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PROGRAMME OF ABSTRACTS TO BE PRESENTED DURING THE CONFERENCE

Wednesday 23rd

Parallel Session One

1.1 Overnight stay hip replacement surgery and the part played by preoperative assessment (003)
Ms Kim Boorman, Orthopaedic Preoperative Assessment Sister; Mr Hugh Apthorp, Consultant Orthopaedic Surgeon; Mr Kriss Chettiar, Clinical Research Fellow, Conquest Hospital, St Leonards-on-Sea.

Orthopaedic preassessment and the Orthopaedic Community Rehabilitation Scheme (006)
Mrs Tina Hodgson, Orthopaedic Preassessment Sister, York Hospital, York

1.2 Development of a patient-completed screening questionnaire to identify patients needing preoperative anaesthetic assessment (009)
Dr Nicholas Lavies, Consultant Anaesthetist, Worthing Hospital, West Sussex

New preoperative assessment strategy: Halving the rate of cancellation for patient unfitness (025)
Dr Nathalie Frayssinet, Consultant Anaesthetist, James Paget Hospital, Great Yarmouth

1.5 'What do you do with a patient ‘query’?: Problem solving approach to optimising patient health care to prevent cancelled operations (030)
Mrs Maria McAuliffe, Senior Sister Preoperative Assessment; Mrs Mandy Campbell, Sister Preoperative Assessment, Birmingham Heartlands Hospital, Birmingham.

Parallel Session Two

2.3 Preoperative cardiovascular optimisation: A review of the referral system in a district general hospital (010)
Dr Kim Soulsby, SHO Anaesthetics; Dr Lucy Hudsmith, SpR Cardiology; Dr JA Bell, Consultant Cardiologist; Dr Karen Luxton, Associate Specialist Cardiology; Dr Charlie McKenna, Consultant Cardiologist; Dr William Orr, Consultant Cardiologist, The Royal Berkshire and Battle Hospital, Reading

Improving preoperative assessment of the high risk surgical patient: A joint anaesthetic and medical clinic (021)
Dr Lui Forni, Consultant Physician/Intensivist; Dr Nicholas Lavies, Consultant Anaesthetist, Worthing and Southlands Hospital Trust, West Sussex.
Thursday 24th

Parallel Session Three

3.2 Preoperative assessment links with Her Majesty’s Prison Service (005)
Mrs Jane Jackson, Consultant Nurse, St Albans City Hospital, St Albans

Preoperative fasting – Effect of staff knowledge and patient information (023)
Dr Mary Taylor, Consultant Anaesthetist; Dr Somnath Chatterjee, Consultant in Anaesthesia and Critical Care; Dr Rupa Jeyaraj, SHO Anaesthetics, Birmingham Heartlands Hospital, Birmingham.

Parallel Session Four

4.2 Preoperative assessment: A survey of current practice in the UK (014)
Dr Ajit Sivasankaran, SHO in Anaesthesia; Dr Neil Agnew, Consultant Anaesthetist, North West Wales NHS Trust, Wrexham.

Results of an audit of 184 patients assessed using OPPASS at the Hillingdon Hospital (016)
Sister Janet Lynam, Sister i/c Preassessment Clinic; Dr Mark Nel, Consultant Anaesthetist; Dr Peter Emerson, Honorary Consultant Physician; Ms Saki Hajnal, Decision Support Engineer, The Hillingdon Hospital, Uxbridge

4.5 Preoperative smoking cessation - Is it worthwhile and is it feasible? (028)
Dr Ross Kerridge, Director, Perioperative Service, John Hunter Hospital, Australia.

Troponin T as a predictive marker of morbidity in patients with fractured neck of femur (019)
Miss Isobel Fitzgerald O’Connor, ENT SHO, Conquest Hospital, St Leonards-on-Sea; Mr Sebastian Dawson-Bowling, Orthopaedic SpR, Radcliffe Infirmary, Oxford.

All other abstracts will be presented as posters and will be on display throughout the conference.

In addition, authors of abstracts selected for oral presentation may also choose to exhibit their work as a poster.
Introduction
Pre-operative assessment ensures that the patient is fully prepared for their impending procedure both physically and psychologically.

At Newark, the combination of this nurse led service alongside booked admissions, ensures that the pre-operative assessment department is matching investment with reform thereby supporting the NHS Plans vision of the provision of a service redesigned around the patient.

Method
The pre-operative assessment team identified a problem with the urology patients requiring flexible cystoscopy.

These patients had no control over the choice of date for their procedure, or over any further procedures identified at scoping as necessary. Now, once the patient has been seen by the urologist, and the need for scoping is identified, the patient immediately comes to see the pre-operative assessment team who explain the procedure to the patient, and negotiate a mutually suitable date for them.

When the patient attends for the procedure, if a surgical need is identified; they are escorted to the pre-operative assessment team, where they are assessed for surgery, and a mutually acceptable date for surgery is chosen. If the patient is not fit for surgery, then an individually designed care pathway is immediately initiated for them, ensuring that they are safe for surgery as soon as possible.

Results
The outcome is that not only has urology achieved 100% booked admissions, but also the waiting time for procedures has reduced from 6 months to 5 weeks and the patients have autonomy over their care.
At the inaugural Preoperative Association meeting, we presented our experience of a system that at that time was in its infancy. A year on we're fully on our feet.

This system is one of nurse led preoperative assessment at time of decision to operate giving time to optimise co-morbidity with support of anaesthetic clinics, and using an integrated care pathway that can then be used as the backbone of multidisciplinary notes.

We thought that it was going to work, but now we have the evidence. We will present audit data about what patients think, what ward nurses, physios and pharmacists think, what surgeons think and what anaesthetists think.

Then we’ll discuss our overall philosophy of ‘fit for life, not just for surgery’, with some discussion about individual optimised patients, and some papers about how outcomes are improved for major surgery for patients optimally treated on statins, and a plea for a more joined up approach to medicine as espoused in a BMJ personal view from March 2005.

References
Gannon C. Will the lead clinician please stand up? BMJ 2005;330:737
Introduction
A regime of overnight stay for minimally invasive surgery (MIS) total hip replacement, with a modified anaesthetic technique, has been instituted at the Conquest Hospital in Hastings. Patients requiring MIS total hip replacement, who satisfy the necessary criteria, are admitted for surgery and discharged the following day, with the support of an outreach team comprising of a senior Sister in orthopaedics and physiotherapy assistant to visit them in their home.

It was recognised in the preparation for this programme that the Pre-Operative Assessment Clinic would have a significant impact in ensuring the success of the project, providing a focal point for the ensuring of the fitness of the patient for the procedure, whilst at the same time placing the emphasis on patient education.

Method
All patients placed on the waiting list for total hip replacement surgery are immediately seen by the Pre-operative Nurse in the Pre-Screening Clinic, where they are assessed to establish if they meet the criteria for overnight stay surgery. Patients are thus categorised and asked to attend a further specialised clinic and are told at this time that the likelihood is that they will be in-patient for one night only and will be discharged with adequate analgesia and support in their home from the outreach team.

At the clinic, the following members of the multi-disciplinary team are seen; an orthopaedic Pre-Assessment Sister, Outreach Sister, Physiotherapist, Occupational Therapist and Senior House Officer. Each has a specific task to carry out at the clinic, whilst all sharing responsibility for patient education and changing their expectations.

The overall aim of the Pre-Operative Assessment clinic is to prepare fully the patient for what might otherwise seem a novel and perhaps frightening procedure, placing emphasis at every step of the process on comprehensive education through listening to and understanding patients’ questions and concerns. The information obtained in the process is not solely recorded, but is used as a basis for intervention to ensure the successful outcome for the individual.

Results
So far 41 patients have been through the programme, with a mean length of stay of 1.2 days and mean pain scores of 1.6/10 on the day of discharge. Feedback via a patient satisfaction survey shows that all of those who responded evaluated the nurses and team as supportive, with 86% classifying them as “very supportive.” Only one respondent was dissatisfied with the amount of information given at pre-assessment and the overall experience was evaluated as very good by 82%.

Conclusion
Minimally Invasive Hip surgery with a suitable infrastructure can be used to dramatically reduce the length of stay in suitable patients. With adequate patient counselling at pre-assessment, patients’ attitudes and expectations of joint replacement surgery can be altered so that they feel more confident when they are discharged home.
The main objective of this poster is to demonstrate the journey a patient takes through our preoperative assessment clinic. Aiming to illustrate the individual nature of each patient’s experience and highlighting the potential outcomes. The poster will show how this journey is determined by the two way flow of information between patient and staff, and input from other inter professionals where necessary and the resulting outcomes that benefit all involved in the process.

The poster will also present the outcomes from our 2004 audit in the form of pie charts and graphs.

The poster will be presented in the format of a Monopoly board. It was designed this way to graphically represent the journey a patient takes through our clinic. The layout of the poster is patient friendly and easy to read. It is designed to evolve as the assessment process changes in line with new guidelines and patient requirements, and will be updated on a yearly basis to include yearly audit results.

After the conference the poster will be displayed within the pre-op assessment clinic providing information about the pre-operative assessment process to staff, patients and their relatives.
Traditionally prisoners detained at Her Majesty's prisons have had to attend secondary care for specialist opinion. The prisoner is accompanied by two prison wardens for this external visit. The patient arrives handcuffed to the wardens, and waits for their appointment. Consultation is conducted in the presence of the wardens.

As with all patients expecting elective surgery, they attend the preoperative assessment (POA) clinic for an anaesthetic assessment prior to admission.

In terms of privacy and dignity, as well as confidentiality, it is difficult to conduct the POA interview in the presence of two prison wardens who are handcuffed to the patient. Concerns on accuracy of the information obtained from the patient, as well as their dignity in waiting in the waiting room amongst other prospective patients must be considered as not being the best practice.

An innovative approach to this issue has led to the development of a new service for the prisoners at the local prison. The Consultant nurse in the preoperative assessment clinic at West Hertfordshire NHS Trust, and the health care team at the local HMP The Mount, Bovingdon have discussed the issues and have set up a service of POA conducted within the healthcare centre of the prison.

