

BREAK THE FAST-AND THE DOGMA:
Reinforcement of Existing Peri-operative Fasting Guidelines for Elective Caesarean Patients among Maternity Team in a District General Hospital

Herdman J., Hameed F. Tyagi E.
Milton Keynes University Hospital

INTRODUCTION

National and local enhanced recovery guidelines state that patients undergoing elective caesarean sections should be able to ‘sip until send’ and also be allowed and to eat and drink post operatively ‘as normal’ – aiming for normality within four hours¹. These measures have been shown to improves patient satisfaction by alleviating anxiety, post-operative thirst, nausea and vomiting as well as reducing post-operative gastric discomfort¹. Equally of note, a reduction in pre-operative fasting times for fluids comes with no added risk of pulmonary aspiration as demonstrated by ample evidence which suggests that prolonged fasting does not necessarily mean reduce gastric volumes.² Anecdotaly, the implementation of these guidelines is variable at our institution. A quality improvement initiative was undertaken to evaluate our maternity team’s knowledge of existing guidelines and use that as a surrogate for current patient care practices. This was then followed by serial teaching sessions to improve understanding and hence implementation of existing guidelines.

METHODS

A pre-intervention survey was sent out to maternity staff including midwifery team, obstetricians and obstetric anaesthetists of all grades (Fig.1) via email and in person. Responses were anonymous and asked multiple choice questions about their knowledge of peri-operative fasting for elective caesarean sections. Following this, over the course of a month, eight ‘Tea Trolley Teaching’ sessions were conducted in labour ward, pre and post-natal wards, antenatal clinic and elective obstetric theatres. These involved providing interactive, bite-size teaching with ample opportunity to ask questions and with the added encouragement of cake. A repeat survey was then undertaken to establish if knowledge of the guidelines had improved.

