Pre-operative fasting for elective surgical patients


Abstract

**Aim** To explore the knowledge, past experience, perceptions and opinions of nurses working in surgical units at a local hospital with regard to pre-operative fasting times.

**Method** A qualitative research design, using a grounded theory approach, was adopted. Semi-structured interviews were undertaken with a sample of 15 staff nurses employed within five surgical units in one hospital.

**Findings** After thematic analysis, three core categories emerged from the data: knowledge, practice and systems. Nurses stated that there were significant barriers to an individual approach to pre-operative fasting within the organisation. These included lack of knowledge and skills, limited autonomy with regard to changing practice, and an operating room system that contributed to patients being fasted for a longer period than necessary.

**Conclusion** Further research is required on how long patients should be fasted before theatre. In addition, all healthcare professionals require education pertaining to best practice, and organisations should have in place clear policies and guidelines to prevent variances in fasting procedures.

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Anaesthesia; Surgery: patient care; Surgical nursing

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PRE-OPERATIVE PREPARATION for theatre includes a period of fasting before the administration of an anaesthetic. This is necessary to prevent aspiration of stomach contents that can be potentially fatal (Dean and Fawcett 2002). Ensuring that a patient fasts before an operation is perhaps one of the most fundamental pre-operative responsibilities that nurses perform on a daily basis. In the hospital in this study, all adult patients scheduled for elective surgery are fasted from midnight the night before, which suggests that current practice is ritualistic and does not reflect evidence-based practice.

Literature review

General anaesthesia has always carried the risk of vomiting during induction, which may lead to serious complications and can even be fatal (Dean and Fawcett 2002). Therefore, it is usual to deny all oral intake for up to four hours, and solid food from four to six hours before surgery (Rowe 2002). According to studies by Hung (1992) and Rowe (2002), a four-hour fast from solid food is adequate, and clear liquids can be given to patients up to three hours pre-operatively with no harmful effects.

While the dangers of aspiration are well established (Hung 1992), there is comparatively little concern regarding the acceptable maximum dietary restrictions before inducing anaesthesia and the negative aspects of prolonged fasting (Jester and Williams 1999). It is, however, common practice in many clinical settings to deprive patients of food and fluids for unnecessarily long periods (Chapman 1996). Studies by Jester and Williams (1999) and Rowe (2002) concluded that healthy patients undergoing elective surgery were able to ingest unlimited fluids up to three hours pre-operatively which did not affect gastric content, and therefore the danger of aspiration during induction of anaesthesia was virtually none.
In comparison, a study by Seymour (2000) indicated that unlimited fluids up to three hours before surgery did show an increase in gastric volume, and thus aspiration on anaesthesia could occur. However, patients in both studies had other related physiological problems, such as cancer and diabetes, so were not healthy. Additionally, many of the patients were on morphine-based medications that can slow down gastric emptying (Hung 1992). More recently, the Royal College of Nursing (2005) launched a new national guideline for fasting before surgery recommending that patients can be given water and clear fluids two hours before general anaesthesia and that food can be given six hours beforehand. Babies can be given breast milk four hours before general anaesthesia.

Based on the literature review, it appears that there are still gaps where further research and theories could be developed to assess nurses’ knowledge, opinions and perceptions of pre-operative fasting. While the literature available relates to quantitative studies, a more qualitative review has the potential to analyse the perceptions of nursing staff to establish why practice has remained unchanged. New theories could be generated from asking nurses about their current feelings and attitudes with regard to pre-operative fasting times.

**Aim**

The main aim of this research was to draw out and explore nurses’ attitudes, opinions and current knowledge of pre-operative fasting times to generate new theories on why the practice of patients enduring a long fast is still occurring. In terms of the literature on pre-operative fasting, there was an abundance of quantitative empirical literature but little qualitative data that could be used to explore indepth driving and restraining forces. Once understood, these could give direction to nurse managers in preparing for change (Rowe 2002) and explore strategies to achieve best practice. Qualitative research, therefore, has the potential to produce gainful outcomes. The data collected were used to highlight awareness and make recommendations to senior leadership on how pre-operative fasting practice could be changed.