At HMP The Mount the healthcare facilities allow for privacy during interview. Phlebotomy, ECG, x-ray facilities are available on site, and pre arranged appointments ensure that the prisoner arrives in the healthcare centre for their assessment.

Full medical notes are available during the interview – both from the Trust and from the prison health records. Patients are assessed and examined in an interview room on a 1:1 basis, assessor and prisoner thus maintaining patient dignity. Questions pertaining to past and current medical history can be asked without the presence of two wardens, thereby ensuring confidential history taking and potential for improved accuracy. The support of phlebotomy, ECG and x-ray on site provides for a full one-stop POA service.

This service has been well received from both teams – West Hertfordshire NHS Trust and HMP The Mount as well as from the patients.
Orthopaedic pre-assessment and the Orthopaedic Community Rehabilitation Scheme

Abstract No. 006

Mrs Tina Hodgson, Orthopaedic Preassessment Sister
York Hospital, York

Orthopaedic Pre-Assessment had been carried out in York for several years on an adhoc basis until 1987 when several members of the ward nursing team started to initiate a pre-operative assessment service for one consultant. This proved to be a good service and gradually this was expanded to include all consultants however due to the lack of funding and nursing hours not all patients were assessed.

A research study in 1998 into pre-assessment for Orthopaedic patients, requiring Total Hip and Total Knee Replacements in York Hospital, was carried out to prove that Pre-Operative Assessment is beneficial to patients. It was also to prove that a full time pre-operative assessment nurse would be both beneficial to the patients and the trust by improving patients knowledge and reducing wasted theatre time.

In 1999 funding was made available and a full time nurse was employed to assess patients for 6 consultants, with the increase of patients being listed for surgery and the introduction of government targets to reduce waiting times a 2nd full time nurse was employed in 2001.

Due to the need to reduce waiting times we needed to look at ways to reduce the length of stay for patients to increase the capacity and therefore allow more patients to be operated on. The length of stay in 1998/99 was 10-14 days following Hip /Knee Replacement this had been reduced following the implementation of a full time pre-assessment clinic.

Patients who are fully informed and educated regarding all aspects of pre and post-operative cares and complications and who are informed that their expected length of stay will be 7-10 days will go home as planned unless complications occur. To reduce the length of stay from 7-10 days to 5-7 days would increase the capacity and dramatically reduce waiting times to bring these in line with the government target of 9 month waiting. Also better education for the patients would improve their outcome.

Visits were made to several hospitals that had early discharge schemes in place. These visits were made by, the Orthopaedic Directorate Manager and Elective Ward Sister. A model developed at Gateshead Hospital was the one that York based their plans on. Meetings were set up with Managers, Consultants, Finance Managers, Pre-assessment, Physiotherapists and Occupational Therapists. The scheme was named OCRS (Orthopaedic Community Rehabilitation Scheme).

Following several meetings and discussions it was decided that a team made up of 2 Physiotherapist, 1 Occupational Therapist and 1 Nurse would be employed to put this process into place. Pre-Assessment was also very involved in the process, as they were the ones who would be deciding who should be on the scheme.

A care pathway was implemented which was commenced at the Pre-operative assessment 8 weeks pre-op. Patients are expected to take responsibility for this until their admission as they need to have this available for the physio and OT assessments.

Patients have a physio assessment 6 weeks pre-op and OT assessment 4 weeks pre-op. Discharged from Hospital 5-7days post op with Physiotherapist visiting daily for 5 days and nurse visiting as needed.

The scheme has been audited and has improved the waiting times. Length of stay as expected has been reduced from 7-10 days to 3-5 days, questionnaires were sent to patients for their feedback.

Changes have been made and more patients are now being accepted onto the scheme. The team are always looking at ways of improving the service and making changes as needed.
One of the main objectives of medical guidelines is the reduction of variance. Great variance in medical processes leads to impairment of quality and high costs. The standardisation of the anaesthetic pre-assessment process is a key component to improve the quality of medical care and to reduce costs. One important part of the pre-assessment process is the performance of laboratory tests. Several studies confirm the lack of associated benefit of routine laboratory testing. Inappropriate laboratory testing is costly and leads to an increase in false-positive results and inappropriate work-ups. Therefore pre-operative laboratory testing guidelines should be implemented in order to improve the quality of pre-assessment and to reduce patient's discomfort, unnecessary waiting times, unnecessary cancellations of surgery, unnecessary direct and opportunity costs. We describe in our presentation the development and implementation of a medical guideline for “Pre-operative tests for elective surgery” in a private hospital setting.

Conclusions
- The NICE guidelines provide useful decision criteria for pre-operative testing in elective surgery. There are three useful instruments for decision making based on the NICE guidelines (booklet, poster, tables “Simplifying the NICE Guidelines”). We recommend the use of the tables “Simplifying the NICE Guidelines” in order to facilitate the decision process.
- The NICE guidelines do not cover specific co-morbidities apart from cardiac, respiratory and renal diseases. These should be added to the NICE guidelines in order to optimise the quality of the pre-assessment process. There is only little evidence in the literature, what preoperative tests should be carried out in the presence of specific co-morbidities. Therefore we follow the expert opinion published by RD Miller (Anesthesia, 6th edition, chapter 27, 2004). The information is provided in a table where relevant co-morbidities are listed.

References
Preoperative assessment for day surgery patients in a local community setting in Derbyshire

Abstract No. 008

Mrs Mary O’Halloran, Preoperative Assessment Nurse Specialist
Mrs Pamela Nickerson, Preoperative Assessment Nurse Specialist
Mrs Meg Lane, Preoperative Assessment Nurse Specialist
Derbyshire Royal Infirmary, Derby

Background information / Current Service
- Derbyshire is a large geographical area; consequently some of the Consultants who undertake day surgery within this Trust have outpatient clinics at community hospitals and health-centres approximately 20 miles from the District Hospital. Patients are referred from these outlying clinics for day surgery in Derby.
- Patients are offered the choice to have their preoperative assessment at the same community facility as the outpatient consultation rather than travelling to Derby for the Assessment.
- The clinic staff at the community clinic telephone the Day Case Unit in Derby and arrange a convenient surgery date with consultation with the patient.
- Patients are offered a choice of place for assessment. The appointment is arranged for a time that is mutually convenient. The patient leaves the OPA with the dates arranged.
- The agreed appointments are booked by the community clinic staff onto a shared electronic patient administration system.
- A preoperative assessment nurse specialist from the Day Case Unit in Derby attends each community health facility every 4 weeks to undertake assessments for patients who have chosen to book appointments at that site. 4 community sites are visited at present.

Patient benefits
- Patients have agreed dates for POA & surgery before they leave the community Out Patient Appointment
- Patient choice of POA location.
- Patients more relaxed in local environment, which improves the information exchange at POA.
- Convenient time & location for patient – reduced travelling, ease of access.
- Able to meet a member of staff from the unit.
- Able to orientate to Day Case Unit using photographs of unit.
- ¾ hour appointment giving time to discuss fears and anxieties in confidence.
- One stop appointment for POA – blood tests and ECG are done in the appointment if necessary.
- High patient satisfaction

Hospital benefits
- Better communication between hospital & community
- Promote hospital as place of choice for patient, GP & local community.
- Increase throughput in Day Surgery
- Reduced DNA rates as choice is offered to patients.
- High patient satisfaction

Changes for the future
- Virtual tour of the Day Case Unit could available on the internet so patients and carers can further orientate themselves to the unit.
- Expand the choice of site of POA to other patients who live in the location.
- Expand the availability of this POA service to other health centres in Derbyshire.
- We are currently seeking the opinion of patients who attend another Community Hospital about 30 miles away in view to offering a local POA service to that area.
The reduction in junior doctors’ hours, general acceptance of nurse-led pre-assessment and more recently the gradual enforced reduction in waiting times and “choose & book” have forced a new look at how patients are pre-assessed. Many hospitals have already moved to nurse-led pre-assessment with little or no involvement by junior doctors and indeed currently at Worthing hospital only general surgery and urology pre-assessment involves junior doctors. However, these new pressures mean we now need a system which:

1. Pre-assesses all patients soon after the decision to operate
2. Fast-tracks healthy patients so an operation date can be booked within 24 hrs of decision to operate
3. Reliably identifies patients with significant medical or anaesthetic problems so these can be seen by an anaesthetist first before they are put on the waiting list.

With these objectives in mind we decided in Worthing to change from a proforma that the pre-assessment nurse filled in with the patient 2-4 weeks before the TCI date, to a comprehensive questionnaire which the patient completes at the time of the outpatient appointment. We looked at several examples of questionnaires from other hospitals and decided on the Bath model which uses a colour-coded template overlay to direct patients into one of three groups – red, amber or green. Green are healthy patients who do not need further pre-assessment. Amber are those who are booked for early nurse pre-assessment and red are those who are booked to see an anaesthetist. A trained nurse is available to help the patients complete the questionnaire if they have difficulties.

A pilot trial of the new questionnaire in 50 ENT and Gynecology patients gave useful information about the way patients were going to fill it in and led to several modifications. There were more green and less amber and red patients in the ENT group as expected from the patient population. The overall division (ENT + Gyny) was green 37%, amber 53% and red 10%. On this basis we estimated that we would need a weekly anaesthetic review clinic seeing up to 10 patients. However we expect that the colour template may need to change as experience grows. There have also been many practical details to overcome in the implementation of the new style system. This presentation will give an account of the development and initial experience of the new screening questionnaire.
Preoperative cardiovascular optimisation: A review of the referral system in a district general hospital

Abstract No. 010

Dr Kim Soulsby, SHO Anaesthetics
Dr Lucy Hudsmith, SpR Cardiology
Dr JA Bell, Consultant Cardiologist
Dr Karen Luxton, Associate Specialist Cardiology
Dr Charlie McKenna, Consultant Cardiologist
Dr William Orr, Consultant Cardiologist
The Royal Berkshire and Battle Hospital, Reading

Background
Increasing demands on both Anaesthetic and Cardiology services are being made by an ageing population, with its attendant incidence of cardiovascular comorbidity, presenting for elective orthopaedic surgery. Large joint replacement surgery in this group has a significant morbidity and mortality, necessitating a system for preoperative assessment and optimisation. It is important that this process is streamlined and efficient, to avoid unnecessary referrals adding to an increasing workload for Cardiology services, while still allowing appropriate referrals to be assessed in a timely manner. This audit reviewed existing referral practice in Reading. The audit, together with referral guidelines drawn up by the local Cardiology department, was used to drive a change in the referral system to allow a more streamlined service.

