satisfied. The average LOS was reduced from 2.4 to 1.8 days and day one discharge increased from 12% to about 60%.
Conclusions In hospitals where the inpatient LOS is already low, day case arthroplasty can be safely introduced without producing increased readmission rates or decreased patient satisfaction.

B152 TWENTY-FOUR HOUR PROVISION OF REGIONAL ANAESTHESIA FOR RIB FRACTURE PATIENTS- A DEPARTMENTAL SURVEY

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Background and Aims Early patient controlled analgesia (PCA) and regional anaesthesia (RA) are key for patients with severe rib fractures. In 2019, the Queen Elizabeth Hospital King's Lynn, implemented Thoracic Injury Pathway To Optimise Pain and physiotherapy (TIPTOP). As a part of this project, an electronic departmental survey was performed.
Methods In August 2021, all anaesthetists who provide on call cover were surveyed as to what analgesic strategy they would be happy to provide for rib fractures. Options included opioid PCA, off-label analgesics and RA blocks.
Results 28 of 38 anaesthetists responded (response rate 74%). All anaesthetic grades responded. Results are presented in table 1. All respondents were happy to provide PCA. The next most common option was thoracic epidural (20, 71%) followed by intravenous Ketamine or Magnesium (both 18, 64%). Few were happy to provide a chest wall catheter such as Erector Spinae plane Block (7, 25%).

Abstract B152 Table 1

	Number	Percentage
Morphine PCA	28	100.00%
Magnesium bolus	18	64.29%
Ketamine bolus	18	64.29%
Ketmaine infusion	7	25.00%
IV lidocaine bolus	13	46.43%
IV lidocaine infusion	11	39.29%
Lidocaine plaster	12	42.86%
Thoracic epidural	20	71.43%
Paravertebral	7	25.00%
Paravertebral catheter	3	10.71%
Erector spinae plane block	13	46.43%
Erector spinae plane catheter	7	25.00%
Serratus anterior plane	11	39.29%
Serratus anterior plane catheter	6	21.43%
Intercostal block	8	28.57%
Interpleural block	2	7.14%

Table 1. Results of rib fracture analgesia survey. Total number respondents 28.

Conclusions Despite regular training sessions, when results were filtered to those providing resident out-of-hours cover, only 60% were happy to perform RA. As such a 24/7 analgesic service focusing on RA is not feasible. This mirrors the wider health-care community. A twitter poll last year found only 18% of departments offered reliable 24/7 access to RA for rib fractures (n = 210).

We currently provide day-time RA via a team of regional anaesthetists and have optimised the non-RA options for out-of-hours admissions (e.g morphine-ketamine PCA). This work makes a strong argument for assessment and standardisation of provision via a National Audit Project.

B153 PERIOPERATIVE MANAGEMENT OF PATIENTS RECEIVING ANTITHROMBOTIC THERAPY THAT UNDERWENT SURGERY UNDER REGIONAL ANESTHESIA. COMPARISON OF THE PERIOPERATIVE MANAGEMENT OF THE ANTITHROMBOTIC AGENTS TO CURRENT GUIDELINES

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Background and Aims The aim of the study was to assess the degree of compliance to current guidelines of perioperative antithrombotic therapy management for patients undergoing surgery under regional anesthesia.
Methods During the year 2019 any patient receiving antithrombotic therapy that underwent surgery in "G. Papanicolaou" under regional anesthesia were enrolled in this retrospective study. Ethics committee approval was acquired. Follow-up was performed 1 month postoperatively in order to identify possible thrombotic or hemorrhagic complications.
Results A total of 274 patients were enrolled. 24.1% (n=66) were receiving DOACs, 7.3% (n=20) received VKAs and 71.5% (n=196) were treated with antiplatelet agent(s). These drugs were managed perioperatively by the respective surgeons or cardiologists and in a lesser degree by anesthesiologists. Compliance was judged taking into account the most up to date guidelines regarding each specific antithrombotic agent. Recent guidelines regarding the perioperative management of antithrombotic therapy for patients about to receive regional anesthesia applied only for the few patients that anesthesiologists were consulted.
Conclusions The main conclusion of this study is that a lesser degree of compliance is evident between patients under DOACs. Management of these agents proves more challenging than antiplatelets or VKAs. The errors in the perioperative management lie both in the longer than suggested period of withdrawal before surgery and bridging with LMWH that is prevalent when it should not be. Finally, a correlation between the appropriate perioperative management of antithrombotic agents and postoperative thrombotic complications was not observed in our sample. There proves to be ample space for improvement and future audits.

B154 PERIOPERATIVE BEOZODIAZEPINE UTILIZATION PATTERNS IN MAJOR ORTHOPEDIC SURGERY

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