

Strategy 432448/8

#	Database	Search term	Results
8	EMBASE	((audit* OR "quality improvement").ti,ab OR exp "CLINICAL AUDIT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/ OR exp "NATIONAL HEALTH SERVICE"/)) [Since 25-Jan-2019]	134

Contents 100 of 134 results on EMBASE - (((audit* OR "quality improvement").ti,ab OR exp "CLINICAL AUDIT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/ OR exp "NATIONAL HEALTH SERVICE"/)) [Since 25-Jan-2019]

1. Going digital with clinical treatment plans.....	Page 5
2. Outpatient hysteroscopy: Scope for improvement?	Page 5
3. Efficiency of surgical management of miscarriage within a central London teaching hospital.....	Page 6
4. Does caesarean section at night increases risk of wound infection?.....	Page 6
5. Real-world experience of switching from deferasirox dispersible to film-coated tablets: Impact on adherence to chelation therapy, iron overload and renal function	Page 7
6. Trends in surgical and catheter interventions for isolated congenital shunt lesions in the UK and Ireland.....	Page 8
7. 2015 UK software audit of hepatobiliary scintigraphy.....	Page 9
8. Impact and sustainability of centralising acute stroke services in English metropolitan areas: Retrospective analysis of hospital episode statistics and stroke national audit data.....	Page 9
9. Analysis of whole genome-transcriptomic organization in brain to identify genes associated with alcoholism.....	Page 10
10. Impact of surgical site infection (SSI) following gynaecological cancer surgery in the UK: A trainee-led multicentre audit and service evaluation.....	Page 10
11. Effectiveness of an antifungal stewardship programme at a London teaching hospital 2010-16.....	Page 11
12. Improving the management of musculoskeletal conditions: Can an alternative approach to referral management underpinned by quality improvement and behavioural change theories offer a solution and a better patient experience? A mixed-methods study.....	Page 11
13. Comparative outcomes in patients with ulcer- vs non-ulcer-related acute upper gastrointestinal bleeding in the United Kingdom: a nationwide cohort of 4474 patients.....	Page 12
14. A large 10-year series from a single-site institution in the United Kingdom of vulva carcinoma: An audit on adherence of United Kingdom guidelines and overall survival	Page 12
15. Social media usage within the cancer community of northern New England	Page 13
16. Do doctors in dispensing practices with a financial conflict of interest prescribe more expensive drugs? A cross-sectional analysis of English primary care prescribing data.....	Page 14
17. Factors associated with receiving surgical treatment for menorrhagia in England and Wales: Findings from a cohort study of the National Heavy Menstrual Bleeding Audit.....	Page 15
18. Causes of renal allograft failure in the UK: trends in UK Renal Registry and National Health Service Blood and Transplant data from 2000 to 2013	Page 15

19. Temporal trends in survival following ward-based NIV for acute hypercapnic respiratory failure in patients with COPD	Page 16
20. Incidence of severe critical events in paediatric anaesthesia in the United Kingdom: secondary analysis of the anaesthesia practice in children observational trial (APRICOT study)	Page 16
21. Major obstetric haemorrhage of 2000 ml or greater: a clinical audit.....	Page 17
22. Abstracts From the Neuro Anaesthesia and Critical Care Society of Great Britain and Ireland Annual Scientific Meeting...	Page 17
23. Timing and quality of neurological observation in a postanesthetic care unit following day-time and out-of-hours neurosurgery	Page 18
24. Central venous, peripherally inserted central and midline catheters on neurointensive care: A retrospective audit	Page 18
25. Developing the multidisciplinary intra-arterial thrombectomy service for hyperacute stroke in wessex neurological centre: A new role for simulation.....	Page 19
26. What is the role of cell salvage in spinal surgery?.....	Page 19
27. Going paperless: improved cataract surgery outcome data quality in a new fully electronic unit	Page 20
28. Genome-wide association study meta-analysis of the alcohol use disorders identification test (AUDIT) in two population-based cohorts.....	Page 20
29. Diagnosis and referral delays in primary care for oral squamous cell cancer: A systematic review	Page 21
30. Medical leadership and general practice: Seductive or dictatorial?.....	Page 22
31. The protective effects of cognitive reserve in major depressive disorder	Page 22
32. Implementation of tranexamic acid for bleeding trauma patients: A longitudinal and cross-sectional study	Page 23
33. UK national audit of safety checks for radiology interventions.....	Page 24
34. The mental health and wellbeing of medical trainees - autonomic, immunological and behavioural considerations.....	Page 24
35. My Diabetes My Way: supporting online diabetes self-management: progress and analysis from 2016.....	Page 25
36. Findings of Impaired Hearing in Patients with Nonfluent/Agrammatic Variant Primary Progressive Aphasia.....	Page 25
37. Associations between childhood deaths and adverse childhood experiences: An audit of data from a child death overview panel	Page 26
38. Canine dystocia in 50 UK first-opinion emergency care veterinary practices: clinical management and outcomes.....	Page 27
39. Associations between socio-economic factors and alcohol consumption: A population survey of adults in England	Page 27
40. Outcomes of urgent suspicion of head and neck cancer referrals in Glasgow.....	Page 28
41. Use of core outcome sets: NICE guidelines, surveillance reviews, and quality standards.....	Page 28
42. An organisational participatory research study of the feasibility of the behaviour change wheel to support clinical teams implementing new models of care.....	Page 29
43. Lessons Learned in Creating Interoperable Fast Healthcare Interoperability Resources Profiles for Large-Scale Public Health Programs.....	Page 30
44. Disparities in the management of paediatric splenic injury	Page 30
45. "Struggling with practices" - a qualitative study of factors influencing the implementation of clinical quality registries for cardiac rehabilitation in England and Denmark.....	Page 31
46. British Society of Gastroenterology Endoscopy Quality Improvement Programme (BSG EQIP): Implementing new endoscopic techniques and technologies into clinical practice	Page 31
47. Guidelines for the safe provision of anaesthesia in magnetic resonance units 2019: Guidelines from the Association of Anaesthetists and the Neuro Anaesthesia and Critical Care Society of Great Britain and Ireland.....	Page 32

48. Structured lifestyle education for people with schizophrenia, schizoaffective disorder and first-episode psychosis (STEPWISE): Randomised controlled trial	Page 32
49. How to get started in quality improvement	Page 33
50. Transparency of the UK medicines regulator: Auditing freedom of information requests and reasons for refusal.....	Page 33
51. Decision-Making in the Emergency Laparotomy: A Mixed Methodology Study	Page 34
52. British society of gastroenterology Endoscopy Quality Improvement Programme (EQIP): Overview and progress	Page 34
53. Erratum to "Population-based cross-sectional study to assess newborn hearing screening program in Central Germany" [Int. J. Pediatr. Otorhinolaryngol., 107 (2018) 110-120](S016558761830051X)(10.1016/j.ijporl.2018.01.035).....	Page 35
54. Partner notification and contact tracing must accompany provider-initiated counselling and testing in population screening for HIV infection in Nigeria	Page 35
55. Six months on: NHS England needs to focus on dissemination, implementation and audit of its low-priority initiative	Page 36
56. Standards and core components for cardiovascular disease prevention and rehabilitation	Page 36
57. International comparison of acute myocardial infarction care and outcomes using quality indicators	Page 36
58. Refractory status epilepticus in adults admitted to ITU in Glasgow 1995-2013 a longitudinal audit highlighting the need for action for provoked and unprovoked status epilepticus	Page 37
59. Simultaneous trauma patients in emergency department's: A difference in mortality?.....	Page 37
60. Frailty flying squad: An emergency department focussed acute care of the elderly service Dr Genevieve Robson, Royal United Hospital NHS foundation trust.....	Page 38
61. To pan-scan or not to pan-scan? further analysis of the tarn database 2012-2017	Page 39
62. Are we measuring what we think we are measuring? Qualitative research exploring the role of the 0-10 pain score within the adult emergency department	Page 39
63. Major incident triage and the implementation of a new triage tool, the MPTT-24.....	Page 40
64. Organ donation in emergency departments: An analysis of best practice	Page 41
65. Investigating the effects of under-triage by existing major incident triage tools	Page 41
66. Paediatric traumatic cardiac arrest in England and Wales a 10 year epidemiological study	Page 42
67. Utilisation of the principles of the Armed Forces Covenant in NHS Trusts and Clinical Commissioning Groups across England: A freedom of information investigation	Page 43
68. Leading the Charge: Achievement of National Accreditation for a Nurse Residency Program	Page 43
69. Predictive performance of the competing risk model in screening for preeclampsia.....	Page 44
70. Harveian Oration 2018: Improving quality and safety in healthcare	Page 45
71. Implant-ADM based breast reconstruction: "A tale of two techniques"	Page 46
72. Locoregional recurrence in breast cancer following wide local excision - Are we performing breast conserving surgery for larger lesions and does this affect locoregional recurrence?	Page 46
73. Pleomorphic LCIS what do we know? A UK multicenter audit of pleomorphic lobular carcinoma in situ.....	Page 47
74. Prehospital analysis of northern trauma outcome measures: The PHANTOM study	Page 48
75. prepectoral breast reconstruction: do we need to use the chest wall muscle at all?.....	Page 49
76. Comparison of re-excision rates between standard wide local excision and therapeutic mastectomy in a district general hospital	Page 49
77. Clinical anxiety disorders in the context of cancer: A scoping review of impact on resource use and healthcare costs	Page 50

78. Renal inpatient ward nurse experience and job satisfaction: A qualitative study	Page 50
79. Rapid tranquillisation: The science and advice	Page 51
80. Postoperative analgesia following caesarean section: A Forth Valley Royal Hospital quality improvement project	Page 51
81. Cardiopulmonary exercise testing: Have you checked the haemoglobin?	Page 52
82. The use of a bespoke 'view' derived from the SystmOne electronic patient record as a pre-assessment tool	Page 52
83. Royal free hospital safer cath lab	Page 53
84. Innovative approach using quality improvement practitioners to improve patient care: Think Drink project - The Leeds way	Page 54
85. Peri-operative cardiac arrest: Anaesthetists' attitudes and perceptions	Page 55
86. Improving antiepileptic medication administration time reduces seizure duration and need for intensive care in paediatric status epilepticus	Page 55
87. Understanding QI: A novel approach to using Trust mandatory audits for Medical Training Initiative doctors	Page 56
88. Documentation of consent for anaesthesia at the Christie NHS Foundation Trust (2018)	Page 56
89. Re-audit on epidural waiting times in a regional tertiary referral maternity unit	Page 57
90. An audit to assess anaphylaxis boxes at the Queen Alexandra Hospital, Portsmouth NHS Trust	Page 58
91. Frailty, multimorbidity and the ageing surgical population: A snapshot audit	Page 58
92. Review of the pathway for children with 'Swollen' optic discs; A service evaluation and quality improvement study	Page 59
93. Dystonia in the Paediatric Intensive Care Unit (PICU): A retrospective prevalence study	Page 60
94. Technology as a tool to monitor anaesthetic practice and patient satisfaction in obstetrics patients over 4 years	Page 60
95. The GEARS Checklist: Introduction of a newly devised decision-making and communication tool to aid care for patients participating in an enhanced recovery after surgery programme at the Royal Marsden	Page 61
96. A service evaluation of silver trauma in a North West England major trauma centre	Page 62
97. Peri-operative management of the ophthalmic surgical patient with diabetes	Page 62
98. A qualitative study exploring healthcare experiences of elderly patients and their carers undergoing hip fracture surgery	Page 63
99. Assessing the cost effectiveness of pre-diluted metaraminol	Page 64
100. Anaesthetic record keeping at Newcastle Hospitals: Preparing for electronic records	Page 64

Results 100 of 134 results on EMBASE - (((audit* OR "quality improvement").ti,ab OR exp "CLINICAL AUDIT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/ OR exp "NATIONAL HEALTH SERVICE"/)) [Since 25-Jan-2019]

1. Going digital with clinical treatment plans

Authors Mangles S.; Cordial M.H.; Oyesiku L.
Source Haemophilia; Feb 2019; vol. 25 ; p. 168-169
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Haemophilia](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at [Haemophilia](#) 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: New approaches to service delivery through the introduction of technology, as part of the NHS challenge to go paperless, are well underway. As technological advances in healthcare gather pace, and as hospitals develop electronic patient records (EPR), information required to ensure the appropriate treatment of patients with bleeding disorders should be readily available to all clinicians. Prompt assessment and treatment of bleeding problems is associated with a better outcome. Delays in treatment may lead to hospital admissions, the need for prolonged therapy and long term sequelae. In the UK, patients are issued with bleeding disorder information cards to show when they present to a hospital in an emergency, which includes their diagnosis and treatment. However, we know that many patients may not carry them, or may lose them. We therefore wanted to create a way that all patients registered with our centre could have a treatment plan accessible on the EPR. Method(s): At our centre, the development of an in-house EPR by the hospital allowed us to work with the developers to create a critical treatment plan (CTP) template. This included diagnosis, baseline levels, usual treatment as well as contact numbers for the team in and out of hours and some general advice. The plan flashes so that it is very visible on the EPR. Result(s): All patients with bleeding disorders were first tagged, using a red stick person symbol, then a CTP was created. In the first 12 months since this was developed 587 people have been tagged. Treatment plans have been written for 452 people. An audit of 88 patients attending clinic over a 3 month period showed 74/88 (84%) had a CTP. 100% of the treatment plans were up to date and reflected current treatment. Discussion/ Conclusion: The introduction of the CTP has been a success. It has allowed on-call physicians to have quick access to the correct treatment plan. An additional benefit of the red stick person/ CTP has involved other hospital teams, e.g. radiology and general surgery contacting the haemophilia team to say a patient has been admitted or is booked for a procedure. A process is now in place to review all CTPs when a patient attends clinic, to create new plans for new patients and to review patient tags and CTPs on a bi-annual basis.

2. Outpatient hysteroscopy: Scope for improvement?

Authors Main A.; Rose K.
Source European Journal of Obstetrics Gynecology and Reproductive Biology; Mar 2019; vol. 234
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [European Journal of Obstetrics Gynecology and Reproductive Biology](#) 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: Outpatient hysteroscopy is a well-established and safe diagnostic test in widespread use across Europe. It is the gold standard for the diagnosis of abnormal uterine bleeding. In NHS Lothian there are two clinical sites where outpatient hysteroscopies are performed, one a central tertiary referral centre, the other a district general hospital. There are currently perceived differences in the services provided at each site which may be affecting patient outcomes.
Objective(s): This study sought to audit and review the outpatient hysteroscopy service provided and identify areas of potential improvement.
Method(s): We conducted a retrospective study of all outpatient hysteroscopies in NHS Lothian from March to September 2017. Cases were identified using hysteroscopy clinic lists. Data on these cases were collected using their online patient notes. Data was collected using a standardised excel spreadsheet. Discussion and conclusions: 420 outpatient hysteroscopies were audited across both sites; 299 (71.2%) at site A and 121 (28.8%) at site B. Overall the success rate of entry into the uterine cavity was 82.9%. Site A's success rate was 78.6%, whereas site B's was higher at 93.4%. Of the unsuccessful cases, 90% at site A and 75% at site B went on to require a hysteroscopy under general anaesthetic. Cervical dilatation was used in 14 cases at site B (11.6%). However, at site A it was only documented as being used once (0.3%) as cervical dilators are not routinely available at site A. Immediate complication rates were low; 2.6% at site A and 1.65% at site B. Overall, outpatient hysteroscopy is highly successful across NHS Lothian, with low immediate complication rates. However, there is a significant difference in the success rates when comparing site A to site B. This suggests there are areas for improvement at site A that may increase success rates, for example the availability of cervical dilators in clinics.
Copyright © 2018

3. Efficiency of surgical management of miscarriage within a central London teaching hospital

Authors Richards K.; Andrews V.; Lawson K.; Begum F.; Ofili-Yebovi D.
Source European Journal of Obstetrics Gynecology and Reproductive Biology; Mar 2019; vol. 234
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Journal of Obstetrics Gynecology and Reproductive Biology](#) 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: The National Institute for Health and Clinical Excellence advises women diagnosed with miscarriage should be offered, where appropriate, all three management options: expectant, medical and surgical (which includes surgical management of miscarriage under general anaesthetic [SMM]). Women who opt for surgery often expedite the miscarriage process for physical, social, and psychological reasons. Currently there is no standard for the maximum time a woman should need to wait for her preferred SMM option. In our unit, we aim to achieve SMM within five days of decision.
Objective(s): We conducted an audit on the efficiency of our service to meet the 'within five-day target' for women who want SMM and if delays have an implication on complications.
Method(s): We collected retrospective data for August and September 2017 on women diagnosed with a delayed or incomplete miscarriage who opted for SMM. We assessed if all three management options were offered, the interval from decision to treatment and if delayed SMMs resulted in spontaneous miscarriage or complications. Discussion and conclusions: A total of 124 women were diagnosed with delayed or incomplete miscarriage for two months. 65% opted for SMM. Although the mean time-interval from decision to surgery was only 2.8 days, 24.7% of women waited five days or longer. 15% (3/20) of women waiting five days or more, bled heavily before their planned surgical date, compared to 1.6% (1/62) of the women who met our target timing for SMMs (OR 10.8, 95% CI: 1.1-110.2). In all 4 cases the result was either emergency surgery to stop excessive haemorrhage or complete miscarriage through expectant management which had not been initial patient choice. In general, our women have their preferred SMM option in a timely manner. However, 25% of women were not treated within our five-day target; this is associated with an increased risk of heavy bleeding prior to planned surgery.
Copyright © 2018

4. Does caesarean section at night increases risk of wound infection?

Authors Unger H.; Delaney L.; Hadoura E.
Source European Journal of Obstetrics Gynecology and Reproductive Biology; Mar 2019; vol. 234
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [European Journal of Obstetrics Gynecology and Reproductive Biology](#) 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: Surgical site infection (SSI) after caesarean section (CS) is common and carries significant morbidity. Recent research suggests that wound healing efficacy may be influenced by time of surgery, with injuries sustained at night healing more slowly. A possible downstream effect may include an increased risk of SSI.

Objective(s): To assess the association of time of surgery, and other clinical factors, with SSI within 10 days following CS amongst women delivering at Victoria Hospital, Kirkcaldy, UK, from 01 January 2014 until 31 August 2017.

Method(s): We conducted a retrospective cohort study on routinely collected audit data. The relationship between clinical factors including time of surgery, length of surgery, maternal age, maternal body mass index, emergency CS and SSI were assessed using the Chi-squared test, the Student's t-test or the Mann-Whitney U test. Factors associated with SSI on univariate analysis ($p < 0.05$) were included in a multivariable logistic regression model. Discussion and conclusions: A total of 3360 women had a caesarean section, of whom 3015 (89.7%) had SSI follow-up. There were 106 SSIs. Delivery between 8 pm and 8 am was associated with SSI on univariate analysis ($p = 0.033$). Other factors associated with SSI included maternal age < 25 years ($p = 0.006$), emergency procedures ($p = 0.028$), length of procedure ($p < 0.001$), and a maternal body mass index of > 30 kg/m² ($p = 0.001$). In multivariable analysis, only high BMI (2.88, 1.48-5.61, $p = 0.002$), young age ($p = 0.035$), and length of operation ($p = 0.012$) remained associated with SSI. Our study re-affirms BMI and length of surgery are associated with SSIs. Time of operation does not associate with SSIs when adjusted for other established risk factors. Possible explanations include absence of a link between wound healing efficacy and SSI risk, confounding due to alterations between circadian gene expression and cell function as a result of labour, antenatal steroids, and pregnancy, or unadjusted confounding in previously published work.
Copyright © 2018

5. Real-world experience of switching from deferasirox dispersible to film-coated tablets: Impact on adherence to chelation therapy, iron overload and renal function

Authors Cheesman S.; Shah R.; Trompeter S.; Eleftheriou P.; Hylton B.; Garbowski M.W.; Porter J.

Source Blood; Nov 2018; vol. 132

Publication Date Nov 2018

Publication Type(s) Conference Abstract

Database EMBASE

Available at [Blood](#) 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 Chronic iron overload is an important complication of long-term blood transfusions for severe beta-thalassaemias, sickle cell disease and other blood disorders. Iron chelation therapy (ICT) is required to bind and excrete excess iron, which would otherwise accumulate and lead to organ damage or failure. Deferasirox is a once-daily, orally administered ICT approved for the treatment of chronic iron overload due to frequent blood transfusions in patients with beta-thalassaemia major and other anaemias. A film-coated tablet (FCT) formulation was launched in the UK in 2016 and replaced the dispersible tablet (DT) formulation. In the context of a randomised clinical trial, the FCT formulation showed greater adherence and patient satisfaction, better palatability and fewer tolerability concerns than the DT. Furthermore, treatment compliance by pill count was higher with FCT (92.9%) than with DT (85.3%) (Taher et al, 2017). Little information exists however about compliance, efficacy and tolerability outside of a clinical trial setting. Objectives We wished to assess in a 'real world' situation, the effects of switching the deferasirox formulation from DT to FCT on patient adherence to ICT, iron overload and renal function. Methods Patients receiving ICT with deferasirox who were switched from the DT to FCT formulations were followed over a 12-month period and results audited using hospital dispensing and biochemistry records. The date of the first FCT prescription was defined as baseline. The initial daily dose used for switching from DT to FCT was as per manufacturer's recommendations: 70% of the DT daily dose. The impact on iron overload was assessed by comparing serum ferritin levels at 3, 6, 9 and 12 months post-switch with baseline values. The impact on renal function was assessed by comparing serum creatinine levels at 3, 6, 9 and 12 months post-switch with baseline values as well as the number of serum creatinine increases of 30% or greater above baseline. The changes in serum ferritin and creatinine were subsequently analysed by paired t-test. The Proportion of Days Covered (PDC) was calculated as a measure of patient adherence to ICT in the 12 months before and after switching formulations. Results 74 patients switched from deferasirox DT to FCT with the following diagnoses: beta-thalassaemia (n = 45), sickle-cell disease (9), thalassaemia-intermedia (6), HbE-thalassaemia (5), other transfusion-dependent disorders (9). The median age was 36 (range: 1-78yo), mean baseline serum ferritin was 2767µg/L (range: 412-8742), mean baseline creatinine was 64.5 µmol/L (range: 17-140) and the median prescribed daily dose of DT was 1250mg (range: 62.5-3500). The mean PDC was 0.80 (range: 0.31-1.00). This increased to 0.91 (range: 0.21-1.00) in the 12 months following the switch to FCT. The median prescribed daily dose of FCT was 900mg (range: 90-2520). The mean changes in serum ferritin at 3, 6, 9 and 12 months post-switch are shown in the table. The mean increase in ferritin of >30% from baseline whilst receiving the FCT, occurring after an average of 120 days (range: 30-263) was significantly reduced. Adjustment of FCT and creatinine returned to the normal range in 5 out of 6 cases. The switch to FCT improved patient adherence to chelation, a reduction in mean serum ferritin and a modest rise in mean creatinine. A reversible rise in creatinine from baseline. The mean PDC was 72% of the DT formulation, approximately equivalent according to the known bioavailability of the two formulations and suggesting that improvements in serum ferritin were due to the more consistent daily administration of the FCT rather than an increased daily deferasirox dose. We suggest that when the fall in ferritin is abrupt and/or to levels <1000µg/L, serum creatinine should be followed particularly carefully to avoid over-exposure to deferasirox from the FCT. We further speculate that patients who may have over-reported adherence to the DT prior to switching may be most susceptible to this effect.

6. Trends in surgical and catheter interventions for isolated congenital shunt lesions in the UK and Ireland

Authors Farooqi M.; Stickley J.; Barron D.J.; Jones T.J.; Brawn W.J.; Drury N.E.; Dhillon R.; Clift P.F.; Stumper O.
Source Heart; 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE
 Available at [Heart](#) from BMJ Journals - NHS
 Available at [Heart](#) 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 [Heart](#) 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 evaluate time trends in the use of catheter and surgical procedures, and associated survival in isolated congenital shunt lesions.
Method(s): Nationwide, retrospective observational study of the UK National Congenital Heart Disease Audit database from 2000 to 2016. Patients undergoing surgical or catheter procedures for atrial septal defect (including sinus venosus defect), patent foramen ovale, ventricular septal defect and patent arterial duct were included. Temporal changes in the frequency of procedures, and survival at 30 days and 1 year were determined.
Result(s): 40 911 procedures were performed, 16 604 surgical operations and 24 307 catheter-based interventions. Transcatheter procedures increased over time, overtaking surgical repair in 2003-2004, while the number of operations remained stable. Trends in interventions differed according to defect type and patient age. Catheter closure of atrial septal defects is now more common in children and adults, although surgical interventions have also increased. Patent foramen ovale closure in adults peaked in 2009-2010 before falling significantly since. Surgery remains the mainstay for ventricular septal defect in infants and children. Duct ligation is most common in neonates and infants, while transcatheter intervention is predominant in older children. Excluding duct ligation, survival following surgery was 99.4% and 98.7%, and following catheter interventions was 99.7% and 99.2%, at 30 days and 1 year, respectively.
Conclusion(s): Trends in catheter and surgical techniques for isolated congenital shunt lesions plot the evolution of the specialty over the last 16 years, reflecting changes in clinical guidelines, technology, expertise and reimbursement, with distinct patterns according to lesion and patient age.
Copyright © Author(s) (or their employer(s)) 2019. Re-use permitted under CC BY. Published by BMJ.

7. 2015 UK software audit of hepatobiliary scintigraphy

Authors O'Shaughnessy E.R.; Murray A.; Taylor J.C.; Barnfield M.; Cullis J.; Cade S.; Kenny B.; Carson K.J.; Towey D.J.; White D.

Source Nuclear Medicine Communications; Feb 2019; vol. 40 (no. 2); p. 136-144

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30650067

Database EMBASE

Available at [Nuclear Medicine Communications](#) 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 This audit investigated hepatobiliary function imaging in UK hospitals, reviewing protocol differences in acquisition and processing parameters and the effect on calculated gallbladder ejection fraction (GBEF). Participants and methods Two dynamic data sets were available: one continuous dynamic data set, and the other with a 5-min break to administer the fatty stimulus. Participants used a set of 12 anonymized patient data sets most similar to their standard protocol calculating GBEF using their routine method. Results Fifty-two UK centres responded. Across all centres for all data sets, there was large variability in GBEF quoted, mostly owing to variations in the calculation method, motion correction and imaging type/times. The largest contributor to GBEF variation was time acquired after stimulus which varied from 20 to 70 min. Only 48.1% centres acquired for 60 min after stimulus, which is the acquisition time stated in normal range references. Overall, 13.5% participating centres administered fatty stimuli that fell below the recommended 10 g. Widespread variations were found in GBEF normal ranges and fatty stimulus administration. Motion correction has a large effect on GBEF; in one data set, motion correction alone changed GBEF from 44 to 9%, but 25% of the participants stated motion correction was not used. Conclusion The authors proposed gold standard is fat content of the stimulus should be at least 10 g; and images should be acquired for 60 min after stimulus. If GBEF is quoted, motion correction should be used, and if compared with a normal range, the stimulus used must fit with the reference.

Copyright © 2018 Wolters Kluwer Health, Inc. All rights reserved.

