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1. Switching from originators to biosimilars using DAS28 and ultrasound to measure disease activity: Experience from Portsmouth, UK

Authors Ringer A.; Bellenie H.; Parkes M.; Harvey G.; Young-Min S.; Wong E.
Source International Journal of Rheumatic Diseases; Sep 2018; vol. 21 ; p. 178
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Publication Type(s) Conference Abstract
Database EMBASE
Available at International Journal of Rheumatic Diseases from Wiley Online Library Medicine and Nursing Collection 2018 - NHS

Abstract Biologic therapies have improved the management of Rheumatoid Arthritis. Biosimilars are promising treatments with similar efficacy and safety. To assess disease stability when switching from originator to Biosimilar Treatments using the Disease Activity Score (DAS28) and Power Doppler Ultrasound Score (PDUS) in patients with Rheumatoid Arthritis. Retrospective, observational audit of a cohort of 80 patients. For 3 years, patients receiving originator drugs-infliximab and etanercept, were stratified according to disease activity and switched to respective biosimilar medications. Data was retrieved from hospital electronic systems. A non-parametric statistical analysis was performed. In the infliximab group in remission-low-disease-activity 21/24 (87.5%) patients had no change in their disease activity whilst 3/24 (12.5%) had disease worsening. Of those with moderate-severe-disease-activity, 2/6 (33.3%) patients had no change and 4/6 (66.7%) improved activity. In the etanercept group in remission-low-disease-activity, 33/36 (91.7%) patients remained stable. Of those with moderate-severe-disease, 8/14 (57.1%) had no change in disease activity whilst 6/14 (42.9%) improved it. The PDUS correlated with DAS28 in most cases. Overall there were no statistically significant differences between the originator drugs and biosim-ilars. Disease activity on average remained stable without adverse disease activity outcomes attributable to biosimilar switching, particularly apparent in the remission/low disease activity groups, whilst in individuals with higher disease activity, improvements in disease activity did occur after switching, reflecting the nature of Rheumatoid Arthritis, the placebo effect or type I error, requiring a more advanced study to clarify further.

2. Single-pulse transcranial magnetic stimulation (STMS) for the treatment of migraine: A prospective realworld experience

Authors Lambru G.; Lloyd J.; Andreou A.P.; Hill B.; Al-Kaisy A.
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Available at Cephalalgia 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: Single pulse transcranial magnetic stimulation (sTMS) is a non-invasive neuromodulation technique which has been approved in 2014 by the National Institute for Health and Care Excellence (NICE) for the acute and preventive treatment of migraine. However, its effectiveness in a real world NHS service has not been explored yet. The Headache Centre, Guy's and St Thomas' NHS Trust is cur-rently the only NHS service commissioned to offer sTMS to migraine patients. Here we present our interim results. Objectives: This is an open-label prospective clinical audit. It aims to evaluate the effectiveness of sTMS (eNeura) as a non-pharmacological modality for the treatment of migraine with and without aura in a real world setting. Methods: The audit is ongoing. We present here the out-come of the first 44 consecutive treated patients with chronic or high frequency episodic migraine. Audit inclusion criteria were a documented diagnosis of chronic migraine documented in a headache diary and patients willingness in filling a headache diary and HIT-6 score, which were used to collect clinical outcomes. Change in headache days, migraine days and HIT-6 at 3 months of treatment compared to baseline were analysed. Adverse events and treatment compliance were also collected. Results: Forty-two migraine patients (11 with aura, 31 without aura) treated with sTMS were analysed. Twenty patients (47.6%) received sTMS after failing Botox^{O} therapy, hence were considered refractory to medical treatments. At baseline, patients displayed an average of 14.7 headache days (HD)/month, 11.1 migraine days (MD)/month and HIT-6 score of 63.3. Following 3-month trial, 28 patients (64%) obtained a clinically meaningful benefit (-2.7 MD/month and-5.4 points on HIT-6 score) hence con-tinued the treatment. Seventeen patients (36%) did not benefit from the therapy and discontinued the treatment. Of those, the majority were Botox non-responders. At 6 months 1 out of 28 responders stopped the treatment due to lack of effect durability. Amongst responders, five patients continued sTMS treatment for 12 months, 10 for nine months and 12 for six months. Treatmentcompliance was satisfactory with sTMS used up to eight pulses three times a day. Side effects were minor and include, worsening of the headache (n = 3), transient mild dizziness during the treatment (n = 1) and scalp tenderness (n= 2).Conclusion: sTMS may constitute an effective and well tolerated preventive treatment option for difficult-to-treat high frequency/chronic migraine patients in a real world setting. Since sTMS is less costly than Botox^{O} on the NHS, it could be included as one of the three preventive treatment to offer to chronic migraine patients prior to Botox.

3. Vocal cord injury in thyroidectomy and parathyroidectomy patients: UK tertiary center experience of improving patient pathways over 12 months

Authors Liu A.; Fung S.W.; Seymour N.; McGilligan J.A.
Source Otolaryngology - Head and Neck Surgery (United States); Oct 2018; vol. 159 (no. 1)
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Available at Otolaryngology–Head and Neck 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 Objectives: The British Association of Endocrine and Thyroid Surgeons recommends laryngoscopy before and after surgery for all patients undergoing thyroid and parathyroid surgery. The commonly cited risk of vocal cord injury includes 2% risk of vocal cord palsy and 5% risk of voice change. A 2016 audit showed that no such patients in the general surgery department received postoperative laryngoscopy, and a new patient pathway was agreed to automatically offer all patients pre- and postoperative laryngoscopy in the ear, nose, and throat department. The objectives of this study were to measure the impact of a new pathway on rates of postoperative laryngoscopy and to compare the incidence of vocal cord injury with that in a previous cohort. Methods: All patients undergoing thyroidectomy and parathyroidectomy at a United Kingdom tertiary referral center between June and December 2017 were included and their records retrospectively analyzed. Forty-four operations were carried out by general surgeons on 42 patients (30 female and 12 male). Results: Forty (91%) patients were offered postoperative laryngoscopy, improving from 0% (P < .01). One (2%) patient had subjective voice assessment only, and 3 (7%) had neither laryngoscopy nor voice review. Forty-three (98%) patients had documented preoperative laryngoscopy. Four (9%) patients had abnormal vocal cord movement, but 3 resolved within 4 weeks. There were fewer vocal cord palsies compared with 11% previously (P < .01). Conclusions: Departmental cooperation was required to improve patient care. Further audit is needed to identify if improvements are sustained. Routine assessment of vocal cords is crucial to accurately advise patients about operative risks.

4. The workload, value and complexity of the headache specialist nurse

Authors Bhola R.; Bahra A.; Goadsby P.
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Abstract Introduction: Due to its high prevalence and impact, headache is burdensome and costly to the sufferer, society and healthcare services. Multidisciplinary care is increasingly regarded as an efficient mode of service delivery (1). Professional nurses who have acquired the necessary education, skills and expertise increasingly meet patient needs in the UK. However, managing frequent and disabling primary headache, together with co-morbidities, present challenges and complexities.Objectives: We aim to provide an overview of the workload, complexity and value of the specialist headache nurse.Methods: We have evaluated patient needs within headache services and the service demands facing the team in practice. The broad aspects of the specialist nurse's role, its complexity and the required skills will be illustrated. Results: Our results will provide a representation of how complex care is delivered by the specialist nurse. These professional aspects will include: the nurse's pro-fessional expertise in promoting patient safety, improving quality through audit and research (2), optimising the use of time and costs within the service, meeting the education needs of patients and others involved in patient care and treatment delivery e.g. ward based staff (3) and developing the service. A level of competence is achieved which is adapted to the needs of the organisation and service users and done within resource-constraints.Conclusion: Patients in headache centres will typically present with complex needs and often co-morbidities. The specialist nurse has a key role within UK healthcare. To be effective and efficient the nurse will acquire the necessary education, skills and expertise to manage care and develop their services. The role of the specialist nurse could be extended with more nurses trained to provide the care and support for patients with headache between primary, secondary and tertiary care. Headache services can thus be optimised by the addition of specialist nurses, wherever they may be located in the world (4).

5. Adjuvant chemotherapy following pancreaticoduodenectomy for pancreatic ductal adenocarcinoma - inter-hospital variability in uptake

Authors Sultana A.; Marudanayagam R.; Dasari B.; Muiesan P.; Mirza D.; Isaac J.; Sutcliffe R.; Roberts K.; Hodson J.; Ma Y.T.
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Abstract Introduction: Evidence from randomised controlled trials supports adjuvant chemotherapy following resection for pancreatic ductal adenocarcinoma (PDAC), showing clear survival benefit. Though pancreatic surgery in the United Kingdom is centralised, provision of chemotherapy is not, being given in the local hospital. This study assessed the administration of adjuvant chemotherapy following pancreaticoduodenectomy (PD) for PDAC, focusing on rates of administration and how these differed between the 14 hospitals that delivered this service. Methods: A prospectively maintained database was reviewed, and patients undergoing PD for PDAC between January 2007 and December 2015 were identified for inclusion (N=272), although data were missing for 4 patients (1.5%). Data were collected on whether adjuvant chemotherapy was given and the hospital where chemotherapy was administered. Chemotherapy uptake rates were compared between sites using Fisher's exact test. Results: Adjuvant chemotherapy was administered to 67% (N=180/268) of patients. There was generally similar provision of chemotherapy between hospitals, with the majority providing chemotherapy to between 71 and 82% of their patients. However, there were two hospitals with low provision of chemotherapy (54 and 30% respectively), resulting in a statistically significant difference between the hospitals (p=0.015). Conclusion: In spite of current level 1A evidence supporting the use of adjuvant chemotherapy after resection for PDAC, there is significant variability between hospitals who provide this therapy. Though centralisation may not be needed to the same extent as surgery, individual hospitals practice should be audited. Ensuring equality of provision of chemotherapy may be a simple way to improve outcomes after PD for PDAC.

6. Management of postpartum haemorrhage: from research into practice, a narrative review of the literature and the Cardiff experience

Authors Collins P.W.; Bell S.F.; de Lloyd L.; Collis R.E.
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Available at International Journal of Obstetric Anesthesia 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 Postpartum haemorrhage (PPH) is caused by obstetric complications but may be exacerbated by haemostatic impairment. In a 10-year programme of research we have established that haemostatic impairment is uncommon in moderate PPH and that fibrinogen falls earlier than other coagulation factors. Laboratory Clauss fibrinogen and the point-of-care surrogate measure of fibrinogen (FIBTEM A5 measured on the ROTEM machine) are predictive biomarkers for progression from early to severe PPH, the need for blood transfusion and invasive procedures to control haemorrhage. Fibrinogen replacement is not required in PPH unless the plasma level falls below 2 g/L or the FIBTEM A5 is below 12 mm. Deficiencies of coagulation factors other than fibrinogen are uncommon even during severe PPH, and ROTEM monitoring can inform withholding FFP safely in most women. In the absence of placental abruption, clinically significant thrombocytopenia is uncommon unless the platelet count is low before the bleed started, or very large bleeds (>5000 mL) occur. Measuring blood loss is feasible in routine practice during PPH and is more accurate than estimation. These research findings have been collated to design an ongoing quality improvement programme for all maternity units in Wales called OBS Cymru (Wales) (The Obstetric Bleeding Strategy for Wales).

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

Authors Higgins L.E.; Heazell A.E.P.; Whitworth M.K.
Source Paediatric and Perinatal Epidemiology; 2018
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Available at Paediatric and Perinatal Epidemiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

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

8. Improving patient care in major haemorrhage in the emergency department: A subtle intervention

Authors Latif M.; McAlllister S.; McGarvey M.; Tod N.; Littlewood N.
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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 Coagulopathy specific to trauma was described back in 1969 [1]. There is controversy over the exact ratios needed, but concomittent delivery in rations of a 1:1 (red blood cells (RBC):fresh frozen plasma(FFP)) have been widely accepted [2]. A major audit in Scotland in 2016 [3] highlighted that the delivery of FFP from the laboratory to the Emergency Department (ED) following major haemorrhage protocol (MHP) activation and subsequent early transfusion ratios were poor. The aim of this audit was to assess whether introduction of pre-thawed FFP (ptFFP) at the Queen Elizabeth University Hospital (QEUH) in Glasgow has improved time to FFP administration. Methods ptFFP was introduced on 15 June 2017. A period around this, from January to November, was chosen to compare pre- and post-introduction of ptFFP. All MHP activations from the adult ED of QEUH were analysed, including those by prehospital medical teams. Data were gathered by looking at the telephone log for the MHP calls to switchboard, interrogating the Trackcarea electronic patient record and via laboratory records at the QEUH blood bank. Results There were 88 cases of activation of the MHP; of these 26 went on to receive FFP or ptFFP within the ED, with one case being excluded owing to insufficient data. In the pre-June cohort, four were traumas and five were non-traumas. The average time from admission of the MHP to FFP administration in the trauma cohort was 35.8 min. In the post-June cohort, 11 were traumas and five were non-traumas. Of the trauma patients, the average time to administration of ptFFP was 25.6 min. In the trauma cohort receiving FFP, the average RBC:FFP ratio was just under 1:2, whereas the ratio was almost 1:1 in the ptFFP trauma group. Trauma patients who received ptFFP also had shorter ED stays, with average times falling from 180 to 156 min. Discussion The use of ptFFP vs. FFP appears to confer significant advantages to patients. It improved time to first transfusion of these products and also improved RBC:FFP ratios. In the ptFFP/trauma cohort of this audit, activation of the MHP/admission to transfusion averaged 25.6 min vs. 50 min in the previously mentioned national audit [3]. Along with this it also reduced time patients remained in the ED, suggesting improved times to stabilising patients for transfer. QEUH is the only hospital in Scotland using ptFFP. Consideration should be given by other hospitals throughout the country to improving time to FFP and blood transfusion ratios in major trauma.

9. A paperless system: The key to improved documentation of consent for obstetric anaesthesia?

Authors Baker R.; Whibley H.
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Abstract Between 1995 and 2007, 841 anaesthesia-related claims were handled by the National Health Service Litigation Authority [1]. Of these, 366 related to regional anaesthesia, with 50% specific to obstetrics. The cost to the NHS was > 12million. Clear documentation of potential risks of obstetric anaesthesia could reduce such litigation costs. Guidance published by the AAGBI clearly states that the anaesthetist is responsible for documenting discussions about risks and benefits of anaesthesia [2]. An electronic recording system for anaesthetic practice was introduced in our centre with the aim of improving and standardising record keeping, incorporating easy-to-use drop-down boxes. Methods Data were collected prospectively over a 1-month period for all women undergoing obstetric surgery. Details of documentation of consent for anaesthesia were collected with referral to both the paper anaesthetic chart and electronic recording system. Standards were taken from the RCoA's compendium of audit recipes [3]. Results Data were collected for 67 women. Ninety per cent of patients had a regional technique (spinal or combined spinal-epidural). No consent for anaesthesia was recorded in 26% of cases. The most frequently discussed risks recorded on paper included headache, nerve damage, hypotension and failure. Using the electronic system the 'tick all' box (listing 20 possible complications) was selected in more than 80% of those using this system. Discussion There was no documented evidence of obtaining consent in one-quarter of cases. There was a significant time lag between introduction of the electronic system and compliance by clinicians. This may reflect unfamiliarity with the system, particularly in view of frequent trainee turnover and short-term locum staff. It may also reflect difficulty accessing or using the system. Greater consistency was noted on the electronic system than in the paper records. However, electronic records were often completed retrospectively and may not have truly reflected the discussion. It should also be noted that the presence of a 'tick all' box may have been used for ease and speed, and some of the risks therefore ticked were not, in fact, applicable to mode of anaesthesia. It is clear that a single system should be adopted, and although electronic systems have weaknesses, they have clear advantages in terms of legibility, durability and accessibility.

10. Blood transfusion at CoRSU Hospital, Uganda

Authors Kendall A.; Hodges S.
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Abstract CoRSU Hospital provides reconstructive and rehabilitative surgery to primarily paediatric patients in Uganda. Surgeries range from minor to major. While surgery is primarily elective, it is not uncommon for seriously unwell patients who require optimisation (i.e. transfusion) prior to surgery to be admitted. Despite frequently prescribing blood, there had never been a local audit of blood transfusion practices. There is also very little guidance regarding the use of blood and management of peri-operative anaemia in this population. Given this, an audit was carried out looking at our blood transfusion practice. Methods Ugandan [1] and UK [2, 3] national guidelines were used as audit standards. World Health Organization (WHO) guidance was also used to evaluate the practicalities of blood prescription and administration. All patients receiving a blood transfusion at CoRSU over a 4-week period were included in the audit. There were no exclusion criteria. Data were collected in real time or retrospectively from patient notes by a single data collector and the relevant parameters entered into a spreadsheet. Data were collated, analysed, written up and presented at the CoRSU Hospital monthly continuing medical education meeting. Results Over a period of 4 weeks, blood was transfused in 27 cases. The mean overall pre-transfusion haemoglobin was 7.1 g. dl^{-1} and post-transfusion haemoglobin 8.5 g. dl^{-1}. Justification for the transfusion episode was felt to be appropriate in 26 of 27 cases. Results were analysed in more detail, considering age, sex, intercurrent illness and transfusion timing. Data were also collected looking at administration of blood and general management of peri-operative anaemia. These results demonstrated that blood was not being administered as per WHO guidance (a patient safety issue) and that more could be done to manage and investigate peri-operative anaemia. Discussion We were pleased to find that blood was generally transfused appropriately. Prescription of blood products outside the theatre setting was poor: it was evident that education and training are required in this area. Simple measures to help manage peri-operative anaemia were identified. From this audit, work is continuing to set up standard procedures at CoRSU around the prescription, checking and administration of blood. Staff education on the importance of a multimodal management approach to peri-operative anaemia will continue.

11. Unplanned hospital admissions for paediatric day case adenoidectomy and tonsillectomy surgery at Royal Bolton Hospital

Authors Anwar A.; Hobbs A.; Harrison A.

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Abstract Unplanned overnight stays in hospital have an implication on patients and adverse effects on hospitals. They are inconvenient and unsettling for children and their families, and should be minimised where possible. Unplanned admissions increase pressure on acute beds in hospitals and create added financial strains on health care. The Royal College of Anaesthetists (RCoA) and the Royal College of Surgeons of England have identified unplanned admission rates of < 2% as a quality indicator of day case surgery [1, 2]. Guidance [3] suggests 'well' children requiring surgery for symptoms suggestive of mild obstructive sleep apnoea/hypopnoea can be safely operated on at district general hospitals for tonsillectomies. We audited our care for unplanned admissions and postoperative complications for paediatric day case adenoidectomy and tonsillectomy surgery at Royal Bolton Hospital (RBH). Methods We undertook retrospective analysis of all 195 paediatric adenotonsillectomy cases between January and December 2016. We looked at patient comorbidities, who underwent sleep studies, planned and unplanned admissions, complication rates, grades of anaesthetist and surgeon, the anaesthetic delivered and what analgesia was given. The aim was to identify unplanned hospital stays, if there were postoperative complications and to develop guidance to improve patient safety and patient experiences. Results There were 195 patients identified (98 boys, 97 girls), aged 2-15.5 years. Six of the children were overweight/obese and seven children were below the ninth centile. In total, 139 cases were ASA 1, 55 were ASA 2 and one was ASA 3. Thirty-three unplanned admissions were identified as part of our audit and all were for one night. Postoperative nausea and vomiting (PONV; 10 cases) was the most common reason for unplanned stay followed by returning too late from theatre to the ward from an afternoon list (nine cases). Other reasons included desaturation in the postoperative period (n = 3), postoperative pain (n = 3), not passing urine (n = 1) and sepsis (n = 1). In six cases the reason was unclear. Discussion The unplanned admission rate (17%) at RBH is higher than that found with RCoA best practice. The biggest reason for unplanned admission was PONV and late return of children to the ward. Children were given ondansetron and dexamethasone at a lower dose range. Guidance of appropriate doses of anti-emetics and analgesia was given. Owing to late return of patients from theatre, we have asked tonsillectomy cases to be booked for morning lists, not afternoon ones.

