Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

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Subject: Adult elective patient pre-operative nil by mouth (or fasting or fluids and feeding) guidelines

Q1 Please would it be possible for you to share a copy of your Trusts adult elective patient pre-operative nil by mouth (or fasting or fluids and feeding) guideline.

This is to understand national practice from key centres to support a local QI initiative.

A1 Please see attached document: Pre-Operative Fasting of Adults v2.2

Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Preoperative Fasting of Adults

Policy and Procedure

For completion by Author			
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Executive Lead	Sue Pemberton		

For completion by Approving Committee			
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Policy Statement

This policy is designed to provide information and guidance to all staff within the trust in relation to preoperative fasting.

The Liverpool Heart and Chest Hospital (LHCH) Trust intends that all staff involved with the preoperative care of patients will provide the highest standard of care by following set guidelines for the safe and appropriate administration of solids and fluids in the pre-operative period.

1. Roles and Responsibilities

1.1. The Director of Nursing

To ensure implementation and audit of compliance with the policy and to ensure that there is documentation of any action plan in the event of non-compliance.

To establish, develop and maintain the pre-operative fasting policy as required.

1.2 All Relevant Clinical Staff

This policy applies to all healthcare professionals working within the LHCH who are involved in the pre-operative care of patients. This includes student nurses, bank and agency staff, locum staff and trainees. It is imperative that all staff who are involved with this policy:

- Adhere to the guidelines within this policy
- Ensure that they have read and understood sufficient detail of the policy to enable them to carry out their work according to trust policies
- Clarify with their line manager or senior nurse if unsure about any part of the pre-operative fasting policy
- Are able to access the trust's intranet site to view policies, protocols and procedures

2. Document Standards

Pre-operative fasting aims to reduce the risk of aspiration of gastric contents during general anaesthesia or sedation. The 4th national audit project conducted by the Royal College of Anaesthetists suggested that this occurs in less than 1 in 100, 000 cases.

This policy is produced taking into account recent recommendations and guidelines on pre-operative fasting in adults and children designed by The Royal College of Anaesthetists, The Association of Anaesthetists of Great Britain and Ireland (AAGBI), and The European Society of Anaesthetists (ESA).

3. Protocol

Recommendations for administration of solids and fluids prior to surgery:

3.1 Elective Procedures requiring either General Anaesthetic or Sedation Fluids

Previous guidelines recommended a fasting period of 2 hours following ingestion of clear fluids, however, research has indicated that many patients undergo much longer fasting periods of up to 15 hours. Prolonged fasting is known to be associated with an increased incidence of post-operative nausea and vomiting (PONV), in addition to lower patient satisfaction scores.

A recent study of over 5000 patients in the UK who were permitted to drink water up until the point they were transferred to theatre showed lower PONV scores, with no increased aspiration risk. In addition, observational studies have failed to show that patient specific characteristics such as obesity, diabetes or physical status, translated into an increase in gastric residual volume. As a response to these findings multiple high-volume centres have adopted a 'sips until send policy'.

3.1.1 'Sips until Send'

Patients should be allowed to drink sips of water until the point of transfer to theatre, a sip of water would be a volume of no more than 30mls in one hour for the two hours prior to surgery. Water will be allowed in normal volumes until the two hour period before surgery.

This will be applicable to elective patients, with no significant risk factors for gastric aspiration.

This guideline will be at the discretion of the treating anaesthetist or clinician.

Risk factors for gastric aspiration include:

- Significant history of symptomatic gastro-oesophageal reflux disease or hiatus hernia
- Obesity (BMI >30)
- Documented history of gastric immobility e.g. autonomic dysfunction related to diabetes
- Admission for upper gastrointestinal surgery where the patient has a known obstructing lesion
- Significant dementia or learning difficulties where a patient is unable to limit water consumption to 30ml sips (unless facilities to monitor exist e.g. parental or carer supervision in the context of learning difficulties)

Where patients are part of an enhanced recovery programme, that pathway should be followed preferentially.

