Mr Jones is on the surgical ward following an elective hemicolectomy. A wound infection has complicated his recovery and he has been added to the operating theatre list for an examination under general anaesthesia. The list for that day has two elective patients before him. The anaesthetic team has asked for Mr Jones to be starved from 6am.

The first elective case proves complicated and someone from the anaesthetic team arrives on the ward at 4.30pm to say the procedure will be performed on the following day’s list. Mr Jones is not only irritated by this but is also hungry, thirsty and quite possibly dehydrated, as he has not eaten or drunk anything for over 10 hours.

The factors influencing the prolonged fasting time here were in the main unpredictable. But pre-operative fasting in such cases could be better managed.

Fasting is an essential component of preoperative care. It is based on the premise that it allows time for gastric emptying, so reduces the risk of aspiration pneumonitis at induction of anaesthesia. Fasting periods of up to and exceeding 12 hours have been used.

But many authors have questioned the relationship between long starving periods and the incidence of anaesthesia-related aspiration. Their findings influenced the Royal College of Nursing’s guidelines on pre-operative fasting. These should be used to guide local policy in a variety of situations, including elective or emergency surgery in adults and children.

However, these guidelines can still fall short of the mark. This is where the nurse’s role is pivotal in improving patient experience and service delivery. Improvements can be made at ward or department level by using multidisciplinary communication, and questioning operational policy.

Nurses need to ask whether local or national recommendations for fasting are in place and being used, and if all staff are aware of the guidelines. In Mr Jones’s case, the decision to fast from 6am could have been discussed with the anaesthetic team to ensure he was not starved inappropriately. While theatre time may be unpredictable, it is important to establish the estimated time of surgery.

Documenting the fasting process properly and ensuring patients are aware of what it involves can improve their experience. Intravenous hydration may help by reducing thirst and the risk of dehydration.

It is also important to ask whether communication channels between the ward and operating theatres could be improved. Changes to planned surgery time should be relayed to patients, as keeping them informed will have a dramatic effect on reducing anxiety and improving satisfaction. If there is a risk of cancellation or postponement because of an emergency, it is worth mentioning when providing patients with pre-operative information.

Pre-operative fasting practice is at best non-uniform. While the RCN guidelines go some way to informing practice, what is crucial to patients’ experiences is how nurses implement and deliver them.

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Learning clinical skills on the wards is essential to being a good nurse. To do this you need to able to ask questions – even those you think may sound stupid – without fear of ridicule; as such, your relationship with a mentor is key. While a good relationship can help you flourish, a bad one can scar your learning experience and make you lose confidence.

It can be daunting on the wards but the support and guidance in a good mentoring relationship is invaluable. Our article on page 23 emphasises the importance of trust between mentor and mentee and looks at how using attachment theory can help to enhance this vital relationship.

This week we at Nursing Times launch studentnursingtimes.net. Our way of supporting students and helping to build their knowledge and experience, it’s our version of mentoring. We hope it will deepen our relationship with student nurses.

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