

investigation results. We conducted a retrospective review of clerking documentation against criteria with target standards of 100% for all criteria.

Results: The initial audit (n=30) identified need for improved documentation in 8 out of 10 criteria. A clerking proforma was instigated and documentation re-audited (n=51). Improvement was observed in 5 out of 10 criteria. Notably at re-audit 100% (audit 96%) of clerking documentation contained a clear management plan and 90% (audit 67%) included a clinical impression or diagnosis.

Conclusion: A clerking proforma can improve documentation and therefore improve written communication and patient safety.

0383: AN AUDIT OF PREOPERATIVE FASTING TIMES FOR SURGICAL PATIENTS AT A DISTRICT GENERAL HOSPITAL

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Aim: Surgical patients have traditionally been starved for at least six hours before a general anaesthetic, with many patients made 'nil-by-mouth from midnight'. Current literature shows that shorter fasting times do not result in an increased risk of aspiration, regurgitation or other related morbidity when compared to traditional fasting policies, and that patients should rather be encouraged to drink. Shorter fasting times enhance recovery post-operatively and may improve patient experiences. We aimed to see whether patients at our hospital were being starved appropriately.

Methods: Preoperative fasting times from food and fluid were audited prospectively against recommendations over one day in theatres at our hospital. Patients were also asked about their level of discomfort.

Results: The data for 20 adult patients was collected. The mean fasting time for elective patients was 14h 16min from food and 3 h 53 min from fluid. The mean fasting time for emergency patients was 13 h 7min from food and 9 h 57 min from fluid. Mean fasting time from fluids in elective patients was significantly shorter than in emergency patients (p=0.005).

Conclusion: Fasting times at our centre are longer than recommended, particularly for emergency surgical patients. Increased fasting time from fluid may be associated with higher levels of discomfort.

0404: AN AUDIT TO ASSESS WHETHER ABDOMINAL X-RAYS ARE REQUESTED APPROPRIATELY FOR EMERGENCY SURGICAL PATIENTS

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Aim: There is both literary and anecdotal evidence to suggest that not all patients undergoing abdominal x-ray (AXR) do so appropriately. There is a significant radiation dose associated with AXR and the findings are often non-specific with poor diagnostic rates. We aimed to see whether patients were undergoing AXR appropriately by carrying out an audit looking at the use of AXR for emergency surgical admissions.

Methods: We retrospectively identified whether emergency surgical patients at our hospital had undergone AXR at the time of presentation. The presenting complaint and examination findings were recorded, as were the indication on the AXR request and the AXR report. The audit standards were taken from the Royal College of Radiologists (RCR) iRefer guidelines.

Results: We collected the data of 73 emergency surgical adult patients over a 3 week period. 41 patients underwent AXR. AXR was indicated in 36% of these patients according to RCR guidelines. 44% of AXRs had an abnormal finding, including non-specific findings. Occasionally there was disparity between the presenting complaint and what was written on the request form.

Conclusion: Clinicians should consider more carefully the need for AXR. This would likely be aided by education on radiological imaging referral guidelines.

0407: AUDIT OF RED FLAG REFERRALS FOR SUSPECTED CANCER MADE BY GP PRACTICE TO SECONDARY CARE

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Aim: Red flag referrals made by GPs for suspected cancer diagnosis in Northern Ireland are made according to standards set in the Northern

Ireland Cancer Network (NICAN) guidelines. Standards are: 100% referrals made according to NICAN guidelines; 100% of patients seen within 14 days of referral date.

Methods: Audit performed within Abbey Court practice, Armagh in Northern Ireland.

Search made on the practice electronic record system (EMIS) for all patients who had a red flag referral between 01/06/2013 and 31/12/2013.

Records of identified patients were then analysed further for outcome data.

Results:

- 34 red flag referrals made.
- One referral downgraded by the hospital triaging system.
- 21/33 patients seen by specialist within 14 days (63.6%).
- Range of waiting time: 0–46 days.
- 31/34 referrals were made in accordance with guidelines (91.2%).
- Three cancer diagnoses made within those referred.

Conclusion: The percentage of patients who were assessed within 14 days is significantly below target of 100%. A high percentage of referrals made by the GP practice were in accordance with NICAN guidelines.

Results of audit shared with GP practice and local cancer services with aim for improvement in waiting times. Aim to re-audit in the future to establish if improvement made.