8. Impact and sustainability of centralising acute stroke services in English metropolitan areas: Retrospective analysis of hospital episode statistics and stroke national audit data

Authors Morris S.; Ramsay A.I.G.; Fulop N.J.; Boaden R.J.; Perry C.; Hunter R.M.; McKeivitt C.; Wolfe C.D.A.; Paley L.; Rudd A.G.; Turner S.J.; Tyrrell P.J.

Source BMJ (Online); 2019; vol. 364

Publication Date 2019

Publication Type(s) Article

PubMedID 30674465

Database EMBASE

Available at [BMJ \(Online\)](#) from BMJ Journals - NHS

Available at [BMJ \(Online\)](#) 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 investigate whether further centralisation of acute stroke services in Greater Manchester in 2015 was associated with changes in outcomes and whether the effects of centralisation of acute stroke services in London in 2010 were sustained. Design Retrospective analyses of patient level data from the Hospital Episode Statistics (HES) database linked to mortality data from the Office for National Statistics, and the Sentinel Stroke National Audit Programme (SSNAP). Setting Acute stroke services in Greater Manchester and London, England. Participants 509 182 stroke patients in HES living in urban areas admitted between January 2008 and March 2016; 218 120 stroke patients in SSNAP between April 2013 and March 2016. Interventions Hub and spoke models for acute stroke care. Main outcome measures Mortality at 90 days after hospital admission; length of acute hospital stay; treatment in a hyperacute stroke unit; 19 evidence based clinical interventions. Results In Greater Manchester, borderline evidence suggested that risk adjusted mortality at 90 days declined overall; a significant decline in mortality was seen among patients treated at a hyperacute stroke unit (difference-in-differences -1.8% (95% confidence interval -3.4 to -0.2)), indicating 69 fewer deaths per year. A significant decline was seen in risk adjusted length of acute hospital stay overall (-1.5 (-2.5 to -0.4) days; $P < 0.01$), indicating 6750 fewer bed days a year. The number of patients treated in a hyperacute stroke unit increased from 39% in 2010-12 to 86% in 2015/16. In London, the 90 day mortality rate was sustained ($P > 0.05$), length of hospital stay declined ($P < 0.01$), and more than 90% of patients were treated in a hyperacute stroke unit. Achievement of evidence based clinical interventions generally remained constant or improved in both areas. Conclusions Centralised models of acute stroke care, in which all stroke patients receive hyperacute care, can reduce mortality and length of acute hospital stay and improve provision of evidence based clinical interventions. Effects can be sustained over time. Copyright © 2018 Published by the BMJ Publishing Group Limited.

9. Analysis of whole genome-transcriptomic organization in brain to identify genes associated with alcoholism

Authors Kapoor M.; Wang J.-C.; Bertelsen S.; Chao M.; Raj T.; Goate A.; Farris S.P.; Mayfield R.D.; Liu Y.; McClintick J.; Nurnberger J.; Foroud T.; Edenberg H.J.; Gupta I.; Meyers J.L.; Porjesz B.; Tischfield J.; Harari O.; Zeran L.; Agrawal A.; Hesselbrock V.; Bauer L.
Source Translational psychiatry; Feb 2019; vol. 9 (no. 1); p. 89
Publication Date Feb 2019
Publication Type(s) Article
PubMedID 30765688
Database EMBASE

Available at [Translational psychiatry](#) from ProQuest (Hospital Premium Collection) - NHS Version
 Available at [Translational psychiatry](#) from Europe PubMed Central - Open Access
 Available at [Translational psychiatry](#) from Nature Publishing Group - Open Access

Abstract Alcohol exposure triggers changes in gene expression and biological pathways in human brain. We explored alterations in gene expression in the Pre-Frontal Cortex (PFC) of 65 alcoholics and 73 controls of European descent, and identified 129 genes that showed altered expression ($FDR < 0.05$) in subjects with alcohol dependence. Differentially expressed genes were enriched for pathways related to interferon signaling and Growth Arrest and DNA Damage-inducible 45 (GADD45) signaling. A coexpression module (thistle2) identified by weighted gene co-expression network analysis (WGCNA) was significantly correlated with alcohol dependence, alcohol consumption, and AUDIT scores. Genes in the thistle2 module were enriched with genes related to calcium signaling pathways and showed significant downregulation of these pathways, as well as enrichment for biological processes related to nicotine response and opioid signaling. A second module (brown4) showed significant upregulation of pathways related to immune signaling. Expression quantitative trait loci (eQTLs) for genes in the brown4 module were also enriched for genetic associations with alcohol dependence and alcohol consumption in large genome-wide studies included in the Psychiatric Genetic Consortium and the UK Biobank's alcohol consumption dataset. By leveraging multi-omics data, this transcriptome analysis has identified genes and biological pathways that could provide insight for identifying therapeutic targets for alcohol dependence.

10. Impact of surgical site infection (SSI) following gynaecological cancer surgery in the UK: A trainee-led multicentre audit and service evaluation

Authors O'Donnell R.L.; Angelopoulos G.; Beirne J.P.; Biliatis I.; Bolton H.; Bradbury M.; Craig E.; Gajjar K.; Mackintosh M.L.; Macnab W.; Madhuri T.K.; McComiskey M.; Myriokefalitaki E.; Newton C.L.; Ratnavelu N.; Taylor S.E.; Thangavelu A.; Crosbie E.J.; Edmondson R.J.; Rhodes S.A.; Wan Y.-L.L.
Source BMJ Open; Jan 2019; vol. 9 (no. 1)
Publication Date Jan 2019
Publication Type(s) Article
PubMedID 30679297
Database EMBASE

Available at [BMJ Open](#) from Europe PubMed Central - Open Access
 Available at [BMJ Open](#) from HighWire - Free Full Text

Abstract Objectives Surgical site infection (SSI) complicates 5% of all surgical procedures in the UK and is a major cause of postoperative morbidity and a substantial drain on healthcare resources. Little is known about the incidence of SSI and its consequences in women undergoing surgery for gynaecological cancer. Our aim was to perform the first national audit of SSI following gynaecological cancer surgery through the establishment of a UK-wide trainee-led research network. Design and setting In a prospective audit, we collected data from all women undergoing laparotomy for suspected gynaecological cancer at 12 specialist oncology centres in the UK during an 8-week period in 2015. Clinicopathological data were collected, and wound complications and their sequelae were recorded during the 30 days following surgery. Results In total, 339 women underwent laparotomy for suspected gynaecological cancer during the study period. A clinical diagnosis of SSI was made in 54 (16%) women. 33% (18/54) of women with SSI had prolonged hospital stays, and 11/37 (29%) had their adjuvant treatment delayed or cancelled. Multivariate analysis found body mass index (BMI) was the strongest risk factor for SSI (OR 1.08[95% CI 1.03 to 1.14] per 1 kg/m² increase in BMI [p=0.001]). Wound drains (OR 2.92[95% CI 1.41 to 6.04], p=0.004) and staple closure (OR 3.13[95% CI 1.50 to 6.56], p=0.002) were also associated with increased risk of SSI. Conclusions SSI is common in women undergoing surgery for gynaecological cancer leading to delays in discharge and adjuvant treatment. Resultant delays in adjuvant treatment may impact cancer-specific survival rates. Modifiable factors, such as choice of wound closure material, offer opportunities for reducing SSI and reducing morbidity in these women. There is a clear need for new trials in SSI prevention in this patient group; our trainee-led initiative provides a platform for their successful completion.
 Copyright © Author(s) (or their employer(s)) 2019.

11. Effectiveness of an antifungal stewardship programme at a London teaching hospital 2010-16

Authors Whitney L.; Al-Ghusein H.; Glass S.; Youngs J.; Wake R.; Houston A.; Bicanic T.; Koh M.; Klammer M.; Ball J.
Source Journal of Antimicrobial Chemotherapy; Jan 2019; vol. 74 (no. 1); p. 234-241
Publication Date Jan 2019
Publication Type(s) Article
PubMedID 30376118
Database EMBASE

Available at [Journal of Antimicrobial Chemotherapy](#) 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 The need for antifungal stewardship is gaining recognition with increasing incidence of invasive fungal infection (IFI) and antifungal resistance alongside the high cost of antifungal drugs. Following an audit showing suboptimal practice we initiated an antifungal stewardship programme and prospectively evaluated its impact on clinical and financial outcomes.
 Patients and Methods: From October 2010 to September 2016, adult inpatients receiving amphotericin B, echinocandins, intravenous fluconazole, flucytosine or voriconazole were reviewed weekly by an infectious diseases consultant and antimicrobial pharmacist. Demographics, diagnosis by European Organization for Research and Treatment of Cancer (EORTC) criteria, drug, indication, advice, acceptance and in-hospital mortality were recorded. Antifungal consumption and expenditure, and candidaemia species and susceptibility data were extracted from pharmacy and microbiology databases.
 Result(s): A total of 432 patients were reviewed, most commonly receiving AmBisomeVR (35%) or intravenous fluconazole (29%). Empirical treatment was often unnecessary, with 82% having no evidence of IFI. Advice was given in 64% of reviews (most commonly de-escalating or stopping treatment) and was followed in 84%. Annual antifungal expenditure initially reduced by 30% (0.98 million to 0.73 million), then increased to 20% above baseline over a 5 year period; this was a significantly lower rise compared with national figures, which showed a doubling of expenditure over the same period. Inpatient mortality, Candida species distribution and rates of resistance were not adversely affected by the intervention.
 Conclusion(s): Provision of specialist input to optimize antifungal prescribing resulted in significant cost savings without compromising on microbiological or clinical outcomes. Our model is readily implementable by hospitals with high numbers of at-risk patients and antifungal expenditure.
 Copyright © 2018. Published by Oxford University Press on behalf of the British Society for Antimicrobial Chemotherapy. All rights reserved.

12. Improving the management of musculoskeletal conditions: Can an alternative approach to referral management underpinned by quality improvement and behavioural change theories offer a solution and a better patient experience? A mixed-methods study

Authors Tzortziou Brown V.; Morrissey D.; Underwood M.; Westwood O.M.
Source BMJ Open; Feb 2019; vol. 9 (no. 2)
Publication Date Feb 2019
Publication Type(s) Article
Database EMBASE
 Available at [BMJ Open](#) from Europe PubMed Central - Open Access

Abstract Available at [BMJ Open](#) from HighWire - Free Full Text
 Objectives To assess whether a quality improvement-based approach to referral management can result in better musculoskeletal care within general practice. Design Prospective cohort study using mixed methodology including random-effects meta-analysis and interrupted time series. Setting and participants 36 general practices in East London. Intervention Informed by the results of a Cochrane review on educational interventions to improve general practitioners' (GPs) musculoskeletal care, we developed a multifaceted intervention, underpinned by quality improvement and behavioural change theories. It combined locally agreed clinical pathways, feedback on referral rates, clinical audit and peer review. Main outcome measures Referral letter content, pathway adherence, referral rates, inter-practice variability and patient experience were evaluated before and after the intervention. Results Referral letter content on suspected diagnosis and prior management improved from a pooled preintervention proportion of 59% (95% CI 53% to 65%) and 67% (95% CI 61% to 73%), respectively, to 77% (95% CI 70% to 84%) and 81% (95% CI 74% to 88%). Pathway adherence improved from a pooled preintervention percentage of 42% (95% CI 35% to 48%) to 66% (95% CI 57% to 76%). The effect was greater across all quality outcomes for practices with baseline performance below or equal to the pooled baseline performance. There were reductions in the variability and rates of orthopaedic referrals at 6, 12 and 18 months (referral rate relative effect 32% (95% CI 14% to 48%), 30% (95% CI 7% to 53%) and 30% (95% CI 0% to 59%), respectively). Patient rating of how well GPs explained the musculoskeletal condition improved by 29% (95% CI 14% to 43%) and patient perception on the usefulness of the GP appointment improved by 24% (95% CI 9% to 38%). Conclusions A quality improvement-based approach to referral management which values GPs' professionalism can result in improvements across a range of outcomes including referral quality, patient experience, referral rates and variability.
 Copyright © Author(s) (or their employer(s)) 2019. Re-use permitted under CC BY. Published by BMJ.

13. Comparative outcomes in patients with ulcer- vs non-ulcer-related acute upper gastrointestinal bleeding in the United Kingdom: a nationwide cohort of 4474 patients

Authors Sey M.S.L.; Brahmania M.; Jairath V.; Mohammed S.B.; Singh S.; Kahan B.C.
Source Alimentary Pharmacology and Therapeutics; Mar 2019; vol. 49 (no. 5); p. 537-545
Publication Date Mar 2019
Publication Type(s) Article
PubMedID 30628112
Database EMBASE

Available at [Alimentary Pharmacology and Therapeutics](#) from Wiley
 Available at [Alimentary Pharmacology and Therapeutics](#) 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 [Alimentary Pharmacology and Therapeutics](#) 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: Outcomes after Nonvariceal upper gastrointestinal bleeding (NVUGIB) have historically focused on ulcer-related causes. Little is known regarding non-ulcer bleeding, the most common cause of NVUGIB. Aim(s): To compare outcomes between ulcer- and non-ulcer-related NVUGIB and explore whether these could be explained by differences in baseline characteristics, bleeding severity or processes of care. Method(s): Analysis of 4474 patients with NVUGIB from 212 United Kingdom hospitals as part of a nationwide audit. Logistic regression models were used to adjust for baseline characteristics, bleeding severity and processes of care. Result(s): 1682 patients had ulcer-related and 2792 patients had non-ulcer-related bleeding. Those with ulcer-related bleeding were older (median age 73 vs 69, $P < 0.001$), less likely to have been taking a PPI (18% vs 32%, $P < 0.001$), more likely to have been taking aspirin (40% vs 27%, $P < 0.001$) and present with shock (43% vs 32%, $P < 0.001$). Furthermore, those with ulcer-related bleeding were more likely to receive blood transfusion (66% vs 39%, $P < 0.001$), PPI infusion (27% vs 5%, $P < 0.001$) and endoscopic therapy (37% vs 8%, $P < 0.001$). Overall, ulcer-related bleeding had higher odds of in-hospital mortality (OR: 1.54; 95% CI: 1.21-1.96, $P < 0.0001$), rebleeding (OR: 2.08; 95% CI: 1.73-2.51, $P < 0.0001$) and need for surgical/radiologic intervention (OR: 2.64; 95% CI: 1.85-3.77, $P < 0.0001$). The associations disappeared after adjustment for bleeding severity, whereas adjustment for patient characteristics or process of care factors had no impact. Conclusion(s): Patients with ulcer-related NVUGIB bleeding have worse outcomes than those with non-ulcer-related NVUGIB bleeding, which is due to more severe bleeding.
 Copyright © 2019 John Wiley & Sons Ltd

14. A large 10-year series from a single-site institution in the United Kingdom of vulva carcinoma: An audit on adherence of United Kingdom guidelines and overall survival

Authors Lwin M.T.; MulaKh A.; Adeagbo T.; Nagar Y.S.; Khoury G.; Rahimi S.; Ihezue C.; Yeoh C.C.
Source Journal of Clinical Oncology; May 2018; vol. 36 (no. 15)
Publication Date May 2018

Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Journal of Clinical Oncology](#) from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.
 Available at [Journal of Clinical Oncology](#) 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 [Journal of Clinical 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 audited if our 10-year-series in our Institution's Vulva Carcinoma adhered with the Royal College of Obstetrician and Gynaecology (RCOG) Guidelines. In United Kingdom, from 2014, the guidelines states 1) Wide local excision of primary tumor with minimum 15mm of disease free tissue is often sufficient 2) Sentinel lymph node (LN) biopsy can be done in unilateral tumor of less than 4cm and if no clinical suspicion of LN involvement 3) In bilateral tumors, only ipsilateral groin node surgery needs to be done initially. Contralateral LN dissection may be required if ipsilateral nodes are positive 4) Groin node dissection should be omitted in stage Ia SCC, BCC, verrucous tumor and melanoma 5) Patient unfit for surgery can be treated with primary radiotherapy (RT) Methods: All Vulva Carcinoma Cancer coded from 2009-2017 were mined from database.
 Result(s): Total of 121 patients. Mean age 74 years old (36-104 years old). Squamous cell carcinoma = 105, Melanoma = 5, Adenoid cyst = 1, Paget's = 2, Verrucous = 2, Basal cell carcinoma = 2, Sarcoma = 1, Adenocarcinoma = 3. All stages of Vulva cancer were 100% compliant with RCOG guidelines, except for Stage 1C, which achieved 62.5% compliance. *Out of 104 vulva cancer, 32 had no indications for surgical groin LN assessment (16 patients in 1a disease + 16 patients stage 4 disease) *72 had indications and were offered surgical groin LN assessment. *However, 45 out of 72 (62.5%) had surgical groin LN assessment. *12 out of 72 (16.7%) were declined due to co morbidities. *15 out of 72 (20.8%) did not wish surgical groin node assessment. Conclusion(s): WLE were offered to all vulva patients. Clear margins were achieved in 97%. RT was offered to 2% of patients as there was not possible to achieve clear margin with re-excision. All eligible patients with indications for groin LN surgical assessment had offered nodal surgery. Patients with multiple comorbidity and not fit for surgery due to their advanced staging were treated with RT alone, chemo/RT and best supportive care. Overall survival was 205.7 weeks. (Table Presented).

15. Social media usage within the cancer community of northern New England

Authors Emery L.P.; Batukbhai B.D.O.; Lansigan F.; Agarwal N.
Source Journal of Clinical Oncology; May 2018; vol. 36 (no. 15)
Publication Date May 2018
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Journal of Clinical Oncology](#) from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.
 Available at [Journal of Clinical Oncology](#) 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 [Journal of Clinical 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: Social media (SM) has changed how patients and caregivers experience cancer. This quality improvement project aims to evaluate and understand the SM experience in a rural northern New England (NNE) cancer community, and design SM content for patient education, support, and engagement. Method(s): We surveyed patients/caregivers (PC) and healthcare providers (HP) across three NNE cancer centers using a survey measuring access and usage of SM. PC surveys were offered to patients in the waiting area. HP surveys were given to NNE providers and solicited via e-Mail. Surveys were done on paper or online with SurveyMonkey. Result(s): 190 PCs and 103 HPs were surveyed. Most had access to the internet (89% PC, 99% HP) and owned mobile devices (67% PC, 99% HP). iPhone was the most common mobile device (57% PC, 75% HP). Few responders utilize cancer-related apps (24% PC, 28% HP). 68% of PCs prefer phone communication over ePortals/e-Mail (36%) and less than half have interest in a secure text messaging system (48% PC, 44% HP). Personal SM use was high (70% PC, 92% HP); cancer or workrelated use was less (27% PC, 18% HP) due to concerns over privacy (66%) and liability (64%). Both groups preferred Facebook (FB) for personal use (57% PC, 80% HP). Among HPs, LinkedIn (71%) was favored over FB (50%) and Twitter (21%) for professional use. 65% of PCs would like to see increased cancer-related SM content from their institution, but only a minority have visited the homepage (40%) or FB page (3%). Conclusion(s): Lack of electronic connectivity can isolate patient populations hindering information sharing. Compared to HPs, PCs had less access to the internet and mobile devices. This may reflect the socioeconomic status of patients in rural communities. In our area, FB is the most commonly used SM platform, favored over other sites such as YouTube and Twitter. PCs would like to see an increase in cancerrelated content from their cancer center, however, the utilization of current platforms is low. There is an opportunity to utilize SM to engage the cancer community in NNE. Enhancing SM visibility by streaming FB Live, promoting "Like us on FB", and forming FB interest groups may improve engagement. By understanding the voice of the customer, cancer centers can tailor their SM content.

16. Do doctors in dispensing practices with a financial conflict of interest prescribe more expensive drugs? A cross-sectional analysis of English primary care prescribing data

Authors Goldacre B.; Powell-Smith A.; Walker A.J.; Croker R.; Reynolds C.; Yates T.A.; Smeeth L.
Source BMJ Open; Feb 2019; vol. 9 (no. 2)
Publication Date Feb 2019
Publication Type(s) Article
Database EMBASE

Available at [BMJ Open](#) from Europe PubMed Central - Open Access
 Available at [BMJ Open](#) from HighWire - Free Full Text

Abstract Objectives Approximately one in eight practices in primary care in England are 'dispensing practices' with an in-house dispensary providing medication directly to patients. These practices can generate additional income by negotiating lower prices on higher cost drugs, while being reimbursed at a standard rate. They, therefore, have a potential financial conflict of interest around prescribing choices. We aimed to determine whether dispensing practices are more likely to prescribe high-cost options for four commonly prescribed classes of drug where there is no evidence of superiority for high-cost options. Design A list was generated of drugs with high acquisition costs that were no more clinically effective than those with the lowest acquisition costs, for all four classes of drug examined. Data were obtained prescribing of statins, proton pump inhibitors (PPIs), angiotensin receptor blockers (ARBs) and ACE inhibitors (ACEis). Logistic regression was used to calculate ORs for prescribing high-cost options in dispensing practices, adjusting for Index of Multiple Deprivation score, practice list size and the number of doctors at each practice. Setting English primary care. Participants All general practices in England. Main outcome measures Mean cost per dose was calculated separately for dispensing and non-dispensing practices. Dispensing practices can vary in the number of patients they dispense to; we, therefore, additionally compared practices with no dispensing patients, low, medium and high proportions of dispensing patients. Total cost savings were modelled by applying the mean cost per dose from non-dispensing practices to the number of doses prescribed in dispensing practices. Results Dispensing practices were more likely to prescribe high-cost drugs across all classes: statins adjusted OR 1.51 (95% CI 1.49 to 1.53, p<0.0001), PPIs OR 1.11 (95% CI 1.09 to 1.13, p<0.0001), ACEi OR 2.58 (95% CI 2.46 to 2.70, p<0.0001), ARB OR 5.11 (95% CI 5.02 to 5.20, p<0.0001). Mean cost per dose in pence was higher in dispensing practices (statins 7.44 vs 6.27, PPIs 5.57 vs 5.46, ACEi 4.30 vs 4.24, ARB 11.09 vs 8.19). For all drug classes, the more dispensing patients a practice had, the more likely it was to issue a prescription for a high-cost option. Total cost savings in England available from all four classes are 628 875 per month or 7 546 502 per year. Conclusions Doctors in dispensing practices are more likely to prescribe higher cost drugs. This is the largest study ever conducted on dispensing practices, and the first contemporary research suggesting some UK doctors respond to a financial conflict of interest in treatment decisions. The reimbursement system for dispensing practices may generate unintended consequences. Robust routine audit of practices prescribing higher volumes of unnecessarily expensive drugs may help reduce costs.
 Copyright © Author(s) (or their employer(s)) 2019.

17. Factors associated with receiving surgical treatment for menorrhagia in England and Wales: Findings from a cohort study of the National Heavy Menstrual Bleeding Audit

Authors Geary R.S.; Gurol-Urganci I.; Kiran A.; Cromwell D.A.; Van Der Meulen J.; Mahmood T.; Bansal-Matharu L.; Shakespeare J.

Source BMJ Open; Feb 2019; vol. 9 (no. 2)

Publication Date Feb 2019

Publication Type(s) Article

Database EMBASE
 Available at [BMJ Open](#) from Europe PubMed Central - Open Access
 Available at [BMJ Open](#) from HighWire - Free Full Text

Abstract Objective To examine the factors associated with receiving surgery for heavy menstrual bleeding (HMB) in England and Wales. Design National cohort study. Setting National Health Service hospitals. Participants Women with HMB aged 18-60 who had a new referral to secondary care. Methods Patient-reported data linked to administrative hospital data. Risk ratios (RR) estimated using multivariable Poisson regression. Primary outcome measure Surgery within 1 year of first outpatient clinic visit. Results 14 545 women were included. At their first clinic visit, mean age was 42 years, mean symptom severity score was 62 (scale ranging from 0 (least) to 100 (most severe)), 73.9% of women reported having symptoms for >1 year and 30.4% reported no prior treatment in primary care. One year later, 42.6% had received surgery. Of these, 57.8% had endometrial ablation and 37.2% hysterectomy. Women with more severe symptoms were more likely to have received surgery (most vs least severe quintile, 33.1% vs 56.0%; RR 1.6, 95% CI 1.5 to 1.7). Surgery was more likely among those who reported prior primary care treatment compared with those who did not (48.0% vs 31.1%; RR 1.5, 95% CI 1.4 to 1.6). Surgery was less likely among Asian and more likely among black women, compared with white women. Surgery was not associated with socioeconomic deprivation. Conclusions Receipt of surgery for HMB depends on symptom severity and prior treatment in primary care. Referral pathways should be locally audited to ensure women with HMB receive care that addresses their individual needs and preferences, especially for those who do not receive treatment in primary care.
 Copyright © Author(s) (or their employer(s)) 2019.

18. Causes of renal allograft failure in the UK: trends in UK Renal Registry and National Health Service Blood and Transplant data from 2000 to 2013

Authors Burton H.; Hilton R.; Iyamu Perisanidou L.; Steenkamp R.; Evans R.; Evans K.M.; Caskey F.J.; Mumford L.

Source Nephrology, dialysis, transplantation : official publication of the European Dialysis and Transplant Association - European Renal Association; Feb 2019; vol. 34 (no. 2); p. 355-364

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 29982787

Database EMBASE
 Available at [Nephrology, dialysis, transplantation : official publication of the European Dialysis and Transplant Association - European Renal Association](#) 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 [Nephrology, dialysis, transplantation : official publication of the European Dialysis and Transplant Association - European Renal Association](#) 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: Improvement in long-term renal allograft survival is impeded by incomplete or erroneous coding of causes of allograft loss. This study reports 13-year trends in causes of graft failure across the UK. Method(s): National Health Service Blood and Transplant (NHSBT) and UK Renal Registry data were linked to describe UK kidney patients transplanted in 2000-13. NHSBT graft failure categories were used, with 'other' recoded when free text was available. Adjusted analyses examined the influence of age, ethnicity and donor type on causes of graft failure. Result(s): In 22 730 recipients, 5389 (23.7%) grafts failed within a median follow-up of 5 years. The two most frequent causes were death with a functioning graft (40.8%) and alloimmune pathology (25.0%). Graft survival was higher in recipients who were younger (mean 47.3 versus 50.7years), received a pre-emptive transplant (20.2% versus 10.4%), spent less time on dialysis (median 1.6 versus 2.4years) and received a living donor transplant (36.3% versus 22.2%), with no differences by sex, ethnicity or human leucocyte antigen mismatch. Allograft failure within 2 years of transplantation fell from 12.5% (2000-4) to 9.8% (2009-13). Surgical- and alloimmune-related failures decreased over time while death with a functioning graft became more common. Age, ethnicity and donor type were factors in recurrent primary disease and alloimmune pathology. Conclusion(s): Since 2000 there have been reductions in surgical and alloimmune graft failures in the UK. However, graft failure codes need to be revised if they are to remain useful and effective in epidemiological and quality improvement trials.