Where patients fail to meet the above criteria, a period of two hours fasting for clear fluid is advised, as per previous guidelines.

All other fluids and milk containing beverages require a minimum period of 6 hours between administration and induction of anaesthesia.

Delays to theatre lists should be recognised early to allow the patient to be given further clear fluids to prevent unnecessary dehydration and thirst.

3.1.2 Solids

All solid food items require a minimum period of 6 hours between administration and induction of anaesthesia.

Patients scheduled as the first patient on the morning list should not eat solids from midnight the night before the procedure. Patients scheduled for an afternoon procedure should be allowed and encouraged to take a light early breakfast at 06:00 hours on the day of surgery.

The issue of unnecessary solid and fluid restriction is particularly relevant to diabetic patients. Prolonged fasting times combined with the physiological stress response to surgery have an adverse effect on glycemic control. It is important therefore that with diabetic patients:

- Fasting times are kept to a minimum

- Diabetic patients are first on the list whenever possible

- Regular pre-operative assessment of blood glucose levels is performed.

When preparing diabetic patients for surgery using this policy, reference should be also be made to the diabetic care pathway and the policy for the management of acutely ill or peri-procedural patients requiring intravenous insulin.

3.1.3 Chewing Gum and Boiled Sweets

Patients should not chew gum or suck boiled sweets prior to a procedure during the pre-operative fasting period, and this should be reinforced on the wards by medical and nursing staff.

However, no patient should have their procedure cancelled or delayed because of chewing gum or boiled sweets, although the ultimate decision rests with the anaesthetising consultant. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) have endorsed the European Society of Anaesthetists (ESA) guidelines on peri-operative fasting in adults and children which states that patients should not have operations cancelled because of chewing gum or sucking a boiled sweet. In addition, the responsibility for making the decision as to whether to proceed with urgent procedures under sedation will rest with the consultant responsible for the case.

If chewing gum has been taken during the preoperative fasting period, it is important that no gum is in the mouth (in gum recesses) prior to induction of sedation or anaesthesia and a quick visual check may be required.

These recommendations apply to all patients undergoing elective procedures under sedation or general anaesthetic.

Certain patients will be at an increased risk of aspiration of gastric contents as outlined above and, consideration should be given in these cases to administer specific measures to ameliorate the effects of acid aspiration.
It will be the responsibility of the anaesthetist in charge of the case to identify high risk patients and to take appropriate action.

3.2 Urgent and Emergency Procedures

If possible, the normal fasting guidance should be followed, but in an emergency situation then clearly surgery and anaesthesia will need to take place without delay. In these situations it may not be possible to guarantee an empty stomach at the time of induction of anaesthesia, and the anaesthetic induction technique will need to be modified to reflect this.

3.3 Post-Operative Recovery

For patients undergoing routine surgery, encouragement should be given to take oral fluids as soon as possible post operatively provided that there are no complications.

For patients who have undergone upper GI Tract /abdominal procedures, the surgical team should be consulted for post-operative guidance on solid and fluid intake.

4. Policy Implementation Plan

The Director of Nursing will be responsible for the implementation of the policy.

The Quality Patient and Family Experience Committee will be responsible for reviewing the progress of the policy and for developing an action plan in the event on non-compliance with the policy.

This policy will be accessible on the wards and critical care areas, and also via the intranet.

Managers have a responsibility to ensure staff know how to access this policy and staff have a responsibility to read the policy and to seek clarification of any issue they do not understand.

The policy is to be made available to the public via the intranet.

5. Monitoring of Compliance

The ward managers and theatre matron will be responsible for the monitoring and audit of the peri-operative fasting policy. The policy will be audited annually by means of observation and questioning and the results presented to the Quality Patient and Family Experience Committee.

6. References

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7. Endorsed By

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

8. Record of Changes

Summary of changes made to produce this version

Section No	Description of Change (prefix description as applicable with Addition / Amendment / Deletion)	Reason