Method
Hospital notes of 85 patients referred for preoperative cardiology assessment over a 24 month period were reviewed retrospectively. They were analysed for age, reason for referral, type of surgery planned, investigations done, and treatment instituted.

Results
59 (69%) of 85 referrals were for patients booked for large joint surgery. Junior orthopaedic staff made 74 (87%) of referrals. Patients were referred for ischaemic heart disease (30), valve disease (20), arrhythmias (17), cardiac failure (10), hypertension (4) and “abnormal ECG” (3). Investigation rates (echocardiography in 50 patients, angiography in 14, stress ECG in 11) and intervention rates (beta blockade in 21, revascularisation in 4) were significant, confirming the high-risk nature of this group. A small number of patients (6) were referred unnecessarily (as decided by Cardiologists), or required no further investigation or treatment.

Implementation of an action plan
A Risk Index Score was established by local Cardiologists, using current evidence for risk stratification of cardiac patients for non-cardiac surgery. This, together with the initial audit findings, was presented at a joint meeting of Cardiology and Anaesthetic departments. It was proposed that the scoring system would identify patients requiring further investigation, who would be discussed with Anaesthetic staff prior to either referral to Cardiology, or treatment with beta blockade, according to a locally established guideline.

A pilot study of the Risk Index Scoring system was run over 30 operating sessions in two Orthopaedic theatres where major cases are performed. All patients were assessed on the day of operation for Risk Index Score, beta blockade, whether that anaesthetist would have made a referral, and whether this decision was in agreement with the Scoring system guideline. 78 cases were assessed over the 30 sessions. 5 patients (6.5%) scored over 10, indicating a referral. Anaesthetists were in agreement in 4/5 cases. 15 patients (19%) scored 5-9, indicating beta blockade but not referral. Only 6/15 (40%) were actually beta blocked, and only 4/15 had a resting heart rate less than 65. Anaesthetists were in agreement with management in all but 1/15 cases, where referral would have been made to exclude valve disease after rheumatic fever in childhood.

Conclusions
The proposed Cardiac Risk Index appears to correlate well with Anaesthetists’ opinions on the need for Cardiology review, and may be used to streamline the referral process. Patients with intermediate risk require beta blockade but not necessarily a referral, requiring identification of such patients at the time of booking for surgery. The role of the GP in this will be important, and
will require a system of communication with GPs by booking Orthopaedic staff. This audit highlights the high-risk nature of the group studied, and may suggest that joint Cardiology / Anaesthetic clinics for preoperative assessment should be explored.

Appendix I: Please see page 42 for a copy of the Cardiac Risk Index.

References
Reducing the risk of non-cardiac surgery: Introducing perioperative beta-blockers

Abstract No. 011

Dr Lucy Hudsmith, Spr Cardiology
Dr Andy Dering, SpR Anaesthetics
Dr Mike Ewart, Consultant Anaesthetist
Dr Karen Luxton, Associate Specialist Cardiology
Dr Charlie McKenna, Consultant Cardiologist
Dr William Orr, Consultant Cardiologist
The Royal Berkshire and Battle Hospitals, Berkshire

Introduction

Perioperative cardiovascular morbidity and mortality represents 45% of all perioperative complications (NCEPOD) and optimisation of these patients is essential to minimise patient risk. Assessment of patients with cardiovascular disease undergoing moderate/high risk non-cardiac surgery has become a significant part of clinical practice. Good communication between cardiologist, anaesthetist and surgeon is paramount. The American College of Cardiology (ACC) and the American Heart Association (AHA) guidelines recommend the use of perioperative beta-blockers in established patients, those at high cardiac risk with ischaemia on preoperative testing (Class I) and patients with coronary disease (Class II)1. Reports have shown a significant reduction in operative risk with adequate beta-blockade and there is evidence that stopping already established beta-blockers at the time of surgery significantly increases risk2,3.

Methods and Results

A postal questionnaire was sent to all consultant anaesthetists in the Oxford Deanery of which 109 of 176 (62%) replied. Of these, only 4% were aware of a departmental policy regarding the use of perioperative beta-blockers. Only 44% would continue established therapy intravenously or via a naso-gastric tube if the patient was unable to tolerate oral therapy. Amongst vascular anaesthetists, 47% routinely used beta-blockers and only 51% of anesthetists for major surgical cases (general, orthopaedic) considered using peri-operative beta-blockers in at risk patients.

Following joint consultation between cardiologists, anaesthetists and the pre-operative assessment team, a perioperative beta-blocker algorithm was then devised and initiated with the support of the cardiology team and local General Practitioners. This protocol involved the identification of patients at least one month before surgery. Patients already established on beta-blockers were assessed to ensure adequate dosage and rate control. Those patients identified by the Cardiac Risk Index for elective non-cardiac surgery for beta-blockers were initiated on bisoprolol 2.5mg od. These patients were then reviewed at their General Practice at 7 and 14 days and the beta-blocker dose titrated appropriately.

Conclusion

The use of beta-blockers during and after non-cardiac surgery can dramatically reduce cardiovascular risk but this is not yet standard practice. We have established a perioperative beta-blocker protocol to identify and treat high-risk patients with the support of the local General Practitioners. This will be audited regularly and aims to optimise patient care and reduce perioperative cardiovascular morbidity and mortality in elective non-cardiac surgery.

References

Introduction
Nursing literature describes two categories of assessment of surgical patients: preoperative assessment and preoperative visiting. This paper explores the difference between the two in the context of planning intraoperative care, suggests some reasons for theatre nurses not using a readily available source of information and recommends a possible solution to the absence of assessment geared towards intra-operative care.

Methods
We interviewed 10 theatre nurses about their role, asking about sources of information on which they planned intra-operative care and aspects of their work that they would delegate to support workers and ODPs. Transcripts of semi-structured interviews, recorded with the participants' consent, were coded using open and axial methods in the NVivo software suite and analysed according to the Framework method. Reflexive notes were made to monitor the process of analysis and to provide a written record of development of the analytical turns that we made as we discussed the findings. The proposal was externally reviewed for scientific merit and ethical approval was granted by an NHS local research ethics committee before the project commenced.

Findings
The nurses interviewed work in a department whereby theatre personnel mostly work within a single specialty. They did not use the preoperative assessment document that is generated by the preoperative assessment service of all surgical specialties in the Trust. A number of barriers prevented preoperative visits being made to all patients and some specialties did not perform visits at all. In most circumstances the first opportunity nurses had to assess patients' intra-operative needs and plan intra-operative care was when the patients arrived in the operating department. Documentation of preoperative visits when they occurred was cursory and individualised plans of care were not documented, a situation at odds with guidance from the NMC.

Recommendations
Based on NMC guidelines, the findings of the research interviews and our combined work in service development and preoperative assessment; to facilitate a truly multidisciplinary approach to surgical care, the following recommendations are made:

1. Trusts may wish to consider setting a standard that all surgical patients should have a prospective care plan logged in their notes before they enter the operating department for surgery
2. Where preoperative assessment facilities already exist, Trusts may wish to consider facilitating the presence of a nurse with expertise in operating department nursing in preoperative assessment clinics to assess a patients actual and potential intraoperative problems
3. Where preoperative assessment facilities do not yet exist or are being developed, Trusts may wish to consider the potential benefit to patients, surgeons, anaesthetists and theatre practitioners of all occupations if theatre expertise is applied when patients care is still in the planning stage
Introduction
The Pre-Admission Assessment Clinic (PAAC) at Charing Cross Hospital, London was established in 2003. It is a nurse led clinic. Each clinical session is supported by a Consultant Anaesthetist. Clinic staff work in close collaboration with the multi-disciplinary team to ensure the pre-operative optimisation of elective surgical patients.

This Abstract describes the introduction of peri-operative beta blockade (bisoprolol) for patients at risk of peri-operative cardiac events in the PAAC.

Background
While there is continued uncertainty about the role of 'prophylactic' re-vascularisation, RCT evidence supports the use of adequate beta-blockade in reducing peri-operative cardiac events in high risk patients undergoing vascular surgery. Recent commentaries have strongly argued that a wider role for peri-operative beta blockade is justified in high risk patients undergoing non-cardiac surgery. Further information is needed before the peri-operative use of beta-blockers should be considered routinely in other patients at low or intermediate risk.

Method and Results
Informed by these recommendations, a treatment protocol was developed using the following process:

- An initial working party was established (including nursing staff, the lead anaesthetist and a consultant cardiologist) to discuss the feasibility of the project.
- An audit was completed to identify patient numbers and possible resourcing issues. This demonstrated that out of 135 patients audited over a two week period there were 5 candidates and 5 potential candidates for beta-blocker therapy.
- Meetings with stakeholders were arranged to develop a treatment protocol (which includes a 'Patient Assessment Form', the 'Treatment Algorithm', a 'GP letter' and a 'Patient Information Sheet' (example of each to be included)).
- Implementation, monitoring and evaluation of protocol.

At the time of writing, seven patients have been commenced on the protocol. Since the implementation of the protocol remains in its infancy, the monitoring and evaluation of the project is currently ongoing.

Discussion
The implementation of this protocol demonstrates the commitment of the PAAC team to improve the service offered to patients by identifying potential risks at surgery and actively intervening attempting to reduce that risk. We await the results from two on-going RCT's which may help to clarify the role of beta-blockers in low to intermediate risk patients.

References
2. Anesthesiology 2004; 100: 4-5
Introduction
Pre-operative management has been highlighted in many reports as a key point in improving patient outcome after surgery. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) produced a document in November 2001 promoting the increasingly important role of the anaesthetist in producing protocols, providing advice and holding specialist clinics for high risk patients. In 2002, the National Confidential Enquiry into Perioperative Deaths (NCEPOD) recommended that all elective patients should undergo preoperative assessment and that investigations, management and referrals should be guided by protocols. The NHS Modernisation Agency brought together examples of good practice from nine pilot sites in March 2003 to produce guidance on how pre-operative assessment can be improved. A multidisciplinary forum, the Preoperative Association was formed in 2004 and the first national conference highlighted many new and successful preoperative developments.

