to the procedure. Of those patients transferred, several issues were noted with the quality of handover, information shared between transferring and accepting teams, and information given to patients.
Methods: Notes from the ten patients transferred between 01-08-2018 and 01-03-2019 have been evaluated. Documentation including the decision to transfer, who has been informed, coagulation results and discussions with patients/families has been assessed. The accepting teams have discussed the complications for each patient. Data regarding length of stay and discharge outcome has also been evaluated.
A standard proforma has been developed for future patients transferred.
Results: Patient transfer has not been a seamless process, flagged by the accepting UGI firm at RGH. Lack of communication has resulted in patient dissatisfaction, delays in procedure and complications and there are clear areas for improvement.
Conclusion: There are clear areas for improvement in the transfer of patients between hospitals for radiological procedures. The development of a standard proforma should improve communication between teams. It will provide clear information and allow the accepting team to offer excellent continuity of care.

111.
STOP THE CLOT? TOWARDS 'QUALITY' VENOUS THROMBOEMBOLISM PROPHYLAXIS IN THORACIC SURGERY

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Background: Venous Thromboembolism (VTE) is uncommon after general thoracic surgery, but is associated with a persistently-elevated mortality risk. The National Institute for Health and Care Excellence (NICE) introduced recommendations for thoracic surgery in their 2018 guidance on VTE prophylaxis (NG89). These extrapolated from a single systematic review, with no thoracic-specific literature.
We sought to introduce validated, risk-stratified, evidence-based guidance to reduce VTE incidence.
Method: Thoracic surgical patients, and VTE events at our institution (2014 to 2018) were identified from hospital databases. Statistical analysis was performed in STATA v16. A national survey of VTE prophylaxis after thoracic surgery was performed. A review of thoracic-specific literature was conducted, and local guidelines derived through internal cross-specialty consultation.
Results: 18 of 1,203 (1.4%) patients suffered VTE. The Caprini score was positively correlated with VTE risk (OR 1.38, 95% CI 1.10 to 1.72, $p = 0.008$). VTE patients had lower one-year survival (57% vs 88%, $p < 0.001$).
There is significant geographical variation in VTE prophylaxis after thoracic surgery. Only one trust reported following NICE guidance. None practiced a risk-stratified approach, or extended prophylaxis beyond 7 days.
Local evidence-based guidelines for risk-stratified mechanical- and extended course chemical-VTE prophylaxis were developed, and successfully approved by NICE for deviation from NG89.
Conclusion: Our evidence-based approach improves the 'quality' - defined as the right care, to the right patient, at the right time - of VTE prophylaxis offered. There is scope for broadening the reach of this initiative beyond the local level.

115.
COMPARING SIGNIFICANT PROSTATE CANCER DETECTION RATES AFTER THE INTRODUCTION OF PRE-BIOPSY MRI: TURNING PROMIS INTO ACTION

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Background: Basingstoke was a participating centre in the PROMIS trial between 2013 and 2015. Our perception following the introduction of pre-biopsy MRI was that there had been an increase in the proportion of significant cancers detected on biopsy. We therefore decided to undertake a retrospective analysis of prostate histology before and after participation in the study.
Method: Using our hospital histopathology database, we identified 206 patients in both 2012 and 2016 who underwent prostate biopsy. We reviewed the type of biopsy performed (transrectal or transperineal), number of cores sampled, number of positive cores and cancer grade. The proportion of men who had a pre-biopsy multi-parametric MRI (MP-MRI) was also recorded.
Results: 37.4% of patients underwent a transperineal biopsy in 2012, increasing to 54.4% in 2016. The percentage of positive biopsy results increased from 69.9% to 83.0% ($X^2=9.83$, $p=0.002$). Strikingly, the number of grade group 1 cancers significantly decreased from 63.9% (2012) to 22.2% (2016), and the number of grade group ≥ 3 increased from 11.1% to 51.5%. In 2012, 33% of patients had a MP-MRI prior to biopsy compared with 90% in 2016.
Conclusion: Our study has confirmed that the introduction of a pre-biopsy MP-MRI can improve diagnostic accuracy and reduces the number of insignificant cancers detected. This overall upgrading of the biopsied population, and the resulting shift towards detecting an increased number of significant cancers, is likely to have a positive impact on treatment allocation and longer-term outcomes for our patients.