The following questions were asked to try to generate new theory:
- How long do you think patients should be fasted?
- Who governs this practice?
- Do you encounter any barriers or system problems in relation to fasting patients?
- Who usually prescribes the order for fasting patients before surgery?
- Are there any changes you would like to see happen with regard to how long patients are fasted?
- Do you encounter any issues pertaining to the theatre schedule?

**Method**

To understand nurses’ perceptions of pre-operative fasting, a qualitative research method adapted from the grounded theory was chosen. Since the aims of this study were to draw out and explore nurses’ attitudes surrounding the topic under review, it was felt that the most obvious way to discover this was to ask them, as opposed to using a quantitative approach (Strauss and Corbin 1998).

Strauss and Corbin’s (1998) methodology was used because they provide concrete directions on how to develop an empirical-based theory through interviews, analysing observations, and categorising findings, before finally arriving at the story: the process or narrative concerning the context which Glaser and Strauss (1967) call the analytical process, or ‘the constant comparative method of analysis’.

The target population and sample consisted of staff nurses currently employed in five surgical units at the local hospital. Purposeful sampling was used to select information sources and to explore meanings from the identification of appropriate participants who would best inform the study (Rice and Ezzy 1999). This type of sampling is designed to maximise representation of a range of perspectives on an issue, with the aim of challenging the researcher’s own views (Newton et al 2000). In terms of the sample, this was based on the ‘saturation of categories’ (Glaser and Strauss 1967). Categories are saturated when no additional information can be found to develop them further. In the current study, data saturation was reached after 15 interviews.

Burns and Grove’s (1997) framework requires not only expertise and diligence but also honesty and integrity. Therefore, a letter of consent informing the nurses that participating in the interview would mean agreement to participate in the study preceded the interview. The letter informed the participant of the goals of the study and explained that the interviews would be recorded and the results reported confidentially. In addition, the author sent participants an information sheet giving details of the study,
which included why their help was required, how the interviews would proceed, and how the information would be handled and ultimately reported (Fossey and Harvey 2002). Ethical consent was received from the research committee at the hospital. The author funded the study.

Data collection was performed through the use of semi-structured interviews conducted by the author. Semi-structured interviewing techniques allow for a spontaneous exchange of information under the guise of focused questions (Kvale 1996). Semi-structured questions aid a more focused exploration of a specific topic using the topic guide. This approach, in comparison to unstructured questions, is advantageous in ensuring sensitivity to participants’ language and current knowledge in the field (Davidson et al 1996).

The interviews were designed to probe the issue of pre-operative fasting times for adult patients. The basic content of the interviews was constructed from the review of the literature as well as the researcher’s clinical and personal experiences and yet, by design, the topic questions were sufficiently open and free flowing to adjust to each participant (Marshall and Rossman 1999). A topic guide was provided and used, similar labels were ascribed to comparable sections of text. A second and more direct method of verifying the validity of the researcher’s interpretation was a follow-up conversation with a number of participants. Similarities and differences both within and between emerging categories were identified. This enabled the author to build up and break down categories into smaller units of meaning (Willig 2001).

In accordance with the grounded theory method, data management and analysis were carried out to provide a simple, systematic but comprehensive way of ordering, coding and categorising a large volume of contextual data. A conceptual framework derived from the developing themes and their interaction was generated. The common themes were integrated to create an overall description of the experiences of the participants. This was done in an effort to ensure that it was the developing themes, backed by subject-specific quotations, that provided insight into the research question (Tsai 2000).

Two processes were used in an attempt to ensure that a degree of rigour was established. Initially, after codes were assigned to passages of text, copies of three transcripts were given to a co-investigator from the research department within the hospital to assign codes. A comparison of the two sets of codes revealed that, although slightly different wording was used, similar labels were ascribed to comparable sections of text. A second and more direct method of verifying the validity of the researcher’s interpretation was a follow-up conversation with a number of participants. Software was not used to analyse the data.

Findings

Three overarching themes emerged from the data under which all the codes were subsumed. The three primary categories were coded as ‘knowledge’, ‘practice’ and ‘systems’, and these encompassed a number of sub-categories (Table 1).