This survey was conducted to get an overall perspective of the current practice in the UK.

Methods
A postal questionnaire and stamped addressed envelope for reply were sent to the clinical director of 400 departments of Anaesthesia in March 2005. Reminders were then sent six weeks later to non-responders. The results were tabulated and analysed using Microsoft®Excel.

Results
324 completed replies were received giving an overall response rate of 81%. 22 replies were from tertiary referral centres undertaking single specialty surgery and 14 were from paediatric hospitals. Overall:

- 80% of hospitals have specialist nurses conducting the majority of pre-operative assessments.
- 72% have a lead nurse for their unit.
- 68% of the anaesthetic departments have a lead Anaesthetist for preoperative services.
- 39% of hospitals have an anaesthetic preoperative clinic. The number of clinics per week varied from one to twelve.
- 5% of the hospitals have a dedicated pharmacist for preoperative assessment service.
- 45% of the hospitals enable preoperative assessment nurses to examine patients.
- Preoperative assessment nurses obtain consent in 6% of the hospitals.
- All surgical specialties were assessed preoperatively in 45% of hospitals.
- 39% of units assessed children in their preoperative clinics.
- 48% of the hospitals gave the patient the Royal College of Anaesthetist's “You and your anaesthetic” information booklet in the preoperative clinic. 3% of hospitals, which gave out information, used an in-house version of the booklet.
- 7% of hospitals have a dedicated IT system to support their preoperative assessments.

Discussion
It is clear that the majority of Trusts now rely on nurses to undertake the majority of their assessments and have the back up of dedicated consultant anaesthetist clinics. Additional comments included several trusts with plans for developing a new service and many who were experiencing financial constraints. Establishing national standards may help units build stronger business cases to attract more funding. A few replies were very concerned with the concept of nurses obtaining consent for elective surgery. General Medical Council advice does indicate that consent can be delegated to another suitably trained professional and this implies that it does not necessarily need to be a doctor.

Conclusion
This survey helps confirm the significant national developments occurring in preoperative assessment and highlights the examples of good practice yet to be fully implemented.
Replacing nursing roles: Is it really possible?

Miss Clare Evans, Consultant Nurse, Perioperative Care
Miss Sarah Craig, Emergency Perioperative Practitioner
Chelsea and Westminster Hospital, London

Preoperative assessment for elective surgical patients has become an integral and accepted part of the surgical patient pathway. It is predominantly nurse led and offers an improved patient experience as well as realising benefits to the healthcare organisation. The care and information delivered to patients is known to be of a high standard and well received (Kinley et al 2002).

However, the care of emergency surgical patients remains within the realms of the medical teams and with the impact of the European Working Time Directive and changes in surgical training for junior medical staff becoming more evident it is clear that emergency surgical and trauma patients experience a wide difference in care, information and preoperative optimisation.

In response to the above and a need to address waiting times for patients undergoing emergency & trauma surgery the Preoperative Assessment Team at Chelsea & Westminster decided to pilot the model pioneered at Goodhope Hospital – the nurse specialist in anaesthesia and surgery (Radford et al 2003). The pilot was a resounding success and funding for a substantive post was secured from January 2005.

Replicating models of good practice has been a key feature within the changing NHS over recent years. Working across professional boundaries and new ways of working are phrases and scenarios that are now commonplace within healthcare. Although theoretically it should be possible to implement a model of working that has celebrated success in similar organisations our experience demonstrates how easy and yet how difficult this can be.

This presentation will outline the experience of the Consultant Nurse, Perioperative Care and the Emergency Perioperative Practitioner over the last year detailing the background to the role, the achievements and the challenges. Although the role is making a difference to patient care there are still areas that require further work and development. It may be too early to assess the full impact of the role at Chelsea & Westminster but the time is ripe to review its progress and benchmark against the standards set by the original pioneers of this nursing role.

References

2. Kinley, H; Czoski-Murray, C; George, S; McCabe, C; Primrose, J; Reilly, C; Wood, R; Nicolson, P; Healy, C; Read, S; Norman, J; Janke, E; Alhameed, H; Fernades, N; Thomas, E; (2002) Effectiveness of appropriately trained nurses in preoperative assessment: randomized controlled equivalence/non-inferiority trial. British Medical Journal. 325 pp1323=1328
Results of an audit of 184 patients assessed using OPPASS at the Hillingdon Hospital

Sister Janet Lynam, Sister i/c Preassessment Clinic,
Dr Mark Nel, Consultant Anaesthetist,
Dr Peter Emerson, Honorary Consultant Physician,
Ms Saki Hajnal, Decision Support Engineer
The Hillingdon Hospital, Uxbridge

Introduction
We describe the methodology and the results of a semi-automatic audit of 184 consecutive patients assessed using OPPASS (Out Patient Pre-Admission Screening System). OPPASS is a clinical knowledge-based computer system that is routinely used at The Hillingdon Hospital to assess selected patients prior to admission for major orthopaedic surgery (e.g. joint arthroplasty) or major vascular surgery (aortic or other major arterial procedure).

The OPPASS program provides a structured branching logic for an on-screen questionnaire with three layers of questions. The nurse records the patient’s answers to the questions and inputs the nursing observations including, if indicated, the PEFR and SpO2. Clinical rules embedded in the OPPASS program then generate a clinical report, which includes a list of any significant adverse findings with appropriate advice, and the completed request forms for appropriate investigations. The program also generates an Outcomes/Audit form on which the nurse later records the results of the investigations and the final decision about whether to allow the admission to proceed on schedule, or to postpone the admission for some further opinion or intervention, or to cancel the admission.

Method of auditing the initial assessment clinic encounter
The data recorded on the Outcomes/Audit form were transferred to an Access database linked to tables in the main OPPASS database holding the clinical data about the patients’ assessments. This combined database was interrogated to audit the initial results of the assessment clinic encounter.

Results
Table 1 summarises the results of the 184 assessments. The high proportion of patients suspended or cancelled reflects the nature of the population undergoing OPPASS assessment – typically elderly with multiple co-morbidities.

Table 2 shows the frequency with which abnormal results of various investigations were expected or unexpected. Many abnormal results are expected because they are either directly related to the condition for which the elective operation is being undertaken, or related to a known pre-existing co-morbid condition. It is the unexpected abnormal investigation results which are most useful because they are the ones most likely to influence the clinical decisions made. The most common unexpected abnormal test results were an abnormal full blood count or ECG report.

Method of auditing the final outcome of the assessment clinic encounter
The hospital admission and theatre databases were interrogated to establish the dates of the patients’ admissions and operations. If a patient, having been admitted was then discharged without operation, or if the operation was unduly delayed, the clinical notes were consulted to establish the reason for the cancellation or delay.

Results
Table 1 shows the results of this follow-up in the patients assessed using OPPASS. Of the 132 who were admitted, 128 patients had their operations successfully completed on schedule. Two patients changed their minds about having an operation, one patient was sent home by the surgeon who decided that the operation was no longer necessary and another was sent home as the surgeon was not available. No patient was cancelled on account of any co-morbid clinical condition.

Conclusions
1) It can be said that the prime purpose of pre-admission screening is to reduce the frequency with which patients, having been admitted for an elective operation, then have their operation...
cancelled by some adverse clinical finding. Of the 132 patients assessed using OPPASS and subsequently admitted, none then had their operations delayed or cancelled for adverse clinical reasons.

2) Abnormal results of investigations requested by OPPASS could be classified as expected (not useful) or unexpected (useful). The investigations most frequently returning unexpected (useful) abnormal results were FBCs (11%), ECGs (6%) and U&Es (3%). This high proportion of useful abnormal results underlines the efficiency of using the clinical rules incorporated in OPPASS to select investigations, as opposed to relying on regimes where a batch of investigations is ordered routinely.

Table 1. Decisions made on the evidence of the OPPASS assessment and the results of the recommended investigations.

<table>
<thead>
<tr>
<th>Decisions made</th>
<th>Patients assessed using OPPASS</th>
<th>Patients admitted for operation</th>
<th>Patients admitted, operation done on schedule</th>
<th>Patients who were admitted but then had their operation cancelled due to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Change of mind by patient</td>
</tr>
<tr>
<td>Proceed</td>
<td>135</td>
<td>113</td>
<td>111</td>
<td>2</td>
</tr>
<tr>
<td>Postponed</td>
<td>40</td>
<td>17</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Cancelled</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total patients</td>
<td>184</td>
<td>132</td>
<td>128</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 2. Frequencies with which the abnormal results from different investigations recommended by OPPASS were ‘expected’ or ‘unexpected’.

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Total number of investigation results</th>
<th>Expected abnormal results</th>
<th>Unexpected abnormal results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBCs</td>
<td>141</td>
<td>13</td>
<td>16 (11%)</td>
<td></td>
</tr>
<tr>
<td>ECGs</td>
<td>111</td>
<td>9</td>
<td>7 (6%)</td>
<td></td>
</tr>
<tr>
<td>U and Es</td>
<td>131</td>
<td>8</td>
<td>4 (3%)</td>
<td>All 4 ‘unexpecteds’ had diabetes</td>
</tr>
<tr>
<td>Chest X-rays</td>
<td>127</td>
<td>0</td>
<td>1 (0.8%)</td>
<td>Patient was still allowed to proceed</td>
</tr>
</tbody>
</table>
Hull and East Yorkshire Hospitals NHS Trust provides pre assessment services in a variety of settings and across two hospital sites.

**Pre Assessment Nurses Forum**
The pre assessment forum meets monthly bringing together nurses from across the Trust working as single practitioners or within small teams.

The forum not only provides a platform to share and develop ideas but also provides a networking opportunity to further develop clinical skills/practice through the following:

- Teaching Sessions – held monthly and are consultant led
- Sharing best practice which is evidenced based
- Participate in the development of Trust Guidelines
- Development of Generic pre assessment documentation
- Recognition of pre assessments as a specialty in its own right
- Support from Senior Medical Staff and Director of Nursing
- Links to PCT’s

The poster will reflect individual pre assessment specialities and how services are developing across the Trust including the development of a generic pre assessment new build opening late 2005.
Introduction
By December 2005 all patients will be offered Choice of 4/5 providers including independent providers. Primary Care Trusts will set the choice menu and patients will be supported in making their choices by GPs, practice staff and Choose and Book appointment lines.