12. A growing problem? A survey of trainee anaesthetists' attitudes towards the management of obese patients

Authors Fortune J.
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Abstract The prevalence of obesity is increasing; 63% of adults in England were overweight or obese in 2015 [1], and annual NHS spending on treatment of obesity and diabetes is now greater than the amount spent on the police, the fire service and the judicial system combined [1]. In the 4th National Audit Project by the Royal College of Anaesthetists, 45% of the reported patients were obese, with failure to recognise obesity as a risk for airway complications, and, subsequently, to change technique contributing to many adverse events [2]. Recommendations for peri-operative management of the obese surgical patient were made in the AAGBI's 2015 guidelines [3]: we sought to examine trainee practice, attitudes and knowledge based on these. Methods A survey was circulated to all anaesthetists in training (CT1-ST7) during weekly teaching for a 5-week period. Responders were given 13 statements and asked to score their agreement between 1 (strongly disagree) and 5 (strongly agree). The survey examined attitude to risk when managing obese patients, local knowledge of specialist equipment location, limitations and availability, and practice of drug-dosing adjustments. Results The response rate was 55%. Responders had greater concerns about airway at intubation and extubation in obesity (mean score 4.3 (SD 0.6)), and felt more time was required on operating lists with obese patients (3.8 (SD 0.9)). Trainees agreed obese patients often come to theatre on trolleys with limited backrest operation (4.6 (SD 0.7)), which caused difficulty with airway management (4.0 (SD 1.0)). Knowledge of emergency equipment location was mostly good (videolaryngoscope 100%, Oxford HELP pillow 92%, sugammadex 92%), although 8.3% knew where to locate specialist operating tables and 37.5% knew where to find hover mattresses. Trainees were more uncertain about drug dosing for obese patients (3.3 (SD 1.0)). There was a consensus that a site-specific reference sheet for rotational trainees should be kept in each anaesthetic room (4.75 (SD 0.5)). Discussion The survey identified instances of non-specialty equipment use, potentially compromising patient care, and some gaps in knowledge regarding obesity management. In response to this feedback an obesity teaching day will be added to the trainee education program, and a site-specific reference sheet adapted from SOBAUK's own document is in production for each anaesthetic room to inform trainees of local equipment availability and location.

13. Snapshot audit: Consent for anaesthesia-positioning and procedures

Authors Winter V.; Pack E.; Luoma V.; Virmani S.
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Abstract In 2015, changes were made to UK law surrounding consent following the landmark judgement in the Montgomery vs. Lanarkshire case [1]. The judgement stated that to gain valid consent, a patient must be told what they want to know and not what a doctor thinks they should be told. The AAGBI updated guidelines on consent for general anaesthesia [2] and the RCoA acknowledged the importance of discussing rare complications by publishing patient information leaflets. Guidance states that patients should be consented for components of anaesthetic technique, specifics related to procedure and common/significant side-effects/risks. UK government guidelines state 'valid consent for blood transfusion should be obtained'. Our department has audited consent documentation since 2012 [3]. Methods A prospective snapshot audit for documentation of consent for general anaesthetic and surgical positioning conducted in April 2018. Data collected included evidence of discussion of common and significant side-effects of general anaesthetic, prone positioning, procedure specific consent (arterial line, urethral catheter, blood transfusion) and evidence that patient questions were addressed. The audit standard was AAGBI and national blood transfusion guidelines. Data were compared with previously collected local data. Results Bar chart demonstrating documentation of consent for prone positioning (swelling, nerve damage, pressure sores and visual loss) and general anaesthesia (death, awareness, nerve damage, tooth damage, sore throat and PONV) in 2012, 2015 and 2018 Thirty patients were included: nine with spinal and 21 with intracranial surgery, and 11 in the prone position. There was no documentation of discussion of complications of prone positioning by surgeons. Consent was documented for 65% of arterial lines and 39% of urinary catheters. Six patients were consented for blood transfusion -three by the surgeon, two by the anaesthetist and one by both. Three patients received a blood transfusion, one of whom had no documented consent. Documentation of patient questions was only present in one case. Discussion Thorough communication is essential to ensure patients are informed of the risks of general anaesthetic. This should be documented, including patient questions. Despite improved documentation of consent for proning since 2012, consent documentation continues to be inadequate. Although these findings do not necessarily indicate deficiencies in the verbal consenting process, changes in the UK law and this deviation from national standards suggests a need for more protocolised documentation and ongoing education regarding consent for general anaesthetic.

14. An audit of the referrals and outcomes of patients aged >= 85 years attending the preoperative anaesthetic clinic at a university teaching hospital in a 12-month period

Authors Kearsley R.; Gormley G.; Hayes A.
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Abstract The population in Ireland is ageing, with people over the age of 65 years in the fastest-growing age group. With this we predict there will be an increased demand for surgery in the older population. Our aim was to audit the number of 'extreme elderly' patients (> 85 years of age) referred to the pre-operative assessment clinic (POAC) for elective surgery, the complexity of that surgery, the incidence of cancellation and to review the peri-operative course and discharge destination of these patients. Methods A list of POAC attendances was obtained for the period of January 2017 to December 2017. All patients aged >= 85 years on the day of POAC attendance were identified. Their POAC note and medical notes were reviewed. Data were entered into a Microsoft Excel spreadsheet and analysed. Results Of the 2329 patients seen in the POAC, 69 (2.9%) were aged >= 85 years. The mean age was 88.3 years. Fifty-five (79.6%) of the patients seen were female. Of the 69 patients, 50 (72.4%) had their surgery, two (2.8%) had their surgery cancelled in the POAC, 11 (15.9%) did not proceed with surgery and six (8.7%) were still awaiting surgery at the time of audit. The mean age of those who had surgery was 90 years. The complexity of the surgical procedures was classified as minor, intermediate and major, according to National Institute for Health and Care Excellence guidelines. Eight minor, 17 intermediate and 25 major procedures were performed. Nine (18%) patients went to the high-dependency unit postoperatively, with only one unplanned admission. The mean length of stay in hospital was 5.78 days and 45 (90%) patients were discharged home, with five (10%) requiring convalescence. Discussion From our results we can see that the > 85 year age group represents a small percentage of patients seen in the POAC. The majority proceed to have their surgery, spend a short period of time in hospital and return home afterwards. This may reflect the fact that surgeons select suitable patients to refer to POAC or that patients themselves may 'self-select' to have procedures based on their own health. Recommendations from the UK support provision of surgery irrespective of chronological age [1]; however, studies looking at peri-operative outcomes in the 'extremely elderly' show they have poorer outcomes [2, 3]. This population is increasing and from our audit we can see that with appropriate referral to POAC and adequate preparation elective surgery in this age group can be both safe and effective.

15. Time's up! An audit into the display of time in critical care areas

Authors Wilkins H.; Trimble A.; Fernandes P.
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Abstract The accurate display and documentation of the correct time is essential to good clinical practice. The General Record Keeping Standards document produced by the Academy of Royal Colleges (UK) states that 'every entry into the medical record should be dated, timed, legible and signed by the person making the entry' [1]. The incorrect time being displayed can lead to a host of issues for the anaesthetist. Most notable of these are drug prescription and administration errors, inaccurate documentation of time-critical peri-operative events and medico- legal aspects. With respect to these issues it was decided to audit the time displayed on monitors and clocks throughout critical and acute care areas of Southampton General Hospital, a tertiary referral centre on the south coast of the UK. Methods Audit data were collected prospectively over a 2-week period. The time displayed was compared to Greenwich Mean Time (GMT) in all critical care areas, including theatres (main, paediatric, neurosurgery, ophthalmology, obstetrics and gynaecology (O+G)), each respective post-anaesthesia recovery unit and the general intensive care unit (GICU). Real time was classified as satellite-generated GMT as displayed on an iPhone 6 (Apple Inc.) smartphone. Our standard was that 100% of the time displayed should be within 2 min of GMT. Results Data points were collected using a standardised collection sheet and analysed using Microsoft Excel 2010. In total, 74 distinct areas were audited, with 304 separate data points. Discussion These results demonstrate a wide range in the accuracy of time displayed; to our knowledge there are no similar audits or studies published which demonstrate this. Although no clinical area excelled, O+G theatres are an area of particular concern. The standard was not met in any theatre and the IQR [range] shows that this cannot be explained by correcting for daylight-saving time. This could have far-reaching medico-legal consequences, where accuracy of timings during emergency caesarean section are of the upmost importance [2]. It was apparent that those areas with clocks connected to the intranet or radio-controlled clocks were far superior. We are now implementing this through updating anaesthetic machines and procuring radio-controlled wall clocks. We hope to see positive changes in the near future.

16. Airway management for neck breathers

Authors Kim S.; Urquhart L.; Li M.; Paisley P.; McGhie J.
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Abstract Junior doctors and nursing staff working in emergency departments, acute receiving units and hospital wards are occasionally in the unfamiliar position of managing acutely unwell patients who have a tracheostomy or laryngectomy-sometimes known as 'neck breathers'. The familiar ABCDE approach can be ineffective when assessing these patients if healthcare professionals are unable to manage their airway. It is estimated that over 5000 surgical tracheostomies and 600 laryngectomies are performed yearly in England, and while they are becoming more commonplace, associated safety incidents are also rising [1]. We initiated a quality-improvement project on 'airway management for neck breathers' aimed at junior doctors and nursing staff across three hospitals in the West of Scotland: Beatson Oncology Centre, Queen Elizabeth University Hospital and Dumfries and Galloway Royal Infirmary. Methods Teaching sessions included a 20-min lecture highlighting anatomical differences following tracheostomy and laryngectomy, red flag symptoms, common complications and the National Tracheostomy Safety Project (NTSP) algorithm for emergency airway management in an arrest situation. This was followed by demonstrations and hands-on clinical scenarios with a low-fidelity tracheostomy mannequin, basic airway adjuncts and various types of tracheostomy tubes. Pre- and post-teaching assessments consisting of 10 multiple-choice questions selected from e-Learning for Health were used to assess the impact of the sessions. Self-reported confidence scores before and after teaching were also measured. Results All candidates (n = 25) reported higher confidence following the session, and 92% showed an improved assessment score, with an average increase of 21%. Feedback indicated that the sessions were very informative, relevant to daily practice and highlighted that it was an area about which they had received little or no prior teaching. Candidates generally felt more comfortable managing patients with tracheostomies and laryngectomies, and requested regular teaching sessions for new starters. Discussion We plan to extend our project to other hospitals across the West of Scotland with the following objectives: promote safe management of patients with tracheostomies and laryngectomies, increase awareness and familiarise healthcare providers with the NTSP emergency algorithm. (Figure Presented).

17. Bariatric issues in general anaesthesia relating to airway: Reporting of complications related to airway management in the obese

Authors Waiting J.; Shaw M.; Barraclough L.; Black B.

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Abstract The Bariatric Issues in General Anaesthesia relating to Airway (BIGAA) project aimed to collect a variety of data related to airway issues in the context of obese patients undergoing elective surgery. NAP4 [1] identified that patients undergoing a general anaesthetic with a body mass index (BMI) of > 0 $kg.m^{-2}$ were twice as likely to experience an airway complication, and four times more likely with a BMI > 40 $kg.m^{-2}$. A BMI of > 30 $kg.m^{-2}$ affects approximately 28% of the UK population [2] and is therefore a common occurrence in patients presenting for surgery. We analysed the reported airway complications collected during the study for common themes. Methods The Pan-London Perioperative Audit and Research Network was used to recruit patients from 39 hospitals in the Greater London area. A prospective observational service evaluation of anaesthetic practice was carried out over two 24-h collection periods from 12 to 16 March 2018. All adult patients undergoing elective surgery under general anaesthesia were recorded. An anonymised reporting form was completed for any airway-related complication by the local team. Results A total of 1886 cases were submitted and 42 of these had an additional reporting form submitted (0.2% of cases). Four cases were excluded (two allergic reactions and two where no complication occurred). The average BMI of the 38 patients was 30.4 $kg.m^{-2}$ and 17 (44.7%) had a BMI > 30 $kg.m^{-2}$, of whom (15.7%) had a BMI > 40 $kg.m^{-2}$. The results are shown in Table 1. The greatest numbers of complications were reported around recovery (14 patients; 36.8%). Of the 11 reported complications occurring at intubation, five (45.5%) were in obese patients. Discussion Obesity was identified in NAP4 [1] as a risk factor for airway complication particularly when anaesthetic technique was not modified and potential complications not anticipated. Themes of supraglottic airway devices problems, difficult intubation, airway complications at induction and recovery were identified and have been mirrored in this study. While overall rate of complications in this study was low, it should be noted that a high proportion of complications occurred in those with obesity. With an ongoing obesity epidemic we may expect airway complications to increase and should anticipate this and modify our anaesthetic practice to reduce potential harm.

18. Use of a cardiac arrest pro-forma in maternity units: A telephone survey

Authors Harvey-Jones E.; Soysa R.; Yentis S.
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Abstract The General Medical Council's Good Medical Practice states that clinical records must be 'clear, accurate and legible', and that these records should be 'made at the same time as the events' or 'as soon as possible afterwards' [1]. The Resuscitation Council (UK) recommends that 'a complete and detailed record [of cardiac arrest] is retained within the patient's clinical record' and goes on to recommend use of 'a form that is easily recognised and has a standard content and format' (see https://www.resus.org.uk/quality-standards/acute-care-quality-standards-forcpr/). Maternal cardiac arrest is rare but has distinct circumstances that differ from most others. The quality of record-keeping during maternal cardiac arrest has already been found to be variable in quality [2]. We wanted to investigate whether maternity departments in hospitals in England were using a cardiac arrest pro-forma as recommended by RC (UK), and if these were modified in any way for use in maternity units. Methods From 130 hospitals in England with maternity units (see http://webarchive.nationalarchives.gov.uk/20180328131144/http://digital.nhs.uk/catalogue/PUB22384), we randomly chose 57 and contacted the resuscitation officer (RO) in each via telephone, to ask whether a standard pro-forma for cardiac arrest was used in the Trust, and if they had a specific one for maternity. Results Of 40 Trusts for which this information could be provided, eight (20%) had a standard pro-forma for cardiac arrest, which is sent to the resuscitation services for audit purposes (but not retained in the clinical notes). No Trusts used a specific maternity-themed pro-forma for cardiac arrest, although one mentioned that one was in development. Discussion While only surveying a sample of hospitals, this telephone survey suggests that few Trusts, if any, use a pro-forma for cardiac arrests for the purpose of standardising/ improving the quality of record-keeping during the arrest, whereas a minority use a pro-forma for audit purposes (we did not ask whether the proforma used was that associated with the currently ongoing National Cardiac Arrest Audit (see https://www.icnarc.org/Our-Audit/Audits/Ncaa/About). Our results suggest that a standardised document could be of benefit for Trusts generally but especially for maternity units.

19. An audit of the documentation of anaesthetic risks for surgery in the prone position at Salford Royal Foundation Trust

Authors Stedman S.; Wilson M.; Donnelly A.
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Abstract An audit of the anaesthetic risks documented for patients undergoing prone position surgeries at Salford Royal NHS Foundation Trust (SRFT) revealed that prone positioning risks were not being documented to gold standard. We have identified two measures to use for quality improvement. Methods We collated 1006 cases after reviewing spinal surgery lists at SRFT between 1 March 2017 and 28 February 2018. Three hundred and forty-one cases were eliminated owing to lack of prone positioning and a further 10 owing to lack of surgical notes. Of the remaining 655 cases, documented risks discussed at the anaesthetic pre-operative assessment were checked against a predetermined list of four major complications of prone positioning: facial injury, pressure sores, postoperative visual loss, and peripheral nerve damage. Where appropriate, inclusion of other patient-specific risks were also noted. All data recording and analysis was done according to local data protection policies. Results The risk of postoperative visual loss was documented in 434 cases (66.3%); pressure sores in 373 cases (56.9%); peripheral nerve damage in 373 cases (56.9%); and facial injury in 281 (42.9%) cases. In 197 cases (30.1%), all four of these risks of prone positioning were documented. One hundred and sixty-six cases (25.3%) had no prone positioning risk documentation and 67 cases (10.2%) were absent of any risk documentation whatsoever, demonstrating that our current practice is sub-gold standard. Discussion Several complications can occur as a result of prone positioning during surgery [1]. These constitute risks which must be communicated to patients in addition to the risks of general anaesthesia. Without accurate documentation, we are unable to evidence discussions about the risks of prone position surgery, which makes it difficult to assess how consistently patients are being fully informed of these risks. For quality improvement purposes, we intend to produce a detailed information leaflet for patients undergoing prone position surgery. This would ensure that all patients are fully informed and aid discussion of risks on the day of surgery. Furthermore, we intend to produce a pre-printed list of risks, to be used as an aid-memoire for patient discussion, as well as for documentation in the anaesthetic records.

20. Tranexamic acid in major obstetric haemorrhage: Are we achieving the goal?

Authors Harvey E.; Bhardwaj M.
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Abstract Postpartum haemorrhage (PPH) is a leading cause of maternal death worldwide and accounted for 24% (n = 21/88) of the direct causes of maternal death reported in 2013-15 MBRRACE-UK. The RCOG and the AAGBI recommend tranexamic acid (TxA) in PPH. Local policy in our hospital suggests the use of TxA in major obstetric haemorrhage (MOH) but lacks clear guidance on timing and amount of blood loss at which it should be given. A previous local retrospective audit between April 2016 and March 2017, prior to the WOMAN trial results, revealed only 43% of patients with major MOH of >= 2 l received TxA, with some inconsistencies in its timing. Methods Green Top guidelines published in December 2016 re-defined MOH where blood loss is > 1 l. Therefore, this audit, registered with the Trust Audit Department, analysed cases of MOH > 1 l during caesarean section between July and October 2017. We audited appropriate use of TxA along with activation of MOH protocol, documentation of incremental blood loss during the procedure, need for blood transfusion and if cases returned to theatre for laparotomy or re-look. Results In the 4 months audited, 38 of 408 caesarean sections (9.3%) reported MOH > 1 l with a mean blood loss of 1.35 l. TxA was given in 18 of 38 (47%) cases; further breaking this down, TxA was given in 92% (n = 11/12) cases where blood loss was reported to be > 1.5 l, whereas only 27% (n = 7/26) cases received TxA on blood loss between 1 and 1.4 l. MOH protocol was documented to have been activated in 29% of cases where blood loss was reported to be > 1.5 l. Although estimated blood loss was recorded in all cases, all were missing the documentation of 'incremental' blood loss. In addition, seven of 38 cases required blood transfusion, and none of the cases returned to theatre for re-look or laparotomy. Discussion The conclusion of the WOMAN Trial Collaborators is clear: 'TxA reduces the death due to bleeding in women with post-partum haemorrhage with no adverse effects and should be given as soon as possible after bleeding onset'. Work is needed to update our guidelines in line with RCOG-Green Top and WOMAN trial, as well as spreading the awareness among the team to administer TxA soon rather than later.