116.
NEGATIVE PRESSURE WOUND THERAPY IN ELECTIVE STOMA REVERSAL SURGERY: RESULTS OF A UK DISTRICT GENERAL HOSPITAL PILOT

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Introduction: Negative pressure wound therapy use in elective and emergency colorectal surgery has demonstrated significant reduction in superficial and deep surgical site infection complication rates. Stoma reversal surgery constitutes clean contaminated surgery, and the role of negative pressure wound therapy remains unknown. This study evaluated the reduction in wound complications when using negative pressure wound therapy in elective stoma reversal surgery.
Methods: A retrospective, non-randomised, single-institution, pilot study over a two-year period in a rural UK district general hospital. All elective stoma reversal procedures over the pre-defined time period were included. Surgeon preference determined type of wound closure and application of the available single-brand negative wound pressure device at the time of wound closure.
Results: Patient demographics between the two groups were similar and representative of the UK population treated at most hospitals. Colorectal cancer was the commonest indication for stoma formation at initial operation. None of the twelve patients in the intervention group suffered wound complications, but five of the thirty-six patients in whom negative pressure wound therapy was not utilised suffered surgical site infection-related complications. Primary closure and use of negative pressure wound therapy decreased the burden on wound management, both in hospital and in the community.
Conclusions: Negative pressure wound therapy use in elective stoma surgery can reduce the burden of surgical site infection in these clean contaminated wounds. This has cost-saving implications for institutions, and also reduces the burden of community wound care on both patients and health professionals. Further studies are needed.

117.
LEGIBILITY OF THE OPERATIVE NOTES ACCORDING TO THE ROYAL COLLEGE OF SURGEONS GUIDELINES AFTER INTRODUCING ELECTRONIC FORMS AT UNIVERSITY HOSPITALS OF LEICESTER : A PROSPECTIVE QUALITY IMPROVEMENT STUDY

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Background: Proper documentation of the operative notes is one of the pillars of good surgical practice. It ensures safety and maintains communication between MDT members involved in post-op care. Complete and clear operation notes provide a medico legal record to use as evidence when required. Based on 2 previous audits done on hand-written

operative notes at UHL, legibility continued to be a problem. Therefore, we introduced an e-template to compare against RCS guidelines. Our aim was to maintain accurate and legible records of surgical procedures.
Methodology: A total 100 of operative notes were audited prospectively. Audit population of general surgery patients who had procedures between 5th of April and 5th of July 2019 mainly at LRI and less at GH and LGH. Each document was assessed against RCS guidelines.
Results: 100%compliance in recording nature of operation**,** name of surgeon and assistant**,** name of procedure**,** operative findings**,** details of closure**,** blood loss and ability of FY1 and nurse to read.
99% had incision details written up, 98% had post-op instructions listed, 94% had recorded **VTE** prophylaxis and 90% with antibiotics prophylaxis**.** The least compliance was **prosthesis,** 83% Date and time were missed in 6 notes, **Name of anaesthetist** not documented in 3,**Operative diagnosis** not clearly written in 2,**Complications** not filled in 10, **Extra procedure** left blank in 11, Details of tissue removed/added not clarified in 9 and Signature missed in 10.
Conclusion: Remarkable improvement in legibility of operative notes noticed after introducing the e-forms as they are not subjected to handwriting. A better outcome in all standards was also accomplished. We emphasized and discussed about the importance of surgeon signature for authentication.

119.
ARE WE MONITORING URINE OUTPUT IN SURGICAL WARD SETTINGS WHILE INDICATED OR PLANNED?

Safia Zahir Ahmed, Mohammad Miah, Khurram Anwer. *Northern Lincolnshire and Goole NHS Foundation Trust, Scunthorpe, UK*

Background: Occurrence of AKI is associated with substantial in-hospital mortality, exceeding 50% when AKI is part of a multiple organ failure syndrome. According to the guidelines, physiological 'track and trigger' systems should be used to monitor acute patients. Monitoring urine output at admission, initial assessment and as a routine can help in recognising and responding to oliguria. Protocols are in place to monitor the urine output of people who are at risk of acute kidney injury alongside a track and trigger system, and to respond to any changes. Our audit objective was to find out the number of patients undergoing major surgery or advised by the physician do they have urine output monitoring in place?
Methods: Prospective data collected of all general surgical patients who were admitted in 2 weeks between 28th May to 10 June 2019 at District Hospital. The data was reviewed through record and on bedside who had planned or indicated urine output monitoring.
Results: 77 patients were included in which 39 had a plan in place for urine output monitoring while 27 patients had Urine output accurately monitored and in-addition 7 patients had no plan of monitoring but was monitored and all of them was catheterized. Total number of catheterized patients were 26 and unfortunately,3 of them did not have their urine output monitored.
Conclusion: Decrease urine output is common among critically ill patients and prompt fluid resuscitation is needed to prevent.