By 2008 all patients will have the right to choose from any provider, as long as they meet clear NHS standards.

Within East Lancashire Health Community we have been offering choice at the point of referral over the last twelve months in the following specialities:

- Orthopaedics
- Ophthalmology
- General surgery

It was very quickly identified that in order to ensure patients were being given appropriate choice menus, pre-operative assessment needed to be performed much earlier in the patient journey.

Method
A steering group was established to consider the current pre-operative assessment service and identify the changes required to support the implementation of the choice agenda.

Funding from the Booking and Choice programme enabled the appointment of a Pre-operative Assessment Nurse Co-ordinator. This post was also very much linked to Setting a Standard Though Learning, for which the health community were a pilot site.

Initially the group focussed on redesigning services within the acute trust and implemented health screening to support choice at six months. The health screen was sent to all patients on the waiting list to identify any patients who were not fit and needed to be removed from the waiting list.

The health screen was tested out and further developed to address the numbers of patients ‘bouncing back’ from the independent sector which was having an impact on the acute trust and their ability to treat these patients within current waiting time limits as well as causing inconvenience to patients.

We have also worked very closely with our private providers locally to ensure that pre-op screening is standardised and that an assessment carried out locally is also acceptable to the independent providers.

The relevance of the health screen has been well recognised and this has now been rolled out across our MSK services.

Results
The introduction of a robust health screening questionnaire, ensured that those patients who were on the waiting list and could not be treated within six months were offered the choice of transferring their care to the independent sector.

As there were no high dependency facilities within the local IS provider, it was crucial that we ensure patients were fit to be offered this choice.

Implementing this screening process earlier in the patient journey means that we are able to offer the patients a choice of 4/5 providers in line with the NHS Plan. Currently we are seeing 69% of
orthopaedic patients choosing to be treated by providers other than their local hospital trust and 21% of ophthalmology patients are choosing to be treated by independent providers. Having identified a patients health status we are able to take this into account before the choice menu is discussed with patient.

Discussion
Our MSK services have now implemented pre-operative assessment prior to choice being offered. This ensures that those patients requiring extra support due to complex medical history are offered choices appropriate to their individual needs.

As we have continued to develop our screening processes our 'bounce back' rates have reduced and within a one month period only 1 patient was returned as not fit for private provider.

Pre-op screening carried out prior to patients being referred to secondary care ensures that those with very complex medical problems who previously would have been added to a waiting list without any input from anaesthetists, are either supported throughout their peri-operative period via an individual treatment plan or in some cases never added to a waiting list at all.
Troponin T as a predictive marker of morbidity in patients with fractured neck of femur

Miss Isobel Fitzgerald O'Connor, ENT SHO, Radcliffe Infirmary, Oxford
Mr Sebastian Dawson-Bowling, Orthopaedic SPR
Mr Kriss Chettiar, Clinical Research Fellow
Mr Hugh Cottram, Clinical Research Fellow
Mr Richard Worth, Clinical Research Fellow
Mr Hugh Apthorp, Consultant Orthopaedic Surgeon
The Conquest Hospital, St Leonards-on-Sea

Introduction
The principle causes of early death after hip fracture surgery are cardiac failure and myocardial infarction. Troponin T is a sensitive, specific enzymatic marker of myocardial injury. This study aims to assess prospectively whether Troponin T is a useful marker of morbidity in emergency admissions with fractured neck of femur.

Method
All patients aged 65 years and over presenting through the emergency department with fractured neck of femur were invited to participate in the study, for which Ethics Committee approval was obtained. Exclusion criteria of polymyositis, renal failure and conservative treatment were applied. Troponin T levels were measured on admission and on days 1 and 2 post surgery. According to local protocol a level of > 0.03ng/mL was considered to be raised. Outcome measures were defined as adverse cardio-respiratory events (myocardial infarctions, congestive cardiac failure, unstable angina, major arrhythmias requiring treatment and pulmonary embolism), death and length of inpatient stay.

Results
A total of 129 patients were recruited to the study, of which 21 subsequently failed to satisfy the exclusion criteria, leaving 108 patients. The results were analysed using an SPSS statistics package. 42 (38.9%) showed a rise in Troponin T >0.03ng/mL in at least one of the samples, including some patients with normal initial ECG traces. Of these 42, 25 (59.5%) sustained at least one of the outcome complications including death, as opposed to 7 with no Troponin T rise (10.6%). This was a statistically significant difference. The mean length of stay was 25.7 days for patients with Troponin T levels compared with 18.3 days in the normal group. This was also statistically significant. There were 9 deaths in the raised Troponin group (21.4%), and 5 in the group with no rise (7.6%), which was again statistically significant.

Conclusion
The association between raised Troponin T and hip fractures has not previously been made. Many hip fracture patients appear to be having silent cardiac events, which may be a significant cause of morbidity. We recommend measurement of Troponin T levels in all such patients to identify the risk and initiate appropriate treatment.
An audit of the effectiveness of the Royal College of Anaesthetists Preoperative Anaesthetic information leaflets

Abstract No. 020

Dr Simone Carbert, SHO Anaesthetics
Dr Nicholas Lavies, Consultant Anaesthetist
Worthing and Southlands NHS Trust

Introduction and methods
The Royal College and the Association of Anaesthetists have produced information leaflets for different aspects of anaesthesia, which are now available to patients over the internet.[1] Following a previous survey at Worthing Hospital looking at how much information patients want to be given [2] we tailored this information and recently began to distribute leaflets to groups of patients undergoing elective surgical procedures during their pre-assessment visit, so they can read them within their own time. We hope this will help patients not only to be prepared for the events of their anaesthetic experience as well as inform of the risks, but also give them a chance to formulate their own questions, if they so wish, which can be discussed during their pre-operative visit from the anaesthetist. Of course the option not to read the leaflet may also be undertaken.

Two different leaflets are currently distributed: one for adults based on the leaflet ‘You and Your Anaesthetic’ which explains the process of having a regional or general anaesthetic as well as some pre-operative advice, and another for the parents of children based on the leaflet “Your child’s general anaesthetic” which again explains the procedure and gives some idea of risk. The current practice at Worthing and Southlands Hospital Trust is for the anaesthetist to visit their patients on the day of surgery to carry out their assessment and discuss the relevant issues with the patient. On the anaesthetic chart they note down whether the patient/parent has read the information supplied.

We wanted to audit the current policy and try to answer the following questions:

- Were patients receiving the information.
- Were they taking time to read it.
- How did they rate the content.
- Was there any thing they felt should be included.
- Is it acceptable to see their anaesthetist on the day of surgery to discuss any further issues they may have.

The audit was carried out by using a questionnaire (attached) and interviewing the patients at a suitable time postoperatively.

Results
I was able to complete seventy questionnaires, thirty-five from each group. All of the patients questioned were admitted for elective surgery and none were seen for pre-assessment by an anaesthetist prior to admission.

The child / parent information leaflet was read by all of the parents that I questioned. All but one found the information helpful for both them and their child, had no further questions and felt that the level of information was enough (from the options enough / too much / not enough). Everyone questioned was happy to wait till the day of surgery to speak with the anaesthetist.

One parent felt that information was too generalised, as it tries to cover all anaesthetic procedures, and did not feel she knew which ones to explain to her child. Her child was undergoing a tonsillectomy and unfortunately the surgical information leaflet describing this procedure was not available on her pre-assessment. She felt that the leaflets would have complemented each other to provide a better picture of what to expect.

Eight of the adults questioned did not receive an information leaflet. Three of those who did receive the information chose not to read it and they had all had previous anaesthetics. Twenty four patients had read the questionnaire. All found it helpful and useful in their preparations for their operation. They were all happy with the content and felt it was enough, they did not feel that
there was anything that should be added to the leaflet and had felt all their questions were answered. Some were even surprised that an anaesthetist played such an important role in their care. All thirty five said that they were happy to wait until the day of their procedure to see their anaesthetist.

**Conclusions**

This audit shows there has been a positive response to the leaflets the department has distributed and they appear to be effective. Moreover it does not appear that any changes need to be made at the moment. Not all patients are receiving the leaflets and this should be improved so that all patients are included.

**References**

1. www.youranaesthetic.info
2. El-Sayeh S, Lavies NG. Pre-operative patient information – is more better? Anaesthesia 2003
Improving preoperative assessment of the high risk surgical patient: A joint anaesthetic & medical clinic

Abstract No. 021

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Dr Nicholas Lavies, Consultant Anaesthetist
Department of Critical Care, Worthing and Southlands Hospital Trust, West Sussex

Introduction
In 2003, the Association of Anaesthetists recommended consultant anaesthetist-led clinics to be established for pre-operative assessment of high-risk surgical patients. In the same year, the authors (consultant anaesthetist and consultant physician) who work together on the ITU, decided that we would similarly compliment each other in the pre-assessment setting and instigated a joint anaesthetic and medical clinic. This was perceived to have several potential benefits. Firstly, as both of us work in the ITU, we would be involved in the postoperative care of these patients and could facilitate bed availability. Secondly, the presence of a physician may reduce the need for additional medical referrals and enable convenient access to investigations and initiation of new therapy. Thirdly, it should allow for a thorough assessment of the patient by two experienced clinicians with regard to operative risk and suitability for operation.

‘Routine’ pre-assessment is still performed in our trust but this new facility (The Surgical Preassessment Anaesthetic and Medical clinic (SPAM clinic)) allows a point of referral when complex medical problems are found. Referral also occurs directly from surgical colleagues where they feel additional assessment is required or from other anaesthetic or medical colleagues. All major surgery requiring ITU post operatively is referred routinely.

