## 5B MISCELLANEOUS 2

### O122 THE SCARE STATEMENT: CONSENSUS-BASED SURGICAL CASE REPORT GUIDELINES

RA Agha (1), AJ Fowler (2), A Saeta (2), I Barai (3), S Rajmohan (3), DP Orgill (4)
(1) Department of Plastic Surgery, Guy's and St Thomas' NHS Foundation Trust, London, UK (2) Department of Medicine, Guy's and St Thomas' NHS Foundation Trust, London, UK (3) Imperial College School of Medicine, London, UK. (4) Division of Plastic Surgery, Brigham and Women's Hospital, Boston, MA, 02115, USA

**Introduction**: Case reports have been a long held tradition within the surgical literature. Reporting guidelines can improve transparency and reporting quality. However, recent consensus-based guidelines for case reports (CARE) are not surgically focused. Our objective was to develop surgical case report guidelines.
**Method**: The CARE statement was used as the basis for a Delphi consensus. The Delphi questionnaire was administered via Google Forms and conducted using standard Delphi methodology. A multidisciplinary group of surgeons and others with expertise in the reporting of case reports were invited to participate. In round one, participants stated how each item of the CARE statement should be changed and what additional items were needed. Revised and additional items from round one were put forward into a further round, where participants voted on the extent of their agreement with each item, using a nine-point Likert scale, as proposed by the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) working group.
**Result**: In round one, there was a 64% (38/59) response rate. Following adjustment of the guideline with the incorporation of recommended changes, round two commenced and there was an 83% (49/59) response rate. All but one of the items were approved by the participants, with Likert scores 7-9 awarded by >70% of respondents. The final guideline consists of a 14-item checklist.
**Conclusion**: We present the SCARE Statement, consisting of a 14-item checklist that will improve the reporting quality of surgical case reports.
**Take-home message:**
The CARE statement for case reports is not surgically focused. Thus, we present the SCARE Statement, a 14-item checklist that will enhance reporting quality of case reports.

### O123 A SYSTEMATIC REVIEW OF PATIENT-REPORTED OUTCOME MEASURES (PROM) USE IN STUDIES OF ELECTIVE HAND CONDITIONS

(1) L Geoghegan, (2) H Lloyd-Hughes, (3) A Shiatis, (2) M Peters, (2) D Beard, (2) A Jain, (2) J Rodrigues
(1) Imperial College London, (2) University of Oxford, (3) Royal Free Hospital

**Introduction:** The use of patient-reported outcome measures (PROMs) in hand surgery has grown in recent years, and support patient-centred care and research. Their use has been reviewed in Dupuytrens disease and in trauma. The aim of this systematic review was to appraise the usage of hand relevant PROMs in elective hand conditions.
**Method:** A PRISMA-compliant methodology was used. A highly sensitive search strategy was developed in conjunction with a search strategist, and applied to Medline, Embase, PubMed and CINAHL from January 1992 to January 2016. No language limits were applied. Search results were screened by two authors in parallel, with disagreements resolved by a third. A similar approach to data extraction was adopted. Papers related to PROM development were not included.
**Result:** Out of 6028 studies screened, 818 were included. The PROMs identified included 5 disease-specific measures, 6 domain-specific measures and 3 generic quality of life measures.
**Conclusion:** Of the domain-specific instruments the DASH was the most commonly used, and of the disease-specific it was the Boston Carpal Tunnel Questionnaire. The EQ5D was the most used generic QOL measure.
**Take-home message:**
A variety of PROMs have been used to assess outcomes in elective hand conditions. This review suggests that work towards consensus for PROM use in elective hand surgery may be beneficial.

### O124 OPTIMISING HANDOVER OF POSTOPERATIVE PATIENTS TO THE INTENSIVE CARE UNIT AT A TERTIARY CENTRE

AR McKean, S Kumar, S Leaver, C Johnston, A Ramwell
St George's University Hospitals NHS Foundation Trust

**Introduction:** Comprehensive handover of patients being admitted to the Intensive Care Unit (ICU) post-operatively is crucial in ensuring ongoing quality and safety of care. Handover in this setting poses unique challenges, yet few studies have considered or tested approaches to improve the process. Our aim was to assess and improve the quality of information transfer during the handover of post-operative patients to the ICU at a tertiary centre.
**Method:** All post-operative patients >18 were considered over a 3-month period in 2015 using Plan-Do-Study-Act (PDSA) methodology, as part of a quality improvement project. Baseline audit encompassing intraoperative details (allergies, grade of intubation, estimated blood loss, difficulties and complications) and the post-operative plan (analgesia, thromboprophylaxis, antibiotics and nutrition) was undertaken. Changes were implemented over 3 cycles, centred around a novel checklist.