122.
SURGICAL PATIENTS SHOULD BE ASSESSED FOR VTE RISKS AND RECEIVE APPROPRIATE VTE PROPHYLAXIS – WARD PERSPECTIVE

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Background: The House of Commons Health Committee reported in 2005 that an estimated 25,000 people in the UK die from preventable hospital-acquired venous thromboembolism (VTE) every year. The inconsistent use of prophylactic measures for VTE in hospital patients has been widely reported. According to the guidelines risk assessment and VTE prophylaxis on admission for people undergoing abdominal surgery should have anti-embolism stockings or Intermittent pneumatic compression or pharmacological prophylaxis outweighs their risk of bleeding. Continue until the person no longer has significantly reduced mobility relative to their normal or anticipated mobility. Our audit objective is to find out whether all the patients assessed for VTE and bleeding risks, any patient was not on AES, was the pharmacological prophylaxis considered.
Methods: Prospective data were collected over 2 weeks by patients record review and bedside examination. All the patients who were admitted under General surgery were included.
Results: Out of 77 patients 37 underwent Surgery or Invasive procedure and 40 patients were treated conservatively. 99% had VTE risk assessment and 89% received pharmacological prophylaxis while 88% was indicated. 51% did not receive mechanical VTE prophylaxis compared to 71% in Published national report.
Conclusion: Pharmacological VTE prophylaxis is reaching the high-quality standards with almost 100% VTE risk assessment but need more improvement in mechanical VTE prophylaxis in a surgical patient.

123.
HOW ADEQUATE IS THE INFORMATION ON THE HISTOPATHOLOGY FORM FOR COLORECTAL RESECTION: RETROSPECTIVE RE-AUDIT

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Background: Histopathology report is the most important and integral part in the management of colorectal resection. According to Royal college of pathologist, colorectal resection forms should contain confirmation of the specimen along with the diagram of the procedure, type of surgery, dissection plane, tumour detected as part of screening programme, previous biopsy details, previous chemoradiotherapy and its date mentioned on the report, history of familial cancer or IBD and preoperative staging. The aim of this re-audit was to review if we are compatible to the guidelines provided by the Royal college of pathologists.
Material and Methods: Data was collected retrospectively from 1/January 2016 to 30/July 2019 in Scunthorpe General hospital. All patient who underwent colorectal resection for bowel cancers were included in this study.
Results: 131 patients underwent colorectal resection the request form analysis revealed that 83 form mentioned it was open technique, 20 laparoscopic and 28 forms were unclear. The diagram was present in 44% and dissection plane was mentioned in 43%. Mention of previous biopsy on the report, preoperative staging and preoperative therapy was 11.4%, 5.4% and 4.5% respectively. Clinical information of familial cancer/IBD was mentioned in 0.76% request forms and 0% information of screening. In contrast to previous audit, presence of diagram and dissection planes was only 0.4%.
Conclusion: Compared to previous audit there is gradual improvement in clinical details on the request form according to the guidelines but still have not reached the standards. This audit identified that histopathology request form needs to be improved.

126.
INTRODUCTION OF ERAS PROTOCOL TO A LIMITED RESOURCE SETTING – A SURGICAL AUDIT

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The principal aim of the ERAS protocol is to attenuate the stress response to surgery by optimizing the patient's normal physiology.
Elective colorectal cancer resections performed by a single surgeon at the University surgical unit of the Colombo-South-Teaching-Hospital, Sri Lanka from 2011 to 2019 were audited. The modified ERAS protocol was initiated with the aim of assessing the outcome of patients.
One hundred and twelve colorectal resections were performed (71.4% laparoscopic or laparoscopic-assisted). Median age was 60 years. Male: Female was 1.08: 1. Mobilization was started on post-operative day 01. Oral clear fluids were started on postoperative day 01 and normal diet was established by day 03. 70% of the patients had bowel opening on post-operative day 03. Naso-gastric intubation was done in 40% of the cases and median day of removal was day 02. Median day of catheter removal was post-operative day 02. Three, who underwent laparoscopic-assisted low anterior resections had anastomosis leaks. Two, needed re-opening and other was managed conservatively. Median days of hospital stay were 5 days (range 3-21 days). No difference observed between open and laparoscopic groups. Thirty day mortality rate was zero.
Although ERAS has proven promising results in western countries, the data from developing countries are scarce. In this background, this audit shows