19. Temporal trends in survival following ward-based NIV for acute hypercapnic respiratory failure in patients with COPD

Authors Trethewey S.P.; Morlet J.; Mukherjee R.; Turner A.M.; Edgar R.G.
Source Clinical Respiratory Journal; 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE
Available at [Clinical Respiratory Journal](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at [Clinical Respiratory Journal](#) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection

Abstract
Introduction: Non-invasive ventilation (NIV) is recommended for treatment of acute hypercapnic respiratory failure (AHRF) in acute exacerbations of COPD. National UK audit data suggests that mortality rates are rising in COPD patients treated with NIV.
Objective(s): To investigate temporal trends in in-hospital mortality in COPD patients undergoing a first episode of ward-based NIV for AHRF.
Method(s): Retrospective study of hospitalised COPD patients treated with a first episode of ward-based NIV at a large UK teaching hospital between 2004 and 2017. Patients were split into two cohorts based on year of admission, 2004-2010 (Cohort 1) and 2013-2017 (Cohort 2), to facilitate comparison of patient characteristics.
Result(s): In total, 547 unique patients were studied. There was no difference in in-hospital mortality rate between the time periods studied (17.6% vs 20.5%, P = .378). In Cohort 2 there were more females, a higher rate of co-morbid bronchiectasis and pneumonia on admission and more severe acidosis, hypercapnia and hypoxia. More patients in Cohort 2 had NIV as the ceiling of treatment. Patients in Cohort 2 experienced a longer time from AHRF diagnosis to application of NIV, higher maximum inspiratory positive airway pressure, lower maximum oxygen and shorter duration of NIV. Finally, patients in Cohort 2 experienced a shorter hospital length of stay (LOS), with no differences observed in rate of transfer to critical care or intubation.
Conclusion(s): In-hospital mortality remained stable and LOS decreased over time, despite greater comorbidity and more severe AHRF in COPD patients treated for the first time with ward-based NIV.
Copyright © 2019 John Wiley & Sons Ltd

20. Incidence of severe critical events in paediatric anaesthesia in the United Kingdom: secondary analysis of the anaesthesia practice in children observational trial (APRICOT study)

Authors Engelhardt T.; Ayansina D.; Bell G.T.; Oshan V.; Rutherford J.S.; Morton N.S.
Source Anaesthesia; Mar 2019; vol. 74 (no. 3); p. 300-311
Publication Date Mar 2019
Publication Type(s) Article
PubMedID 30536369
Database EMBASE
Available at [Anaesthesia](#) from Wiley
Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 The anaesthesia practice in children observational trial of 31,127 patients in 261 European hospitals revealed a high (5.2%) incidence of severe critical events in the peri-operative period and wide variability in practice. A sub-analysis of the UK data was undertaken to investigate differences compared with the non-UK cohort in the incidence and nature of peri-operative severe critical events and to attempt to identify areas for quality improvement. In the UK cohort of 7040 paediatric patients from 43 hospitals, the overall incidence of peri-operative severe critical events was lower than in the non-UK cohort (3.3%, 95%CI: 2.9-3.8 vs. 5.8%, 95%CI: 5.5-6.1, RR 0.57, $p < 0.001$). There was a lower rate of bronchospasm (RR 0.22, 95%CI: 0.14-0.33; $p < 0.001$), stridor (RR 0.42, 95%CI: 0.28-0.65; $p < 0.001$) and cardiovascular instability (RR 0.69, 95%CI: 0.55-0.86; $p = 0.001$) than in the non-UK cohort. The proportion of sicker patients where less experienced teams were managing care was lower in the UK than in the non-UK cohort (10.4% vs. 20.4% of the ASA physical status 3 and 9% vs. 12.9% of the ASA physical status 4 patients). Differences in work-load between centres did not affect the incidence and outcomes of severe critical events when stratified for age and ASA physical status. The lower incidence of cardiovascular and respiratory complications could be partly attributed to more experienced dedicated paediatric anaesthesia providers managing the higher risk patients in the UK. Areas for quality improvement include: standardisation of serious critical event definitions; increased reporting; development of evidence-based protocols for management of serious critical events; development and rational use of paediatric peri-operative risk assessment scores; implementation of current best practice in provision of competent paediatric anaesthesia services in Europe; development of specific training in the management of severe peri-operative critical events; and implementation of systems for ensuring maintenance of skills.
 Copyright © 2018 Association of Anaesthetists

21. Major obstetric haemorrhage of 2000 ml or greater: a clinical audit

Authors O'Sullivan J.; Mansfield R.; Talbot R.; Cairns A.E.
Source Journal of Obstetrics and Gynaecology; Nov 2018; vol. 38 (no. 8); p. 1065-1072
Publication Date Nov 2018
Publication Type(s) Article
PubMedID 29724141
Database EMBASE

Available at [Journal of Obstetrics and Gynaecology](#) 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 [Journal of Obstetrics and Gynaecology](#) 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 Haemorrhage remains a leading cause of maternal death. We conducted an audit to identify strategies to improve the management at our local NHS Trust. A data collection form was based on our local guideline. A coded database search was conducted for all deliveries where the estimated blood loss was ≥ 2000 ml (from June 1 2015 to December 31 2015), returning 68 search results (13.7/1000 births). Fifty-six records were included. Poor compliance ($< 75\%$) was seen in some key areas including the major obstetric haemorrhage (MOH) call activation (52%), the presence of an anaesthetic consultant (63%) and tranexamic acid administration (46%). Thirty out of 56 cases (54%) were acutely transfused. Women, who were not transfused acutely, appeared to be more likely to need a secondary transfusion if no MOH call had been activated (9/27 (33%) versus 3/29 (10%), $p = .052$). A key area for improvement was the activation of MOH calls. Following this audit, we adjusted our guideline to make it more clinically useful and staff training sessions were held, including simulation training. Impact statement What is already known on this subject? A postpartum haemorrhage (PPH) is an obstetric emergency. A structured approach is important to optimise the care of the mothers during this dangerous time, and has been shown to reduce the transfusion requirements. However, clinical practice may not adhere to the guideline recommendations. What the results of this study add? With the objective evidence of increased rates of PPH ≥ 2000 ml at our institution, our work identifying the flaws in management was a critical component of the work to improve the outcomes. This study gives impetus to find innovative ways to improve adherence to guidelines, and inspired an update of our local guideline to improve the applicability and utility. This project suggests a new marker for the adequacy of an acute management (a requirement for secondary blood transfusion without having received an acute transfusion), and raises questions about what constitutes optimum PPH management. What the implications are of these findings for clinical practice and/or further research? The primary and secondary transfusion data raised new questions to investigate in the future: does the involvement of consultants and the escalation of care via the instigation of major haemorrhage protocols improve decision-making and patient outcomes? Does the necessity for a secondary transfusion indicate a suboptimal acute care?.
 Copyright © 2018, © 2018 Informa UK Limited, trading as Taylor & Francis Group.

22. Abstracts From the Neuro Anaesthesia and Critical Care Society of Great Britain and Ireland Annual Scientific Meeting

Authors anonymous
Source Journal of Neurosurgical Anesthesiology; Jan 2019; vol. 31 (no. 1)

Publication Date Jan 2019
Publication Type(s) Conference Review
Database EMBASE
 Available at [Journal of Neurosurgical Anesthesiology](#) 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 [Journal of Neurosurgical Anesthesiology](#) 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 The proceedings contain 14 papers. The topics discussed include: what is the role of cell salvage in spinal surgery?; developing the multidisciplinary intra-arterial thrombectomy service for hyperacute stroke in Wessex neurological center: a new role for simulation; effect of lateral brain displacement on cerebral autoregulation in acutely comatose neurocritically ill patients; central venous, peripherally inserted central and midline catheters on neurointensive care: a retrospective audit; measurement of patient reported quality outcomes using QoR-15 scores after craniotomy; timing and quality of neurological observation in a post-anesthetic care unit following day-time and out-of-hours neurosurgery; adherence to guidelines for neurosurgical antibiotic prophylaxis in long operations; and a service evaluation of transthoracic echocardiography in neurocritical care: could FICE be useful?.

23. Timing and quality of neurological observation in a postanesthetic care unit following day-time and out-of-hours neurosurgery

Authors Hewson D.W.; Tsim P.C.F.
Source Journal of Neurosurgical Anesthesiology; Jan 2019; vol. 31 (no. 1); p. 93-94
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Journal of Neurosurgical Anesthesiology](#) 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 [Journal of Neurosurgical Anesthesiology](#) 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: Following neurosurgery close observation of neurological function is required to detect early surgical complications. According to local policy, postanesthetic care unit (PACU) staff should perform timely (at least every 15 min for 1 h, 30 min thereafter) and complete (conscious level, pupillary, and limb examination) assessments and escalate concerns to medical colleagues promptly. Standards of care should be maintained for out-of-hours neurosurgical cases.
 Method(s): A retrospective audit was performed to assess the timing and completeness of neurological assessments in PACU in day-time (08:00 to 20:00) and out-of-hours (20:00 to 08:00) neurosurgical patients at Nottingham University Hospitals NHS Trust (NUH). Patients who arrived in PACU in the day-time October 1, 2017 to October 15, 2017, or out-ofhours October 1, 2017 to December 31, 2017 were included. The project was registered with the NUH Clinical Quality Team.
 Result(s): Sixty-seven patients were identified in the out-of-hours group. Twenty-four patients bypassed PACU for critical care and 3 records were not available, therefore 40 patients were included in the analysis. Fiftythree patients were identified in the day-time group. Two patients bypassed PACU for critical care and 1 record was not available, so 50 patients were included in the analysis. Table 1 summarizes the results. Time from PACU arrival to first assessment was not significantly different between groups (Mann Whitney U test, P=0.211). The proportion of correctly timed complete assessments was higher in the out-of-hours group (Fishers exact, P=0.019). The time from last PACU assessment until first ward assessment was shorter in the out-of-hours group (Mann Whitney U test, P=0.009). There were no failure to escalate episodes in this study cohort.
 Conclusion(s): Standards of observation following neurosurgery in this audit were high regardless of time of day. Further work is required to identify reasons for any delays in neurological assessments on the ward. (Table Presented).

24. Central venous, peripherally inserted central and midline catheters on neurointensive care: A retrospective audit

Authors Snooks R.; Catton T.; Harris M.; Galea M.
Source Journal of Neurosurgical Anesthesiology; Jan 2019; vol. 31 (no. 1); p. 92-93
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Journal of Neurosurgical Anesthesiology](#) 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

Available at [Journal of Neurosurgical Anesthesiology](#) 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.

Introduction: Central venous catheters (CVC), peripherally inserted central catheters (PICC), and increasingly midlines, are used frequently in intensive care unit (ICU). Approximately 200,000 CVCs are inserted in the United Kingdom annually.¹ Few data exist on the frequency of use of midlines and PICC lines.² In our ICU a high proportion of CVCs inserted are subclavian lines for management of traumatic brain injury patients with raised ICP. In addition, PICC and midlines are used for access in spinal and long-term patients. The aims of this audit were to compare insertion techniques with the literature and to identify complication rates.

Method(s): We conducted a retrospective audit of all CVC, midline, and PICC lines inserted over a 6-month period. A data list was compiled using the Metavision Clinical Information System. Each insertion record form was analyzed and data entered into Microsoft Excel. Complications were established from the CVC care record. Microbiology data were gathered using hospital e-quest system.

Result(s): One hundred and twenty lines were inserted over the 6-month period: 55 CVCs, 43 midlines, and 22 PICC lines. In total, 24 of 55 CVCs were subclavian lines. Five subclavian CVCs were inserted without ultrasound by consultants. Ultrasound guidance was used for all femoral and jugular lines. All lines were transduced and documented safe to use. No pneumothoraces were reported. One CVC had culture confirmed line infection. In total, 2 of 43 midlines had confirmed line infection with 1 associated upper limb DVT. There were no PICC line complications. Completion of the insertion proforma documentation was 91%.

Conclusion(s): This audit indicates that our unit has low infection rates and comparatively few CVC complications, despite a high rate of subclavian line use.^{1,3} Consequently we are developing formal subclavian line training, which has been identified as a useful educational requirement for anesthetic and ICU trainees placed in the unit. It also demonstrated safe use of PICC and midlines in longer-term patients.

25. Developing the multidisciplinary intra-arterial thrombectomy service for hyperacute stroke in wessex neurological centre: A new role for simulation

Authors Wood L.; Cook C.J.
Source Journal of Neurosurgical Anesthesiology; Jan 2019; vol. 31 (no. 1); p. 91-92
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Journal of Neurosurgical Anesthesiology](#) 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 [Journal of Neurosurgical Anesthesiology](#) 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: Stroke is a devastating disease with an estimated 80,000 admissions per year in England at a cost of 3 billion to the NHS. Intraarterial thrombectomy (IAT) for acute ischemic stroke improves outcomes, one of the biggest contributory factors being rapid access to interventional neuroradiology (INR).¹ Our Sentinel Stroke National Audit Programme report last year suggested room for improvement with regard to door-to-needle time. We therefore instituted a simulation program to streamline this time-critical pathway.

Method(s): We developed 2 IAT simulations: the first critically reviewed the pathway from prealert to the INR suite; the second examined the regional transfer pathway from a district general hospital. We used a fully monitored mannikin, accompanied by a relative. The emergency department, stroke and INR teams were unaware of the simulations, during which a team of observers took notes and documented timings. Immediately after each scenario we had a hot debrief where all participants and observers could reflect on what had happened. Following these discussions, we have disseminated learning and action points.

Result(s): There were a number of areas where we felt improvements could be made, including: improved prealert information; a comprehensive stroke proforma; enhancing team activation by creating an IAT contact board; streamlining radiology requests; defining a place of safety for patient assessment and care; providing written information for relatives; developing an abridged WHO checklist; reviewing the consent process; and improving anesthetic team guidance. We have implemented a comprehensive database and are working to improve regional transfers by developing a transfer checklist.

Conclusion(s): Simulations were very well received by all concerned and have proved a very valuable tool for developing the IAT pathway at UHS. They have resulted in improved collaboration and a better understanding of team members' roles and challenges.

26. What is the role of cell salvage in spinal surgery?

Authors Carroll C.; Makin I.
Source Journal of Neurosurgical Anesthesiology; Jan 2019; vol. 31 (no. 1); p. 91
Publication Date Jan 2019
Publication Type(s) Conference Abstract

Database EMBASE
 Available at [Journal of Neurosurgical Anesthesiology](#) 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 [Journal of Neurosurgical Anesthesiology](#) 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: Cell salvage is a procedure whereby blood lost during surgery is collected from the operating site, processed, and reinfused back into the patient after surgery. The aim of this audit was to determine whether cell salvage use in spinal patients is in accordance with the current guidelines and also to determine the value of cell salvage use in these patients.
 Method(s): Data on the use of cell salvage were collected between June 1, 2016 to September 12, 2016. Patients were included if they had the cell salvage machine set up during their operation and were undergoing spinal surgery. Eighty-four patients were included in this audit. Current guidelines on the use of cell salvage are available from the Association of Anaesthetists of Great Britain and Ireland. Cell salvage use was compared with these guidelines. To determine the value of cell salvage in spinal surgery patients, those who did not derive benefit from cell salvage were identified. These were patients who did not get any blood returned and patients who received autologous blood but who without the transfusion would not have been anemic.
 Result(s): Of the patients undergoing spinal surgery who had the cell salvage machine set up 73 of 84 met the requirements for cell salvage use (Fig. 1). Of the patients who had the machine set up, 11 did not lose enough blood for it to be processed. In addition, 2 patients would not have been anemic had salvaged blood not been returned and so cell salvage could not be justified in these patients. In total only 13 of 84 spinal patients did not derive benefit from the cell salvage machine. Up to 122 units of donated blood were saved due to the use of the cell salvage machine during this time period.
 Conclusion(s): This audit demonstrates that the current guidelines identify patients undergoing spinal surgery who benefit from this resource and that its use has the potential to reduce the volume of donor blood required. (Figure Presented) .

27. Going paperless: improved cataract surgery outcome data quality in a new fully electronic unit

Authors Nghiem A.Z.; Canning C.; Eason J.; Flynn T.H.; Sparrow J.M.
Source Eye (Basingstoke); 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE
 Available at [Eye \(Basingstoke\)](#) 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 \(Basingstoke\)](#) 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 report outcome data on the first 5000 consecutive cataract cases at a new paperless eye unit and benchmark against the Royal College of Ophthalmologists' National Ophthalmology Database (RCOphth NOD).
 Method(s): Using the in-built audit tool of the electronic medical records system, data from all cataract operations performed between 1 April 2014 and 13 January 2017 were compiled.
 Result(s): Five thousand and eight cases were recorded of which the overall intra-operative complication rate was 2.4%, the most common being posterior capsular rupture-1.14%. Follow-up data on post-operative complications were recorded in 98.6% of cases. Pre- and post-operative visual acuities was measured in 98.0% of cases. In all, 40.8% of eyes achieved a visual acuity of 6/6 or better and 90.7% achieved 6/12 or better.
 Conclusion(s): A data set of >5000 consecutive cataract operations was obtained in this eye department. The recording of pre- and post-operative visual acuity in 98% of cases compare very favourably to the RCOphth NOD Audit Report 2017 where pre- and post-operative visual acuities were recorded in only 57.1% of operations. Despite this difference, the outcome measures from this unit and RCOphth NOD were very similar, validating the results of the RCOphth NOD audit reports. Significantly, when applying the RCOphth NOD audit criteria for measuring post-operative visual acuity, approximately 15% of cases were excluded from the data set, reducing the completeness of the data set. Paperless ophthalmology units are feasible in today's NHS and can produce near complete cataract data sets; this can ultimately lead to more comprehensive and reliable aggregate cataract outcome data.
 Copyright © 2019, The Royal College of Ophthalmologists.

28. Genome-wide association study meta-analysis of the alcohol use disorders identification test (AUDIT) in two population-based cohorts

Authors Sanchez-Roige S.; Palmer A.A.; Fontanillas P.; Elson S.L.; Adams M.J.; Howard D.M.; Edenberg H.J.; Davies G.; Crist R.C.; Deary I.J.; McIntosh A.M.; Clarke T.-K.; Elson L.; Furlotte N.A.; Hinds D.A.; Huber K.E.; Kleinman A.; Litterman N.K.; McCreight J.C.; McIntyre M.H.; Mountain J.L.; Noblin E.S.; Northover C.A.M.; Pitts S.J.; Sathirapongsasuti J.F.; Sazonova O.V.; Shelton J.F.; Shringarpure S.; Tian C.; Tung J.Y.; Vacic V.; Wilson C.H.

Source American Journal of Psychiatry; Feb 2019; vol. 176 (no. 2); p. 107-118

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30336701

Database EMBASE

Available at [American Journal of Psychiatry](#) 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 [American Journal of Psychiatry](#) 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: Alcohol use disorders are common conditions that have enormous social and economic consequences. Genome-wide association analyses were performed to identify genetic variants associated with a proxy measure of alcohol consumption and alcohol misuse and to explore the shared genetic basis between these measures and other substance use, psychiatric, and behavioral traits.

Method(s): This study used quantitative measures from the Alcohol Use Disorders Identification Test (AUDIT) from two population-based cohorts of European ancestry (UK Biobank [N=121,604] and 23andMe [N=20,328]) and performed a genome-wide association study (GWAS) meta-analysis. Two additional GWAS analyses were performed, a GWAS for AUDIT scores on items 1-3, which focus on consumption (AUDIT-C), and for scores on items 4-10, which focus on the problematic consequences of drinking (AUDIT-P).

Result(s): The GWAS meta-analysis of AUDIT total score identified 10 associated risk loci. Novel associations localized to genes including JCAD and SLC39A13; this study also replicated previously identified signals in the genes ADH1B, ADH1C, KLB, and GCKR. The dimensions of AUDIT showed positive genetic correlations with alcohol consumption ($r_g=0.76-0.92$) and DSM-IV alcohol dependence ($r_g=0.33-0.63$). AUDIT-P and AUDIT-C scores showed significantly different patterns of association across a number of traits, including psychiatric disorders. AUDIT-P score was significantly positively genetically correlated with schizophrenia ($r_g=0.22$), major depressive disorder ($r_g=0.26$), and attention deficit hyperactivity disorder ($r_g=0.23$), whereas AUDIT-C score was significantly negatively genetically correlated with major depressive disorder ($r_g=0.24$) and ADHD ($r_g=0.10$). This study also used the AUDIT data in the UK Biobank to identify thresholds for dichotomizing AUDIT total score that optimize genetic correlations with DSM-IV alcohol dependence. Coding individuals with AUDIT total scores ≥ 4 as control subjects and those with scores ≥ 12 as case subjects produced a significant high genetic correlation with DSM-IV alcohol dependence ($r_g=0.82$) while retaining most subjects.

Conclusion(s): AUDIT scores ascertained in population-based cohorts can be used to explore the genetic basis of both alcohol consumption and alcohol use disorders.

Copyright © 2019 American Psychiatric Association. All Rights Reserved.

29. Diagnosis and referral delays in primary care for oral squamous cell cancer: A systematic review

Authors Grafton-Clarke C.; Chen K.W.; Wilcock J.

Source British Journal of General Practice; Feb 2019; vol. 69 (no. 679)

Publication Date Feb 2019

Publication Type(s) Review

PubMedID 30455220

Database EMBASE

Available at [British Journal of General Practice](#) from EBSCO (MEDLINE Complete)

Available at [British Journal of General Practice](#) 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 [British Journal of General 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.

Abstract Background The incidence of oral cancer is increasing. Guidance for oral cancer from the National Institute for Health and Care Excellence (NICE) is unique in recommending cross-primary care referral from GPs to dentists. Aim This review investigates knowledge about delays in the diagnosis of symptomatic oral squamous cell carcinoma (OSCC) in primary care. Design and setting An independent multi-investigator literature search strategy and an analysis of study methodologies using a modified data extraction tool based on Aarhus checklist criteria relevant to primary care. Method The authors conducted a focused systematic review involving document retrieval from five databases up to March 2018. Included were studies looking at OSCC diagnosis from when patients first accessed primary care up to referral, including length of delay and stage of disease at time of definitive diagnosis. Results From 538 records, 16 articles were eligible for full-text review. In the UK, more than 55% of patients with OSCC were referred by their GP, and 44% by their dentist. Rates of prescribing between dentists and GPs were similar, and both had similar delays in referral, though one study found greater delays attributed to dentists as they had undertaken dental procedures. On average, patients had two to three consultations before referral. Less than 50% of studies described the primary care aspect of referral in detail. There was no information on inter-GP-dentist referrals. Conclusion There is a need for primary care studies on OSCC diagnosis. There was no evidence that GPs performed less well than dentists, which calls into question the NICE cancer option to refer to dentists, particularly in the absence of robust auditable pathways. Copyright © British Journal of General Practice.

30. Medical leadership and general practice: Seductive or dictatorial?

Authors Manthorpe J.; Iliffe S.
Source British Journal of General Practice; Feb 2019; vol. 69 (no. 679); p. 52-53
Publication Date Feb 2019
Publication Type(s) Editorial
PubMedID 30704990
Database EMBASE
Available at [British Journal of General Practice](#) from EBSCO (MEDLINE Complete)
Available at [British Journal of General Practice](#) 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 [British Journal of General 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.

31. The protective effects of cognitive reserve in major depressive disorder

Authors Serra-Blasco M.; Vicent-Gil M.; Navarra-Ventura G.; Aguilar E.; Goldberg X.; Crivilles S.; Acebillo S.; Palao D.; Cardoner N.; Portella M.J.
Source European Neuropsychopharmacology; 2019; vol. 29
Publication Date 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Neuropsychopharmacology](#) 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: Cognitive reserve (CR) refers to the potential capacity of an adult brain to cope with brain pathology. Although it was first conceptualized for neurological conditions, CR has also demonstrated protective effects in neuropsychiatric disorders [1], being positively associated with cognitive and clinical outcomes [2,3]. However, despite the fact that major depressive disorder (MDD) entails high levels of cognitive and psychosocial dysfunction, the potential role of CR has never been studied.

Aim(s): To explore the association between CR and cognitive and psychosocial functioning in a sample of patients with MDD.

Method(s): The sample included 56 MDD patients at clinical remission (HDRS-17 \leq 7). Clinical data included depressive symptoms (Hamilton Depression Rating Scale, HDRS-17), burden of medication (Antidepressant Treatment History form, ATHF) and illness duration (in months). Five cognitive domains were assessed: Attention (Forward Digits of the WAIS-IV, Spatial Span Forward, WMS-III) and Trail Making Test A, TMT-A); working memory (Backwards Digits of the WAIS-IV and Spatial Span Backward, WMS-III); verbal memory (Rey Auditory Verbal Learning Test, RAVLT -Acquisition (sum of trial 1 to 5) and delayed recall-); processing speed (Digit Symbol Substitution subtest, DSST; WAIS-IV) and executive function (Phonetic fluency; Trail Making Test B, TMT-B; Wisconsin Card Sorting Test, WCST; Tower of London, TOL). Cognitive reserve was obtained through three proxies: premorbid intelligence quotient, education level and occupational attainment across the life course (The International Standard Classification of Occupations, ISCO). Functioning Assessment Short Test (FAST) was used to measure psychosocial functioning. Backward linear regression analyses were performed to explain cognitive and psychosocial functioning including the following variables as explanatory factors: CR, HDRS-17, ATHF and illness duration in months.

Result(s): The mean age of the sample was 50.86 (SD =11.65) and 62.5% of the participants were female. At the time of inclusion, duration of illness in months was 152.58 (SD=129.8) and mean depression severity score was 3.75 (SD =2.32). Multiple regression models showed that CR was the only significant predictor of attention (adjusted R²=0.16, F(1,49)=10.34, p=0.002), working memory (adjusted R²=0.07, F(1,49)=4.54, p=0.038), processing speed (adjusted R²=0.17, F(2,48)=6.11, p=0.004) and executive function (adjusted R²=0.12; F(2,44)=3.99, p=0.026) performance. The verbal memory model did not reach the statistical significance cut-off (adjusted R²=0.055; F(1,49)=3.91, p=0.054). In the case of psychosocial functioning, the model explained a 30% of the variance, and depressive symptoms -HDRS-17- and CR were the significant predictors (adjusted R²=0.3, F(2,48)=11.72, p<0.001).

Conclusion(s): The obtained results showed that cognitive reserve was significantly associated with cognitive functioning of MDD patients. It was the only factor to be significant in all cognitive domains, except for verbal memory. Moreover, higher levels of cognitive reserve and low scores of depressive symptomatology explained a better psychosocial functioning. Therefore, as cognitive reserve may attenuate the manifestation of cognitive deficits and psychosocial dysfunctioning, interventions that may favour its enhancement may constitute an early preventive strategy for those subjects with greater vulnerability for affective disorders.

Copyright © 2018

32. Implementation of tranexamic acid for bleeding trauma patients: A longitudinal and cross-sectional study

Authors Coats T.J.; Fragoso-Iniguez M.; Roberts I.
Source Emergency Medicine Journal; Feb 2019; vol. 36 (no. 2); p. 78-81
Publication Date Feb 2019
Publication Type(s) Review
PubMedID 30530744
Database EMBASE

Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS

Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 describe the use of tranexamic acid (TXA) in trauma care in England and Wales since the Clinical Randomization of an Antifibrinolytic in Significant Hemorrhage (CRASH-2) trial results were published in 2010. Method(s): A national longitudinal and cross-sectional study using data collected through the Trauma Audit and Research Network (TARN), the clinical audit of major trauma care for England and Wales. All patients in the TARN database injured in England and Wales were included apart from those with an isolated traumatic brain injury, with a primary outcome of the proportion of patients given TXA and the secondary outcome of time to treatment. Result(s): Among 228 250 patients, the proportion of trauma patients treated with TXA increased from near zero in 2010 to 10% (4593) in 2016. In 2016, most patients (82%) who received TXA did so within 3 hours of injury, however, only 30% of patients received TXA within an hour of injury. Most (80%) of the patients who had an early blood transfusion were given TXA. Patients treated with TXA by an ambulance paramedic received treatment at a median of 49 min (IQR 33-72) compared with 111 min (IQR 77-162) for patients treated in hospital. Conclusion(s): There is a low proportion of patients treated with TXA across the range of injury severity and the range of physiological indicators of severity of bleeding. Most patients receive treatment within the existing target of 3 hours from injury, however there remains the potential to further improve major trauma outcomes by the earlier treatment of a wider patient group. Copyright © Author(s) (or their employer(s)) 2019.