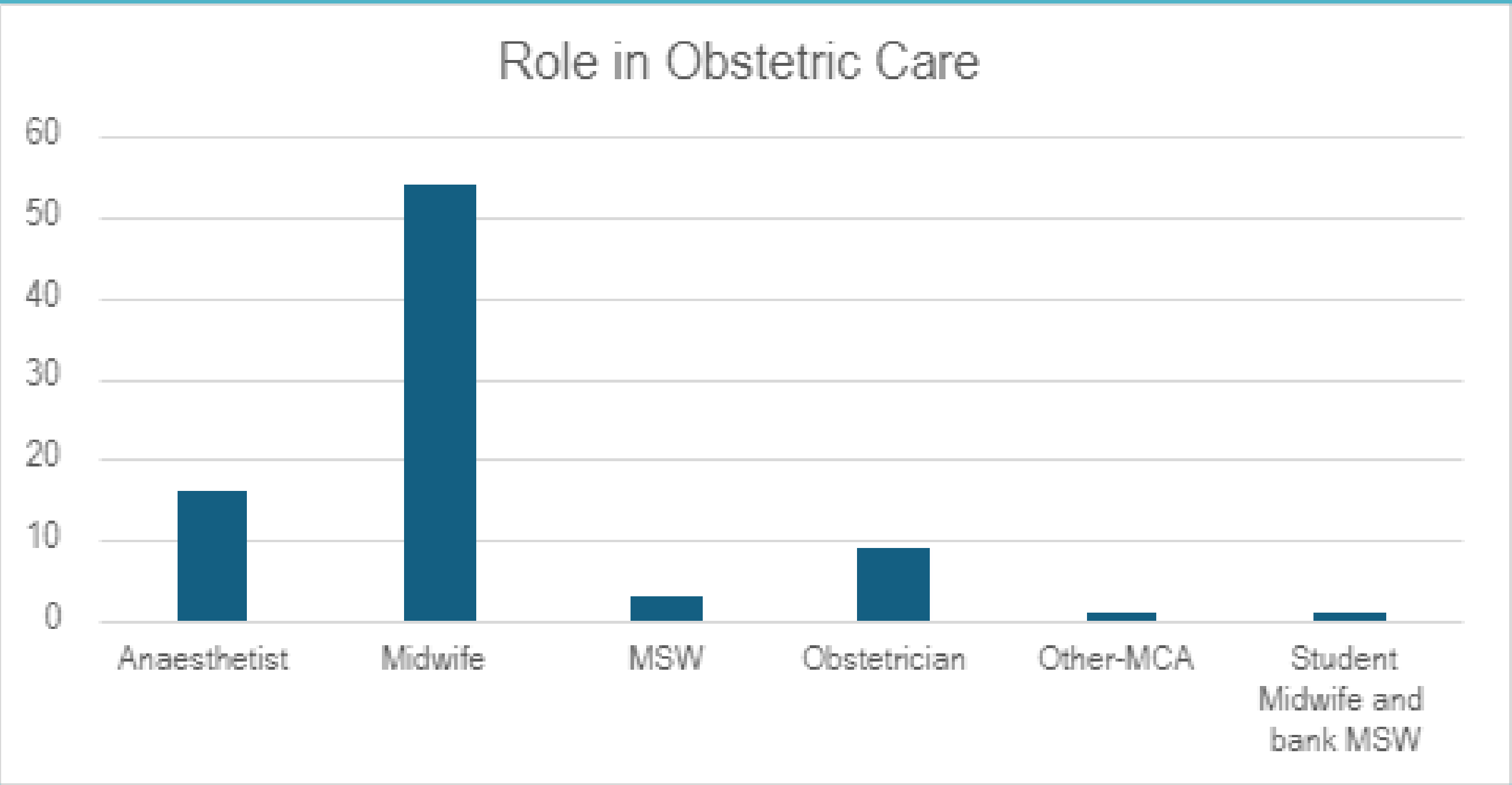


Figure 1

Not heard of Sip Till Send Fasting Guidelines



Figure 2

RESULTS

The pre-intervention survey had 84 responses. Only 48 respondents believed that patients should be allowed clear fluids till they were sent for theatres and could eat and drink post-operatively as soon as they felt ready. 17 respondents felt delayed feeding was one of the factors that prevented post-op ileus, however interestingly 15 of them had responded that patients should be fed as soon as they felt ready after operation, which may signify a response bias. 40 respondents reported they had not heard of the Sip Till Send guideline, while 69 said they would like more teaching on peri-operative fasting in elective caesarean patients. Post-intervention, 92 responses were received to the survey, with 74 participants responding that patients could drink up till operation and start eating and drinking as soon as they felt ready post-operatively. 10 respondents still felt that delayed feeding prevented post-op ileus. 79 respondents now had heard of the Sip till Send guideline and 30 respondents reported they would like more teaching on the subject. (Fig.2 & 3)

Pre and Post-Intervention Perceptions

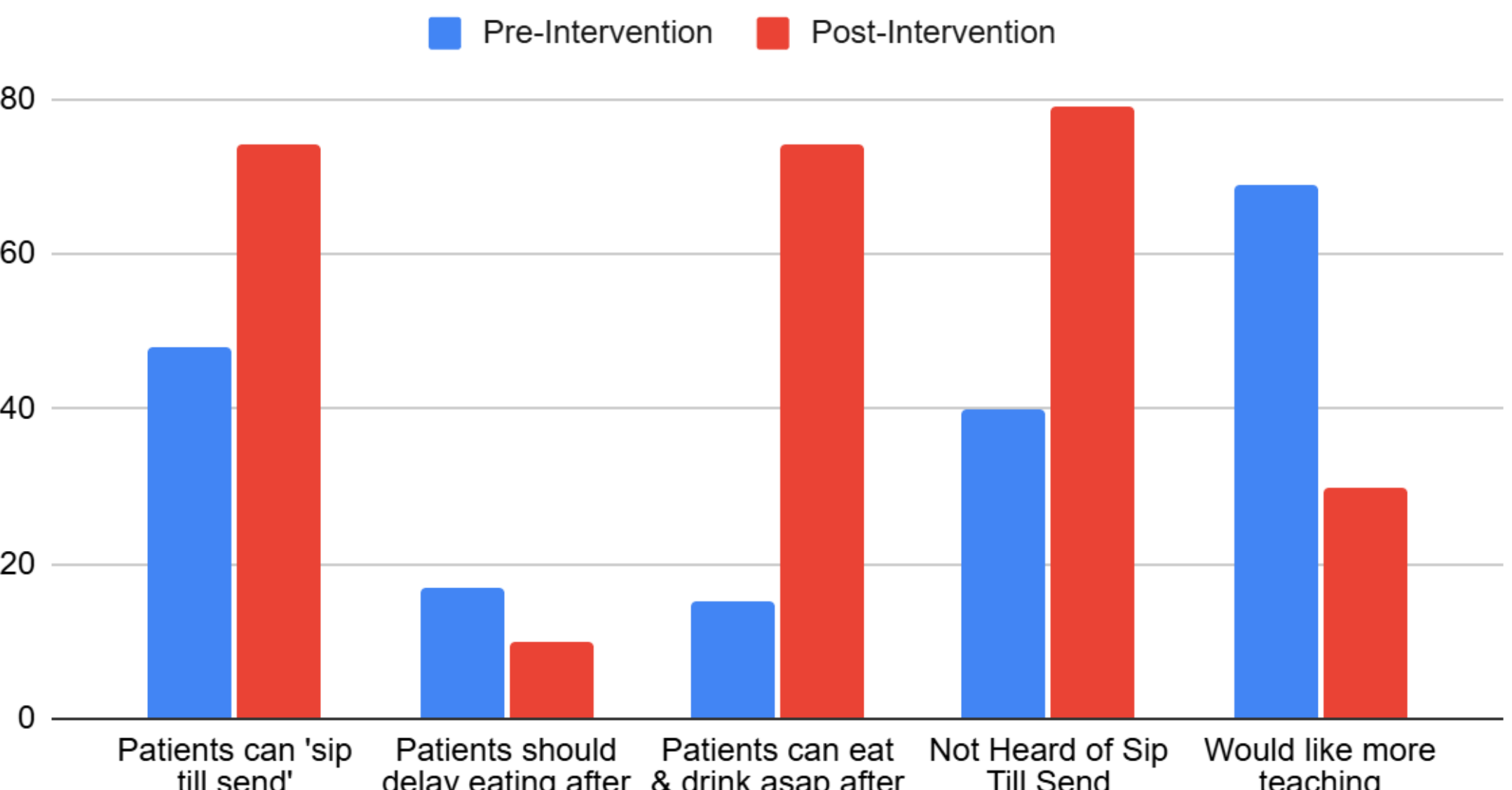


Figure 3

DISCUSSION

In our pre-intervention questionnaire, there appeared to be a wide variation in knowledge of current guidance, including a belief that delayed feeding prevented post-operative ileus. Serial targeted teaching sessions received globally positive feedback including comments that the provision of snacks increased engagement. Our post-operative questionnaire showed an improvement in knowledge and understanding of existing guidelines by 31%. Staff education has been shown to be one of the key factors in improving patient outcomes² and we plan on sustaining the effect of our teaching by adding ‘Break the Fast’ teaching into induction for new trainees and student midwives, reinforcing the guideline into multidisciplinary meetings as well as using visual reminders in the form of posters (Fig. 4) in key clinical areas. We also plan to conduct patient surveys in future to assess the cascading effect of staff education on patient care.



Figure 4