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CLINICAL REPORT

Bariatric Support Line: A Prospective Study of Support Line Activity

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Abstract In this prospective study, we examine the workload of the North London Obesity Surgery Service Bariatric telephone support line (BTSL) and its effects on service provision. Over a 3-month period (June to August 2008), a prospective record was kept of all calls, who they were from, whether the patient was presurgery or post-surgery, the type of procedure planned or undertaken, the nature of the enquiry, and the time taken to answer the query. Seventy-five (72%) calls were related to patients who were postsurgery and 29 (28%) presurgery. Patients scheduled for or having undergone Roux-en-Y gastric bypass accounted for 46 (44%) calls; 24 (23%) were preprocedure and 22 (21%) postprocedure. Patients scheduled for or having undergone gastric banding accounted for 56 (54%) calls; five (0.5%) were preprocedure and 51 (49%) postprocedure. Patients undergoing sleeve gastrectomy accounted for two (<1%) calls. Both calls were postprocedure. The reason for the support line enquiry was psychological support in 15 (14%) patients, questions postsurgery in 26 (25%), general enquiries in 27 (26%), and clinical enquiries in 36 (36%). This study of the BTSL has allowed us to identify areas of need within our bariatric population and improve the service we deliver. The changes we have made should lead to a better use of the team's time, greater patient compliance, and satisfaction as well as reduced complaints and litigation.

Keywords Bariatric surgery · Gastric banding · Obesity · Patient education · Roux-en-Y gastric bypass · Support line

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Introduction

One of the central tenets in the running of a bariatric surgical service is the provision of a multidisciplinary team approach to managing patients at all stages along their path [1, 2]. While there are no hard and fast rules regarding which individuals should take on which roles or the extent of these roles, it is clear that good communication with patients and a willingness to answer questions and address concerns is essential. In addition, there should be some method by which patients who are unwell can contact the team in an emergency. At the North London Obesity Surgery Service (NLOSS), we have a bariatric telephone support line (BTSL) which is one means by which we address these aims. In this prospective study, we examine the workload of the (NLOSS) telephone support line and its effects on service provision.

Methods

The BTSL was established in April 2008 and is manned between 0830 and 1630 hours, Monday to Friday, by the Specialist Bariatric Nurse (KMcD) who carries a mobile phone. This allows her to answer calls when away from her desk. Outside these hours, calls go to an answer phone which instructed patients to leave a message. Calls are returned the next working day. In the event of an emergency, patients are instructed either to call their general practitioner or to go to the Accident and Emergency Department at the Whittington Hospital or, if they lived a long way from the Whittington Hospital, the Accident and Emergency Department at their local hospital.

Over a 3-month period (June to August 2008), a prospective record was kept of all calls, who they were from, whether the patient was presurgery or postsurgery, the

type of procedure planned or undertaken, the nature of the enquiry, and the time taken to answer the query.

Results

Over the 3-month study period, the BTSL received a total of 104 calls (92 female and 12 male patients). The median call duration was 7 min (range 2 to 40 min), with the greatest number of call being in August (27 in June, 29 in July, and 48 in August). There was no significant difference in the call duration by month (data not shown). Most calls were received on Wednesday and fewest calls on Monday and Friday (Figs. 1 and 2).

Seventy-five (72%) calls were related to patients who were postsurgery and 29 (28%) presurgery. Patients scheduled for or having undergone Roux-en-Y gastric bypass (RYGB) accounted for 46 (44%) calls; 24 (23%) were preprocedure and 22 (21%) postprocedure. Patients scheduled for or having undergone gastric banding (GB) accounted for 56 (54%) calls; five (0.5%) were preprocedure and 51 (49%) postprocedure. Patients undergoing sleeve gastrectomy accounted for two (<1%) calls. Both calls were postprocedure.

The reason for using the BTSL was psychological support in 15 (14%) patients, enquiries postsurgery in 26 (25%), general enquiries in 27 (26%), and clinical enquiries in 36 (36%; Table 1).

Discussion

The high number of calls received by the BTSL during the study period demonstrates the need for some point of contact for patients outside clinics and represented a significant workload for the bariatric specialist nurse.

Most calls were received on Tuesday and Wednesday. We had expected that after a break of 2 days over the weekend, when there was nobody staffing the support line or checking the messages, that there would be a large number of enquiries to be dealt with on Monday.