33. UK national audit of safety checks for radiology interventions

Authors Ariyanayagam T.; Malcolm P.; Drinkwater K.; Howlett D.; Cozens N.
Source British Journal of Radiology; 2019; vol. 92 (no. 1094)
Publication Date 2019
Publication Type(s) Article
PubMedID 30495979
Database EMBASE

Available at [British Journal of Radiology](#) 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 reaudit the use of safety checklists in radiology departments in NHS departments throughout the UK. Method(s): This audit was performed on behalf of The Royal College of Radiologists Audit Committee in 2016 and was sent to radiology audit leads at every NHS department in the UK to determine the use of safety checks in various modalities and subspecialties. Freeform text boxes gathered data on problems with checklist implementation. Result(s): 109/177 (62%) trusts responded. 48% of respondents used safety checklists for all radiological procedures in all modalities. 50% used checklists for some procedures. 2% did not use a checklist. Checklist use had increased since the previous audit (98% 2016, compared to 94% in 2012) but implementation for different procedures remains variable. For example, in ultrasound-guided fine needle and breast stereotactic procedures (49%), use has not increased since 2012. Conclusion(s): Reasons for not using checklists include a perception that intervention suite checklists were not appropriate for minor procedures and the limited flexibility of radiology information systems. The limitations of checklists are discussed. Advances in knowledge: Our reaudit shows that in spite of increased implementation, use of safety checks is variable. Local ownership and radiology information system flexibility are needed to support the culture of safety processes in radiology departments. Copyright © 2019 The Authors. Published by the British Institute of Radiology

34. The mental health and wellbeing of medical trainees - autonomic, immunological and behavioural considerations

Authors Vollmer-Conna U.; Huang S.; Macnamara C.; Beilharz J.; Imants P.; Cvejic E.; Parker G.
Source Brain, Behavior, and Immunity; Feb 2019; vol. 76
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Brain, Behavior, and Immunity](#) 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 News of unacceptable levels of mental health problems among medical trainees was widely broadcast. The available evidence is largely derived from survey-based studies. Less is known about biological concomitants of distress in this group. In a series of studies, we assessed behavioural (health behaviours, sleep, cognitive performance), and biological (autonomic and inflammatory) contributors to wellbeing in more than 300 medical trainees. Psychiatric interviews (M.I.N.I.7) were conducted in a subset of 150 student doctors. Autonomic activity was derived from ambulatory electrocardiogram (Equival, UK). C-reactive protein levels were determined via HS-ELISA (Invitrogen, Australia). Consistent with previous reports, 32% of respondents reported substantive psychological distress (Kessler10 > 20). This was linked to poor sleep quality ($p < 0.001$), reduced nocturnal parasympathetic activity [heart rate variability (HRV) $p = 0.006$], and lower physical health scores ($p < 0.003$). Executive functioning was impacted by both poor sleep ($p = 0.02$) and low nocturnal HRV ($p = 0.009$). One third of trainees fulfilled diagnostic criteria for at least one mental disorder (current or past, DSM-V); these also showed significant nocturnal autonomic dysfunction. Trainees at risk of harmful alcohol use (AUDIT > 8) were more likely to have mental health problems ($p = 0.027$), disordered sleep ($p = 0.035$), and CRP levels above 3 mg/L (0.016). Disturbances in biological systems are evident in student doctors who experience mental health problems during their training. This may engender a vicious cycle of ill health at great cost to the individual and society.
 Copyright © 2018

35. My Diabetes My Way: supporting online diabetes self-management: progress and analysis from 2016

Authors Cunningham S.G.; Brillante M.; Allardice B.; Conway N.; McAlpine R.R.; Wake D.J.
Source Biomedical engineering online; Feb 2019; vol. 18 (no. 1); p. 13
Publication Date Feb 2019
Publication Type(s) Article
PubMedID 30736798
Database EMBASE

Available at [Biomedical engineering online](#) from ProQuest (Hospital Premium Collection) - NHS Version
 Available at [Biomedical engineering online](#) from BioMed Central
 Available at [Biomedical engineering online](#) from Europe PubMed Central - Open Access
 Available at [Biomedical engineering online](#) 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: My Diabetes My Way (MDMW) is the National Health Service (NHS) Scotland website for people with diabetes and their carers. It consists of an interactive information website and an electronic personal health record (ePHR) available to the 291,981 people with diabetes in Scotland. We aimed to analyse the demographic characteristics of current registrants and system usage and activity during 2016. METHOD(S): We analysed system audit trails to monitor user activity and page accesses on the information website, and logins and activity within the ePHR. The ePHR contains data from SCI-Diabetes, NHS Scotland's flagship diabetes record, sourcing data from primary and secondary care, specialist screening services and laboratory systems. We reviewed patient registration characteristics to collate demographic data for the MWDH cohort, then compared this to aggregate data published in the 2016 Scottish Diabetes Survey. The Scottish Diabetes Survey is an annual population-based report detailing diabetes statistics for the whole diabetes population in NHS Scotland. RESULT(S): The MDMW information website received an average of 101,382 page accesses per month during 2016 (56.9% increase from 2015; $n=64,607$). ePHR registrants were more likely to be younger ($p<0.001$) and have an ethnicity of "white" ($p<0.001$) than the background diabetes population. At the end of 2016, 11,840 people with diabetes had accessed their personal clinical information (58.6% increase since end 2015; $n=7464$). During 2016, an average of 1907 people accessed their records each month (48.3% increase from 2015; $n=1286$). CONCLUSION(S): My Diabetes My Way is a useful tool aid to diabetes self-management. The service is unique in offering records access to a national population, providing information from all relevant diabetes-related sources, rather than a single silo. MDMW supports the diabetes improvement, self-management, healthcare quality and eHealth strategies of the Scottish Government. The service also has potential to be adapted to work with other clinical systems and conditions.

36. Findings of Impaired Hearing in Patients with Nonfluent/Agrammatic Variant Primary Progressive Aphasia

Authors Hardy C.J.D.; Frost C.; Sivasathiseelan H.; Johnson J.C.S.; Augustus J.L.; Bond R.L.; Benhamou E.; Russell L.L.; Marshall C.R.; Rohrer J.D.; Warren J.D.; Bamiou D.-E.
Source JAMA Neurology; 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE

Abstract

Importance: Despite being characterized as a disorder of language production, nonfluent/agrammatic variant primary progressive aphasia (nfvPPA) is frequently associated with auditory symptoms. However, to our knowledge, peripheral auditory function has not been defined in this condition.

Objective(s): To assess peripheral hearing function in individuals with nfvPPA compared with healthy older individuals and patients with Alzheimer disease (AD).

Design, Setting, and Participant(s): This cross-sectional single-center study was conducted at the Dementia Research Centre of University College London between August 2015 and July 2018. A consecutive cohort of patients with nfvPPA and patients with AD were compared with healthy control participants. No participant had substantial otological or cerebrovascular disease; all eligible patients fulfilling diagnostic criteria and able to comply with audiometry were included.

Main Outcomes and Measures: We measured mean threshold sound levels required to detect pure tones at frequencies of 500, 1000, 2000, 4000, and 6000 Hz in the left and right ears separately; these were used to generate better-ear mean and worse-ear mean composite hearing threshold scores and interaural difference scores for each participant. All analyses were adjusted for participant age.

Result(s): We studied 19 patients with nfvPPA (9 female; mean [SD] age, 70.3 [9.0] years), 20 patients with AD (9 female; mean [SD] age, 69.4 [8.1] years) and 34 control participants (15 female; mean [SD] age, 66.7 [6.3] years). The patients with nfvPPA had significantly higher scores than control participants on better-ear mean scores (patients with nfvPPA: mean [SD], 36.3 [9.4] decibels [dB]; control participants: 28.9 [7.3] dB; age-adjusted difference, 5.7 [95% CI, 1.4-10.0] dB; $P = .01$) and worse-ear mean scores (patients with nfvPPA: 42.2 [11.5] dB; control participants: 31.7 [8.1] dB; age-adjusted difference, 8.5 [95% CI, 3.6-13.4] dB; $P = .001$). The patients with nfvPPA also had significantly higher better-ear mean scores than patients with AD (patients with AD: mean [SD] 31.1 [7.5] dB; age-adjusted difference, 4.8 [95% CI, 0.0-9.6] dB; $P = .048$) and worse-ear mean scores (patients with AD: mean [SD], 33.8 [8.2] dB; age-adjusted difference, 7.8 [95% CI, 2.4-13.2] dB; $P = .005$). The difference scores (worse-ear mean minus better-ear mean) were significantly higher in the patients with nfvPPA (mean [SD], 5.9 [5.2] dB) than control participants (mean [SD], 2.8 [2.2] dB; age-adjusted difference, 2.8 [95% CI, 0.9-4.7] dB; $P = .004$) and patients with AD (mean [SD], 2.8 [2.1] dB; age-adjusted difference, 3.0 [95% CI, 0.9-5.1] dB; $P = .005$).

Conclusions and Relevance: In this study, patients with nfvPPA performed worse on pure-tone audiometry than healthy older individuals or patients with AD, and the difference was not attributable to age or general disease factors. Cases of nfvPPA were additionally associated with increased functional interaural audiometric asymmetry. These findings suggest conjoint peripheral afferent and more central regulatory auditory dysfunction in individuals with nfvPPA.

Copyright © 2019 American Medical Association. All rights reserved.

37. Associations between childhood deaths and adverse childhood experiences: An audit of data from a child death overview panel

Authors Grey H.R.; Ford K.; Bellis M.A.; Wood S.; Lowey H.

Source Child Abuse and Neglect; Apr 2019; vol. 90 ; p. 22-31

Publication Date Apr 2019

Publication Type(s) Article

Database EMBASE

Available at [Child Abuse and Neglect](#) 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 [Child Abuse and Neglect](#) 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: Despite strong associations between adverse childhood experiences (ACEs) and poor health, few studies have examined the cumulative impact of ACEs on causes of childhood mortality.
Method(s): This study explored if data routinely collected by child death overview panels (CDOPs) could be used to measure ACE exposure and examined associations between ACEs and child death categories. Data covering four years (2012-2016) of cases from a CDOP in North West England were examined.
Result(s): Of 489 cases, 20% were identified as having ≥ 4 ACEs. Deaths of children with ≥ 4 ACEs were 22.26 (5.72-86.59) times more likely (than those with 0 ACEs) to be classified as 'avoidable and non-natural' causes (e.g., injury, abuse, suicide; compared with 'genetic and medical conditions'). Such children were also 3.44 (1.75-6.73) times more likely to have their deaths classified as 'chronic and acute conditions'.
Conclusion(s): This study evidences that a history of ACEs can be compiled from CDOP records. Measurements of ACE prevalence in retrospective studies will miss individuals who died in childhood and may underestimate the impacts of ACEs on lifetime health. Strong associations between ACEs and deaths from 'chronic and acute conditions' suggest that ACEs may be important factors in child deaths in addition to those classified as 'avoidable and non-natural'. Results add to an already compelling case for ACE prevention in the general population and families affected by child health problems. Broader use of routinely collected child death records could play an important role in improving multi-agency awareness of ACEs and their negative health and mortality risks as well in the development of ACE informed responses.
Copyright © 2019

38. Canine dystocia in 50 UK first-opinion emergency care veterinary practices: clinical management and outcomes

Authors O'Neill D.G.; Manson E.A.; Church D.B.; Brodbelt D.C.; O'sullivan A.M.; Boag A.K.; Mcgreevy P.D.
Source Veterinary Record; 2019
Publication Date 2019
Publication Type(s) Article
Database EMBASE

Available at [Veterinary Record](#) 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 Canine dystocia is a relatively common veterinary presentation. First opinion emergency care clinical data from 50 Vets Now clinics across the UK were used to explore dystocia management and outcomes in bitches. Caesarean section (CS) was performed on 341/701 (48.6 per cent (95 per cent CI 44.9 to 52.4)) of dystocia cases. The bulldog (OR 7.60, 95 per cent CI 1.51 to 38.26, $P=0.014$), Border terrier (OR 4.89, 95 per cent CI 0.92 to 25.97, $P=0.063$) and golden retriever (OR 4.07, 95 per cent CI 0.97 to 17.07, $P=0.055$) had the highest odds of CS among dystocic bitches compared with crossbreds. Brachycephalic dystocic bitches had 1.54 (95 per cent CI 1.05 to 2.28, $P=0.028$) times the odds of CS compared with non-brachycephalics. Oxytocin was administered to 380/701 (54.2 per cent) and calcium gluconate was administered to 82/701 (11.7 per cent) of dystocic bitches. 12 of 701 dystocia cases (1.7 per cent) died during emergency care. These results can help veterinary surgeons to provide better evidence on the risks to owners who may be contemplating breeding from their bitches. In addition, the results on the management and clinical trajectory of dystocia can facilitate clinical benchmarking and encourage clinical audit within primary care veterinary practice.
Copyright © British Veterinary Association 2019. Re-use permitted under CC BY-NC. No commercial re-use. Published by BMJ.

39. Associations between socio-economic factors and alcohol consumption: A population survey of adults in England

Authors Beard E.; Brown J.; West R.; Kaner E.; Meier P.; Michie S.
Source PLoS ONE; Feb 2019; vol. 14 (no. 2)
Publication Date Feb 2019
Publication Type(s) Review
PubMedID 30716098
Database EMBASE
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 Aim To gain a better understanding of the complex relationships of different measures of social position, educational level and income with alcohol consumption in England. Method Between March 2014 and April 2018 data were collected on n = 57,807 alcohol drinkers in England taking part in the Alcohol Toolkit Study (ATS). Respondents completed the AUDIT-C measure of frequency of alcohol consumption, amount consumed on a typical day and binge drinking frequency. The first two questions were used to derive a secondary measure of quantity: average weekly unit consumption. Socio-economic factors measured were: social-grade (based on occupation), employment status, educational qualifications, home and car ownership and income. Models were constructed using ridge regression to assess the contribution of each predictor taking account of high collinearity. Models were adjusted for age, gender and ethnicity. Results The strongest predictor of frequency of alcohol consumption was social-grade. Those in the two lowest occupational categories of social grade (e.g. semi-skilled and unskilled manual workers, and unemployed, pensioners, casual workers) has fewer drinking occasions than those in professional-managerial occupations (beta = -0.29, 95%CI -0.34 to -0.25; beta = -0.31, 95%CI -0.33 to -0.29). The strongest predictor of consumed volume and binge drinking frequency was lower educational attainment: those whose highest qualification was an A-level (i.e. college/high school qualification) drank substantially more on a typical day (beta = 0.28, 95%CI 0.25 to 0.31) and had a higher weekly unit intake (beta = 3.55, 95%CI 3.04 to 4.05) than those with a university qualification. They also reported a higher frequency of binge drinking (beta = 0.11, 95%CI 0.09 to 0.14). Housing tenure was a strong predictor of all drinking outcomes, while employment status and car ownership were the weakest predictors of most outcomes. Conclusion Social-grade and educational attainment appear to be the strongest socioeconomic predictors of alcohol consumption indices in England, followed closely by housing tenure. Employment status and car ownership have the lowest predictive power.
 Copyright © 2019 Beard et al. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

40. Outcomes of urgent suspicion of head and neck cancer referrals in Glasgow

Authors Douglas C.M.; Carswell V.; Montgomery J.
Source Annals of the Royal College of Surgeons of England; Feb 2019; vol. 101 (no. 2); p. 103-106
Publication Date Feb 2019
Publication Type(s) Article
PubMedID 30372125
Database EMBASE
 Available at [Annals of the Royal College of Surgeons of England](#) from Ovid (Journals @ Ovid) - Remote Access
 Available at [Annals of the Royal College of Surgeons of England](#) from EBSCO (MEDLINE Complete)
 Available at [Annals of the Royal College of Surgeons of 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 [Annals of the Royal College of Surgeons of 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.

Abstract INTRODUCTION: Primary care patients with a suspected head and neck cancer are referred through the urgent suspicion of cancer referral pathway. Rates of cancer detection through this pathway are low. Evidence surrounding the pathway of these patients is lacking. This study aimed to determine the outcome of urgent suspicion of cancer referrals for head and neck cancer. METHODS AND METHODS: All head and neck cancer urgent suspicion of cancer referrals in NHS Greater Glasgow and Clyde between June 2015 and May 2016 were analysed in regard to their clinical pathway.
 RESULT(S): There were 2116 urgent suspicion of cancer referrals in the one-year period. The overall cancer rate was 235 (11.8%), compared with 152 (7.6%) that resulted in a primary head and neck cancer diagnosis. Of the total, 851 (42.6%) were reassured and discharged after one clinic appointment; 536 (26.8%) were followed up for suspected benign pathology and 436 (21.8%) were actively investigated for cancer.
 CONCLUSION(S): A significant proportion of patients attending urgent suspicion of cancer clinic appointments can be seen and discharged in one clinic appointment, provided there is same day imaging available. Cancer identification rates through urgent suspicion of cancer pathways remain low.

41. Use of core outcome sets: NICE guidelines, surveillance reviews, and quality standards

Authors Tan T.; McFarlane E.; Minchin M.; Taske N.
Source Journal of Evidence-Based Medicine; Jan 2019; vol. 12 ; p. 22-23
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Journal of Evidence-Based Medicine](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS

Abstract

Background: The difficulties caused by heterogeneity in outcome measurement are well known to those involved in synthesizing evidence to inform decision making. To address this issue, various initiatives have been established to promote the development and use of core outcome sets (COS) in clinical trials, health technology assessments, systematic reviews, and clinical guidelines. The National Institute for Health and Care Excellence (NICE) produces guidelines and quality standards for the UK's National Health Service and the public health and social care sectors. To improve the quality of its guidelines and quality standards, NICE actively encourages the use of COS during development. NICE Guidelines: NICE encourages the use of relevant, high-quality COS to inform the development of guidelines in clinical, public health, and social care areas. In the 2018, draft of Developing NICE guidelines: the manual 3 (to be published in January 2019), the use of COS, and COMET database are formally endorsed, where suitable and appropriate, during the development of guideline scope and guideline review protocols. There are also ongoing methods project within the guidelines program: * COS for asthma management: consensus project between NICE, Cochrane Airways, and the COMET Initiative. The objective is to reach consensus on a core outcome set for asthma management across the three organizations. * Exploring the use of core outcome sets in public health and social care research and evidence-based decision-making. The objectives are (i) to map existing COS work in public health and social care; (ii) to raise awareness; (iii) to explore the barriers and facilitators to use of COS; and (iv) methodological issues in the development of COS for public health and social care. NICE Surveillance reviews: NICE also has a guideline surveillance program that reviews new evidence after guidelines are published, to decide whether an update is needed. New evidence on COS is considered to be one of the key indicators for update. Current informal processes for identifying outcomes during surveillance bring up a lot of outcomes that may be "unimportant," but which are still used when deciding whether to update a guideline. An exploratory research to investigate how outcomes in surveillance are currently considered was carried out, with the consideration of the need to create a more formal process in the future. Preliminary results from this exploratory research found that there are a lot of outcomes not included in COS and original guidelines that are being identified in surveillance evidence summaries. This suggests that a high number of potentially "unimportant" outcomes are being identified in surveillance. Therefore, there is reason to create a more formal process for outcome assessment in surveillance of NICE guidelines NICE Quality standards: NICE quality standards identify priority areas for quality improvement in a defined area, with almost all being underpinned by NICE guidance. There are two main components to a quality standard: the actionfocused quality statements and the measures associated with them. The statements specify and describe the area for quality improvement, and the measures can be used to assess the quality of care or service provision. The quality standards always include the identification of outcomes attributable to individual statements and "overarching outcomes" that the standard will contribute to. To ensure the outcomes included in NICE quality standards align to the underpinning evidence and support measurement so users can assess changes in outcomes, moving forward, outcomes included in quality standards will be based on existing COS when possible, reflecting the approach set out in the draft 2018 update to Developing NICE guidelines: the manual. More formal use of COS will be considered further when the quality standards process guide is next updated (ongoing).

42. An organisational participatory research study of the feasibility of the behaviour change wheel to support clinical teams implementing new models of care

Authors Bull E.R.; Hart J.K.; Joseph S.; Byrne-Davis L.M.T.; Swift J.; Baxter K.; McLauchlan N.

Source BMC health services research; Feb 2019; vol. 19 (no. 1); p. 97

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30717764

Database EMBASE

Available at [BMC health services research](#) from ProQuest (Hospital Premium Collection) - NHS Version

Available at [BMC health services research](#) from BioMed Central

Available at [BMC health services research](#) from Europe PubMed Central - Open Access

Available at [BMC health services research](#) from EBSCO (MEDLINE Complete)

Abstract BACKGROUND: Health and social care organisations globally are moving towards prevention-focused community-based, integrated care. The success of this depends on professionals changing practice behaviours. This study explored the feasibility of applying a behavioural science approach to help staff teams from health organisations overcome psychological barriers to change and implement new models of care. METHOD(S): An Organisational Participatory Research study was conducted with health organisations from North West England, health psychologists and health workforce education commissioners. The Behaviour Change Wheel (BCW) was applied with teams of professionals seeking help to overcome barriers to practice change. A mixed-methods data collection strategy was planned, including qualitative stakeholder interview and focus groups to explore feasibility factors and quantitative pre-post questionnaires and audits measuring team practice and psychological change barriers. Qualitative data were analysed with thematic analysis; pre-post quantitative data were limited and thus analysed descriptively. RESULT(S): Four clinical teams from paediatrics, midwifery, heart failure and older adult mental health specialties in four organisations enrolled, seeking help to move care to the community, deliver preventative healthcare tasks, or become more integrated. Eighty-one managers, medical doctors, nurses, physiotherapists, midwives and other professionals contributed data. Three teams successfully designed a BCW intervention; two implemented and evaluated this. Five feasibility themes emerged from the thematic analysis of qualitative data. Optimising the BCW in an organisational change context meant 1) qualitative over quantitative data collection, 2) making behavioural science attractive, 3) co-development and a behavioural focus, 4) effective ongoing communication and 5) support from engaged leaders. Pre-post quantitative data collected suggested some positive changes in staff practice behaviours and psychological determinants following the intervention. CONCLUSION(S): Behavioural science approaches such as the BCW can be optimised to support teams within health and social care organisations implementing complex new models of care. The efficacy of this approach should now be trialled.

43. Lessons Learned in Creating Interoperable Fast Healthcare Interoperability Resources Profiles for Large-Scale Public Health Programs

Authors Matney S.A.; Heale B.; Davis N.; Langford P.; Huff S.M.; Hasley S.; Ramey N.; Decker E.; Frederiksen B.
Source Applied clinical informatics; Jan 2019; vol. 10 (no. 1); p. 87-95
Publication Date Jan 2019
Publication Type(s) Article
PubMedID 30727002
Database EMBASE
Abstract OBJECTIVE: This article describes lessons learned from the collaborative creation of logical models and standard Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) profiles for family planning and reproductive health. The National Health Service delivery program will use the FHIR profiles to improve federal reporting, program monitoring, and quality improvement efforts. MATERIALS AND METHODS: Organizational frameworks, work processes, and artifact testing to create FHIR profiles are described. RESULT(S): Logical models and FHIR profiles for the Family Planning Annual Report 2.0 dataset have been created and validated. DISCUSSION: Using clinical element models and FHIR to meet the needs of a real-world use case has been accomplished but has also demonstrated the need for additional tooling, terminology services, and application sandbox development. CONCLUSION(S): FHIR profiles may reduce the administrative burden for the reporting of federally mandated program data. Copyright Georg Thieme Verlag KG Stuttgart . New York.

44. Disparities in the management of paediatric splenic injury

Authors Warwick A.M.; Jenks T.; Lecky F.; Yates D.; Fisher R.; Garrett-Cox R.
Source The British journal of surgery; Feb 2019; vol. 106 (no. 3); p. 263-266
Publication Date Feb 2019
Publication Type(s) Article
PubMedID 30277259
Database EMBASE
 Available at [The British journal of surgery](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
 Available at [The British journal of surgery](#) from Ovid (Journals @ Ovid) - Remote Access
 Available at [The British journal of surgery](#) 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 [The British journal of surgery](#) 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 non-operative management of splenic injury in children is recommended widely, and is possible in over 95 per cent of episodes. Practice appears to vary between centres.
METHOD(S): The Trauma Audit and Research Network (TARN) database was interrogated to determine the management of isolated paediatric splenic injuries in hospitals in England and Wales. Rates of non-operative management, duration of hospital stay, readmission and mortality were recorded. Management in paediatric surgical hospitals was compared with that in adult hospitals.
RESULT(S): Between January 2000 and December 2015 there were 574 episodes. Children treated in a paediatric surgical hospital had a 95.7 per cent rate of non-operative management, compared with 75.5 per cent in an adult hospital ($P < 0.001$). Splenectomy was done in 2.3 per cent of children in hospitals with a paediatric surgeon and in 17.2 per cent of those treated in an adult hospital ($P < 0.001$). There was a significant difference in the rate of non-operative management in children of all ages. There was some improvement in non-operative management in adult hospitals in the later part of the study, but significant ongoing differences remained.
CONCLUSION(S): The management of children with isolated splenic injury is different depending on where they are treated. The rate of non-operative management is lower in hospitals without a paediatric surgeon present.
Copyright © 2018 BJS Society Ltd Published by John Wiley & Sons Ltd.

45. "Struggling with practices" - a qualitative study of factors influencing the implementation of clinical quality registries for cardiac rehabilitation in England and Denmark

Authors Egholm C.L.; Helmark C.; Doherty P.; Nilsen P.; Zwisler A.-D.; Bunkenborg G.
Source BMC health services research; Feb 2019; vol. 19 (no. 1); p. 102
Publication Date Feb 2019
Publication Type(s) Article
PubMedID 30728028
Database EMBASE

Available at [BMC health services research](#) from ProQuest (Hospital Premium Collection) - NHS Version
Available at [BMC health services research](#) from BioMed Central
Available at [BMC health services research](#) from Europe PubMed Central - Open Access
Available at [BMC health services research](#) from EBSCO (MEDLINE Complete)

Abstract BACKGROUND: The use of clinical quality registries as means for data driven improvement in healthcare seem promising. However, their use has been shown to be challenged by a number of aspects, and we suggest some may be related to poor implementation. There is a paucity of literature regarding barriers and facilitators for registry implementation, in particular aspects related to data collection and entry. We aimed to illuminate this by exploring how staff perceive the implementation process related to the registries within the field of cardiac rehabilitation in England and Denmark.
METHOD(S): A qualitative, interview-based study with staff involved in collecting and/or entering data into the two case registries (England N=12, Denmark N=12). Interviews were analysed using content analysis. The Consolidated Framework for Implementation Research was used to guide interviews and the interpretation of results.
RESULT(S): The analysis identified both similarities and differences within and between the studied registries, and resulted in clarification of staffs' experiences in an overarching theme: 'Struggling with practices' and five categories; the data entry process, registry quality, resources and management support, quality improvement and the wider healthcare context. Overall, implementation received little focused attention. There was a lack of active support from management, and staff may experience a struggle of fitting use of a registry into a busy and complex everyday practice.
CONCLUSION(S): The study highlights factors that may be important to consider when planning and implementing a new clinical quality registry within the field of cardiac rehabilitation, and is possibly transferrable to other fields. The results may thus be useful for policy makers, administrators and managers within the field and beyond. Targeting barriers and utilizing knowledge of facilitating factors is vital in order to improve the process of registry implementation, hence helping to achieve the intended improvement of care processes and outcomes.