0408: SURGEONS' PERCEPTIONS ON THE IMPACT OF LANGUAGE BARRIERS IN THE DELIVERY OF HEALTHCARE

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Aim: The number of patients with limited English proficiency requiring access to National Health services is rising; communication difficulties may arise and lead to adverse consequences. We wished to explore the perceptions of surgeons on the impact of language barriers on their clinical practice.

Methods: A nine-point questionnaire survey was used to assess the perceptions of doctors in General Surgery in a District General Hospital on the impact of language barriers in their delivery of care. Frequency of encounters with patients with language barriers, access to interpreters, and strategies to minimise the impact on patient care were evaluated.

Results: 22 of 32 eligible doctors completed the questionnaire. 17 (77%) reported regular encounters with patients with significant language barriers. Professional interpreters were not available to 20 (90%). Of these only 12 (55%) were able to communicate with the patients satisfactorily. Alternate strategies included use of other staff, patients' relatives, and personal language skills. 16 (73%) felt that care delivery was compromised, and improved access to facilities to mitigate the problem was required.

Conclusion: In an increasingly diverse population, language barriers in patient care cannot be overemphasised. Further work is required to delineate the impact, increase awareness and provide effective resolution strategies.

0427: REFERRALS TO A COLORECTAL TWO-WEEK-WAIT CLINIC DO NOT FULFIL REFERRAL CRITERIA AND CONTRIBUTE TO LOW DETECTION RATES OF COLORECTAL CANCER

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Aim: An audit was performed to determine if referrals from primary care to a colorectal two-week-wait (2ww) clinic fulfilled the 2ww criteria. Patient outcomes and the rate of diagnosis of colorectal cancer (CRC) were also evaluated.

Methods: Referrals to the Trust colorectal 2ww clinic over 3 months were analysed to determine if clinical features on the referral form fulfilled 2ww criteria, and if these correlated with findings in the clinic. Investigations were reviewed to determine the final diagnoses.

Results: 55 patients were assessed (median age of 69 years). The commonest presentations were persistent change in bowel habit (33%), rectal bleeding (25%) or both (25%). There was correlation between the referral

and clinic findings in 37 patients (63%). The majority had further investigation (lower GI endoscopy or imaging). The commonest diagnoses were diverticulosis (44%) and benign polyps (22%) but 3 patients had CRC of which 2 had metastatic disease at presentation.

Conclusion: Most data from 2ww clinics show low rates of diagnosis of CRC, with little evidence of any improvement in prognosis. Low adherence to referral guidelines from primary care may be a factor. It is crucial that primary care providers are aware of the guidelines when referring to 2ww clinics.

0435: READMISSION AFTER GENERAL SURGERY (RAGES)

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Aim: Readmissions are undesirable for patients and carry financial penalties for hospitals where they occur within 30 days of discharge. The aim of this study was to determine the readmission rates and potential contributing factors within the South Yorkshire region.

Methods: A prospective region-wide audit was undertaken over two weeks, including all patients undergoing NHS-financed general surgery in the region. All patients were followed up for 30 days to identify readmissions. Demographics, procedure data including BUPA and CEPOD classifications and basic post-operative data were collected.

Results: One teaching hospital, 3 private providers and 4 DGH's undertook 698 procedures in this period with 38 readmissions within 30 days (5.44%). Unit-level readmissions ranged from 0.02–11.7%. When preventable readmissions were excluded, the readmission rate was 3.29% (0.02–6.48%). There was no correlation between age, gender or comorbidities and readmission. The least deprived had a lowest readmission rates ($p=0.02$). There was no difference in readmission rates following planned or unplanned surgery. Readmission rates increased with complexity of surgery (3.45% minor vs 11.1% complex, $p=0.05$).

Conclusion: In our region, unavoidable readmissions follow 3.3% of operations. Readmission is associated with complexity of surgery and deprivation. There is unit-level variation which may reflect how re-attenders are managed.

0438: A COLLABORATIVE STUDY PROPOSAL: TO ASSESS RATES OF UK POST-OPERATIVE PNEUMONIA (RAPP)

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Aim: Post-operative pulmonary infection is amongst the most prevalent of complications following surgical procedures. Infections are associated with significant mortality, morbidity and heightened costs of hospital stay.

