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1. Bacteraemia and its treatment in sepsis on the wards: Results of a large point-prevalence study

Authors McNulty P.; Kulikouskaya S.; Grother T.; Al Hassan H.; Abreu J.; Heng S.Y.; Ng S.; West N.; Kopczynska M.; Sharif B.; Szakmany T.
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Abstract INTRODUCTION. Bacteraemia has been linked to increased mortality in sepsis, depending on the causative organism [1]. Quality improvement projects aimed to increase frequency and reliability of blood cultures obtained from this population revealed mixed results. Currently there is little known about the frequency and causative organisms of bacteraemia on the general wards and emergency departments (ED) in confirmed sepsis. OBJECTIVES. The aim of the study was to establish the rate and organisms of bacteraemia related to the sepsis episode on the general wards and ED. METHODS. Secondary analysis of patient episodes was performed on patient population recruited into two annual 24-hour point-prevalence studies on the general wards and ED across all Welsh acute hospitals in 2016 and 2017 [2]. Inclusion criteria were: clinical suspicion of infection and NEWS 3 or above in-line with established escalation criteria in Wales. Sepsis was defined according to Sepsis-3 definition based on SOFA and qSOFA scores. Microbiology data on collected blood cultures within 48 hours of the index episode were collected, together with data on antimicrobial regime. RESULTS. 791 patients were recruited over the two 24-hour periods in 2016 and 2017. 514 patients fulfilled Sepsis-3 criteria. 321 (63.6%) patients had blood cultures taken. 16 blood cultures (4.9%) were positive with likely significant results: 6 Escherichia Coli, 1 Pseudomonas aureginosa., 2 Klebsiella pneumoniae, 1 Proteus mirabilis, 1 Gram negative organism, 1 Enterobacter cloacae, 1 Streptococcus pneumoniae, 2 Gram positive cocci. Out of the 514 patients, 212 (41.2%) were treated with intravenous antibiotics. 3 patients with positive blood cultures (2 with E. Coli and 1 with Gram positive cocci) were not treated with antibiotics, all survived. On the other hand, 70 (13.6%) patients were treated with two or more antimicrobials without microbiology investigations performed, and 57 were treated with 2 or more antimicrobials with negative blood culture results. CONCLUSIONS. Despite ongoing quality improvement initiatives, blood culture attainment in sepsis is low. This could partially explain the 3% bacteraemia rate observed in our study. There is evidence that one in seven patients with sepsis are treated with two or more antimicrobials, without attempts to establish causative organism, which could lead to spread of antimicrobial resistance.

2. Comparing intravenous unfractionated heparin and subcutaneous low molecular weight heparin as therapeutic anticoagulation on intensive care

Authors Case S.; Gayner R.; Weston-Smith N.; Clarke A.
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Abstract INTRODUCTION. Intravenous unfractionated heparin (UH) and subcutaneous low molecular weight heparin (LMWH) are used as therapeutic anticoagulants on intensive care units (ICUs) for a variety of indications. In the treatment of venous thromboembolism (VTE) a recent Cochrane review has shown LMWH is associated with fewer major haemorrhagic episodes, lower mortality and reduced incidence of recurrence compared to intravenous UH[1]. There is limited evidence comparing their use in non-VTE indications or in the ICU setting. OBJECTIVES. . Compare prescribing practices for UH and LMWH as therapeutic anticoagulants in ICU and the frequency of complications . Assess ICU monitoring of UH using activated partial thromboplastin time ratios (APTRs) METHODS. Retrospective audit of admissions to a 21-bed mixed medical/surgical ICU in Bristol, UK. The electronic clinical record was interrogated over a 12 month period to return a dataset of prescriptions for therapeutic anticoagulation. From the UH group, we defined a subgroup (n=20) to identify the frequency of APTR monitoring, duration of therapeutic APTR results and compliance with hospital infusion protocol. RESULTS. We identified 45 prescriptions for UH and 31 prescriptions for LMWH. Of the 65 patients involved, 11 received both UH and LMWH (separately) during the audit period. The commonest indication for anticoagulation was new VTE (34 prescriptions, 45%; 18 UH vs 16 LMWH) and second commonest indication was for a pre-existing condition (23 pre-scriptions, 30%; 11 UH vs 12 LMWH). Other indications included new atrial fibrillation, acute coronary syndrome and arterial thrombosis. 10 patients received UH for haemofiltration. In the UH group 58% of APTR measurements were done within 6 hours of the last measurement. 40% of APTR measurements were not in the therapeutic range and appropriate dose adjustments were made in 82% of occurrences. 11 (24%) patients in the UH group had bleeding complications; 2 were life-threatening: one had a fatal subarachnoid haemorrhage despite sub-therapeutic anticoagulation; another had a massive intra-abdominal haemorrhage and survived. The LMWH group had no bleeding complications although 2 patients had procedures delayed due to anticoagulation. CONCLUSIONS. UH and LMWH are used for a variety of indications on ICU, with crossover between conditions. UH was associated with minor and major bleeding complications, whilst no complications were seen with LMWH. Given the higher rates of complications and difficulties maintaining UH in the therapeutic range it may be worth considering using LMWH more frequently as a therapeutic anticoagulant. Therapeutic anticoagulation may expose patients to higher bleeding risk than necessary, particularly for non-acute indications.

3. The bedhead EndoTracheal tube airway information (BETTA-In) project

Authors Davies E.; Sills A.; Covas B.; Atkinson D.
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Abstract INTRODUCTION. Airway emergencies contribute to significant morbidity and mortality on the intensive care unit (ICU), as explored by the 4th National Audit Project of The Royal College of Anaesthetists (NAP_4). There was an apparent failure to identify ICU patients who had high-risk airways.[1] Bedhead signs have been introduced to provide easy access to airway information. They provide a reference point for assessment and have the potential to save time in emergencies. Tracheostomy and laryngectomy signs have had widespread success in the United Kingdom due to the National Tracheostomy Safety Project.[2] Signs detailing other airway variances or devices have been introduced. NAP_4 recommended that "patients at risk of airway events should be identified and clearly identifiable to those caring for them".[1] The Greater Manchester Critical Care & Major Trauma Services Network also recommends that signs record any intubation difficulties.[3] OBJECTIVES. The aim of this project was to improve compliance with use of a bedhead endotracheal tube (ETT) sign on our ICU. METHODS. A standard was set: 100% patients with an ETT in situ on ICU should have a bedhead airway information sign. A quality improvement project was carried out at Manchester Royal Infirmary from 2017 to 2018. In each study period, all intubated patients on ICU were identified at the start of a day shift for 5 consecutive days. The presence or lack of an airway sign was noted. Percentage compliance was calculated. Interventions were made between study periods. Following presentation at the departmental audit meeting and feedback throughout the project, the sign was redesigned by the authors. (Figure 1) RESULTS. Baseline compliance was 8%. Following interventions, this was increased and maintained despite changeover of staff and stopping intervention. The project has yet to meet the standard. (Figure 2) CONCLUSIONS. The identification of patients at risk of adverse airway events and subsequent display of information are crucial in preventing harm on the ICU. This project identified a need to improve compliance with bedhead airway information signs for intubated patients. Interventions improved compliance. The project is ongoing but a cultural change has already been shown. The authors would support the use of this sign's design on other ICUs. [Figure Presented].

4. Age and mental status influence on extubation success

Authors Aluwihare C.; Gerrard K.; Jethudasan A.; Metaxa V.
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Abstract INTRODUCTION. Weaning is the process by which a patient is liberated from mechanical ventilation and extubation is the process of liberation from endotracheal tube[1]. Extubation failure is defined as the need for reintubation within a specific time period: either within 24-72 hours or up to 7 days[1,2]. Failed extubation, is common in intensive care units (ICU). This can lead to higher morbidity and mortality, higher cost and increased length of hospital stay. There is limited literature available on weaning/extubation predictors and outcomes. Main objective of the study was to identify the rate, causes and predictors of extubation failure and to identify the rate of reintubation across 3 Intensive care uni-ts(ICU) at King's College Hospital, London. OBJECTIVES. To determine the reintubation rate. To determine the causes and predictors of reintubation. METHODS. This was a prospective study. A standard questionnaire was filled by the auditors by direct observation, observation of daily chart or by direct questioning from the person who decided to extu-bate. The study was carried out over 1 month across 3 ICU s. All elective extubations during this period was analysed. Patients over 18 years of age, intubated and mechanically ventilated for more than 24 hours and extubated electively were included in the study. Patients less than 18 years of age and all self extubations were excluded. The results were statistically analysed. RESULTS. A total of 49 (male 77.6%) elective extubations were analysed. 49% were more than 61 years of age. Patient with cardiovascular diseases were the commonest indication for intubation (24.5%). The mean heart rate, systolic and diastolic blood pressure, PaO_2 and FiO_2 were 86.2 +/- 20.64p/min, 138.9 +/- 23.77mmHg, 87.72 +/- 26.59mmHg, 11.28 +/- 1.90mmHg, 27.27 +/- 7.26% respectively prior to extubation. 36 (73.4%) patients were extubated successfully and 13(26.5%) were re-intubated. Acute respiratory failure/respiratory distress was the commonest indication for re-intubation (33.3%). 10 (76.9 %) of reintubations took place within 48 hours of extubation and the rest within 72 hours. Based on logistic regression analysis (adjusted) patients who were agitated had higher risk of re-intubation than non (EXP (B) =4.195, p=0.0.015). Higher the age there was 16% more risk of re-intubation (EXP (B) =1.159, p=0.042). CONCLUSIONS. Extubation success was significantly influenced by the age of the patient and the mental status.

5. Thriving or surviving, national targets verses regional needs: Outcomes for out of hospital cardiac arrests (OHCA) from intensive care in a geographically, architecturally and economically challenged region

Authors Lee G.; Caines K.; John J.; Chelliah R.; Vijayan A.
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Abstract INTRODUCTION. The chain of survival is a tool implemented to highlight various stages following out of hospital cardiac arrest. Early cardiac intervention protocols were designed using trials for ST Elevation Myocardial Infarction (STEMI), in patients who maintain cardiac output, but are being applied to OHCA patients without ongoing return of spontaneous circulation. Our hospital has a unique set of circumstances; we are one ofthe most socioeconomically deprived and geographically challenged regions in the UK. In addition we have a split hospital site meaning that all ongoing cardiac arrests are transferred to an intensive care via the emergency department (ED) on a site without percutaneous coronary intervention (PCI) abilities and a resident cardiologist unless a STEMI is demonstrated. OBJECTIVES. To determine if national guidance and targets in combination with our unique set of circumstances are having an adverse effect on the outcomes of OHCA patients in our region. METHODS. 94 OHCA were identified via ICNARC between January 2012 and June 2017 and appraised for a set of predetermined parameters, with telephone interviews, using the EQ-5D tool, for those whom survived. RESULTS. Results were applied to the Myocardial Ischemia National Audit Project 2016. We achieved direct transfer to a PCI centre in 26%, call to balloon in 31% and hospital to balloon time in19% of patients. However we achieved a survival to hospital discharge of 43%. With respect to our split site, transfer from ED to the PCI centre adds on average 173 minutes to call-balloon time yet there was no mortality difference between direct or indirect admissions. An increase in mortality was evident in the cohort whom remained on the non-cardiac site. We found that patients whom survived had by comparison to the general population an overall reduction in quality of life (QOL) by 7%. However despite the life-changing event, 20% of those whom survived had a very good-excellent quality of life, well above the national average. CONCLUSIONS. Overall and quality of survival from OHCA is reduced in socioeconomically deprived areas. We have demonstrated that despite significantly underperforming against the national targets, we almost achieve the national average of survival to hospital discharge. The demonstrated modifiable domains in our region propose that we refocus priorities, concentrate on quality of care and outcomes rather than targets. In particular addressing the incorporation of cardiac interventions into good evidence based post resuscitation protocols on all of our intensive care unit across the city and standardizing OHCA guidance including prognostication and appropriate transfer, regardless of the patient's route of admission to our hospital and the immediate presence of a cardiologist The need for fast turn around to meet inappropriate national targets puts a vulnerable cohort at risk, particularly if they are not transferred for PCI at all.

6. Critical care drug pouch a case to avoid mistakes

Authors Rubulotta F.
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Abstract INTRODUCTION. Drugs errors are common and their incidence may vary depending on the clinical setting. Human factors remain a major contributor to these. OBJECTIVES. The concept of a "drug grab pouch" is an established and essential part of military and paramedic equipment. The project designed at Charing Cross Hospital, London, UK, proposes the use of a pre-set Critical Care Drug Pouch (CCDP) for the following uses in critical care (critical care drug pouch): Emergency intubation Interdepartmental and inter-hospital transfer of patients Safe transfer and sedation of critically unwell patients METHODS. A modified Delphi method was used to gather consensus on an initial pilot CCDP by sending an online questionnaire. The results of this questionnaire were analysed and consensus agreed by an expert panel thereafter before introduction to the end-user. RESULTS. 88% response rate was achieved among doctors (consultant and registers) and nurses. There was global agreement that drawing of drugs for emergency rapid sequence induction and transfer was subject to errors and delays, the available drugs were insufficient. 100% of respondents agreed that always or sometimes, patient care was compromised due to delays in drawing up of medications and 96% of respondents felt a CCDP would improve this experience. The questionnaire allowed respondents to express drugs they felt would be of use in such a project. A second round of consultation of departmental consultants and senior registrars permitted consensus of the bag form, contents (drugs and adjuncts) that would be essential based on the above results. Consensus was obtained that the pouch should be minimalistic in size and contents, to permit easy use, daily check and reduction of waste. It was agreed that it should be in keeping with infection control guidelines and have clinical governance procedures in place to ensure sustained quality and safety. The pouch should also contain all necessary syringes akin to routine anaesthetic practice and drawing up needles. It was agreed that colour coded syringe labels would be contained in harmony with UK regulations and common anaesthetic practice as per Royal College of Anaesthesia guidelines to prevent "wrong drug" administration. To facilitate standardisation, two small bags (20cm x 20cm x 7cm) with elasticated vial and mini-jet compartments, were introduced across the 25 bed unit. The bag also contained an fixed inventory and audit form permitting accountability and ease of daily check. CONCLUSIONS. "To err is human" but instituting basic measures such as provision of essential drugs, standardised syringes and colour-coded labels in a single, compact and portable device, the CCP, is a solution to many preventable errors in critical care environments.

7. Physiotherapy outcome measure use on adult intensive care units in the United Kingdom (UK)

Authors Purkiss C.
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Abstract INTRODUCTION. Standardised, validated outcome measures are an essential tool when measuring quality and efficacy of therapy interventions. NICE guideline CG83 recommends assessment with an outcome measure to assess physical function at regular intervals during critical illness, however does not recommend a specific tool with which to do so. A 2015 review identified inconsistency in tools used to measure physical function in survivors of critical illness and there is currently no consensus regarding which tools best assess physical impairment in this cohort. OBJECTIVES. To review outcome measure use throughout Adult Correspondence: Intensive Care Units (AICU's) in the UK, and benchmark the use of outcome measures at the Royal Brompton Hospital against other UK AICUs. METHODS. A questionnaire regarding outcome measure use was posted to 247 AICU's across the UK taken from the Intensive Care National Audit Research Centre (ICNARC) in 2016. RESULTS. 36.8% (n=91/247) of surveys were returned. 79.1% (n=72/91) of responding trusts were using outcome measures, with a range of 27 different outcome measures reported. Of those using measures the most commonly used was the Chelsea critical care physical assessment tool (66.7% n=48/72), followed by the Manchester Mobility Scale (25% n=18/72), Functional Independence Measure (11.1% n=8/72), Barthel Index (11.1% n=8/72), and the Goal Attainment Scale (6.9% n=5/72). 22.2% (n=16/72) of trusts were using a combination of several measures, hence the sum total of outcomes used exceeds the response rate of the survey. The most sited reasons for choosing a measure were ease of use (23.61% n=17/72), evidence base (22.22% n=16/72) and appropriateness of the tool (20.83% n=15/72). 33.3% (n=24/72) of units completed measures with all patients on AICU, others used set time frame criteria. 12.5% (n=9/72) assessed after >48hrs AICU stay, 11.1% (n=8/72) after >48 hrs ventilated. The longest time frame until patients were assessed was a stay of >2 weeks on AICU (1.4% n=1/72). The frequency of assessment varied widely with a range from daily, to on admission and discharge from AICU only. The most common intervals for assessment were weekly (22.2% n=16/72) and daily (19.4% n=14/72). On discharge from AICU, 66.7% (n=48/72) of the trusts using measures continued to do so on high dependency units and the ward. CONCLUSIONS. The scope of this survey is limited due to the response rate, however it shows a wide disparity of UK AICU outcome measure use. This variance includes the tools being used, which patients are assessed, and the timing and frequency of assessment. This may be due to heterogeneous patient cohorts, staffing levels, patient acuity and a lack of consensus regarding the best outcomes to use. Further investigation into specific outcome measures would be beneficial to provide best quality, standardised care and the creation of a core outcome set to make outcomes translatable for research purposes.

8. The prevalence of suspected ventilator-associated pneumonia in Scottish intensive care units: A prospective analysis

Authors Hart R.; Hornsby J.; Ramsay S.; MacLean S.; McNeill S.
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Abstract INTRODUCTION. Ventilator-associated pneumonia (VAP) is the most common healthcare associated infection (HAI) in mechanically ventilated patients[1]. Given there are many modifiable risk factors, VAP rates may be viewed as a quality indicator. The diagnostic criteria applied to detect VAP must therefore be robust and standardised[2]. There is concern that our existing diagnostic tool (HELICS) has be-come outdated. A sub-group of patients may therefore exist, who are being treated for VAP but not positively diagnosed or declared through our HAI screening process. OBJECTIVES. We aim to determine the magnitude and characteristics of patients in Scottish ICUs who are being treated for suspected VAP but not be detected using the HELICS criteria. METHODS. A prospective national sprint audit was conducted over a one-month period. Local data collectors in Scottish ICUs were re-cruited and co-ordinated by the Scottish Intensive Care Society (SICS) Trainee Committee. All patients ventilated for more than 48-hours were included. Baseline HAI data was gathered for each eligible patient on a daily basis. Further collection of physiological data occurred if a new lower respiratory tract infection was suspected in order to determine whether that episode could be diagnosed as a VAP according to the HELICS definition. RESULTS. This study included 227 patients and 1751 days of data collection. We successfully recruited 14 ICU sites from 11 Scottish NHS Health Boards. 32 patients were suspected of having a VAP (S-VAP). By applying the HELICS criteria, only 13/32 (40.6%) patients were positively diagnosed with VAP (H-posVAP). Of the 19 patients with S-VAP who failed to achieve a positive HELICS VAP diagnosis, 12 patients (63.2%) were due to the lack of radiological evidence alone. Median duration of ventilation was increased in patients with suspected VAP (14 days) compared to baseline (8 days). Hospital mortality was higher in patients with suspected VAP (42.8%) compared to baseline (33.7%). Patients who were HELICS negative had a higher hospital mortality than the HELICS positive patients (47.1% vs 36.4%). CONCLUSIONS. We have demonstrated the existence of a sub-group of patients who are treated for suspected VAP but not diagnosed by the HELICS criteria. These patients would therefore be missed by our national HAI screening process. This population demonstrates a raised hospital mortality regardless of the HELICS screen. We believe the HELICS criteria is not compatible with modern ICU practice and an alternative tool should be sought.

9. Death verification-after 5 years, we still can't diagnose death

Authors Archer K.; Mann H.; Arora N.; Groves C.
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Abstract INTRODUCTION. Five years ago, we performed an audit looking at the process of death verification in comparison to the guidance published by the Academy of Medical Royal Colleges[1]. Our results highlighted varied and sometimes inadequate practice amongst healthcare professionals. This lead to the introduction of a proforma for the verification of death in the intensive care units in our hospitals. OBJECTIVES. Our objectives were to i) see if practice has changed with regards to death verification, ii) to see how many deaths were being verified using the proforma, and iii) to see if the proforma made a difference to the quality of documentation. METHODS. Using the same method of data collection as our previous audit, two investigators reviewed the death verification notes of patients who died between December 2017-January 2018 across two hospitals within our NHS Trust. RESULTS. The results of 100 patients were included in our audit. Whether the death verification had been performed using our proforma, as well as 28 other parameters, were recorded. Our results regarding the process of death verification without using our proforma were comparable to previous. There had been minor improvements with 83% of notes having the appropriate number of patient identifiers. There were 3 patients that did not have pulses palpated. 11 patients did not have heart sounds auscultated and in 8% there was no documentation of listening for breath sounds. 98% of patients had their pupils checked. Only 28% were tested for pain stimulus using supraorbital pressure, as per guidance. 7 entries did not have a printed name and 3 were illegible. 45% did not have a professional registration number documented. 18 of the 100 patients were verified using our proforma. Of these, 1 patient did not have the required patient identifiers on the document. 100% of patients had their pulses checked. Only 94% had their heart and breath sounds auscultated. All 18 of patients had their pupils checked. Only 89% were tested for painful stimuli using supra-orbital pressure. 100% were signed, dated and timed but 1 patient (6%) did not have the verifying professional's printed name or registration number stated. CONCLUSIONS. The process of death verification remains varied and sometimes inadequate. Practice has not changed significantly from our audit 5 years ago. However, the proforma we created has helped healthcare professionals to carry out death verification in a more efficient and standardised way. We are moving forward to take our proforma and make it a Trust-wide necessity for death verification.

10. A point prevalence study of ventilator associated pneumonia (VAP) across four London ICUs

Authors Shah N.; Hadley J.; Zolfaghari P.; Hinds C.