46. British Society of Gastroenterology Endoscopy Quality Improvement Programme (BSG EQIP): Implementing new endoscopic techniques and technologies into clinical practice

Authors Bhandari P.; Subramaniam S.; East J.E.
Source Frontline Gastroenterology; 2019
Publication Date 2019
Publication Type(s) Review
Database EMBASE

Available at [Frontline Gastroenterology](#) from BMJ Journals - NHS
Available at [Frontline Gastroenterology](#) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection

Abstract Endoscopy has rapidly evolved from a diagnostic modality to a therapeutic tool with the advent of new technologies (medical devices or imaging) and techniques (types of procedures). Although the rapid advancement of technology is welcomed, this can pose its own problems if there is no robust system in place to assess the safety and efficacy of new endoscopic devices or practices or guide its use among clinicians prior to adoption. This is unlike the rigorous process that medical drugs need to go through from preclinical to clinical phases of development, often with controlled trials being conducted prior to integration of a new drug into clinical practice. In this review, we will identify the problems related to implementation of new technologies and techniques as well as propose solutions. We will outline the use of comparative effectiveness studies as a model for assessing new technologies and provide a structured pathway to support clinicians in their endeavour to introduce new devices or procedures in their clinical practice safely. We will also discuss the role of the British Society of Gastroenterology in risk stratifying new techniques and supporting clinicians in setting up national registries, training and business case development. This review will provide a framework for improving the quality and safety of our current practice of implementing new endoscopic technologies and techniques in the National Health Service.
 Copyright © Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

47. Guidelines for the safe provision of anaesthesia in magnetic resonance units 2019: Guidelines from the Association of Anaesthetists and the Neuro Anaesthesia and Critical Care Society of Great Britain and Ireland

Authors Wilson S.R.; Shinde S.; Appleby I.; Boscoe M.; Conway D.; Dryden C.; Ferguson K.; Gedroyc W.; Kinsella S.M.; Nathanson M.H.; Thorne J.; White M.; Wright E.

Source Anaesthesia; 2019

Publication Date 2019

Publication Type(s) Article

Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 There has been an increase in the number of units providing anaesthesia for magnetic resonance imaging and the strength of magnetic resonance scanners, as well as the number of interventions and operations performed within the magnetic resonance environment. More devices and implants are now magnetic resonance imaging conditional, allowing scans to be undertaken in patients for whom this was previously not possible. There has also been a revision in terminology relating to magnetic resonance safety of devices. These guidelines have been put together by organisations who are involved in the pathways for patients needing magnetic resonance imaging. They reinforce the safety aspects of providing anaesthesia in the magnetic resonance environment, from the multidisciplinary decision making process, the seniority of anaesthetist accompanying the patient, to training in the recognition of hazards of anaesthesia in the magnetic resonance environment. For many anaesthetists this is an unfamiliar site to give anaesthesia, often in a remote site. Hospitals should develop and audit governance procedures to ensure that anaesthetists of all grades are competent to deliver anaesthesia safely in this area.

Copyright © 2019 The Authors. Anaesthesia published by John Wiley & Sons Ltd on behalf of Association of Anaesthetists.

48. Structured lifestyle education for people with schizophrenia, schizoaffective disorder and first-episode psychosis (STEPWISE): Randomised controlled trial

Authors Holt R.I.G.; Gossage-Worrall R.; Hind D.; Bradburn M.J.; McCrone P.; Morris T.; Edwardson C.; Barnard K.; Carey M.E.; Davies M.J.; Dickens C.M.; Doherty Y.; Etherington A.; French P.; Gaughran F.; Greenwood K.E.; Kalidindi S.; Khunti K.; Laugharne R.; Pendlebury J.; Rathod S.; Saxon D.; Shiers D.; Siddiqi N.; Swaby E.A.; Waller G.; Wright S.

Source British Journal of Psychiatry; Feb 2019; vol. 214 (no. 2); p. 63-73

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30251622

Database EMBASE

Available at [British Journal of Psychiatry](#) from Glenfield Hospital Library Local Print Collection [location] : Glenfield Library.

Available at [British Journal of Psychiatry](#) 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

Available at [British Journal of Psychiatry](#) 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.

Background Obesity is a major challenge for people with schizophrenia. **Aims** We assessed whether STEPWISE, a theory-based, group structured lifestyle education programme could support weight reduction in people with schizophrenia. **Method** In this randomised controlled trial (study registration: ISRCTN19447796), we recruited adults with schizophrenia, schizoaffective disorder or first-episode psychosis from ten mental health organisations in England. Participants were randomly allocated to the STEPWISE intervention or treatment as usual. The 12-month intervention comprised four 2.5 h weekly group sessions, followed by 2-weekly maintenance contact and group sessions at 4, 7 and 10 months. The primary outcome was weight change after 12 months. Key secondary outcomes included diet, physical activity, biomedical measures and patient-related outcome measures. Cost-effectiveness was assessed and a mixed-methods process evaluation was included. **Results** Between 10 March 2015 and 31 March 2016, we recruited 414 people (intervention 208, usual care 206) with 341 (84.4%) participants completing the trial. At 12 months, weight reduction did not differ between groups (mean difference 0.0 kg, 95% CI -1.6 to 1.7, P = 0.963); physical activity, dietary intake and biochemical measures were unchanged. STEPWISE was well-received by participants and facilitators. The healthcare perspective incremental cost-effectiveness ratio was 246 921 per quality-adjusted life-year gained. **Conclusions** Participants were successfully recruited and retained, indicating a strong interest in weight interventions; however, the STEPWISE intervention was neither clinically nor cost-effective. Further research is needed to determine how to manage overweight and obesity in people with schizophrenia. **Declaration of interest** R.I.G.H. received fees for lecturing, consultancy work and attendance at conferences from the following: Boehringer Ingelheim, Eli Lilly, Janssen, Lundbeck, Novo Nordisk, Novartis, Otsuka, Sanofi, Sunovion, Takeda, MSD. M.J.D. reports personal fees from Novo Nordisk, Sanofi-Aventis, Lilly, Merck Sharp & Dohme, Boehringer Ingelheim, AstraZeneca, Janssen, Servier, Mitsubishi Tanabe Pharma Corporation, Takeda Pharmaceuticals International Inc.; and, grants from Novo Nordisk, Sanofi-Aventis, Lilly, Boehringer Ingelheim, Janssen. K.K. has received fees for consultancy and speaker for Novartis, Novo Nordisk, Sanofi-Aventis, Lilly, Servier and Merck Sharp & Dohme. He has received grants in support of investigator and investigator-initiated trials from Novartis, Novo Nordisk, Sanofi-Aventis, Lilly, Pfizer, Boehringer Ingelheim and Merck Sharp & Dohme. K.K. has received funds for research, honoraria for speaking at meetings and has served on advisory boards for Lilly, Sanofi-Aventis, Merck Sharp & Dohme and Novo Nordisk. D.Sh. is expert advisor to the NICE Centre for guidelines; board member of the National Collaborating Centre for Mental Health (NCCMH); clinical advisor (paid consultancy basis) to National Clinical Audit of Psychosis (NCAP); views are personal and not those of NICE, NCCMH or NCAP. J.P. received personal fees for involvement in the study from a National Institute for Health Research (NIHR) grant. M.E.C. and Y.D. report grants from NIHR Health Technology Assessment, during the conduct of the study; and The Leicester Diabetes Centre, an organisation (employer) jointly hosted by an NHS Hospital Trust and the University of Leicester and who is holder (through the University of Leicester) of the copyright of the STEPWISE programme and of the DESMOND suite of programmes, training and intervention fidelity framework that were used in this study. S.R. has received honorarium from Lundbeck for lecturing. F.G. reports personal fees from Otsuka and Lundbeck, personal fees and non-financial support from Sunovion, outside the submitted work; and has a family member with professional links to Lilly and GSK, including shares. F.G. is in part funded by the National Institute for Health Research Collaboration for Leadership in Applied Health Research & Care Funding scheme, by the Maudsley Charity and by the Stanley Medical Research Institute and is supported by the by the Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London. Copyright © 2018 The Royal College of Psychiatrists.

49. How to get started in quality improvement

Authors Jones B.; Vaux E.; Olsson-Brown A.

Source BMJ (Online); 2019; vol. 364

Publication Date 2019

Publication Type(s) Article

PubMedID 30655245

Database EMBASE

Available at [BMJ \(Online\)](#) from BMJ Journals - NHS

Available at [BMJ \(Online\)](#) 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.

50. 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; Feb 2019; vol. 24 (no. 1); p. 20-25

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30377149
Database EMBASE

51. Decision-Making in the Emergency Laparotomy: A Mixed Methodology Study

Authors Hendra L.; Hendra T.; Parker S.J.
Source World journal of surgery; Mar 2019; vol. 43 (no. 3); p. 798-805
Publication Date Mar 2019
Publication Type(s) Article
PubMedID 30456483
Database EMBASE

Available at [World journal of surgery](#) 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 [World journal of surgery](#) 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: More than 30,000 emergency laparotomies take place annually in England and Wales (Symons et al. in Br J Surg 100(10):1318-1325, 2013; Shapter et al. in Anaesthesia 67(5):474-478, 2012). They are associated with high morbidity and an average inpatient 30-day mortality rate of 11%. Inextricably linked to outcomes is the decision-making process of whether or not to operate (NELA Project Team First patient report of the National Emergency Laparotomy Audit. RCoA, London, 2015; Crebbin et al. in Aust N Z J Surg 83(6):422-428, 2013). A mixed-methods study was undertaken to investigate decision-making in the emergency laparotomy and influencing factors.
 METHOD(S): Semi-structured interviews were undertaken amongst general surgeons, exploring the decision-making process. Results helped guide design of an online survey, consisting of vignettes and subsequent questions. Respondents were asked to decide whether or not they would perform a laparotomy for each vignette and the results compared to grade, risk attitudes and reflective practice. Responses were analysed for effect of previous positive and negative experiences and for consistency.
 RESULT(S): Interviews revealed multiple important factors when considering whether or not to perform an emergency laparotomy, broadly categorised into patient-related, surgeon-related and external factors. A total of 116 general surgeons completed the survey: 12 SHO's, 79 registrars and 25 consultants. Non-consultants were 10.4% (95% CI +/-9.7%) more likely to perform an emergency laparotomy than consultants (p=0.036) on multivariate analysis. No association was observed between operative practices and risk attitudes (p=0.22), reflective practice (p=0.7) or previous positive or negative experiences in univariate (p=0.67) or multivariate analysis. Surgeons were not proven to be either consistent nor inconsistent in their decision-making.
 CONCLUSION(S): The decision to operate or not in an emergency laparotomy directly effects patient outcome. This study demonstrates a difference in decision-making and risk attitudes between consultants and their juniors. To address this, formal teaching of models of decision-making, influencing factors and vignette-based consultant-led discussions should be introduced into surgical training.

52. British society of gastroenterology Endoscopy Quality Improvement Programme (EQIP): Overview and progress

Authors Rees C.J.; Koo S.; Anderson J.; McAlindon M.; Veitch A.M.; Morris A.J.; Bhandari P.; East J.E.; Webster G.; Oppong K.W.; Penman I.D.
Source Frontline Gastroenterology; 2019
Publication Date 2019
Publication Type(s) Review
Database EMBASE

Available at [Frontline Gastroenterology](#) from BMJ Journals - NHS

Available at [Frontline Gastroenterology](#) from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection

Abstract High quality gastrointestinal (GI) endoscopy improves patient care. Raising standards in endoscopy improves diagnostic accuracy, management of pathology and ultimately improves outcomes. Historical identification of significant variation in colonoscopy quality led to the development of the Joint Advisory Group (JAG) on GI Endoscopy, the Global Rating Scale (GRS), JAG Endoscopy Training System (JETS) training and certification. These measures led to major improvements in UK endoscopy but significant variation in practice still exists. To improve quality further the British Society of Gastroenterology Endoscopy Quality Improvement (EQIP) has been established with the aim of raising quality and reducing variation in the quality of UK endoscopy. A multifaceted approach to quality improvement (QI) will be undertaken and is described in this manuscript. Upper GI EQIP will support adoption of standards alongside regional upskilling courses. Lower GI EQIP will focus on supporting endoscopists to achieve current standards alongside approaches to reducing postcolonoscopy colorectal cancer rates. Endoscopic retrograde cholangiopancreatography EQIP will adopt a regional approach of using local data to support network-based QI. Newer areas of endoscopy practice such as small bowel endoscopy and endoscopic ultrasound will focus on identifying key performance indicators as well as standardising training and accreditation pathways. EQIP will also support QI in management of GI bleeding as well as standardising the approach to new techniques and technologies. Where evidence is lacking, approaches to gather new evidence and support the translation into clinical practice will be supported. Copyright © Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

53. Erratum to "Population-based cross-sectional study to assess newborn hearing screening program in Central Germany" [Int. J. Pediatr. Otorhinolaryngol., 107 (2018) 110-120](S016558761830051X)(10.1016/j.ijporl.2018.01.035)

Authors Rissmann A.; Koehn A.; Loderstedt M.; Schwemmler C.; Vorwerk U.; Goetze G.; Bartel S.; Plontke S.K.; Langer J.; Begall K.; Matulat P.; Roehl F.-W.

Source International Journal of Pediatric Otorhinolaryngology; 2019

Publication Date 2019

Publication Type(s) Erratum

Database EMBASE

Available at [International Journal of Pediatric Otorhinolaryngology](#) 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 [International Journal of Pediatric Otorhinolaryngology](#) 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 The publisher regrets to inform that the abstract published in the original version of this article is incorrect. The correct version of the abstract is given below. Objectives Early diagnosis of congenital hearing loss is fundamental to minimize the negative consequences on the speech development. To lower the age at diagnosis and at intervention in hearing impaired children, not only universal newborn hearing screening (NHS) but also tracking is considered essential. The aim of the study was to evaluate the first six years after implementation of the population based newborn hearing screening program in Saxony-Anhalt, one German Federal State. Methods The cross-sectional cohort study consisted of three cohort samples. Overall 102,301 infants born between January 2010 and December 2015 were included. NHS protocol was developed as dual target group protocol with two sub-protocols. The screening technique included Transient Evoked Otoacoustic Emissions (TEOAE) and Automated Auditory Brainstem Response (AABR) test. Newborns were assigned to the sub-protocols according to their audiological risk factors. Additionally, to evaluate the quality of NHS and tracking (false-negative screening) we were analysing data from a cohort of hearing impaired children diagnosed up to the age of three years. We calculated quality indicators and compared them with international guidelines. Results 101,102 (98.8%) infants were screened. The prevalence of bilateral neonatal hearing loss was 2.32 per 1000 newborns. The median age was two days at first screening, three month at diagnostic testing, and four month at intervention onset. 2.6% infants were lost to follow-up. 56.3% had a final diagnosis of bilateral sensorineural hearing loss. The sensitivity of 0.85 (KI 95%: 0.76-0.91) and a specificity of 0.84 (KI 95%: 0.84-0.85) was calculated for the NHS program. Conclusion The analysis of benchmarks and outcomes of NHS demonstrated that the program reaches its main goal to identify the hearing impaired newborns in a timely manner. The publisher would like to apologise for any inconvenience caused. The correct version of the abstract is updated now in the original article. For citation purpose, please use the updated version of the article. Copyright © 2018 Elsevier B.V.

54. Partner notification and contact tracing must accompany provider-initiated counselling and testing in population screening for HIV infection in Nigeria

Authors Harry T.C.; Ebuenyi I.; Ogoina D.

Source International Journal of STD and AIDS; Jan 2019; vol. 30 (no. 1); p. 99-100

Publication Date Jan 2019

Publication Type(s) Letter

Database EMBASE

Available at [International Journal of STD and AIDS](#) 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 [International Journal of STD and 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.

55. Six months on: NHS England needs to focus on dissemination, implementation and audit of its low-priority initiative

Authors Walker A.J.; Bacon S.; Curtis H.; Croker R.; MacKenna B.; Goldacre B.

Source Journal of the Royal Society of Medicine; Jan 2019; vol. 112 (no. 1); p. 4-5

Publication Date Jan 2019

Publication Type(s) Letter

Database EMBASE

Available at [Journal of the Royal Society of Medicine](#) from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.

Available at [Journal of the Royal Society of 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.

56. Standards and core components for cardiovascular disease prevention and rehabilitation

Authors Cowie A.; Buckley J.; Doherty P.; Furze G.; Hayward J.; Hinton S.; Jones J.; Speck L.; Dalal H.; Mills J.

Source Heart; 2019

Publication Date 2019

Publication Type(s) Review

Database EMBASE

Available at [Heart](#) from BMJ Journals - NHS

Available at [Heart](#) 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 [Heart](#) 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

In 2017, the British Association for Cardiovascular Prevention and Rehabilitation published its official document detailing standards and core components for cardiovascular prevention and rehabilitation. Building on the success of previous editions of this document (published in 2007 and 2012), the 2017 update aims to further emphasise to commissioners, clinicians, politicians and the public the importance of robust, quality indicators of cardiac rehabilitation (CR) service delivery. Otherwise, its overall aim remains consistent with the previous publications - to provide a precedent on which all effective cardiovascular prevention and rehabilitation programmes are based and a framework for use in assessment of variation in service delivery quality. In this 2017 edition, the previously described seven standards and core components have both been revised to six, with a greater focus on measurable clinical outcomes, audit and certification. The principles within the updated document underpin the six-stage pathway of care for CR, and reflect the extensive evidence base now available within the field. To help improve current services, close collaboration between commissioners and CR providers is advocated, with use of the CR costing tool in financial planning of programmes. The document specifies how quality assurance can be facilitated through local audit, and advocates routine upload of individual-level data to the annual British Heart Foundation National Audit of Cardiac Rehabilitation, and application for national certification ensuring attainment of a minimum quality standard. Although developed for the UK, these standards and core components may be applicable to other countries.

Copyright © Author(s) (or their employer(s)) 2019. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

57. International comparison of acute myocardial infarction care and outcomes using quality indicators

Authors Zusman O.; Kornowski R.; Iakobishvili Z.; Bebb O.; Hall M.; Dondo T.B.; Gale C.P.; Timmis A.; Schiele F.; Fox K.A.A.

Source Heart; 2019

Publication Date 2019

Publication Type(s) Article

Database EMBASE

Available at [Heart](#) from BMJ Journals - NHS

Available at [Heart](#) 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 [Heart](#) 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 compare temporal changes in European Society of Cardiology (ESC) acute myocardial infarction (AMI) quality indicator (QI) attainment in the UK and Israel.
Method(s): Data cross-walking using information from the Myocardial Ischaemia National Audit Project and the Acute Coronary Syndrome in Israel Survey for matching 2-month periods in 2006, 2010 and 2013 was used to compare country-specific attainment of 14 ESC AMI QIs.
Result(s): Patients in the UK (n=17 068) compared with Israel (n=5647) were older, more likely to be women, and had less diabetes, dyslipidaemia and heart failure. Baseline ischaemic risk was lower in Israel than the UK (Global Registry of Acute Coronary Events (GRACE) risk, 110.5 vs 121.0). Overall, rates of coronary angiography (87.6% vs 64.8%) and percutaneous coronary intervention (70.3% vs 41.0%) were higher in Israel compared with the UK. Composite QI performance increased more in the UK (1.0%-86.0%) than Israel (70.2%-78.0%). Mortality rates at 30 days declined in each country, with lower rates in Israel in 2013 (4.2% vs 7.6%). Composite QI adherence adjusted for GRACE risk score was inversely associated with 30-day mortality (OR 0.95; CI 0.95 to 0.97, p<0.001).
Conclusion(s): International comparisons of guideline recommended AMI care and outcomes can be quantified using the ESC AMI QIs. International implementation of the ESC AMI QIs may reveal country-specific opportunities for improved healthcare delivery.
Copyright © Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

58. Refractory status epilepticus in adults admitted to ITU in Glasgow 1995-2013 a longitudinal audit highlighting the need for action for provoked and unprovoked status epilepticus

Authors Abbasi H.; Leach J.P.
Source Seizure; Feb 2019; vol. 65 ; p. 138-143
Publication Date Feb 2019
Publication Type(s) Article
Database EMBASE

Available at [Seizure](#) 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 [Seizure](#) 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: Our primary objective was to determine incidence of status epilepticus in adults admitted to 5 ITU settings in Glasgow over 18 years. We wanted to investigate if there are any change in causes and outcomes of SE over last decade. We also compared outcomes of De Novo status Epilepticus (DNSE) and Status Epilepticus in patients with previous Epilepsy (SEPE).
Method(s): The NHS GGC Research Ethics Committee gave permission for this study to continue without a full ethics submission. Between 2013 and 2016, coding records were searched across NHS Greater Glasgow and Clyde for adults over the age of 16 years admitted to an Intensive Care Facility in any of the hospitals in Glasgow.
Result(s): 633 cases were included in study. Cases were separated depending on whether there had been previous epilepsy (SEPE n = 214) or De Novo Status Epilepticus (DNSE, n = 419). Causes in both groups were listed, with 52% of those with DNSE having some contribution from substance misuse. In SEPE, this was felt to play a role in 33.7%. Duration of stay in both groups was similar, but the longest in-patient stays were in the DNSE group. Admission mortality was significantly higher in DNSE than in SEPE (13.8% versus 7.5%). This mortality risk was most closely associated with substance misuse in the group with DNSE.
Conclusion(s): DNSE has a worse prognosis than SEPE. A presentation with DNSE is sign of a system in peril, even where episodes are provoked by alcohol and or drug use. Such episodes should spark off a chain of multispecialty care in order to address this recurring and persisting public health catastrophe.
Copyright © 2019 British Epilepsy Association

59. Simultaneous trauma patients in emergency department's: A difference in mortality?

Authors Morrow L.; Nutbeam T.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 888-889
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE
Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS

Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 presentation of multiple simultaneous trauma patients in an Emergency Department, is likely to place significant stress and strain on trauma care resources. Currently there is limited data available to understand the impact simultaneous trauma demands on patient outcomes. For the purposes of this project we define simultaneous trauma as occurring when there is more than one TARN qualifying major trauma patient within an Emergency Department at any one time. We hypothesise that with increasing numbers of simultaneous trauma patients a relative increase in mortality will be seen. Methods Data was obtained from the Trauma Audit and Research Network for calendar years 2010-2015 on TARN qualifying trauma patients presenting directly to Emergency Departments. Simultaneous patients were identified and the data was categorised by total number of TARN qualifying patients within the Emergency Department (range 2-6). Patient characteristics were obtained which included sex, age, Glasgow Coma Score and Injury Severity Score (ISS). A standardised comparison using a stratified W statistic (Ws) was conducted to assess mortality and the Charlson co-morbidity score was used to assess morbidity outcomes. Results Results were obtained for 2 07 094 of which 66 734 (33.7%) patients were eligible simultaneous patients. The distribution of simultaneous patients was 2 patients, 24.9% (51,466), 3 patients, 6.7% (13,820), 4 patients, 1.7% (3,539), 5 patients, 0.3% (671), and 6 patients, 0.01% (185). The median age was 61 (IQR 39.5-80.3), 55.7% of patients were male, median ISS score was 9 (IQR 9-16) and median GCS was 15 (IQR 15-15) Isolated and simultaneous patients, regardless of number of patients, showed no difference in W statistic. The average mortality for all patients was 7.2% (range 6.5%-7.6%). Conclusion The impact of simultaneous trauma patients on patient outcomes within the UK has not been previously defined. Simultaneous trauma patients do not appear to have an impact on overall mortality rate. Further work planned will understand the impact of multiple trauma patients on length of stay and time to CT/operating theatre.

60. Frailty flying squad: An emergency department focussed acute care of the elderly service Dr Genevieve Robson, Royal United Hospital NHS foundation trust

Authors Ballham S.; Buxton S.; Camacho R.; Sinclair A.; Dyer C.; Jakeman N.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 885-886
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS

Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 The over 75 s make up 20% of our ED attendances. The greatest increase has been in the over 85 s. This very elderly cohort are more likely to be frail and are 10X more likely to require admission than 20-40 year olds and once in hospital have longer stays. There is evidence that multidisciplinary care and early Comprehensive Geriatric Assessment (CGA) improves outcomes for older patients, reducing readmissions, long term care, greater satisfaction and lower costs. The aim of this project was to improve the acute care provided to our older patients at the Front Door of the hospital. Methodology 3 month pilot project underpinned by Big Room Quality Improvement methodology. The Frailty Big Room meets weekly and includes input from clinicians, QI experts and a data analyst. This project was driven by the following aims: *Frailty Flying Squad to see as many older+/-frail patients referred for admission as close to the front door as possible. *CGA at the front door with discharge planning from first review *MDT approach *Expedited discharge or transfer to other services from ED. *Review following day to make sure management plans being followed through or discharge without ward teams having to become involved. *Frailty Flying Squad Team: 2 Medical Nurse Practitioners Physiotherapist Consultant geriatrician . Key Performance Indicators: Length of Stay *Readmission within 30 days of initial review Results 355 patients were seen. 168 (47%) of patients were over 85 and the median Rockwood frailty score for the whole cohort was 6. 209 patients were ED referrals and 85 were GP referrals for admission. 237 (67%) patients were seen in ED, 49 in MAU and 7 in ED obs. During the pilot period, 97 patients who had been referred for admission were discharged direct from ED. 56 (16%) of patients had zero length of stay. A low number (9.4%) of patients were readmitted within 30 days. Figure 2 Length of stay for the > 85s 2016 and 2017 compared Conclusion A multidisciplinary Acute Care of the Elderly Team predominantly based in the Emergency department can provide effective early Comprehensive Geriatric Assessment; facilitating discharge home from the Emergency Department, reducing length of stay for those admitted and reducing readmission rates within 30 days. (Figure Presented).