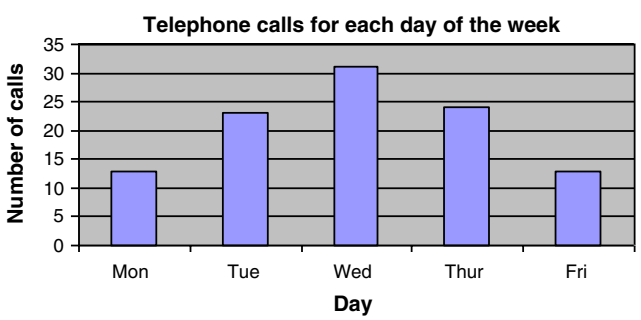

Fig. 1 Telephone call received for each day of the week

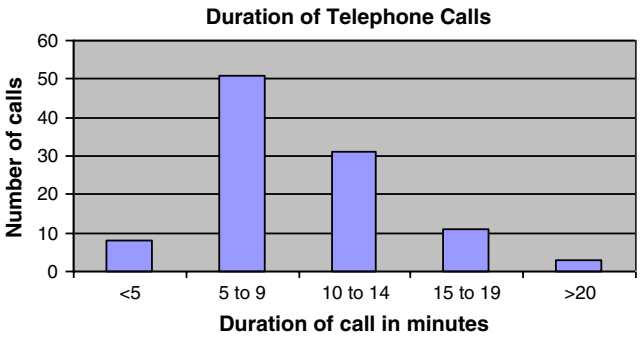

Fig. 2 Duration of bariatric telephone support line calls

Surprisingly, this was not the case. It is possible that patients did not call because they did not expect anyone to be available to answer their query over the weekend. However, we might then expect them to call the support line first thing Monday morning, something which did not occur. It may be that patients had sought advice from alternative sources such as their General Practitioner or the Accident and Emergency Department. It is also possible that our pattern of working with a band fill clinic being held on Monday morning and a bariatric clinic on Monday afternoon (band fills were also undertaken here) influenced the timing of calls. When we examined the diary in detail, we noted that seven of the 23 (30%) enquiries made on Tuesday and four of the 31 (13%) enquiries made on Wednesday were related to band fills undertaken on Monday. Such enquiries were usually because the band was "too loose" or "too tight" or they were unsure about what they could eat and drink or whether they could take tablets.

While a number of calls relate to "housekeeping" issues such as pending appointments and whether funding had been granted, there were significant numbers of enquiries relating to important clinical issues.

The single group from whom we received most calls was those patients who had or were having GB with a clear majority of callers being postprocedure. These figures are

Table 1 Reason for calls to the support line

Problems post surgery					
Wound infection		Overfilled band/undue restriction		Other	
4		5		17	
General enquiries					
Status of funding		Clinic appointments		Referrals to other specialties	Others
3		9		8	7
Clinical enquiries					
Medication	Diet	Psychological support	Requesting band fill	Requesting test results	Other
2	2	15	12	14	7

more remarkable when we consider that we currently undertake one GB for every five RYGBs (3 years previously, the ration was closer to 1:1), demonstrating that patients undergoing GB require a greater degree of support postoperatively than patients undergoing RYBG.

The majority of enquiries from patients post-GBs related to the degree of postoperative weight loss, degree of restriction experienced from the band, and arrangements for band fills. It was apparent that a number of calls came from patients who were expecting a degree of weight loss greater than 1 to 2 lb per week or from those who felt that the band was not "tight enough" although the degree of restriction was appropriate. These tendencies among some patients with GBs have been noted by other authors [3] and been associated with a poorer outcome, possibly due to difficulties in adjusting lifestyle postoperatively [3].

Calls from patients considering or having undergone RYGB fall into two main categories. The first group were preoperative patients who rang because they were anxious about the risk of serious complications following surgery and the irreversibility of the procedure. This is something not seen in patients undergoing other surgical procedures and is probably related to the lack of access to objective material on bariatric surgery [4] and the propensity of the media to concentrate on the risks and failures rather than the benefits of surgery. The second group was patients shortly after discharge, and their queries were related to concerns about what they could eat and drink, taking medication, and wound care.

It is clear from this study that there are areas of patient education that need to be addressed (postoperative care in patients undergoing GB and preoperative education for patients undergoing RYGB). We also found it very difficult finding time to provide each "new patient" attending clinic with all the information needed to help them make an informed decision as to which type of surgery they wished to undergo as the number of new referrals increased. Originally, each new appointment lasted one hour and was followed by a further half-hour appointment with the bariatric dietician. When we factor in calls to the BTSL, each individual patient required a great deal of time to assess and educate. In order to overcome these problems, we have introduced group education sessions in which a group of 12 to 15 "new patients" attend a half-day education session. They are encouraged to bring along their spouses or partner. The sessions are run by the BSN and bariatric dietician and cover the risks and benefits of surgery, preoperative and postoperative diets, and the process of assessment. Patients are also encouraged to attend the support group where they can speak with patients who have already undergone the procedures. The aim is to ensure that all patients have the information needed to make an informed decision regarding which operation is best for them and to ensure that they get the best result following surgery. By the time they attend their first clinic appointment, they should have a clearer idea about which procedure they wish to undergo, and it is a relatively simple matter to address any outstanding issues. We believe that this change in approach has been one of the factors influencing the increase in the proportion of patients selecting RYGB.

This study of the BTSL has allowed us to identify areas of need within our bariatric population and improve the service we deliver. The changes we have made should lead to a better use of the team's time and greater patient understanding, compliance, and satisfaction as well as reduced complaints and litigation [3–5].

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