21. Incidence of clinically apparent residual neuromuscular blockade in recovery areas throughout Wales

Authors Spinney S.; Babic A.; Roberts R.; Walker J.; Maloney D.; Laquiere D.; Hadzovic I.
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Abstract Postoperative residual neuromuscular blockade was noted to be a significant cause of awareness in the 5th National Audit Project (NAP5) [1] and contributed to death from airway compromise in the 4th National Audit Project [2]. We simultaneously audited all NHS hospitals in Wales, and found an incidence of 0.08% among cases involving neuromuscular blockade. Methods Following a pilot audit, we enlisted recovery staff across all Welsh NHS hospitals to take part in an observational audit over a continuous 12-week period in 2015. They identified patients who they felt had clinically observable partial reversal. Local representatives of the All Wales Airway Group then completed a data-collection form. The likelihood of partial reversal was categorised as possible, probable or unlikely. This was done by group consensus with no predefined criteria. We used data from the NAP5 UK activity survey and Office for National Statistics to estimate the number of general anaesthetics with neuromuscular blockade taking place throughout Wales during the audit period. Results From an estimated 14,100 anaesthetics 12 cases were identified, of which 11 were deemed probable and one deemed unlikely. This gave an incidence of 0.08% (95%CI 0.03-0.13%). The median (IQR [range]) time reversal was given following neuromuscular blockade was 50 (50-70 [15-100]) min. The most common symptom noted in recovery was being 'jerky'. Either a first or second dose of reversal was then given in five cases. S_pO_2 was < 90% in three cases. Only two cases had documented use of a nerve stimulator. One patient was found to have a train of four count of zero after up to half an hour with no anaesthetic agent administered. Discussion Our audit showed poor recording of nerve stimulator usage and one near miss of awareness. It was felt that the desaturations had been contributed to by substandard reversal, and may have been avoidable. There was apparent misunderstanding of the appropriate timings necessary for neostigmine administration, and its peak effect. A limitation of this audit is the use of subjective clinical signs; it is recognised that weakness may exist and not be appreciated clinically. However, this method was pragmatic as many centres did not have access to quantitative monitors. We feel that the use of quantitative monitors combined with further education could drive the incidence towards zero.

22. An audit of the peri-operative care of high-risk patients at the Norfolk and Norwich University Hospital

Authors Gutsell J.
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Abstract The Royal College of Anaesthetists [1] and Royal College of Surgeons of England [2] have stressed the need for senior involvement in the care of high-risk patients. Consultant involvement is recommended when P-POSSUM mortality is > 5%, and critical care admission when P-POSSUM is > 10%. An audit at this hospital in 2013 identified the need for improvement in the documentation of senior discussion where cases are managed by junior anaesthetists. This audit examined which personnel manage high-risk cases, quality of documentation of senior discussion, discharge destination and other metrics. Methods The 30 most recent laparotomies, and 30 most recent non-laparotomies, with P-POSSUM mortality > 5% were identified using the emergency booking system. Network systems and patient notes were used to determine operative dates and times, seniority of staff, evidence of consultant discussion, discharge destination and evidence of discussion with critical care. Results Consultant anaesthetists were present for 73% of laparotomies and 72% of nonlaparotomies. Consultant surgeons were present for 87% of laparotomies and 52% of non-laparotomies. Forty per cent of laparotomies took place out of hours vs. 10.3% of non-laparotomies. Seventeen per cent of high-risk procedures took place at the weekend. Within available notes, evidence of discussion with consultant anaesthetists was 33% for laparotomies but only 20% for non-laparotomies. Where 74% of higher-risk (P-POSSUM > 10%) laparotomies went to critical care, 71% of higher risk non-laparotomies did not. Of these cases not admitted to critical care, among the laparotomies none had evidence of intensivist discussion, and only 10% of non-laparotomies showed any evidence. Discussion High-risk patients were preferentially managed during weekdays, perhaps suggesting a preference to delay weekend cases. Similarly, the smaller number of nonlaparotomies taking place out of hours may suggest less clinical urgency. Documentation of consultant discussion was infrequent. Efforts are being made at Norwich to mitigate this, including the introduction of new anaesthetic charts. Similarly there was poor documentation of discussion regarding critical care admission. There is a need to use both educational and technological means to address these issues. (Figure Presented).

23. Impact of a regional prehospital critical care team on UK Trauma Audit and Research Network outcomes: A retrospective analysis

Authors Hepple D.; Durrand J.; Godfrey P.; Bouamra O.

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Abstract The Great North Air Ambulance Service (GNAAS) provides a pre-hospital critical care service for the Northern Trauma Network (NTN). GNAAS attends injured patients via ground and air ambulance, in a globally adopted model [1, 2]. The UK Trauma Audit Research Network (TARN) manages a national database of all injured patients arriving alive where at least one of the following occurs: death, admission to critical care, transfer for specialist care or admission > 72 h. Individual patients are awarded a probability of survival based (Ps) based on an injury severity score (ISS) allowing calculation of a weighted survival score (Ws). Ws reflects the observed minus expected survival rate and the number of unexpected survivors for every 100 patients treated. The study aimed to investigate if attendance by a GNAAS ECT conferred a greater number of unexpected survivors. Methods We retrospectively reviewed TARN data sets for the two NTN Major Trauma Centres (MTCs) between April 2012 and March 2016. We identified TARN-recorded patients who had received pre-hospital ECT care, allowing comparison with those who had not. We recorded basic demographic data, injury details, ISS, Ps and survival to hospital discharge. This allowed calculation of a Ws score for the ECT and non-ECT groups. Results A total of 6860 MTC patients were identified on the TARN database with 637 patients attended by an ECT. The proportion of male patients was higher in the ECT group and patients in this group were younger. The median ISS was higher in the ECT group. Crude mortality rate was higher in the ECT group. When expected vs. observed survival was compared, the Ws score (95% CI) was higher in the ECT group than in the non-ECT group, but this was not statistically significant (Table 1). Discussion We identified a younger, predominantly male and more severely injured population attended by our regional ECT. This is reflected in the greater crude mortality observed in the ECT group. We present a novel analysis of survival using robust TARN methodology, but we did not identify a statistically significant difference in the number of unexpected survivors among patients attended by an ECT.

24. Do pre-operative assessment clinic patients belong to a high-risk population for undiagnosed diabetes and non-diabetic hyperglycaemia?

Authors Gorstige D.; McAndrew P.; Mann A.; Laws D.
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Abstract Patients with pre-existing hyperglycaemia have a significantly increased relative risk for major peri-operative complications. This relative risk increases with the degree of hyperglycaemia [1]. The 2018 Perioperative Quality Improvement Programme (PQIP) Annual Report highlighted that 13% of patients undergoing major surgery had diabetes compared vs. an estimated prevalence in the general adult population of 9% (which includes an estimated prevalence of undiagnosed diabetes in England of 2.3%). Current pre-operative testing guidelines do not address identification of undiagnosed hyperglycaemia or diabetes in the pre-operative assessment clinic [2]. Methods Our improvement plan was designed to address this deficiency. We calculated the Leicester Diabetes Risk Score (LDRS) for patients aged 50-75 years with no history of hyperglycaemia who attended the clinic between October 2017 and March 2018 [3]. We used Chi-square analysis to compare pre-operative patient risk category frequencies with the original LDRS summary dataset. From March 2018 patients with a LDRS in the very-high-risk category had an additional serum glycosylated haemoglobin (HbA1c) test. Results In total, 1933 qualifying patients were screened during this period. The pre-operative group was determined to be statistically different from the original LDRS dataset ($p < 0.0001$). The frequencies in each category for each group is shown in Table 1. Our pre-operative clinic data indicates that 3.6% of patients have undiagnosed diabetes and a further 17.4% have undiagnosed non-diabetic hyperglycaemia. In total, 101 patients qualified for serum HbA1c measurements: eight patients had a provisional diagnosis of diabetes and 33 patients had a provisional diagnosis of non-diabetic hyperglycaemia. These results are in keeping with the rate predicted by the LDRS (for a LDRS of >= 25, one in three patients have non-diabetic hyperglycaemia and 1 in 14 have diabetes). Discussion Our pre-operative clinic population can be classed as a high-risk group for undiagnosed hyperglycaemia and diabetes. Such patients are at high risk for potentially avoidable major peri-operative complications. Research is required to determine the best pathway to identify and manage such patients prior to scheduled operative intervention. (Table Presented).

25. Pilot of the research and audit federation of trainees national project 3: Drug allergy labels in elective surgical patients (DALES): Innovative data collection and study set-up techniques

Authors Thomas C.; Savic L.; Ashcroft A.; Yen S.; Clark S.; Fallaha D.
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Abstract The Research and Audit Federation of Trainees (RAFT) is the umbrella organisation for 20 regional and subspecialty anaesthetic Trainee Research Networks (TRNs). With reach across the UK, RAFT is uniquely able to develop multi-centre studies and to enable anaesthetic trainees to be involved in large-scale audit, quality improvement and research. RAFT's innovative use of novel data-collection techniques, study design and manpower has been demonstrated in RAFT's previous national study, iHypE [1]. More recently, Drug Allergy Labels in Elective Surgical patients (DALES), RAFT's 2018 national project has been piloted. DALES is a portfolio-adopted project and examines drug allergy labels. It comprises two key elements: a patient survey looking at the incidence and impact of drug allergy labels and an anaesthetist survey exploring knowledge and attitudes towards these labels. Methods Local trainees undertook a pilot at the DALES host site. Aspects of the project that were tested included the use of Bring Your Own Device (BYOD) for data collectors, an electronically verified verbal consent process and paper-free direct data upload to the MachForm and REDCap-based Anaesthesia. Audit system [2, 3] via personalised links generated for data collectors. Results The pilot took place in March 2018. Eighty-four patients were approached, with 79 (37 males and 42 females) recruited. The age ranges of participants were recorded; three patients were aged 16-25 years, 22 were aged 26-50 years, 32 were aged 51-75 years and 22 were over 75 years of age. All consenting patients were able to verify verbal consent electronically. All nine data collectors successfully generated their secure data upload links and used these to upload survey data on either a personal smartphone or a Trust 'Computer-on-Wheels' device. Discussion RAFT employs innovative techniques to coordinate trainees at a national level to allow delivery of high-quality projects. The DALES pilot has demonstrated successful use of BOYD data collection, electronically confirmed verbal consent and online data collection via the Anaesthesia. Audit system to manage both large numbers of investigators and study subjects. The UK-wide DALES rollout will take place between May and July 2018. An anticipated 17 TRNs, involving > 600 anaesthetic trainees will collect data over a 3-day period at each participating site. This study represents an exciting fusion of collaborative working and the effective use of technology.

26. Measuring central venous pressure using the proximal lumen

Authors Orzylowski P.; Foggo G.; O'Brien P.
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Abstract Many UK Critical Care Units use the distal lumen for central venous pressure monitoring (CVPM) [1]. This poses an increased risk in the event of central venous catheter (CVC) displacement [1]. There is limited evidence to suggest any particular lumen is superior to others for CVPM [2]. It has been suggested that the proximal lumen offers an added degree of safety and should be the lumen of choice for CVPM [1, 3]. The aim of this audit was to increase compliance of CVPM using the proximal lumen in critical care units of NHS Ayrshire & Arran. Methods We performed daily checks on each CVC within the ICU at University Hospital Crosshouse (UHCH) and the intensive care unit and high-dependency unit at University Hospital Ayr (UHA), encompassing all critical care units of NHS Ayrshire & Arran. Data were collected between November 2016 and February 2017 at UHCH, and between August 2017 and November 2017 at UHA. Results were presented to the anaesthetic departments and ICU staff at both sites. Posters were placed at each bedside to remind staff to use the appropriate lumen. A proximal lumen check was introduced into the daily ICU ward round. Following implementation of changes, both sites were re-audited between December 2017 and February 2018. Results A total of 181 daily CVC checks were performed; 131 at UHCH and 50 at UHA. Proximal lumens were used only 60% of the time (66.4% at UHCH, 44% at UHA). We identified this as a significant safety risk and changes were implemented. Upon re-audit, 238 checks were performed: 180 at UHCH and 58 at UHA. Proximal lumen were used 92% of the time (98% at UHCH and 86% at UHA). Discussion CVC displacement can lead to complications and death [1]. The use of proximal lumen for CVPM can reduce unnecessary risk to the patient. Implemented changes have lead to greater compliance with using the proximal lumen for CVPM and therefore improved patient safety.

27. To SATARN and back: Establishing a national audit and research network among specialist anaesthesia trainees in Ireland

Authors Geoghan P.; Black C.; Gilroy J.; Kelleher E.; Vinagre J.
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Abstract Research and audit form essential components of both the training of future anaesthetists and the maintenance of good professional conduct among established clinicians [1]. The transient nature of training scheme rotations has traditionally restricted the degree of trainee involvement in substantive, ongoing research efforts. In answer to this challenge and following in the footsteps of similar trainee-led efforts in the UK we sought to establish SATARN-the 'Specialist Anaesthesia Trainee Audit and Research Network'. Methods Following a period of investigation and enquiry among similar trainee-led efforts in the UK and under the auspices of the Committee of Anaesthesia Trainees (CAT), we made contact with the Audit, Research and Innovation (ARI) Committee of the College of Anaesthetists of Ireland. Having received the support of the ARI, we proceeded to publicising the initiative at a CAT-sponsored Research Methods Study Day in the College with a view to recruiting interested trainees to take part in future projects and identifying trainees to co-opt onto an executive committee. An executive committee was formed and plans were made for an initial, pilot project to test our standard operating procedures (SOPs) and communication pathways. After successful completion of this pilot and following a period of evaluation and refinement of our SOPs and communication pathways we plan to move on to identifying an area and elucidating a hypothesis for our first prospective research project to commence in the second half of 2018. Results Establishing this trainee-led network had been a challenging and illuminating but ultimately successful endeavour to date. We have learnt valuable lessons and collected important data during our pilot project (the data from the pilot project has been submitted as an abstract to this meeting). We hope to use the lessons learned to refine our approach, streamline our efforts and ultimately help our trainees contribute to the vital area of research in anaesthesia, pain medicine and intensive care. We also hope that through their engagement with the network during their training, they will develop skills and knowledge that will continue to help them engage with this area throughout the full course of their careers.

28. Opioid mobile applications: A swipe too far?

Authors Noyes J.; Underwood M.; Yeung J.
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Abstract Globally, there is huge inconsistency in opioid equivalence for online calculators and equivalence tables. Medical staff risk either under or overdosing patients with their use. An audit of mobile applications (apps) was conducted to establish their constancy. Methods The audit standard was that morphine equivalence to other opioids should be consistent across all the apps. Opioid apps were found using the Apple Store search field with the terms 'opioid calculator' and 'morphine conversion'. The searches were performed for the Apple Store in English language-speaking regions (UK, USA, Ireland, Canada, Australia and New Zealand). All apps were considered. Within the apps, all opioids were examined against 10 mg oral morphine, to find equivalence. As the apps considered different opioids, only opioids that appeared in more than half of the apps were reviewed. The range and the median of each opioid equivalence was found. Results Eight apps were found to use this method. One app was dismissed as it was not in English. Two apps were dismissed as they were not able to calculate opioid equivalence in this manner. In apps where a range or two doses were given, the mean was taken. Six opioids were considered with the median stated and range bracketed: transdermal fentanyl 4.2 mug.h^{-1} [1-5 mug.h^{-1}], oral codeine 66.67 mg [33.3-100 mg], oral hydrocodone 10 mg [5-15 mg], oral hydromorphone 2 mg [1.665-2.5 mg], oral oxycodone 6 mg [5-6.67 mg] and methadone 3.3 mg [2- 3.667 mg]. Discussion Within the five apps available across the main English-speaking countries, none of the opioids produced a consistent opioid equivalence. There was a fivefold discrepancy between the lowest and highest transdermal fentanyl equivalence. Opioid apps may not be used by experienced pain clinicians, but their use by inexperienced juniors who have not assessed the apps' quality could lead to prescription errors. At low doses this may be clinically insignificant; however, at higher doses there is a risk of overprescribing opioids with potentially fatal consequences. This is particularly relevant in paediatric patients or those who have issues concerning opioid metabolism and elimination. Further work needs to be done to assess true opioid equivalence, as well as establishing the validity of popular medical apps.

29. Cardiopulmonary exercise testing to detect patients with exercise-induced myocardial ischaemia and unidentified increased mortality in major oncological colorectal surgery

Authors Mann J.; Williams M.; Yates D.; Wilson J.; Davies S.; Harrison A.; Doherty P.
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Abstract In the UK, 170,000 high-risk non-cardiac major operations are undertaken, which result in approximately 100,000 postoperative complications and 25,000 deaths. It is estimated that 80% of these complications arise from a high-risk population accounting for 12.5% of the overall cohort [1]; identifying high-risk patients remains elusive. Current guidelines separate the population into patients at increased risk of major adverse cardiac events (MACE) and those at less than 1% risk, as judged by the National Surgery Quality Improvement Project (NSQIP) or Revised Cardiac Risk Index (RCRI). It is recommended that the low-risk group proceeds to surgery without further assessment [2]. We propose that an abnormal oxygen pulse response (O_2PR) can be used to elucidate a cohort of patients classified as low risk who demonstrate exercise-induced myocardial ischaemia (EIMI) and a high VeVCO_2 that have increased risk of mortality. Methods Data were extracted from the cardiopulmonary exercise testing (CPET) database held at York Hospital for patients undergoing oncological colorectal surgery and who had an O_2PR assessment recorded. Descriptive statistics analysed the two groups described above, using Chi-square or Fisher exact test for categorical variables and independent t test or Mann-Whitney U-test for continuous variables. Thirty-day or in-hospital mortality was compared with OR and 95%CIs. Binary logistic regression was used to control for significantly different demographics. Results In total, the records of 1214 patients were extracted from the database and 342 patients had a < 1% risk of MACE and reduced functional capacity, as classified by RCRI and a VE/VCO_2> 34 respectively. When split by O_2PR, the groups were found to be statistically different by sex ($p<0.001$) and BMI ($p=0.006$). For patients with normal O_2PR, VeVCO_2> 34 and RCRI < 1%, there was an observed 30-day/in-hospital mortality of 1.3% vs. 6.9% for an abnormal O_2PR. The OR for 30-day/in-hospital mortality was 5.82 (95%CI 1.47-22.98; p = 0.009). Controlling for sex and VE/VCO_2 with binary logistic regression, the OR was 6.95 (95%CI 1.65-29.34, p = 0.008). Patients with a RCRI > 1% but a normal functional capacity (n = 141) had a 30-day or in-hospital mortality of 1.4%. Discussion Current guidelines fail to identify a group of patients with EIMI or undiagnosed cardiac risk factors who are recommended to proceed to surgery without intervention and have approximately six times the risk of mortality at 30 days. We propose an altered algorithm that incorporates CPET and oxygen pulse to identify this lost high-risk population.

30. Front-of-neck access without fear: Fashioning surgical airway simulators and skills

Authors Peroos S.; Willers J.; Speers S.; Shimmin H.; Mildon J.
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Abstract Front-of-neck access (FONA) is the last resort to achieve an airway in the rare emergency where an anaesthetist 'Can't intubate and can't ventilate'. Following the fourth National Audit Project (NAP4) in 2011, the Difficult Airway Society (DAS) concluded that 'a simple plan to rescue the airway using familiar equipment and rehearsed techniques is likely to increase the chance of a successful outcome' [1]. The use of easily replicable, high-fidelity simulation equipment can allow the anaesthetist to be more comfortable using the unfamiliar equipment and procedures in this 'can't intubate can't oxygenate' scenario [2]. Methods The development of the High-fidelity Extreme Airway Trainer (HEAT) has facilitated procedural simulation of challenging FONA [3]. The manikin was used as a successful educational aid for a 'Difficult airway and FONA' simulation teaching workshops at our hospital in Worthing, West Sussex, with incredibly positive feedback and demand from other hospitals for similar workshops. Subsequently, a 'train the trainers' course was run for anaesthetic simulation leads from around the UK to enable other simulation leads to run similar workshops at their own hospitals. The models and teaching methods are very sustainable and economical. Current models in the market run at a minimum of 800 for the cheapest model and approximately 60 for a single-use neck insert. Capital outlay for our manikin is approximately 5, with recycling costs < 2.50. Results Feedback from our initial workshop had a positive response, measured using a 5-point Likert scale (median (IQR [range]). The 'Manufacturing the FONA manikin' workshop was attended and evaluated by eight anaesthetists. Delegates rated (4.8 (4-5 [4-5])) for being 'able to replicate the various manufacture techniques and produce the models' at their institution. All delegates (5 (5-5 [5-5])) said they agree strongly that they 'would use this training approach' at their institution and (4.8 (4-5 [4-5])) rated that 'the manufacture and use of these FONA models entails easily transferable skills'. Discussion This brief study shows the potential for transferability of teaching methods in FONA simulation, providing a sustainable, expanding and valuable teaching resource. Plans for the future would be to amplify this even further nationally, and eventually extend this low-cost sustainable model on an international level.