**Result:** Baseline audit (n=30) revealed a need for improvement across all domains. Raising awareness amongst colleagues (cycle 1) had negligible impact with performance weaker in 5/9 domains studied (n=29). In cycle 2, implementation of a novel checklist led to global improvement with performance exceeding 70% in all but 3/9 domains (n=33). Engaging key stakeholders (cycle 3) resulted in overall improvement from baseline (n=31).
**Conclusion:** Successful implementation of a series of simple interventions resulted in more effective handover of post-operative patients admitted to ICU. Sustained long-term improvement is a major challenge and can only be achieved with the global engagement of all staff and incorporation of changes into routine clinical practice.
**Take-home message:**
Successful implementation of a series of simple interventions resulted in more effective handover at our centre. Sustained long-term improvement is a major challenge and needs the global engagement of all staff and incorporation of changes into routine clinical practice.

## O125 SURGICAL REFERRALS AT A MAJOR TRAUMA CENTRE: AN UNSUSTAINABLE FUTURE?

SJ McCluney, A Jamalfar, AT Abraham, HM Kocher
Barts and the London HPB Centre, Department of Surgery, The Royal London Hospital, Barts Health NHS Trust, Whitechapel, London, UK
**Introduction:** The past decade has seen an increase in surgical workload across England, with 4.7 million surgical patients admitted in 2013-2014, a rise of 27% from 3.7 million in 2003-2004. Furthermore, general surgery is the busiest surgical specialty with 1.3 million procedures annually. The Royal London Hospital (RLH) is a major trauma centre, and the centre of the London Air Ambulance.
**Method:** We performed a retrospective analysis of a prospectively maintained database of general surgical, vascular and trauma referrals to RLH from December 2012 to February 2016. Data regarding time to theatre was gained from emergency theatre records. Statistical analysis was performed using Prism 6.0 (GraphPad, CA, USA).
**Result:** 22,841 patients were referred during this time, an average of 19.26 referrals per 24 hours. This figure rose from 17.93 in 2013 to 20.26 in 2015 (KW, df = 2, p-value <0.05). Friday was the busiest day of the week, with no significant seasonal or monthly variation. On average, time to theatre was quickest for trauma patients, at 2.5 hours. In February 2013, 63 patients underwent emergency surgery, which increased to 103 in February 2016. Time from booking to operation start time increased from 7.0 hours in February 2013 to 10.5 hours in February 2016 (KW, df = 3, p-value <0.05).
**Conclusion:** This study has shown that the RLH emergency surgery workload has increased dramatically since 2013, with no consequent increase in staffing levels. This may have an impact upon patient outcome and training opportunities for surgical juniors.
**Take-home message:**
Emergency surgery referrals and admissions are increasing, with no subsequent increase in staffing levels, leading to a larger workload and increased theatre waiting times.

## O126 THE INFLUENCE OF INHERENT PATIENT FACTORS ON INFORMED CONSENT FOR SURGERY

RS McCain (1,2), M Dempster (3), WJ Campbell (2), M Clarke (1), SJ Kirk (2)
(1) Centre for Public Health, Queen's University Belfast (2) The Ulster Hospital, Belfast (3) Department of Psychology, Queen's University Belfast
**Introduction:** To allow effective decision making and valid consent to surgery, patients must be able to recall, understand and weigh up the information provided. Current evidence suggests that patient recall and understanding is suboptimal, despite increasingly comprehensive consent processes. Furthermore, there is little understanding with regard to which inherent patient characteristics influence informed consent. The aim of this study was to assess the influence of inherent patient characteristics on informed consent.
**Method:** Patients underwent a standardized informed consent process using shared decision making methodology. Assessment of memory was by Wechsler memory scale, intelligence by Wechsler Abbreviated Scale of Intelligence and personality by Neo-FFI. Recall and understanding were measured by a questionnaire. The study was powered to detect a correlation $R \geq 0.24$. Research approval was granted by the Regional Ethics Committee (14/NW/1188).
**Result:** 100 patients (97 males) with inguinal hernia were recruited. Median (IQR) age at diagnosis was 61 (50-69) years. Mean intelligence quotient (IQ) was 110 (SD 16.5). Median memory score was 97 (89-108). Mean recall was 51.6% (SD 12.455) and understanding was 36.9% (SD 15.2). IQ positively correlated with recall (R=0.320, p=0.003) but not with understanding. Age and Memory were not correlated with either recall or understanding. Recall and understanding did not differ with individual personality traits.
**Conclusion:** IQ of participants was above the population average, but despite this and a comprehensive consent process, patients had poor recall and understanding. IQ was only weakly correlated with recall, with no other patient factors affecting recall or understanding of consent information.
**Take-home message:**
Patient recall and understanding of consent information was worryingly low. The only patient factor which was correlated to recall was intelligence quotient.

