Conclusion The introduction of telemedicine can release some HPN clinic capacity and help reduce the increasing pressure for patient access to HPN services. Importantly, compliance with NICE and ESPEN guidelines can be maintained. Whilst maintaining patient satisfaction and patient safety.

**PTU-082** OPTIMISATION OF PATIENTS PRIOR TO IBD RELATED RESECTION USING A QUALITY IMPROVEMENT METHODOLOGY

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Introduction Up to 70% of patients with Crohn’s disease and some 30% of patients with ulcerative colitis require abdominal surgery during their lifetime. Perioperative adverse events such as anastomotic leaks, intra-abdominal abscess and unplanned stoma formation are associated with potentially modifiable risk factors. Impaired recovery and complications cause considerable loss of quality of life in this population, who are often in a formative stage of life with considerable educational, professional and family commitments. In order to improve outcomes in elective or expedited IBD surgery, identification of these modifiable risk factors and their pre-operative optimisation in each individual patient is important, but preoperative management remains heterogeneous. We therefore aimed to implement a care bundle to systematically identify and optimise preoperative modifiable risk factors in IBD surgery.

Method A literature review identified five important modifiable pre-operative factors in IBD surgery: smoking, anaemia, malnutrition, steroid and immunosuppressant therapy, and intra-abdominal sepsis. From May 2017, a pre-operative patient optimisation bundle was developed to improve these risk factors. It was implemented using a continuous quality improvement (QI) methodology utilising the model for improvement, sequential plan-do-study-act cycles, tests of change and trust-wide upscaling. The main outcome measure was days between failure, where failure was defined as non-compliance with one or more of the five components of the pathway. The care pathway was fully implemented from 1 September 2017, with a continuous QI approach.

Results 18 consecutive patients operated prior to the implementation date, were retrospectively assessed and 14 patients operated with the care bundle were prospectively studied. Mean days between compliance failure increased approximately 2-fold, from 11.7 to 26.1 days. From the first month of implementation, 100% compliance with the anaemia and smoking interventions were achieved, while full compliance with nutritional assessment and steroid weaning elements took longer time to achieve. Length of stay and incidence of Clavien-Dindo grade ≥II morbidity remain unchanged in this preliminary data.

Conclusion Quality improvement methodologies including PDSA cycles, tests of change and trust-wide up-scaling are effective in implement a complex multidisciplinary pre-operative optimisation care pathway for patients undergoing major IBD surgery.

**PTU-083** ADVICE GIVEN TO PATIENTS WITH ALCOHOL EXCESS REGARDING FITNESS TO DRIVE

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Introduction In 2015, around 5740 accidents and 220 fatalities occurred on UK roads and involved drivers under the influence of alcohol. Following discussions amongst the gastroenterology team and Hospital Alcohol Liaison Team (HALT), at Southport Hospital it appears that fitness to drive advice is inconsistently given to patients with excess alcohol intake.

Methods The aim was to firstly assess if patients with a history of alcohol excess were being informed about their fitness to drive in accordance with national Driver and Vehicle Licensing Agency (DVLA) guidelines. Then to introduce a simple aide memoire and document that the DVLA advice had been given. The standards used were the Current medical guidelines: DVLA guidance for professionals. Clinical notes were assessed for evidence of a discussion regarding fitness to drive and DVLA guidance for all patients with alcohol excess presenting to Southport hospital over a 2 week period and reviewed by HALT, who also performed the data collection. A label was then designed for insertion into the clinical records. This demonstrates that a patient was advised about their fitness to drive by the HALT nurses. Re-audit was performed by the medical staff by reviewing the clinical records of 30 different patients for evidence of the label.

Results Initial audit showed of the patients with alcohol excess (n=30), 14 (46.7%) patients were currently driving with 0 being informed about their fitness to drive. During the re-audit of the total patients with a history of alcohol excess (n=30), 11 (36.7%) patients were currently driving. 11 (100%) patients had documented evidence being informed about their fitness to drive in accordance with national DVLA guidelines in the form of a label. Ongoing driving was verbally confirmed by HALT for each patient.

Conclusions Patients with alcohol excess were not being informed about their fitness to drive in accordance with national DVLA guidelines. Introduction of our label has since resulted in an improvement in the number of patients informed about their fitness to drive and adherence with national guidance. Therefore, the use of a simple aide memoire has demonstrated improved compliance with DVLA guidance and potentially reduced the risk of alcohol-related driving incidents.

REFERENCES
