. Almost all (85%) had not had fluid for >2 hours.

Thirst score	n
Mild	9 (17%)
Moderate	21 (40%)
Severe	23 (43%)

There was no obvious correlation between starvation time and thirst scores. The patient with the lowest thirst score was starved for >12 hours whilst 6 out of 7 who were starved between 2-3 hours scored between 6.1 & 11.1.

Conclusion

Our current patient information, based on the AAGBI guidelines (1) advises free fluids until 2 hours preoperatively. This is not being followed. Reasons include not waking up in time, miscommunication and patient's preconceived ideas. Those on morning lists were more likely to have a longer starvation period (n=6 >11hrs) than afternoon patients (n=2 >9hrs). Active encouragement in the preoperative period is needed to avoid prolonged starvation times. Other units allow clear fluids up to theatre itself. Risk of aspiration in elective patients is low and subsequent risk of serious co-morbidity is even lower (2).

It is clear that we need to change our practice.

References

1 Smith I, et al. Perioperative fasting in adults and children: guidelines from the European Society of Anaesthesiology. *European Journal of Anaesthesiology* 2011, Vol 28 No 8.556–569.

2 Thomas M, Engelhardt T. Think drink! Current fasting guidelines are outdated. *BJA* 118(3):291–3(2017).

P8 Are the paediatric tonsillectomy patients being provided with adequate TTAs

Tracy Noble

Torbay Hospital, Torquay, UK

Objectives

The purpose of this audit was to identify if we were providing adequate pain relief for our paediatric tonsillectomy patients on discharge home. Our pain protocol is for these children to be sent home with paracetamol and ibuprofen . A paediatric regional nurses forum identified that Torbay Hospital was one of the only hospitals in the area that was not giving the tonsillectomy patients Oramorph on discharge . Previously patients received TTA codeine but this was stopped as per national guidelines.

Our aim was to ascertain that the patients were comfortable at home post operatively, were receiving adequate pain relief and to ensure they were receiving the best care which was not impacting on other community services.

Method

An audit was designed to ascertain whether the pain relief was adequate. The patients routinely receive a phone call the day after surgery however further information was needed for this audit. The parents were informed of the audit and permission was gained. They were then contacted by phone 1 week post op and asked if the pain relief given had controlled their child`s pain or if they had to have additional analgesia prescribed.

Results

30 patients were included in the audit aged from 2 to 17. Only 1 required additional pain relief but it was not oramorph. The feedback was that the parents felt that their child had been comfortable and had not needed additional analgesia.

Conclusion

The audit was conclusive and indicates that the analgesia provided on discharge home is providing adequate pain relief for the paediatric tonsillectomy patient`s. This meant we do not have to change the TTA protocol for this group of patients.

P11 Influence of a pathway on Laparoscopic cholecystectomy outcomes

C. Lalani, J Sweeney, D. Lawson, Dr M.L Wattie
Ashford and St Peters NHS Foundation Trust, Chertsey, UK

Objective
To assess if a standardised pathway for laparoscopic cholecystectomy improved pain scores and increased patient satisfaction. To evaluate attitudes to standardising pathways of the anaesthetic staff.

Having noticed a disparity in post operative pain and analgesia requirements in patients undergoing Laparoscopic cholecystectomy. A pathway for management of lap choles was devised and distributed. [1]. This pathway included suggestion for perioperative analgesia regime. The initial feedback from recovery staff was the patients on the pathway experienced less pain in recovery.

Methods
This audit looked at 52 patients undergoing lap chole over a 3 month period and compared analgesia requirements and patient satisfaction of those patients on the pathway and those that deviated from the pathway. We also looked at attitudes to a pathway amongst the anaesthetic medical staff and willingness to standardise techniques.

Results
Initial results show that those that followed the pathway required less analgesia in recovery. Where the pathway was followed (pre-med and intra-op): post-op pain occurred in 4.5% cases

Where the pathway was not followed (neither pre-med nor intra-op): post-op pain occurred in 50% cases. The rate of unplanned admission remained the same however.

Patient experience rating were all good to excellent and appeared to be independent of pain scores.

Conclusions
Attitudes amongst anaesthetic staff to standardising a Lap chole pathway were varied.

We concluded that patients were better managed on a standardised pathway due to improved post operative pain scores with reduced analgesia requirements. However it did not affect unplanned admission rate. The timing of clexane should also be standardised to avoid double dosing and this would be another advantage of a pathway.

References
1 *JODS* Vol22, No4.