## O127 USE OF THE PAEDIATRIC SEPSIS SIX IN PAEDIATRIC SURGICAL PATIENTS AT A LARGE TEACHING HOSPITAL

R Callan (1), C Jackson (2)
(1) North Middlesex University Hospital NHS Trust, (2) Department of Paediatric Surgery, Addenbrooke's Hospital

**Introduction:** The successful treatment of sepsis requires prompt delivery of diagnostic and therapeutic interventions. The paediatric sepsis six is adapted for paediatric patients, with a checklist for sepsis recognition and interventions. We aimed to establish the incidence of sepsis in patients admitted under paediatric surgery at a large teaching hospital, and examine the management of patients fitting the diagnosis criteria of the paediatric sepsis six.

**Method:** Ehospital notes for all patients (792) admitted under paediatric surgery between the dates 26/10/2014 and 14/09/2015 were analysed - examining the problem list and applying the sepsis six diagnostic criteria left 10 patients for analysis. The treatment and time to treatment were then examined, focusing on the sepsis six criteria.

**Result:** There was a large variation in interventions – all patients received IV access and senior clinical review. 7/10 received IV fluids, and 1/10 had blood glucose levels tested. The time taken to intervention was similarly variable; fluids were administered on average 58 minutes after clerking, blood cultures 100 minutes, other blood tests 82 minutes, and antibiotics 218 minutes.

**Conclusion:** Few septic patients, as defined by the sepsis six criteria are seen by this paediatric surgical team. The sepsis six was not followed in all patients, and often took over 1 hour, the time limit advised by the sepsis six. Despite this, all patients were treated appropriately based on their clinical presentation – of those included, none had positive blood cultures, and later notes revealed that they had no systemic signs of septic shock.

**Take-home message:**
Few patients treated under the paediatric surgery team had sepsis as defined by the paediatric sepsis six. The sepsis six were not uniformly adhered to, but all patients were treated appropriately based on their clinical presentation.

## O128 STRIKE THROUGH TIME OF SURGICAL GOWNS AND THE RISK POSED TO SURGEONS

T Richards, R Thompson, N Wilson-Jones, S Hemington-Gorse, E Azzopardi,
The Welsh Centre for Burns and Plastic Surgery, Morriston Hospital Swansea

**Introduction**: CDC guidelines clearly state that bodily fluids should never come into contact with a healthcare workers clothes, undergarments, skin or mucous membranes. This study evaluates the perception of risk of cutaneous exposure to blood or bodily fluids. It also quantifies the level of protection through strikethrough time, offered by surgical gowns used locally

**Method**: A standard solution of 40ml 0.9% Saline with 2ml povoiodine was poured into material (100 cm2) from the anterior torso of disposable, reinforced and reusable gown suspended over a graduated measuring container. Volume of strikethrough fluid was recorded at 15 minute intervals in duplicate. A structured, quantitative questionnaire was circulated to all surgeons in the department to determine frequency of strikethrough and their perception of risk this poses.

**Result**: At 15 minutes there was strikethrough from both disposable and reusable gowns. Volume of fluid soaked through increased with time to 50mls in unreinforced disposable gown and 3mls in reusable gown at 45 minutes. 6/17 of questionnaire respondents had experienced gown strikethrough over 3 times in the last 3 months. Only 2/17 did not recall any episodes of strikethrough during this period.

**Conclusion**: Combined seroconversion risk from HIV, Hepatitis B and Hepatitis C through completely intact skin is 0.38% but this risk is higher with broken skin or through mucous membranes. Current commonly used gowns provide only short periods of protection from percutaneous contact shown by short strikethrough time and high volume of fluid strikethrough and ineffective gown should be withdrawn from use.

**Take-home message:**
Surgical gowns should protect the surgeon from bodily fluids and the small but significant risk of blood borne viruses. Thought should be given to the level of protection provided by the gown used and ineffective gowns withdrawn from use.

## O129 WITHDRAWN