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P.96 Development of effective and safe virtual pre-operative assessment during the Covid-19 pandemic through utilisation of telemedicine: a quality improvement project in a stand-alone maternity hospital

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Introduction: Risk factor identification and preoperative optimisation can reduce morbidity and mortality and is the accepted standard of care. The COVID-19 pandemic presented issues in providing quality and preoperative assessment (PA) for elective caesarean section (CS). We needed to balance best medical practice with ensuring safety of patients and staff. Although mobile technologies have facilitated remote provision of medical services, its applicability to PA remains unclear.¹ We hypothesised that virtual anaesthetic assessment could offer a high quality, safe alternative to in-person PA.

Methods: Following ethics approval we established evidence-based definitions for virtual assessment, and developed a virtual pathway to run with the in-person system. The team followed the 3-step Institute of Healthcare Improvement model.² We aimed for 100% of women scheduled for elective CS to be placed on the correct pathway by February 2021. We measured outcomes (number of patients correctly identified and referred to the anaesthetic clinic [AC]), and process measures (number of patients not referred, did not attend [DNA] rate, unanticipated surgery delays/cancellations). Measures including patient/provider satisfaction and cost were assessed. We implemented plan-do-study-act (PDSA) cycles (referral form for virtual and in-person assessment, equipment and video platform provision [WebEX], GDPR compliance, ethics, consent, documentation). The team executed the project in three phases, with Jan-Feb 2021 being our target for mainstream rollout of video PA. Patients who did not meet the criteria for virtual PA were assessed in person.

Results: Between July and December 2020, 1031 women were referred to the AC. 41% (419) were assessed virtually and 612 (59%) in person. Over 97% elective CS patients were referred. DNA rate was 9% for in-person assessment and 3% for virtual. There were no day of surgery cancellations or delays. Despite an initial cost in the set up of hardware there was a reduction in footfall by 41% and more effective utilization of resources. Patient and staff feedback surveys are ongoing however anecdotal feedback is positive in terms of ease of use and satisfaction with the assessment.

Discussion: We have described the development and implementation of virtual PA for elective CS. Strengths of our project include excellent compliance by referring obstetricians, low DNA rate, and no cancellations/delays. We acknowledge limitations: lack of physical examination and pre-operative tests, questionable airway exam, possibility of confidentiality breach. Our project demonstrates the development

of a safe, effective video anaesthetic consultation pathway. More research is needed to address some of the challenges presented by the virtual assessment of obstetric patients.

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P.97 Enhancing multidisciplinary communication in emergency obstetric surgery during the COVID 19 pandemic

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Introduction: The COVID 19 pandemic has presented significant challenges to the delivery of safe, efficient care for emergency obstetric surgery. In particular donning airborne personal protective equipment (PPE) in a timely fashion and the associated barriers to communication in the operating theatre. Improvements to multi-disciplinary communication (MDT) has been identified in MBRRACE reports¹ as an area that is crucial in reducing maternal and fetal morbidity and mortality. We introduced a new “Emergency Pre-Brief” communication process for all obstetric surgical cases prior to transfer to theatre in May 2020 and evaluated feedback from an MDT staff survey about the impact of this change in practice on communication and patient care.

Methods: An “Emergency Pre-Brief” communication document was designed and introduced with MDT input through the labour ward forum. It included essential patient information: category of urgency, procedure type, indication for delivery/procedure, obstetric and medical complications, fetal concerns, allergies, abnormal blood results, G&S status, blood or cell salvage required, COVID swab result, type of anaesthetic, risk of GA conversion and PPE to be used. The brief takes place on labour ward, led by the theatre coordinator with members of the MDT before transfer to theatre. The coordinator returns to theatre to communicate the details to the team to ensure they are prepared for the correct anaesthesia and surgery, in the correct PPE and are aware of the concerns relating the case. In June 2020 a snap shot audit was completed to look at decision to delivery times for Category 1 CS to ensure standards are being upheld. We conducted an MDT staff survey in January 2021 to assess the impact of this change in practice.

Results: The Emergency Pre-Brief has been fully implemented in our clinical practice since May 2020. The decision-to- delivery snap shot audit for Category 1 CS ranged from 9-33 min. The MDT staff survey reported 87% of respondents agreed the pre brief had improved MDT communication, 80% reported a positive change to efficiency of theatre preparations and safe delivery of care, 74% reported improved postpartum surgical theatre efficiency. 84% reported improved mutual understanding of multi-speciality concerns.

Discussion: The COVID-19 pandemic has presented many challenges for obstetric services. We have shown the Emergency Pre-Brief process has improved communication and ensured timely preparations for surgery. It is an example of effective MDT working and is something that