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Abstract INTRODUCTION. There are few studies describing the incidence and prevalence of VAP in the UK. This may partly be due to the complexity of the various definitions of VAP in current use. We describe a one-day point-prevalence study of VAP using a pragmatic definition and a specially adapted electronic case report form. OBJECTIVES. To determine the point prevalence of VAP with 30-day follow-up using an electronic data collection tool in 4 ICUs at Barts Health NHS Trust: The Royal London (RLH-trauma/neuro/general), St. Bartholomew's Cardiac ICU (SBH cardiac), St.Bartholomew's gen-eral/oncology (SBH), and Whipps Cross University Hospital (WXH-general). METHOD. This was a multi-centre 24-hour cross-sectional observa-tional study. Data was collected for all patients receiving Advanced Respiratory Support over a 24-hour period on the 13 April 2016 with 30-day follow-up on the 13 May 2016. Study data was collected using a purpose built REDCapTM (Research Electronic Data Capture) portal hosted at Queen Mary University of London (UK). Additional data were collected for patients with a study definition of VAP (commenced on antibiotics for chest sepsis 48 hours or more after initiation of invasive ventilation). This audit was registered with the clinical effectiveness unit. RESULTS. Data was submitted for 35 patients across 4 ICUs on study entry: mean age 54.7 years (std+/-18.1,17-83); male 28 (80%) and female 7 (20%); mean ICU length of stay 18.8 days (range 1-126); duration of ventilation 17.3(std+/-26.6,1-126); mean FiO_2 0.4 (std+/-0.1,0.21-0.90). Seven patients (20%) met the study definition for a current VAP: mean age 60.3 years (std+/-19.0,34-82); mean initial APACHEII score 21.1 (std+/-8.6,13-34); mean ICNARC score (5 of 7 patient data) 17.8 (std+/-4.0,12-22) and mean initial SOFA score (5 of 7 patient data) 7.2 (std+/-3.9,3-13). 30-day follow-up for those who met study definition of VAP revealed: mean ventilator days 23.7 (+/-19.7,8-65); mean ICU LOS (days) 26.4 (+/-17.8,13-65); 2 patients (28.6%) died on ICU; 3 patients (42.9%) were discharged from ICU; 2 patients (28.6%) remained as ICU inpatients; mean hospital LOS (days) 38.4 (std+/-14.8, 21-65) and tracheostomy was performed in 4 (57%) patients. Pathogens were identified in 6 cases (85.7%), E.coli was isolated most frequently (3/7, 42.9%); Proteus spp. in 2 cases (28.6%); S.aureus (MSSA) in 2 cases (28.6%); with single cases of Klebsiella spp., unidentified S.aureus and Candida spp. Antibiotics for VAP included piperacillin tazobactam (4); vancomycin (2); meropenem (2); amikacin (1) and fosfomycin (1). CONCLUSIONS. This pilot study of an electronic data collection portal was successfully used to determine a point prevalence of 20% (7/35) of VAP across 3 ICUs with a varied case-mix. The methodology used showed good feasibility to carry out a wider national VAP study to identify the epidemiology of VAP. GANt ACKNOWLEDGMENT Support from Barts Charity Clinical Research Training Fellowship Grant.

11. Implementation of a new sedation hold protocol

Authors Shankla S.; Trimmings A.
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Abstract INTRODUCTION. Sedation in the ICU is primarily used to facilitate endotracheal tube tolerance and ventilation[1]. Over-sedation is associated with well-recognised complications. Regular sedation holds have been demonstrated to decrease weaning times, ICU[2] and hos-pital stays, and one-year mortality[3]. Objectives. To introduce a protocol across both our local NHS Trust ICUs to ensure that all eligible patients have a daily sedation hold with documented target sedation score (Richmond Agitation and Sedation Score (RASS)) and titration of sedation. This follows recommendations from the Guidelines for the Provision of Intensive Care Services (GPICS) 2016[4] (nil audit standards set). METHODS. A retrospective audit was carried out 18th-31st Dec 2017, the new protocol implemented and a re-audit conducted 12th-25th Mar 2018. The protocol was adapted from the Spontaneous Awakening Trial (SAT) of the "Wake Up and Breathe" protocol by the ICU Liberation Initiative[5]. All ventilated patients who passed the SAT safety and failure screens were eligible. The first 24 hours of admission were discounted unless a hold had specifically been requested. We collected data on whether eligible patients had had a hold requested and completed, or a contraindication documented; a target RASS documented; the protocol for stopping and restarting the propofol infusion followed; changes in RASS and propofol infusion rates. RESULTS. The retrospective audit had 31 patient-days of data and the prospective re-audit 65. Extubated patients or those with a documented contraindication other than in the SAT screen were excluded. Our results demonstrated: An improvement in holds requested (55% retrospective/62% re-audit) and completed (59%/75%) An improvement in documentation of contraindications (55%/79%) Poor documentation of target RASS (0%/8%) No change in the proportion of holds where sedation was stopped rather than reduced (50%/50%) An improvement in restarting the sedative infusion at a lower rate (33%/53%) An improvement in the number of patients with an improved sedation score (33%/56%) Retrospective: median pre-hold RASS of-4 (range-3 to-4) and me-dian post-hold RASS of-3 (range-2 to-4) Re-audit: median pre-hold RASS of-4 (range-3 to-5) and median post-hold RASS of-3 (range-1 to-5). CONCLUSIONS. Education about sedation holds and implementation of a new protocol has increased both our ICUs' compliance with GPICS. Target RASS documentation and sedation titration is lacking. Moving forwards, we will continue the new protocol and will look to extend to the Spontaneous Breathing Trial of the Wake up and Breathe protocol[5].

12. Learning from within: A quality improvement programme to identify and address key themes for successful critical care rehabilitation

Authors Bean S.; Chapman R.; English W.
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Abstract INTRODUCTION. Each year around 110,000 people are admitted to critical care units in England and Wales and the majority survive to discharge home (1). Unfortunately many survivors face a protracted recovery period, with a high incidence of both physical and psychological problems. OBJECTIVES. To describe the development and outcomes of a quality improvement programme using information gained by the critical care follow-up clinic team on the experiences of our patients and their relatives. METHODS. Since April 2017 we have been obtaining structured feedback from patients and relatives attending our critical care follow-up clinic. This information has been used to identify important common themes of ways in which patient care can be improved. Addressing these themes has allowed our unit to collectively learn, develop and implement a number of fundamental positive changes, primarily concerning early rehabilitation and improved support and information for patients and relatives. RESULTS. Main themes identified: *Poor patient understanding of their illness and treatment. *A high incidence of psychological morbidity. Amongst clinic attenders; 66% reported delusional memories, 20% reported persecutory delusions that had a significant impact on the quality of their life, 15% had no recollection of their time on critical care and 25% had trauma screening scores suggestive of PTSD. *Poor psychological preparation of patients for critical care discharge. *Excessive noise levels in critical care. *Poor access to psychological help after hospital discharge. New service developments: *Appointment of a rehabilitation link nurse specialist. *Regular dissemination of patient and relative feedback to the critical care team, including high incidence of psychological morbidity. *New agreed specialist referral pathways for patients requiring expert psychological input. *Patient testimonials have been used to support a business case for regular clinical psychology input, to support a charity funding bid for noise monitoring equipment and to help embed the use of patient diaries into unit practice. *Improved psychological preparation of long-term patients for critical care discharge. This has included visits to ward that they are due to be discharged to and steps to decrease reliance on staff help with activities of daily living. CONCLUSIONS. Obtaining and using information sourced from patients and relatives at the critical care follow-up clinic has enabled the identification and subsequent introduction of many varied tools to help improve the care of our patients. Some have little or no additional cost associated with them. Some of the themes that we have identified will be common to other units.

13. A practices-in-prevention and active surveillance survey of Ventilator Associated Pneumonia (VAP) across four London ICUs

Authors Shah N.; Hadley J.; Zolfaghari P.; Hinds C.
Source Intensive Care Medicine Experimental; Oct 2018; vol. 6
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Database EMBASE
Available at Intensive Care Medicine Experimental from ProQuest (Hospital Premium Collection) - NHS Version
Available at Intensive Care Medicine Experimental from Europe PubMed Central - Open Access

Abstract INTRODUCTION. We hypothesised that management strategies and active surveillance for VAP varies widely across intensive care units, and that in clinical practice the criteria used for antibiotic treatment of chest sepsis differ from published definitions of VAP. OBJECTIVES. To determine the management and prevention strategies, including active surveillance monitoring and diagnostic criteria, of VAP across four London ICUs (Barts Health NHS Trust, London, UK): The Royal London (RLH-trauma/neuro/general), St. Bartholomew's Cardiac ICU (SBH cardiac), St.Bartholomew's (SBH-general/oncology), and Whipps Cross University Hospital (WXH-general). METHOD. Audit data was collected and managed using a purpose built REDCapTM (Research Electronic Data Capture) portal hosted at Queen Mary University of London (UK), designed to take 30 minutes per centre to complete. Units were given 30 days to collect data in April 2016, from 12-month ICNARC dataset (except St. Bartholomew's hospital who supplied 6-month data following recent merger). The audit was registered with the clinical effect-iveness unit. RESULTS. There was a varied mix of Level-3 patients across the units surveyed in keeping with their speciality areas. Table 1 shows characteristics of these units. All 4 units used VAP care bundles with the same core components: head of bed elevation, sedation level assessment with daily sedation interruption (unless contraindicated), oral care with chlorhexidine mouthwash (0.125%), teeth brushing, ventilator circuit changes, hand hygiene using alcohol before airway management, tracheal tube cuff pressure control and daily review of stress ulcer prophylaxis. Table 2 shows variance in the VAP care bundles. All 4 units audited compliance with their VAP care bundle with 2 units performing this continuously. Two units were aware of their VAP rate from local audits in the preceding 12 months (12 and 15 VAP cases per 1000 ventilator days). Three units had no strict VAP definition for audit and the remaining ICU used a simplified definition of a patient commenced on antibiotics for chest sepsis 48 hours or more after initiation of invasive mechanical ventilation. Two units audited frequency of causative pathogens, with Enterobacteriaceae being most prevalent in both cases. Two units had an antibiotic treatment policy for VAP. Two units had access to quantitative microbiological results (e.g. CFU/mL) and the remaining 2 used semi-quantitative results (e.g. +, ++, +++) from local laboratories. CONCLUSIONS. This pilot study highlights considerable variation in the management strategies and active surveillance for VAP, even within the same NHS Trust. The methodology used showed good feasibility to carry out a wider national/international VAP study and identify areas of good practice. [Table Presented].

14. Sodium input in intensive care

Authors Samal N.; O'Neill E.; Carpenter M.
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Available at Intensive Care Medicine Experimental from Europe PubMed Central - Open Access

Abstract INTRODUCTION. Sodium is a key electrolyte that is crucial in main-taining homeostasis through the regulation of blood pressure, blood volume, and pH levels. Administration of fluids containing sodium is an essential part of re-suscitation and ongoing care. However, sodium overload is thought to be common in intensive care patients with hypernatraemia occurring in up to 25% of patients during their stay [1], potentially adding further complications to care. OBJECTIVES. To collect the individual daily sodium intake data of all patients on a general UK ICU over a 14-day period. The sodium contents of all fluids, drugs, and nutritional sources was calculated and divided into source categories. Daily weights were recorded to calculate the recommended sodium intake for each patient according to current National Institute for Health and Care Excellence (NICE) guidelines [2]. Serum sodium results, and fluid balance data were also collected. METHODS. Prospective audit of all patients admitted to the ICU, during a 14-day period in January 2018. Data was collected from daily charts, and e-records at the end of a 24-hour period. Sodium content of all fluids, drugs, and nutrition was calculated using electronic Med-icines Compendium, Institute of Food Research/Public Health Eng-land, and British Dietetic Association resources. Patient days were divided into 2 phases; resuscitation and maintenance. Resuscitation was defined as administration of vaso-active therapy at any stage during the 24-hour period. All individual fluid, drug, or nutritional sources totalling less than 1mmol of sodium were excluded. Daily weights were monitored using bed scale readings. RESULTS. 28 patients were reviewed, totalling 158 bed days. Maintenance days: n=116, resuscitation days: n=42. 2/3 of all patients were over the NICE recommended guidelines for sodium intake. The mean sodium intake for the maintenance phase was x1.4 NICE recommendations, with a median of 1.1 (IQR 0.8-1.7). In the resuscitation phase mean average was x2.1, with a median of 1.7 (IQR 1.1-2.3). 18% of all patients were hypernatraemic (>=146 mmol: n=29, >=155 mmol: n=11), and 4/5 of these patients had received more than their recommended daily sodium intake. In the maintenance group 24% of sodium came from fluids, whilst 64% was from nutrition. In comparison, 41% of the sodium in the resuscitation group was from fluid, and 38% from nutrition. In both groups nearly 20% came from other sources with the potential to reduce input. CONCLUSIONS. The majority of intensive care patients receive more than their recommended sodium intake. It may be possible to reduce sodium input from background fluids and nutrition whilst maintaining fluid homeostasis, and protein calorie intake.

15. Outcomes of in-Hospital cardiac arrest in a British District General Hospital

Authors Landymore E.; McLoughlin J.; Morgan P.
Source Intensive Care Medicine Experimental; Oct 2018; vol. 6
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Database EMBASE
Available at Intensive Care Medicine Experimental from ProQuest (Hospital Premium Collection) - NHS Version
Available at Intensive Care Medicine Experimental from Europe PubMed Central - Open Access

Abstract INTRODUCTION. Return of spontaneous circulation following cardiac arrest in the adult population is a common reason for admission into intensive care. It is known that there is a substantial mortality rate following admission even if the patient survived the initial arrest. OBJECTIVES. To compare the outcome of adult in-hospital cardiac arrests at East Surrey Hospital to a national Cardiac Arrest Audit data-base and to also assess outcome by age. METHODS. A retrospective search of a critical care data base of 3576 patients from 03/10/2010 until 02/11/2017 revealed 151 in-hospital adult cardiac arrests that were subsequently admitted to intensive care. RESULTS. The overall unadjusted discharge rate from the intensive care unit (ICU) to the wards was 42.4%. This does not reflect the number that were discharged home or later died on the wards. This rate falls within the rates of survival to discharge from hospital of 10.5% to 49.0% as per a 2014 UK National Cardiac Arrest Audit database [1]. Table 1 shows the discharges to back to the ward following ICU admission categorized by age. CONCLUSION. These results show that the greatest number of ICU admissions post in hospital cardiac arrests peaks in the 8th decade of life. The proportion of patients who survive following in-hospital cardiac arrest decreases with each subsequent decade. This retrospective analysis allows us to better prognosticate and to be able to provide more accurate information to relatives of these patients.

16. Patient selection and attendance/non-attendance at critical care rehabilitation clinic

Authors Morino E.; Ma L.; Allen M.; Dabliz M.
Source Intensive Care Medicine Experimental; Oct 2018; vol. 6
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Publication Type(s) Conference Abstract
Database EMBASE
Available at Intensive Care Medicine Experimental from ProQuest (Hospital Premium Collection) - NHS Version
Available at Intensive Care Medicine Experimental from Europe PubMed Central - Open Access

Abstract INTRODUCTION. Large investments are made during a patient's stay on critical care and their care can only be sustained with good quality care following discharge. Rehabilitating patients discharged from a critical care setting has been recommended by the National Institute for Health and Clinical Excellence (NICE) in 2009 (Clinical Guidance 83)[1]. Non-attendance at these clinics may negatively impact the health of this often vulnerable patient group. OBJECTIVES. Our aims were to review our patient selection methods and processes leading to invitation to our newly-developed multi-disciplinary intensive care rehabilitation clinic over a 6-month period between October 2017 to March 2018. Our purpose was to analyse the frequency and reasons for non-attendance in order to devise strategies to reduce 'Did Not Attend' (DNA) rates in the future. METHODS. Our study took place at Kingston Hospital, Surrey, UK. We retrospectively reviewed the cohort of patients for selection to our clinic based on length of stay in critical care, discharge destination and time since discharge. We reviewed their suitability for invitation to clinic via electronic medical records and contact via general practitioners. We recorded attendance/non-attendance rates and reasons for the latter if these were known if patients informed us prior to clinic or via telephone conversation. RESULTS. When developing the clinic, it was decided that patient would be selected for invitation to clinic if they had been on critical care for longer than 5 days and discharged from hospital. In total, we identified 57 patients eligible for invitation to clinic. Of these, 14 pa-tients (25%) were deemed unsuitable. There were 3 deaths (5%), 2 moved out of area on discharge (4%), and 9 patients (16%) had moved to a nursing home or were too unwell or were hospitalised at the time of the clinic appointment. 43 patients were invited to clinic with a DNA rate of 13 (30%). Reasons given for non-attendance were unknown (41%), did not feel they needed to attend (23%), frailty (12%), transport (12%), and language (12%). CONCLUSIONS. Non-attendance at clinic appointments is a multi-factorial problem. In our study it appeared that a significant propor-tion of patients eligible for invitation to rehabilitation clinic after discharge home were unsuitable due to worsening ill health and frailty. The DNA rate was considerable, and caused by many reasons. Strategies to reduce DNAs in the future may rely on increasing awareness and understanding of the purposes of critical care rehabilitation via leaflets/posters/communication from outreach teams prior to discharge home/social media, as well as administrative processes including electronic text reminders, phone-calls to confirm attendance prior to clinic date, and auditing patient feedback.

17. SMASH! The Salford medication safety dashboard

Authors Williams R.; Keers R.; Gude W.T.; Jeffries M.; Ashcroft D.M.; Davies C.; Brown B.; Peek N.; Kontopantelis E.; Avery A.J.
Source Journal of innovation in health informatics; Oct 2018; vol. 25 (no. 3); p. 183-193
Publication Date Oct 2018
Publication Type(s) Article
PubMedID 30398462
Database EMBASE
Abstract BACKGROUND: Patient safety is vital to well-functioning health systems. A key component is safe prescribing, particularly in primary care where most medications are prescribed. Previous research demonstrated that the number of patients exposed to potentially hazardous prescribing can be reduced by interrogating the electronic health record (EHR) database of general practices and providing feedback to general practitioners in a pharmacist-led intervention. We aimed to develop and roll out an online dashboard application that delivers this audit and feedback intervention in a continuous fashion.
METHOD(S): Based on initial system requirements we designed the dashboard's user interface over 3 iterations with 6 general practitioners (GPs), 7 pharmacists and a member of the public. Prescribing safety indicators from previous work were implemented in the dashboard. Pharmacists were trained to use the intervention and deliver it to general practices.
RESULT(S): A web-based electronic dashboard was developed and linked to shared care records in Salford, UK. The completed dashboard was deployed in all but one (n=43) general practices in the region. By November 2017, 36 pharmacists had been trained in delivering the intervention to practices. There were 135 registered users of the dashboard, with an average of 91 user sessions a week.
CONCLUSION(S): We have developed and successfully rolled out of a complex, pharmacist-led dashboard intervention in Salford, UK. System usage statistics indicate broad and sustained uptake of the intervention. The use of systems that provide regularly updated audit information may be an important contributor towards medication safety in primary care.

18. Assessing antibiotic stewardship using the surgical site infection prevention bundle

Authors Mohamed R.; Wall J.; Arumainathan R.; Fink D.; Sandhu T.; Garg S.; Spiers S.; Hughes J.; Burdett E.
Source British journal of hospital medicine (London, England : 2005); Nov 2018; vol. 79 (no. 11); p. 643-647
Publication Date Nov 2018
Publication Type(s) Article
PubMedID 30418827
Database EMBASE

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Available at British journal of hospital medicine (London, England : 2005) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND:: Antibiotic prophylaxis is crucial in head and neck surgery to prevent infection from clean contaminated wounds. Scottish Intercollegiate Guidelines Network (SIGN) guidance, the gold standard of practice, recommends that administration of broad spectrum antibiotics is discontinued after 24 hours post-operation. A three-audit cycle quality improvement project was conducted to assess clinical practice against SIGN guidance at a large London teaching hospital.
METHOD(S):: Three change initiatives were implemented to improve antibiotic stewardship. First, an update of Trust guidelines with an associated poster campaign to educate staff and improve awareness. Second, introduction of a specific 'prophylactic antibiotics in head and neck surgery' bundle on the electronic hospital-wide prescribing system. Third, an update to an antibiotic prescribing guide (Microguide).
RESULT(S):: Over a 3-year study period the number of patients receiving antibiotics beyond 24 hours declined significantly (88% in 2015, 76% in 2016, 25% in 2018), demonstrating improved compliance with SIGN guidelines overall. Despite this, staff documentation of indications for extended antibiotic use remains suboptimal (58% in 2016 and 44% in 2018) as does the number of specimens sent for microbiological analysis (52% in 2016 and 0% in 2018).
CONCLUSION(S):: Appropriate prophylactic antibiotic prescribing can improve morbidity and mortality rates in head and neck cancer patients. Three change initiatives have been demonstrated which can help to improve prescribing compliance in line with SIGN guidance. Ongoing auditing is required to maintain the longevity of improvements made and encourage staff documentation of indications for extended antibiotic use and microbiology specimen analysis.

19. Quality improvement collaborative aiming for Proactive HEAlthcare of Older People in Care Homes (PEACH): a realist evaluation protocol

Authors Devi R.; Chadborn N.; Hinsliff-Smith K.; Long A.; Usman A.; Gordon A.L.; Meyer J.; Bowman C.; Banerjee J.; Goodman C.; Gladman J.R.F.; Logan P.; Dening T.; Housley G.; Martin F.; Lewis S.
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PubMedID 30420349
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Available at BMJ open from HighWire - Free Full Text

Abstract INTRODUCTION: This protocol describes a study of a quality improvement collaborative (QIC) to support implementation and delivery of comprehensive geriatric assessment (CGA) in UK care homes. The QIC will be formed of health and social care professionals working in and with care homes and will be supported by clinical, quality improvement and research specialists. QIC participants will receive quality improvement training using the Model for Improvement. An appreciative approach to working with care homes will be encouraged through facilitated shared learning events, quality improvement coaching and assistance with project evaluation.
METHODS AND ANALYSIS: The QIC will be delivered across a range of partnering organisations which plan, deliver and evaluate health services for care home residents in four local areas of one geographical region. A realist evaluation framework will be used to develop a programme theory informing how QICs are thought to work, for whom and in what ways when used to implement and deliver CGA in care homes. Data collection will involve participant observations of the QIC over 18 months, and interviews/focus groups with QIC participants to iteratively define, refine, test or refute the programme theory. Two researchers will analyse field notes, and interview/focus group transcripts, coding data using inductive and deductive analysis. The key findings and linked programme theory will be summarised as context-mechanism-outcome configurations describing what needs to be in place to use QICs to implement service improvements in care homes. ETHICS AND DISSEMINATION: The study protocol was reviewed by the National Health Service Health Research Authority (London Bromley research ethics committee reference: 205840) and the University of Nottingham (reference: LT07092016) ethics committees. Both determined that the Proactive HEAlthcare of Older People in Care Homes study was a service and quality improvement initiative. Findings will be shared nationally and internationally through conference presentations, publication in peer-reviewed journals, a graphical illustration and a dissemination video.

20. Renal inpatient ward nurse experience and job satisfaction: A qualitative study

Authors McKenzie A.T.; Addis G.