61. To pan-scan or not to pan-scan? further analysis of the tarn database 2012-2017

Authors Hunt P.; Lecky F.; Bouamra O.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 884-885
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
 Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 A 'whole body' or 'pan-scan' computed tomography (CT) imaging approach is now becoming the standard of care during the early management of adult patients with suspected severe blunt multitrauma. A number of studies have variously reported a mortality benefit or no benefit from a pan-scan approach compared to that of carrying out body region-focused CT and/or plain radiographs or a mixture of imaging modalities. However, unanswered questions still remain due to the significant heterogeneity in practice between institutions, and the limitations of published studies. The potential risk for harm from ionising radiation or intravenous contrast-induced nephropathy is still a concern, especially where mortality benefit from an unselective pan-scan approach is yet to be definitively proven. We present the results of our latest analysis of the Trauma Audit and Research Network (TARN) database; updated to take into account the establishment of the regional trauma network system and focusing on the Major Trauma Centre's (MTC's).
Methods We analysed retrospective, multicentre data of severe blunt multitrauma (ISS >15) direct MTC admissions aged >15 years recorded in the UK TARN database from 2012-2017 to compare survival at 30 days between two groups of patients: (1) those undergoing pan-scan, and (2) those in receipt of a focussed/non-pan-scan approach as part of their initial management within the first 4 hours in the Emergency Department (ED). The final dataset included 44 407 cases. Results 15 645 (35.2%) of 44 407 cases underwent pan-scan from the ED. The median ISS for the pan-scan group was 18 (IQR 10-29) compared to 16 (IQR 9-25) for the non-panscan group. The calculated crude mortality rate for the panscan group was 11.2% compared to 10.6% in the focussed CT group (p=0.0673). Patient characteristics are shown in table 1. Propensity scoring (PS) was used to create a balance in patient characteristics between the two groups and various statistical models derived to analyse the effect of imaging type (exposure factor) on outcome (mortality at 30 days) as shown in table 2. The results show that pan-scan has an adverse effect on outcome in all of the models, although not statistically significant in all except Model 2 (adjustment based only on stratified PS).
Conclusion The results of our investigation demonstrate that there is no risk adjusted mortality benefit observed from current practice in MTCs in England and Wales. Key issues remain to be addressed such as pan-scan selection criteria and the significant heterogeneity observed in practice across institutions. (Table Presented).

62. Are we measuring what we think we are measuring? Qualitative research exploring the role of the 0-10 pain score within the adult emergency department

Authors Sampson F.; O'Cathain A.; Goodacre S.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 879
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
 Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 and background The assessment of pain in the emergency department (ED) is difficult but important for appropriate management of pain. Guidelines for the management of acute pain in the ED worldwide advocate using numeric rating scales such as the 0-10 pain score as tools to ensure consistency of documenting patient's pain, and this is mandated at initial assessment in many EDs. Studies of interventions to improve pain management in the ED indicate that whilst the inclusion of mandatory pain scoring within interventions may improve documentation of pain, there was mixed evidence as to whether this resulted in improvements in provision of analgesia. As part of a wider study looking at barriers and enablers to pain management in the ED, we explored how pain scoring was used in the ED. Methods Qualitative data were collected within 3 case study EDs in the UK. Data comprised 143 hours of non-participant observation, 37 ED staff interviews and 19 patient interviews. Data were analysed using thematic analysis. Results Observation showed variation in how the pain score was documented between EDs. Some staff documented the score directly reported by the patient, whilst others documented a score they formulated using a combination of physiological signs, behavioural signs and presence of a 'known' painful condition. ED staff appeared to understand the score as an absolute measure used to guide analgesia requirements or triage categories rather than a relative measure used to document changes in pain levels. Even when documenting patient reported scores, they perceived patient reported scores to be inconsistent with their own assessment of the patients pain level, particularly where this could lead to patients being managed under a higher triage category or receiving stronger analgesia than ED staff considered appropriate. Staff documented pain scores that were appropriate for the treatment they planned to provide, rather than the scores reported by the patient, in particular when the pain score was used as a tool for auditing appropriate pain management. Conclusions The pain score appeared to have parallel but misaligned roles: to assess patient pain and ED staff practice. ED staff faced conflict between the need to record pain to ensure accountability of pain management, and recording pain to reflect the patient's report. The role of the pain score needs to be reviewed in order for pain scoring to improve the patient experience of pain management in the ED.

63. Major incident triage and the implementation of a new triage tool, the MPTT-24

Authors Vassallo J.; Smith J.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 860-861
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
 Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) from Unpaywall

Abstract Introduction Over the last decade, a number of European cities including London, have witnessed high profile terrorist attacks resulting in major incidents with large numbers of casualties. Triage, the process of categorising casualties on the basis of their clinical acuity, is a key principle in the effective management of major incidents. The Modified Physiological Triage Tool (MPTT) is a recently developed primary triage tool which in comparison to existing triage tools, including the 2013 UK NARU Sieve, demonstrates the greatest sensitivity at predicting need for lifesaving intervention (LSI) within both military and civilian populations. To improve the applicability and usability of the MPTT we increased the upper respiratory rate threshold to 24 breaths per minute (MPTT-24), to make it divisible by four, and included an assessment of external catastrophic haemorrhage. The aim of this study was to conduct a feasibility analysis of the proposed MPTT-24 (figure 1). Methods A retrospective review of the Joint Theatre Trauma Registry (JTTR) and Trauma Audit Research Network (TARN) databases was performed for all adult (>18 years) patients presenting between 2006-2013 (JTTR) and 2014 (TARN). Patients were defined as priority one (P1) if they had received one or more life-saving interventions. Using first recorded hospital physiology, patients were categorised as P1 or not-P1 by existing triage tools and both MPTT and MPTT-24. Performance characteristics were evaluated using sensitivity, specificity, under and over-triage with a Mc Nemar test to determine statistical significance. Results Basic study characteristics are shown in Table 1. Both the MPTT and MPTT-24 outperformed all existing triage methods with a statistically significant (p<0.001) absolute reduction of between 25.5%-29.5% in under-triage when compared to existing UK civilian methods (NARU Sieve). In both populations the MPTT-24 demonstrated an absolute reduction in sensitivity with an increase in specificity when compared to the MPTT. A statistically significant difference was observed between the MPTT and MPTT-24 in the way they categorised TARN and JTTR cases as P1 (p<0.001). Conclusion Existing UK methods of primary major incident triage, including the NARU Sieve, are not fit for purpose, with unacceptably high rates of under-triage. When compared to the MPTT, the MPTT-24 allows for a more rapid triage assessment and continues to outperform existing triage tools at predicting need for life-saving intervention. Its use should be considered in civilian and military major incidents. (Table Presented).

64. Organ donation in emergency departments: An analysis of best practice

Authors Empson K.; Beale S.; Kerr J.; Gardiner D.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 877-878
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
 Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 The 2015 RCEM End of Life Care best practice guideline highlighted the need for organ and tissue donation to be a usual part of end of life care in the Emergency Department (ED). NICE guideline states that all deaths meeting defined clinical triggers in the ED (in practice - mechanical ventilation, plan to withdraw life sustaining treatment, death expected) should prompt timely referral to organ donation services. Any family discussion in the ED regarding organ donation should be held collaboratively with a specialist nurse for organ donation (SNOD). What is the evidence in UK EDs that this is always the case? Methodology The NHS Blood and Transplant Potential Donor Audit, carried out by specialist nurses in organ donation, audits every death aged 80 years and under in UK Emergency Departments and Intensive Care Units. Data from the Potential Donor Audit was analysed and compared across the 12 Regional NHSBT teams. Results Almost all deceased donors in the UK are admitted to hospital via an Emergency Department (ED). The number of patients dying in UK EDs aged under 80 years of age and under (1 st April 2015 to 31 st March 2016) is variable across the country and not directly correlated with population. Patients dying in ED, who meet criteria for referral is equally variable across the UK (Range 1% Scotland - 3.9% Eastern). PDA data (1 April 2016 - 31 March 2017) reveals that 284 patients died in ED meeting referral criteria but only 47% were referred (Range 22%-65% across the 12 regions). Longer 4 year analysis (1 st April 2012 - 31 st March 2016) demonstrated that up to 16% of these patients are on the Organ Donor Register. Of the 125 families approached in the ED (1 April 2016 - 31 March 2017) only 67% involved a SNOD (Range 0%-100% across the 12 regions). Discussion In 2017, with the endorsement of RCEM, NHS Blood and Transplant published Organ Donation and the Emergency Department: A Strategy for Implementation of Best Practice. The strategy promotes identification and referral of potential organ donors in the emergency department and collaborative approach of their families when withdrawal of treatment is planned in the Emergency Department. Most importantly it is emphasised that organ donation should be firmly established as a usual part of end of life care irrespective of the location of the patient. (Figure Presented).

65. Investigating the effects of under-triage by existing major incident triage tools

Authors Vassallo J.; Smith J.
Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 871-872
Publication Date Dec 2017
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
 Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) from Unpaywall

Abstract

Introduction Triage, the process of prioritising patients on the basis of clinical acuity, is a key principle in the effective management of a major incident. The overall effectiveness of the triage process is not only a balance between identifying those who need or don't need a life-saving intervention, but also those who are under or over-triaged as either incorrectly needing/not needing intervention. The primary aim of this study was to describe the implications of under-triage using existing major incident triage tools, including the 2013 National Ambulance Resilience Unit (NARU) Sieve. The secondary aim was to describe the safety profile of the Modified Physiological Triage Tool (MPTT) in comparison to other triage tools, and to report mortality and identification of serious injury (AIS>3) in discrete AIS body regions. Methods A retrospective database review was undertaken using the UK Trauma Audit Research Network for all adult patients (>18 years) between 2006-2014. Patients were defined as Priority One using a previously published list. Using first recorded hospital physiology, patients were categorised by the MPTT, NARU Sieve and existing Triage Sieve. Data are presented as number (%) and median (IQR) as appropriate. Categorical data were analysed using a Chi Square test and continuous data with a Mann-Whitney U test. Results During the study period, 2 18 985 adult patients were included with 24 791 (19.5%) identified as Priority One. 70% were male, aged 51 years [33-71], ISS 16 [9-25] with road traffic collision the most common mechanism (34%). The MPTT demonstrated the lowest rate of under-triage (42.4%, p<0.001). Overall 30 day mortality for the Priority One cohort was 12.4%. Compared to existing methods, the MPTT under-triage population had significantly lower mortality (5.7%, p<0.001), identical to the overall study population. Patients under-triaged by the MPTT had significantly lower requirement for intubation, thoracocentesis and massive transfusion than both the NARU Sieve and Triage Sieve (p<0.001). Serious injuries to the thorax (47.0%) and head (27.4%) predominated, with the MPTT again significantly under-triaging fewer of these patients (p<0.001). Conclusion This study has defined the effects of and compared the implications of under-triage when different triage tools are used in the context of a major trauma population. The MPTT misses fewer severely injured patients, with fewer LSIs necessary in the under-triaged population. We suggest that the MPTT should be considered as an alternative to existing major incident triage tools. (Table Presented).

66. Paediatric traumatic cardiac arrest in England and Wales a 10 year epidemiological study

Authors Vassallo J.; Webster M.; Lyttle M.; Barnard E.; Iniguez M.F.; Smith J.

Source Emergency Medicine Journal; Dec 2017; vol. 34 (no. 12); p. 897-899

Publication Date Dec 2017

Publication Type(s) Conference Abstract

Database EMBASE

Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS

Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 Traumatic cardiac arrest (TCA) has traditionally been described as futile, with poor outcomes. Reported survival rates vary widely, with higher rates observed from mechanisms leading to a respiratory cause of traumatic cardiac arrest (e.g., drowning and hanging). Currently there is little evidence regarding outcomes following TCA in children. The primary aim of our study was to describe 30 day survival following TCA. Secondary aims were to provide an analysis of injury patterns (severe haemorrhage or traumatic brain injury), describe the functional outcome at discharge and to report the association between survival and interventions performed. Methods Using the Trauma Audit and Research Network (TARN) database, we conducted a population-based analysis of all paediatric (<18 years) trauma patients presenting to hospitals in England and Wales between 2006-2015. Patients with TCA in the pre-hospital setting and/or in the Emergency Department were included. Those without a GCS entry were excluded. Basic demographics are reported as number (%) and median (interquartile range), as appropriate. Survival odds ratios (95% CIs) and Chi Square tests were used during statistical analysis. Results During the study period, 21 710 paediatric patients were included in the database with 129 (0.6%) sustaining traumatic cardiac arrest and meeting study inclusion criteria (1.3%). The majority had a pre-hospital traumatic cardiac arrest (103 (79.8%)). Overall, 62.8% were male, aged 11.7 years (3.4-16.6), ISS 34 (25-45) and 110 (85.3%) had blunt injuries with road-traffic collision the most common mechanism (56.6%). 123 (95.3%) had severe haemorrhage and/or traumatic brain injury. Overall survival was 5.4% (95% CI:2.6 to 10.8) with 7 cases surviving to 30 days. 'Pre-hospital only' traumatic cardiac arrest (13.0%) had a significantly higher survival than 'pre-hospital and Emergency Department' traumatic cardiac arrest (1.8%), (p=0.04). Those with injuries to the thorax predominated the severe haemorrhage group (67.6%). There were no survivors from 'Emergency Department only' traumatic cardiac arrest. Treatment at a major trauma centre was associated with a statistically significant increase in survival (p=0.02). There was no difference in survival between different times of day of presentation. Of those with Glasgow Outcome Scale recorded at discharge (n=6), four (66.7%) had either a moderate disability or good functional outcome. Conclusion Although a rare event, this study has demonstrated that resuscitation of children in traumatic cardiac arrest is not futile with overall outcomes comparable to survival rates seen in adults. Survival from pre-hospital traumatic cardiac arrest is possible and the early identification and aggressive management of these patients is advocated. (Table Presented).

67. Utilisation of the principles of the Armed Forces Covenant in NHS Trusts and Clinical Commissioning Groups across England: A freedom of information investigation

Authors McGill G.; Wilson G.; Hill M.; Kiernan M.D.
Source BMJ Open; Jan 2019; vol. 9 (no. 1)
Publication Date Jan 2019
Publication Type(s) Article
Database EMBASE
 Available at [BMJ Open](#) from Europe PubMed Central - Open Access
 Available at [BMJ Open](#) from HighWire - Free Full Text

Abstract Objectives To determine the extent to which National Health Service (NHS) service providers appoint a named Armed Forces veteran lead or champion, and to explore the commissioning of veteran-specific services by Clinical Commissioning Groups. Design A convergent mixed method design was used to improve understanding obtained from the information provided by respondents on their practice. The study comprised two parts: phase 1 involved NHS Trusts, and phase 2 involved Clinical Commissioning Groups. Setting All NHS Trusts and Clinical Commissioning Groups in England were contacted using a freedom of information request. Participants All NHS trusts and Clinical Commissioning Groups across England. Interventions Initially, existing national websites were searched to gather information within the public domain. An audit was carried out, using the Freedom of Information Act (FOIA) 2000 to gather further information. Primary and secondary outcome measures The FOIA 2000 applies to UK Government departments and public authorities, including NHS Trusts in England, Wales and Northern Ireland. Results Responses from the freedom of information requests illustrate inconsistencies in relation to adopting the principles of the Armed Forces Covenant. The inconsistencies extend to the practice of appointing an Armed Forces Veteran Lead or an Armed Forces Veteran Champion. There is also evidence to suggest a lack of commitment to and understanding of policy guidance in relation to Clinical Commissioning Group responsibility for commissioning veteran-specific services. conclusions Findings from this study support the case for making improvements to, and improving the consistency of, commissioning practices for veterans.
 Copyright © 2019 Author(s) (or their employer(s)).

68. Leading the Charge: Achievement of National Accreditation for a Nurse Residency Program

Authors Brown Tyo M.; Gundlach M.; Brennan C.; Esdale L.; Knight A.; Provencher S.; Tardy K.
Source Journal for nurses in professional development; Sep 2018; vol. 34 (no. 5); p. 270-276
Publication Date Sep 2018
Publication Type(s) Article
PubMedID 30188480
Database EMBASE

Abstract This article describes best practice recommendations in program development for a nurse residency program. This registered nurse residency program is the first in New England to acquire the American Nurses Credentialing Center's Practice Transition Accreditation. Best practices identified in this effort include (a) use of a quality improvement analyst for data trending, (b) inclusion of an off-shift nurse educator, (c) use of evidence-based practice, (d) a standardized preceptor program, and (e) appropriate evaluation instruments. New graduate nurse satisfaction increased and turnover decreased after program implementation.

69. Predictive performance of the competing risk model in screening for preeclampsia

Authors Wright D.; Wright A.; Tan M.Y.; O'Gorman N.; Poon L.C.; Syngelaki A.; Nicolaides K.H.

Source American Journal of Obstetrics and Gynecology; Feb 2019; vol. 220 (no. 2); p. 199

Publication Date Feb 2019

Publication Type(s) Article

PubMedID 30447210

Database EMBASE

Available at [American Journal of Obstetrics and Gynecology](#) from Leicester General Hospital Library Local Print Collection [location] : Leicester General Library. [title_notes] : Issues before 2000 held in Archive.
Available at [American Journal of Obstetrics and Gynecology](#) 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 [American Journal of Obstetrics and Gynecology](#) 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 established method of screening for preeclampsia is to identify risk factors from maternal demographic characteristics and medical history; in the presence of such factors the patient is classified as high risk and in their absence as low risk. However, the performance of such an approach is poor. We developed a competing risks model, which allows combination of maternal factors (age, weight, height, race, parity, personal and family history of preeclampsia, chronic hypertension, diabetes mellitus, systemic lupus erythematosus or antiphospholipid syndrome, method of conception and interpregnancy interval), with biomarkers to estimate the individual patient-specific risks of preeclampsia requiring delivery before any specified gestation. The performance of this approach is by far superior to that of the risk scoring systems.

Objective(s): The objective of the study was to examine the predictive performance of the competing risks model in screening for preeclampsia by a combination of maternal factors, mean arterial pressure, uterine artery pulsatility index, and serum placental growth factor, referred to as the triple test, in a training data set for the development of the model and 2 validation studies.

Study Design: The data for this study were derived from 3 previously reported prospective, nonintervention, multicenter screening studies for preeclampsia in singleton pregnancies at 11⁺⁰ to 13⁺⁶ weeks' gestation. In all 3 studies, there was recording of maternal factors and biomarkers and ascertainment of outcome by appropriately trained personnel. The first study of 35,948 women, which was carried out between February 2010 and July 2014, was used to develop the competing risks model for prediction of preeclampsia and is therefore considered to be the training set. The 2 validation studies were comprised of 8775 and 16,451 women, respectively, and they were carried out between February and September 2015 and between April and December 2016, respectively. Patient-specific risks of delivery with preeclampsia at <34, <37, and <41⁺³ weeks' gestation were calculated using the competing risks model and the performance of screening for preeclampsia by maternal factors alone and the triple test in each of the 3 data sets was assessed. We examined the predictive performance of the model by first, the ability of the model to discriminate between the preeclampsia and no-preeclampsia groups using the area under the receiver operating characteristic curve and the detection rate at fixed screen-positive rate of 10%, and second, calibration by measurements of calibration slope and calibration in the large.

Result(s): The detection rate at the screen-positive rate of 10% of early-preeclampsia, preterm-preeclampsia, and all-preeclampsia was about 90%, 75%, and 50%, respectively, and the results were consistent between the training and 2 validation data sets. The area under the receiver operating characteristic curve was >0.95, >0.90, and >0.80, respectively, demonstrating a very high discrimination between affected and unaffected pregnancies. Similarly, the calibration slopes were very close to 1.0, demonstrating a good agreement between the predicted risks and observed incidence of preeclampsia. In the prediction of early-preeclampsia and preterm-preeclampsia, the observed incidence in the training set and 1 of the validation data sets was consistent with the predicted one. In the other validation data set, which was specifically designed for evaluation of the model, the incidence was higher than predicted, presumably because of better ascertainment of outcome. The incidence of all-preeclampsia was lower than predicted in all 3 data sets because at term many pregnancies deliver for reasons other than preeclampsia, and therefore, pregnancies considered to be at high risk for preeclampsia that deliver for other reasons before they develop preeclampsia can be wrongly considered to be false positives.

Conclusion(s): The competing risks model provides an effective and reproducible method for first-trimester prediction of early preeclampsia and preterm preeclampsia as long as the various components of screening are carried out by appropriately trained and audited practitioners. Early prediction of preterm preeclampsia is beneficial because treatment of the high-risk group with aspirin is highly effective in the prevention of the disease.

Copyright © 2018 Elsevier Inc.

70. Harveian Oration 2018: Improving quality and safety in healthcare

Authors Dixon-Woods M.
Source Clinical Medicine, Journal of the Royal College of Physicians of London; Jan 2019; vol. 19 (no. 1); p. 47-56
Publication Date Jan 2019
Publication Type(s) Review
PubMedID 30651245
Database EMBASE
 Available at [Clinical Medicine, Journal of the Royal College of Physicians of London](#) from ProQuest (Hospital Premium Collection) - NHS Version
 Available at [Clinical Medicine, Journal of the Royal College of Physicians of London](#) from EBSCO (MEDLINE Complete)
 Available at [Clinical Medicine, Journal of the Royal College of Physicians of London](#) 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 [Clinical Medicine, Journal of the Royal College of Physicians of London](#) 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.

71. Implant-ADM based breast reconstruction: "A tale of two techniques"

Authors Murthy K.; Prasad R.; Deshpande A.
Source European Journal of Surgical Oncology; Feb 2019; vol. 45 (no. 2)
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Journal of Surgical Oncology](#) 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 [European Journal of Surgical 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: The availability of a wide range of acellular dermal matrices (ADMs) has facilitated a novel single-stage implant breast reconstruction (IBR) following skin-sparing mastectomy. Implant and ADM based breast reconstruction accounts for 37% of immediate reconstruction following mastectomy in the UK and emerging as a viable alternative to tissue based breast reconstructions. We present our initial outcomes of our prospective study in a District General Hospital of sub pectoral and pre-pectoral IBR with ADM coverage.
Method(s): Immediate and delayed breast reconstruction with ADM was performed on 55 patients in our district general hospital institution, over a period of 3 years, from January 2015 to December 2017. The cohort included patients undergoing Immediate breast reconstruction (45 patients) and delayed breast reconstruction (10 patients). The surgical complications, and outcomes from a prospective database were analysed and compared with NMBRA 2011 (National Mastectomy and Breast Reconstruction Audit) target standard as a bench mark, as a part of Joint guidelines of ABS (The Association of Breast Surgeons, UK) and BAPRAS (British Association of Plastic,Reconstructive and Aesthetic Surgeons). Data analysis conducted IBM SPSS statistical software 2018.
Result(s): The mean follow up period was 9 months. An initial assessment has shown that patient satisfaction and cosmetic outcomes have been reported to be satisfactory/good. [Figure presented] All patients were treated on a 24 hours day case basis. There were no delays to adjuvant treatment in therapeutic cases.
Conclusion(s): Our initial experience over the last 3 years show that implant based ADM reconstruction is well accepted in our study cohort and has had minimal morbidity and no arm or chest wall related morbidity. The Implant-ADM based breast reconstruction facilitates breast reconstruction with a good cosmetic outcome and quick recovery with minimal morbidity and has proven beneficial in our study cohort. Conflict of interest: No conflict of interest.
Copyright © 2018

72. Locoregional recurrence in breast cancer following wide local excision - Are we performing breast conserving surgery for larger lesions and does this affect locoregional recurrence?

Authors Blake I.; Ooi J.
Source European Journal of Surgical Oncology; Feb 2019; vol. 45 (no. 2)
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Journal of Surgical Oncology](#) 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 [European Journal of Surgical 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. Wide Local Excision (WLE) with radiotherapy is comparable to mastectomy in the treatment of early stage breast cancer. With the increasing use of oncoplastic techniques such as therapeutic mammoplasty we hypothesise that we are performing breast conserving surgery for larger lesions. We aimed to assess the 5 year locoregional recurrence rate (LRR) in patients diagnosed with invasive breast cancer who underwent WLE at Bolton Breast Unit (BBU) in 2011. A previous audit at BBU of 353 cancers diagnosed between 01/09/2008 and 01/09/2009 revealed 124 (35%) patients underwent WLE. The majority of tumours were invasive ductal, the commonest grade was grade 2 and the median tumour size was 18.5 mm (range 3-65mm). The 5 year LRR was 2.4%. We aim to determine whether the proportion of patients undergoing WLEs, tumour size or LRR had changed. Materials and Methods. All patients diagnosed with invasive breast cancer between 01/01/2011 and 31/12/2011 who underwent WLE were identified from the Somerset Cancer Registry. The following information was collected: tumour type, size, grade, and occurrence of locoregional metastasis. The data was compared to the previous audit. Results. Between 01/01/2011 and 31/12/2011 355 cancers were diagnosed and 120 (34%) people underwent WLE. One was excluded due to incomplete records. Invasive ductal carcinoma accounted for the majority of cases and the most common histological grade was grade 2. Median tumour size was 13mm (range 3-35mm) and the 5 year LRR was 2.5% (Table 1). [Figure presented] Discussion. The number of cancers diagnosed, the proportion of WLEs being performed and the 5 year LRR did not change significantly between the two datasets. This concordance may be due to the two audits being closely related in time. Interestingly the median tumour size decreased between the 2 audits, yet more WLEs were performed for grade 3 tumours. Further audit would be needed to see if this is a consistent trend or an incidental finding. The audited LRR compared favourably to published data reporting a 5 year LRR of approximately 7%, although there is little in the way of UK specific data regarding 5 year LRR. A planned multicentre regional audit of breast cancer recurrence in the Greater Manchester area aims to address this. Acknowledgments: With thanks to S Shillito, AJ Volleamere, and J Ooi for access to previous BBU audit data. Conflict of interest: No conflict of interest.

Copyright © 2018

73. Pleomorphic LCIS what do we know? A UK multicenter audit of pleomorphic lobular carcinoma in situ

Authors Masannat Y.; Husain E.; Roylance R.; Heys S.D.; Carder P.; Ali H.; Maurice Y.; Pinder S.; Sawyer E.; Shaaban A.M.

Source European Journal of Surgical Oncology; Feb 2019; vol. 45 (no. 2)

Publication Date Feb 2019

Publication Type(s) Conference Abstract

Database EMBASE

Available at [European Journal of Surgical Oncology](#) 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 [European Journal of Surgical 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: Pleomorphic lobular carcinoma in situ (PLCIS) is a relatively newly described pathological lesion that is distinguished from classical LCIS (cLCIS) by its large pleomorphic nuclei. The lesion is uncommon and its appropriate management has been debated. The aim of this study is to review data from a large series of PLCIS to examine its natural history in order to guide management plans.

Material(s) and Method(s): Comprehensive pathology data were collected from two cohorts; one from a UK multicentre audit and the other a series of PLCIS cases identified from within the GLACIER study cohort. 179 cases were identified of whom 176 had enough data for analysis making this the largest cohort in the literature.