31. Enhancing patient safety in the regional anaesthesia 'block room' at University College London Hospital

Authors O'Flaherty D.; Kamming D.; Farrar D.
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Abstract Ensuring patient safety is an ongoing challenge, especially in a healthcare environment where new and innovative changes alter a previously well-established patient pathway. It is important to be aware of possible unintended consequences of such changes and where possible, mitigate safety concerns. At University College London Hospital (UCLH), a dedicated 'block-room' has been implemented, allowing regional anaesthesia to be consistently delivered by skilled anaesthetists, with the effect of enhanced patient satisfaction and increased efficiency [1]. Safety strategies such as an additional Block-Room World Health Organization (WHO) 'Sign-In' and the 'Stop Before You Block' campaign have already been implemented and engrained in block-room culture [2]. Methods As a 'Surgical Safety' initiative, UCLH has a team dedicated to ongoing surveillance of communication and teamwork surrounding all interventional procedures with the '5 Steps to Surgical Safety' at its core [3] . Working with the Surgical Safety team, we devised a quality improvement project to enhance safety in the block-room. After a peer-review surgical safety visit, safety concerns identified included (i) ensuring that each theatre's 'team brief' has taken place prior to sending for the patient, to avoid potentially carrying out regional anaesthesia on a patient whose procedure is later cancelled for a reason highlighted at the brief; and (ii) ensuring effective formal handover of regional anaesthesia procedure. The block-room configuration allows for parallel performance for service provision with the effect of improved efficiency. This occurs at the cost of loss in continuity of patient care and, potentially, lack of communication between blockroom and theatre staff. Results We implemented the following changes to improve patient safety. (i) Adaptation of the theatre 'WHO checklist' to incorporate a regional anaesthesia section at 'time out', with the aim of enhancing continuity of care and raising awareness of the hazard of repeat dosing. (ii) Implementation of a morning block-room 'huddle' to identify suitable patients and the use of a whiteboard for clear documentation that a theatre 'team brief' has occurred. Information regarding changes was disseminated to staff via weekly work emails and local posters. Discussion Patient safety has been improved through formalising communication pathways by instituting a regional anaesthesia block-room 'huddle' and incorporating regional anaesthesia on the WHO 'time out'. These processes are becoming embedded in theatre culture, ensuring sustainability of the project. Processes are in place to review patient safety practices continually.

32. Quality improvement: Removal of medical air flowmeters from Aneurin Bevan Health Board hospital-based wards

Authors Lodhi S.; Ellis R.; Duff E.; Davies C.
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Abstract The aim of our quality-improvement project was to reduce morbidity and mortality resulting from misconnection to medical air, an NHS Never Event. This has potentially important legal and financial ramifications for our health board. Nationally, 208 patients have been inappropriately connected to medical air instead of oxygen (2013-16), with two National Patient Safety Alerts (NPSA) in 2016. Four cases directly led to patient mortality. There have been multiple incidents during cardiac arrests within the Aneurin Bevan Health Board. This poses a great safety issue. Methods We surveyed all air flowmeter ports on medical and surgical wards and classified them as safe or unsafe, according to NPSA guidelines. The survey findings were disseminated to the Health Board directorate. All air flowmeters were removed from wall ports and a flowmeter was stored on drugs trollies on each ward for when air was needed. A red alert card was hung on active flowmeters to remind staff of its removal once it was no longer required. A pilot was carried out on a single medical ward over a 2-week period. A follow-up questionnaire sent to ward nurses showed the changes were well accepted. This intervention was continued, and instigated hospital wide, with many medical air wall ports being capped. Any use of medical air now requires air cylinders. Re-education in oxygen use to drive nebulisers and a cultural change in their prescription has been encouraged. Following this, a re-audit showed 205 safe air flowmeters and eight unsafe ones. The secondary intervention is to target specific problem wards, troubleshoot barriers to change, and re-audit again. The overall intervention will then be rolled out health board-wide and provide a framework for achieving change in other health boards. Results In total, 197 air flowmeters were deemed safe and 97 air flowmeters were unsafe. A re-audit showed 205 safe air flowmeters and eight unsafe ones. Discussion The mistaken use of medical air is a recurring problem locally and nationally. This poses great risk to patients, particularly in the resuscitation setting. Initial interventions have greatly improved patient safety with multidisciplinary cooperation. Removing air flowmeters is an easy, cost neutral and effective method of reducing the chance of inadvertent medical air connection that improves patient safety from iatrogenic harm.

33. Reducing non-essential pre-operative tests in adults undergoing elective surgery: A costimprovement project/quality-improvement programme

Authors McGrath A.; Nguyan H.; Kynoch M.; McNeilly S.
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Abstract Pre-operative assessment (POA) investigates patients for unexpected conditions that could affect upcoming surgery. These investigations are expensive, resource intensive and contribute to morbidity and delays owing to spurious results. This is on a background of a rising number of elective operations, with ~8 million per annum in the UK [1]. National Institute for Health and Care Excellence (NICE) guideline NG45 [2] advises which tests are essential, based on patients' ASA grade and surgical severity. We are undertaking a quality-improvement project aimed at safely reducing non-essential tests in our POA clinics. Methods Current practice was compared with NG45 [2] in a baseline snapshot audit in 2016. A total of 60 patients attending POA were randomly selected and stratified by ASA grade and category of surgery, and data was obtained using the electronic patient records system. The results showed an over-ordering of nonessential tests: non-essential full blood count (FBC) in 91%, coagulation screen in 86.7% and renal function testing in 100%. In contrast, only 54% of patients recommended by NICE for ECG received one, whereas 50% of unrecommended patients received one. In March 2018, we carried out the following interventions: (i) posters outlining NICE NG45 put in all POA clinical areas; (ii) training sessions delivered to all POA staff; (iii) introduction of the 'NHS preoperative assessment' app [3]. One month later a re-audit was performed. A total of 59 patients were randomly selected with an even spread across ASA grade and surgical severity. Results In the re-audit 20.3% of patients had NG45-appropriate tests. Non-essential renal function was ordered in 42.6% (57.4%); coagulation in 28.1% (58.6%); and FBC in 88.6% (2.4%). Some 21.1% (24.9%) of patients requiring an ECG did not have one, whereas 51.7% (1.7%) of patients incorrectly received one. We have thus shown a significant ($p < 0.05$) reduction in non-essential tests, greater than our 5% target. Discussion A collaborative approach with the POA team as described increased compliance with NICE NG45, with a significant reduction in the ordering of non-essential tests. This is likely to represent a significant cost saving. The degree of improvement varied across the different tests, however, and there is scope for further work to improve compliance with the guidelines further.

34. Developing an anaesthetic alert system

Authors Garside M.; Hatfield A.
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Abstract Following critical incidents in our department, we found an inconsistent approach to managing future patient anaesthetic safety concerns. Our aim was to create a robust system to provide information to patients and general practitioners (GP); flag up anaesthetic risks; prompt specialist investigations; and link into evolving electronic records. We undertook a survey of UK-wide practice before developing an anaesthetic alert system (AAS). Our system started in 2013 and has since been audited and revised more than once. We present a 'tried-and-tested' AAS for use by other departments. Methods An initial two-part survey was completed in 2011. In the first part, 305 college tutors were contacted and asked if their department currently had an AAS. In the second part, a questionnaire was sent to Clinical Governance Leads in departments with an AAS in place. Dr David Ball and the Difficult Airway Society (DAS) gave permission to modify their Airway Alert form [1, 2], enabling us to create our own Anaesthetic Alert form. Colleague feedback and audit at 1 year led to the addition of GP Read codes [3] and Alert Stickers for patient notes. Further review in 2017 embedded the AAS into our newly introduced electronic patient records. Results Part 1 of the survey produced 86 replies. Thirty-nine (45%) had an AAS and 47 (55%) did not. In part 2, 16 questionnaires were returned. Of the 16 returned, three covered difficult airway only, < 50% had a named clinician and only 13% were linked to electronic systems. The information received did not lead us to alter the plan for our initial AAS. We consistently generate 20-25 alerts per year. They are difficult airway (60%); anaphylaxis (31%); suxamethonium apnoea (6%); malignant hyperpyrexia (1.5%); and other (1.5%). Audit of our system shows that anaesthetists find it helpful and easy to use and appreciate feedback at governance meetings. Discussion Prior warning of potentially serious anaesthetic complications and risks can improve safety. Following a serious complication, it is the duty of the anaesthetist to document and disseminate details of the event and plan follow-up. Our system creates a clear pathway for all of the above using a single form. A clinical coordinator maintains an Alert File and supports colleagues in using the system. They also deliver feedback at departmental meetings. This simple AAS is easily transferable to other departments to improve patient safety.

35. Using quality-improvement principles to develop a thematic 'Learning from Excellence' dictionary to ensure reviewer reliability and support wider organisational learning

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Abstract Learning from Excellence (LfE) is a positive reporting system that allows peers to provide appreciative feedback to their colleagues. LfE was introduced to University Hospitals Plymouth NHS Trust in 2017 and we have had over 1200 nominations. The primary benefit of LfE is the positive feedback the individual receives. A secondary benefit is the wider learning that can be elicited by examining events where things have gone well, which can enable improvements in safety, quality and resilience across the organisation. This aligns to Safety II [1]. Such a system requires the development of a tool to thematically analyse the nominations to maximise opportunities for learning and sharing and to ensure reviewer reliability. Methods To develop the thematic dictionary, three core members of the LfE team independently reviewed an initial sample of 30 nominations to determine themes. The group then met face to face to discuss rationale and agree the first group of high-level themes and a process for ongoing thematic review. Using PDSA methodology, the team tested the thematic dictionary with a further two sets of 30 nominations by comparing reviewer application, theme definitions and appropriateness. For every data set, levels of agreement were tested. The thematic tool has continued to undergo refinement. Results Version 1 of the thematic dictionary contained 33 themes. Following seven PDSA cycles over 11 weeks, the dictionary evolved to contain 30 high-level themes housing 91 lower-level descriptors. A single nomination could be assigned more than one theme if appropriate. Crude inter-rater reliability (defined as complete consensus across all three reviewers against four themed fields or shared consensus bar addition or omission of one theme) was 76%. All 1200 nominations have been analysed. Discussion Consultation with a statistician confirmed that agreement levels of 76% across 30 themes indicated high and reliable levels of agreement. Distilling approximately 100 lower-level descriptors to 30 high-level themes makes handling the volume of information more manageable when eliciting common themes for further investigation and sharing the learning across the Trust. The Plymouth LfE dictionary has now been shared more widely across the LfE community to assess usability, applicability and reliability for other organisations. If successful, the dictionary will be uploaded to learningfromexcellence.com. Continual review of themes and reviewer agreement will occur to ensure continued reliability of tool perfomance.

36. Quality improvement methodology to enhance uptake of 'Learning from Excellence' at a large UK teaching hospital

Authors Crossingham G.; Viira D.; Hannon F.; Underdown C.
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Abstract Traditionally, learning about safety has focused on learning from adverse events. 'Learning from Excellence' (LfE) is an emerging concept that adopts a 'safety II' approach [1], and focuses on learning about safety and quality from events where things have gone well. Furthermore, staff can be thanked for their contribution, thus improving resilience, culture and morale. In December 2016, LfE was introduced into our large tertiary teaching hospital in the South West of England. Since then, we have had over 1200 nominations. The initiative has only been actively promoted within theatres and the emergency department. Here, we report the use of quality improvement methodology that has significantly contributed to the rapid, high uptake of the initiative at the Trust. Methods Plan Do Study Act (PDSA) cycles were used to refine elements of the process to enhance compliance, user friendliness and quality of the nominations. Where appropriate, solutions were co-created with staff and patients using focus groups. Feedback from stakeholders was actively encouraged throughout the process. Results Discussion Active listening to stakeholders and co-modifying the intervention to suit the local context has significantly improved the uptake of LfE at Plymouth Hospitals NHS Trust. Close collaboration with management and the Trust Board have been key to the successful upscaling of this project. Ongoing challenges include ensuring meaningful system improvement from LfE and ensuring usable, constructive and timely feedback is provided to participating departments. (Table Presented).

37. Monitoring of motor blockade after regional anaesthesia for caesarean section

Authors Cordrey V.; Alder R.; Yentis S.
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Abstract Recovery after regional anaesthesia in obstetrics is not monitored consistently in the UK [1]. For the last two years our maternity unit has routinely used a chart for hourly recording of postoperative motor block after regional anaesthesia. We wished to audit its completion and establish recovery profiles after spinals and epidural top-ups for caesarean section. Methods In our Trust, all clinical records are scanned into an online system after the treatment episode. This was searched retrospectively to find details of 100 caesarean sections carried out under spinal anaesthesia and 100 under epidural anaesthesia. The Bromage score was extracted from the motor block charts and plotted over time. Combined spinal-epidurals were omitted for clarity. The charts specify that escalation to an anaesthetist should occur if there is no improvement in three consecutive motor scores. We recorded (i) if this was required and (ii) written evidence to show it had been done. Results Overall, 150 (75%) charts were fully completed to full bilateral recovery, five (3%) were completed to full recovery but with some missing scores, 27 (14%) were partially completed but not to full recovery, and 18 (9%) were not filled in at all or were missing from the notes. In 18/ 188 (10%) charts the motor score remained the same over three consecutive measurements; however, escalation only occurred in 2/18 (11%) instances. Median (IQR [range]) spinal dose of heavy bupivacaine 0.5% was 2.4 ml (2.4-2.5 [2.0-2.7]) (n = 89). Epidural top-ups were with lidocaine 2% + adrenaline + $NaHCO_3$ 8.4% (87%) [2] or l-bupivacaine 0.375-0.5% (13%). Median (IQR [range]) volume was 20 ml (15-20 [10-30]) (n = 94). In 66% of epidurals, a dose of epidural diamorphine (2.0-4.0 mg) was recorded before Recovery Unit admission. Recovery of motor block is shown in Figure 1. Discussion Overall, completion of charts was good but we remain concerned at the shortfall from our 100% standard. Additionally, in the 18 cases with an unchanging level of motor blockade, escalation only occurred twice. It is unclear why these omissions occurred; poor documentation may play a part, but there remains a need for continued multidisciplinary education. The recovery profiles in Figure 1 provide a useful guide for parturients and recovery staff as to what can be expected after regional anaesthesia for caesarean section in our unit. (Table Presented).

38. Economy and ecology friendly anaesthesia

Authors Jani S.; Kalla A.
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Abstract This project emphasises two components related to anaesthesia practice: economy and ecology (ECO2). When Dr Jani started her anaesthetic career in India, the cost of treatment was a major factor. Patients were paying for their treatment, which had an economical impact. Upon moving to the UK to work for the NHS, it was the subject of climate change that made her aware of the ecological impact of anaesthesia. So, being an NHS employee and an inhabitant of this planet, we have an obligation to modify and provide a cost-effective, green practice. Methods We carried out a review of the evidence [1, 2], which highlighted that expensive volatile anaesthetic agents are culprits in global warming. To review our ECO2 friendly contribution, we investigated the management of the anaesthetic agents in our department. We designed a questionnaire in order to collect data for our practice. This was completed by a trained observer doing a randomly timed visit to the anaesthetic room and the theatre. The collected data were analysed and presented in the form of pie chart. Results The results were astonishing. Of the 54 returned questionnaires there were 20 episodes where, despite the patient having been transferred to the theatre, anaesthetic gases were left running in the anaesthetic room for varying periods of time. Once in the theatre the high flow of gases was continued in 11 episodes, despite adequate volatile agent wash in. The waste in and contamination of anaesthetic rooms by anaesthetic gases, as well as an inability to convert to a low-flow technique in theatre, was highlighted by the audit. Findings were shared with colleagues and trainees within the department. We also displayed visual prompts on the theatre doors and the anaesthetic machine in anaesthetic rooms, as well as theatres. This was a reminder to switch off the gases on transfer and to reduce the flow during anaesthesia. After 6 months, data were re-collected and analysed using the same methods. This enabled us to assess our practice, following interventions such as display of the visual prompts and email reminders. Despite this, there were 11 episodes of anaesthetic gases not being switched off in anaesthetic rooms and 28 episodes of high-flow anaesthesia Discussion The audit loop was closed, and showed a mixed picture. There was a marked improvement in anaesthetic gases being switched off at the time of transfer. In contrast, the low-flow anaesthesia technique was not widely adopted. To improve the outcome, reminders are required on a regular basis. Over and above visual prompts, other means are necessary to achieve a sustainable practice.

39. Patient-controlled analgesia following cervical brachytherapy: A 12-month Trust review

Authors Brown M.
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Abstract There are around 3000 new cases of cervical cancer per year in the UK [1]. More advanced cancers, stage IIB-IVA, are treated with high-dose rate brachytherapy (HDR) to maximise radiation to tumour and spare surrounding tissues [2]. One problem for anaesthetists is pain incurred from HDR, particularly from applicators that stay in situ for up to 24 h. This quality-improvement project looked at use of epidural with postoperative patient-controlled analgesia (PCA) as an appropriate management plan for cervical brachytherapy. Methods We reviewed 45 admissions for cervical brachytherapy over a 12-month period. Patients were either admitted for first-dose HDR, in which case the applicator was in place for up to 2 h, or admitted for HDR doses two and three, in which case applicator was inserted and remained in situ for 24 h, allowing dose 3 to be administered the following morning before removal. Our aims were to quantify PCA use and pain scores postoperatively once spinal anaesthesia had worn off, and to review if the applicator in situ for 24 h caused higher pain scores and more opioid use. Information was gathered from anaesthetic and PCA charts alongside electronic records. Results Forty-five admissions (23 patients) presented over a 12-month period. All admissions received PCA postoperatively. Table 1 shows PCA use per hour alongside highest pain scores for each admission. An increase was shown in PCA use per hour and higher maximum pain scores when the applicator was in situ for HDRs 2 and 3. When patients' pain scores where compared individually there was an increase in pain score of 3 between admissions. Discussion Patients admitted overnight with applicator in situ had higher pain scores and increased PCA use. This is corroborated by comparing patients' individual admissions with an increase of 3 on highest pain score between HDR 1 and HDRs 2 and 3. This adds a degree of control as the same patient received the same anaesthetic, the difference being duration of applicator. The results highlight an area that can be targeted for better analgesic control in our admissions for brachytherapy. The Trust has looked at methods of analgesia trialled elsewhere, namely epidurals and caudal nerve blocks, which could stay in for duration of admission, improving analgesia. At present this involves training of ward staff to manage epidurals and has not yet been implemented. This audit is ongoing; our progress with implementing a new strategy alongside a second year of data. (Table Presented).

40. QUAIL: Quality of anaesthetic information given for labour-initial results

Authors Brinkler R.; Edwards Z.; Abid S.
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Abstract Obstetric Anaesthestists' Association (OAA)/AAGBI guidelines [1] recommend all expectant mothers, irrespective of birthing plan, receive information regarding analgesia for labour and anaesthesia for caesarean section. Information should be given antenatally and revisited, if needed, during labour. The AAGBI 2017 consent guidelines reiterate that labour is the wrong time for women to receive information for the first time and that all units must provide analgesia and anaesthesia information during early pregnancy [2]. Methods We conducted an electronic survey of all eligible patients present on the postnatal ward over two non-consecutive 24-h periods. All postnatal women over 18 years of age were eligible, with exclusion criteria being patient refusal and poor English language skills. We enquired about women's planned and actual analgesic and anaesthetic choices during delivery, as well as the content, quality and source of their information regarding analgesia and anaesthesia. The audit standards were based on the OAA/AAGBI Guidelines for Obstetric Services 2013 [1]: * All pregnant women should be given up-to-date, good quality, evidence-based information on analgesia for labour and anaesthesia for caesarean section. * Information should be given antenatally and revisited, if needed, during labour. Results Twenty-eight London hospitals identified 1283 eligible patients and 903 (70.4%) completed the survey. In total, 55.9% were primiparous and 44.9% were high risk, while 20% had antenatal contact with an anaesthetist. Results are shown in the table. Discussion Information provision antenatally and at the time of intervention was well below the standard recommended by the OAA/AAGBI. Informed consent is vital before performing an intervention and without complete provision of information, consent may be deemed invalid. Our method relied on patient recall so under-reporting may have occurred; however, ability to recall information is a vital component of informed consent [2]. Data will be further analysed to assess whether information provision varies among different patient groups. The centres involved have been provided with local feedback and advised to schedule provision of information into antenatal visits using standardised leaflets from the OAA (labourpains.com), as well as regular teaching of labour ward anaesthetists on standards of consent. Study limitations include only surveying English speakers admitted to the postnatal ward. (Table Presented).