Knowledge There was consensus from participants that patients were required to fast from food and fluids for a minimum length of time pre-operatively. All the nurses agreed that this was because the administration of a general anaesthetic carries the risk of vomiting and aspiration of gastric contents. They also stated that it was a medical and legal requirement that patients scheduled for elective surgery should fast before being anaesthetised.

The majority of the sample (n=10) believed that the digestion of solid food occurs within approximately eight hours. The nurses were asked how long patients have to fast before surgery. The majority (n=10) felt that patients should be fasted from solid food for around eight hours and from clear liquids for four to six hours. However, four nurses stated six hours for solid food and four hours for clear fluids. The nurses admitted that these times are rarely adhered to as the majority of...
patients are fasted from midnight the night before surgery. One nurse stated: ‘It is far safer to fast patients for about eight to ten hours just in case the operating lists may change due to a cancellation which can frequently happen here’ (Participant 2). She also pointed out that: ‘Due to the late admissions some patients require tests before they go to surgery, so keeping patients fasted for eight hours will allow the flexibility of the operating list if it needed to be changed’ (Participant 2).

In terms of hospital policy, all of the participants stated that a policy existed in the hospital but they could not articulate its content. Two participants, however, stated the content of the current policy but said that it was outdated. Interestingly, two other nurses verbalised that they were aware of a ‘nil by mouth’ (NBM) guideline that had been developed by the anaesthesiology department in 1999, which stated that all patients should be NBM four to six hours before surgery from solid food. In addition, all participants stated that they had no formal in-services regarding hospital policies and procedures. Several nurses also indicated that written NBM instructions in different surgical units were to be found in a variety of places, including the Kardex, patients’ charts and instruction sheets for surgical day cases. One nurse stated: ‘It is very confusing when the patient arrives in the unit and they start asking questions in relation to what time should I start to fast before my operation’ (Participant 4). She went on to say that ‘there was no clear consistency in the practice as the policy and guidelines are in direct conflict with one another’. Additionally, she commented: ‘Some anaesthesiologists don’t follow either as some of them have their own regimen.’

The nurses were asked if they had read any research articles pertaining to pre-operative fasting recently and they replied they had not. The majority (n=12) felt that nurses’ awareness of current research findings was poor. However, the majority interviewed had positive attitudes towards this area of research within nursing. They felt nursing research was aimed at developing nursing practice by way of producing knowledge that nurses can use in their everyday work. However, most of them (n=10) felt that nursing research is not always accessible physically and many nurses find it difficult to understand.

One nurse stated: ‘The majority of my nurse training consisted mostly of practical assignments and working towards competencies in the units. There was very little time to actually review and critique articles in the unit setting’ (Participant 8). She also added: ‘At the time of my nurse training, there was very little evidence of research based practice in the place where I was working.’

**Practice** The majority of participants reported that patients were always fasted from midnight the night before surgery. In terms of the fasting procedure, it is the physician who orders that all patients scheduled for theatre the following day are to be NBM from midnight. When questioned further, the nurses admitted that patients who do not go to theatre until the afternoon are fasted for more than 12 hours, a practice that they know to be wrong.

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**TABLE 1**

<table>
<thead>
<tr>
<th>Primary categories and sub-categories</th>
<th>Knowledge</th>
<th>Practice</th>
<th>Systems</th>
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<tr>
<td>Sub-categories</td>
<td>Rationale for pre-operative fasting</td>
<td>Current practice</td>
<td>Delays in theatre</td>
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<td>Policies and procedures</td>
<td>Nil by mouth after midnight</td>
<td>Late admissions</td>
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<td>Lack of reading articles</td>
<td>Custom and ritual</td>
<td>Stand-by cases</td>
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<td>Language of articles</td>
<td>Power and authority</td>
<td>Disorganisation of the operating room list</td>
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<td>Comprehension of articles</td>
<td>Conflicting orders</td>
<td>Lack of communication</td>
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<td>Lack of research in the area</td>
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<td>Motivation for nurses</td>
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**Note:**