Setting
The clinic is in the general out-patient department with nursing support and is run in such a way that time is allowed for full patient assessment as well as for discussion of pre and post operative care. The results shown are from the initial 125 patients seen in the SPAM clinic. Follow up data was collected from the patient notes after 6 months. Referral pattern was as follows: Urology 23%, General Surgery 41%, Upper GI Surgery 18%, Orthopedics 15% and O&G 3%

Results
Outcomes from clinic and surgery and causes of death

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Fit: Not Operated On</th>
<th>Fit: Operated On</th>
<th>Unfit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Progression</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Myocardial Infarct</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>CVA</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>GI Bleed</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Discussion
Although a significant reduction in mortality is observed in the group deemed fit for surgery in part this probably reflects the overall differences in case mix. Of as much interest is the fate of those deemed fit for surgery. Overall 9 patients deemed fit for surgery died within 6 months of assessment. Of these, 6 died before operation. 3 died within 6 months of surgery. 2 of disease progression and one following trauma 4 months postoperatively. There were no immediate post-operative deaths.

Conclusions
We believe the introduction of the SPAM clinic has provided a useful and cost-effective service to our trust for three principal reasons: firstly, the clinic has given high risk patients an opportunity to discuss the risks and accept - or reject surgery; secondly it has given their surgeons and anaesthetists confidence that they are operating on patients in optimal condition; and thirdly that those deemed inappropriate for surgical intervention are cancelled in good time allowing alternative treatment to be instigated where appropriate. Most encouragingly, the overall mortality in those high risk patients deemed fit is low.

References
1. Association of Anaesthetists of GBI 2003, Pre-operative Assessment – the role of the anaesthetist
Improving preoperative assessment of the high risk surgical patient: A joint anaesthetic & medical clinic

Mrs Angela Tilston, Deputy Manager, Preoperative Assessment Unit
Clatterbridge Hospital, Wirral

To discuss the stages of redesign within the Pre-Operative Assessment Unit to streamline the patients journey through the Elective Surgical Unit at the Clatterbridge Site of the Wirral Hospital NHS Trust.

Stages of redesign

1. Streamlining documentation.
2. Identifying and implementing Role Redesign
3. Developing a ‘One Stop Shop’.

Objectives.

To provide an appropriate and timely service for patients requiring elective surgery.

To remove or prevent patients being placed on the suspend list unnecessarily.

To streamline the patients journey.

1. Streamlining the Documentation
   The introduction of a patient Health Questionnaire.
   The previous process.
   Our areas of concern.
   How we addressed our concerns.
   The implementation of the Health Questionnaire.
   The new process.

2. Role Redesign.
   The role of the Advanced Nurse Practitioner,
   Pharmacist
   Physiotherapist.
   Occupational Therapist.
   Staff within the unit

3. Developing a ‘One Stop Shop’.

Preoperative fasting: Effect of staff knowledge and patient information

Dr Mary Taylor, Consultant Anaesthetist
Dr Somnath Chatterjee, Consultant in Anaesthesia and Critical Care
Dr Rupa Jeyaraj, SHO Anaesthetics
Birmingham Heartlands Hospital, Birmingham

Introduction
Preoperative drinking does not increase gastric contents and decreases PONV. Our Trust’s preoperative fasting guidelines were in line with the AAGBI and ASA guidelines.

Aims
To assess
1. Preoperative fasting in patients for elective surgery.
2. Awareness of fasting guidelines among staff.
3. Uniformity of fasting instructions sent to patients.

Methodology
A prospective audit was conducted in December 2003 in three parts.
Part 1: Duration of preoperative fasting (solids and liquids) and hunger and thirst scores (scale of 0-4) were noted prior to induction.
Part 2: Questionnaire to assess knowledge regarding preoperative fasting sent to theatre and ward staff.
Part 3: Preoperative admission letters of all surgeons were collected.

Findings
Preoperative Fasting
- A total of 233 patients from 89 elective lists on two sites were audited.
- Majority (45%) of patients appeared on Whole Day (WD) lists, as against AM or PM lists.
- 60% of patients admitted on day of surgery - fasting instructions in pre-admission letter.
- 28% of patients were affected by changes to the order of the list.
- The mean fasting time was 11.9 hours for fluids and 14.8 hours for food.
- Mean fasting advice reported by patients was 9 hours for food and 7.5 hours for clear fluids.
- No correlation between the duration of fasting and the hunger and thirst scores.

Staff knowledge: 115 staff members (65% nurses) completed questionnaire
- 80% gave the correct 6 hour fasting restriction for food.
- Only 21% gave the correct 2 hour restriction for clear fluids.
- 77% stated they would deny a patient a drink of water 2.5 hours before anaesthesia.

Preadmission letters
- 12 letters for AM or WD lists - 10 request NBM from midnight (9 hrs fasting) 2 advise NBM from 0300 hrs.
- 10 letters surveyed for PM lists, 9 advice light breakfast but times vary from 0600 – 0800 hrs.
- Only Solihull DPU issue instructions to take clear fluids up to 3 hours before start of list

Conclusion
- The majority of elective surgical patients are being instructed to fast too long.
- Many patients fast even longer than instructed, on average 9 hours more than necessary. They obey the preadmission letter in preference to preoperative clinic instructions.
- High scores of 3-4 were reported by 30% patients (hunger) and 53% (thirst).
- Staff have poor knowledge of the fasting time for clear fluids.

Actions Planned
- Redraft preadmission letters with uniform fasting instructions.
- Place fasting guideline posters on wards.
• List order changes to be agreed before start of list and patients instructed to drink accordingly.
• Re-audit in 1 years time.

References
Can the preoperative service assist in reducing the incidence of transfusions and transfusion errors?  

Abstract No. 024

Dr Melanie Westmoreland, Transfusion Liaison Nurse  
National Blood Service, Oxford  
Mrs Jane Jackson, Nurse Consultant  
St Albans City Hospital, St Albans

Introduction
The Health Service Circular Better Blood Transfusion - the Appropriate Use of Blood 009/2002 actions hospitals to ‘ensure that mechanisms are in place for the pre-operative assessment of patients for planned surgical procedures’. The National Blood Conservation Strategy for National Blood Transfusion Committee and National Blood Service 2004 encourages preoperative assessment clinics to ‘explore the aspects of patient health relevant to their requirements for blood transfusion both autologous and allogeneic’.

Method
In order to draw together current thinking surrounding this subject a multidisciplinary meeting was organised and attended by clinicians (including haematologists and surgeons) nurses (Preoperative nurses and Transfusion Practitioners), members of the Preoperative Association and National Blood Service. The aim of the meeting was to develop a ‘tool’ which would be useful to practitioners working within pre operative clinics to optimise patients haemoglobin prior to surgery thus reducing the need for donor blood transfusions. The group decided that the tool should comprise the following principles:

- Simple flowchart
- Easy to understand
- Adaptable for local use
- Appropriate to the target audience
- Easily reproduced
- Would be effective in the clinical environment

Results
Attendees at the meeting took the flowchart back to their respective hospitals for review and comment. The flowchart was amended accordingly and currently is being developed into a poster. A short paper is being presented to the National Blood Transfusion Committee in September asking for support of the tool and will be available, on the BBT2 Toolkit available at www.transfusionguidelines.org.

Discussion
The tool was developed to assist clinical colleagues to consider the steps necessary to optimise patients for surgery and thus potentially reduce the need for a blood transfusion and the inherent risks involved with this. Although this tool is not based on a scientific model it never the less represents a useful aid memoir to be used alongside other guidelines e.g. NICE whilst preparing patients for surgery.
New preoperative assessment strategy: Halving the rate of cancellation for patient unfitness

Dr Nathalie Frayssinet, Consultant Anaesthetist
James Paget Hospital, Great Yarmouth

Abstract No. 025

Introduction
At JPH NHS Trust, unfitness for surgery counted as the second reason for inpatient cancellations prior to admission and on the day of admission/surgery (8.9% in 2004). This problem is nationwide as reported by the NHS [1]. The reason for these cancellations is strongly linked to an insufficient/inaccurate patient’s pre-operative (=pre-op) preparation. With the aim of decreasing this rate of cancellation I reorganized our patient pre-op pathway using a new guideline for patient pre-op preparation. It is the first of its kind which takes into account the two major risk factors for an elective operation: surgical and anaesthetic factors. For all of our patients, grade of surgery and modified ASA score (mASA score = ASA score specifically modified for pre-operative screening purpose) are identified at an early stage. Grade of surgery and mASA score are used to define, utilising a ‘simple-to-use’ table, the personalised patient’s pre-op care plan. The results of the audit conducted on orthopaedic patients are in many respects very encouraging; consequently the system has started to spread to other specialty.

Method
At the outpatient clinic, when the decision to operate is made, the patient is asked to complete a ‘Well-being Questionnaire’ (=WBQ). The analysis of the questionnaire gives the patient’s level of health using a modified ASA score scale (Table 1). Then each patient is classified using a table (mAS Table 2): In abscissa patient’s mASA score, in ordinate: grade of surgery. This table identifies 4 different groups of patients and, accordingly, 4 specific guidelines for pre-op preparation. The logic of the table is: the higher the mASA score or the grade of surgery, the more the pre-op staff involvement.

Group 1: Healthy patient or patient having a mild systemic disease well controlled by medication, waiting for minor/intermediate operation. Pre-op plan: telephone assessment, done by a specialist nurse 2 weeks before admission (unless face-to-face assessment is requested by the patient).
Group 2: Healthy patient or patient having a mild systemic disease well controlled by medication, waiting for major surgery. Therefore pre-op assessment occurs face-to-face with a specialist nurse, 2 weeks before admission. Group 3: Patient with a mild systemic disease that is not well controlled under medication. Pre-op plan: patient is referred at an early stage to their GP to optimise their level of health before the patient is put on the waiting list and any surgery is attempted. Then, 2 weeks before admission a specialist nurse assesses the patient face-to-face.
Group 4: Patients have complex health issues. Pre-op plan: for a patient waiting for major surgery a clinic with a consultant anaesthetist is arranged. For minor/intermediate surgery, a consultant anaesthetist analyses patient’s WBQ and organises the necessary further investigation or referral, to optimise the patient’s health before his/her is put on a waiting list and surgery is attempted. Finally, 2 weeks before admission, a specialist nurse reviews the ‘optimised’ patient face-to-face.

In the following prospective trial, I audited the surgical outcome and the rate and reason for cancellation of patients using this system.