P12 Reaudit of Day Case ACL Reconstruction at RJAH NHS Foundation Trust

P Craig, A Jaiswal, P Gallacher, R Longfellow
RJAH NHS Foundation Trust, Oswestry Shropshire, UK

Objectives
A primary audit of ACL reconstruction resulted in the following recommendations:

i. Create a protocol for pain and PONV management, to enable patients to manage their symptoms at home. Addition of rescue oromorph doses and antiemetics on TTO to be standardised.

ii.Re-audit once these measures are in place

A re- audit was then undertaken to assess patient experience following introduction of standardised analgesia TTO after day case ACL reconstruction.

Method
A data collection tool was produced. This was used on the day of surgery, then by the nursing team in the day case unit during follow-up telephone consultations with the patients. Repeat calls were made to ensure high follow up rates. Data was collected on Microsoft excel

Standards
All patients should receive the following (unless CI) Cocodamol, ibuprofen, oramorph, ondansetron

Results
22 patients were included in the audit. 1 converted to overnight stay. Intra-op analgesia lasted mean 8 hours (2-26 hours)

12 hour pain score 6.8/10 (0-9 / 10). 24 hour pain score 6/10 (3-8 / 10). 6 Patients used antiemetics. 10 patients used oramorph

PONV reported in 10/21. 5 of these 10 patients specifically attributed PONV to oramorph

All 21/21 patients would be happy to have the procedure as a day case again

100% patients were prescribed TTO Cocodamol, ibuprofen, oramorph, ondansetron

Conclusions
All 21 patients were satisfied with day case ACL reconstruction care. 3 patients who complained of PONV did not realise Ondansetron was to treat sickness and so had not taken any.

Medicines information should be improved to ensure that patients understand what medicines they are taking and for what purpose. Oramorph was required in fewer than half of cases but was associated with 50% PONV. Despite this patients should have the option to take oramorph at home to manage their pain.

P13 Cholecystectomy post Acute Gallstone Pancreatitis, are we meeting the guideline targets?

Nichola Coleman, Voon Kune Lim

Worcestershire Royal Hospital, Worcestershire, UK

The aetiology of pancreatitis is multi-causal, in the United Kingdom gallstones is considered a primary precipitator (1). This audit was completed to evaluate the rate and timing of cholecystectomies following a diagnosis of gallstones pancreatitis.

Aims

1. To evaluate the rate of cholecystectomies performed during the index admission or within two weeks post discharge.
2. To review readmission rate and examine the cost implications of secondary admission versus guideline advised cholecystectomy (1).

Method

Patient notes containing a diagnosis of pancreatitis were assessed between 01/07/2016 - 30/09/2016. Diagnosis was determined using a rise in amylase and gallstones seen on imaging. The notes were reviewed for co-morbidities, justifications for not operating during the index admission, and proposed date of surgery.

Results

- 15 eligible patient notes were identified.
- 1 patient with gallstone pancreatitis had their operation as per guidelines (1).
- 12 patients had their procedure post-discharge (between 39-173 days).
- 4 of the patients were re-admitted with pancreatitis and 1 patient with cholecystitis; this lead to an extra 31 days admission, with an estimated additional cost of £49,879(2).

Discussion

The guidelines for cholecystectomies post gallstone pancreatitis appear not to be being followed; there is a significant delay in surgery, resulting in some cases with readmission for pancreatitis or cholecystitis. The majority of patients had few co-morbidities and were suitable for day case surgery.

Recommendations

1. To liaise with the theatre and management teams to increase availability of theatre space for patients with gallstone pancreatitis.
2. To liaise with the anaesthetic department for patient reviews to maximise the use of day surgery slots.
3. To re-audit after discussions and recommendations have been implemented.

References

1. UK Working Party on Acute Pancreatitis (2005) UK Guidelines for the Management of Acute Pancreatitis; *GUT*, 54;1–9
2. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

P14 Improving The Day Case Mastectomy Rate at Chesterfield Royal Hospital

Shazia M Khan, Mahmoud Bakr, Iman A Azmy, Ciaran J Hollywood, Amar Jawad, Julia C Massey

Chesterfield Royal Hospital, Chesterfield, UK

Objectives

In 2016 BADS target for day case mastectomies was 30%1. At Chesterfield Royal Hospital we achieved 25%2. To try to improve this we conducted a retrospective audit, aiming to document inpatient mastectomy rate, determine causes for inpatient stay and identify modifiable factors.

Method

All mastectomies performed in our unit over 4 months were included. Studied factors influencing inpatient stay included: availability of responsible adult at home post operatively, distance from hospital, co-morbidities, ASA, type of surgery, use of wound drain, regional block, morphine and anti-emetics.