Result(s): The mean age of all the 176 cases was 53 (34-94) years. When excluding the GLACIER patients because of the age limits for recruitment (all below 60 years), the mean age increased to 60. Of the 176 cases that had surgery, 133 had unifocal disease while 43 had evidence of multifocality. Pure non-invasive disease was seen in 47 patients. 14 patients had pure PLCIS, 20 had a mixture of PLCIS and cLCIS while concurrent PLCIS and DCIS was seen in 13. Invasive disease was seen in 130 patients, whilst 2 had microinvasive disease (<1mm). Out of the 130 that had invasive disease 117 (90.0%) had a subtype of invasive lobular malignancy, either as the only invasive component or admixed with other types. 43 (33.1%) classical invasive lobular carcinoma (ILC), 36 (27.7%) invasive pleomorphic lobular carcinoma (IPLC) and 12 (9.2%) showing a mixture of both. Only 11 (8.5%) had pure invasive ductal/no special type carcinoma (IDC). In 36 patients (27.7%) there was either mixed or multifocal/multicentric tumours, the commonest being mixed ILC and IPLC (12 cases), mixed ILC with IDC (10 cases) or IPLC and IDC 10 cases. A high incidence of histological grade 2 (71.1%) and grade 3 (24.5%) invasive cancers was noted with a predominance of ER positive (92%) and HER-2 negative (92.3%) malignancy. The preoperative diagnosis was known in 87 patients; of these, 22 had pure PLCIS diagnosed preoperatively. On excision 7 of these 22 had evidence of invasive disease (31.8%) and one (4.5%) had associated DCIS. So when PLCIS was the most significant finding on diagnostic biopsy the upgrade to invasive disease on excision was 31.8%, which is higher than pooled data for classical LCIS and DCIS.

Conclusion(s): The older age at presentation, high rate of upgrade to invasive cancer, common association with higher grade tumours suggest that PLCIS is an aggressive form of insitu disease. These findings support the view that PLCIS is a more aggressive form of lobular in situ neoplasia and supports the tendency to treat akin to DCIS. Conflict of interest: No conflict of interest.

Copyright © 2018

74. Prehospital analysis of northern trauma outcome measures: The PHANTOM study

Authors Smith C.A.; Leclerc S.; Howes R.J.; Hardern R.D.
Source Emergency Medicine Journal; 2019
Publication Date 2019
Publication Type(s) Article In Press
Database EMBASE

Available at [Emergency Medicine Journal](#) from BMJ Journals - NHS
Available at [Emergency Medicine Journal](#) 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 [Emergency Medicine Journal](#) 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 compare the mortality and morbidity of traumatically injured patients who received additional prehospital care by a doctor and critical care paramedic enhanced care team (ECT), with those solely treated by a paramedic non-ECT.

Method(s): A retrospective analysis of Trauma Audit and Research Network (TARN) data and case note review of all severe trauma cases (Injury Severity Score ≥ 9) in North East England from 1 January 2014 to 1 December 2017 who were treated by the North East Ambulance Service, the Great North Air Ambulance Service or both. TARN methods were used to calculate the number of unexpected survivors or deaths in each group (W score (Ws)). The Glasgow Outcome Scores were contrasted to evaluate morbidity.

Result(s): The ECT group treated 531 patients: there were 17 unexpected survivors and no unexpected deaths. The non-ECT group treated 1202 patients independently: there were no unexpected survivors and 31 unexpected deaths. The proportion of patients requiring critical care interventions differed between the two groups 49% versus 33% (CI for difference 12% to 20%). In the ECT group, the Ws was 3.22 (95% CI 0.79 to 5.64). In the non-ECT group, the Ws was a '2.97 (95% CI a '1.22 to a '4.71). The difference between the Ws was 6.18 (95% CI 3.19 to 9.17). There was no evidence of worse morbidity in the ECT group.

Conclusion(s): This is the first UK ECT service to demonstrate a risk-adjusted mortality benefit in trauma patients with no detriment in morbidity: our results demonstrate an additional 3.22 survivors per 100 severe trauma casualties when treated by an ECT. The authors encourage other ECT services to conduct similar research.

Copyright © Author(s) (or their employer(s)) 2019. No commercial re-use. See rights and permissions. Published by BMJ.

75. prepectoral breast reconstruction: do we need to use the chest wall muscle at all?

Authors Al-Ishaq Z.; Green M.; Salem F.; Sircar T.; Vidya R.
Source European Journal of Surgical Oncology; Feb 2019; vol. 45 (no. 2)
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Journal of Surgical Oncology](#) 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 [European Journal of Surgical 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 Introduction: Prepectoral breast reconstruction is an evolving new technique that is replacing standard submuscular reconstruction. We report the UK experience of a novel muscle-sparing breast reconstruction procedure with a preshaped acellular dermal matrix completely wrapping the breast implant.
Method(s): All patients who underwent a muscle-sparing breast reconstruction from Jan 2014 to Sept 2016 were included in the audit and the data was collected from the data base prospectively. Braxon is the only dermal matrix, which is pre-shaped and is 0.6mm thick. The mesh is porcine derived ADM, which totally wraps the implant and is placed prepectorally over the chest wall to form a new breast.
Result(s): A total of 78 prepectoral breast implant reconstructions were carried out in our centre in the UK with a median follow up of 13 months (range 3-35 months). 58 were unilateral and 10 were bilateral procedures. The age ranged between 30-76 years (median 56 yrs). The implant size varied between 120- 540cc (median 360cc). Complications included hepatoma 1.2 % (n=1), implant loss 2.5 % (n=2), seroma needing aspiration in 7.6 % (n=6) and superficial skin necrosis 2.5 % (n=2). The outcomes have been excellent, with high patient satisfaction, less pain, a more natural shape and feeling with good cosmetic outcome.
Conclusion(s): The Braxon wrap-around muscle sparing technique adds a new dimension to implant based breast reconstruction. It eliminates the problem of implant animation and procedure of choice in athletes, active patients who do not want disturbance of their musculoskeletal structure. Conflict of interest: No conflict of interest.
Copyright © 2018

76. Comparison of re-excision rates between standard wide local excision and therapeutic mammoplasty in a district general hospital

Authors Ayoub F.; Latifi L.; Trapszo P.; Seetharam S.
Source European Journal of Surgical Oncology; Feb 2019; vol. 45 (no. 2)
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [European Journal of Surgical Oncology](#) 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 [European Journal of Surgical 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: The UK national re-excision rate for positive margins in patients undergoing breast conservation surgery is around 17-33%. Wide local excision (WLE) in women with large or ptotic breasts is often associated with unsatisfactory surgical outcomes. Therapeutic mammoplasty (TM) in this group of patients offers an alternative even with larger tumours. This technique is only available in few hospitals across the UK. The aim of this audit is to determine the rate of re-excision positive margins in breast conserving surgery, and to compare standard WLE with TM.
 Method(s): Cases of breast conservation surgery at Darent Valley Hospital during 2016 and 2017 were evaluated from a retrospective database. Patients with previous breast surgery or requiring neo-adjuvant therapy were excluded from the study. The rate of positive margins, tumour weight and size in WLE and TM was directly compared.
 Result(s): 257 patients with primary breast cancer met the inclusion criteria. The rate of positive margins in the WLE group was 26% (62/240) versus 0% (0/17) in the TM group. 46 patients required one further re-excision of margins while 7 patients required two further re-excisions. 9 patients with positive margins required mastectomy, because of extensive disease. The average specimen weight was 47g (range 9-201) in the WLE group, compared to 593g (range 129-1747) in the TM group. The overall tumour size was 21mm (range 1-69) mm in the WLE group compared 32mm (range 15-50) in the TM group.
 Conclusion(s): While our re-excision rates were comparable to the UK average, TM provided a better surgical option for optimal oncological outcome with no re-excision required in women with larger breasts. Conflict of interest: No conflict of interest.
 Copyright © 2018

77. Clinical anxiety disorders in the context of cancer: A scoping review of impact on resource use and healthcare costs

Authors Shaw J.; Lopez A.-L.; Price M.A.; Pearce A.
Source European journal of cancer care; Sep 2018; vol. 27 (no. 5)
Publication Date Sep 2018
Publication Type(s) Review
PubMedID 30016004
Database EMBASE
 Available at [European journal of cancer care](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
 Available at [European journal of cancer care](#) 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 [European journal of cancer care](#) 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 Prevalence of clinical anxiety among patients with cancer is higher than the general population. Clinical anxiety in people with other medical conditions is associated with greater healthcare resource use and costs. This scoping review describes the evidence relating to costs associated with clinical anxiety in cancer populations. We conducted searches of online databases Medline, Embase, Cinahl, National Health Service Economic Evaluation Database (NHS-EED) and Cochrane Library of systematic reviews to identify studies published between 2006 and 2017 that included healthcare cost in terms of monetary or health service utilisation variables. Of 411 records screened, six studies met inclusion criteria. Only one study used formal diagnostic criteria to identify clinical anxiety. The healthcare system perspective was most common, with direct costs such as medications, hospital visits, type of therapy and use of mental health services reported. All studies found anxiety was related to increased costs/resource use; however, methodological differences mean specific costs and potential impact of interventions on resource use remain relatively unquantified. Despite the prevalence of clinical anxiety, there is little data on the economic impact on health service costs and utilisation. Future studies quantifying the true cost are urgently needed to inform healthcare service planning and delivery, and quality improvement initiatives.
 Copyright © 2018 John Wiley & Sons Ltd.

78. 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
Publication Date Dec 2018
Publication Type(s) Article
PubMedID 29896763
Database EMBASE
 Available at [Journal of clinical nursing](#) from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
 Available at [Journal of clinical nursing](#) 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

Available at [Journal of clinical 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.

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(S): Using purposive sampling, semistructured individual interviews were conducted on twelve registered nurses working on renal inpatient wards.

RESULT(S): 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.

CONCLUSION(S): 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.

Copyright © 2018 John Wiley & Sons Ltd.

79. Rapid tranquillisation: The science and advice

Authors Cookson J.
Source BJPsych Advances; Sep 2018; vol. 24 (no. 5); p. 346-358
Publication Date Sep 2018
Publication Type(s) Article
Database EMBASE

Available at [BJPsych Advances](#) 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

'Rapid tranquillisation' refers to the use of medication to calm highly agitated individuals experiencing mental disorder who have not responded to non-pharmacological approaches. Commonly it is the initial stage in the treatment of severe and enduring illness. Using medication in this way requires particularly robust evidence of efficacy and the management of side-effects. This article attempts to integrate current understanding of the neurochemical mechanisms of underlying illness and drug actions with therapeutic interventions. It distinguishes arousal from agitation, and effects on sedation from tranquillisation. It reviews critically the practice of rapid tranquillisation in the light of new evidence, changes in the NICE guidelines and British National Formulary recommendations and a national audit (POMH-UK). Broader aspects of management, known as 'restrictive practices' (such as control and restraint and seclusion), psychological support of team members, incident reporting, risk assessment, monitoring and medico-legal aspects are not covered.
© Copyright 2018 The Royal College of Psychiatrists.

80. Postoperative analgesia following caesarean section: A Forth Valley Royal Hospital quality improvement project

Authors Hutchison C.; Owen S.; Hannah S.; McIntosh K.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 23
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Adequate analgesia following caesarean section is of paramount importance given the unique set of recovery needs faced by new mothers. This quality improvement project was designed to assess and enhance postoperative pain management following caesarean section in the obstetric unit at Forth Valley Royal Hospital (FVRH). Methods A clinical audit of postoperative pain scores, side effects and satisfaction following caesarean section was carried out over a 4-week period from October to November 2017 at FVRH. Worst pain scores in the first 48 h following caesarean section were recorded using a visual analogue scale 0-10. Following the initial audit, our departmental postoperative caesarean section analgesia protocol was altered, in line with pharmacy guidance and established protocols elsewhere in Scotland, to include a long-acting opioid and regular anti-emetic and re-audited during June and July 2018. Results There were 25 patients in the initial audit and 28 in the second. All had LUSCS with spinal anaesthetic, epidural top-up or combined spinal-epidural (CSE). The median worst pain score was 6 (IQR [5-8]) in the initial audit and 4 (IQR [2.75-5]) in the re-audit. There were eight pain scores ≥ 8 in the first audit cycle (32%) and only one in the second (3.6%). Itch was similar in both groups with 68% complaining of itch in the initial audit and 67.8% in the re-audit. Nausea was slightly increased in the second group with 25% complaining of postoperative nausea and vomiting in the re-audit versus 16% in the first audit. All patients reported satisfaction in both phases of the audit cycle. Discussion The introduction of a long-acting opioid to our postoperative analgesia protocol has shown a trend towards reduction in both median pain score and the number of severe scores following caesarean section without any marked increase in side effects. All women were satisfied with their postoperative care, including those that reported severe postoperative pain, highlighting that pain is not the only indicator of patient contentment after the arrival of a newborn baby.

81. Cardiopulmonary exercise testing: Have you checked the haemoglobin?

Authors Timbrell D.; Lynch S.; Prabhu P.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 48
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Cardiopulmonary exercise testing (CPET) provides a non-invasive assessment of functional exercise capacity that has been correlated with clinical outcomes after surgery [1]. The UK provision of peri-operative CPET has expanded significantly in the last decade where it is used to provide individualised risk stratification, aid in pre-operative optimisation of comorbidities, guide intra-operative and postoperative management and improve shared decision-making [2]. Recent guidelines published by the PeriOperative Exercise Testing and Training Society (POETTS) advise that all CPET tests should be interpreted in the context of a recent haemoglobin level [1], as it has been shown that anaemia may impair exercise capacity [3]. We sought to identify our compliance with these recommendations. Methods We reviewed CPET reports for all surgical patients tested at our institution between January 2015 and August 2017. The most recent haemoglobin level prior to testing was obtained from the hospital's computerised laboratory system. This service evaluation was registered with the hospital's audit department. Results Four hundred and forty-one test reports were identified. The majority of patients were male (325, 73.7%) with a median age 70 years. Referring specialties included upper gastrointestinal (233, 52.8%), hepatobiliary (106, 24.0%), major urology (94, 21.3%) and colorectal (8, 1.8%). Just 268 (60.8%) patients had had a haemoglobin level checked within 28 days of CPET testing. Of the patients with recently recorded haemoglobin, levels were obtained on average 9 days prior to CPET testing. The haemoglobin level was not reliably recorded on any CPET reports. Discussion This project highlights that even in an experienced centre the haemoglobin level is not reliably recorded prior to CPET testing in accordance with national guidelines. This has prompted an update session for CPET practitioners on the new guidelines and a redesign of the CPET report proforma. Based on our experience, we would prompt others to review practice in their units.

82. The use of a bespoke 'view' derived from the SystmOne electronic patient record as a pre-assessment tool

Authors Hood J.; Johnston V.; Edmondson H.; Kotze A.; Beaumont A.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 22
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [Anaesthesia](#) from Wiley

Abstract

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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.

SystemOne (S1) is 'a fully integrated, cloud-based clinical system' [1] and is the chosen electronic patient record (EPR) at our acute hospital. It is used by 2500 GP practices nationwide and hosts over 35 million patient records, making it the dominant care record across Yorkshire and the UK. Interrogation of this shared care record in a secondary care setting allows a real-time search of 'read codes' assigned to diagnoses made in primary care. This quality improvement project reports a novel way to present the information contained within the shared care record to assist the pre-operative process and perhaps pave the way for a more time-efficient and patient-centred approach. Methods Within S1, it is possible to perform a pre-defined search of over 18,000 'read codes' of relevance to the anaesthetist and present the results as a 'view'. This view was developed, tested and refined with an initial group of seven patients to ensure all relevant codes were captured. Parallel assessment was then undertaken of 57 unselected patients listed for elective surgery at Airedale Hospital. Firstly, each patient attended the nurse-led pre-operative assessment department for a conventional face-to-face appointment and completion of standard paperwork, including an ASA grading. Secondly, the S1 pre-operative assessment view for each patient was studied within the EPR by the author and an ASA grade assigned. These two allocated ASA grades were then compared to assess reliability of the view against conventional pre-assessment. (Figure Presented) Results Assigned ASA grades from all parallel assessments were concordant in 42/57 (73.7%) and within one grade for 56/57 (98.2%) of cases. Concordance rose to 25/28 (89.3%) for those assigned an ASA grade of 1 or 2 from the S1 view. Discussion ASA grading is subjective but measured inter-rater variability in our study was similar to that in a retrospective study of > 10,000 patients, which found concordance in 67% and within one grade in 99% of parallel assessments [2]. In our project, concordance was higher for lower-risk patients (ASA 1 or 2) and the next phase is to institute an abbreviated pre-operative pathway whereby patients identified as ASA 1 from the SystemOne view are given the opportunity for 'one-stop' simplified pre-assessment at the time of surgical booking.

83. Royal free hospital safer cath lab

Authors Hills N.; Kyle B.; Lockie T.; Dhadwal K.; Omosilade M.

Source Anaesthesia; Jan 2019; vol. 74 ; p. 22

Publication Date Jan 2019

Publication Type(s) Conference Abstract

Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 The Royal Free Hospital (RFH) is a busy north Central London heart attack centre, providing a round-the-clock primary percutaneous coronary intervention (PPCI) service. A proportion of patients (2.5% in 2015 at RFH [1]) requiring peri-PPCI will need mechanical ventilation to facilitate this. This service is provided by intensive care registrars, with consultant support as required. General anaesthesia in remote locations is recognised as a challenging environment for all grades of trainee. Reasons are multi-factorial including frequent trainee rotation, unfamiliarity with equipment or teams and the ergonomics of a remote environment [2]. Trainees of grade ST3 to ST7 are placed in a time-critical scenario, providing emergent anaesthesia for often complex patients. Situational awareness, communication and multi-professional teamwork are human factors that are at the forefront of the work undertaken. Multiprofessional analysis of a serious incident occurring in a ventilated PPCI patient identified several human and environmental factors as contributory. The RFH Safer Cath Lab QIP was launched. Methods Key interventions: * Morning inter-professional Cath Lab Team brief * 'Anaesthetic Time Out' incorporated into the PPCI pathway * Formal Cath Lab induction for new trainees * Equipment standards in line with guidelines for the Provision of Anaesthetic Services (2018) recommendations Results We chose to use 'communication' and 'teamwork' as barometers for the success of these interventions through pre- and post-intervention surveys 3 months apart (Fig. 1). (Figure Presented) Discussion Our results suggest these simple interventions led to significant improvements in teamwork and communication, even during perceived 'worst-case scenarios' i.e. mid PPCI anaesthetic intervention or cardiac arrest. This is supported by anecdotal evidence that team morale, leadership and support for a 'human factors culture' during these pressured scenarios is improved. The World Health Organization (WHO) safer surgery checklist has resulted in global reduction of mortality [3]. The RFH Safer Cath Lab project uses a WHO-based emergency checklist and other alterations to daily working patterns to enhance communication, teamwork and patient safety for patients undergoing emergency coronary intervention in the Cath Lab. Phase 2 includes introduction of hot de-brief after difficult cases, multi-professional simulation and performance of audits to assess quality of both anaesthetic time out and morning team briefs.

84. Innovative approach using quality improvement practitioners to improve patient care: Think Drink project - The Leeds way

Authors Sivanandan I.; Hutton C.; Francis L.; Ingram J.
Source Anaesthesia; Jan 2019; vol. 74; p. 47
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Peri-operative fasting guidelines in adults from the European Society of Anaesthesiology and Association of Anaesthetists recommend that adults should be encouraged to drink clear fluids up to 2 h before elective surgery. Traditionally fasting consisted of being nil by mouth (NBM) from midnight before surgery. These outdated practices persist despite emerging evidence revealing that excessive fasting results in negative outcomes and delayed recovery. An audit in October 2017 of fasting times for patients for elective surgery showed an average of almost 13 h fluid fast. Patients were falling under the obsolete instructions of 'fast from midnight' resulting in no fluids given on the day of their surgery and potential detrimental effects to health, wellbeing and experience. Patient feedback showed they were very thirsty and felt tired due to long periods of fasting prior to surgery. Methods Working with Nottingham Hospitals NHS Trust successful project team, the Think Drink initiative was established in 2018 at The Leeds Teaching Hospitals NHS Trust (LTHT) with the appointment of two quality improvement (QI) practitioners to improve quality of care, patient experience and reduce morbidity. The Think Drink team in collaboration with a multidisciplinary team including the Patient Experience Team, corporate nursing, informatics, medical illustrations, central print, executive board, PALS, surgeons, anaesthetists, business managers, surgery schedulers, HR, communications, wards, theatres, clinics, help to disseminate guidelines and provide education and training to all staff and patients in order to promote understanding and engagement. Theatre team briefs now include a 'Think Drink' stop and a golden phone call where a named member of the team clarifies with the anaesthetist and surgeon which patients can drink and until what time, based on the expected duration of cases. Patient feedback has improved with excellent feedback about the quality of care. Results The latest audit in July 2018 shows 91% of Leeds Teaching Hospitals Trust adult patients who had elective surgery had a drink the morning of their surgery and 30% were given additional drinks given whilst waiting on the day and 30% of patients hydration status hit the 2 h target as per guidelines. Discussion Challenging the long-held dogma ('nil by mouth from midnight') is not easy and requires persistence and credible champions. Innovative appointment of Think Drink QI practitioners has helped Leeds achieve better quality of care for patients and successfully implement the Think Drink initiative.

85. Peri-operative cardiac arrest: Anaesthetists' attitudes and perceptions

Authors Oglesby F.; Armstrong R.; Soar J.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 73
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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

The National Audit Projects (NAPs) have sought to examine important complications of anaesthesia in the UK since their inception in 2003. As part of a topic proposal for NAP7, we undertook a survey of anaesthetists' attitudes and perceptions towards peri-operative cardiac arrest (POCA). There are no existing UK data on this topic. Applying the incidence rates from published US data to the activity survey estimate from NAP5 suggests there may be > 1500 episodes of POCA in the UK each year with a resultant 1000 deaths [1, 2]. The voluntary contributions of anaesthetists are vital to the NAP model and as such, any topic to be undertaken must be of interest to the profession to ensure sufficient 'buy-in'. Methods Anaesthetists at two teaching hospitals in the southwest were invited to participate in an anonymous online survey to explore their attitudes and perceptions of POCA. The survey was open for 1 week in June 2018 with invitations and reminders sent by email. Questions explored views on the topic proposal, definitions and inclusion/exclusion criteria. Responses were summarised and presented as numbers with percentages. Free-text responses were analysed to produce a word-cloud based on frequency. Results One hundred and three out of 248 invitees (42%) responded. Yes/no responses are summarised in Table 1. Table 1 Percentage responding 'yes' to questions. (Table Presented) The most commonly accepted inclusion criteria were 'any patient requiring defibrillation or chest compressions' (99%) and 'hypotension < 50 mmHg leading to chest compressions' (86%). Alongside general anaesthesia > 90% felt regional, obstetrics, sedation in theatre, and recovery areas should be included. Only 80% supported sedation in other areas and 68-71% transfers. Respondents felt the peri-operative period should end either on completion of transfer to the ward/high-dependency unit (HDU; 47%) or 24 h after anaesthesia (40%). The top three things people hoped to learn were incidence, risk factors and outcomes. Discussion Our survey suggests that POCA is important to anaesthetists and patients. We believe the results of this survey support an NAP on this topic, which could generate valuable information for patients, carers and anaesthetists. However, several important definitions and inclusion/exclusion criteria would need to be clarified before proceeding.

86. Improving antiepileptic medication administration time reduces seizure duration and need for intensive care in paediatric status epilepticus

Authors Soo A.K.S.
Source Developmental Medicine and Child Neurology; Jan 2019; vol. 61 ; p. 55
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Developmental Medicine and Child Neurology](#) from Wiley

Available at [Developmental Medicine and Child Neurology](#) 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 [Developmental Medicine and Child Neurology](#) 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 reduce seizure treatment administration time and time spent in convulsive status epilepticus through quality improvement methodology.
 Method(s): A retrospective case notes analysis was performed. Patients <18 years old presenting to an emergency department in convulsive status epilepticus were included in the analysis. Data was compared between two time periods (Year 1=July 2016 to July 2017; Year 2=July 2017 to July 2018). The UK Advanced Paediatric Life Support (APLS) 2016 guidelines for status epilepticus was used as the standard approach. A series of quality improvement interventions were administered: Regular multidisciplinary, in situ simulation sessions attended by nursing and medical staff from various specialties. Ensuring easy access to APLS guidelines and commonly used status epilepticus medications in paediatric resuscitation areas. Ensuring families of patients with previous prolonged seizures were provided with clear emergency rescue plans and training to deliver home buccal midazolam. Developing an Achieving Clinical Excellence initiative to highlight good practices through educational meetings and newsletters.
 Result(s): There was a 50% reduction (from 15 to 8 cases) in the number of status epilepticus presentations in the second year. The average time spent in status epilepticus reduced by 35 minutes (from 108 to 73min). More patients in the second year (75%) were administered a benzodiazepine dose by their parents/carers compared to the first year (53%). The average time to administration of intravenous phenytoin/phenobarbitone also improved by 21 minutes (from 36 to 15min). No patients required rapid sequence induction anaesthesia to terminate the seizure in year 2.
 Conclusion(s): Status epilepticus is a medical emergency that requires the concerted efforts of all to deliver the right intervention at the right time. Quality improvement in status epilepticus can reduce administration time of medications, seizure morbidity and the need for intensive care.

87. Understanding QI: A novel approach to using Trust mandatory audits for Medical Training Initiative doctors

Authors Elahmedawy H.; Acharya Basrur R.; Sivanandan I.; Elayaperumal A.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 18
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 The Medical Training Initiative (MTI) is a national scheme designed to allow a small number of doctors to enter the UK from overseas for a maximum of 24 months, so that they can benefit from training and development in NHS services before returning to their home countries [1]. Under the supervision of a fully qualified NHS consultant doctor, MTI receive core or speciality medical training to the same standards of UK national trainees. RCoA curriculum requires QI as a core competency to be achieved. One of the challenges trainees working for the first time in the NHS is getting to understand principles of QI and undertake a project in a short time [2]. At Leeds Teaching Hospitals we developed a novel approach using Trust mandatory audit. Methods At Leeds we have 15 MTI trainees working in the Trust over a 2-year period. We piloted the QI project with two MTI trainees who worked closely with consultants. Having audit tool kits with clear description of the audit, instructions to conduct and a data collection sheet made it much simpler. The first looked into compliance of the World Health Organization (WHO) checklist and second assessed the standard of anaesthetic record keeping in our Trust. Results Having successfully completed these audits, the feedback was the trainees felt much better informed about QI and became confident to undertake further audits with a reduced level of supervision. Trainees with no experience felt it was a steep learning curve. It also highlighted the importance of documentation of anaesthetic charts, understanding of the importance of the WHO checklist and various departmental policies related to these. Discussion MTI doctors come to the UK for a variety of reasons. Some have specific skills, or areas of interest they wish to develop; others seek to broaden their general experience. It has been always a challenging issue to integrate the international medical graduates into the UK medical system and to gain maximum training within a short period. Trust mandatory audits conducted in every department every year with a pre-approved tool kit, designed by audit lead consultants and tested multiple times are an ideal start for MTI doctors to understand QI and its importance and provide a useful tool to take back after their training time.