Results
This prospective study enrolled the first 100 patients booked for surgery at the orthopaedic clinic between August and September 2004. Patient mean age is 60 years (17-89y). Patients have been classified in the 4 groups by the mAS table. The audit is still ongoing. 95 patient outcomes have so far been collected. The preliminary result shows: 80% of patients have had their operation with good surgical outcome and no anaesthetic problem. 7.5% of patients have been removed from the waiting list (5 on patient request, 2 on hospital request). Finally, 12.6% of operation has been cancelled: 6.3% by the patient (e.g. appointment inconvenient), 2.1% by the hospital (e.g. ward bed unavailable) and 4.2% of patients were unfit for surgery or anaesthesia (none in group 1 or group 4, 2 in group 2, and 2 in group 3).
Conclusion
The pilot study shows that using this simple guideline to screen patients at an early stage, as a function of surgical grade and level of health, decreases the rate of cancellation for unfitness by 53% (4.2% patients cancelled in the audit, compared to 8.9% in the previous system for all of 2004). After I first explained the system and showed the results at the James-Paget Healthcare, the head of 3 surgical departments wanted to use it immediately. Therefore, a much larger audit is now running and it is continuing to confirm the effectiveness of the system: fewer cancellations, patient waiting time minimised, peri-operative morbidity reduced and patients more satisfied.

Reference

Modified ASA scores, by Dr Frayssinet

<table>
<thead>
<tr>
<th>ASA I</th>
<th>Normal healthy patient” (that is without any clinically important co-morbidity and without clinically significant past/present medical history)</th>
</tr>
</thead>
<tbody>
<tr>
<td>mASA II</td>
<td>“A patient with mild systemic disease”, well controlled under medication/diet</td>
</tr>
<tr>
<td>ASA II+</td>
<td>“A patient with mild systemic disease that requires treatment to be adjusted or started”</td>
</tr>
<tr>
<td>ASA III</td>
<td>“A patient with severe systemic disease that is not incapacitating”</td>
</tr>
<tr>
<td>ASA IV</td>
<td>“A patient with severe and incapacitating systemic disease that is constant threat to life”</td>
</tr>
</tbody>
</table>

Table 1: Modified ASA scores

<table>
<thead>
<tr>
<th>mASA</th>
<th>ASA I</th>
<th>mASA II</th>
<th>ASA II+</th>
<th>ASA III/IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Group 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate</td>
<td></td>
<td>Group 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major, Major +</td>
<td></td>
<td></td>
<td>Group 4</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: mAS Table – modified ASA score/Surgery Table
An audit of pre-operative investigations performed in a DGH according to local guidelines as compared to NICE guidelines

Dr Jon Stacey, SHO
Nuffield Department of Anaesthetics, Oxford
Ms Wendy Harlow, Audit Officer
Clinical Audit Office, Worthing Hospital, East Sussex
Dr Nicholas Lavies, Consultant Anaesthetist
Worthing Hospital, West Sussex

Abstract No. 026

Aims
To compare current practice in the ordering of pre-operative investigations with both local and NICE guidelines, to define the need for new local guidelines.

Method
The notes of all patients who underwent elective surgery in each of the specialities of Gynaecology, Orthopaedics and Ear, Nose and Throat surgery during four separate periods between November 2003 and October 2004 (n=110) were reviewed retrospectively. Any pre-operative investigation from the list of eleven featured in the NICE guidelines was recorded, and ASA2 grade, co-morbidity and grade of surgery1 were applied by the authors. Investigations (and omissions) were compared against both pre-existing local guidelines3 and the 2003 NICE guidelines.

In addition, pre-operative investigation of Gynaecology patients was compared for doctor- and nurse-led pre-admission clinics.

Results
16% of pre-operative investigations were considered inappropriate under local guidelines, compared to 44% under NICE guidelines. However, when dipstick urinalysis (recommended for all in local guidelines) was excluded, this discrepancy disappeared entirely, with 22% of the remaining tests inappropriate both when compared to local and NICE guidelines. 10% of patients had one or more indicated investigation omitted.

In the Gynaecology subgroup (n=56), 28% of investigations ordered by doctors were considered inappropriate, compared to only 3% by nurses.

Discussion
Similar performance was seen against both sets of guidelines if urinalysis was excluded, suggesting that the local guidelines remain otherwise valid. However, a large number of inappropriate investigations were performed, and a smaller number omitted. Inappropriate investigations have obvious implications to the patient (including time, travel and anxiety) and the Trust (financial and personnel). Inadequate pre-operative investigation may lead to cancellation or delay in surgery, sub-optimal peri-operative care and possible medico-legal repercussions. Both areas would provide fertile ground for further audit, as would a more detailed comparison of the ordering of tests by doctors and nurses.

References
1. Preoperative tests; The use of routine preoperative tests for elective surgery. NICE, June 2003
2. American Society of Anesthesiologists
Over the last five years in the UK, there has been an increasing emphasis in the underpinning of clinical practice with best evidence. This has resulted in a large increase in the number of national guidelines produced, initiated either by Royal Colleges and professional bodies or by guideline organisations such as NICE, CREST and SIGN. During this time, as one would expect, significant improvements have taken place in both the methodology and the rigor of guideline development. Clinical guidelines enable synthesis of evidence, promote evidence-based health care and actively engage both clinicians and patients in the development process.

Guidelines are advisory, and historically, because of their non-legislative power, have often failed to change practice or deal with the many variations in practice reported in the literature. Changes in practice rely on guidelines being adopted and implemented locally, and in this presentation we demonstrate the importance of engaging clinicians in both the development and implementation processes.

In doing so, we will discuss the methodology used in the development of the Royal College of Nursing’s Perioperative Fasting guideline, which is due for launch later this year. Further to this, we will share our vision for implementation, drawing on contemporary evidence, and will consider some of the innovative ways that evidence can impact on the day-to-day reality of clinicians. At present, there is a paucity of evidence addressing what does and does not work in the implementation of clinical guidelines, and we will discuss a current Health Foundation funded project that aims to fill this research gap.
Smoking is one of the greatest preventable causes of death and ill-health in the world. The widespread development of preoperative clinics provides a window of opportunity to become involved in preoperative smoking cessation. Anecdotal experience suggests that many patients presenting for elective surgery are willing to use the event as a time to quit smoking.

It is well established that smokers have a broad spectrum of increased adverse outcomes after surgery. There are good theoretical reasons for suggesting that even short-term preoperative smoking cessation would be beneficial. There is very little ‘evidence’ in the published literature demonstrating improved outcomes as a result of short-term preoperative smoking cessation. This is unsurprising, as the logistic challenges of studying this intervention in a scientifically valid way are very great.

Three ‘studies’ have been published that have been widely interpreted as suggesting that there is little benefit from smoking cessation of less than six weeks. All these studies have major methodological flaws. Probably the most important flaw in these studies was that none were truly prospective or controlled—they studied smokers immediately preoperatively, and asked when they had ceased smoking, rather than randomising smokers to cessation or not. A ‘smoker’ who smoked one cigarette per day was thus compared to an ex-smoker who stopped a twenty-a-day habit two weeks previously.

The reality is thus unclear. It is certain that prolonged smoking cessation is beneficial:- the benefits or otherwise of short-term preoperative cessation are unclear. Many patients remain interested in using the perioperative period as an opportunity to quit smoking, if only for the long-term benefits.

There is a large body of evidence to guide appropriate smoking cessation interventions in the hospital setting. At John Hunter Hospital in Newcastle, Australia we have created a comprehensive program aiming to increase smoking cessation in pre-operative surgical patients. The program includes tailored counselling by an interactive computer program; a computer-generated quit program; prompted brief interventions by clinic staff; provision of NRT preoperatively and during hospitalisation; and referral to Quit line.

The Newcastle program has been studied in a formal randomised controlled trial of 210 smokers. For dependent smokers (>10/day), high abstinence rates were obtained on day of surgery for both groups, but increased in the intervention group (73% vs 56%). Perhaps more importantly, abstinence rates at 3 months were much higher in the intervention group (18% vs 5%). We are now hoping to conduct further (multi-centre, randomised) studies to establish whether there is an improvement in patient outcomes as a result of smoking cessation.

Preoperative Clinics may have a niche role in continuing smoking cessation campaigns. Those considering this role should consider their own view of the philosophical issue of individual vs. social responsibility in regards to smoking. This is a matter of personal political philosophy, but ‘blaming the victim’ is not a constructive approach when attempting to change patient behaviour.

References
Setting up preoperative assessment
target times to improve efficiency

Abstract No. 029

Dr Osman Abdelatti, Consultant Anaesthetist
Rochdale Infirmary, Lancashire

Preoperative assessment clinics have several advantages, however, efficiency may be affected by potential delays namely during referral of patients for special tests, further assessment and or optimization. Can we predict and act on delays to further improve efficiency?

1. Referral to the anaesthetist and for diagnostics

It has been estimated that 15% of day cases and 40% of in-patients need preoperative clinic-based assessment. Of these a fair proportion are referred to the anaesthetist. The rest can be assessed using a questionnaire and telephone conversation. Referral for an anaesthetic assessment or a special test may involve several stages where potential delay may occur. This delay may be associated with the process of referral e.g. manual letter system.

2. Predicting optimization times

Hypertension

Short term ‘cosmotic’ therapy of hypertension is not sufficient because acute treatment with vasodilator reduces the blood pressure reading but does not alter the reactivity of the blood vessels. Treatment should be given for weeks to bring the regression of curve back to normal. An interval of four weeks should be allowed until control of blood pressure is achieved and reactivity of the blood vessels is altered.

Diabetes

Diabetes control may take 4-8 weeks to achieve and this can be confirmed using Hb A1c.

Obesity

Diet, increased physical activity, and behaviour change are the three main components that constitute the effective management of obesity plus or minus drug treatment. A three-months structured weight loss programme aiming for 5-10 kg weight loss (0.5 kg/week), or 5-10% reduction from initial body weight will usually achieve the target weight loss. Referral to a specialist centre should be considered for people with BMIs which remain greater than 35. Experience in UK shows that reduction of 5-10 kg weight may take four to six months. The aim of most General Practitioners is to be able to reduce weight in obese patients by 2-4 pounds / month to a target of BMI of 30.