Results

27 patients had mastectomies. 8 day cases were excluded, making our day case mastectomy rate for this period 30%. One patient was excluded as case notes were unavailable. Unplanned admission accounted for 2 inpatients (PONV, desaturation). Unavailable carer accounted for 3 of the 16 planned inpatients. ASA ranged from 1 to 3 with 3 patients requiring planned stay due to co-morbidity and frailty. 2 patients had bilateral mastectomies which was their reason for planned admission. 8 patients had axillary node clearance (ANC). For 4 of these ANC was their only reason for admission. All 4 patients with drains were planned as inpatient. 3 of these had other reasons necessitating admission. Distance from hospital, morphine, anti-emetic and block use did not impact admission rate.

Conclusions

This snapshot audit highlights that we need robust documentation of and consistency in admission planning for different types of surgery as ANC and bilateral mastectomies alone do not need inpatient stay. A new unit policy is required to not use drains in axillary clearances. We will re-audit our practice following implementation of these changes.

References

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P15 Patient reported postoperative outcomes following day surgery in Leeds Teaching Hospitals NHS Trust (LTHT): Guiding quality improvement using TheatrePro

Lilian Loh, Monalisa Marbaniang, Indu Sivanandan
Leeds Teaching Hospitals NHS Trust, Leeds, UK

Day surgery units (DSU) provide efficient surgical care that is cost-effective, and is considered best option for 75% of elective operations. Increasing numbers of patients are considered fit for DSU, leading to demands for its availability. Quality improvement in DSU is based on quality of care received and unit efficiency. Patient surveys aid in assessing quality of care. Studies show higher patient satisfaction with good post-op pain control and no postoperative nausea and vomiting (PONV).

Method
TheatrePro is an online platform that records real-time information regarding every operation in LTHT. It records metrics regarding theatre efficiency and provides feedback from each patient regarding specific postoperative patient reported outcomes (pain, PONV) and temperature. Theatre metrics are entered in real-time while the operation is ongoing, and patient feedback is collected in recovery and entered into the online system. Each individual consultant anaesthetist can access the platform and obtain personalized, objective outcomes regarding care delivered.

Results
The online platform gives easily understood information from patient feedback for postoperative outcomes (pain and PONV) and temperature. Scores are displayed in comparative percentages and pie charts. There were variations noted amongst consultants in the outcomes. Easy access to regular real-time feedback helps in guiding delivery of a good anaesthetic, and be used for revalidation

Discussion
Displaying the outcomes in comparative percentages allows variations in postoperative care to be easily noticed. This helps focus on areas requiring immediate improvement. TheatrePro enables room for personal development and encourages meaningful quality improvement to better patient care.

References
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2 Jenkins K, Grady D, Wong J, Correa R, Armanious S, Chung F. Post-operative recovery: Day surgery patients' preferences. *British Journal of Anaesthesia* 2001;86:272–4.

P16 Mired in Inertia – A Drive to Increase Day Case Laparoscopic Cholecystectomy Rates

Margaret Aslet, Steven Wasawo
York Hospital NHSFT, York, UK

Introduction
York has had low laparoscopic cholecystectomy day case rates, a nadir of 6% in 2010-11. The day case rate increased but remained stagnant at 40-45% from 2014-16 with the introduction of a pathway standardising anaesthetic technique and change of culture. We revisited day case laparoscopic cholecystectomy with a view to improving day case rates.

Method
The patient journey was examined and an existing pathway was updated. Retrospective data was collected on patient demographics, date and time of surgery, whether all, part or none of the pathway was used. The primary outcome was the day case rate. Key components of the pathway were analysed to assess whether they influenced the same day discharge rate.

We advocated that; laparoscopic cholecystectomy should be routinely booked as day cases, laparoscopic cholecystectomies should be scheduled on the morning or first on the afternoon list, multi-modal pre-med analgesia and standardised intra-operative local anaesthetic used, morphine should be avoided and use of dual anti-emetics resulting in decreased pain scores, decreased requirement for rescue medication and decreased length of stay in PACU and increased chance at same day discharge

Results
Rates have increased to 50-60%. 95% of cases were booked as day cases. A substantial increase in overnight stays was noted if anaesthetic start time was after 14:00. The most common reason for overnight stays were late start times. There was a positive correlation between same day discharges and the proportion of pathway followed; 37.5% if none, 50% if part of it and 100% if all of it was followed.

Conclusions
Increased day case laparoscopic cholecystectomy rates remain multi-factorial. This study, though small in numbers, demonstrates that a change in culture and adherence to a dedicated laparoscopic cholecystectomy pathway results in increased day case rates

References
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