Source Journal of clinical nursing; Dec 2018; vol. 27 (no. 23); p. 4353-4360
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Abstract AIMS AND OBJECTIVES: To examine the experience of registered nurses working in renal inpatients wards at an acute National Health Service (NHS) hospital Trust. Nurse perceptions of their experience particularly in relation to job satisfaction were analysed. BACKGROUND: Increased understanding of workplace organisation and culture can contribute to improved nurse work experience and better patient care. Worldwide many studies conducted on nurse experience and job satisfaction show that job satisfaction level varies across work settings so analysis of job satisfaction at a local level such as in a ward is important for producing useful analysis and recommendations. METHOD: Using purposive sampling, semistructured individual interviews were conducted on twelve registered nurses working on renal inpatient wards. RESULTS: The study identified three themes: safe care, organisational culture and work environment. Although staffing was identified as a key element to providing safe care maintaining adequate staffing levels remained a challenge. Whilst there were opportunities for professional development more support is needed for newly qualified nurses. CONCLUSIONS: Findings highlighted that renal patients were complex. It is important to maintain adequate staffing levels. Good clinical leadership is required to support and develop the positive experience of nurses. RELEVANCE TO CLINICAL PRACTICE: The high turnover of newly qualified nurses is a particular problem and nurse managers need to develop strategies to retain such nurses. Regular audits on staffing levels as part of improving workforce planning and patient safety need to be conducted.

21. Improving the personalisation of care in a district nursing team: a service improvement project

Authors McKendry M.; Green H.
Source British journal of community nursing; Nov 2018; vol. 23 (no. 11); p. 552-558
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Publication Type(s) Article
PubMedID 30398923
Database EMBASE
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Available at British Journal of Community Nursing from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Service users can benefit in a variety of ways from a personalised approach to care. This service improvement project aimed to improve personalisation for patients being cared for by a community nursing team in the south of England. A plan, study, do, act (PDSA) approach to the project was undertaken with a community nursing team. Both quantitative and qualitative data showed improvement once the focus on personalisation had been improved. Patient and staff satisfaction scores improved and a documentation audit showed the focus on personalisation had increased. Qualitative data suggested that personalisation had also saved staff time, although this measurement was not included in the project. A focus on personalisation can be beneficial for staff and service users.

22. Factors influencing variation in participation in the National Diabetes Audit and the impact on the Quality and Outcomes Framework indicators of diabetes care management

Authors Wright C.E.; Yeung S.; Knowles H.; Woodhouse A.; Evans S.; Barron E.
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Database EMBASE

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Available at BMJ Open Diabetes Research & Care from HighWire - Free Full Text

Abstract Objective Participation in the National Diabetes Audit (NDA) has become a contractual requirement for all general practices in England and is used as part of the assessment framework for sustainability and transformation partnership (STP) footprints. The study aimed to investigate general practice-related factors which may influence participation in the NDA, and the impact that participation in the NDA may have on diabetes management and patient care. Research design A cross-sectional analysis of routine primary care data from 45 725 646 patients aged 17+ years registered across 7779 general practices in England was performed using logistic regression. The main outcome measures included general practice voluntary participation in the NDA, general practice-related factors (practice size, deprivation, diabetes prevalence, geographic area, practice population age) and diabetes management outcomes (cholesterol, blood pressure, hemoglobin A1c (HbA1c)). Results Participation in the NDA differed significantly according to practice size (t(7653)=-9.93, p=0.001), level of deprivation (xi^2 (9)=36.17, p<0.0001), diabetes prevalence (p<0.0001), practice population age (p<0.0001), and geographic area (xi^2 (26)=676.9, p<0.0001). In addition, the Quality and Outcomes Framework diabetes indicator HbA1c (OR 1.01, CI 1.0 to 1.01, p=0.0001) but not cholesterol (p=0.055) or blood pressure (p=0.76) was independently associated with NDA participation when controlling for practice-related factors. Conclusion Variation in NDA participation exists. It is suggested that some practices may need additional support when submitting data to the NDA and that NDA participation may have an impact on diabetes outcomes. However, the use of NDA outcomes as a measure of progress with diabetes care by STPs is still unclear and further investigation is needed.

23. Proceedings from 'Clinical Audit in Retina 2017': summaries and discussion: Crowne Plaza, Birmingham City Centre, UK; Wednesday 28 June 2017

Authors anonymous
Source Eye (Basingstoke); Nov 2018; vol. 32 ; p. 2-7
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24. Proceedings from 'Clinical Audit in Retina 2017': Chairman's introduction

Authors Mushtaq B.
Source Eye (Basingstoke); Nov 2018; vol. 32
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Publication Type(s) Editorial
PubMedID 30390027
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Available at Eye (London, England) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Eye (London, England) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

25. Use of acronyms in anaesthetic and associated investigations: appropriate or unnecessary? - the UOAIAAAIAOU Study

Authors Weale J.; Soysa R.; Yentis S.M.
Source Anaesthesia; Dec 2018; vol. 73 (no. 12); p. 1531-1534
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Abstract We examined the prevalence of novel acronyms in the titles of anaesthetic and related studies and the response of anaesthetists to them. We separately analysed trainee-led research projects in the UK supported by the Research and Audit Federation of Trainees (RAFT), and a 10-year cohort of papers identified using the PubMed literature search tool. We also conducted a survey of 20 anaesthetists within our institution regarding the utility and impact of titles containing acronyms, and their recall of the associated topics. Finally, we developed a scoring system for acronym accuracy and complexity, the ORigin of AcroNym letterinG Used Term AppropriateNess (ORANGUTAN) score, and measured the progression of acronym usage over the 10-year period studied. Our results show that while acronyms themselves are sometimes considered memorable, they do not aid recall of topics and are, in general, not considered helpful. There has been an increase in the prevalence of acronymic titles over 10 years, and in the complexity of acronyms used, suggesting that there is currently a selective pressure favouring the use of acronyms even if they are of limited benefit.

26. The link between data integrity and quality culture

Authors Schniepp S.
Source Pharmaceutical Technology Europe; Oct 2018; vol. 30 (no. 10)
Publication Date Oct 2018
Publication Type(s) Short Survey
Database EMBASE
Available at Pharmaceutical Technology Europe from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

27. The colorectal surgeon's personality may influence the rectal anastomotic decision

Authors Moug S.J.; Bisset C.N.; Henderson N.; Tiernan J.; Ferguson E.; Harji D.; Maxwell-Armstrong C.; MacDermid E.; Acheson A.G.; Steele R.J.C.; Fearnhead N.S.; Abbott S.; Adedeji O.; Anderson R.; Armstrong A.; Arnott B.; Arthur L.M.; Bharathan B.; Campbell K.; Chapman M.; Chaudhri S.; Cook T.; Cope A.; Davies J.; Dworkin M.; Dawson P.; Durai R.; El-Masry S.; Harikrishnan A.; Hawkin P.; Helley M.; Hompes R.; Jayne D.; Kapur S.; Kelly S.; Kumar S.; Lacy-Colson J.; Lieske B.; Maw A.; McDermott F.; McLennan E.; McNair A.; Miles A.; Muhammed A.; McNaught C.; Noyes A.; Payne C.; Peel N.; Perthiani H.K.; Poh A.; Rajagopal R.; Roe A.; Sagar P.; Saunders M.; Scarpinata R.; Secker A.; Senapati A.; Shah P.; Sharif H.; Simpson A.; Skaife P.; Smart N.; Sultan S.; Thomson J.; Tilney H.; Vasey C.; Verjee A.; Wheeler J.; Williams N.; Wright J.
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Database EMBASE
Available at Colorectal disease : the official journal of the Association of Coloproctology of Great Britain and Ireland from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at Colorectal disease : the official journal of the Association of Coloproctology of Great Britain and Ireland from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Colorectal disease : the official journal of the Association of Coloproctology of Great Britain and Ireland from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Aim: Colorectal surgeons regularly make the decision to anastomose, defunction or form an end colostomy when performing rectal surgery. This study aimed to define personality traits of colorectal surgeons and explore any influence of such traits on the decision to perform a rectal anastomosis. Method: Fifty attendees of The Association of Coloproctology of Great Britain and Ireland 2016 Conference participated. After written consent, all underwent personality testing: alexithymia (inability to understand emotions), type of thinking process (intuitive versus rational) and personality traits (extraversion, agreeableness, openness, emotional stability, conscientiousness). Questions were answered regarding anastomotic decisions in various clinical scenarios and results analysed to reveal any influence of the surgeon's personality on anastomotic decision. Results: Participants were: male (86%), consultants (84%) and based in England (68%). Alexithymia was low (4%) with 81% displaying intuitive thinking (reflex, fast). Participants scored higher in emotional stability (ability to remain calm) and conscientiousness (organized, methodical) compared with population norms. Personality traits influenced the next anastomotic decision if: surgeons had recently received criticism at a departmental audit meeting; were operating with an anaesthetist that was not their regular one; or there had been no anastomotic leaks in their patients for over 1 year. Conclusion: Colorectal surgeons have speciality relevant personalities that potentially influence the important decision to anastomose and could explain the variation in surgical practice across the UK. Future work should explore these findings in other countries and any link of personality traits to patient-related outcomes.

28. Proceedings from 'Clinical Audit in Retina 2017': Meeting Abstracts : Crowne Plaza, Birmingham City Centre, UK; Wednesday 28 June 2017

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Available at Eye (London, England) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

29. Patient preferences in tinnitus outcomes and treatments: a qualitative study

Authors Pryce H.; Hall A.; Culhane B.-A.; Swift S.; Claesen B.; Shaw R.; Straus J.
Source International journal of audiology; Oct 2018; vol. 57 (no. 10); p. 784-790
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Database EMBASE
Abstract In order to identify patient preferences in care for tinnitus an in depth grounded theory study was conducted. This consisted of interviews with 41 patients who had sought help for tinnitus across a range of locations and tinnitus services in England. Preferences for outcomes were for both the removal of the tinnitus and for improved coping and management of the tinnitus. Preferences for treatment were for individualized care, tailored information and for treatment to assist with psychological adjustment and auditory distraction. Adoption of treatments to manage tinnitus were based on a trial and error approach. Patients? preferences for individual treatments varied but were informed by the information they received. Information plays an important role in care for people with tinnitus. Patients hold individual preferences and require engagement in shared decision making.

30. Explaining organisational responses to a board-level quality improvement intervention: Findings from an evaluation in six providers in the English National Health Service

Authors Jones L.; Pomeroy L.; Morris S.; Capelas Barbosa E.; Fulop N.J.; Robert G.; Anderson J.E.; Burnett S.
Source BMJ Quality and Safety; 2018
Publication Date 2018
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Database EMBASE
Available at BMJ quality & safety from BMJ Journals - NHS

Abstract Background: Healthcare systems worldwide are concerned with strengthening board-level governance of quality. We applied Lozeau, Langley and Denis' typology (transformation, customisation, loose coupling and corruption) to describe and explain the organisational response to an improvement intervention in six hospital boards in England. Methods: We conducted fieldwork over a 30-month period as part of an evaluation in six healthcare provider organisations in England. Our data comprised board member interviews (n=54), board meeting observations (24 hours) and relevant documents. Results: Two organisations transformed their processes in a way that was consistent with the objectives of the intervention, and one customised the intervention with positive effects. In two further organisations, the intervention was only loosely coupled with organisational processes, and participation in the intervention stopped when it competed with other initiatives. In the final case, the intervention was corrupted to reinforce existing organisational processes (a focus on external regulatory requirements). The organisational response was contingent on the availability of 'slack' - expressed by participants as the 'space to think' and 'someone to do the doing' - and the presence of a functioning board. Conclusions: Underperforming organisations, under pressure to improve, have little time or resources to devote to organisation-wide quality improvement initiatives. Our research highlights the need for policy-makers and regulators to extend their focus beyond the choice of intervention, to consider how the chosen intervention will be implemented in public sector hospitals, how this will vary between contexts and with what effects. We provide useful information on the necessary conditions for a board-level quality improvement intervention to have positive effects.

31. Transparency of the UK medicines regulator: Auditing freedom of information requests and reasons for refusal

Authors Grigg S.E.; O'Sullivan J.W.; Goldacre B.; Heneghan C.
Source BMJ Evidence-Based Medicine; 2018
Publication Date 2018
Publication Type(s) Article In Press
Database EMBASE

32. The Guideline-Policy Gap in Direct-Acting Oral Anticoagulants Usage in Atrial Fibrillation: Evidence, Practice, and Public Policy Considerations

Authors Wan D.; Simpson C.S.; Healey J.S.
Source Canadian Journal of Cardiology; Nov 2018; vol. 34 (no. 11); p. 1412-1425
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Available at Canadian Journal of Cardiology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Canadian Journal of Cardiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Atrial fibrillation has a high disease burden-both in prevalence and associated consequences. Despite anticoagulation being an effective treatment in atrial fibrillation, stroke prevention is slow to reflect evidence-based practice. Real-world data reveal a substantial portion of patients who would benefit from anticoagulation, yet do not receive it adequately or at all. A large part of this suboptimal treatment is due to the underutilization of direct oral anticoagulants (DOACs). In response to abundant evidence published over a short timeframe, international guidelines have adopted DOAC usage ahead of policy and fund holders. This paper reviews the evidence and values that influence published guidelines, patient-physician decision making, and policy framework on DOAC usage. An important factor is the access gap between patients who qualify for DOAC according to evidence-based guidelines and the subset of this cohort who are eligible for DOAC based on government funded policy. We analyse the Canadian health system in detail-including drug approval and funding process. Health care systems in other countries are explored, with emphasis on similar universal health care systems that may help overcome barriers common to Canada. We will discuss strategies to: (1) improve awareness of the risk and preventability of stroke; (2) enable physicians to provide evidence-based DOAC usage; (3) empower patients to improve adherence and persistence; (4) collect real-life data that encourages patient self-monitoring, physician outcomes auditing, and building evidence that is useful for policy makers; and (5) use postmarketing data in negotiating shared risk management between pharmaceuticals and government to improve access to DOACs.

33. Letters: What tasks can physicians delegate to pharmacists?

Authors Yeung E.Y.H.; Mohammed R.S.D.
Source British Journal of General Practice; Nov 2018; vol. 68 (no. 676); p. 519
Publication Date Nov 2018

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Available at The British journal of general practice : the journal of the Royal College of General Practitioners from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

34. Audit of COPD exacerbations in secondary care

Authors anonymous
Source Drug and Therapeutics Bulletin; Nov 2018; vol. 56 (no. 11); p. 129
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Available at Drug and therapeutics bulletin from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

35. Open tibial fractures in major trauma centres: A national prospective cohort study of current practice

Authors Young K.; Aquilina A.; Costa M.L.; Chesser T.J.S.; Kelly M.B.; Hettiaratchy S.; Moran C.G.; Pallister I.; Woodford M.
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Database EMBASE
Available at Injury from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Injury from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract Aims: To assess current national practice in the management of severe open tibial fractures against national standards, using data collected by the Trauma and Audit Research Network. Materials and methods: Demographic, injury-specific, and outcome data were obtained for all grade IIIB/C fractures admitted to Major Trauma Centres in England from October 2014 to January 2016. Results: Data was available for 646 patients with recorded grade IIIB/C fractures. The male to female ratio was 2.3:1, mean age 47 years. 77% received antibiotics within 3 h of admission, 82% were debrided within 24 h. Soft tissue coverage was achieved within 72 h of admission in 71%. The amputation rate was 8.7%. 4.3% of patients required further theatre visits for infection during the index admission. The timing of antibiotics and surgery could not be correlated with returns to theatre for early infection. There were significant differences in the management and outcomes of patients aged 65 and over, with an increase in mortality and amputation rates. Conclusions: Good outcomes are reported from the management of IIIB/C fractures in Major Trauma Centres in England. Overall compliance with national standards is particularly poor in the elderly. Compliance did not appear to affect rates of returning to theatre or early infection. Appropriately applied patient reported outcome measures are needed to enhance the evidence-base for management of these injuries.

36. How do hospitals respond to feedback about blood transfusion practice? A multiple case study investigation

Authors Gould N.J.; Lorencatto F.; During C.; Francis J.J.; Michie S.; Rowley M.; Glidewell L.; Foy R.; Walwyn R.; Stanworth S.J.; Grimshaw J.M.
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Available at PloS one from EBSCO (MEDLINE Complete)

Abstract National clinical audits play key roles in improving care and driving system-wide change. However, effects of audit and feedback depend upon both reach (e.g. relevant staff receiving the feedback) and response (e.g. staff regulating their behaviour accordingly). This study aimed to investigate which hospital staff initially receive feedback and formulate a response, how feedback is disseminated within hospitals, and how responses are enacted (including barriers and enablers to enactment). Using a multiple case study approach, we purposively sampled four UK hospitals for variation in infrastructure and resources. We conducted semi-structured interviews with staff from transfusion-related roles and observed Hospital Transfusion Committee meetings. Interviews and analysis were based on the Theoretical Domains Framework of behaviour change. We coded interview transcripts into theoretical domains, then inductively identified themes within each domain to identify barriers and enablers. We also analysed data to identify which staff currently receive feedback and how dissemination is managed within the hospital. Members of the hospital's transfusion team initially received feedback in all cases, and were primarily responsible for disseminating and responding, facilitated through the Hospital Transfusion Committee. At each hospital, key individuals involved in prescribing transfusions reported never having received feedback from a national audit. Whether audits were discussed and actions explicitly agreed in Committee meetings varied between hospitals. Key enablers of action across all cases included clear lines of responsibility and strategies to remind staff about recommendations. Barriers included difficulties disseminating to relevant staff and needing to amend feedback to make it appropriate for local use. Appropriate responses by hospital staff to feedback about blood transfusion practice depend upon supportive infrastructures and role clarity. Hospitals could benefit from support to disseminate feedback systematically, particularly to frontline staff involved in the behaviours being audited, and practical tools to support strategic decision-making (e.g. action-planning around local response to feedback).

37. A preliminary audit of medical and aid provision in English Rugby union clubs: compliance with Regulation 9

Authors Wing K.; Bailey H.J.; Gronek P.; Podstawski R.; Clark C.C.T.
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Available at Irish journal of medical science from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Irish journal of medical science from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Governing bodies are largely responsible for the monitoring and management of risks associated with a safe playing environment, yet adherence to regulations is currently unknown. The aim of this study was to investigate and evaluate the current status of medical personnel, facilities, and equipment in Rugby Union clubs at regional level in England. Methods: A nationwide cross-sectional survey of 242 registered clubs was undertaken, where clubs were surveyed online on their current medical personnel, facilities, and equipment provision, according to regulation 9 of the Rugby Football Union (RFU). Results: Overall, 91 (45. 04%) surveys were returned from the successfully contacted recipients. Of the completed responses, only 23.61% (n = 17) were found to be compliant with regulations. Furthermore, 30.56% (n = 22) of clubs were unsure if their medical personnel had required qualifications; thus, compliance could not be determined. There was a significant correlation (p = -0.029, r = 0.295) between club level and numbers of practitioners. There was no significant correlation indicated between the number of practitioners/number of teams and number of practitioners/number of players. There were significant correlations found between club level and equipment score (p = 0.003, r = -0.410), club level and automated external defibrillator (AED) access (p = 0.002, r = -0.352) and practitioner level and AED access (p = 0.0001, r = 0.404). Follow-up, thematic analysis highlighted widespread club concern around funding/cost, awareness, availability of practitioners and AED training. Conclusion: The proportion of clubs not adhering overall compliance with Regulation 9 of the RFU is concerning for player welfare, and an overhaul, nationally, is required.

38. Developing a learning health system: Insights from a qualitative process evaluation of a pharmacist-led electronic audit and feedback intervention to improve medication safety in primary care

Authors Jeffries M.; Keers R.N.; Phipps D.L.; Ashcroft D.M.; Williams R.; Brown B.; Avery A.J.; Peek N.
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Available at PloS one from Europe PubMed Central - Open Access
Available at PloS one from Public Library of Science (PLoS)
Available at PloS one from EBSCO (MEDLINE Complete)

Abstract Introduction Developments in information technology offer opportunities to enhance medication safety in primary care. We evaluated the implementation and adoption of a complex pharmacist-led intervention involving the use of an electronic audit and feedback surveillance dashboard to identify patients potentially at risk of hazardous prescribing or monitoring of medicines in general practices. The intervention aimed to create a rapid learning health system for medication safety in primary care. This study aimed to explore how the intervention was implemented, adopted and embedded into practice using a qualitative process evaluation. Methods Twenty two participants were purposively recruited from eighteen out of forty-three general practices receiving the intervention as well as clinical commissioning group staff across Salford UK, which reflected the range of contexts in which the intervention was implemented. Interviews explored how pharmacists and GP staff implemented the intervention and how this affected care practice. Data analysis was thematic with emerging themes developed into coding frameworks based on Normalisation Process Theory (NPT). Results Engagement with the dashboard involved a process of sense-making in which pharmacists considered it added value to their work. The intervention helped to build respect, improve trust and develop relationships between pharmacists and GPs. Collaboration and communication between pharmacists and clinicians was primarily initiated by pharmacists and was important for establishing the intervention. The intervention operated as a rapid learning health system as it allowed for the evidence in the dashboard to be translated into changes in work practices and into transformations in care. Conclusions Our study highlighted the importance of the combined use of information technology and the role of pharmacists working in general practice settings. Medicine optimisation activities in primary care may be enhanced by the implementation of a pharmacist-led electronic audit and feedback system. This intervention established a rapid learning health system that swiftly translated data from electronic health records into changes in practice to improve patient care. Using NPT provided valuable insights into the ways in which developing relationships, collaborations and communication between health professionals could lead to the implementation, adoption and sustainability of the intervention.

39. Validation of the LITHUANIAN version of the 19-item audit of diabetes dependent quality of life (ADDQOL - LT) questionnaire in patients with diabetes

Authors Visockiene Z.; Narkauskaite-Nedzinskiene L.; Puronaite R.; Mikaliukstiene A.
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Available at Health and quality of life outcomes from ProQuest (Hospital Premium Collection) - NHS Version
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Available at Health and quality of life outcomes from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUND: Currently there is no diabetes-specific quality of life (QOL) instrument available in Lithuanian language. We aimed to develop a Lithuanian version of a widely-used individualised instrument - the Audit of Diabetes Dependent Quality of Life questionnaire (ADDQOL-19) and assess the validity and reliability in patients with type 1 and type 2 diabetes mellitus (DM).METHODS: This study was conducted at the Primary Care and Endocrinology Outpatient Clinics in Vilnius. The ADDQOL was translated from the original English (UK) into Lithuanian using a standardized methodology of forward and back translation. After cognitive "debriefing" the validity and reliability of LT-ADDQOL questionnaire were assessed in a sample of 138 diabetes patients. Cronbach's alpha coefficient, factor analysis, independent t tests and ANOVA were used.RESULTS: There were 106 participants with type 2 and 32 with type 1 DM included in the study with a mean age of 55.5 years (+/- 14.5) and 56.2% women. The Cronbach's alpha coefficient was 0.908 and most of items loading values onto one single factor were larger than 0.40 (varied from 0.41 to 0.77), indicating good internal consistency and reliability of instrument.CONCLUSIONS: We developed the Lithuanian version of ADDQOL-19 which is a valid and reliable instrument to measure impact of diabetes on QOL. It could be further used by clinicians and researchers for comprehensive assessment of QOL in adults with diabetes.