41. Strategies to prevent wrong site block and improve compliance with stop before you block

Authors Madhok A.; Lum Y.; Patil A.; Bhatia K.
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Abstract Wrong site block (WSB) is 10 times more common than wrong site surgery [1]. Data from NHS Improvement highlights that 72 WSBs were reported between April 2015 and 2017, making it one of the most common never events in the NHS [2]. Protocol violation of the 'Stop Before You Block' (SBYB) moment is one of the key aspects contributing to WSBs. Methods Following a WSB at our Trust, we conducted an audit of SBYB in 2015, in Trafford General Hospital and Manchester Royal Infirmary in the orthopaedic and trauma theatres. A proforma was designed and completed during performance of the SBYB moment in the anaesthetic room by a neutral observer. Staff undertaking the SBYB moment were unaware an audit was taking place. The initial audit highlighted the possible factors that could contribute to WSB, including inaccurate identification of surgical site, errors on theatre lists and consent forms, and poor compliance with SBYB. Following this initial audit, over a period of 1 year, changes were introduced on the World Health Organization (WHO) brief and the 'Sign in' component of the surgical safety checklist. ODPs were trained to be key members in the check: yellow trays for regional anaesthesia and SBYB stickers to be applied on the proposed site of surgery on an awake patient were introduced. Re-enforcement of the SBYB technique was done at trainee induction and for ODPs at audit and clinical effectiveness meeting days. A re-audit of SBYB was carried out in 2017. Results The results of both audits are given in Table 1. No WSBs have been reported at our Trust since 2015. Discussion Significant improvement was observed in all areas, but the most marked response was the compliance with the SBYB moment in the 2017 audit. The compliance with application of SBYB stickers was low and due to multi-factorial reasons, including the presence of agency staff in theatre. Team training, awareness about WSB, education about human factors, compliance with checklists, use of SBYB stickers, patient involvement at 'sign in' and continuous re-enforcement of SBYB for staff at induction have been key strategies leading to quality improvement in preventing WSBs at our Trust. We plan to introduce videos as part of mandatory training and introduce 'mock before you block' simulation strategies to further enhance patient safety. (Table Presented).

42. Recognising our carbon footprint in anaesthesia and the potential for improvements

Authors MacKenzie L.; O'Carroll J.; Arnold F.; Brigue U.
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Abstract Climate change is a major public health priority and delivery of health care generates considerable greenhouse gas emissions. Anaesthetic gases have potent greenhouse effects, causing an estimated 2.5% of total NHS England carbon footprint [1]. Furthermore, the use of nitrous oxide in health care contributes to 1.3% of the total emissions of the entire UK. It is our responsibility to reduce the carbon impact of anaesthesia while maintaining patient safety. The Kyoto Protocol has set emissions targets for all greenhouse gases, and has standardised the unit of emissions to carbon dioxide equivalence (CO_2e), to allow comparison between various gases [2]. Methods We collected gas and volatile consumption for elective and emergency cases (excluding total intravenous anaesthesia and regional-only cases) from the main theatre complex, using GE healthcare Aisys CS2 and Carestation 650 anaesthetic machines from theatres and anaesthetic rooms at one site in our Trust. Data were analysed with Microsoft Excel to quantify the CO_2e for every anaesthetic, using previously published data by Dr JMT Pierce [3]. The data are due to be presented at local audit meeting, accompanied by educational materials regarding the importance of sustainable anaesthesia, and how we can all individually reduce the impact of our anaesthesia. Following on from the meeting, we will repeat the data collection, expecting to see a reduction in carbon footprint. Results We took a snapshot of 25 general anaesthetics performed in the main theatre complex. Eighty-eight per cent used sevoflurane as the main volatile agent, and nitrous oxide was used in 68% of cases. The total carbon dioxide emissions for the 25 cases was 1600.8 kg, which is the equivalent of travelling 10,004 km in a standard 160 g. CO_2. km^{-1} emission car. Discussion This snapshot audit, clearly demonstrates the problem that we face in anaesthesia. With an average of approximately 800 kg. CO_2e per day, this equates to over 200 tonnes CO_2e per year, simply from our main theatre complex of a moderate- sized district general hospital. Desflurane and nitrous oxide usage lead to significantly higher CO_2e emissions than sevoflurane alone. Therefore, using sevoflurane within oxygen and air mixture has both a clear environmental and financial benefit. (Table Presented).

43. Development of an acute pain management pathway in adults with pelvic and acetabular fracture in a tertiary referral centre in London

Authors Ma S.; Ranote P.; Ng L.
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Abstract Evidence suggests that good acute pain management in major trauma improves outcome and the converse is also true [1]. Chronic pain, which present in as much as 80% of pelvic trauma, can be prevented by early analgesic intervention in the acute phase; this is true for both surgical and conservative management [2]. Opiates have adverse effects that will affect the quality of anaesthetic services and should be avoided where possible. Regional anaesthesia offers significant benefit to polytrauma patients, including reduction of morphine consumption and associated side-effects. The regional block of choice at our institution is Quadratus Lumborum Block (QLB); neuraxial blocks are avoided to allow examination and monitoring of perineal sensation immediately postoperatively. Methods We standardised analgesic management based on latest evidence and reviewed audit data in order to formulate a multidisciplinary care pathway. The final pathway was produced over several developmental meetings with surgeons, anaesthetists (trauma and pain specialists with acute pain team), physiotherapists and specialist nurses. The pathway is made to resemble a checklist so things can be ticked when completed, to avoid overlooking certain steps in the pathway. Results Discussion The latest National Institute for Health and Care Excellence guidance for management of pelvic fractures was published in February 2016 [3]. This did not address analgesic regimes in detail, nor did it extend to beyond the acute admission period. This work is therefore novel in this respect as it encompasses the pain management through admission till discharge and follow-up. During follow- up the patients with chronic pain issues will be identified and managed appropriately by the pain team. We hope this will improve patient outcomes both objectively and subjectively. This pain management pathway is now being used in our institution and will be audited in 6-12 months' time.

44. Retrospective review of adjuvant chemoradiotherapy practice in cervix cancer in nottingham city hospital, UK

Authors Sivanandan M.; Lim J.H.; Anand A.
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Abstract Background and Aims: In cervical cancer, adjuvant chemoradiotherapy improves survival in high risk patients. In patients with intermediate risk features, adjuvant radiotherapy reduces local recurrence rates but provides no overall survival benefit. We performed a retrospective audit to examine practice of adjuvant treatment in our centre. Methods: Histopathology was reviewed for patients with stage 1B cervical cancer who had radical hysterectomy between 2010 and 2014 at Nottingham City Hospital, UK examining for high-risk (positive/close surgical margins [<5mm], positive lymph nodes or microscopic parametrial involvement) and intermediate risk factors (deep cervical stromal invasion, tumour size > 4cm or LVSI), adjuvant treatment and follow up data. Results: 53 patients were identified. 9(17%) patients were identified with a high-risk factor with 8/9 receiving adjuvant radiotherapy with 5 of those receiving concurrent chemotherapy. 4(7.5%) patients had intermediate-risk factors alone with one receiving adjuvant radiotherapy. 3(5.6%) patients developed a local recurrence with one of those having distant recurrence at the same time. In this subgroup, one patient had no negative prognostic factors, one patient had all negative prognostic factors and had received adjuvant chemoradiotherapy, and one patient had deep stromal invasion and close surgical margins (3mm) and did not receive adjuvant treatment. Conclusions: Adjuvant treatment in the intermediate-risk group is less commonly offered in our centre. Observed overall recurrence in this cohort of early stage cervical cancer patients was low. Therefore observation is a valid alternative option.

45. Why we must review our practice: Results of a UK-wide national survey regarding surgical practice for FIGO stage 1a1 to 1b1 cervical cancer

Authors Ratnavelu N.; Fisher A.; Kucukmetin A.
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Abstract Background and Aims: NCCN guidelines advocate minimally-invasive(MIS) or open radical hysterectomy for Stage 1A2 to 2A disease. LACC trial demonstrated 4-fold increase in cumulative recurrence rate in MIS compared to open surgery. We aimed to establish current UK practice and demand for discussion/reflection following LACC. Methods: A survey was distributed in May 2018 to BGCS-members, including 95 Consultant Gynaecological Oncologists. Members were asked 1)current surgical practice for 1A1 with LVSI to 1B1 cervical cancer; 2) if they had heard of the LACC trial; 3) if they had since changed practice; 4) what hypotheses they had for poor oncological outcomes in MIS group; and 5) whether they would participate in a national audit. Results: 45/95 Consultant members responded, from 28 centres in UK. For 1A1 with LVSI and 1A2 surgical practice ranged from LLETZ alone, simple trachelectomy to radical hysterectomy with node dissection. For 1B1 disease practice ranged from offering LLETZ for small volume tumours to radical surgery. 3 Consultants offered robotic surgery, 18 offered laparoscopic. 43/45(96%) members had heard of the LACC trial. 8/43(19.%) Consultants had modified/changed their practice since LACC. Hypotheses for poor performance in MIS group were: a)poor surgical performance/radicality; b)patient selection bias; c)insufficient tumour data presented ; d)surgical techniques(manipulation/pneumoperitoneum/tumour seeding); and e)lack central pathology review. 38/45(85%) Consultants would consider participating in a national collaboration. Conclusions: A fifth of UK respondents have changed their surgical practice despite unpublished data. There is demand for national debate and collaboration to identify surgical trends and predictors of poor oncological outcomes in cervical cancer.

46. Improving physical health assessments and monitoring in a first episode psychosis service

Authors Das D.; Ndlovu A.; Sud D.
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Abstract Introduction: Improving parity of esteem between physical health and mental health is a national agenda in the UK. A previous study (Das, et al 2014) within the PIER Team (a first episode psychosis service, serving 1 million population) found poor recording of physical health assessments and metabolic monitoring in patients on antipsychotic medication; compliance ranging from 25% to less than 50% in various domains. Recommendations were made for a sustainable solution, including development of a Physical Health Register, led by the Pharmacy department and a nurse-led physical health clinic within PIER team. Aim: To measure quality improvement in physical health assessment and monitoring in first episode through service system development. Methods: Retrospective analysis of data held by the Physical Health Clinic (January to May 2017) and Physical Health Register (January to December 2017) was completed. Results: 115 patients went through the Physical Health Clinic, receiving physical health assessment and metabolic monitoring; this included 12 out of 85 (14.2%) newly accepted psychosis patients, who received physical health assessments and monitoring, as per recommendations. 360 patients were monitored by the Physical Health Register, between January 2017 and December 2017 (PIER caseload was 396 in May 2017), 97% of whom had screening at least once and interventions. Conclusion: Physical Health Register has resulted in an improvement in physical health assessments and monitoring of patients with first episode psychosis. Physical Health Clinic needs to improve its uptake for newly diagnosed psychosis patients. Firming up business processes is likely to aid further improvement.

47. Don't just screen, intervene: From margin to mainstream in Australia and England

Authors Curtis J.; Shiers D.
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Abstract Background: The iphYs international collaboration arose out of a shared concern over health system failures to proactively tackle cardiometabolic risk. The UK National Audit of Schizophrenia (NAS, 2012) and the Australian 2nd National Survey of Psychosis (2010) demonstrated the magnitude of this. Yet other than acknowledging social injustice, strategic response was lacking. Methods: To assess mutual impacts of iphYs collaboration: i) Impact in England of adapting original NSW Positive Cardiometabolic Health algorithm (HETI, 2011) to create UK Lester resource; ii) Impact in Australia of adopting HeAL (Healthy Active Lives declaration), a rights-based approach to physical health from outset of psychosis and its treatment Results: ENGLAND: Impact from adopting NSW Don't just screen, intervene approach to cardiometabolic risk: 2014 UK Lester resource endorsed by NICE, professional Royal Colleges, NHS England and Public Health England, Diabetes UK and Rethink. Implementing the Lester resource is key objective of NHSEs quality improvement programme (CQUIN) and Care Quality Commission's regulatory assessment. Aligning with HeAL, service implementation of Lester resource features in national EIP self-assessment audit; latest CQUIN specifically incentivises EIP services to mitigate weight gain and reduce smoking. AUSTRALIA: The HeAL declaration principles have been endorsed by NSW Health, being embedded in statewide and national strategic documents (eg NSW Mental Health Commission; National Mental Health Commission) and the Positive Cardiometabolic health algorithm, alongside HeAL is acknowledged in the RANZCP clinical practice guidelines for Schizophrenia. Conclusion: Synergies resulting from eight years of international collaborations between Australia and England have influenced radical changes in policy and practice at state and national level.

48. The 'talking trauma' project: Implementation of trauma-informed care in early intervention in psychosis services

Authors Hardy A.; Jolley S.; Swan S.; Bradley J.; Thompson C.
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Abstract Background: The United Kingdom's National Institute for Health and Care Excellence guidelines for psychosis and schizophrenia recommend that trauma and PTSD should be routinely assessed in Early Intervention for Psychosis services and, when indicated, therapies for posttraumatic stress disorder and other reactions to trauma provided (NICE, 2014). This is based on research indicating higher rates of trauma and posttraumatic stress reactions in this clinical group compared to the general population, and emerging evidence of the effectiveness of trauma-focused talking treatments (de Bont et al, 2015; van den Berg et al, 2015). However, effective implementation of the guidance is dependent on addressing barriers and opportunities from a range of stakeholder perspectives, multidisciplinary staff training and supervision, and an audit cycle to evaluate trauma-informed practice. Methods: The 'Talking Trauma' audit aims to address these needs, using interviews and surveys with service users and staff, together with case note review, and is being conducted across the psychosis services of a National Health Service Trust in inner city London. Results: A summary of the audit findings to date will be provided, followed by plans for further service development. Discussion: Implementation in early intervention in psychosis services is challenging but feasible. Attention needs to be directed towards establishing and maintaining a culture of trauma-informed care, to support effective case management and access to trauma-focused therapy.

49. The provision of educational and employment focused interventions in early detection for psychosis services within the South London catchment area

Authors Tognin S.; Grady L.; Spencer T.
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Abstract Early Detection for Psychosis Services such as Outreach and Support in South London (OASIS) have been successful in providing psychological intervention and psychosocial support to young people experiencing early signs of psychosis. Despite this, studies have repeatedly shown that vocational and functional recovery in the clinical high risk for psychosis population are still dramatically low. The recent UK National Audit for Schizophrenia highlighted substantial variations in service delivery of vocational support with over half of service users not having their vocational needs met. Therefore, the aim of this project is to evaluate the presence and quality of educational and employment focused interventions within the OASIS services, in order to inform future research and interventions focused on supporting young people with early signs of psychosis in their path to vocational recovery. The specific objectives are to compare current practice (i) to standards defined by the National Institute of Care Excellence (NICE) guidelines; and (ii) to principles defined by Individual Placement and Support (IPS), the most evidence-based vocational support approach. The OASIS caseload electronic records are screened. Data collected include sociodemographic general characteristics, assessment of employment and educational status and support needs, interventions received, contacts with schools, employers and external vocational providers, employment and educational status at the end of service provision. Data is analysed using t-tests and chisquares. Preliminary results suggest that the NICE standards of practice and IPS principles are partially met. Identifying weak areas in current practice is fundamental to provide clear guidance and inform future interventions.

50. A simple care bundle to reduce unplanned admission rate for day case pediatric circumcision

Authors Stoeter D.J.; Roberts S.
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Available at Pediatric Anesthesia 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: An electronic review of unplanned day case admission rates in our hospital demonstrated an average annual rate for pediatric circumcision of 2%-3% in recent years with high levels of perioperative strong opiate use. This lay above target unplanned admission rates (<2%) set out by the Royal College of Anaesthetists for day case surgery. A targeted quality improvement initiative was undertaken to improve patient flow through the pediatric day case surgery unit for elective circumcision. Among the reasons for unplanned admission, factors modifiable by the anesthetist (pain, postoperative nausea and vomiting, somnolence) are significant contributors. Methods: A prospective audit was undertaken over a 3-month period. Our practice was compared with evidence-based analgesic and antiemetic interventions in accordance the Association of Paediatric Anaesthetists of Great Britain and Ireland. Perioperative strong opiate administration rates occurred in 44% of cases. Four strategic interventions were selected based on quality of evidence, ease of implementation, and low cost: selection of higher concentration local anesthetic use for penile blocks, intravenous dexamethasone, and preoperative paracetamol combined with maximum dose nonsteroidal anti-inflammatory. Results: The audit was duplicated a year later demonstrating a significant increase in application of these interventions with a parallel fall in strong opiate use from 44% to 9% and an unprecedented zero unplanned admission rate in our unit for 10 months in a row after implementation. Conclusion: Regular scrutiny of patient electronic data helps identify high impact areas for audit and intervention. Unplanned admission in pediatric day case surgery is an area amenable to such targeted intervention.

51. National hospital mortality surveillance system: A descriptive analysis

Authors Cecil E.; Bottle A.; Aylin P.P.; Wilkinson S.; Esmail A.; Vincent C.
Source BMJ Quality and Safety; 2018
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Publication Type(s) Article In Press
Database EMBASE
Available at BMJ quality & safety from BMJ Journals - NHS

Abstract Objective: To provide a description of the Imperial College Mortality Surveillance System and subsequent investigations by the Care Quality Commission (CQC) in National Health Service (NHS) hospitals receiving mortality alerts. Background: The mortality surveillance system has generated monthly mortality alerts since 2007, on 122 individual diagnosis and surgical procedure groups, using routinely collected hospital administrative data for all English acute NHS hospital trusts. The CQC, the English national regulator, is notified of each alert. This study describes the findings of CQC investigations of alerting trusts. Methods: We carried out (1) a descriptive analysis of alerts (2007-2016) and (2) an audit of CQC investigations in a subset of alerts (2011-2013). Results: Between April 2007 and October 2016, 860 alerts were generated and 76% (654 alerts) were sent to trusts. Alert volumes varied over time (range: 40-101). Septicaemia (except in labour) was the most commonly alerting group (11.5% alerts sent). We reviewed CQC communications in a subset of 204 alerts from 96 trusts. The CQC investigated 75% (154/204) of alerts. In 90% of these pursued alerts, trusts returned evidence of local case note reviews (140/154). These reviews found areas of care that could be improved in 69% (106/154) of alerts. In 25% (38/154) trusts considered that identified failings in care could have impacted on patient outcomes. The CQC investigations resulted in full trust action plans in 77% (118/154) of all pursued alerts. Conclusion: The mortality surveillance system has generated a large number of alerts since 2007. Quality of care problems were found in 69% of alerts with CQC investigations, and one in four trusts reported that failings in care may have an impact on patient outcomes. Identifying whether mortality alerts are the most efficient means to highlight areas of substandard care will require further investigation.

52. Audit of COPD exacerbations in secondary care

Authors anonymous
Source Drug and Therapeutics Bulletin; 2018
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Database EMBASE
Available at Drug and therapeutics bulletin 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 Drug and therapeutics bulletin from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract Review of: Review of: Stone RA et al. COPD: working together. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: clinical audit of COPD exacerbations admitted to acute hospitals in England and Wales. 2017. National Clinical Audit Report. London. RCP, April 2018.