The majority of participants reported that patients were always fasted from midnight the night before surgery. In terms of the fasting procedure, it is the physician who orders that all patients scheduled for theatre the following day are to be NBM from midnight. When questioned further, the nurses admitted that patients who do not go to theatre until the afternoon are fasted for more than 12 hours, a practice that they know to be wrong.
Two nurses felt that surgical units are characterised by rigid routines and rituals, that care delivery is organised to meet the requirements of the nursing staff or administration and that the wishes of patients are not the main focus of care delivery. In addition, they stated that some nurses and physicians determine the priority of needs rather than the patient. As a result, short-term nursing goals are influenced by daily routines that necessitate the patient ‘fitting in’. There was strong consensus from these two nurses that the nursing culture should allow nurses to centre on patients’ long-term needs and wishes. One nurse stated: ‘We normally follow what the physician has ordered which is usually nil by mouth from midnight. We always inform the patient that they need to fast from midnight and this is standard procedure’ (Participant 14). Another nurse stated: ‘I have worked on this unit for five years and we have always complied with the nil by mouth from midnight’ (Participant 6), while another nurse stated that this procedure happened on all surgical units.

One nurse (Participant 9), stated that while she was oriented to the unit, the practice of pre-operative fasting was handed down to her from her preceptor. In addition, she stated that she spent three days with her preceptor learning the routines of the unit.

Most participants verbalised feelings of powerlessness in relation to questioning physicians and anaesthetists about the NBM order. The nurses felt unable to influence care that involves other disciplines. They stated that support from other members of the nursing team was essential in the adoption of best practice. Without this support, they thought that nurses lacked authority and confidence. There were pressures on them to accept the status quo. One nurse stated: ‘One of my patients was scheduled as third case and the physician wrote an order to fast from midnight. When I questioned him on the order, he became very rude and insulting and told me not to question his order’ (Participant 13). A similar comment from another nurse explained that ‘it is difficult for nurses to change practices involving other professional groups. For example, if anaesthetic or surgical instructions indicate an all-night fast before surgery and nurses know that a six-hour fast would be more appropriate, it is extremely difficult to adopt the correct policy’ (Participant 10).

Another senior nurse stated: ‘Nurses should have equitable distribution of power so that they can participate fully in action and decision making regarding patient care. Many physicians do not see people holistically where more nurses than doctors do.’ She also stated that ‘because nurses spend more time with patients they get to know them as people with feelings, thoughts and social relationships rather than just diseased bodies’ (Participant 5).

Nurses discussed the difficulties they had in voicing suggestions for change and that when they did their views were often rejected by physicians, anaesthetists and ward managers. They did agree, however, that research could make a helpful contribution to the improvement of clinical practice but its usefulness was limited because of opposition by others. Perceived differences in status, that is, the belief that physicians were ‘higher up the ladder’, were expressed by the nurses. In addition, they believed that it was difficult to make suggestions based on research evidence as they felt it would not be taken seriously. However, one nurse suggested that this problem could be overcome by using a ‘diplomatic’ tactic (Participant 12).

Systems

The nurses verbalised concerns pertaining to the theatre schedule and reported that delays and alterations occurred frequently. This was mainly as a result of emergency cases and patients needing tests before surgery. This places pressure on nurses and departments to try to ensure that tests are completed before the patient goes to theatre. However, sometimes certain tests cannot be carried out so the operating list changes and the third case suddenly becomes the first. The nurses said that when this occurs, the operating room does notify them but sometimes only at the last minute. They all wanted this practice to change and felt the patients were the ones suffering from the disorganisation of the schedule. The changes they advocated related more to the organisation of operating lists and better assessment of patients before surgery.

Nurses also expressed their frustration with the late arrival of patients. Anaesthetists finish work at six in the evening. If patients who are due for surgery the next day are admitted after that time they will not be assessed by the anaesthetist. Nurses then have to use their own clinical judgement and usually advise the patients to fast from midnight. Ideally, it would make sense for all cases to be admitted in time to be seen by an anaesthetist. However, as the hospital is a tertiary care facility, some patients travel long distances, and thus require flights that are sometimes scheduled late in the evening. The majority of nurses stated that it is difficult for them to assess and provide pre-operative education to the patients when they are admitted late and scheduled for surgery the next day.

The hospital also operates a standby list, whereby patients who are not listed that day for surgery are placed on to the list, in case of a cancellation. All of these patients are also fasted from midnight. However, a large proportion of...
these operations are cancelled because of lack of theatre time and over booking by the consultants. Additionally, some of those who are rescheduled for the following day can also be subject to a second cancellation.