Methods: The proposed cohort study aims to establish the risk-adjusted incidence of post-operative pneumonia. As a secondary aim, variation in preoperative optimisation strategies will be investigated. There is scope for cross-speciality engagement. Patients undergoing elective surgery as an inpatient over a four-week period will be included. Risk of post-operative pneumonia will be calculated based on the POP score. Data will include; BMI, co-morbidities, operation, pre-operative optimisation, functional status and post-operative analgesia. The primary outcome will be rate of post-operative pneumonia, as defined by CDC criteria. Secondary outcomes will include length of stay and complication severity.

Conclusion: Further analysis will identify effective interventions for testing in randomised clinical trials.

0445: SURGICAL WEEKEND HANDOVER: AN AUDIT TO IMPROVE STANDARDS WITHIN A TERTIARY HOSPITAL

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Aim: The implementation of EWTD has had a significant impact on working patterns for junior doctors. Effective clinical handover is vital to patient safety and high quality care. Our aim was to improve surgical weekend handover through the use of a standardised handover proforma.

Methods: Retrospective review of weekend handover (8 weekends). Handover sheets were scrutinized for 9 of the most important variables that should be included for any particular patient.

Results: A total of 525 patients. 4 variables (Job Plan, D.O.B, Bed Location, Supervising Consultant) – had less than 50% Compliance. Only 1 variable (Patient Name) was filled out for all patients. A standardised handover proforma was devised and implemented containing all 9 required variables was implemented. A prospective re-audit of 8 weekends was then carried out. Re-audit Results: A total of 487 Patients. 8 variables in total had >99% documentation for handover. 1 variable (Bed Location) continued to have less than optimal compliance (76%).

Conclusion: The development of a standardised proforma has led to a significant improvement in weekend handover of surgical patients and should be common practice in all hospitals.

0455: DOCUMENTING THE USE OF CHAPERONES DURING INTIMATE PATIENT EXAMINATIONS; ADHERENCE TO GMC GUIDELINES

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Aim: To assess our documentation of the use of chaperones during intimate patient examinations using the GMC Guidelines on Good Medical Practice: 'Intimate examinations and chaperones (2013)'.

Methods: Prospective audit of all surgical, urological and gynaecological admissions on surgical assessment unit (SAU) over 1 week. Intimate examinations were defined as those pertaining to examination of the breast, genitalia, digital rectal (DRE) or per vaginal (PV). Case notes reviewed and data collected on a pro-forma.

Results: We collected data for 61 patients, M:25, F:36 with an average age of 55y(22y-90y). Breast: 1, genitalia:15, DRE:38 and PV:7. Of 61 patients receiving intimate examinations by doctors, 10(16.4%) had documentation of a chaperone being used and 9(14.75%) where the chaperone details were documented. 3 patients(4.9%) had the documentation of a chaperone being declined. 51 patients(83.6%) had no documentation pertaining to the use of or offer of a chaperone.

Conclusion: Lack of documentation does not equal absence of chaperone but suggests inadequacy of documentation. Meticulous documentation in this regard needs to be highlighted to all surgical specialities to protect patients from harm and offer medical-legal protection. We intend to re-design our surgical admission pro-forma to include a chaperone checkbox, to educate SAU clinicians and re-audit.

0494: HEAD INJURY MANAGEMENT IN A DISTRICT GENERAL HOSPITAL: A FULL AUDIT CYCLE

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Aim: Head injury (HI) patients span a broad spectrum of clinical severity. Good communication at local and regional levels is necessary to monitor clinical deterioration and instigate appropriate treatments. Two patients with adverse outcomes led us to conduct a full audit cycle of local HI management.

Methods: Adult HI admissions under General Surgery from February–May 2014 were included in the initial audit (43 patients). With reference from NICE, we focussed on: indications for CT or admission; initial neuro-observations, and documentation quality of neurosurgical referrals. Findings were presented at Clinical Governance; a clerking template was introduced; and guidelines displayed in A&E and surgical departments. We re-audited from September - December 2014 on 36 patients.

Results: Post-intervention improvements were observed in the following domains: neuro-observations at presentation written in A&E or surgical clerkings (from 7% to 25%); written EVM breakdown of GCS when <15 (from 7% to 22%); clear documentation of neurosurgical discussions and non-surgical management plans (from 32% to 75%). Use of clerking templates was however poor, attributable to doctors' unfamiliarity with navigating our electronic documentation platform.

Conclusion: Written communications of HI patients' salient clinical features can be improved through increased awareness of clerking and management guidelines.