53. The acute medical unit model: A characterisation based upon the National Health Service in Scotland

Authors Reid L.E.M.; Pretsch U.; Jones M.C.; Lone N.I.; Weir C.J.; Morrison Z.
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Abstract Background Acute medical units (AMUs) receive the majority of acute medical patients presenting to hospital as an emergency in the United Kingdom (UK) and in other international settings. They have emerged as a result of local service innovation in the context of a limited evidence base. As such, the AMU model is not well characterised in terms of its boundaries, patient populations and components of care. This makes service optimisation and development through strategic resource planning, quality improvement and research challenging. Aim This study aims to evaluate a national set of AMUs with the intent of characterising the AMU model. Methods Twenty-nine AMUs in Scotland were identified. Data were collected by semi-structured interviews with multidisciplinary healthcare professionals working in each AMU. A draft report was produced for each unit and verified by a unit representative. The unit reports were then analysed to develop a conceptual framework of key components of AMUs and a service definition of the boundaries of acute medical care. Results Acute medical care in Scotland can be described as being delivered in medical services degree rather than geographically distinct AMUs. Twelve key components of AMU care were identified: Care areas, functions, populations, patient flow, support services, communication, nurse care, allied healthcare professional care, non-consultant medical care, consultant care, patient assessment and specialty care. Discussion This empirically derived characterisation of the AMU model is likely to be of utility to practitioners, managers, policy makers and researchers: It is relevant on an operational level, will aid quality improvement and is a foundation to needed further research into how best to deliver care in AMUs. This is important given the central role AMUs play in the journey of the majority of patients presenting to hospital acutely in Scotland, the UK and internationally.

54. The effectiveness of high-intensity CBT and counselling alone and following low-intensity CBT: A reanalysis of the 2nd UK National Audit of Psychological Therapies data 11 Medical and Health Sciences 1103 Clinical Sciences

Authors Barkham M.; Saxon D.
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Available at BMC psychiatry from EBSCO (MEDLINE with Full Text)

Abstract Background: A previously published article in this journal reported the service effects from 103 services within the UK Improving Access to Psychological Therapies (IAPT) initiative and the comparative effectiveness of CBT and Counselling provision. All patients received High-intensity CBT or High-intensity Counselling, but some also received Low-intensity CBT before being stepped-up to High intensity treatments. The report did not distinguish between patients who received low-intensity CBT before being stepped-up. This article clarifies the basis for collapsing low- and high-intensity interventions by analysing the four treatment conditions separately. Method: Data from 33,243 patients included in the second round of the National Audit of Psychological Therapies (NAPT) were re-analysed as four separate conditions: High-intensity CBT only (n = 5975); High-intensity Counselling only (n = 3003); Low-intensity CBT plus High-intensity CBT (n = 17,620); and Low-intensity CBT plus High-intensity Counselling (n = 6645). Analyses considered levels of pre-post therapy effect sizes (ESs), reliable improvement (RI) and reliable and clinically significant improvement (RCSI). Multilevel modelling was used to model predictors of outcome, namely patient pre-post change on PHQ-9 scores at last therapy session. Results: Significant differences obtained on various outcome indices but were so small they carried no clinical significance. Including the four treatment groups in a multilevel model comprising patient intake severity, patient ethnicity and number of sessions attended showed no significant differences between the four treatment groups. Comparisons between the two high-intensity interventions only (N = 8978) indicated Counselling showed more improvement than CBT by 0.3 of a point on PHQ-9 for the mean number of sessions attended. However, this result was moderated by the number of sessions and for 12 or more sessions, the advantage went to CBT. Conclusions: This re-analysis showed no evidence of clinically meaningful differences between the four treatment conditions using standard indices of patient outcomes. However, a differential advantage to high-intensity Counselling for fewer than average sessions attended and high-intensity CBT for more than average sessions attended has important service implications. The finding of equivalent outcomes between high-intensity CBT and Counselling for more severe patients also has important policy implications. Empirically-informed procedures (e.g., predictive modelling) for assigning patients to interventions need to be considered to improve patient outcomes.

55. Can the completeness of radiological cancer staging reports be improved using proforma reporting? A prospective multicentre non-blinded interventional study across 21 centres in the UK

Authors Patel A.; Rockall A.; Brown G.; Guthrie A.; Gleeson F.; Worthy S.; Grubnic S.; Burling D.; Allen C.; Padhani A.; Carey B.; Cavanagh P.; Peake M.D.
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Available at BMJ open from HighWire - Free Full Text
Abstract Objectives Following a diagnosis of cancer, the detailed assessment of prognostic stage by radiology is a crucial determinant of initial therapeutic strategy offered to patients. Pretherapeutic stage by imaging is known to be inconsistently documented. We tested whether the completeness of cancer staging radiology reports could be improved through a nationally introduced pilot of proforma-based reporting for a selection of six common cancers. Design Prospective interventional study comparing the completeness of radiology cancer staging reports before and after the introduction of proforma reporting. Setting Twenty-one UK National Health Service hospitals. Participants 1283 cancer staging radiology reports were submitted. Main outcome measures Radiology staging reports across the six cancers types were evaluated before and after the implementation of proforma-based reporting. Report completeness was assessed using scoring forms listing the presence or absence of predetermined key staging data. Qualitative data regarding proforma implementation and usefulness were collected from questionnaires provided to radiologists and end-users. Results Electronic proforma-based reporting was successfully implemented in 15 of the 21 centres during the evaluation period. A total of 787 preproforma and 496 postproforma staging reports were evaluated. In the preproforma group, only 48.7% (5586/11 470) of key staging items were present compared with 87.3% (6043/6920) in the postproforma group. Thus, the introduction of proforma reporting produced a 78% improvement in staging completeness. This increase was seen across all cancer types and centres. The majority of participants found proforma reporting improved cancer reporting quality for their clinical practice. Conclusion The implementation of proforma reporting results in a significant improvement in the completeness of cancer staging reports. Proforma-based assessment of cancer stage enables objective comparisons of patient outcomes across centres. It should therefore become an auditable quality standard for cancer care.

56. The effect of parental drinking on alcohol use in young adults: the mediating role of parental monitoring and peer deviance

Authors Mahedy L.; MacArthur G.J.; Hammerton G.; Macleod J.; Hickman M.; Heron J.; Edwards A.C.; Kendler K.S.; Moore S.C.
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Available at Addiction from Unpaywall

Abstract BACKGROUND AND AIMS: Evidence demonstrating an association between parental alcohol use and offspring alcohol use from robust prospective studies is lacking. We tested the direct and indirect associations between parental and young adult alcohol use via early alcohol initiation, parental monitoring and associating with deviant peers.DESIGN: Prospective birth cohort study. Path analysis was used to assess the possible association between parental alcohol use (assessed at 12 years) and alcohol use in young adults (assessed at 18 years) via potential mediators (assessed at 14 and 15.5 years, respectively).SETTING: South West England.PARTICIPANTS: Data were available on 3785 adolescents and their parents from the Avon Longitudinal Study of Parents and Children.MEASUREMENTS: The continuous Alcohol Use Disorders Identification Test (AUDIT) score was used as the primary outcome measure. Maternal alcohol use was defined as light (< 4 units on any day), moderate (>= 4 units on 1-3 days) and high-risk (>= 4 units on >= 4 days in 1 week). Partner alcohol use was also defined as light, moderate and high risk. Socio-economic variables were included as covariates.FINDINGS: There was strong evidence of a total effect from maternal alcohol use to young adult alcohol use [moderate: b = 1.07, 95% confidence interval (CI) = 0.64, 1.49, P < 0.001; high risk: b = 1.71, 95% CI = 1.07, 2.35, P < 0.001]. The majority of this association was explained through early alcohol initiation (moderate: b = 0.14, 95% CI = 0.04, 0.25, P = 0.01; high risk: b = 0.24, 95% CI = 0.07, 0.40, P < 0.01) and early alcohol initiation/associating with deviant peers (moderate: b = 0.06, 95% CI = 0.02, 0.10, P < 0.01; high risk: b = 0.10, 95% CI = 0.03, 0.16, P < 0.01). There was strong evidence of a remaining direct effect (moderate: b = 0.81, 95% CI = 0.39, 1.22, P < 0.001; high risk: b = 1.28, 95% CI = 0.65, 1.91, P < 0.001). A similar pattern of results was evident for partner alcohol use.CONCLUSIONS: Young adults whose parents have moderate or high-risk alcohol consumption are more likely to consume alcohol than those with parents with lower alcohol consumption. This association appears to be partly accounted for by earlier alcohol use initiation and higher prevalence of association with deviant peers.
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57. Koronerskaia autopsiia v Velikobritanii: problemy kachestva issledovanii, standartizatsii, audita, finansirovaniia i puti ikh resheniiaThe coroner's autopsies in the Great Britain: the problems related to the quality of the studies, standardization, auditing, financial support and the approaches to their solution

Authors Makarov I.Y.; Kuprina T.A.; Fetisov V.A.; Minaeva P.V.
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58. The use of naltrexone in pathological and problem gambling: A UK case series

Authors Ward S.; Smith N.; Bowden-Jones H.
Source Journal of Behavioral Addictions; 2018; vol. 7 (no. 3); p. 827-833
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PubMedID 30238780
Database EMBASE
Available at Journal of behavioral addictions from Europe PubMed Central - Open Access

Abstract Background and aims: To investigate the potential indications and adverse effects of using the opioid antagonist naltrexone to treat problem gamblers. Case presentation: The files of the 1,192 patients who were referred to the National Problem Gambling Clinic between January 2015 and June 2016 were audited. Seventeen patients were considered appropriate for treatment with naltrexone, having attended and failed to respond to psychological therapies at the clinic. Fourteen patients were placed on a regimen of 50 mg/day naltrexone. Discussion: Of the 14 patients who were treated with naltrexone, there were 10 for whom sufficient follow-up existed to analyze the treatment efficacy and side effects of naltrexone. Patients showed significant decreases in their craving to gamble and the majority (60%) were able to abstain completely from gambling in the treatment period, with a further 20% reducing their gambling to almost nothing. The reported side effects from the naltrexone included: Loss of appetite, gastrointestinal pain, headaches, sedation, dizziness, and vivid dreams. Two patients with concurrent alcohol-use disorder relapsed during the treatment. One patient relapsed after the treatment period. Conclusions: The study showed significant outcomes in reducing gambling cravings for the sample set. Given the design of the study as a case series, there was no control group, and a number of patients were on other psychotropic medications. We recommend care when prescribing to those suffering from concurrent alcohol-use disorder.
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59. Impact of the introduction of a universal childhood influenza vaccination programme on influenza-related admissions to paediatric intensive care units in England

Authors Hardelid P.; Gilbert R.; Kapetanstrataki M.; Norman L.; Fleming S.J.; Parslow R.C.; Lister P.
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Available at BMJ Open Respiratory Research from HighWire - Free Full Text
Available at BMJ Open Respiratory Research from Unpaywall
Abstract Introduction A universal childhood influenza vaccination programme was introduced in the UK in September 2013. We examine the impact of the gradual introduction of this programme on influenza-related paediatric intensive care unit (PICU) admission rates in England. Methods We extracted data on all influenza-related admissions to PICUs in England in resident children aged 0-15 years old between October 2003 and March 2017 from the Paediatric Intensive Care Audit Network (PICANet) database. We estimated influenza-associated PICU admission rates per 100 000 children by age group, sex and winter season (October to March), and used Poisson regression models to estimate incidence rate ratios (IRRs) in the winter seasons since the introduction of universal childhood vaccination compared with the two winters before the introduction of the programme (2011-2013). Results We identified 929 influenza-related PICU admissions among 873 children. 48.3% of admissions were among children aged less than 2 years old. The influenza-associated PICU admission rate was 1.32 per 100 000 children (95% CI 1.23 to 1.40). We identified a significant increase in influenza PICU admissions in the winters following the introduction of the universal childhood vaccination programme compared with the winters of 2010/2011-2012/2013 among children aged <5 years old: IRR 1.58 (1.05, 2.37) in children <1 year, 2.71 (1.43, 5.17) in 1 year-olds and 1.98 (1.18, 3.31) in children 2-4 years old. No significant difference was found among children aged 5-15 years. Conclusion The universal childhood influenza vaccination has not yet reduced the influenza-associated burden on PICUs in England during its early phase of introduction. Monitoring of influenza PICU admission rates needs to continue in England to assess the long-term impact of universal paediatric influenza vaccination. Linkage between PICANet and national infection surveillance databases would better enable such monitoring.

60. Self-reported knowledge, correct knowledge and use of UK drinking guidelines among a representative sample of the English population

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

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

61. Pregnancy outcomes in women with antiphospholipid antibodies: Interim results from a single centre cohort study

Authors Schreiber K.; Frishman M.; Breen K.; Cuadrado M.J.; Hunt B.J.
Source Research and Practice in Thrombosis and Haemostasis; Jul 2018; vol. 2 ; p. 202
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Publication Type(s) Conference Abstract
Database EMBASE
Abstract Background: Persisting antiphospholipid antibodies (aPL) are associated with adverse obstetric events including recurrent miscarriage, late fetal loss or early delivery due to pre-eclampsia or placental insufficiency (obstetric APS) and also thrombosis. We are a tertiary referral centre for those with aPL, and have a management protocol for women with aPL during pregnancy & the puerperium with the aim of preventing obstetric complications and maternal thrombosis. Aims: To report the fetal and maternal outcomes from a single centre cohort of 511 pregnancies in 372 women over a period of eight years. Methods: This is an ongoing retrospective observational study registered as an audit. Data was collected from clinic lists of patients attending the pregnancy clinic at the Thrombosis centre of St. Thomas' Hospital in London, UK between Jan 2010 to December 2017. Women persistently positive for aPL were included if pregnancy outcome data was available Results: 511 pregnancies in 372 women were included in the study (Table 1). The overall live birth rate was 79%. Fetal outcomes were as follows: rate of preterm delivery <34 weeks gestation and <37 weeks was 2.5% and 10%, respectively. Birthweight <1500 g and <2500 g was 1% and 11%, respectively. The rate of pregnancy loss at <10 weeks was 14%. Intrauterine death after 24 weeks occurred in 1%. Maternal outcomes were as follows: 5.5% developed pre-eclampsia and 33% had a caesarean section (Table 2). Conclusions: These results from the largest single centre cohort reported show that using our management protocol, nearly 80% of women with aPL had a successful pregnancy outcome. (Table Presented).

62. Real-life bleeding risk of anti-factor Xa direct oral inhibitors; does prothrombin complex concentrate work?

Authors Graham J.; Gupta P.; Badugama B.; Sutton D.; Chandra D.; Sivers R.
Source Research and Practice in Thrombosis and Haemostasis; Jul 2018; vol. 2 ; p. 53
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Abstract Background: Outside of clinical trials, the management of life-threatening bleeding in patients receiving anticoagulation with an anti-factor Xa direct oral inhibitor (Xa-DOAC) (apixaban, rivaroxaban, edoxaban) is currently dependent on non-specific measures. National guidelines suggest consideration of non-activated, 4-factor prothrombin complex concentrate (PCC); with data supporting correction of in vitro clotting studies in healthy human subjects. Aims: This audit of clinical practice at a large UK university teaching hospital aimed to assess the frequency of PCC usage, efficacy and complications in a real-life cohort of patients receiving anticoagulation with a Xa-DOAC. Methods: PCC issue by the transfusion laboratory was recorded prospectively using specific flowcharts designed to aid laboratory decision making and record clinical reasoning. Management was crossed-referenced against electronic clinical records by three individuals; to confirm indication for PCC, anticoagulant, additional PCC required, complications, length of stay and mortality at 30 days. Results: Over a 7-month period PCC was issued for patients receiving Xa-DOAC in 34% of cases (30/89), as off-label Octaplex 50 IU/ kg up to 3000 units. Issue was associated with bleeding in 73% (22/30) and pre-operatively in 27% (8/30). No additional PCC was given. There was a trend towards lower 30 day mortality in patients on Xa-DOAC issued PCC for bleeding; VKA 15/32 (47%) versus Xa-DOAC 7/22 (32%) (P=0.14), although mortality in those with intracerebral haemorrhage was higher; VKA 8/19 (42%) versus Xa-DOAC 6/11 (55%) (P=0.27). There was no thrombosis or DIC noted in patients on Xa-DAOC receiving PCC. Conclusions: The issue of PCC for patients with life-threatening bleeding receiving a Xa-DOAC is a frequent occurrence. Despite being a non-specific reversal agent, real-life clinical data supports non-inferiority to PCC use in patients receiving a VKA. Mortality in both groups remains high.

63. Demonstrating equity of access from the national health service cord blood bank

Authors Ross A.; Parkes G.; Gillibrand R.
Source Stem Cells Translational Medicine; Sep 2018; vol. 7 ; p. 14-15
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Publication Type(s) Conference Abstract
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Abstract Introduction The National Health Service (NHS) Cord Bank was established in 1996 to build an inventory of altruistically donated cord blood units to provide equity of access to all patients eligible for a stem cell transplant. Fixed cord blood collection sites were selected in areas of high black and minority ethnic (BAME) populations, and a performance indicator was set to routinely bank 40%-50% of cord blood units from BAME donors. Objectives The primary aim of this study was to bank at least 40% of donations from BAME donors at each of the six collection sites. To analyze the total nucleated cell count (TNC) of banked BAME donations. The study also aimed to monitor the provision of cord blood transplants to BAME patients. Methods Data are input to National Health Service - Blood and Transplantspecific software from the point of collection through banking to transplantation to ensure a robust audit trail. This data was extracted using a database query and analyzed for both banked cord blood units and for cord units provided for transplant. Data relating to the self-reported donor ethnicity and collection site were extracted and analyzed as a proportion of the whole bank, as a contribution of BAME donors from each collection site, and to ascertain the proportion of BAME donations with a high TNC. Results Banking of at least 40% BAME donations was routinely met. Representation from all groups listed on our donor screen was demonstrated in the collected and banked cord donations. Non- BAME donations comprise the greater proportion of high TNC cord units. Provision of cord blood transplants to BAME patients comprises at least 50% of all transplants provided by the NHS cord blood bank. Discussion The initial strategy to select collection sites in areas of high BAME birth rates has been successful in building an inventory with a high proportion of BAME donations. The value of this has been borne out by the provision of cord transplants to more than 50% BAME patients. Further work to understand any link between the volume and TNC of collected cord blood with ethnicity and subsequently to improve the efficiency of collections from BAME donations is needed to improve the suitability for transplant of an HLA matched cord. Further work to establish the number of patients unable to find a suitably matched stem cell transplant with sufficient cell dose is being undertaken.

64. Improved medical treatment and surgical surveillance of children and adolescents with ulcerative colitis in the United Kingdom

Authors Auth M.K.-K.; Bunn S.K.; Protheroe A.L.; Williams L.J.; Fell J.M.; Muhammed R.; Croft N.M.; Beattie R.M.; Willmott A.; Spray C.; Vadamalayan B.; Rodrigues A.; Puntis J.; Pigott A.J.; Wilson D.C.; Mitton S.; Furman M.; Charlton C.; Chong S.K.F.; Russell R.K.
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Abstract Background: Pediatric ulcerative colitis (UC) presents at an earlier age and increasing prevalence. Our aim was to examine morbidity, steroid sparing strategies, and surgical outcome in children with active UC. Methods: A national prospective audit was conducted for the inpatient period of all children with UC for medical or surgical treatment in the United Kingdom (UK) over 1 year. Thirty-two participating centers recruited 224 children in 298 admissions, comparisons over 6 years were made with previous audits. Results: Over 6 years, recording of Paediatric Ulcerative Colitis Activity Index (PUCAI) score (median 65)(23% to 55%, P < 0.001), guidelines for acute severe colitis (43% to 77%, P < 0.04), and ileal pouch surgery registration (4% to 56%, P < 0.001) have increased. Corticosteroids were given in 183/298 episodes (61%) with 61/183 (33%) not responding and requiring second line therapy or surgery. Of those treated with anti-TNFalpha (16/61, 26%), 3/16 (18.8%) failed to respond and required colectomy. Prescription of rescue therapy (26% to 49%, P = 0.04) and proportion of anti-TNFalpha (20% to 53%, P = 0.03) had increased, colectomy rate (23.7% to 15%) was not significantly reduced (P = 0.5). Subtotal colectomy was the most common surgery performed (n = 40), and surgical complications from all procedures occurred in 33%. In 215/224 (96%) iron deficiency anemia was detected and in 51% treated, orally (50.2%) or intravenously (49.8%). Conclusions: A third of children were not responsive to steroids, and a quarter of these were treated with anti-TNFalpha. Colectomy was required in 41/298 (13.7%) of all admissions. Our national audit program indicates effectiveness of actions taken to reduce steroid dependency, surgery, and iron deficiency.