Communication with the nurses in the study identified different practices on several of the surgical units with regard to fasting patients for surgery. On one unit, patients with diabetes were put on the standby list and kept NBM from midnight. On another unit, patients with diabetes were always put on the operating list and never on standby because of their condition. The nurses felt that there was a need for consistency in the hospital with regard to fasting guidelines otherwise patients were at risk. They also stipulated that patient care cannot be individualised without clear policies and protocols to act as a foundation for practice.

Discussion and reflection
This study has reflected nurses’ perceptions and attitudes in relation to pre-operative fasting times for adult patients. Using a grounded theory approach, the author was able to generate the three categories of knowledge, practice and systems.

General anaesthesia has always carried with it the risk of vomiting during induction, which can lead to serious complications and even death (Dean and Fawcett 2002). Therefore, it is usual to deny oral intake for up to four to six hours before an operation (Rowe 2002). However, the length of time patients are fasted is controversial, since the actual time it takes food to pass through the stomach is variable and the stomach is never truly empty at any one time (Bateman and Whittingham 1982).

Within this study, the nurses felt that patients should be fasted up to eight hours from solid food and four to six hours from clear fluids. Recent evidence, however, stipulates that patients should only be fasted for four to six hours from solid food and be allowed clear fluids up until two to three hours pre-operatively (Dean and Fawcett 2002). The current study indicated that while the nurses were aware of the rationale behind why a patient needs to fast, there was an apparent lack of awareness regarding up-to-date studies. This appears consistent with the study findings of Hamilton-Smith (1972) and Hung (1992).

Within the present study there was a lack of knowledge and understanding regarding policies. Additionally, there were conflicting practice guidelines relating to pre-operative fasting. The nurses in the study indicated that there was an organisational policy but many of them could not articulate its content. Several nurses also indicated that a NBM practice guideline was available in the hospital procedure manual which conflicted with the organisational policy. It was found that the procedure manual was written sometime after the policy but the policy was never retired. This finding was similar to the study findings of Thomas (1987) and a later study by Chapman (1996), in which nurses were uncertain and unclear about who stipulated the fasting policy for the hospital. In addition, the nurses in the present study were confused about the different protocols used on other surgical units and as stated in patient notes and the Kardex. O’Callaghan (2002) also found that fasting practice guidelines were written in a variety of places and that practices varied.

The results indicated that nurses do not keep themselves updated with the latest evidence relating to pre-operative fasting times and, in addition, highlighted barriers to achieving best practice in the clinical setting. Winkley (1998) reported that nurses may have trouble finding and reading anaesthetic journals in which research surrounding pre-operative fasting is published. It could be argued that there are a plethora of articles relating to pre-operative fasting in many of the nursing journals (Bird 2000). However, there is a risk that if research is oversimplified, the subtleties of the findings may be lost (Nolan et al 1998) and nurses will be denied the chance to make their own critical appraisal of original research. However, it is optimistic to expect nurses to read anaesthetic journals because of time constraints at work. Any method that encourages evidence-based practice should not be ignored (Bird 2000). If nurses can be encouraged to read journal articles, then hopefully this will give them the knowledge to use best practice in their clinical areas.

Nurses commented that the procedure of NBM from midnight for patients had been inherent in the organisation for many years and had never been challenged. This appears to link with Walsh and Ford’s (1995) theory of ‘rituals in nursing’, which claims that nurses base their practice on tradition and ritual (Jester and Williams 1999). The nurses stated that whenever some of the surgeons were questioned on the length of time that patients were fasted, they would usually make excuses, and say that ‘this is the way we do things here’. From this statement, it would appear that interventions regarding fasting times are ritualistic. Hung (1992) found that nurses would follow the instructions from the physician regarding the NBM status without question, which correlates with the findings of the present study.

Several staff nurses voiced a feeling of ‘powerlessness’ against the ‘authority figure’ of
the surgeon or anaesthetist when it came to challenging practice. Some verbalised feelings of tension and anxiety when questioning the physician. Medical dominance in the delivery of health care was highlighted in a study by Kenny and Adamson (1992). However, their views on medical dominance were later challenged by Adamson et al (1994) who stated that ‘nurses are no longer willing to follow medical instructions without question and this change in level of compliance is probably associated with increasing self-esteem among nurses’.