40. Epidemic of (meth)acrylate allergic contact dermatitis in the UK requires change in baseline patch test series

Authors Rolls S.
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Available at Contact Dermatitis from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Contact Dermatitis from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract (Meth)acrylates are potent sensitizers and a common cause of allergic contact dermatitis (ACD). The frequency of (meth)acrylate ACD has increased recently with soaring demand for acrylic nails. (Meth)acrylates are not yet routinely tested in the baseline patch test series in the UK although recently there has been a proposal that 2-hydroxyethyl methacrylate (2-HEMA) be added to the European baseline series. The European Society of Contact Dermatitis (ESCD) suggests that an allergen might be included in the baseline series when the proportion of consecutively patch tested patients with a positive test to a specific allergen exceeds 0.5-1.0%. Our preliminary retrospective audit in 9 UK dermatology centres between 2008 and 2015 found the frequency of sensitization to any (meth)acrylate to be a minimum of 1.3%; and to 2-HEMA to be 0.7%. Patients had been selectively patch tested to (meth)acrylates based on history of exposure, therefore the true rate of sensitization to 2-HEMA remains unknown. We performed a prospective multicentre audit, including 2-HEMA (2% in petrolatum (pet.)) in an extended baseline series in 11 UK dermatology centres over a fifteen month period, from December 2016 to March 2018. Patients with a history of (meth)acrylate exposure, or who tested positive to 2-HEMA, were selectively tested with a series of eight (meth)acrylate allergens. A total of 4667 patients were tested, of whom 540 were also tested to the acrylate series. 79 of 4667 (1.7%) tested positive to 2-HEMA and 103 (2.2%) to at least one (meth)acrylate. Had 2-HEMA been excluded from the baseline series, 26 (0.6% of 4667) (meth)acrylate positive patients would have been missed. The top (meth)acrylates eliciting a positive reaction were 2-HEMA (n=79; 1.7%), 2-hydroxypropy methacrylate (n=53; 1.1%) and ethylene glycol dimethacrylate (n=48; 1%). We have shown an increase in the number of (meth)acrylate ACD cases identified when 2-HEMA is included in the baseline series, rather than relying on a history of (meth)acrylate exposure. Had 2-HEMA not been added, treatable cases of (meth)acrylate ACD would have been missed. We believe that such patients remain undiagnosed in many UK dermatology units. We recommend that 2-HEMA 2% pet. be added to an extended British baseline patch test series. We also suggest a standardized short (meth)acrylate series, including the most popular (meth)acrylates to test positive, which is likely to detect most cases of (meth)acrylate ACD.

41. Tobacco Addiction In Secondary Prevention: Results From Euroaspire V Coronary Patients' Survey of CVD Prevention and Diabetes From 27 European Regions

Authors Jennings C.S.; Kotseva K.; Wood D.; De Bacquer D.; De Backer G.; Ryden L.; Grobbee D.E.; Marques-Vidal P.; Hoes A.W.; Maggioni A.
Source Global Heart; Dec 2018; vol. 13 (no. 4); p. 464
Publication Date Dec 2018
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Introduction: The EUROASPIRE (EA) surveys of preventive care in coronary and high risk patients have been conducted since 1996.They provide an audit of guideline implementation for prevention of CVD in primary and secondary care (SC). Objectives: The EUROASPIRE V survey conducted in secondary care (SC) investigated lifestyle and risk factor management in patients following an acute coronary event. Amongst other factors, tobacco use and cessation was investigated. Methods: Patients >= 18 and <80 years of age in selected geographical areas across 27 regions, 6 months to 2 years following a cardiac event, were identified consecutively and retrospectively from hospital records and invited for interview and measurement of lifestyle, risk factors and prescribed medications. Current self reported smoking status was validated by breath CO > 10ppm. Results: 8261 patients (26% females) were interviewed (participation rate 51%), mean age 63.6 and 57% educated to secondary school level. Overall smoking prevalence was 18.7%, with regions varying from between 8.6% - 9.7% in Sweden, UK and Finland and up to between 26% - 28.9% in Turkey, Bulgaria and Egypt. Prevalence was higher in patients < 50 years old (32.8 v 17.2%) and in men compared to women (20.7 v. 12.8%). 54.6% were persistent smokers and this did not differ significantly with gender. 46.6% reported an intention to quit in the next 6 months. This was lowest in women under 50 years (31.8%). In those smoking at the time of their event, 49% had made a successful quit attempt, 37.6% had tried reduction. Small numbers had accessed specialist (5.2%) or pharmacological support: NRT 7.1%; Bupropion 1.4%; varenicline 2.4%. Conclusion: The prevalence of smoking in coronary patients varies considerably between European regions, being highest in countries where public health legislation on tobacco is weakest. Prevalence is highest in men and younger patients. More than half of coronary patients are persistent smokers. Although almost half of current smokers intend to quit, specialist and pharmacological support is not provided for most of them. The potential to help more patients quit smoking is not being realised in clinical practice. Disclosure of Interest: None declared

42. VeggieMaths: Exposing children to vegetables using arithmetic in a fun mobile application

Authors Farrow C.; Hakobyan L.; Coulthard H.; Haycraft E.; Lumsden J.; Thomas J.
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Abstract Greater consumption of vegetables is associated with the prevention of chronic illnesses in later life, but fewer than 1 in 10 children in the UK consume the recommended amounts of vegetables. Many children will reject vegetables on sight and multiple exposures are needed to encourage children to become familiar with, taste and like them. This can be disheartening, expensive and time consuming for families. We have conducted focus groups and interviews with parents, teachers and children (N=10) to discuss their views on integrating strategies to support vegetable intake within an educational platform. The findings suggest that parents would welcome such a resource, particularly one that is advertisement free, visually and auditorily engaging and based around the national curriculum. Based on this knowledge we are developing a free mobile application called 'VeggieMaths'. Parents, teachers and childcare staff will be able to use this app to increase children's familiarity with vegetables whilst at the same time supporting their arithmetical skills. The app draws on psychological research to integrate different methods which have been shown to increase interest in vegetables, and eagerness to try them (e.g., exposure, rewards and social norms). The app combines visual exposure to vegetables with maths-tasks; making it a potentially useful tool for parents and educators wanting to support children with healthy eating and maths. Funding: The development of VeggieMaths is funded by the British Psychological Society as part of a Public Engagement Grant to support public engagement with Psychology. VeggieMaths will be free from marketing and the authors make no financial gain from the product.

43. Management of peripheral arterial disease in diabetes: a national survey of podiatry practice in the United Kingdom

Authors Normahani P.; Standfield N.J.; Jaffer U.; Mustafa C.; Duguid C.; Fox M.
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Available at Journal of foot and ankle research from Unpaywall

Abstract Background: We aimed to investigate podiatry practice in diagnosing peripheral arterial disease (PAD) in diabetes, decision making once PAD is suspected and limitations of referral pathways.Methods: A survey, comprising 26 questions was distributed to podiatrists across the UK via mailing lists of collaborating organizations including the College of Podiatry (UK). Response rates were estimated based on NHS workforce data. Analysis of responses from the open-ended questions was performed using inductive content analysis.Results: Data from 283 respondents were analyzed. Response rate for all NHS podiatrists across the UK was estimated to be 6%. For the detection of arterial disease only 18.8% (n=49/260) of participants reported using a full combination of history, pulse palpation, Doppler and ABPI assessment. Self-reported confidence in detecting arterial disease was highest amongst podiatrists who felt they had received adequate training compared to podiatrists who felt they had not (median 85 (IQR 75-90) vs 67 (50-77), respectively; p<0.001) as well as those who see >20 diabetic patients per week compared to those who see <20 (median 80 (IQR 70-90) vs 72 (60-82.8), respectively; p<0.001). Over one third of respondents (35.8%, n=93/260) were aware of missed cases of PAD in the past year and 17.5% (n=38/217) believed that this resulted in an amputation in some cases.The survey highlighted a lack of clarity amongst podiatrists regarding referral guidelines. Additionally, 69% (n=169/242) reported that their patients had to wait longer than 2-weeks for specialist vascular assessment and 67.6% (n=54/80) reported similar waits for a Duplex Ultrasound scan. There was a statistically significant variation in DUS waiting time across the UK (X2 (10, N=80)=21.59, p=0.017). Inability to make a direct referral to vascular services and long delays were reported as major limitations of the referral pathway.Conclusion: We have identified important targets for further investigation and quality improvement.

44. NHS in Scotland is "not financially sustainable," auditors warn

Authors Christie B.
Source BMJ (Clinical research ed.); Oct 2018; vol. 363
Publication Date Oct 2018
Publication Type(s) Article
PubMedID 30361299
Database EMBASE
Available at BMJ (Clinical research ed.) from BMJ Journals - NHS

45. An evaluation of the TARGET (Treat Antibiotics Responsibly; Guidance, Education, Tools) Antibiotics Toolkit to improve antimicrobial stewardship in primary care-is it fit for purpose?

Authors Jones L.F.; Hawking M.K.D.; Owens R.; Lecky D.; McNulty C.A.M.; Francis N.A.; Gal M.; Butler C.
Source Family Practice; 2018; vol. 35 (no. 4); p. 461-467
Publication Date 2018
Publication Type(s) Article
Database EMBASE
Available at Family Practice from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Family Practice from Unpaywall

Abstract Background. The TARGET (Treat Antibiotics Responsibly; Guidance, Education, Tools) Antibiotics Toolkit aims to improve antimicrobial prescribing in primary care through guidance, interactive workshops with action planning, patient facing educational and audit materials. Objective. To explore GPs', nurses' and other stakeholders' views of TARGET. Design. Mixed methods. Method. In 2014, 40 UK GP staff and 13 stakeholders participated in interviews or focus groups. We analysed data using a thematic framework and normalization process theory (NPT). Results. Two hundred and sixty-nine workshop participants completed evaluation forms, and 40 GP staff, 4 trainers and 9 relevant stakeholders participated in interviews (29) or focus groups (24). GP staffs were aware of the issues around antimicrobial resistance (AMR) and how it related to their prescribing. Most participants stated that TARGET as a whole was useful. Participants suggested the workshop needed less background on AMR, be centred around clinical cases and allow more action planning time. Participants particularly valued comparison of their practice antibiotic prescribing with others and the TARGET Treating Your Infection leaflet. The leaflet needed greater accessibility via GP computer systems. Due to time, cost, accessibility and competing priorities, many GP staff had not fully utilized all resources, especially the audit and educational materials. Conclusions. We found evidence that the workshop is likely to be more acceptable and engaging if based around clinical scenarios, with less on AMR and more time on action planning. Greater promotion of TARGET, through Clinical Commissioning Group's (CCG's) and professional bodies, may improve uptake. Patient facing resources should be made accessible through computer shortcuts built into general practice software.

46. Organisation de la prise en charge de la neurofibromatose de type 2 en AngleterreNeurofibromatosis type 2 service delivery in England

Authors Lloyd S.K.; Evans D.G.
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Available at Neurochirurgie from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Neurofibromatosis type 2 (NF2) is a complex disease characterized by the development of multiple schwannomas, especially vestibular schwannomas, as well as other types of benign tumours including meningioma and spinal ependymoma. Due to its multisystem nature, the management of NF2 requires a multidisciplinary approach. In England, the delivery of care for NF2 patients has been centralized to four-"hub" centres in Manchester, Cambridge, Oxford and London each having associated "spoke" centres. Each centre has a core multidisciplinary team consisting of genetics, otolaryngology, neurosurgery, paediatrics, neurology, audiology, radiology, psychology, physiotherapy, specialist nurses and administrative staff. In addition, the core team has access to plastic surgery, ophthalmology, peripheral nerve surgery and adult and paediatric oncology. There are weekly multidisciplinary clinics each with six to eight patients. Each patient is discussed during a team meeting and the management decisions that are made are then discussed with the patients. All patients are reviewed at least annually and have annual head magnetic resonance imaging (MRI) and three yearly spinal MRI. Annual audiological assessment is performed. Cochlear implantation and auditory brainstem implantation are offered if indicated. Surgery, stereotactic radiosurgery and bevacizumab therapy are available for the management of intracranial and spinal tumours. The integration of the service in England has provided significant benefits to patient care and, in the long term, will provide robust patient outcome data that will provide an evidence base to assist in optimizing management of patients with NF2.

47. Each baby counts: Driving improvements in frontline care with centralised analysis of incident reports

Authors Morris E.
Source International Journal of Gynecology and Obstetrics; Oct 2018; vol. 143 ; p. 59
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Abstract Each Baby Counts is the RCOG's national quality improvement programme to reduce the number of babies who die, or are left with severe disability, as a result of incidents occurring during term labour. The aim of this project is to reduce by 50% the incidence of stillbirth, neonatal death and severe brain injury as a result of incidents during term labour by 2020. In the UK stillbirths, neonatal deaths and brain injuries occurring due to incidents in labour are initially investigated at a local level. But what makes the Each Baby Counts programme so different is that it brings together the results of these local investigations to understand the bigger picture and share the lessons learned. The results presented are based on analysis of the data submitted along with in-depth thematic analysis of several key topics. The presentation will highlight the methodology used, the initial findings and the plans the team and the RCOG have for really making a difference in the UK. We will also show our initial implementation package. Whilst our plans have very much been centred on the UK it has become clear that several countries are now interested in our project. The team will be happy to answer questions about Each Baby Counts. We are committed to ensure that each baby receives the safest possible care during labour.

48. Using the power of big data sets to optimise decisions and improve outcomes

Authors Morris E.
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Abstract The RCOG has worked hard over past years to use routinely collected data to improve the safety and quality of care for women and to aid the design of safe and efficient women's health services. The main drivers to perform this work have been the fact that there is a readily available pool of high quality national data on interventions and outcomes along with data held within NHS Trust Maternity information systems. The RCOG's first project in this area was the "Maternity indicators project". The first report presented a set of clinically relevant and technically robust indicators, developed from Hospital Episode Statistics, by a panel of clinical and methodological experts. What made the methodology unique in comparison to previous reports was that the data were risk adjusted to enable more robust comparisons between units. The main outcome of the second report revealed that NHS maternity units in England were achieving similar outcomes but that there were large degrees of variation in some areas of practice. Following this the RCOG and key collaborators were commissioned by HQIP (the Healthcare Quality Improvement Partnership) to perform a much larger project using similar methodology but using information from NHS Trust Maternity Information Systems in addition to a high quality survey of the organisation of the resources used by Trusts to deliver maternity care. In 2017 the RCOG were pleased to launch the first National Maternity and Perinatal Audit (NMPA) Organisational and clinical reports. The data provided in this presentation are only a fraction of the data we have obtained from every Trust in the UK in over 700 000 deliveries in one year. The project is ongoing and a demonstration of the NMPA website will be performed during this presentation.

49. Vaginal repair for pelvic organ prolapse: Where are we now?

Authors Su T.-H.
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Abstract Pelvic organ prolapse (POP) is not an uncommon disorder, and the lifetime risk of undergoing surgical intervention is around 10%. The risk of recurrent prolapse was estimated to be as high as 30% to 50% after traditional vaginal repairs. As a result, prosthetic mesh implants were developed to enforce the weakened pelvic floor [1]. The use of mesh in pelvic organ reconstructive surgery became popular in the past decade until serious complications related with mesh in 2008 when FDA issued the warnings regarding vaginal mesh repairs and declared the complications of vaginal mesh procedures were not rare, such as urinary tract symptoms, postoperative sexual dysfunction, bladder or bowel injuries, infection, mesh erosion, and so on. Although the systemic reviews of randomized trials supporting the benefit of anatomic cure for anterior compartment prolapse, the functional outcomes and quality of life for patients were similar [2]. There was no evidence showing the benefit of using vaginal prosthetic mesh outweighing the risks of its associated complications. As a result, it is advised that transvaginal mesh has limited utility in primary surgery [2]. In late 2017 and early 2018, mesh ban was proposed in several countries including United Kingdom, Scotland, Australia, and New Zealand. Although some professional societies (such as AUGS, ACOG and so on.) supported mesh sling is standard treatment and advisable for stress incontinence; however, the slings were involved in litigations even more than mesh kits for prolapse [3]. The mesh sling was suspended in New Zealand. There have been a lot of controversy for mesh use in recent years. On other hand, mesh use is popular with acceptable outcomes in some countries in Asia. There are some light weight meshes launched recently and it may reduce the mesh related complications. The results still need to wait if it's advisable. Therefore, the mesh use should be limited to whom really indicated. The management of POP should be individualized and the use of mesh needs to be selective and appropriate. Patients who were scheduled for mesh use should be well informed about the benefit and risks of surgical procedures. The training of physicians should be enough for construction skill competency and, also, to how to manage the possible mesh-related complications. After operation, patient should be followed up regularly. Besides, the associated authorities should audit and record the outcomes of using mesh.

50. The future of mesh use

Authors Su T.-H.
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Abstract Synthetic mesh was first used for vaginal prolapse repair in 2004. The mesh device was classified as class II (moderate risk) at that time by the US Food and Drug Administration. Soon after, varied mesh kits were launched by several different companies and spread worldwide. However, complications associated with vaginal mesh use were reported at follow-up thereafter. The adverse effects after vaginal mesh repairs included pelvic pain, dyspareunia, vaginal stiffness, mesh exposure, infection, organ perforation and de novo lower urinary tract symptoms. In 2011, many transvaginal permanent meshes were voluntarily withdrawn from the market after FDA warnings released.1 Mesh kits were reclassified as Class III (high risk) devices in January 2016. A Cochrane Review in 2016 reported the transvaginal permanent mesh was associated with less subjective awareness of prolapse, repeat surgery for prolapse, and better objective anatomical results than those of native tissue repair. But it was also associated with higher incidence of repeat surgery for stress urinary incontinence or mesh exposure, bladder injury at surgery and de novo stress urinary incontinence.1 The Review therefore suggested that transvaginal mesh had limited utility in primary surgery. Nonetheless, it still remains much controversy surrounding mesh use in these years. In late 2017 and early 2018, mesh ban was proposed in several countries including United Kingdom, Scotland, Australia, and New Zealand where even mesh slings were suspended. On other hand, it shows acceptable outcomes some countries, such as Asia for example. As there have been some new, lightweight transvaginal permanent meshes launched, the impact of mesh on vaginal stiffness may decrease. 2 But the evidence was still unavailable without enough results reported by randomized controlled trials.1 It is suggested that more data are needed to better understand risk and benefit regarding mesh use for prolapse and incontinence. As caregivers, it is important to give patients proper preoperative counsels and share decision makings. The authorities should audit the annual mesh use and assess its associated complications. Also, proper technique training for qualified surgeon is imperative for safe mesh use in the future.

51. The impact of the montgomery ruling on the rates of maternal request caesarean section

Authors Cohen A.; Andrews V.; Singh N.
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Abstract Objectives: Caesarean section (CS) rates in the UK have increased from 9% in 1980 to 26% in 2014. Maternal request CS is a contributing factor and the recent Montgomery ruling has influenced our approach in managing women requesting a CS for 'large babies.' NICE guidance advocates elective CS for babies with an estimated fetal weight (EFW) >4.5 kg. CS is not without risks: haemorrhage, visceral injury and complications in future pregnancies 1. In our unit, the CS rate is higher than the national average (42%). We undertook this audit to identify contributory factors and hence develop a strategy to reduce the local CS rate. Method: A retrospective audit of all elective CS was conducted over a 3 month period (May, July 2017) and this was compared to the same time period in 2011. Results: 193 elective CS were performed over three months compared to 192 in 2011. The most common indication was one previous CS which showed an increasing trend from 29% (n=55) in 2011 to 38% (n=73) in 2017. Maternal request for non medical indication was the next most common reason and this increased from 14% (n=27) in 2011 to 16% (n=31) in 2017. Interestingly there were no CS performed for 'large babies' (ultrasound with suspected EFW >95th centile) in 2011, but this has contributed to 29% of the maternal request CS in 2017. Conclusions: Over half of all Elective CS performed at our unit are for women who declined a VBAC or have requested one for no medical reason. These rates have continued to increase. In both groups of women, there is potential for antenatal and intrapartum intervention to support and encourage women to achieve vaginal deliveries. This could reduce maternal and neonatal morbidity, as well as the financial burden associated with CS. A review of CS for 'large babies' will be undertaken to understand the impact of the GROW pathway on the identification of large for gestational age babies and its influence on the local CS rate.

52. Reintroduction of operative vaginal delivery at a large tertiary referral hospital in Cairo, Egypt

Authors Halawani M.; Webster S.; Soliman E.; El-Nouri A.
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Abstract Objectives: Operative vaginal delivery (OVD) describes the use of vacuum/forceps. The practice is a lost skill in Egypt, where the caesarean section rate is approximately 52%. Repeat caesarean section carries significant risks. Cairo has 19 government hospitals offering maternity services including Cairo University Maternity Hospital (18,000 deliveries annually). Since 1996, the use of vacuum/forceps was abandoned. We sought to understand the extent of OVD training and practice and to examine the impact of targeted OVD training on clinical skills, knowledge and reintroduction of vacuum/forceps into obstetric practice. Method: Firstly, a short survey was sent to a representative obstetric training doctor in each of 19 government hospitals. Secondly, a one-day OVD workshop (theory and simulation) was held, led by an experienced UK consultant. 47 doctors attended of various training grades. Pre and post course questionnaires were completed and results compared. Formal course feedback was completed. An audit of OVD use was undertaken after 4 months and a questionnaire sent to the doctors regarding their experience of implementation. Results: 13% of the representative training doctors had forceps in their hospital and 45% vacuum. 6% had received formal training on forceps and 33% vacuum. For the doctors undertaking the course, the mean pre-test score was 65% and post-test 85%. 94% of candidates strongly agreed/agreed the course met their expectations and the same number strongly agreed/agreed it would alter their clinical OVD practice. The audit of OVDs demonstrated 21 forceps and 7 vacuum deliveries in the 4 months following the course. There were no significant fetal complications and 3 cases of significant perineal trauma. Conclusions: Operative vaginal delivery is rarely practiced in Egypt and obstetricians working and training currently have no or little exposure to the skills. Training courses including the use of simulation can improve knowledge and skills such that the vacuum and forceps may start to be used again in clinical practice. This could, over time, make a significant impact on the caesarean section rate. An ongoing audit of cases should take place. We invite discussion from other parts of the world which are facing a similar loss of skill.

