ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

Obesity, defined as a body mass index of more than or equal to 30, is a growing problem around the world. Since 1980, the prevalence of obesity worldwide has more than doubled, with 39% of the adult population being estimated to be obese in 2014. High-calorie diets, little exercise and poverty in affluent countries are a few of the many reasons attributed to this exponential increase in our waistlines.

Crucially, obesity is a widely cited risk factor for a myriad of conditions, including cardiovascular and endocrine problems. In relation to post-operative outcomes, the literature paints a somewhat conflicting picture with some studies suggesting an increased risk of post-operative complications while others finding no difference between the rate of complications in obese and non-obese patients2, 3. However, the current consensus driven by the National Institute of Health and Clinical Excellence (NICE) is to identify such patients early on in their hospital admission in order to optimise weight and nutrition.

An audit evaluating the level of compliance with the following NICE guidelines was performed at a local District General Hospital earlier this year:

1. NICE CG 32, 1.2.2 - 'All hospital inpatients on admission should be screened for malnutrition'5

2. NICE CG 32, 1.2.6 - 'Screening should assess body mass index'5

It was found that over a 6-week period 74.5% of patients who attended this hospital for gastro-intestinal and hepatobiliary procedures had their BMI calculated within the first 24 hours of admission.

Subsequent to this, and in order to improve the level of compliance, this data was presented to the nurses at the hospital Surgical Centre. Here a discussion around the barriers to the timely recording of patient BMI and methods to improve this were explored. A follow up snap-shot audit was then performed 2 months after the intervention for a 3-week period, where the compliance rate was found to have dropped to 48.7%. This fall in the compliance rate is neither intuitive nor desired.

There are of course some differences between the initial audit and the follow up, which may have contributed to the observed difference. The follow-up audit was not conducted for the same period of time as the first audit, which may have confounded the results to some extent. Also, the audits where conducted at different times of the year. This means that the rotation of front line staff causing a change in the expertise at hand, could therefore have affected the level of compliance. Though the above reasoning may be valid, it is clear that a verbal presentation and discussion is not sufficient to maintain or action meaningful change in the long-term. More effective interventions to be implemented in the future may come in the form of:

(i) Regular reminders at departmental meetings regarding the timely calculation and recording of patient BMI

(ii) Having written reminders at desks and workspaces

(iii) Encouraging frontline staff on the wards to also take an active role in recording BMI should they notice it missing from the patients notes

(iv) Adding the calculation of BMI to the Surgical Centre proforma thereby reducing the chance of it being missed

When I began this process I had some preconceived notions about the difficulties that I might encounter as a junior member of the team trying to effect change. I was pleasantly surprised to find that most people were interested in finding out how they could help improve the hospital's compliance rate particularly when it became evident that this would ultimately lead to a better outcome for our patients.

Though this experience has been less successful than I had hoped, it has been invaluable in teaching me the skill of audit, which I will undoubtedly find useful in my future career. It has also given me insight into some of the obstacles that well-meaning and hardworking frontline staff experience in attempting to adhere to guidance issued by sometimes idealistic governing bodies: time constraints and routine understaffing being major players.

Bibliography:

1. World Health Organisation. WHO: Obesity and overweight. Factsheet no. 311. January 2015. Available at: http://www.who.int/mediacentre/factsheets/fs311/en/

2. Dindo D, Muller MK, Weber M, Clavien PA. Obesity in general elective surgery. Lancet 2003; 361(9374): 2032-2035

3. Pierpont YN et al. Obesity and surgical wound healing: a current review. ISRN Obes. 2014; 2014: 638936.

4. Mullen JT, Moorman DW, Davenport DL. The obesity paradox: body mass index and outcomes in patients undergoing nonbariatric general surgery. Annals of surgery 2009; 250(1): 166-172.

5. Nutrition support in adults (CG 32): National Institute for Health and Clinical Excellence; 2006.