Nurses verbalised feelings of frustration regarding the organisation of the theatre list as they felt this was another major factor in the prolonged fasting of patients. Winkley (1998) observed that in some institutions only the first theatre case was officially timed (at 7am) and that patients scheduled for the afternoon were starved from the same time as the morning cases, so there was no individuality or forethought of where the patient was on the operating list. However, Jester and Williams (1999) found that it was possible to set individual times for patients to fast, with morning cases being allowed clear fluids up until three o’clock in the morning and patients on the afternoon list being given a light breakfast before fasting.

**Summary**

This study was conducted using a grounded theory method in which nurses described their perceptions of pre-operative fasting. The categories that were generated served the purpose of describing and explaining nurses’ knowledge, feelings and perceptions of their current practice. While an explicit theory cannot be stated, several conclusions can be drawn that not only raise questions for future research but also provide a framework to address the subject and highlight awareness to senior leadership in the hospital.

Using this framework for the study, the author was able to develop theories based on the study of human conduct and the concepts that impinge on it. A positive finding of this study was that some nurses recognised that excessive pre-operative fasting times was an issue in the surgical units and expressed concerns about the ritualistic tradition of NBM from midnight. In addition, the nurses felt that improving this aspect of care was a legitimate part of their role in practice, although they felt that they had little autonomy in terms of the decision-making process.

Through grounded theory, nurses can identify and explain the generalities that can form the substance of theories. However, at the same time they must appreciate that the themes produced cannot always be applied to the context of individual patients, nurses and sets of circumstances (Thorne 1991). It was evident from the findings that some nurses felt confident about their ability to control their practice and, consequently, were able to attain a degree of satisfaction in their work. In contrast, inadequate resources and a lack of support from management and physicians were found to be problematic by nurses who stated that they felt powerless.

The nurses acknowledged the importance of evidence-based practice surrounding the area of pre-operative fasting. Words and phrases drawn from their statements, such as ‘no control’ and ‘what’s the point’, demonstrated the frustrations that they held.

However, apart from providing insight into the phenomenon of nurses’ attitudes and perceptions, a number of recommendations can be made which include the following:

- To conduct quantitative research on how long patients are fasted.
- To provide education and training for staff in terms of evidence-based practice through workshops and the nursing education and research committee.
- Formalise a multidisciplinary team including physicians, anaesthetists, nursing executives, staff nurses, head nurses and dieticians to implement a performance improvement project to improve current practice.
- Update the current policy relating to pre-operative fasting.

**Limitations**

In view of the small sample size, specific context and methodological decisions in this study, some caution must be exercised when generalising these findings to wider populations of nurses as they are limited by the methodology used and the context in which the data were collected. Thus, the study would merit replication with a wider sample, including anaesthetists and surgeons. However, this study has been undertaken in an area where there has been a lack of qualitative research and does provide insight into some of the barriers affecting the use of best practice in relation to pre-operative fasting.

**Conclusion**

This qualitative study was based on the perceptions and attitudes of nurses with regard to pre-operative fasting times. By using this approach, the researcher was able to gain an understanding of nurses’ knowledge, feelings and perceptions within this particular area and, as a result of the methodology used, was able to...
establish reasons why the practice of starving patients from midnight is still occurring within the organisation.

From using the qualitative approach, nurses were given the opportunity to verbalise their feelings regarding this ritualistic approach to practice. Hence, they were able to state that there were significant barriers within the organisation such as communication difficulties, lack of knowledge and skills, a general feeling of lack of autonomy with regard to changing practice, and an operating room system that contributed to patients being fasted for a long time.

IMPLICATIONS FOR PRACTICE

- Better communication and collaboration are required between the unit nurses and the operating room staff.
- Nurses require further education about the effects of long pre-operative fasting regimens.
- All hospital policies need to be up to date, relevant and based on current evidence.
- Support is required from surgeons and anaesthetists to implement evidence-based practice regarding pre-operative fasting times.

References