53. Discharge process of patients with hypertension in pregnancy

Authors Sheth S.; Yulia A.; Whitten M.
Source International Journal of Gynecology and Obstetrics; Oct 2018; vol. 143 ; p. 235-236
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Abstract Objectives: It was highlighted by junior doctors that when discharging patients with hypertension in pregnancy from the postnatal ward, there were no clear guidelines for how they should be counselled and followed up in the community, with particular regard to medication and blood pressure monitoring. Method: We retrospectively analysed the discharge summaries of 88 patients who had been coded as having hypertension in pregnancy; either essential hypertension, pregnancy induced hypertension or pre-eclampsia; and delivered in the months of July to September 2017 at University College London Hospital. We specifically looked for presence of a discharge summary; instructions to the community midwives and GP for blood pressure monitoring and medication review; and also when and how often this should be done as per both NICE and local guidelines. Results: We found that 9% of the patients had no identifiable discharge letter or means of communication to the community for follow up. Of that 9%, 38% were re-admitted with high blood pressure. Of the 91% with discharge letters, only 59% had mention of blood pressure review or medication review on the letter. However, 25% of those had no specific time frame suggested for this monitoring. 24% of patients were discharged on anti-hypertensives with a discharge letter which did not request any form of blood pressure or medication review in the community. Conclusions: These results demonstrate that we are not discharging women with hypertension in pregnancy appropriately. We have thus produced an auditable pro-forma in the form of stickers to be attached to the relevant postnatal notes for doctors to check against on discharge. This should ensure all appropriate advice is given to the patient and communicated to the GP via the discharge letter. Further, we have produced a standardised letter to be sent to the GP to ensure consistent follow up; as well as a new patient information leaflet to empower these patients to know more about their condition.

54. Effectiveness of detecting fetal anomalies by ultrasound scan

Authors Kalla S.; Mohsini S.; Axelsson F.; St Lawrence E.
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Abstract Objectives: To assess the effectiveness of detection of fetal congenital anomalies by Ultrasound Scan in our Fetal Medicine Unit and if an anomaly was detected if we were appropriately referring patients to pediatric and tertiary care teams. An additional aim of this audit was to determine if we are adequately offering patients the option for invasive testing to confirm anomalous diagnoses as early as possible, thus allowing patients to be educated on the outcomes and risks or benefits of further intervention. With early detection patients are allowed more time to make an informed decision in regards to future planning. Method: A retrospective audit was performed by looking at the total number of patients who had an anomaly on ultrasound scan over a one-year period between 2015-2016 at Wexham Park Hospital. It was established that 57 patients were identified as having an anomaly on ultrasound scan. There were no discriminating factors that prevented women from being included in our audit such as age, parity or ethnicity. Transabdominal ultrasound was the imaging method of choice by which the congenital anomalies were detected. Ultrasound scans were performed by sonographers or physicians and were interpreted by consultant physicians. Results: The majority of congenital anomalies identified were between 20-27 weeks representing 61.4% of patients. Additionally, 26.3% of anomalies were detected between 12-20 weeks, 8.8% of anomalies were detected over 27 weeks and 3.5% of anomalies detected below 12 weeks. Of the 106 anomalies detected among the 57 patients, 28.3% were identified as lethal, and 71.7% were found to be non-lethal. Invasive testing was accepted in 31.6% and declined in 22.8% of cases. Invasive testing was not offered in 45.6% of cases, and referrals for joint antenatal or post-natal care were made in 51.8% and 17.5% of cases respectively. Conclusions: During the period of study the total number of deliveries in our unit was 4500 . Routine ultrasound scans detected 57 of patients (1.26%) with fetuses having congenital anomalies. However 9 patients (.2%) with fetuses having anomalies were missed by USS. Overall, detection rate for identifying anomalies with ultrasound scan remains high at 86% which is comparable to the NICE, UK recommendation for detection of congenital anomalies in fetuses during the routine Antenatal screening. Ultrasound remains the most effective tool for detection of fetal anomalies, which is highly acceptable to the patient and cost effective.

55. Fresh eye into CTG fetal monitoring: Our experience from DGH in the UK

Authors Arafa A.
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Abstract Objectives: To review our current practice in fetal monitoring during labour at ditract general maternity unit in London. Also to asses our compliance of the use of CTG compared with Nice guidelines and our local protocol and to identify any gaps or incorrect use & practice with any underlying reasons. The overall purpose to improve the quality of care during labour Method: We present an Audit study (designed as prospective audit but some of information collected retrospectively) over 3 months period. It include 60 patients in total via use of patients notes and paper audit proforma. Results: The overall result showed, risk assessment recorded and interpretation of CTG according to NICE 100%. However, we still need to improve our records for a plan of action, maternal pulse recording and fresh eye. STAN machine has not used. There was clear evidence of shortage of midwifery staff. Conclusions: With more Locum staff on some shifts unfamiliar with guidelines and lack of staff Training-using STAN. Recommendation of new stickers to have larger area for recording Plan of action. Also additional stickers for regular maternal observations. All LW coordinator/ Midwife in charge empowered to "control fresh eyes" reviews with m ore senior midwifery input to be involved in review of CTG.

56. Study protocol: healthy urban living and ageing in place (HULAP): an international, mixed methods study examining the associations between physical activity, built and social environments for older adults the UK and Brazil

Authors Ellis G.; Cleland C.L.; Ferguson S.; Murtagh B.; Sengupta U.; Hunter R.F.; Tully M.; Kee F.; Hino A.A.F.; Anez C.R.R.; Melo S.; Reis R.
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Abstract BACKGROUND: The ability to 'age in place' is dependent on a range of inter-personal, social and built environment attributes, with the latter being a key area for potential intervention. There is an emerging body of evidence that indicates the type of built environment features that may best support age friendly communities, but there is a need to expand and consolidate this, while generating a better understanding of how on how research findings can be most effectively be translated in to policy and practice.METHODS: The study is based on two case study cities, Curtiba (Brazil) and Belfast (UK), which have highly contrasting physical, social and policy environments. The study deploys a mix methods approach, mirrored in each city. This includes the recruitment of 300 participants in each city to wear GPS and accelerometers, a survey capturing physical functioning and other personal attributes, as well as their perception of their local environment using NEWS-A. The study will also measure the built environments of the cities using GIS and develop a tool for auditing the routes used by participants around their neighbourhoods. The study seeks to comparatively map the policy actors and resources involved in healthy ageing in the two cities through interviews, focus groups and discourse analysis. Finally, the study has a significant knowledge exchange component, including the development of a tool to assess the capacities of both researchers and research users to maximise the impact of the research findings.DISCUSSION: The HULAP study has been designed and implemented by a multi-disciplinary team and integrates differing methodologies to purposefully impact on policy and practice on healthy ageing in high and low-middle income countries. It has particular strengths in its combination of objective and self-reported measures using validated tools and the integration of GPS, accelerometer and GIS data to provide a robust assessment of 'spatial energetics'. The strong knowledge exchange strand means that the study is expected to also contribute to our understanding of how to maximise research impact in this field and create effective evidence for linking older adult's physical activity with the social, built and policy environments.

57. How do primary care doctors in England and Wales code and manage people with chronic kidney disease? Results from the national chronic kidney disease audit

Authors Kim L.G.; Cleary F.; Nitsch D.; Wheeler D.C.; Caplin B.; Hull S.A.
Source Nephrology Dialysis Transplantation; 2018; vol. 33 (no. 8); p. 1373-1379
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Available at Nephrology Dialysis Transplantation from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Nephrology Dialysis Transplantation from Unpaywall

Abstract Background. In the UK, primary care records are electronic and require doctors to ascribe disease codes to direct care plans and facilitate safe prescribing. We investigated factors associated with coding of chronic kidney disease (CKD) in patients with reduced kidney function and the impact this has on patient management. Methods. We identified patients meeting biochemical criteria for CKD (two estimated glomerular filtration rates <60 mL/ min/1.73 m^2 taken >90 days apart) from 1039 general practitioner (GP) practices in a UK audit. Clustered logistic regression was used to identify factors associated with coding for CKD and improvement in coding as a result of the audit process. We investigated the relationship between coding and five interventions recommended for CKD: achieving blood pressure targets, proteinuria testing, statin prescription and flu and pneumococcal vaccination. Results. Of 256 000 patients with biochemical CKD, 30% did not have a GP CKD code. Males, older patients, those with more severe CKD, diabetes or hypertension or those prescribed statins were more likely to have a CKD code. Among those with continued biochemical CKD following audit, these same characteristics increased the odds of improved coding. Patients without any kidney diagnosis were less likely to receive optimal care than those coded for CKD [e.g. odds ratio for meeting blood pressure target 0.78 (95% confidence interval 0.76-0.79)]. Conclusion. Older age, male sex, diabetes and hypertension are associated with coding for those with biochemical CKD. CKD coding is associated with receiving key primary care interventions recommended for CKD. Increased efforts to incentivize CKD coding may improve outcomes for CKD patients.

58. The impact of relocation of chronic pain service from hospital setting to community centre on patient experience: a single-centre audit

Authors Tsui J.J.; Davey V.; Colvin L.
Source British Journal of Pain; Nov 2018; vol. 12 (no. 4); p. 220-229
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Publication Type(s) Article
Database EMBASE
Available at British Journal of Pain from Europe PubMed Central - Open Access
Abstract Background and aims: The Lothian Chronic Pain Service relocated from a university teaching hospital (Western General Hospital (WGH)) to a community centre (Leith Community Treatment Centre (LCTC)) in 2015. Transportation and geographical location were noted by staff to be potential challenges that could negatively impact on the patient experience. The objective of this study is to evaluate how relocating pain clinic from an urban-based hospital to a peripheral community centre on patient experience. Methods: An assessment and audit of the impact of the relocation on the Patient-Reported Experience Measure (PREM) of pain services was conducted. Using a nationally developed questionnaire, the patient-reported experience from LCTC was prospectively collected in 2016 and was compared to historical data obtained from WGH in 2014 by National Health Service (NHS) Scotland. All patients attending Lothian Chronic Pain Service clinics were deemed eligible for the audit. Patient demographics were compared between the two data sets. The impact of patient deprivation on patient experience was investigated using the Scottish Index of Multiple Deprivation (SIMD16). Results: Data from 111 patients from LCTC were compared to 206 patients from WGH. Percentage of patients rating care as 'excellent' was found to be significantly greater at LCTC than WGH (0.0049). However, overall patient rating of care from LCTC was not significantly different from WGH data and ratings were higher at LCTC. No correlation was found between patient deprivation and PREM. Conclusion: There is no clear evidence that PREM was negatively affected by the move from a university teaching hospital to a community setting. As this only reported experiences of patients who attended the service, further studies may be warranted to investigate the impact of patient nonattendance.

59. Correction to: Intraoperative oxygenation in adult patients undergoing surgery (iOPS): A retrospective observational study across 29 UK hospitals (Perioperative Medicine) (2018) 7:17 DOI: 10.1186/s13741-018-0098-3)

Authors Morkane C.M.; McKenna H.; Martin D.S.; Cumpstey A.F.; Grocott M.P.W.; Oldman A.H.
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Abstract Following publication of the original article (Morkane et al., 2018), it was noticed that the second collaborating group 'South Coast Perioperative Audit and Research Collaboration (SPARC)' was not displayed on the HTML online version due to an error by the Publisher.

60. Brief coping strategy enhancement for distressing voices: Predictors of engagement and outcome in routine clinical practice

Authors Paulik G.; Jones A.-M.; Hayward M.
Source Clinical psychology & psychotherapy; Sep 2018; vol. 25 (no. 5); p. 634-640
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Available at Clinical Psychology & Psychotherapy from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Cognitive behaviour therapy is recommended internationally as a treatment for psychosis (targeting symptoms such as auditory hallucinations, or "voices"). Yet mental health services are commonly unable to offer such resource-intensive psychological interventions. Brief, symptom-specific and less resource-intensive therapies are being developed as one initiative to increase access. However, as access increases, so might the risk of offering therapy to clients who are not optimally disposed to engage with and benefit from therapy. Thus, it is important to identify who is most/least likely to engage with and benefit from therapy, and when. In the current study, 225 clients were assessed for suitability for a brief, 4-session, manualized, cognitive behaviour therapy-based intervention for voices (named coping strategy enhancement therapy) and 144 commenced therapy, at a transdiagnostic voices clinic based in Sussex, UK. This article reports on the value of depression, anxiety, stress, insight into the origin of voices, length of voice hearing, and demographics in the prediction of engagement and outcomes. The study found that higher levels of baseline depression, anxiety, and stress were significantly associated with poorer outcomes, especially if clients also had high levels of voice-related distress. The engagement analyses showed that levels of voice-related distress at baseline predicted dropout. These findings highlight the importance of assessing negative affect and voice-related distress prior to commencing therapy for distressing voices, to help determine if the client is suitable or ready for brief-coping strategy enhancement.

61. Key strategies to improve systems for managing patient complaints within health facilities - what can we learn from the existing literature?

Authors Mirzoev T.; Kane S.
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Available at Global health action from Unpaywall

Abstract BACKGROUND: Information from patient complaints - a widely accepted measure of patient satisfaction with services - can inform improvements in service quality, and contribute towards overall health systems performance. While analyses of data from patient complaints received much emphasis, there is limited published literature on key interventions to improve complaint management systems.OBJECTIVES: The objectives are two-fold: first, to synthesise existing evidence and provide practical options to inform future policy and practice and, second, to identify key outstanding gaps in the existing literature to inform agenda for future research.METHODS: We report results of review of the existing literature. Peer-reviewed published literature was searched in OVID Medline, OVID Global Health and PubMed. In addition, relevant citations from the reviewed articles were followed up, and we also report grey literature from the UK and the Netherlands.RESULTS: Effective interventions can improve collection of complaints (e.g. establishing easy-to-use channels and raising patients' awareness of these), analysis of complaint data (e.g. creating structures and spaces for analysis and learning from complaints data), and subsequent action (e.g. timely feedback to complainants and integrating learning from complaints into service quality improvement). No one single measure can be sufficient, and any intervention to improve patient complaint management system must include different components, which need to be feasible, effective, scalable, and sustainable within local context.CONCLUSIONS: Effective interventions to strengthen patient complaints systems need to be: comprehensive, integrated within existing systems, context-specific and cognizant of the information asymmetry and the unequal power relations between the key actors. Four gaps in the published literature represent an agenda for future research: limited understanding of contexts of effective interventions, absence of system-wide approaches, lack of evidence from low- and middle-income countries and absence of focused empirical assessments of behaviour of staff who manage patient complaints.

62. The relationship between unwarranted variation in optometric referrals and time since qualification

Authors Parkins D.J.; Benwell M.J.; Evans B.J.W.; Edgar D.F.
Source Ophthalmic & physiological optics : the journal of the British College of Ophthalmic Opticians (Optometrists); Sep 2018; vol. 38 (no. 5); p. 550-561
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Abstract PURPOSE: To investigate variation in optometric referral decision-making and the influence of experience and continuing education and training (CET).METHODS: To gain insight into unwarranted variation in referral activity in the United Kingdom (UK): (1) triage data were audited to investigate source of referral, provisional diagnosis, and outcome; (2) an online system was developed to present two sets of 10 vignettes, designed to avoid prompting answers. Participating optometrists completed 10 pre-CET vignettes, recording their tests and management decisions. The main group of participants chose whatever CET they wished over a 6-month period and then completed another 10 post-CET vignettes. A second group of newly-qualified optometrists completed the vignettes before and after a CET course intervention, followed by a third group of pre-registered optometrists with an intervention of 6-months experience of their pre-registration year.RESULTS: The audit identified 1951 optometric referrals and 158 optometrists (211 referrals were from general medical practitioners), with 122 of the 158 optometrists making fewer than ten referrals. Two newly-qualified optometrists generated 12.5% of the total referrals in the audit (N = 2162). Many suspect glaucoma referrals were based on a single suspect measurement resulting in a high discharge rate after community review, as did referrals for certain fundus-related appearances for which no treatment was indicated. The intervention of gaining CET points appeared to have no significant impact (p = 0.37) on referral decision-making, although this part of the study was underpowered. Self-selection bias was confirmed in the main group. When the main group and newly-qualified practitioners were compared, the number of referrals was negatively associated with time since qualification (p = 0.005). When all 20 referral decisions were compared, all optometrists referring more than 10 vignette patients came from a group of newly-qualified practitioners up to 2 years post-qualification. Pre-registered optometrists generally referred more appropriately than newly-qualified. Upon qualification, there was a significant increase in the number of sight tests undertaken per day (p = <0.0005).CONCLUSIONS: Gaining CET points alone is unlikely to significantly improve referral decision-making. Mentoring and targeted CET for the newly-qualified up to 2 years post-qualification should be considered. Ophthalmology replies to the referring newly-qualified optometrist are vital for moderating future referrals and developing clinical confidence.

63. Improving out-of-hours surgical patient care

Authors Hart T.; Samways J.W.; Chaudhri S.; Kukendrarajah K.; Keenan M.
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Available at International journal of health care quality assurance from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract PURPOSE: The Royal College of Surgeons recognises patient handover as the point at which patients are collectively at their most vulnerable. Concerns were raised in a London teaching hospital surgical department regarding an unstructured handover system, poor access to relevant clinical information, and inadequate weekend staffing. A quality improvement programme was designed and implemented to respond to these concerns and improve patient safety. The paper aims to discuss these issues.DESIGN/METHODOLOGY/APPROACH: A structured questionnaire was distributed to staff and results used to construct a diagram outlining the main factors influencing weekend patient safety. This framework was used to design changes, including a new electronic handover tool, regular handover meetings and additional weekend staff. Regular staff training was provided, and success was assessed in a continuous audit cycle with the results fed back to team leaders.FINDINGS: Over a three-month period, the handover meeting recorded an attendance rate consistently above 80 per cent. The electronic handover entries were scored according to seven criteria (correct layout; key information, i.e.: patient location, clinical priority, active issues, resuscitation status, test results and weekend plan), averaging between 42.2 and 92.9 per cent, with progressive improvement seen over the assessment period. Weekend staffing was increased by 50 per cent, allowing a dedicated team to care for stable inpatients and to oversee discharges.ORIGINALITY/VALUE: This improvement programme delivered lasting and significant change in response to staff concerns. It resulted in a more structured and reliable weekend system and established key mechanisms for dynamic performance feedback.

64. Associations Between 30-Day Mortality, Specialist Nursing, and Daily Physician Ward Rounds in a National Stroke Registry

Authors Paley L.; Hoffman A.; Williamson E.; Bray B.D.; Rudd A.G.; James M.A.
Source Stroke; Sep 2018; vol. 49 (no. 9); p. 2155-2162
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Available at Stroke from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background and Purpose- Well-organized stroke care is associated with better patient outcomes, but the most important organizational factors are unknown. Methods- Data were extracted from the Sentinel Stroke National Audit Programme of adults with acute stroke treated in stroke hospitals in England and Wales between April 2013 and March 2015. Multilevel models with random intercepts for hospitals were used to estimate the association of each variable with 30-day mortality to estimate the impact of admission to differently organized hospitals. Results- Of the 143578 patients with acute stroke admitted to 154 hospitals, 14.4% died within 30 days of admission. In adjusted analyses, admission to hospitals with higher ratios of nurses trained in swallow screening was associated with reduced odds of death (P=0.004), and admission to hospitals with daily physician ward rounds was associated with 10% lower odds of mortality compared with less-frequent ward rounds (95% CI, 0.82-0.98; P=0.013). Number of stroke admissions and overall ratio of registered nurses on duty at weekends were not found to be independently associated with mortality after adjustment for other factors. Conclusions- If these associations are causal, an extra 1332 deaths annually in England and Wales could be saved by hospitals providing care associated with a ratio of nurses trained in swallow screening of at least 3 per 10 beds and daily stroke physician ward rounds.

65. Evaluation of the cost-effectiveness of rifaximin-alpha for the management of patients with hepatic encephalopathy in the United Kingdom

Authors Berni E.; Conway P.; Currie C.J.; Murphy D.; Whitehouse J.; Di Maggio P.; Poole C.
Source Current Medical Research and Opinion; Nov 2018; vol. 34 (no. 11); p. 2001-2008
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Available at Current medical research and opinion from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objective: Rifaximin-alpha 550 mg twice daily plus lactulose has demonstrated efficacy in reducing recurrence of episodes of overt hepatic encephalopathy (OHE) and the risk of hepatic encephalopathy (HE)-related hospitalizations compared with lactulose alone. This analysis estimated the cost effectiveness of rifaximin-alpha 550 mg twice daily plus lactulose versus lactulose alone in United Kingdom (UK) cirrhotic patients with OHE. Method: A Markov model was built to estimate the incremental cost-effectiveness ratio (ICER). The perspective was that of the UK National Health Service (NHS). Clinical data was sourced from a randomized controlled trial (RCT) and an open-label maintenance study in cirrhotic patients in remission from recurrent episodes of OHE. Health-related utility was estimated indirectly from disease-specific quality of life RCT data. Resource use data describing the impact of rifaximin-alpha on hospital admissions and length of stay for cirrhotic patients with OHE was from four single-center UK audits. Costs (2012) were derived from published sources; costs and benefits were discounted at 3.5%. The base-case time horizon was 5 years. Results: The average cost per patient was 22,971 in the rifaximin-alpha plus lactulose arm and 23,545 in the lactulose arm, a saving of 573. The corresponding values for benefit were 2.35 quality adjusted life years (QALYs) and 1.83 QALYs per person, a difference of 0.52 QALYs. This translated into a dominant base-case ICER. Key parameters that impacted the ICER included number of hospital admissions and length of stay. Conclusion: Rifaximin-alpha 550 mg twice daily in patients with recurrent episodes of OHE was estimated to generate cost savings and improved clinical outcomes compared to standard care over 5 years.