65. National survey of gastric emptying studies in the UK

Authors Notghi A.; Hansrod S.
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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 Aim This study was undertaken to investigate the extent of variation in meals, radiopharmaceuticals and methodology used for gastric emptying studies in the UK. Materials and methods Overall, 178 nuclear medicine departments across the UK were contacted by telephone and the gastric emptying protocol was requested. In all, 128 (72%) performed routine gastric emptying studies; 83 protocols were received. Results Liquid meal gastric emptying: 15 departments performed liquid gastric emptying either as a dual isotope technique (27%) or as a separate test using 99m Tc-diethylenetriamine pentacetic acid (53%) or 99m Tc-colloid (20%). The radiopharmaceutical was administered in a variety of liquid mediums including water, orange juice/squash or milk. Although dynamic acquisition was most often used for liquid gastric emptying (60%), significant number of departments used static images (40%). Solid meal gastric emptying: 99m Tc was the radioisotope most predominantly used for solid meals (98%). 99m Tc-colloid was the most commonly used radiopharmaceutical (38%), followed by macroaggregated albumin (25%) and diethylenetriamine pentacetic acid (23%). Egg-based meals are most popular (59%) followed by porridge (27%) that was also used as an alternative to egg in some departments. Alternative meals (cooked meals, ready meals, All-Bran, Weetabix, etc.) were used in 22% of the surveyed departments. Patient preparation and positioning: There was a wide range in patient preparation and methodology used. Patients fasted between 2 and 12 h for the test. Overall, 55% departments acquire images with patient sitting or standing. Although 45% of the departments acquired images supine, most allowed patients to stand or walk in between the images, and only 22% performed the entire test with patient supine. Acquisition parameters: 58% of departments used intermittent static images with intervals ranging from 5 to 15 min, followed by hourly static images of up to 4 h. Twenty-five per cent of departments used dynamic acquisition images. Seventeen per cent of departments used a combination with early dynamic study followed by static images. Normal ranges: There was a wide variation in the normal ranges used for reporting. Most departments used 50% emptying time to assess gastric function. The maximum normal range values for solid gastric emptying ranged from 60 to 120 min, with four departments relying on the percentage of activity remaining at 4 h (normal<10%). Liquid gastric emptying also had a wide range of values for the normal range. The most commonly used range for liquid gastric emptying was 40-60 min. Conclusion There is a wide variation in radiopharmaceuticals, meals and the methodology used for gastric emptying studies. Solid meal gastric emptying is performed universally by all the departments, while relatively few performed liquid meal gastric emptying. Our survey shows that egg-based meals are most prevalent, followed by a porridge meal. Intermittent static imaging is also the most popular method of imaging. In view of this audit, it would be prudent to establish a protocol for solid meal gastric emptying on the basis of the most commonly used meals and methods that may then be universally acceptable. We propose to undertake a study to establish normal ranges for these meals (egg meal and porridge), using the most accepted imaging methodology in an attempt to establish a standardized normal range and acquisition method for solid gastric emptying studies in the UK.

66. Early screening and treatment of gestational diabetes in high-risk women improves maternal and neonatal outcomes: A retrospective clinical audit

Authors Ryan D.K.; Haddow L.; Ramaesh A.; Kelly R.; Johns E.C.; Denison F.C.; Reynolds R.M.; Dover A.R.
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Abstract Aims: Evidence suggests that screening for gestational diabetes (GDM) occurs too late in pregnancy, when changes in glucose metabolism and fetal growth rates can already be detected. In August 2016 NHS Lothian began screening women with risk factors for GDM during early pregnancy (11-13 weeks). We hypothesised that an earlier identification and treatment of dysglycaemia would improve pregnancy outcomes compared to previous standard care. Methods: We compared management and outcomes for singleton pregnancies with GDM delivering at Royal Infirmary Edinburgh, UK, diagnosed through routine or early screening from 01/01/2015-31/10/2017 (routine screening n = 335, early screening n = 241). Results: Early screening increased the proportion of women diagnosed before 24 weeks' gestation (n = 59/335, 17.6% vs n = 103/241, 42.7%, p < 0.001) but did not change the average monthly rate of diagnosis. Early screening increased the median duration of GDM during pregnancy (71 vs 93 days of gestation, p < 0.001) with no significant changes in the pharmacological management. Early screening improved the primary composite outcome (emergency caesarean section, neonatal hypoglycaemia and macrosomia; n = 138/335, 41.2% vs n = 73/241, 30.3%, adjusted Odds Ratio [95% confidence interval] 0.62 [0.43-0.91]. Conclusions: There is a role for early screening and management of GDM however it is unclear whether this represents a cost-effective intervention.

67. Incidence and outcomes for patients with cirrhosis admitted to the United Kingdom Critical Care Units

Authors McPhail M.J.W.; Wendon J.A.; Bernal W.; Parrott F.; Harrison D.A.; Rowan K.A.

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

Abstract Objective: To assess the epidemiology and outcome of patients with cirrhosis following critical care unit admission. Design: Retrospective cohort study. Setting: Critical care units in England, Wales, and Northern Ireland participating in the U.K. Intensive Care National Audit and Research Centre Case Mix Programme. Patients: Thirty-one thousand three hundred sixty-three patients with cirrhosis identified of 1,168,650 total critical care unit admissions (2.7%) admitted to U.K. critical care units between 1998 and 2012. Interventions: None. Measurements and Main Results: Ten thousand nine hundred thirty-six patients had alcohol-related liver disease (35%). In total, 1.6% of critical care unit admissions in 1998 had cirrhosis rising to 3.1% in 2012. The crude critical care unit mortality of patients with cirrhosis was 41% in 1998 falling to 31% in 2012 ($p < 0.001$). Crude hospital mortality fell from 58% to 46% over the study period ($p < 0.001$). Mean(sd) Acute Physiology and Chronic Health Evaluation II score in 1998 was 20.3 (8.5) and 19.5 (7.1) in 2012. Mean Acute Physiology and Chronic Health Evaluation II score for patients with alcohol-related liver disease in 2012 was 20.6 (7.0) and 19.0 (7.2) for non-alcohol-related liver disease ($p < 0.001$). In adjusted analysis, alcohol-related liver disease was associated with increased risk of death (odds ratio, 1.51 [95% CI, 1.42-1.62; $p < 0.001$]) with a year-on-year reduction in hospital mortality (adjusted odds ratio, 0.95/yr, [0.94-0.96, $p < 0.001$]). Conclusions: More patients with cirrhosis are being admitted to critical care units but with increasing survival rates. Patients with alcohol-related liver disease have reduced survival rates partly explained by higher levels of organ failure at admission. Patients with cirrhosis and organ failure warrant a trial of organ support and universal prognostic pessimism is not justified.

68. Needle core vs open biopsy for diagnosis of neuroblastoma, a UK survey

Authors Hotonu S.; Elliott M.; Tweddle D.; Losty P.; Gabra H.
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Available at Pediatric Blood & Cancer 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/Objectives: Open (surgical) biopsy has been traditionally utilised for diagnosis of neuroblastoma in the previous UKCCLG protocols. Over the last decade, there has been an increase in the number of centres in the UK and abroad utilising needle core biopsies (NCB). However, there is a lack of knowledge about the current trend for biopsying neuroblastoma in the UK. Design/Methods: An online survey conducted among UK-CCLG surgeons. The data included the type of biopsy (surgical vs needle core), who performed it (surgeon vs radiologist), when NCB: the number of cores and where it was perfomed. In addition, the outcome of the survey was compared to data obtained by a retrospective audit of the current practice of Neuroblastoma biopsy in 19 UK centres, in which data over 12 months period obtained and analysed. Results: Sixteen centres responded to the survey (74% UK response rate) (UK=14, Netherland=1, France=1), 75% performed NCB under image guidance with 70% reported that >5 cores are usually obtained to yield adequate tissues and the gauge of the needle utilised was 14-16 G (74%). 60% are done by the radiologists while 40 % are still done by the paediatric surgeons with the majority (81%) performed at the operating theatre and 20% at the interventional radiology suites. The results of the audit showed that 52% of the biopsies were obtained via NCB vs19% via open surgery with no significant morbidity while in 22% of cases, biopsies were not performed and the diagnosis was achieved via different route (e.g. bone marrow sampling). Conclusions: The current survey reflects the change in practice in the UK regarding the biopsying for neuroblastoma. Both open and NCB appear to yield adequate tissue sampling for diagnosis. Further larger international studies may be useful to provide further guidance for the future neuroblastoma protocols.

69. Cutting it to the core in neuroblastoma biopsy: How many cores are enough?

Authors Hotonu S.; Wood K.; Bown N.; McDonald L.; Losty P.; Campbell-Hewson Q.; Tweddle D.; Gabra H.
Source Pediatric Blood and Cancer; Nov 2018; vol. 65

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Database EMBASE
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Available at Pediatric Blood & Cancer 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/Objectives: Needle core biopsy (NCB) has been increasingly utilised in the diagnosis and biological staging for Neuroblastoma. It has proven to be safe and reliable. However, there is a lack of consensus regarding the gauge of the core needle used and the adequate minimal number of cores which are required to yield adequate tissues for histology and cytogenetics. The aim is to develop UK guidelines for neuroblastoma core needle biopsy including the needle gauge and number of cores required to yield "an adequate biopsy". Design/ Methods: A retrospective audit of the all core biopsies received by the histoPathology and cytogenetics laboratories at the Newcastle University hospitals in the period of 2011-2016. Data included the needle gauge, number of cores received per biopsy, the total length of cores and the final outcome regarding the adequacy of the biopsy for diagnosis of neuroblastoma. Results: A total number of 19 cores per biopsy were received. All cores were performed using 14-16 G needles. The overall adequacy was 74% (n=14). The mean number and length of NCB that yielded adequate diagnosis was 4 cores (range 1-9) and 25 mm (range 4-54 mm) respectively. It appeared that the total length on NCB was more reliable indicator of the adequacy than the number of cores. Our impression that a total cores length of 25-40 mm seemed to be the length of choice. Conclusions: Our study reflects the current practice in a UK Neuroblastoma specialist centre as NCB is the approach of choice. It highlighted that the minimal total length of cores is more important factor that the minimal number of cores. There is a need to have national/International standard guidelines for Neuroblastoma. We propose size 14-16G needle aiming for 6-8 cores with a minimal total cores length of 25-40mm.

70. Audit on the turnaround time reporting of cervical biopsy at a tertiary care hospital

Authors Khalid S.; Zakarneh L.; Wilkinson N.
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Available at Journal of Pathology 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 of Study: NHS Cervical Screening programme (NHSCSP) is one of the successful screening programs in the world and histopathology reporting plays a vital role as the biopsies are the gold standard against which cytological and colposcopic findings are co-related. Hence it's of paramount importance that the turnaround time (TAT) of reporting cervical biopsies is audited regularly and reasons for delays explored, for the efficient functioning of the screening program. According to NHSCSP document 10 and RCPath key performance indicators 80% of the cases would be reported within 7 calendar days and 90% of all cases are reported within 10 calendar days Objectives: 1.To compare the reporting TAT of cervical biopsy specimens to the NHSCSP-KPI standards. 2.To compare the results with the previous audit conducted in 2013 (Jan-March) Methods: The biopsies received in the department from 01/04/2017 to 30/06/2017 were retrieved from the computer assisted search using the SNOMED codes for Cervix and Gynaecological biopsy. The TAT was calculated as calendar days from the receipt of the specimen to the authorisation of reports. Summary of results: 274 biopsies were retrieved using this method.9 cases were excluded(n=265).The average turnaround time was 5.9 calendar days (Range: 2-23 days) in comparison to 6.03 calendar days in 2013.The TAT was <=7 days in 221 cases (83%) compared to 233 cases (74%) in 2013. The TAT was >7 days in 44 cases (17%).The TAT was <10 days in 249 cases (93%).The reasons behind the delays were also looked into and showed that in 14 cases (32%) extra levels and immunohistochemistry was required, 6 cases (14%) were delayed because of long bank holiday weekend and no explanation could be found in 24 cases (54%) Conclusion: The TAT was compliant with KPI standards in the current audit with reporting of 83% (80%) cases and 93% (90%) cases within 7 and 10 days respectively.

71. Scene findings pointing towards suspected suicidal venous air embolism: A difficult autopsy diagnosis to make

Authors Johnson G.A.
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Publication Date Sep 2018
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Database EMBASE

Available at Journal of Pathology 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 routine autopsy rate in the UK is declining, likely as a result of mounting financial pressures and improvements in medical technology making more accurate clinical diagnoses. With the threshold to refer a case for post mortem (PM) examination being raised, there is a higher concentration of more complicated cases coming to the PM room. Whilst the pathology in many of these cases is obvious through thorough examination, other cases are not, and rely heavily on the information coming to the pathologist regarding the circumstances surrounding a death. Here we present one such case, where the autopsy findings provided no obvious cause of death, but retrospective analysis of the scene photographs pointed heavily towards a diagnosis of sudden death secondary to venous air embolism (AE). The photographs showed that the deceased had targeted a large dilated varicosity overlying the saphenous vein, which had collapsed and was no longer visible at the time of autopsy. This case supports a previous audit conducted in our department which evaluated the importance of scene photography in routine coronial practice. One of the key findings of this audit was that scene photography is taken in up to about one third of routine, non-suspicious cases, but this is not always made clear to the pathologist. As a consequence the scene photographs are not viewed and important information concerning the scene can be missed. With conflicting opinions in the literature, diagnosing an AE at autopsy remains challenging. We discuss the promises and pitfalls of radiological versus dissection techniques, but suggest that having a high index of suspicion for AE is centrally important. This is of particular value where the cause of death appears obscure or where there are incised wounds to the skin that could be associated with venous damage.

72. An audit of the quality of pathology reporting for colorectal cancer resections across a population of 5.7 million through the regional bowel cancer improvement programme

Authors Westwood A.C.; Quirke P.; West N.P.; Rossington H.
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Available at Journal of Pathology 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 Colorectal cancer (CRC) is the second most common cause of cancer related mortality in the UK. There is significant variation in management and outcomes nationally. The Bowel Cancer Improvement Programme (BCIP) is a regional 5 year study aiming to standardise practice across surgery, pathology, radiology and oncology to improve outcomes across a population of 5.7 million. We aimed to audit the quality of CRC resection pathology reporting in the 16 regional hospitals against the Royal College of Pathologists (RCPath) Dataset. 48 pathologists from 9 hospitals participated by submitting 10 consecutive pre-2018 CRC resection pathology reports, anonymised for both patient and pathologist details. Reports on local excisions, neuroendocrine tumours, and those with no cancer (except complete response to neoadjuvant therapy) were excluded (n=7). A total of 473 reports were audited against the 3rd edition RCPath Dataset for CRC. Overall, macroscopic "core" items were reported in over 95%. The majority of microscopic "core" items such as: tumour type, differentiation and pT stage were included in all reports, however, distance to the circumferential resection margin (CRM) was only reported in 72%. In rectal cancers (n=133), the relationship of tumour to the peritoneal reflection was reported in 99% and the mesorectal grade, distance to dentate line and sphincteric grade in 91%, where applicable. Macroscopic "non-core" items were given in the majority of cases where relevant except mesocolic grade (11%). Microscopic "non-core" items including tumour budding and perineural invasion were infrequently given with the exception of lymphatic invasion (34%).Pathologists across the region are generally excellent at including "core" macroscopic and microscopic items in pathology reports following CRC resection, however, there are some areas that require improvement. Education on the importance of a complete dataset is planned and we will re-audit against the 4th edition later this year.

73. Brief Coping Strategy Enhancement for Distressing Voices: an Evaluation in Routine Clinical Practice

Authors Hayward M.; Edgecumbe R.; Strauss C.; Jones A.-M.; Berry C.
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Abstract BACKGROUND: Hearing voices can be a common and distressing experience. Psychological treatment in the form of cognitive behavioural therapy for psychosis (CBTp) is effective, but is rarely available to patients. The barriers to increasing access include a lack of time for clinicians to deliver therapy. Emerging evidence suggests that CBTp delivered in brief forms can be effective and offer one solution to increasing access.AIMS: We adapted an existing form of CBTp, coping strategy enhancement (CSE), to focus specifically on distressing voices in a brief format. This intervention was evaluated within an uncontrolled study conducted in routine clinical practice.METHOD: This was a service evaluation comparing pre-post outcomes in patients who had completed CSE over four sessions within a specialist out-patient service within NHS Mental Health Services. The primary outcome was the distress scale of the Psychotic Symptoms Rating Scale - Auditory Hallucinations (PSYRATS-AH).RESULTS: Data were available from 101 patients who had completed therapy. A reduction approaching clinical importance was found on the PSYRATS distress scale post-therapy when compared with the baseline.CONCLUSIONS: The findings from this study suggest that CSE, as a focused and brief form of CBTp, can be effective in the treatment of distressing voices within routine clinical practice. Within the context of the limitations of this study, brief CSE may best be viewed as the beginning of a therapeutic conversation and a low-intensity intervention in a stepped approach to the treatment of distressing voices.

74. Associations of transcranial doppler velocity, age, and gender with cognitive function in children with sickle cell anemia in Nigeria

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Source Child Neuropsychology; 2018
Publication Date 2018
Publication Type(s) Article In Press
Database EMBASE
Abstract Children with sickle cell anemia (SCA) have elevated cerebral blood velocity relative to healthy peers. The primary aim of this study was to evaluate the association between cerebral blood velocity, measured by transcranial Doppler (TCD) ultrasound, age, and gender with cognitive function in children with SCA in Nigeria. Eighty-three children (M_{age} = 9.10, SD = 1.90 years; 55% female) with SCA in Nigeria completed cognitive assessments and a TCD ultrasound. The association between TCD velocity and measures of perceptual reasoning (Raven's Progressive Matrices), working memory (WISC-IV Digit Span), and executive planning (Tower of London, TOL) were assessed. Results showed that elevated TCD velocity significantly predicted lower scores on TOL Time Violations and Total Problem-Solving Time when controlling for BMI, hemoglobin level, and parent education, suggesting that TCD velocity is related to the efficiency of executive function. Further, age was negatively related to children's performance on the Ravens Matrices and TOL Total Correct, and boys showed greater deficits on the TOL Total Correct relative to girls. Moderation analyses for gender showed that there was a conditional negative association between TCD velocity and Digit Span for boys, but not for girls. Findings suggest that children with SCA in Nigeria with elevated TCD velocity are at risk for deficits in efficiency of executive planning, and boys with elevated TCD velocity are particularly at increased risk for deficits in auditory working memory. Implications of this study are important for interventions to reduce cerebral blood velocity and the use of TCD in this population.