88. Documentation of consent for anaesthesia at the Christie NHS Foundation Trust (2018)

Authors Clark S.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 17
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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

The General Medical Council (GMC) publishes guidance underpinning the consent process for all doctors [1]. The 2015 case of Montgomery vs. Lanarkshire gathered renewed attention to the process of gaining informed consent and moved the onus from providing information that a medical professional would deem necessary to information that a reasonable person in the patient's position would be likely to attach significance to. In response to this, the Association of Anaesthetists produced guidance outlining the duty of anaesthetists in this process, including what should be documented during it [2]. Methods A retrospective case record audit of patients undergoing general and/or regional anaesthesia was undertaken with data collected over a 2-week period. The electronic patient record and anaesthetic chart were examined against agreed standards for documentation of the consent process. Following the initial audit, change was implemented by means of a new anaesthetic chart with a dedicated section for consent documentation and the audit process repeated to examine the impact of this change. Results Data were collected from 29 and 10 patient records, respectively (original and re-audit). An element of consent (a statement suggesting explanation of the proposed procedure, risks, benefits, alternatives and/or consent given) was documented in 58.6% vs. 90% of cases. Documentation of the individual elements of consent were found to be 42.9% vs. 90% for risks of general anaesthesia; 44.8% vs. 100% for risks of regional anaesthesia; benefits were not documented in any case; 0% vs. 33.3% for alternatives of regional anaesthesia; alternatives were not documented for any case of general anaesthesia; 58.6% vs. 90% for consent obtained. There was no documentation of consent for awareness (in cases of general anaesthesia) or for electively inserted arterial or central lines in the initial audit, but an element of consent was documented in 50% and 100%, respectively, for these in the re-audit. Discussion The sample size was limited; however, this was relative to the centre's size and population wherein we manage primarily complex cases of long duration. The introduction of a new anaesthetic chart containing a dedicated section for consent to anaesthesia and related procedures appears to have improved compliance with standards for documentation in the patient record. Some changes are evidently needed to improve compliance across all standards. The Trust will revise the proposed document and implement it across all theatres imminently.

89. Re-audit on epidural waiting times in a regional tertiary referral maternity unit

Authors Ching R.; Howells A.

Source Anaesthesia; Jan 2019; vol. 74 ; p. 17

Publication Date Jan 2019

Publication Type(s) Conference Abstract

Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 St Mary's Hospital, Manchester, UK, is a regional centre that provides tertiary services for complex obstetrics patients. Our maternity unit delivers in excess of 9000 newborns each year, yet, due to the closure of two smaller neighbouring units and centralisation of services to look after complex medical patients, such as those with co-existing cardiac and renal diseases, we noticed a much increased demand in the provision of anaesthetic services for peripartum patients. Methods We used guidelines published by the Royal College of Anaesthetists on response time for the provision of intrapartum anaesthesia and analgesia as performance indicators for the provision of labour analgesia for patients in our delivery suite [1]. Through retrospective analysis of two two-monthly data collected in 2016 and 2018 from our electronic database, K2, we managed to audit and re-audit our attendance to patients within 30 min and 60 min following their requests for labour epidurals. Results Following good practices between February and April 2016, which recorded 90.3% and 92.6% response rates within 30 min and 60 min out of the 313 epidural requests, our performance has improved further to 91% and 95.2%, respectively, based on the epidurals that were undertaken for 334 patients between April and June 2018. We scrutinised reasons for the delay in attendance by anaesthetists within the two time points and we found 'busy in theatre' to be the most frequently reported reason for delay especially during out-of-hour services. The second most common reason for delay was due to the lack of up-to-date blood results such as full blood counts and C-reactive protein. Discussion We value having two resident anaesthetists during out of hours to ensure timely assessment and initiation of epidural for patients in active labour. However, issues with the lack of adequate and in-date laboratory blood tests remain a potential source of delay. This in fact echoes the results of one of the recent surveys undertaken by the Obstetrics Anaesthetists' Association, which concluded that there is currently no consensus of opinion or robust guidance on which blood tests are needed, and if so, when for the parturients before epidural [2]. Further training on the indication and timing of clinical tests, such as full blood counts and C-reactive protein, should take place to minimise the unnecessary delay. Regular surveillance of the anaesthetic service would also improve the quality of clinical care.

90. An audit to assess anaphylaxis boxes at the Queen Alexandra Hospital, Portsmouth NHS Trust

Authors Carta S.; Davies J.; Gormley R.; Kenchington A.; Garner R.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 16
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 An audit investigating the location and contents of anaphylaxis boxes was undertaken due to a problem locating the box on a ward during the writing of a simulation scenario for foundation trainees. The first cycle was completed in May 2017 with recommendations proposed to the pharmacy and the resuscitation committee with a re-audit in June 2018. Methods Data were collected from all hospital wards (44). The nurse in charge was identified and timed to locate the anaphylaxis box. The contents and expiry dates were audited against Trust guidelines. Recommendations proposed following the 2017 audit included replacement of expired contents by the pharmacy; distribution of a laminated algorithm into all anaphylaxis boxes [1], retraining by resuscitation nurses of wards in which problems were identified with location and time to locate along with review of the top-up process. The re-audit followed the previous method. Additionally, this year a range of ward staff were questioned on the location of the anaphylaxis box and incident forms pertaining to anaphylaxis were reviewed. Results All wards had an anaphylaxis box on both audits. The correct location was found on 95% of wards, showing a 4% improvement. All medication was in date this year, showing a 20% improvement. A 9% increase in time to locate < 1 min was found on 95% wards. All wards had adrenaline and chlorphenamine showing a 16% and 7% improvement, respectively. Hydrocortisone was present on 93% of wards, which was similar to 2017. Other contents were found on 30% wards, showing a 40% improvement; algorithm presence [2] was improved by 56%. Knowledge of the location of the anaphylaxis box was collected from a variety of grades and wards; 100% of nurses and F1/F2 doctors, 17% registrars and 50% of consultants were able to identify location. Review of incident forms revealed common themes including intravenous instead of intra-muscular administration of adrenaline, delays in locating the box and absence of adrenaline and algorithms [1]. Discussion The results demonstrate an improvement in anaphylaxis boxes in all parts of the audit. Significant improvements were seen in algorithm [1] presence along with the absence of other contents in boxes. Incident form themes have been addressed by our intervention following our 2017 audit. The Trust is introducing a small number of tamperproof sealed cardiac arrest trolleys and will trial weekly checks of anaphylaxis boxes on these wards. The anaphylaxis boxes will continue to be audited on a yearly basis.

91. Frailty, multimorbidity and the ageing surgical population: A snapshot audit

Authors Broadbent E.; Stewart K.; Chapman S.; Beecroft C.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 15
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 As the UK population ages, frailty and multimorbidity will place increasing demands on health services. Although greater numbers of elderly patients will require surgery, these patients are at increased risk of adverse postoperative outcomes, including longer hospital stays, increased risk of mortality and less chance of returning home [1]. To face these challenges, a radical change in our current care pathways is required. Prior to the introduction of interventions, we audited the scale of frailty and multimorbidity in our surgical population. **Methods** We undertook a 1-day 'snapshot' audit of the demographics of all the surgical patients in a large teaching hospital in the east of Scotland. A case note review was used to collect age, speciality, admission type (planned or unplanned) and multimorbidity (two or more comorbidities as defined by Barnett [2]). Frailty was assessed using the Clinical Frailty Scale (CFS) measured 1-9, with a score of 5-8 classified as frail. The CFS was self-assessed, except where limited by delirium or cognitive impairment in which case relatives or nursing staff where consulted. **Results** There were 236 surgical patients in the audit. The age range was 21-95 years (mean 65 years). Of the surgical inpatients, 53 (22%) were planned and 183 (73%) were unplanned admissions. Overall, 29% of the surgical population had a CFS of ≥ 5 (range 1-8). Of the 53 planned admissions, eight (15%) had a CFS of ≥ 5 , and of 60 unplanned admissions, 20 (33%) had a CFS of ≥ 5 . The mean number comorbidities in patients ≥ 65 years was four (range 0-10) compared to two (range 0-10) in ≤ 65 years. The specialities with the highest proportion of patients with CFS ≥ 5 were orthopaedic surgery (29% planned, 42% unplanned) and vascular surgery (46% planned, 75% unplanned). **Discussion** Our audit shows that frailty and multimorbidity have a significant impact on the surgical population. An established local orthogeriatric pathway guides the care of elderly trauma patients, but other surgical specialties do not benefit from this pathway. The audit demonstrates the need to develop similar pathways, based on comprehensive geriatric assessment, for frail surgical patients. Barriers to the development of such pathways include funding, workforce and lack of inter-specialty collaboration [3]. In our hospital, we are planning alternative multidisciplinary ways of delivering this package of care rather than relying solely on leadership from medicine for the elderly physicians.

92. Review of the pathway for children with '? Swollen' optic discs; A service evaluation and quality improvement study

Authors Christodoulou L.; Parida A.; Wu K.; Donnachie A.; Wren S.; Bentley C.
Source Developmental Medicine and Child Neurology; Jan 2019; vol. 61 ; p. 92
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Developmental Medicine and Child Neurology](#) from Wiley
 Available at [Developmental Medicine and Child Neurology](#) 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 [Developmental Medicine and Child Neurology](#) 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: Papilloedema is defined as swelling of the optic disc caused by raised intracranial pressure. Following a recent highly publicised court case, our paediatric and other services have experienced an unprecedented increase in referrals of children with 'suspicious optic discs'. We aimed to evaluate the patient journey of all children presenting with suspected optic disc swelling and make recommendations for an integrated multidisciplinary pathway.

Method(s): A retrospective case notes review in a single UK centre of all patients under 16 presenting with suspected optic disc swelling to Paediatric or Ophthalmology departments.

Result(s): During a 9-month period in 2016, 42 referrals concerning 'suspicious' optic discs were received. 39 (92%) of these were from community optometrists. Mean age was 11, ranging from 4-17-years old. 38 (90%) of these patients presented to Ophthalmic Emergency, of whom 18 were sent straight to paediatrics. The remainder came via their GP. 11 (61%) were sent for urgent MRI without seeing a paediatrician or ophthalmologist; 10 (91%) of these MRI scans were normal. 6 had 'USS proven' disc drusen. Only 3 children (11.5%) were found to have underlying pathology. Only 2 (5%) children had 'true' papilloedema related to intracranial pathology (1= astrocytoma, 1=idiopathic intracranial hypertension).

Conclusion(s): The large majority of children with a suspicion of a swollen optic disc raised by a community optometrist do not have any significant pathology. Increased referrals for suspicious optic discs create a significant workload for paediatric and eye services and generates high levels of anxiety for the patient and family. Careful assessment by a Paediatrician and a Paediatric Ophthalmologist is mandatory before embarking on neuroimaging or further investigations. Optical coherence tomography and eye ultrasound should be considered in cases of diagnostic uncertainty. Multidisciplinary integration of guidelines is recommended.

93. Dystonia in the Paediatric Intensive Care Unit (PICU): A retrospective prevalence study

Authors Ahmed R.; Lumsden D.E.; Griffiths B.
Source Developmental Medicine and Child Neurology; Jan 2019; vol. 61 ; p. 27
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [Developmental Medicine and Child Neurology](#) from Wiley
Available at [Developmental Medicine and Child Neurology](#) 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 [Developmental Medicine and Child Neurology](#) 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 determine the incidence of dystonia as (1) a contributor to the need for PICU admission and (2) a factor complicating PICU admission for children and young people (CYP).

Method(s): Administrative databases were interrogated in a single tertiary centre. CYP with ICD-9 codes likely to give rise to dystonia experiencing a PICU admission between September 2007 and September 2017 were identified. Electronic notes were reviewed to confirm a diagnosis of dystonia. For eligible subjects, collected data included reason for admission, contribution of dystonia to the need for admission, and whether dystonia complicated the admission. The Paediatric Intensive Care Audit Network (PICANet) database was searched to identify admissions due to dystonia from contributing units in the UK during this time period using Read Codes describing dystonic states, and free text search terms related to "status dystonicus".

Result(s): Amongst 12,103 PICU admissions in our centre, 369 (3.0%) were in CYP with dystonia. Dystonia was the main reason for admission in 20/369 (5.4%) of these admissions, contributing to the need for admission in a further 19/369 (5.1%). Dystonia complicated 128/369 (34.7%) admissions (~1% of all PICU admissions). For CYP with dystonia, the median length of hospital stay was 21 days, compared to 7 days when dystonia complicated the admission ($p < 0.0001$). The PICANet search identified a total of 29 admissions, none from our own centre.

Conclusion(s): Dystonia is likely to be a more frequent reason for PICU admission amongst CYP than previously considered. Limitations in current clinical coding terms are likely to have resulted in a highly conservative estimate of the incidence of dystonia in this clinical setting. CYP with dystonia frequently experienced symptom exacerbations during PICU admission, which appear to correlate with longer hospital stays. Further prospective studies are required to determine the true burden of dystonia in the critical care environment.

94. Technology as a tool to monitor anaesthetic practice and patient satisfaction in obstetrics patients over 4 years

Authors Agarwal M.; Chitre D.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 9
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
Available at [Anaesthesia](#) from Wiley

Abstract

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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.

Southend University Hospital was the second hospital in the UK to introduce the electronic Computer Science Corporation (CSC) database in September 2013 as a quality improvement project over the paper logbooks. Specific advantages include superior data storage capacity, faster data retrieval, user-friendly, quicker data analysis, less chance of data loss and easy sorting of data by specific parameters. It was designed by the department to align with the dataset required by the National Obstetrics Anaesthetic Database and Royal College of Anaesthesia audit recipes [1]. Aims of the electronic anaesthetic database included monitoring anaesthetic workload, comparing our performance against national standards for anaesthetic techniques and complication rates, a tool to survey patient satisfaction and to improve patient care. Methods This was a retrospective analysis of every anaesthetic intervention in our unit for all obstetric patients in the peripartum period. The data presented were collected between 1 January 2014 and 31 December 2017. Data collected included anaesthetic details, patient characteristics, complications, obstetric history and outcome and patient satisfaction. Results The average annual delivery rate in our unit over the last 4 years was 3800, and around 52% needed anaesthetic input. The annual caesarean rate improved from 34.6% in 2015 to 26.8% in 2017. The average labour epidural rate was 16.7% and annual accidental dural puncture rate was around 1% over the last 4 years. The average primary general anaesthetic for caesarean sections over the last 4 years has been 4.3%, compared to the national average of 8%. On average, 97% of the parturients rated the anaesthetic service in the peripartum period as excellent/ good. (Figure Presented) Discussion Introduction of the electronic database has provided an accurate comprehensive review of our practice against national standards. Our local electronic database can be a useful tool for appraisal and trainee supervision, and monitoring rare complications. We have performed well against national standards despite a challenging local obstetric patient population (10% of the population is class 3 obese). The patient satisfaction survey results over the last 4 years have been very positive and are able to achieve Trust objectives. A standardised national obstetric anaesthetic database will help to meet the challenges faced by many obstetric units, by enabling comprehensive regional and national comparison of data for quality improvement.

95. The GEARS Checklist: Introduction of a newly devised decision-making and communication tool to aid care for patients participating in an enhanced recovery after surgery programme at the Royal Marsden

Authors Morrison B.; Walker S.; Evans M.; Kasivisvanathan R.; Brown M.; O'Mahony M.; Nicol D.

Source Anaesthesia; Jan 2019; vol. 74 ; p. 34

Publication Date Jan 2019

Publication Type(s) Conference Abstract

Database EMBASE

Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Compliance with enhanced recovery after surgery (ERAS) programmes (ERPs) has been shown to improve postoperative outcomes [1]. Perioperative Quality Improvement Programme (PQIP) results suggest a low rate of uptake of ERAS in The Royal Marsden in London and audit figures demonstrated poor postoperative documentation of intent to enrol onto, or continue with, an ERP. Following interviews with members of the perioperative team at the Trust, it was found that communication and complexity of existing protocols were issues affecting effective delivery of ERPs. (Figure Presented) **Methods** We devised a novel programme with the aim of simplifying the entire ERAS process from lengthy protocols to five specific components for both staff and patients. This involved the introduction of bespoke literature for patients, setting their expectations, and developing the GEARS ('Get-up, Eat, Analgesia, Remove and Speak') checklist into the World Health Organization (WHO) sign-out and first few days of postoperative care. This enables the surgeons to more effectively communicate that their patients are to follow an ERP and any expected deviations. Although the care has been standardised, where possible each day the surgeons can revise the targets based upon their patient's recovery and more easily communicate changes. The presence of a GEARS checklist in the patient's notes makes it easy for critical care staff to identify those patients enrolled in an ERP and thus steer them towards achieving full compliance with it. The 'Speak' section of the checklist offers patients an opportunity to voice questions or concerns as part of the ward round helping them remain fully involved with their ERP. Having been made familiar with the GEARS programme pre-operatively, patients should feel more confident to speak up if they desire. **Results** As GEARS becomes more fully integrated, we look forward to gathering feedback and audit data from staff and patients as to how the process is helping communication and decision-making amongst everyone involved in delivering an ERP. Early feedback suggests a high level of enthusiasm towards the project with a wide scope for expansion beyond the original isolated checklist idea. **Discussion** The use of a postoperative checklist to aid in the delivery of ERPs has previously been shown to demonstrate an improvement in compliance to the programme [2]. Once fully established, we hope to expand this project to all surgical specialities at The Royal Marsden to improve the delivery of ERAS promoting its use and benefits to staff and patients.

96. A service evaluation of silver trauma in a North West England major trauma centre

Authors Kennett A.; Mercer S.; Cromer D.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 27
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Elderly trauma accounts for > 20% of UK major trauma [1]. In 2017, the Trauma Audit & Research Network (TARN) published a report into major trauma in older people with an Injury Severity Score (ISS) > 15 [2]. Key findings were that two distinct types of major trauma are seen: high-energy transfer trauma in younger patients and lower energy in the elderly where a fall of < 2 m was the most common mechanism. Older people were more likely to be injured indoors, presenting during daytime hours. Time to computed tomography (CT) of the head was 1.5 h longer than younger patients. This service evaluation reviews patients > 65-years old presenting at a major trauma centre in the North West England in 2017. **Methods** Institutional Clinical Audit Department permission was granted (CAMS 6455). A case note review was undertaken of all patients who were included in our TARN records who were > 65-years old, with an ISS > 15 who activated the Trauma Team. **Results** Total TARN cases for 2017 were 1075 with those > 65 years accounting for 411 (38.2%), 220 activated a trauma call and 131 cases of these had an ISS score of > 15. We analysed 127 cases, (77 men and 50 women) with a mean age of 76.7 years, range 65.1-99.4). Mechanisms of injury were blow (n = 4), crush (n = 1), fall < 2 m (n = 32), fall > 2 m (n = 67) and vehicle collision (n = 23). The 30-day mortality rate was 80%. Other selected results are listed in Table 1. Table 1 Selected results. (Table Presented) **Discussion** In 2017, patients > 65-years old accounted for 2/5 of patients on the TARN database in our institution. The most common mechanism was fall from > 2 m, which is in contrast to the national database (fall from < 2 m) [2]. Traumatic brain injury is recognised nationally as the commonest cause of death [2]. Despite half our patients presenting out of hours they all received consultant-delivered care with time to CT of < 45 min in over 4/5 of cases. An increased workload of elderly trauma may require an elderly medicine physician on the trauma team in the future.

97. Peri-operative management of the ophthalmic surgical patient with diabetes

Authors Pett E.; Pavlakovic L.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 40
Publication Date Jan 2019

Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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
 In 20 years, diabetes prevalence in the UK has doubled to 3.7 million [1]. Diabetes complicates the peri-operative period, increasing morbidity, mortality and length of stay. Moorfields Eye Hospital (MEH) initiated an audit project to improve peri-operative care of surgical patients with diabetes. The third cycle of this audit is complete. Methods Six standards were identified: (1) measure glycated haemoglobin (HbA1c) in all surgical patients with diabetes; (2) HbA1c should be < 69 mmol.mol⁻¹ (8.5%) for elective surgical cases under general anaesthesia; (3) perform urea and electrolytes analysis (U&E) and electrocardiogram (ECG) on all patients with diabetes having general anaesthesia; (4) fasting should be limited to one missed meal; (5) intra-operative capillary blood glucose (CBG) should be 6-12 mmol.l⁻¹ and (6) test for ketones if CBG is > 17 mmol.l⁻¹. Data forms were in all operating theatres at MEH. The audit ran for 17 continuous days in March 2018. NHS patients > 16-years old with diabetes were eligible. Clinical coding provided data for the total number of surgical patients with and without diabetes during the audit period. Results The prevalence of diabetes in surgical patients was 18%. Seventy-eight patients with diabetes were captured (41.5% of all surgical patients with diabetes). See Table 1 for further results. Table 1 (Table Presented) Discussion Diabetes affects 10-15% of the surgical population [2]. Higher prevalence at MEH (18%) is unsurprising given the link between diabetes and eye disease. Improvements in patient care can be seen with each audit cycle. Pre-operative measurement of HbA1c is now > 90%. The number of patients with poor diabetic control is constant; nearly 30% have HbA1c >= 69 mmol.mol⁻¹ in each audit cycle (67% being elective cases in 2018), despite more patients being managed with insulin. Harm from errors in insulin prescribing/administration is now an NHS England 'never event'. As peri-operative physicians, anaesthetists must be confident using insulin. Indeed, of the 39% with CBG outside the target range on the day of surgery, ~75% were insulin-dependent. Disappointingly, no ketone testing occurred, but all those undergoing general anaesthesia had ECG and U&E, and only 6.8% missed more than one meal before surgery. Limitations of this audit are the low capture rate and small subsample of general anaesthesia patients. Nonetheless, this audit highlights valuable trends. It is hoped the next cycle will show improved ketone testing. Continued education on insulin prescribing/administration remains key.

98. A qualitative study exploring healthcare experiences of elderly patients and their carers undergoing hip fracture surgery

Authors Patel V.; Yeung J.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 65
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 With an ageing population, the number of patients being admitted for hip fracture surgery is rising. Recovery for patients is multifaceted and includes physical, social and emotional domains. Patient outcomes and experience underpin the NHS Constitution in driving quality improvement and performance. Traditionally patient's views on healthcare have been sought through measuring patient satisfaction, but there is now a drive to focus on patient experiences. The aim of this qualitative study was to explore the physical, mental and emotional impact on patients and care-givers following hip fracture surgery. Methods Semi-structured interviews were conducted with 16 patients and five carers. Interpretative phenomenological analysis was used to identify themes. It is well-suited to the aims and objectives of exploring lived experiences and it has successfully been applied in the context of healthcare. Results There were three male patients. All care-givers that consented to participate were female. Patient age range was 65-78 years (median = 77 years). Table 1 Conceptual framework of patient themes. (Table Presented) Carer superordinate themes included being informed, relinquishing control, carers as observers, interactions with healthcare professionals, changing relationships and their role as carers. Discussion Hip fracture surgery can have a life-changing impact. This study found rehabilitation and recovery stages to be important in regaining independence. Support from healthcare professionals, family and friends is required to facilitate and enable transition from hospital to the community. In exploring the important lived experiences of patients and their carers following hip fracture surgery, the results can be used to inform healthcare policy and guidance. Existing guidance is rarely developed with involvement from public and patient groups and is at risk of being irrelevant to the target population. This conceptual framework of themes constructed using the experiences of patients and their carers can better inform health service guidance facilitating patient-centred care.

99. Assessing the cost effectiveness of pre-diluted metamorphol

Authors Walley K.; Jones D.; Stokes E.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 50
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley
 Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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 Reduction in pharmaceutical waste is a priority in the National Health Service (NHS) [1]. Most NHS Trusts purchase metamorphol ampoules 10 mg.ml⁻¹, which are diluted in a 20 ml syringe to the standard concentration of 0.5 mg.ml⁻¹. This 20 ml is frequently decanted into 5 ml syringes to minimise medication wastage during a theatre list. This presents several risks: of accidentally administering 'neat' metamorphol, of contamination while decanting across syringes, and of wastage of both metamorphol and associated equipment and packaging. Prediluted metamorphol is available in ampoules of 2.5 mg/5 ml and 5 mg/10 ml: we investigated the potential costs of changing metamorphol supply at Prince Charles Hospital. Methods Due to idiosyncrasies in each physician's handling of metamorphol, simply recording the number of ampoules used would not accurately calculate the costs of changing supply. This would require finding: (1) the quantity of metamorphol administered to each patient, (2) whether an ampoule was opened and pre-drawn at the start of the list, and (3) whether pre-drawn metamorphol unused on a previous list was included in the emergency drugs of a later list. These data were gathered through forms issued to each anaesthetic team and retrieved at the end of the list. Results Data were recorded from 32 theatre lists (69 cases). Metamorphol was pre-drawn at the start of 28 lists. Of the other four, all had pre-drawn metamorphol available from an earlier list. In total, 28 ampoules of 10 mg.ml⁻¹ (4.71/ampoule, 131.88) were drawn. After factoring in use for individual patients, this was equivalent to 34 ampoules of 2.5 mg/5 ml (3.04/ampoule, 103.36) or 31 ampoules of 5 mg/10 ml (6.18/ampoule, 191.58). With 2.5 mg/5 ml ampoules, the saving was 0.89 per theatre list. Discussion These data persuaded the pharmacy to approve a change in purchasing. Through repeated auditing, we will be able to directly compare the monthly purchasing of metamorphol to discern whether there is a true cost-saving from changing to pre-diluted ampoules. This does not consider the additional costsavings from the use of fewer syringes, needles and ampoules of diluent, nor the associated reduction in risk of harm to patients.

100. Anaesthetic record keeping at Newcastle Hospitals: Preparing for electronic records

Authors Wright R.
Source Anaesthesia; Jan 2019; vol. 74 ; p. 52
Publication Date Jan 2019
Publication Type(s) Conference Abstract
Database EMBASE
 Available at [Anaesthesia](#) from Wiley

Available at [Anaesthesia](#) 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 [Anaesthesia](#) 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

The Newcastle upon Tyne Hospitals have been chosen as an NHS England Global Digital Exemplar. Within this, an electronic anaesthetic chart (eRecord) will be introduced by May 2019. An audit of anaesthetic record keeping was undertaken to identify current practice compared with RCoA [1] and Association of Anaesthetists [2] standards and to inform the design of the new eRecord. Method Anaesthetic charts for all general anaesthetics at the Royal Victoria Infirmary were analysed against the standards with the aim of analysing a randomly selected 25% of charts produced in a 7-day period: elective and emergency lists in and out of hours were included. Results During 1 week in June 2018, 25.2% of charts produced were assessed. There was 81% compliance with standards overall. Patient demographics were completed in 100%; however, pre-induction physiological values (18%), blood results (28%), fasting state (66%), and neck and airway assessment (58%) were less well documented; the surgeon's name (63%) and supervising anaesthetic consultant (if not in theatre; 44%), were often missed; 77% had anaesthetic consent and risk documented. The intra-operative chart showed good compliance, but the frequency of documentation of SpO2 and ETCO2 (minimum of every 10 min) showed 80% and 62% compliance respectively. In the postoperative period, 32% had a clear analgesic plan documented, (although prescribed electronically) and 61% had additional postoperative instructions documented. Discussion It is hoped that the implementation of the eRecord will improve compliance. The programme chosen is made by the current provider of the Trust's electronic patient record so many pre-operative fields could be pre-populated. However, lack of computers on wards and the time required to add free-text information may hinder the completion of the pre-operative assessment fields, including areas of current good compliance. This could be tackled with mandatory fields, likewise with postoperative plans. The frequency of SpO2 and ETCO2 documentation would be solved by automatic data input intra-operatively. However, RCoA standards state that a printed record of each anaesthetic should be available in the patient's case notes. This may require revision if all relevant data are captured and can be accessed electronically. This audit should be repeated following implementation of the eRecord to compare pre- and post-change compliance.