66. Improving weekend review for trauma and elective orthopaedic patients in the post-operative period

Authors Khoury A.; Williamson M.; Slater G.; Jones M.; Buckle C.
Source International Journal of Health Governance; Dec 2018; vol. 23 (no. 4); p. 264-268
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Available at International Journal of Health Governance from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Abstract Purpose: Weekend surgery carries higher mortality than weekday surgery, with complications most commonly arising within the first 48 hours. There is a reduced ability to identify complications at the weekend, with early signs going undetected in the absence of thorough early patient review, particularly in the elderly with multiple co-morbidities. Weekend working practices vary amongst UK hospitals and specialties. The weekend effect has been a prominent feature in the literature over the past decade. The purpose of this paper is to identify the number of patients undergoing weekend surgery who receive a Day 1 post-operative review and improve this outcome by implementing an effective change. Design/methodology/approach: It was observed that not all patients undergoing surgery on a Friday or Saturday at the authors' District General Hospital were receiving Day 1 post-operative review by a clinician. A retrospective audit was carried out to identify percentage of patients reviewed on post-operative Day 1 at the weekend. A change in handover practice was implemented before re-audit. Findings: In Phase 1, 54 per cent of patients received Day 1 post-operative reviews at the weekend against a set standard of 100 per cent. A simple change to handover practice was implemented to improve patient safety in the immediate post-operative period resulting in 96 per cent of patients reviewed on Day 1 post-operatively at re-audit. Originality/value: This study confirms that simple changes in handover practices can produce effective and translatable improvements to weekend working. This further contributes to the body of literature that acknowledges the existence of a weekend effect, but aims to evolve weekend working practices to accommodate improvement within current staffing and resource availability by maximising efficiency and communication.

67. The British Association for Sexual Health and HIV 2016 UK national audit and survey of clinic policies in relation to risk assessment, HIV testing and follow-up

Authors Bhaduri S.; Curtis H.; McClean H.; Sullivan A.K.
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Available at International Journal of STD & AIDS from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract This national audit of 142 clinics demonstrated that the majority of clinics surveyed had policies and agreed clinical practice for alcohol and recreational drug enquiry, as well as documentation of HIV test refusal, although this was not the case in 24% of clinics as regards alcohol usage, 21% of clinics as regards recreational drugs use and 43% of clinics as regards chemsex usage. Regarding management of HIV test refusal, there was no policy or agreed practice in 13% of clinics with respect to men having sex with men (MSM) attenders, and in 18% of clinics for heterosexual attenders. Seventy percent of clinics had HIV point of care tests (POCT) available. Recommendations include: all clinics should have a policy of routine enquiry about alcohol, recreational drugs and chemsex, all clinics should record reasons for HIV test refusal and all clinics should provide testing alternatives to improve uptake, e.g. point of care testing or home sampling.

68. BASHH 2016 UK national audit and survey of HIV testing, risk assessment and follow-up: case note audit

Authors Bhaduri S.; Curtis H.; McClean H.; Sullivan A.K.
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Available at International Journal of STD & AIDS from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract This national audit demonstrated discrepancies between actual practice and that indicated by clinic policies following enquiry about alcohol, recreational drugs and chemsex use. Clinics were more likely to enquire about risk behaviour if this was clinic policy or routine practice. Previous testing was the most common reason for refusing HIV testing, although 33% of men who have sex with men had a prior test of more than three months ago. Of the group declining due to recent exposure in the window period, 21/119 cases had an exposure within the four weeks prior to presentation, but had a previous risk not covered by previous testing. Recommendations include provision of risk assessments for alcohol, recreational drug use and chemsex, documenting reasons for HIV test refusal, provision of HIV point-of-care testing, follow-up for cases at higher risk of HIV and advice about community testing or self-sampling/testing.

69. Alcohol screening and brief intervention in police custody suites: Pilot Cluster Randomised Controlled Trial (AcCePT)

Authors Addison M.; Mcgovern R.; Brown H.; Crowe L.; Gilvarry E.; Howel D.; Mccoll E.; Muirhead C.; Kaner E.; Angus C.; Brennan A.; Becker F.; Coulton S.; Hickman M.; Newbury-Birch D.; Waqas M.
Source Alcohol and Alcoholism; 2018; vol. 53 (no. 5); p. 548-559
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Available at Alcohol and Alcoholism from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Alcohol and Alcoholism from Unpaywall
Abstract Aims: There is a clear association between alcohol use and offending behaviour and significant police time is spent on alcohol-related incidents. This study aimed to test the feasibility of a trial of screening and brief intervention in police custody suites to reduce heavy drinking and reoffending behaviour. Short summary: We achieved target recruitment and high brief intervention delivery if this occurred immediately after screening. Low rates of return for counselling and retention at followup were challenges for a definitive trial. Conversely, high consent rates for access to police data suggested at least some outcomes could be measured remotely. Methods: A three-armed pilot Cluster Randomised Controlled Trial with an embedded qualitative interview-based process evaluation to explore acceptability issues in six police custody suites (north east and south west of the UK). Interventions included: 1. Screening only (Controls), 2. 10 min Brief Advice 3. Brief Advice plus 20 min of brief Counselling. Results: Of 3330 arrestees approached: 2228 were eligible for screening (67%) and 720 consented (32%); 386 (54%) scored 8+ on AUDIT; and 205 (53%) were enroled (79 controls, 65 brief advice and 61 brief counselling). Follow-up rates at 6 and 12 months were 29% and 26%, respectively. However, routinely collected re-offending data were obtained for 193 (94%) participants. Indices of deprivation data were calculated for 184 (90%) participants; 37.6% of these resided in the 20% most deprived areas of UK. Qualitative data showed that all arrestees reported awareness that participation was voluntary, that the trial was separate from police work, and the majority said trial procedures were acceptable. Conclusion: Despite hitting target recruitment and same-day brief intervention delivery, a future trial of alcohol screening and brief intervention in a police custody setting would only be feasible if routinely collected re-offending and health data were used for outcome measurement.

70. Persistent inaccuracies in completion of medical certificates of stillbirth: A cross-sectional study

Authors Higgins L.E.; Heazell A.E.P.; Whitworth M.K.
Source Paediatric and Perinatal Epidemiology; Sep 2018; vol. 32 (no. 5); p. 474-481
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Available at Paediatric and perinatal epidemiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: The UK Medical Certificate of Stillbirth (MCS) records information relevant to the cause of stillbirth of infants >=24 weeks' gestation. A cross-sectional audit demonstrated widespread inaccuracies in MCS completion in 2009 in North West England. A repeat study was conducted to assess whether practice had improved following introduction of a regional care pathway. Methods: 266 MCS issued in 14 North West England obstetric units during 2015 were studied retrospectively. Cause of death was assigned following review of information available at the time of MCS completion. This was compared to that documented on the MCS, and to data from 2009. Results: Twenty-three certificates were excluded (20 inadequate data, 3 late miscarriages). 118/243 (49%) MCS contained major errors. Agreement between the MCS and adjudicated cause of stillbirth was fair (Kappa 0.31; 95% CI 0.24, 0.38) and unchanged from 2009 (0.29). In 2015, excluding 34 terminations of pregnancy, the proportion of MCSs documenting "unexplained" stillbirths (113/211; 54%) was reduced compared to 2009 (158/213; 74%); causality could be assigned after case note review in 78% cases. Recognition of fetal growth restriction (FGR) as a cause of stillbirth improved (2015: 30/211; 14% vs 2009: 1/213; 0.5%), although 71% cases were missed. 47% MCSs following termination of pregnancy documented an iatrogenic primary cause of death. Conclusions: Completion of MCSs remains inaccurate, particularly in recognition of FGR as a cause of stillbirth. Detailed case note review before issuing the MCS could dramatically improve the usefulness of included information; evaluation of practitioner education programmes/internal feedback systems are recommended.

71. Assessment of start dose in patients prescribed rivaroxaban for atrial fibrillation with chronic kidney disease-results from the ROSE study

Authors Davies M.; Evans A.; Coukan F.; Wise L.; Shakir S.
Source Drug Safety; Nov 2018; vol. 41 (no. 11); p. 1154
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Available at Drug Safety from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background/Introduction: Rivaroxaban is used to treat patients with non-valvular atrial fibrillation (AF) for the prevention of stroke and systemic embolism. This requires a fixed daily dose (20 mg) with dosage reduction only recommended in patients with a reduced creatinine clearance (15-49 ml/min), a range encompassed within chronic kidney disease (CKD) stage 3-4 (eGFR 15-59) although CKD 3a (eGFR 45-59) is largely outside this range. Rivaroxaban is not recommended in patients with severe renal impairment (creatinine clearance <15 ml/min). Objective/Aim: To assess starting dose amongst patients with chronic kidney disease stage 3-4 or 5. Methods: The Rivaroxaban Observational Safety Evaluation (ROSE) study was a specialist cohort event monitoring study of patients prescribed rivaroxaban. Specialists provided information via detailed questionnaires at baseline (and >= 12 weeks). Baseline characteristics included starting dose and presence of either CKD stage 3-4 (eGFR 15-59) or CKD stage 5 (eGFR <15). Starting dose was examined amongst patients with CKD stage 3-4 and 5 to assess how many patients had a reduced starting dose of less than 20 mg od. Results: The cohort consisted of 965 patients with AF: 75 patients with history of either stage 3-4 CKD (n = 73, 7.6%) or stage 5 CKD (n = 2, 0.2%). Of the patients with CKD stage 3-4, 36 (49.3%) were started on <20 mg daily [15 mg od (n = 35); 10 mg od (n = 1)]. 35 patients (48.0%) were started on >= 20 mg [20 mg od (n = 34); 30 mg od (n = 1)]. Starting dose was missing for two patients (2.7%). Neither patient with CKD stage 5 had a dose reduction. Conclusion: Our results suggest that amongst patients with CKD stage 3-4, approximately half were started on the recommended reduced dose of <20 mg od. Not all patients with CKD stage 3-4 would be recommended a dose reduction as per the product label. A UK audit suggests that approximately 20% of patients in the UK with CKD 3 are 3b rather than 3a although the frequency may be higher in a hospital cohort.

72. Curative Intent Treatment for Stage III NSCLC in England

Authors Harden S.; Beckett P.; Adizie J.B.; Khakwani A.
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Abstract Background: The National Lung Cancer Audit (NLCA) produces annual reports detailing standards of care for lung cancer. This further analysis investigates the use of curative intent multi-modality treatment for people in England diagnosed with stage III NSCLC during 2016, including, for the first time, details about use of concurrent and sequential chemoradiation (cRT). Method: Data on patients diagnosed during 2016 with stage III NSCLC in England were extracted from the National Cancer Registration and Analysis Service (NCRAS); information submitted through the Cancer Outcome and Services Dataset (COSD) were linked to other NCRAS datasets, including Hospital Episode Statistics (HES), the National Radiotherapy Dataset (RTDS) and the Systemic Anti-Cancer Dataset (SACT). Result: 6,288 cases of stage III NSCLC were analysed, 3839 Stage IIIA and 2449 Stage IIIB (Table 1). 813 (13%) people underwent surgery with 447 (7%) of these also receiving chemotherapy (predominantly adjuvant). 1047 (17%) people were treated with radical radiotherapy with 676 (11%) of these also receiving chemotherapy. For the 589/676 cRT cases where complete treatment dates were available, 199 (34%) received concurrent and 390 (66%) received sequential chemoRT (37% and 63% for stage IIIA). For 481/589 cases with performance status (PS) available, 171 (36%) PS0-1 cases received concurrent and 310 (64%) received sequential cRT (38% and 62% for stage IIIA) Of note, 2148 (34%) people received anti-cancer treatment of palliative intent and 2290 (36%) received supportive care only. Survival data will also be presented. Table 1 Conclusion: Multi-modality treatment with either surgery or radical radiotherapy combined with chemotherapy was delivered to 1123 (18%) patients with stage III NSCLC. Concurrent cRT, optimal cRT based on meta-analysis, was delivered to just over one third of people receiving cRT, including for patients of good PS0-1. This analysis provides a baseline for future quality improvement initiatives to optimise treatment and outcomes for patients with stage III NSCLC. Keywords: multi-modality treatment, sequential chemoradiotherapy, Concurrent Chemoradiation

73. Post-Treatment Survival Difference Between Lobectomy and Stereotactic Ablative Radiotherapy in Stage 1 Non-Small Cell Lung Cancer in England

Authors Khakwani A.; Harden S.; Navani N.; Beckett P.; Hubbard R.
Source Journal of Thoracic Oncology; Oct 2018; vol. 13 (no. 10)
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Available at Journal of Thoracic Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Non-small cell lung cancer (NSCLC) accounts for almost 85% of all lung cancer cases diagnosed in England. Stage 1 lung cancer represents around 15-20% of all NSCLC cases, and while surgical resection (the current standard of care) offers the best chance to improve survival and is the standard of care in early lung cancer, not all patients undergo surgical treatment due to their advanced age and/or multiple comorbidities, while others may refuse surgery. Stereotactic ablative radiotherapy (SABR), a non-invasive external beam radiotherapy, has become an established treatment option for such patients. The aim was to compare survival at 90 days, 6 months, one year and overall for patients who received either lobectomy or SABR for NSCLC stage IA and IB. Method: We used data from the 2015 National Lung Cancer Audit (NLCA) database that were collected by Public Health England (PHE) and linked with Hospital Episode Statistics (HES) and the Radiotherapy Dataset (RTDS) to identify patients with NSCLC stage IA-IB and performance status 0-2 who underwent surgery or SABR treatment. We looked at survival risk difference at 90 days, 6 months, 1 year and 1 year between the two patient groups using propensity score derived using a logistic regression model with covariates that were predictive of treatment including age, sex, performance status and stage. Result: We identified 2373 patients in our cohort, 476 of whom had SABR. The median difference between date of diagnosis and date of treatment for surgery patients was 17 days while for SABR patients it was 73 days. Increasing age and worsening performance status were associated with having SABR rather than surgery. Patients who had SABR had 1.4% better survival at 90-days; however, this survival benefit dropped at 6 months after treatment started and patients who had surgery had 14% better overall survival. Conclusion: Our analysis suggests that, while patients who underwent SABR have better short-term survival, patients who have surgery have better overall survival. However, the time to the start of treatment with SABR was 8 weeks longer than for surgery. Thus early survival may be underestimated for SABR although other (conflicting) factors may be at play including stage-shift (more in SABR group) and length time (potentially more indolent tumours in the SABR group). Keywords: Surgery, Lung neoplasm, survival

74. Implementing a Comprehensive National Audit of Lung Cancer Surgery: The English Lung Cancer Clinical Outcomes Publication (LCCOP) Project

Authors West D.; Page R.; Navani N.; Harden S.; Khakwani A.; Hubbard R.; Beckett P.
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Available at Journal of Thoracic Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: We report the establishment of a national audit of outcomes after lung cancer resection (LCCOP) in the English National Health Service (NHS), a government healthcare system providing the great majority of lung cancer surgery. LCCOP is a compulsory audit commissioned by NHS England. Method: Unusually, for a surgical audit, data is initially obtained from the cancer registry, and matched to national Hospital Episode Data (HES), before local validation by clinical teams. After case mix adjustment, unit level survival rates at 30, 60 and 90 days, and length-of-stay data are published online and in an annual report. The first annual report was released in 2014. Survival is adjusted for age, sex, performance status, stage, laterality, FEV1 percentage, comorbidity and socioeconomic status Result: The number of resections rose by 21% between 2015-2017 (4892 to 5936). Median annual activity per surgeon rose from 30 to 49 cases between 2014-2017, a 63% increase. In 2015 survival at 30, 90 and 365 days was 98.1%, 96.3% and 87.9% respectively. Median length of stay was 6 days (IQR 4-9). In 2015, 43.9% of lobectomies were completed by VATS, 4.3% were started VATS and completed by open surgery and 0.7% completed by robotics. Adjusted 90 day survival by surgical unit: 2017 report (2015 data) Conclusion: Using routinely collected NHS activity data for surgical audit is feasible, and reduces the data collection burden for hospital teams. Clinical validation remains important to correct discrepancies. Surgical activity has risen significantly. Increases in individual surgeon case volume may reflect increasing subspecialisation. Significant inter-provider variation remains, particularly in length of stay. More lung cancer surgery is being done in the English NHS. Surgeons are increasingly subspecialising, with higher case volumes. Local variation remains, particularly around length of stay. A mixed model of routinely collected data with local validation appears acceptable to clinical units. Keywords: Surgery, audit, outcomes [Figure presented]

75. Telephone Preassessment Clinic Incorporating Holistic Needs

Authors Beattie V.; Shepherd P.; Guerin M.
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Available at Journal of Thoracic Oncology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background: Approximately 44,000 people are diagnosed with Lung Cancer in the United Kingdom (CRUK,2012). In Liverpool we serve a population of 330,00. As health care providers we constantly look to new models of care to aid earlier diagnosis. Introduction of a new referral system into the diagnostic service at our hospital including: pre planned investigations prior to first outpatient appointment, it was identified that some pre planned investigations were inappropriate for some patients due to unknown performance status and co-morbidities. There was an increase in patients failing to attend outpatient appointments. The Lung CNS team looked provide intervention to provide patients with early access to key worker support with the aim of enhancing and reducing the lung cancer pathway Method: In 2016 a pre assessment proforma was developed. CT scan reports and referrals are assessed by Lead Lung Physician and appropriate referrals forwarded to Lung CNS. Lung CNS team contact patients via telephone and a pre assessment proforma completed. Patients informed of date of outpatient appointment need for investigations and explanation provided of what to expect. Holistic needs assessment undertaken to enable any concerns to be raised and allow early intervention by the specialist team with an aim of improving symptoms and performance status prior to commencing a treatment pathway. Result: Initial audit results looking at case studies, failure to attend rates and patient satisfaction met our objectives. There has been a reduction in failure of patients attending investigations; reduction in cancellation of prebooked investigations; provides early rapport between lung CNS and patient/carer with earlier recognition of symptoms and earlier access to urgent treatments; allows health education prior to first outpatient appointment including: smoking cessation; exercise and nutrition. Conclusion: This work has been an opportunity to demonstrate a positive impact on the patient pathway by streamline complexities in the pre diagnostic phase. Whilst it had a marked impact on the Lung CNS job plan it accommodates a growing demand on a constrained service. A revised job plan has been put in place for Lung CNS, there is improved communication and coordination between departments, importantly patients view this service positively. Keywords: assessment, telephone, holistic

76. Improving Quality of Care for Pleural Mesothelioma: 2018 National Mesothelioma Audit Results for England and Wales

Authors Harden S.; Beckett P.; Khakwani A.

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Publication Date Oct 2018
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Abstract Background: The National Lung Cancer Audit (NLCA) has previously produced reports detailing standards of care for mesothelioma in 2013 (covering diagnoses in 2008-2012) and in 2015 (covering 2014), funded by Mesothelioma UK. We have completed a further analysis using the most recent data available. Method: Data on patients in England and Wales with a diagnosis of mesothelioma in the years 2014-2016 were extracted from the National Cancer Registration and Analysis Service (England), and the Cancer Network Information System Cymru (Wales). The data were linked to other datasets, including Hospital Episode Statistics (HES), the National Radiotherapy Dataset (RTDS), the Systemic Anti-Cancer Dataset (SACT), pathology reports and death certificate data. Result: 6,932 cases of malignant pleural mesothelioma were analysed. 84% of cases were male. Performance Status (PS) was recorded in 69% (falling) and tumour stage in 54% (rising). 88% of patients had a pathological confirmation of the diagnosis, and in 64% there was a pathological subtype recorded. 51% of patients received active anti-cancer treatment, and 59% of PS 0-1 patients received chemotherapy (up from 41% and 54% in previous reports). 4% of patients received radical debulking surgery. One-year survival of 38% was lower than previous reports but should be interpreted with caution. Three-year survival was only 7%. Variation in the quality of the pathological diagnosis and in rates of treatment and survival are seen across regions (Table 1). Conclusion: Despite a rise in the number of eligible patients receiving chemotherapy, there remains poor long-term survival for patients with mesothelioma. As well as introduction of novel therapies, improvements in care and outcome could be achieved by reducing variation. Keywords: Pleural mesothelioma, variation, outcome [Figure presented]

77. Multi-Centred, Prospective, Audit to Identify Readmission Causes and Complications Within 30 of Primary Lung Cancer Surgery

Authors King M.; Hunter V.; Kerr A.; Dixon S.; Taylor S.; Smith A.; Merriman C.; Mitchell J.
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Abstract Background: Surgery remains the first choice of curative treatment, for patients with non-small lung cancer, the proportion of patients undergoing surgery has risen in recent years. Post-operative complications are well recognised following curative lung cancer surgery but there is limited data on readmission rates and causes. The UK Thoracic Surgery Group (TSG), a subgroup of the National Lung Cancer Forum (NLCNF) conducted a multicentre audit to assess readmission potential causes and patient experience. Method: The audit involved 6 UK thoracic surgical centres with prospective data collection over 3 months from primary lung cancer resection patients. Patients were contacted 1 month post discharge by telephone. Data collection included demographics, socioeconomic, smoking status, comorbidities, surgery, postoperative recovery, discharge satisfaction and readmission details. Result: 268 patients underwent thoracic surgery, the overall readmission rate was 11% (30), with variable readmission rate across the centres (range 3-24%), most readmission occurred within 7 days of discharge 47% (14) with patients being readmitted to a hospital that did not performed the procedure 43%(17). The most common cause of readmission was mainly pulmonary related with chest infections being largest cause, pain, wound infection and pneumothorax were also common. Length of stay following readmission was longer than initial surgical stay median 8 (range 0-94) vs 5 (range 2-27).Type of surgical approach had no impact on readmission. However readmission was associated with smoking, post-operative complications, discharge with drain, length of stay post-surgery and the patient's readiness for discharge (see table 1). Conclusion: This audit provides a broad overview of the pattern and trend of readmissions rates within 30 days post discharge following lung cancer resection. Whilst not every readmission can be avoided, there is opportunity to identify and prevent patient readmission. Listening to patient's assessment of their readiness for discharge is crucial to facilitating patient compliance with discharge and confidence in community carers. Keywords: Re-admission, Thoracic Surgery, NSCLC [Figure presented]

78. Quantitative hepatitis B surface antigen (qHBsAg) has poor performance as a marker of high risk antenatal chronic hepatitis B (CHB) in a multi-ethnic population

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Abstract Background: Mother-to-child transmission (MTCT) of hepatitis B virus (HBV) occurs predominantly in e antigen (eAg) positive mothers with high viral load and is a major driver of global endemicity. EASL guidelines recommend antiviral prophylaxis from 24-28 weeks gestation in women with high HBV DNA levels (>200,000 IU/ml) or qHBsAg levels >4 log10 IU/ml to reduce MTCT, in combination with infant immunisation. The threshold of qHBsAg has been derived from high-risk eAg positive (eAg+) antenatal cohorts in Taiwan and China. qHBsAg is strongly correlated with HBV DNA levels in eAg+ CHB, but only weakly in eAg-CHB. We investigated the utility of qHBsAg to predict high-risk antenatal HBV cases in a multi-ethnic urban cohort. Methods: Women receiving antenatal care in a large London centre were screened for HBsAg in accordance with UK policy. HBV positive women were risk stratified using eAg/eAb status, HBV DNA level and qHBsAg. Women with HBV DNA >200,000 IU/ml were defined as high-risk. Data were collected in a retrospectiveprospective audit including cases from 2013-2018 and data were analysed in SPSS. Results: 423 pregnancies in 400 hepatitis B positive women were included, none of whom were on antiviral treatment at conception. The median age was 30 years (IQR 28-35). Ethnicity was categorised as Chinese (4.5%); South Asian (28.1%); Black (20.1%); White (35.9%) and Other (5.9%). eAg+ cases were most prevalent in Chinese patients (47.4%) and least prevalent in White patients (1.97%). 33/423 (78.0%) pregnancies were in eAg+ CHB and 390/423 (92.7%) were eAg-cases. eAg+ cases: 26/33 (78.8%) pregnancies in eAg+ women were high-risk. 4/26 (15%) high-risk pregnancies would be misclassified using a threshold of qHBsAg >4 log10 IU/ml. 3/7 low-risk pregnancies were correctly classified using qHBsAg, although repeat DNA testing in 2 of these cases altered status to high risk. qHBsAg >4 log10 IU/ml had a positive predictive value (PPV) of 77% to identify high-risk cases and a negative predictive value (NPV) of 57%. eAg-cases: 6/390 (1.5%) eAg-cases were classified as high-risk and all would have been misclassified using a threshold of qHBsAg >4 log10 IU/ml. 83/390 (21.3%) low-risk pregnancies would have been misclassified using qHBsAg. PPV was 0% and NPV 98%. The AUC for qHBsAg to predict high-risk in eAg+ cases was 0.698 (95% CI 0.498-897) and 0.487 (95% CI 0.321-0.652) for eAg-. Figure 1 shows the case classification based on qHBsAg and HBV DNA and categorised by eAg status. Conclusion: In our centre, a cut off of >4 log10 IU/ml qHBsAg performed poorly in predicting high-risk antenatal cases, particularly in eAg-CHB. This challenges the clinical utility of qHBsAg to inform decisions to initiate antiviral prophylaxis in antenatal CHB across all ethnicities. We recommend that HBV DNA should remain the gold standard to inform decisions about antiviral prophylaxis until the utility of qHBsAg has been evaluated in a wider range of clinical contexts. (Figure Presented).

