numbers of RS between December 2020 and April 2022 and COVID-19 infections (CI) amongst patients.

**Results** There was no delay in the simulation training. Wet lab training was delayed due to temporary center closure. The surgeon’s learning curve was slower at the beginning of the program. This was attributed to the lower influx of patients as a result of prioritization, lesser operative sessions, and delays in the mandatory training completion. 41 RS procedures were done in the first 8 months following a COVID-19 free pathway and were operated in an elective surgery hub with no visitors allowed. There were no cancellations due to CI during this period. Following the return to NHS hospital, 102 patients underwent RS in the subsequent 8 months. Pre-operative isolation was gradually reduced then cancelled. One patient had a CI and was rescheduled accordingly.

**Conclusion** Covid pandemic has impacted the learning curve for RS with significant improvement noted after the gradual release of Covid related restrictions.

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**PATIENT WALK TO THE OPERATING THEATRE AS A NEW TOOL FOR PATIENT EMPOWERMENT – KORE-INNOVATION: THE FIRST PROSPECTIVE CLINICAL TRIAL TO ASSESS A PERIOPERATIVE PATHWAY TO REDUCE POSTOPERATIVE COMPLICATIONS IN OVARIAN CANCER PATIENTS**


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**Introduction/Background** Patient empowerment is an essential, yet neglected resource of the patient’s health journey. Through a patient-centered approach, patients are encouraged to take on an active role in their health and recovery. We report our first experiences of the patient walk intervention as part of the patient empowerment module, which is embedded in the KORE-INNOVATION trial as a subpopulation analysis.

**Methodology** The KORE-INNOVATION trial is an ongoing clinical trial to assess an innovative perioperative care pathway to reduce complications for patients undergoing surgery for ovarian cancer. We implemented the patient walk intervention to encourage patients’ autonomy before surgery. Patients were given the option to walk to the operation room instead of being pushed in their bed as part of the standard patient care pathway. The only requirement for walking was to omit sedating pre-medications. To evaluate patients’ and staff’s experiences, we administered a questionnaire between the 2nd and 3rd postoperative day.

**Results** Of the 63 patients offered to walk to the operating room, 48 participated. All patients reported that the experience was either better than expected or as expected; nobody reported that it was worse than expected. Patients reported that if given the choice would walk again. Patients also stated that they felt strengthened in their autonomy. Reasons for not walking were refusal to omit sedatives or anxiety before the operation. The main barriers from the staff’s perspective were logistical difficulties, which decreased over time.

**Conclusion** Providing patients with the option to walk to the operating theatre is a simple but effective method of increasing patients’ autonomy and engagement. Furthermore, it promotes the active patient role in their health and recovery. This easily implementable no-cost intervention should be routinely integrated in the context of ERAS protocols.