Smoking cessation

Complications of smoking are well recognized. Cessation for 6 -8 weeks is required to reduce post-operative complications.

Asthma and chronic bronchitis (COAD)

Control of COAD symptoms may take up to 6-12 weeks. The peak expiratory flow rate may not become normal for a week after institution of treatment for asthma.

Improving preoperative assessment times:

1. Improving referral times:
   a) Provision & use of Dictaphones
   b) Use of electronic referral letters.
   c) Develop systems for monitoring referral letters.
   d) Develop referral letters follow up teams.
   e) Telephone referral.

2. Use of Integrated care pathways

3. Fast tracking urgent cases e.g. cancer.

4. Effective communication with GPs.

5. Integration of the patient choice agenda and preoperative assessment.

6. Train medical clerks / secretaries / patient to fill up medical questionnaire.

References

7. Personal communication.

Preopertive Assessment & Optimization Target Times

The patient pathway, referral and potential delay

POA = Preop. assessment.
A = Anaesthetist
S = Secretary
M&F= Monitoring & follow up system
PD = Potential delay (1- 5)
Referral by POA, arrange TCI date
Order further tests, dictate letter,
letter checked /amended,letter signed
The Heart of England Foundation Trust for the last four years, has had a Nurse led centralised Pre-Operative Assessment (POA) Service for all adult elective surgical cases (except ophthalmology). The service includes all elective Day Cases, Short stay and Inpatients receiving both general and local anaesthetics.

The service is ‘Patient Led’ run by Nurses although not Nurse exclusive. The team of Nurses working in POA come from a variety of surgical\theatre backgrounds. This diversity has enabled us to educate each other in providing a comprehensive service to patients to include information about their procedure regardless of what that may be.

Patients are seen within a clinical time frame around an Out patient model and this is easily measured. Fit and well patients require very little follow up. The results from any investigations are checked and the notes are sent to the appropriate department.

The service currently sees approximately 13,000 inpatients & 20,000 day surgery cases per annum. The service is proud to boast that only 0.5% of elective surgical patients seen in the POA unit are cancelled on the day for avoidable clinical reasons as a direct result of the protocols & standards in place to ‘deal’ with patient ‘queries’.

Patients who are not so straight forward are termed by the team as ‘queries’. This time is hard to measure ranging from a few minutes to a few hours/days. Managing queries efficiently and effectively is crucial to the successful management of a POA service optimising the time available to see patients.

Over the last 4 years the authors have encountered many diverse queries and have worked out the most effective and efficient ways to manage them. A query could be anything from a patient with hypertension, heart murmur, abnormal blood results to a patient refused asylum. As the roles of the POA nurses become more specialised & able to co-ordinate the queries, the queries too become more complex.

The authors believe that experiences encountered in the Heart of England POA service, will be beneficial to others health care professionals working in the field of POA.

The presentation will introduce the setting up of guidelines & protocols to simplify and standardise how practitioners handle queries at this Trust. Examples will be given of the most frequently encountered ‘issues’ and how we deal with them. Experiences will be shared that were out of the ordinary and required lateral thinking to achieve a successful outcome.
The concept of Agenda for Change was first discussed in Making a Difference (DoH 1999) as a means to address competence based progression and equity for those working in the health system, i.e. equal pay for work of equal value. Many nurses working in pre-operative assessment clinics around the country have found that their remuneration for working in a pre-operative clinic as autonomous practitioners has not been satisfactory. With the introduction of Agenda for Change this was supposed to address this imbalance. However from the vast number of complaints and appeals regarding where pre-operative nurses have been pay banded, this does not appear to have been achieved.

Why?

1. Because many staff have not previously been in positions to write job descriptions prior to Agenda for Change thus not realising the importance of their job description in the pay banding process.

2. The awareness of the need to make clear the level of knowledge, training and education required to undertake a competent, satisfactory and comprehensive assessment on a pre-operative patient.

3. The excellent communication skills required to discuss sensitive, emotional and highly distressing news with patients at the assessment clinic, working as the patient's advocate, supporting them and their families.

4. The need to address nurses' freedom to act as autonomous practitioners as little has been done to recognise and reward the autonomy vested in pre-op nurses. Autonomy has increased since the reduction in junior doctors hours, they now run nurse-led clinics, undertake physical examinations, order tests and in some cases take Consent (previously the roles of the junior doctors).

5. The fact that there is no specific job profile in the Agenda for Change profiles against which pre-operative assessment nurses' job descriptions can be matched.

Solution?

Having looked at various members of the association's job descriptions it became clear that a stratified version is required, theoretically this should provide a standard pay banding for all pre-operative nurses thus avoiding ambiguity and dissatisfaction with the current situation. Why have we such a vast array of different job descriptions, shouldn't we as an association push for a generic job description that has core competencies for all nurses working in this specialty. It would enable members to use the job description as a template for their own jobs adding to it as necessary depending on their own trust requirements. Furthermore this would then also provide the framework for the Key Skills component required for Agenda for Change.

This presentation would put forward a suggested template for a generic pre-operative assessment job description for members to view and comment upon.

References

Abstract withdrawn
How can safety be increased, costly short-term cancellations avoided and anaesthetists’ lives made less stressful?

We have devised a robust preassessment system to identify and manage patients with significant comorbidity well in advance of surgery. No patient will be put on the waiting list unless given a green light by preassessment staff or an anaesthetist.

After the surgeon has made a decision to operate, the patient is asked to complete a Well Being Questionnaire (WBQ). A preassessment nurse slots the patient into one of 5 risk groups, based on the ASA score (from the WBQ) and type of surgery. Groups 1, 2 and 2+ are managed entirely by the preassessment nurse but the group 2+ patients are referred to their GPs for correction of an insufficiently treated mild systemic disorder. All these patients are put on the waiting list when the preassessment nurse is satisfied that they meet the criteria. Group 3 and 4 patients are referred to a consultant anaesthetist service. Generalists take a week in turn and see all notes submitted with an intensivist colleague as back-up. On the basis of the notes the anaesthetist decides whether to put the patient on the waiting list straight away, arrange an appointment and/or refer for further investigations or to another specialist. Suitability for day surgery, type of list and level of postoperative care are other points addressed. When the anaesthetist gives the green light, the patient’s place on the waiting list will mirror the date of their initial appointment in clinic.

The presentation will give a more detailed overview of the WBQ system, review audit data from the first three months and outline some areas where there is scope for development.
Introduction
Theatre cancellations account to waste of resources and time. Many centres worldwide(1) have reported a drastic improvement in resource management following implementation of a pre-operative assessment procedure. We looked into the causes of cancellations in our centre and ways to restructure our pre-assessment clinic accordingly.

Methods
We followed retrospective case note study to look into the reason of cancellation documented in all the cases cancelled over a period of one year. We also took the opportunity to look into the duration of period between the pre-operative assessment date and the day of surgery.

Results
The results are presented below.

<table>
<thead>
<tr>
<th>Cancellations avoidable</th>
<th>13 (13%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancellations unavoidable</td>
<td>50 (87%)</td>
</tr>
</tbody>
</table>

Conclusions and discussion
Standard guidance is, to have no cancellations which can be avoided by thorough work up of patients scheduled for surgery to identify any surgical, medical and social concerns which may cancel the procedure on the day of the surgery. This is best done at a pre-operative assessment clinic. In our audit, it was found that 13% of the cancellations were due to inadequate optimisation of the clinical status of a medical problem. It was recommended to increase the interval between pre-operative assessment and the day of surgery to give enough time to optimise the patients. It was also recommended to include telephonic call 3 days before, to rule out any cause for cancellation among patients coming on the day of surgery for pre-operative assessment.

References
# Cardiac Risk Index for Elective Non-Cardiac Surgery

Patients with unstable angina or unstable heart failure need urgent Cardiology assessment

<table>
<thead>
<tr>
<th>Tick Points</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> High or Intermediate Risk Surgery</td>
<td>3</td>
</tr>
<tr>
<td>- age &gt; 65</td>
<td></td>
</tr>
<tr>
<td>- major risk [aortic or major vascular]</td>
<td></td>
</tr>
<tr>
<td>- intermediate risk [carotid, head &amp; neck, intra-peritoneal, intra-thoracic, prostate, major orthopaedic (spine, large joints)]</td>
<td></td>
</tr>
<tr>
<td>- prolonged procedure/large fluid shifts</td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> History of Vascular Disease</td>
<td>3</td>
</tr>
<tr>
<td>- previous MI, angina, CABG, percutaneous coronary intervention (balloon, stent), ventricular tachycardia (VT), troponin +ve ACS</td>
<td></td>
</tr>
<tr>
<td>- previous stroke, TIA or other peripheral vascular disease</td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> History of Heart Failure</td>
<td>3</td>
</tr>
<tr>
<td>- previous abnormal echo, current diuretic use</td>
<td></td>
</tr>
<tr>
<td><strong>4</strong> Unable to climb one flight of stairs without stopping</td>
<td>3</td>
</tr>
<tr>
<td><strong>5</strong> Diabetes</td>
<td>2</td>
</tr>
<tr>
<td><strong>6</strong> Smoker within last 2 years</td>
<td>1</td>
</tr>
<tr>
<td><strong>7</strong> Smoker within last month</td>
<td>1</td>
</tr>
<tr>
<td><strong>8</strong> Current BP &gt; 160 systolic or 90 diastolic</td>
<td>1</td>
</tr>
<tr>
<td><strong>9</strong> Cholesterol &gt; 6.2 mmol/L</td>
<td>1</td>
</tr>
<tr>
<td><strong>10</strong> Creatinine &gt; 130 umol/L</td>
<td>1</td>
</tr>
<tr>
<td><strong>11</strong> Creatinine &gt; 200 umol/L</td>
<td>1</td>
</tr>
<tr>
<td><strong>12</strong> Haemoglobin &lt; 11 g/dL</td>
<td>1</td>
</tr>
</tbody>
</table>

**TOTAL POINTS**

| 0 – 4 points | - | no action |
| 5 – 9 points | - | beta-blocker (as per protocol) |
| 10 or more | - | Cardiology Referral (via anaesthetist for comments) |

**Anaesthetist Comments:**

*Patients undergoing vascular surgery not already on a statin should be started on atorvastatin 20mg od*