79. The UK-PBC audit of real-world obeticholic acid use in patients with primary biliary cholangitis (PBC)

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Abstract Background: Obeticholic acid [OCA] gained National Institute for Health and Care Excellence approval in the UK in 2017, facilitating access to a second licensed therapy for patients with PBC based on either lack of treatment response to, or intolerance of, ursodeoxycholic acid [UDCA]. UK-PBC was nominated as a stakeholder in developing care pathways, in part with the goal of capturing outcomes for patients [pts.] receiving new therapies. Aim: To assemble early, real world data on implementation of OCA use across the UK. Methods: Clinical characteristics, laboratory and outcome data was accrued for all pts. treated with OCA across 9 liver units throughout the UK (May 2017 to May 2018). 3-month interim analysis is presented herein. Results: Overall 82 pts. commenced OCA therapy; 56 having completed at least 3 months of treatment and comprise our study population (54 women, median age 49 yrs.; 46 pts. taking UDCA concurrently). OCA led to moderations in serum ALT (Wilcoxon-signed-rank test; median reduction from baseline: 19%, p<0.001), ALP (25%, p<0.001) and gGT (30%, p=001; determined in only 20 pts.) (Fig. 1A), but not overall bilirubin values (1B). The proportion of biochemical non-responders decreased significantly, as per the POISE criteria (composite measure and its individual components; 1C) and the Paris-I criteria (1D). On univariate analysis, older age increased the likelihood of meeting biochemical response (Paris-1) within 3 months (odds ratio [OR]: 1.06, P=0.042), as did baseline ALP (OR: 0.5, P=0.002), ALT (0.47, P=0.019) and serum bilirubin (OR: 0.9, P=0.023). However, on multivariable evaluation, only baseline ALP and bilirubin remained statistically significant (OR: 0.46, P=0.008; and OR: 0.09, P=0.018; respectively). Observing the study population in entirety, 37 pts. (66%) reported pruritus at baseline, 24 (43%) requiring treatment. Notably, 20 pts. (36%) reported deterioration in pruritus within 3 months of starting OCA, including 10 individuals necessitating escalation in symptom-specific therapy. Of the original 82 pts., 5 discontinued OCA within the first 6 weeks due to hepatic decompensation (n=1); pruritus (n=1) or other side effects whilst on treatment (n=3). Conclusion: Consistent with prior trial experience, OCA positively impacts liver biochemistry in PBC albeit with a negative impact on pruritus-related symptoms. Prospective, long-term follow-up of this expanding, real-world cohort is ongoing. (Figure Presented).

80. Identification of and re-engagement with diagnosed but not in care Hepatitis C patients using laboratory database (ireen-C)- a multi-centre study in the east of England

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Abstract Background: Hepatitis C (HCV) leads to long-term morbidity and mortality, and has major health resource implications. The estimated number of people with HCV in the East of England was 13,665 in 2015 (www.phe.gov.uk/FES/East). Newer antiviral medications have dramatically improved treatment outcomes. The current commissioning arrangements in the UK are that these patients are initially tested for antibody (HCV-Ab), which is an indication of exposure only. To confirm the presence of the virus, an RNA test should be performed. Evidence from most audits suggests that this does not happen in most parts of the UK because of inappropriate commissioning or the lack of knowledge in primary care about appropriate testing for HCV. This study interrogated laboratory databases at three district general hospitals in the East of England to identify patients with incomplete testing, and people with active infection but not in care yet, in order to re-engage them with local hepatology services. Methods: All blood samples which tested positive for HCV-Ab from 2012-2016 at the three centres were retrospectively identified. Demographic details, source of referrals and further virology testing were recorded. Results: A total of 1296 people had tested positive for HCV-Ab across all three centres. RNA had been tested in 1263, of whom 943 were positive. 145 had incomplete virology testing. 55 of those who tested positive for RNA had never been referred to specialist care. Data available from two of the three centres showed that of 649 people who had detectable RNA initially, 116 were still viraemic on last tested sample. For patients who had tested positive but were not under hepatology care, their primary care clinicians were sent a letter recommending appropriate specialist referral. Conclusion: Prisons in two centres accounted for a quarter of HCV-Ab positive patients in those centres. The highest number of incomplete virology tests were from a centre with a "short-stay, high turnover" prison. The 3rd centre did not have a prison, but does have a large migrant population, adversely affecting clinic attendances and accounting for the large number who remained viraemic. Techniques to address these challenges need to be customized according to varying local factors so that patient-centred specialist care can be appropriately commissioned.

81. A national audit of paediatric to adult transition liver services in the UK

Authors Samyn M.; Dyson J.; Hudson M.; Levitsky J.; Heldman M.; Joshi D.
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Abstract Background: Transition of young people (YP) from paediatric to adult health services is a challenging period for patients, parents and health professionals. A national survey amongst adult liver transplantation physicians in the USA (n=236) demonstrated that 32% of responders did not have a formal transition strategy at their centre with only 16% having a formal transition programme. Only 31% of patients arrived at their first adult clinic appointment with adequate knowledge about their condition and poor adherence was found to be a frequent barrier to transition. The aim of this study was to investigate the current state of provision of transition liver services provision in the UK. Methods: A questionnaire (adapted from the USA version) was developed and electronically distributed to 26 secondary and tertiary adult liver services in the UK. Results: Responses were received from 18 centres (69%); 9 centres had a dedicated liver transition service, whilst 12 had an affiliation with a paediatric centre. Nine centres received >5 referrals/year. Table 1 illustrates the comparison between UK and USA survey results. In the UK, physicians working in a centre with a dedicated transition service (n=9) perceived YP to be more knowledgeable about their condition (76% vs 50%), less likely to have 'poor adherence' (44% vs 67%) and reported less 'patient/family dependence on the paediatric provider' (56% vs 78%). Two centres with >5 patient referrals/ year did not have a formal transition programme or strategy. Conclusion: Transition service provision is available in half of the secondary/tertiary adult liver centres in the UK who responded to a national survey. Sixty-one % of the centres have a formal transition programme in contrast to 16% in the USA. Poor adherence is perceived to be a significant barrier to transition both in the UK and USA. Whereas the majority of YP attending adult clinic appointments come with parental support, physicians are concerned about YP lacking the capability of discussing their condition independently, parents/guardians managing their child's condition without engagement of the YP and dependence of both YP and parents on the paediatric provider. Transition services promote knowledge and better adherence with less dependence on paediatric service. (Table Presented).

82. Transplantation after viability testing of discarded livers with normothermic machine perfusion (NMP): The vittal (viability testing and transplantation of marginal livers) trial 90-day outcomes

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Abstract Background: Surgeons frequently reject high-risk donor livers, which currently comprise the only increasing and underutilised donor resource. The VITTAL trial assessed "transplantability" of discarded livers with NMP and evaluated 90-day outcomes in these grafts. Methods: This prospective, single-arm phase 2 trial included deceased donor livers, discarded by all UK centres, that met at least one of the following criteria (donor risk index >=2.0, macrosteatosis >=30%, ALT/AST >=1000IU/mL, donor WIT >=30mins in DCD livers, poor perfusion or anticipated CIT >=12 for DBD or >=8hrs for DCD livers. Recipients included consented adults undergoing primary transplantation, with a UKELD score <=62, without portal vein thrombosis or significant cardiovascular comorbidity. Livers clearing lactate to <=2.5mmol/L within 4 hours of NMP and meeting two other criteria (good arterial/ venous flow, bile production, homogenous perfusion, pH improvement) were deemed transplantable. The primary endpoints were liver salvage success rate and recipient 90-day survival. Results: Over 15 months, 185 retrieved livers were discarded for clinical use (Figure 1): 59 were excluded due to cancer, previous perfusion, fibrosis or severe damage. Donor inclusion criteria were not met in 25, 21 were offered when the NMP machine was being used, and there were no suitable recipients for 41. Thirty-one livers (14 DCD) were included in the trial. Donor age was 57yrs(30-84), BMI 29kg/ m2(20-42), DRI 2.2(1.2-3.8), liver weight 1.8kg(1.2-2.6) and the CIT was 7.33hrs(5:17-14:50) [median (range)]. Of these, 22(71%) livers were transplanted after meeting viability criteria. The total preservation time was 17:53hrs(11:21-25:32). Patient and graft 90-day survival were 100%. Seven (32%) patients developed early allograft dysfunction, and 5(23%) patients developed Clavien-Dindo complication grade >=3, including 4(18%) cases with acute kidney injury requiring renal replacement therapy. The median intensive care and in-hospital stay were 3 days (2-39) and 10 days (6-47) respectively. Conclusion: Viability testing of discarded livers with NMP is feasible and predicts early post-transplant function. In this trial, it enabled safe transplantation of 71% of assessed "discarded" livers and the outcomes were comparable with the contemporary audited results. Liver evaluation by NMP can salvage a significant proportion of currently underutilised organs and has the potential to substantially increase access to transplantation in the future. (Figure Presented).

83. Trauma Care Conference 2018

Authors anonymous
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Abstract The proceedings contain 36 papers. The topics discussed include: improving the identification of psychological sequelae in polytrauma patients; time to rapid sequence intubation - a national review of performance by PHOTON: study concept; time to rapid sequence intubation - an audit to establish key performance indicator targets; kayaking casualties requiring search & rescue assistance in Snowdonia; documenting dominance: doctors versus ENPs; early utilisation of an emergency department case feedback service for ambulance staff: what do paramedics want to know?; x-rays of nasal fractures - are we leading the way or lagging behind?; service evaluation of EtCO2 control for emergency medical retrieval and transfer service patients following prehospital anaesthesia; providing and teaching careers to provide collar care; rapid IV infusion - assessment of external pressure sleeve effectiveness; using key performance indicators to drive quality improvement in prehospital blood transfusion: the Thames Valley air ambulance approach; management of chemical injuries: educating the trauma team; missed opportunities for helicopter emergency medical services in trauma; West Midlands central accident, resuscitation & emergency team: prehospital emergency medicine clinical activity review; and the appropriateness of tranexamic acid administration to trauma patients at Sandwell and west Birmingham NHS trust (SWBH).

84. Injury burden of patients presenting with neck injury to a UK major trauma centre

Authors Holli S.; Dodd N.; Morga P.; Thompso J.
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Abstract Introduction: Penetrating neck trauma is a rare though potentially devastating mode of injury; here we review our experience of neck trauma by using the regional Trauma Network Trauma Audit and Research Network database to identify all adult (16 years) patients presenting with neck trauma, during a period from March 2012 to November 2017. Results: A total of 630 patients presented (all values: means, 95% CI); the mean age was 55.8 years (1.8), and 64.8% were male (3.7%). The mean Injury Severity Score (ISS) was 20.3-1.0. Overall, 30-day mortality was 13%2.6%; 1.6% suffered penetrating neck trauma, the other 98.4% were injured as a result of blunt injury pattern; 5% of all patients suffered a major vascular injury, 2% a laryngeal or tracheal injury, and 3% a peripheral nerve injury. The majority of injuries involved the cervical vertebra (73%), and/or cervical cord (24%). Penetrating neck trauma resulted in higher rates of vascular injury (60% vs. 4.7%, z-score, p<0.001), and larynx and tracheal injury (30% vs. 1.6%, z-score, p<0.001), and occurred in a much younger population (36.4 vs. 55.8 years, Mann-Whitney, p=0.019). There was no statistically significant difference in mortality for those suffering vascular injury (14.3 vs. 12.9%), though the mortality from laryngeal/tracheal injury was 30.8% (vs. 12.6%, z-score, p=0.055). Conclusions: Our data highlight the potentially devastating consequence of penetrating neck injury with higher rates of vascular and laryngeal injury compared to blunt trauma. Patients suffering penetrating neck trauma have complex care requirements requiring appropriate specialty input.

85. The appropriateness of tranexamic acid administration to trauma patients at Sandwell and West Birmingham NHS Trust (SWBH)

Authors Elatta M.
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Abstract Background: Trauma is associated with a high level of morbidity and mortality. Appropriate management of bleeding through active prevention and treatment contributes significantly to better outcomes: the CRASH-II trial concluded that timely and appropriate tranexamic acid (TXA) administration significantly decreases mortality due to bleeding. This audit assessed current practice for trauma patients presenting at SWBH. Methods: All trauma patients presenting in a year (April 2015-March 2016) were identified. Patients meeting criteria indicating high risk of bleeding as per CRASH-II met inclusion; those in this cohort presenting after drowning or asphyxiation were excluded. Patient notes were reviewed for evidence of recorded appropriate consideration and use of TXA. Results: Forty trauma patients met inclusion criteria, 33 had no exclusions and sufficient data for analysis; most had fallen <2m. Documentation showed TXA actively considered for two patients (6%). One patient received it (3%) appropriately as per guidelines. Conclusion: Tranexamic acid administration when CRASH-II criteria are present is very low and documented consideration for use of TXA in relevant patients is significantly lacking. The latter prevents interpretation of findings to understand whether TXA is not given due to omission or commission. Recommendations: Active consideration of TXA and clearly documented clinical reasoning in all trauma patients at risk of bleeding are required. Effectiveness of TXA decreases with time to administration: knowledge, training and documentation prompts to facilitate TXA being given appear necessary in our system.

86. Siblings with a PRKRA (DYT16) mutation and startle myoclonus

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Abstract Objective: To characterize and expand the phenotype of a family from North-East England with DYT16. Background: DYT16 is an autosomal recessive disease associated with mutations in the PRKRA gene (protein activator of interferon induced protein kinase) in region 2q31.2. This mutation was first described in 2008 in two non-consanguineous Brazilian families with dystonia. The male proband, aged 30 had classical dystonic features of risus sardonicus, perioral dyskinesia, spasmodic dysphonia, dystonic limb posturing and parkinsonism. The female proband aged 27 was less affected, with some dystonic posturing of the hands and pronounced posturing of the great toes (causing skin abrasions from footwear). Since childhood there were psychiatric issues, with documented depression and mild paranoia. Both were described as 'clumsy' and physically 'slow' as children. The female proband described falls, triggered by loud sounds; her brother described jerking provoked by loud noises. Methods: Case report. Results: Urine organic acids, serum amino acids and acetylcarnitine, VLCFA and MRI brain imaging were normal. The male patient had a normal DAT scan. DYT1 gene testing was normal. Homozygous pathological PRKRA gene mutations (665C>T P (Pro 222Leu) in both probands were found on further genetic testing. MEPs and SEPs were normal. Auditory startle evoked myoelectric potentials confirmed a non-habituating startle response recorded as surface EMG from trapezius, upper and lower limb muscles in both probands. The duration of EMG bursts in response to startling acoustic stimuli was consistent with propagation via a brainstem descending pathway. Identical electrophysiologic features consistent with brainstem/reticular reflex myoclonus, have previously been documented in DYT11 Myoclonus-Dystonia Syndrome (Marelli et al, 2008). Conclusions: DYT16 is a rare genetic diagnosis. We have described siblings with acoustic/reticular startle myoclonus in addition to dystonic features, thus expanding the clinical phenotype of DYT16.

87. Sing to Beat Parkinson's: A Group Singing Intervention for People with Parkinson's and their Carers

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Available at Movement Disorders from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objective: To improve the quality of life (QoL) of People with Parkinson's (PwP) and their carers using a group singing intervention Background: As Parkinson's disease progressively worsens, the QoL of both PwP and their carers can be affected by its relentless challenges. Neurologically, singing is a complex activity integrating auditory and sensorimotor processes. Previous singing studies have found that singing was positively associated with improved QoL in PwP (1). Sing to Beat Parkinson's (StBP) employs a holistic approach to enhancing physical, psychological and social well-being through group singing and has been practised in the UK since 2010 (2). This trial was the first Australian study including both PwP and their carers, to investigate the effects of the StBP program on the QoL. Methods: PwP (N=74) and their carers (N=40) took part in a weekly one-hour group singing. The 6 month program consisted of breathing exercises, vocal warm-ups, and preferred song singing together with home singing exercises (10-15 min x 3 per week). Statistical analysis was performed using SPSS 25 (IBM Corp, Armonk, NY) and the general linear model was used to compare pre and post intervention QoL data of PwP and their carers. Results: 78 participants completed the group singing intervention (including 21 carers) and their QoL status (using PDQ-39, PDQ Carer). The mean age of PwP was 71 (SD=7.7) with mean diagnosis time of 7.4 years (SD=5.2); 46.4% were male. PwP demonstrated statistically significant improvement in the QoL domains of Stigma (p=.001), Social Support (p=.002), Emotional Well-being (p=.005), Activities of Daily Living (p=.006), and Mobility (p=.007), although they showed significantly worsened Bodily Discomfort domain (p=.000). No statistical significance was detected in PDQ39 Summary score, Cognitive impairments and Communication domains. Carers QoL did not demonstrate a statistically significant improvement. Conclusions: We believe this is the largest QoL study of the impact of a group singing intervention. The results suggest that a one-hour weekly group singing program for six months was effective in enhancing QoL of PwP. The StBP program reduced stigma, increased emotional well-being, social support, mobility and everyday activities. Although the carers reported positive experiences of singing, PDQ Carer measures did not show a statistically significant improvement. The StBP program could be included as part of multidisciplinary Parkinson's management plan to promote better QoL supporting PwP and their carers.

88. Olfactory Hallucinations as a Non-motor sign of Parkinson's disease -A cross-sectional study amongst patients in a tertiary movement center

Authors Chandra S.; Schiess M.; Mehanna R.
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Available at Movement Disorders from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objective: Assess the prevalence of olfactory hallucinations (OlfH) in patients presenting to a tertiary movement disorders outpatient clinic. Background: Hallucinations can be considered a non-motor feature of alpha synucleinopathies and occur in 20-50% of patients with PD. Due to a lack of awareness as well as paucity of structured questionnaires/ tests that target psychosis assessment with an emphasis on OlfH, these are often missed during clinical consultations. Methods: Single site, IRB-approved ongoing cross sectional study. Patients diagnosed with PD per UK Brain bank criteria were consecutively enrolled with their consent and completed a questionnaire and a self-administered UPSIT smell test. Inability to understand the instructions due to language barrier or severe underlying pathology were exclusion criteria. Results: 38 male and 18 female subjects were evaluated (n=56). 82% reported no prior olfactory assessment. 19.6% (n=11) patients reported OlfH, 14.2% (n=8) visual, 7.14% auditory and 7.14% tactile hallucinations. 2 patients reported olfactory perseveration but not hallucinations of any modality. Of those with OlfH (see Table-1), mean age was 63.6 years (+/-10.86). 82% scored poorly on the UPSIT (Severe microsmia - 4, Anosmia - 5). While most reported that OlfH were infrequent, 18% (n=2) had hallucinations lasting greater than one hour and found them unpleasant and upsetting. OlfH related to food were more commonly considered pleasant (n=3).The most commonly described OlfH were "smoke/cigarette-smoke" (54.5%) (Table 2). Other concurrent sensory hallucinations reported included visual (36%), auditory (27%) and tactile (18%). Conclusions: Non-motor symptoms of PD are often missed in routine clinical practice and have far-reaching implications in patient care. The preliminary data from our center shows that despite hyposmia being a recognized non-motor feature of PD, OlfH tend to be underreported with prevalence ranging from 2.1% to 10% in prior studies compared to 19.6% in our cohort. Our future goals include analyzing the various associations between OlfH and intrinsic variables with our entire cohort (n=200). (Table Presented).

89. Exploring the role of a prescribing pharmacist in the management of Parkinson's disease

Authors Wong E.
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Available at Movement Disorders from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Movement Disorders from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objective: Aims/Objectives A review to explore the role of a pharmacist NMP within the neurology PD multidisciplinary team during a six month period between 1st April 2017-30th September 2017. Specifically to determine the: * Number of PD patients seen by the pharmacist NMP * Reasons why PD patients were seen by the pharmacist NMP * Number of prescriptions written by the pharmacist NMP Background: Parkinson's Disease (PD) is a progressive neurodegenerative condition that is estimated to affect up to 160 people per 100,000, with an annual incidence in the UK of 15-20 per 100,000.1. The role of a pharmacist can be helpful in the management of PD but is often not recognised. The publication of the Parkinson's Disease Society 2015 UK Parkinson's Audit Summary Report disappointingly has no reference to a pharmacist in the management of PD.2. The latest NICE guideline on Parkinson's Disease in adults (NG71) only refers once to a pharmacist. Pharmacists are able to assist in the medication review to improve adherence and compliance to medications.1. The introduction of a pharmacist non-medical prescriber (NMP) to the Chelsea and Westminster NHS Foundation Trust has facilitated a pathway for PD patients to have another point of contact within the neurology team, improved access to medications and thus enhanced patient care/experience. Methods: Clinic lists were analysed of PD patients who attended to pharmacist led clinic and data collected entered onto a spreadsheet. Ethics approval was not required. Results: A total of 61 patients with PD were seen during the review period with 92 prescriptions written for medication. Patients were seen for initiation; up/down titration; counselling of side effects; medication reviews. Conclusions: A pharmacist's role can be extremely valuable within the multidisciplinary team. The Trust pathway involved consultants referring suitable patients to the pharmacist led clinic. The pharmacist saw patients who required dose initiation and titration specifically for motor symptoms, but also saw patients who were suffering from nonmotor symptoms. Some patients were seen for closer management of their medications in order to optimise therapy and to improve compliance. A pharmacist appointment is easier to obtain than a consultant appointment and therefore patient's had greater access if they experienced any issues. Pharmacists play an important and vital role within the multidisciplinary team and can enhance their existing role as a NMP. Pharmacists have the capability in caring for patients with long term conditions ensuring compliance, adherence and to monitor for safety and efficacy of treatment. It is such a pleasure to write about pharmacists having such a crucial role in the treatment of PD.

90. Erratum: Correction to: An audit of clinical training exposure amongst junior doctors working in Trauma & Orthopaedic Surgery in 101 hospitals in the United Kingdom (BMC medical education (2018) 18 1 (1))

Authors Rashid M.S.
Source BMC medical education; Feb 2018; vol. 18 (no. 1); p. 28
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Available at BMC Medical Education from Unpaywall
Abstract CORRECTION: Following publication of the original article [1], the corresponding author wrote to say that he had missed the names of some of the collaborators in the list he sent to the typesetters. In addition, there was a spelling error in one of the author's names: instead of Nagriz Seyidova it should read Nargiz Seyidova. The complete list of collaborators is as follows.

91. Trauma radiology in the UK: an overview

Authors Chance T.; Haines I.; Graham R.
Source British journal of hospital medicine (London, England : 2005); Oct 2018; vol. 79 (no. 10); p. 567-570
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PubMedID 30290753
Database EMBASE
Available at British journal of hospital medicine (London, England : 2005) from MAG Online Library Please log in before trying to access articles. Click on 'SIGN IN' and then on 'SIGN in via OPENATHENS'. You probably won't need to put your Athens details in again.
Available at British journal of hospital medicine (London, England : 2005) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract NHS Choices defines 'major trauma' as multiple, serious injuries that could result in disability or death. Worldwide, trauma is the leading cause of death and disability in people under 40 years of age. The National Audit Office estimates that there are at least 20 000 major trauma cases in England every year, resulting in 5400 deaths and leaving many others with serious permanent disability. Because the incidence of trauma is particularly high in younger patients, an average of 36 life years is lost for every trauma death (Chaira and Cimbanassi, 2003). The landscape in major trauma imaging has evolved over the last 30 years, and this review chronicles these changes and the reasons for them, and looks at how the current guidelines have been formulated.

92. Talk CPR - A technology project to improve communication in do not attempt cardiopulmonary resuscitation decisions in palliative illness 11 Medical and Health Sciences 1117 Public Health and Health Services

Authors Taubert M.; Finlay I.G.; Norris J.; Edwards S.; Snow V.
Source BMC Palliative Care; Oct 2018; vol. 17 (no. 1)
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Available at BMC palliative care from Europe PubMed Central - Open Access

Abstract Background: A national Do Not Attempt Cardiopulmonary Resuscitation policy was rolled out for the National Health Service in Wales in 2015. A national steering group led on producing information videos and a website for patients, carers and healthcare professionals, forming part of a quality improvement program. Videos were planned, scripted and produced with healthcare professionals and patient/carer representatives, and were completed with both English and Welsh language versions. The TalkCPR videos encourage and promote open discussion about Cardiopulmonary Resuscitation (CPR) and DNACPR in palliative care situations. Methods: We worked with patient/carer groups to evaluate whether video resources to convey the salient facts involved in CPR and DNACPR decisions for people with palliative and life-limiting illness were acceptable or not. We conducted a mixed-method design service review in five phases to evaluate whether this technological resource could help. After creating video and website materials, they were evaluated by doctors, nurses and a patient/carer group. We also sent out one lightweight TalkCPR video media pad to each practice in Wales. These rechargeable electronic video media pads had communication videos pre-loaded for easy viewing, especially in areas with poor roaming data coverage. Results: Videos were demonstrably acceptable to both patient and carer groups, and improved healthcare professional confidence and understanding. Videos went live on the TalkCPR website, in all Welsh Health Boards and on Youtube, and are now used in routine practice throughout Wales. Conclusion: This is the first time that DNACPR information videos are aimed directly at palliative care patients and carers, to explore this sensitive subject with them, and to encourage them to approach their doctor or nurse about it. The website, app and video media pads were developed by patients, the Digital Legacy Association, Welsh NHS IT services, Welsh Government, the Bevan Commission and the Dying Matters Charity in Wales 'Byw Nawr'. The GMC, the Royal College of General Practitioners and NICE have listed TalkCPR as a learning resource. There has also been a collaboration with Falmouth University Art College, who helped produce graphic designs to facilitate and encourage discussions about CPR and end of life care.

93. WHAT WORKS IN PROVIDING DEMENTIA EDUCATION AND TRAINING TO STAFF WORKING IN GENERAL HOSPITAL SETTINGS?

Authors Surr C.; Sass C.; Burnley N.; Smith S.J.; Drury M.; Parveen S.; Capstick A.; Dennison A.; Oyebode J.
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Abstract Background: The quality of care delivered to people with dementia in hospital settings has been raised as an international concern. People with dementia who have a hospital stay experience worse outcomes and longer length of stay than those without dementia. Staff training on dementia is key to improving care quality, however, many staff still report lacking knowledge, confidence and skills in caring for this group. There is limited evidence about the most effective approaches to training hospital staff on dementia. The What Works? study was commissioned by the National Institute for Health Research Policy Research Programme in the UK, in order to investigate the ingredients associated with effective dementia education and training for health and social care staff. This findings related to general hospital settings are presented. Methods: The study involved: 1) a systematic review of existing literature, 2) a national audit and staff survey of available training and its implementation, and 3) in-depth, mixed-methods case studies in ten care organisations demonstrating hallmarks of good practice, of which three were conducted in general hospital settings. Results: The study found that training helped staff to gain knowledge, understanding and empathy about what it may be like to live with dementia. However, this was not consistently seen across all staff. Some positive practices demonstrating staff sensitivity, patience and good communication skills were observed, but positive practice was not consistent across all settings and staff. Training that appeared to lead to better outcomes was interactive, delivered face-to-face in small groups and tailored to the setting and staff roles of those attending. Barriers to training included poor attendance and implementation due to staff shortages, competing priorities and lack of resources. Strong leadership for dementia training at a hospital level and supportive, committed ward management were important facilitators for training application. Conclusions: Providing effective dementia training to general hospital staff is challenging. This study has identified ingredients that can act as potential barriers or facilitators to implementation, which may be considered in training design, delivery and implementation by hospitals.

94. Short- and long-term outcomes of patients with solid tumours following non-surgical intensive care admission

Authors Murphy K.; Cooksley T.; Haji-Michael P.
Source QJM : monthly journal of the Association of Physicians; Jun 2018; vol. 111 (no. 6); p. 379-383
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Abstract Background: There has been a significant increase in the number of patients presenting with cancer related emergencies and potentially requiring critical care admission.Aim: To analyse the short and long-term outcomes of patients with solid tumours requiring unplanned medical admission to a specialist cancer intensive care unit (ICU).Design: An unplanned cohort study.Methods: A retrospective analysis of patients admitted to a UK specialist tertiary oncology CCU between September 2009 and September 2015. The primary outcome measures were survival to CCU discharge and 1-year survival.Results: 687 patients had an unplanned medical admission. The most frequent primary tumours were lymphoma (22.1%), lung (15.2%) and colorectal (13.0%), and 181 (44.4%) were known to have metastases. The median Acute Physiology and Chronic Health Evaluation (APACHE) II and Intensive Care National Audit and Research Centre (ICNARC) scores were 21 and 17, respectively. ICU mortality was 26.7%, with total hospital mortality of 41.9%. The median survival of the total cohort was 56 days after ICU admission, with 107 patients surviving 365 days. Patients with metastatic disease were almost twice as likely to die within the year following ICU admission compared with their counterparts without metastases. Only pancreatic and lung primaries were shown to have a statistically significant impact on survival at 1 year. Pneumonia carried with it the worst prognosis (cumulative survival 0.11), followed by sepsis (0.25) and non-infective respiratory disease (0.26).Conclusions: The stage and type of cancer appear to have minimal impact on short-term ICU outcomes and only confer poorer long-term prognosis related to the disease.

95. An audit of completion of diaries for rehabilitation in an intensive care unit

Authors Ascough L.; Morrell-Scott N.
Source British journal of nursing (Mark Allen Publishing); Oct 2018; vol. 27 (no. 18); p. 1054-1058
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Abstract Intensive care unit (ICU) diaries are increasingly being used in UK hospitals as a therapeutic means to address the psychological effects of an ICU stay on patients. The National Institute for Health and Care Excellence recommends that services are developed to meet the psychological needs of patients following critical illness. This article discusses ICU diaries as a service to meet these needs. There is a greater demand for evidence-based research to support the positive effects of the diaries. Equally, there is a need to highlight the negative impact they may have on patients who would not wish to have a diary because of the traumatic experience of critical illness. To gain an insight into the use of patient diaries, an audit was conducted at one ICU, which found compliance with completing them was poor. This article gives an overview of the available literature. Recommendations are made to improve the use of ICU diaries for clinical practice in the future.

96. Self-Reported Knowledge, Correct Knowledge and use of UK Drinking Guidelines Among a Representative Sample of the English Population

Authors Buykx P.; Gavens L.; Holmes J.; Li J.; Hooper L.; Gomes de Matos E.
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Available at Alcohol and Alcoholism from Unpaywall

Abstract Aims: Promotion of lower risk drinking guidelines is a commonly used public health intervention with various purposes, including communicating alcohol consumption risks, informing drinkers' decision-making and, potentially, changing behaviour. UK drinking guidelines were revised in 2016. To inform potential promotion of the new guidelines, we aimed to examine public knowledge and use of the previous drinking guidelines, including by population subgroup.Methods: A demographically representative, cross-sectional online survey of 2100 adults living in England in July 2015 (i.e. two decades after adoption of previous guidelines and prior to introduction of new guidelines). Univariate and multivariate logistic regressions examined associations between demographic variables, alcohol consumption (AUDIT-C), smoking, and knowledge of health conditions and self-reported knowledge and use of drinking guidelines. Multinomial logistic regression examined the same set of variables in relation to accurate knowledge of drinking guidelines (underestimation, accurate-estimation, overestimation).Results: In total, 37.8% of drinkers self-reported knowing their own-gender drinking guideline, of whom 66.2% gave an accurate estimate. Compared to accurate estimation, underestimation was associated with male gender, lower education and AUDIT-C score, while overestimation was associated with smoking. Few (20.8%) reported using guidelines to monitor drinking at least sometimes. Drinking guideline use was associated with higher education, overestimating guidelines and lower AUDIT-C. Correctly endorsing a greater number of health conditions as alcohol-related was associated with self-reported knowledge of guidelines, but was not consistently associated with accurate estimation or use to monitor drinking.Conclusions: Two decades after their introduction, previous UK drinking guidelines were not well known or used by current drinkers. Those who reported using them tended to overestimate recommended daily limits.SHORT SUMMARY: We examined public knowledge and use of UK drinking guidelines just before new guidelines were released (2016). Despite previous guidelines being in place for two decades, only one in four drinkers accurately estimated these, with even fewer using guidelines to monitor drinking. Approximately 8% of drinkers overestimated maximum daily limits.

97. Results of the British Association of Urological Surgeons female stress urinary incontinence procedures outcomes audit 2014-2017

Authors Cashman S.; Biers S.; Thiruchelvam N.; Greenwell T.; Harding C.; Morley R.; Cooper D.; Fowler S.
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Available at BJU International from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objectives: To analyse the results of the stress urinary incontinence (SUI) audit conducted by the British Association of Urological Surgeons (BAUS), and to present UK urologists' contemporary management of SUI. Patients and Methods: The BAUS audit tool is an online resource, to which all UK urologists performing procedures for SUI are invited to submit data. The data entries for procedures performed during 2014-2016 were collated and analysed. Results: Over the 3-year period analysed, 2 917 procedures were reported by 109 surgeons, with a median of 20 procedures reported per surgeon. A total of 2 366 procedures (81.1%) were recorded as a primary surgery, with 548 procedures (18.8%) performed for recurrent SUI. Within the time period analysed, changes were noted in the frequency of all procedures performed, with a trend towards a reduction in the use of synthetic mid-urethral tapes, and a commensurate increase in the use of urethral bulking agents and autologous fascial slings. A total of 107 (3.9% of patients) peri-operative complications were recorded, with no association identified with patient age, BMI or surgeon volume. Follow-up data were available on 1 832 patients (62.8%) at a median of 100 days postoperatively. Reduced pad use was reported in 1 311 of patients (84.5%) with follow-up data available and 86.3% reported a pad use of one or less per day. In all, 375 patients (85%) reported being satisfied or very satisfied with the outcome of their procedure at follow-up, although data entry for this domain was poor. De novo overactive bladder (OAB) symptoms were reported by 15.2% of patients (263/1 727), and this was the most commonly reported postoperative complication. For those reporting pre-existing OAB prior to their SUI surgery, 28.7% (307/1 069) of patients reported they got better after their procedure, whilst 61.9% (662/1 069) of patients reported no change and 9.4% of patients (100/1 069) got worse. Conclusions: This review identified that, despite urological surgeons undertaking a relatively low volume of procedures per year, SUI surgery by UK urologists is associated with excellent short-term surgeon- and patient-reported outcomes and low numbers of low grade complications. Complications do not appear to be associated with surgeon volume, nor do they appear higher in those undergoing mesh surgery. Shortfalls in data collection have been identified, and a longer follow-up period is required to comment adequately on long-term complications, such as chronic pain and tape extrusion/erosion rates.

98. Use of biosimilar filgrastim for peripheral blood stem cell mobilization: A single centre experience in UK

Authors Elamin F.E.; Manson L.
Source Transfusion Medicine; Oct 2018; vol. 28 ; p. 70-71
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Available at Transfusion Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction: Recent studies showed there are no significant dif-ferences between biosimilar GCSF and originator GCSF in effciency of PBSC (peripheral blood stem cell) mobilisation. In our centre we recently changed to the use of biosimilar G-CSF (Zarzio Filgrastim) as a cost-effective strategy. Our aim was to review whether introduction of Zarzio Filgrastim has impacted on the number of patients achieving target CD34 yield and whether it changed the patterns of collection. Methods: Data were retrospectively collected from 52 consecutive patients undergoing PBSC collection at Royal Infrmary of Edinburgh Hospital between March 2017 and February 2018. All patients were mobilized with Zarzio Filgrastim at a dose of 5?g/kg body weight subcu-taneously starting afer chemomobilisation and continued until completion of PBSC collection. Peripheral blood (PB) cells counts were monitored afer 4-8 consecutive days of Filgrastim injection depending on mobilising chemotherapy regime. Stem cell collection was initiated when PB CD34 counts exceeded 15/?l. Results of this audit were compared with the results of previous local audit done between January 2015-May 2016 using non-biosimilar GCSF (Lenograstim 10?g/kg) for mobilisation. Results: This study included 41 (79%) male and 11 (21%) female patients. Mean age for adult patients was 54 (21-72) years. The indication for stem cell mobilization included 21 (40%) patients with multiple myeloma, 24 (46%) with Non-Hodgkin's lymphoma (NHL), 2 (4%)with Hodgkin's lymphoma (HL) and 5 (10%) patients with germ cell tumours. 88% of patients mobilised with Zarzio Filgrastim achieved their $CD34^{+}$ target yield compared with 82% of patients mobilised with Lenograstim. 71% of patients mobilised with Zarzio Filgrastim required only one leukapheresis procedure to achieve target CD34 yield compared to 50% of patients mobilised with Lenograstim. 49% of patients mobilising with Zarzio Filgrastim achieved their target CD34 yield by collecting 24 hours afer their planned day of first collection (day that it was expected for peripheral CD34 count to exceed 15/?l) Conclusions: Zarzio Filgrastim seems non-inferior to non-biosimilar Filgrastim in terms of achieving target CD34 yield. Delaying planned day of first collection by 24 hours can result in more cost effective and efcient collection.

99. Initiating, implementing and maintaining a comprehensive education program for donor clinicians within NHS Blood and Transplant

Authors Narayan S.; Muller J.; Gaum L.
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Available at Transfusion Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Introduction/Background: NHS Blood and Transplant (NHSBT) is responsible for the efcient, safe and reliable supply of blood in England. Clinical Support Team (CST) with Donor Consultants, SAS Doctors and Senior Nurse Practitioners based at diferent sites, are responsible for the care of blood donors. Continuing professional development (CPD) of CST helps improve the safety and quality of donor care. An educational quality improvement project was initiated in 2017 to establish a robust national system supporting the learning and development of CST staf, using existing Information Technology(IT) to develop and deliver a high quality, diverse, ft-for-purpose and cost-effective educational program. Methods: 'Assess-Plan-Do-Review' framework was followed. An initial 'scoping' meeting with all stakeholders identified the educational needs. A culture of collective ownership was promoted. A dedicated tele-conference line was allocated. All educational resources were saved in an accessible platform. Sessions were delivered by invited speakers and CST members, lasting no longer than 1hour on diferent days of the week 4-6 weekly covering wide topics, interesting clinical cases and relevant publications. This helped cascade information, encouraged shared learning and improved collaboration. A SurveyMonkey questionnaire was circulated in Nov2017 to evaluate this initiative. Results: Twenty educational sessions have been delivered since Jan 2017. Teleconferences have been running smoothly and all have access to the presentations and relevant documents prior to the telecom. A range of topics have been covered including journal clubs and discussion of challenging cases. Operational colleagues have also joined in some sessions promoting shared learning and inter-professional education. Informal feedback has been positive. Results of the formal survey (83% responded) confrmed that the program successfully addressed education needs. The current structure of the program was viewed as appropriate. Suggestions for further improvement were captured. Conclusions: This initiative has instilled a positive, collaborative climate and an enthusiastic, participatory learning environment. This has helped engage CST through empowerment, ownership, responsibility, and accountability for his/her own learning. Having reliable technological facilities such as teleconferencing and accessible information is vital in delivering such a program to geographically dispersed teams. For educational programmes to be ft-for-purpose, they have to be reviewed regularly and refned as needed.

100. Impact of red cell prime on plasma potassium for paediatric apheresis procedures: A national survey of guidelines and local audit of laboratory outcomes

Authors Monaghan M.; New H.; O'Brien N.; Moss R.; Barry A.; Barone G.
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Abstract

Background: Paediatric apheresis procedures in patients <25 kg require a red cell (RBC) circuit prime (>=230 mL), infused over approximately 20 min. Supernatant potassium rises during RBC storage. Rapid transfusions of older RBC may pose a hyperkalaemia risk, with cases of cardiac arrest, particularly in vulnerable patients. For infant transfusion, a maximum infusion rate of 0.5 mL/kg/minute for RBC >=7 days old (D7) has been suggested, slower than many primes. Current UK guidelines recommend 'fresh' RBC (<=D5) and <24 h following irradiation for large volume transfusion in recipients <1 year old, but do not address apheresis prime recipients >=1yr and <25 kg. At 1 year, 50% centile for weight is approximately 9.5 kg, so prime transfusion rate >0.5 mL/kg/min. Study Design and Methods: Telephone survey of 22 UK paediatric apheresis centres' local guidelines on age of RBC for priming circuits. Single centre retrospective audit of age of RBC to prime circuits for patients <25 kg and of patient potassium levels up to 24 hr pre-and post-apheresis (excluding red cell or plasma exchange). Results: Telephone survey: 13/22 responded. For patients >=1 year, 2/13 sites used 'fresh' RBC, within 24 h of irradiation, for patients >=1 year; one only specifed RBC within 24 h of irradiation. The rest used standard RBC shelf-life. The audit included 54 apheresis procedures (30 oncol-ogy/immunodefciency patients); 11/54 < 1 year, 43/54 1-12 years. Age of prime RBC and time post irradiation were compliant with guidelines. For those >=1 year, maximum RBC age was D20 and time post irradiation 14 days. For 28/54 procedures with both pre-and post-potassium results available, median (IQR) change in serum potassium was-0.55 mmol/l (0.53), maximum increase 1.1mmol/l (RBC age D11, 3 days post-irradiation). Tere was no clear correlation between potassium change and age of blood (r = 0.26) or time since irradiation (r = 0.03). Conclusions: Some UK sites have precautionary practice, using 'fresh' RBC, within 24hr of irradiation for children >=1 year. The change in measured potassium following apheresis was unremarkable. However, post tests were up to 8.5 h, so could miss transient changes. Given the theoretical risks, a prospective study of potassium levels immediately following RBC prime, and continuation of RBC prime age recommendations for children beyond 1yr should be considered.

Strategy 432448

#	Database	Search term	Results
1	EMBASE	(audit* OR "quality improvement").ti,ab	217423
2	EMBASE	(NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab	309023
3	EMBASE	exp "CLINICAL AUDIT"/	2146
4	EMBASE	exp "UNITED KINGDOM"/	407871
5	EMBASE	exp "NATIONAL HEALTH SERVICE"/	65431
6	EMBASE	(1 OR 3)	217930
7	EMBASE	(2 OR 4 OR 5)	575560
8	EMBASE	(6 AND 7)	19773
9	EMBASE	8 [DT 2018-2018] [Since 19-Oct-2018]	131
10	EMBASE	(audit*).ti,ab	180804
11	EMBASE	(3 OR 10)	181336
12	EMBASE	(7 AND 11)	18283
13	EMBASE	12 [DT 2018-2018]	365