75. Patient's views of the consent process for groin hernia repair: Use of consent template improves compliance with best practice (Original research)

Authors Khan S.U.; Bowrey D.J.; Williams R.N.; Soh J.Y.; Peleki A.; Waterland P.W.; Muhibullah N.
Source Annals of Medicine and Surgery; Nov 2018; vol. 35 ; p. 67-72
Publication Date Nov 2018
Publication Type(s) Article
Database EMBASE
Available at Annals of Medicine and Surgery from Europe PubMed Central - Open Access

Abstract Background: Informed consent obtained for day case surgery has been historically incomplete. An assessment of consenting practice for groin hernia was performed relative to existing gold standards and patient's perception of the consent process was evaluated with a questionnaire. The aim of the study was to identify areas of improvement to comply with best practice. Methods: A retrospective audit of adult patients undergoing groin hernia repair (June-November 2016) at a tertiary care centre was performed. The same cohort of patients was surveyed with a self-administered questionnaire to identify their view on consenting practice. Results: 113 patients were identified who underwent groin hernia repair during the study period. Pre-printed consent templates-stickers (as opposed to hand-written) were used in 53(47%) cases. In 75(66%) cases, there was complete documentation of the risks and benefits of surgery. 81(72%) patients received information about the full benefits of surgery. 27(23%) patients received partial information and 7(6%) patients had no mention of benefit recorded. Postoperative recovery was fully explained to 85(75%) patients. Use of pre-printed templates ensured 100% documentation compared to handwritten consent forms (risks 37%, benefits 47%, and recovery 53%). Preference for the timing of consent was in clinic (64%), day of surgery (25%). 34(56%) felt the choice for the technique and 22(36%) felt the choice for anaesthesia. Satisfaction was non-significantly better in those consented in clinic (87% versus 76% p = 0.74). 49(80%) felt happy with the overall consent process. 57(93%) felt that they received support and advice. 60(98%) responders felt confidence in the National Health Service and 59(97%) would recommend treatment to family and friends. Conclusions: The use of pre-printed consent and discharge summary templates improve compliance with best practice. Whilst patient preference favours consent in the outpatient clinic, satisfaction levels were high wherever consent was obtained. Patients should have more choice.

76. Reducing variation in leg ulcer assessment and management using quality improvement methods

Authors Dowsett C.; Taylor C.
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Available at Wounds UK 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 NHS is facing significant financial and operational pressures, with services struggling to deliver high-quality care due to increasing demands and limited resources (Dowsett, 2016; McKenna, 2018). Now, more than ever, local and national NHS service leaders and services need to focus on improving the quality of care provided, reducing variation and delivering better-value care (NHS England, 2017). Improving quality is about making healthcare safe, effective, patient-centred, timely, efficient and equitable (Department of Health [DH], 2016). In terms of leg ulcer care, this means ensuring patients receive evidence-based leg ulcer assessments and treatments to ensure their leg ulcer heals in an optimum timeframe and that they have a good experience of their care (Wounds UK, 2016). Improving leg ulcer healing not only benefits the patient but also the health economy with costs reducing when complications are prevented and the patient's leg ulcers heal in a shorter timeframe (NHS RightCare, 2017). This paper outlines a project that focused on improving venous leg ulcer (VLU) assessment and management for housebound patients, using quality improvement (QI) methods.

77. Post-mortem imaging in adults

Authors Smith A.P.; Traill Z.C.; Roberts I.S.
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Available at Diagnostic Histopathology 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 Post-mortem computed tomography (PMCT), offers a non-destructive approach to the investigation of fatal injuries and the diagnosis of deaths from natural causes. Strengths of PMCT include the demonstration of fractures, internal haemorrhage, vascular disease and tumours. Imaging can be combined with minimally invasive techniques in the investigation of deaths secondary to sepsis, metabolic causes and drug toxicity. Unlike traditional invasive autopsy, PMCT creates an observer-independent permanent record of the findings that is amenable to audit, and may be used for courtroom or other demonstration. In the United Kingdom, PMCT is increasingly used as a first line technique in coronial investigation. The cause of death can be ascertained without open autopsy in the majority of cases. The use of PMCT in the UK is driven by religious and cultural objections to invasive autopsy, a shortage of autopsy pathologists and concerns regarding the quality of autopsies. Despite the backing of the Royal Colleges and the Chief Coroner, a number of logistical and financial challenges must be overcome in developing a national service.

78. Insights on assays for blood disorders that have the biggest quality problems

Authors De La Salle B.
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Abstract Quality in laboratory haematology has improved dramatically since the first interlaboratory trials in the 1950s and 1960s highlighted the variation in the results of basic haematology tests such as the measurement of haemoglobin. The drivers for quality improvement are many but fall into three broad categories: professional, technical and political. Professional awareness of quality management and a desire to provide the best service possible for patients has seen laboratory scientists and clinicians pursue a constant cycle of quality improvement in services; advances in laboratory technology and automation have removed many of the sources of error in diagnostic testing, supporting the culture of continuous improvement; oversight bodies, commissioning groups and governments have introduced greater demands for governance in laboratory services, with the demonstration of competence through a robust system of quality assurance against minimum performance standards. As a result, in external quality assessment exercises we have seen, for example, the coefficient of variation for haemoglobin fall from over 15% to approximately 1% since those first trials and, in more recent years, UK NEQAS Haematology has demonstrated a halving of the CV% for the measurement of haemoglobin A2, a key marker for the diagnosis of beta thalassaemia trait. Despite continuous quality improvements, there remain assays within haematology that continue to be associated with quality problems, two of which will be reviewed as part of this presentation, chosen from the repertoire of UK NEQAS Haematology external quality assessment (EQA) programmes. Both relate to the diagnosis of inherited red cell disorders-there will be others in other areas of haematology! The first is haemoglobin A2, which remains an area of concern, despite the improvement in CV% quoted above. Evaluation of recent UK NEQAS Haematology Hb A2 data has shown continued variation in performance both within and between analyser groups, supporting published observations with patients' specimens that the methods for Hb A2 analysis are still not well aligned. This is a concern where a fixed cut-off is used for the identification of beta thalassaemia trait in an antenatal patient, for example as part of a national screening programme algorithm. The quantitation of Hb A2 in UK NEQAS Haematology EQA exercises still fails the available published biological variation criteria. The second area for review is the quantitative assay of the red cell enzyme glucose-6-phosphate dehydrogenase (G6PD), a deficiency of which may cause severe episodes of non-autoimmune haemolytic anaemia. UK NEQAS Haematology EQA data has again shown a wide range of results returned and a varied approach to laboratory practice for this assay. Although in some countries DNA techniques may be an option for the diagnosis of these blood disorders, such an approach is not practical or cost-effective in all situations and all countries. The establishment of metrological traceability through the development of a certified reference material has been identified as a key component in the improvement of Hb A2 quantitation; however, the very small differences in Hb A2 between the normal and the beta thalassaemia carrier state will still pose diagnostic challenges in the borderline region requiring the added value of expert interpretation of the results in the context of the case background.

79. Important issues in providing quality service in hematology labs

Authors De La Salle B.
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Abstract Quality in laboratory haematology has improved dramatically since the first interlaboratory trials in the 1950s and 1960s highlighted the variation in the results of basic haematology tests such as the measurement of haemoglobin. The drivers for quality improvement are many but fall into three broad categories: professional, technical and political. Professional awareness of quality management and a desire to provide the best service possible for patients has seen laboratory scientists and clinicians pursue a constant cycle of quality improvement in services; advances in laboratory technology and automation have removed many of the sources of error in diagnostic testing, supporting the culture of continuous improvement; oversight bodies, commissioning groups and governments have introduced greater demands for governance in laboratory services, with the demonstration of competence through a robust system of quality assurance against minimum performance standards. As a result, in external quality assessment exercises we have seen, for example, the coefficient of variation for haemoglobin fall from over 15% to approximately 1% since those first trials and, in more recent years, UK NEQAS Haematology has demonstrated a halving of the CV% for the measurement of haemoglobin A2, a key marker for the diagnosis of beta thalassaemia trait. There is much more to providing a quality laboratory haematology service than just keeping the internal quality control in range and the external quality assessment in consensus with your peer group. The professional drivers for quality improvement have resulted in the development of the concept of total quality management and end to end quality monitoring, taking responsibility for quality in laboratory medicine beyond the analytical phase to encompass all factors that might impact on the service provided to end-users. For quality management to be effective it must be possible to define what is meant by quality, to measure the quality of our services and to have effective quality indicators that reflect the needs of our service users and stakeholders. However, quality management may be a doubleedged sword, giving a false sense of security because we are able to 'tick all the right boxes' that appear to demonstrate quality, while allowing the conditions for major errors to develop because they seem too difficult to address. This presentation will look at three areas of topical interest in laboratory haematology, what challenges they pose to the improvement of quality and what effect they have on the service experienced by patients. We are all aware that up to 70% of errors in laboratory medicine are estimated to take place in the pre-analytical phase and the international accreditation standard ISO 15189 requires medical laboratories to have processes for monitoring such errors; experience in the UK, however, has shown that this is a major challenge to laboratories and there is no standard approach to what data is being collected and how. The harmonisation of reference ranges and units of measurement for routine haematology diagnostic investigations seems like a simple and straightforward task in an era of increased patient mobility and globally manufactured laboratory equipment and reagents; however, how many laboratory professionals could say how their organisation's reference range for haemoglobin was derived or what might be defined as 'normal'? Finally, despite the increased emphasis on the governance of large, automated laboratories through quality assurance and audit programmes, the future of many haematology tests would appear to lie in a greater provision of point-of-care or physician's office testing. Can we assure adequate levels of governance and service for patients when tested outside the laboratory and should we even be bothered?

80. The use of naltrexone in pathological and problem gambling: A UK case series

Authors Ward S.; Smith N.; Bowden-Jones H.
Source Journal of behavioral addictions; Sep 2018; vol. 7 (no. 3); p. 827-833
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Abstract BACKGROUND AND AIMS: To investigate the potential indications and adverse effects of using the opioid antagonist naltrexone to treat problem gamblers.CASE PRESENTATION: The files of the 1,192 patients who were referred to the National Problem Gambling Clinic between January 2015 and June 2016 were audited. Seventeen patients were considered appropriate for treatment with naltrexone, having attended and failed to respond to psychological therapies at the clinic. Fourteen patients were placed on a regimen of 50 mg/day naltrexone.DISCUSSION: Of the 14 patients who were treated with naltrexone, there were 10 for whom sufficient follow-up existed to analyze the treatment efficacy and side effects of naltrexone. Patients showed significant decreases in their craving to gamble and the majority (60%) were able to abstain completely from gambling in the treatment period, with a further 20% reducing their gambling to almost nothing. The reported side effects from the naltrexone included: loss of appetite, gastrointestinal pain, headaches, sedation, dizziness, and vivid dreams. Two patients with concurrent alcohol-use disorder relapsed during the treatment. One patient relapsed after the treatment period.CONCLUSIONS: The study showed significant outcomes in reducing gambling cravings for the sample set. Given the design of the study as a case series, there was no control group, and a number of patients were on other psychotropic medications. We recommend care when prescribing to those suffering from concurrent alcohol-use disorder.

81. Audit of Endometrial Cancer Pathology for a Regional Gynaecological Oncology Multidisciplinary Meeting

Authors Spoor E.; Cross P.
Source International Journal of Gynecological Pathology; 2018
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Abstract Endometrial cancer is a common disease, and in England all cancer cases are discussed at a central multidisciplinary meeting (MDT) with pathology review. We reviewed cases discussed/reviewed at a regional Gynecology MDT comparing (i) original referral histology with review histology and (ii) final review histology with the final hysterectomy histology. Cases identified as potentially eligible for the study (n=884) were found over a 4-yr period. This was reduced to 630 due to data and other issues for the primary biopsy review, and to 488 for both biopsy and hysterectomy sample. Cases were classed by agreement by grade/type and compared by clinical management (low grade vs. high grade). Of the original biopsies, central review agreed exactly with 67% and disagreed with 33%. A total of 11.6% of low-grade cancers were upgraded to high grade on review, and 6.1% of high-grade cancers were downgraded. For the biopsy/hysterectomy comparison, this was 72.5% agreement and 27.5% disagreement, with 3.5% upgraded to high from low grade, and 7.5% downgraded from high to low grade. The main areas of significant change was the identification of high-grade serous carcinoma from low-grade endometrial cancers, as well some other high grade types (clear cell and carcinosarcoma) and the confident diagnosis of cancer as opposed to an atypical hyperplasia. Central pathology review for MDT discussion does highlight significant areas of pathologic disagreement that would affect clinical management. The audit highlights that a significant disagreement rate in reporting such material between pathologists may be inescapable, but can be reduced by review.

82. Mis-use of antibiotics in acute pancreatitis: Insights from the United Kingdom's National Confidential Enquiry into patient outcome and death (NCEPOD) survey of acute pancreatitis

Authors Barrie J.; Jamdar S.; Siriwardena A.K.; O'Reilly D.A.; Smith N.; McPherson S.J.
Source Pancreatology; Oct 2018; vol. 18 (no. 7); p. 721-726
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Abstract Background: International guidelines for the management of acute pancreatitis state that antibiotics should only be used to treat infectious complications. Antibiotic prophylaxis is not recommended. The aim of this study was to analyse antibiotic use, and its appropriateness, from a national review of acute pancreatitis. Methods: Data were collected from The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study into the management of acute pancreatitis. Adult patients admitted to hospitals in England and Wales between January and June 2014 with a coded diagnosis of acute pancreatitis were included. Clinical and organisational questionnaires were used to collect data and these submissions subjected to peer review. Antibiotic use, including indication and duration were analysed. Results: 439/712 (62%) patients received antibiotics, with 891 separate prescriptions and 23 clinical indications. A maximum of three courses of antibiotics were prescribed, with 41% (290/712) of patients receiving a second course and 24% (174/712) a third course. For the first antibiotic prescription, the most common indication was "unspecified" (85/439). The most common indication for the second course was sepsis (54/290), "unspecified" was the most common indication for the third course (50/174). In 72/374 (19.38%) the indication was deemed inappropriate by the clinicians and in 72/393 (18.3%) by case reviewers. Conclusions: Inappropriate use of antibiotics in acute pancreatitis is common. Healthcare providers should ensure that antimicrobial policies are in place as part of an antimicrobial stewardship process. This should include specific guidance on their use and these policies must be accessible, adherence audited and frequently reviewed.

83. Interhospital Transport of Critically Ill Children to PICUs in the United Kingdom and Republic of Ireland: Analysis of an International Dataset

Authors Ramnarayan P.; Dimitriades K.; Freeburn L.; Kashyap A.; Dixon M.; Barry P.W.; Claydon-Smith K.; Wardhaugh A.; Lamming C.R.; Draper E.S.
Source Pediatric Critical Care Medicine; Jun 2018; vol. 19 (no. 6)
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Available at Pediatric Critical Care Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objectives: International data on characteristics and outcomes of children transported from general hospitals to PICUs are scarce. We aimed to 1) describe the development of a common transport dataset in the United Kingdom and Ireland and 2) analyze transport data from a recent 2-year period. Design: Retrospective analysis of prospectively collected data. Setting: Specialist pediatric critical care transport teams and PICUs in the United Kingdom and Ireland. Patients: Critically ill children less than 16 years old transported by pediatric critical care transport teams to PICUs in the United Kingdom and Ireland. Interventions: None. Measurements and Main Results: A common transport dataset was developed as part of the Paediatric Intensive Care Audit Network, and standardized data were collected from all PICUs and pediatric critical care transport teams from 2012. Anonymized data on transports (and linked PICU admissions) from a 2-year period (2014-2015) were analyzed to describe patient and transport characteristics, and in uni- and multivariate analyses, to study the association between key transport factors and PICU mortality. A total of 8,167 records were analyzed. Transported children were severely ill (median predicted mortality risk 4.4%) with around half being infants (4,226/8,167; 51.7%) and nearly half presenting with respiratory illnesses (3,619/8,167; 44.3%). The majority of transports were led by physicians (78.4%; consultants: 3,059/8,167, fellows: 3,344/8,167). The median time for a pediatric critical care transport team to arrive at the patient's bedside from referral was 85 minutes (interquartile range, 58-135 min). Adverse events occurred in 369 transports (4.5%). There were considerable variations in how transports were organized and delivered across pediatric critical care transport teams. In multivariate analyses, consultant team leader and transport from an intensive care area were associated with PICU mortality (p = 0.006). Conclusions: Variations exist in United Kingdom and Ireland services for critically ill children needing interhospital transport. Future studies should assess the impact of these variations on long-term patient outcomes taking into account treatment provided prior to transport.

84. A survey of regional anaesthesia use ATA specialist Teaching Hospital in London

Authors Gupta A.; Davis L.; Shah R.; Hayward A.
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Abstract Background and Aims: Regional anaesthesia involves the use of local anaesthetics to block sensations of pain from a large area of the body. These techniques may avoid the use of general anaesthesia and its associated risks and side effects, provide analgesia and facilitate recovery. The Royal Free Hospital is a specialist centre for many surgical specialties that may benefit from regional anaesthesia. The aim of this survey was to assess use of regional anaesthesia over a dedicated period, improve patient care and recovery through the peri-operative period. Methods:We performed a prospective survey during daytime hours (8am-5pm) over twoweeks using a data entry proforma. We recorded howmany surgeries that could have received regional anaesthesia did. Following data assessment, we presented the results at our departmental audit meeting and suggested changes to promote practice. A repeat study was then performed over two weeks this year. Results: A preliminary survey in 2016 revealed 75/135 (56%) surgeries amenable to receive regional anaesthesia did. The repeat period assessed 445 surgeries. 215 (48.3%) were excluded because: Block contraindicated: 22/215 (10.2%); Body part inappropriate: 115/215 (53.5%); Paediatrics: 26/215 (12.1%); Local anaesthetic-only: 52/215 (24.2%). 230 (51.7%) cases were included. Of these, 123 (53.5%) were not blocked because: Anaesthetist preference: 100/123 (81.3%); Delay in theatre efficiency: 23/123 (18.7%). Conclusions: Our survey does not demonstrate an improvement over time. Going forward, we plan to introduce a training event along with a 'Regional Anaesthetist of the Day' to facilitate block insertion. We hope to re-survey practice to see if more patients receive regional anaesthesia.

85. Removing barriers to fascia iliaca compartment blocks in the emergency department- disseminating training improves rates of delivery

Authors Fahmy A.; Ahmad A.; Crane E.; Hicks N.; Greenslade J.A.
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Available at Regional Anesthesia and Pain Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Background and Aims: Annually about 75,000 patients present with a neck of femur (NoF) fracture to a UK Emergency Department (ED). The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommend fascia iliaca compartment Blocks (FIBs) for effective analgesia. This block can be performed in ED by a range of trained staff and can achieve good analgesia with a low risk of systemic side effects. This quality improvement project was performed atWexham Park Hospital between 2017-2018. It aimed to improve the rate of FIB delivery to suitable patients with a fractured NoF. Methods: Patients presenting to ED with a fractured NoF were included in the audit cycles. Their notes were reviewed to a certain FIB rates of delivery. After the first audit cycle agreed interventions focused on broadening FIBs training to junior clinicians and nurse practitioners. This was regularly performed to catch new trainees rotating through orthopaedics or emergency medicine. After the audit cycle was repeated. Results: After the interventions, the rate of FIB delivery increased from 15%, to 55%. In cycle one the clinician performing the block was almost exclusively a Registrar (88%). In contrast, in the second cycle nearly half (44%) of the blocks were performed by more junior medical staff and nurse practitioners. Conclusions: A lack of trained staff in ED was identified as an obstruction to consistent FIB delivery. There was a demonstrable increase FIBs performed in ED after disseminating procedural training. This will remain a focus as the department continues to improve its performance in this area.

86. Peripheral nerve block wrong site blocks: Can we prevent these"never events?

Authors Golhar A.; Spiteri C.; Galitzine S.; Pollard R.; Brogna R.
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Abstract Background and Aims: Performing a unilateral peripheral nerve block (PNB) on the side which is different from the planned surgery is classified by NHS England as a "Never Event", with various safety systems advocated to prevent a wrong site block (WSB). In our tertiary institution, with over 3,500 blocks performed annually, a new "Stop Before You Block" (SBYB) policy involving completion of a thorough 2-people check list before performing a PNB was adopted and implemented in spring 2017, following reported WSBs. Adherence to the policy was then audited. Methods: Two prospective audits of 50 anaesthetic charts with PNBs each were conducted in autumn 2017 and winter 2018 to assess the quality of documenting SBYB checks. Results: The first audit revealed 62% adherence to the SBYB policy. This instigated further training of staff, with emphasis on better teamwork between Anaesthetists and Anaesthetic Assistants prior to block placement. The second audit (some 6months later) showed 90%adherence. However, despite improved compliance, further WSBs occurred during the study period in which the new policy was either not used, or adequately used. Time pressures, operational issues and patient factors were implicated in the errors. Conclusions: Adherence to safety checks according to the institutional"SBYB"policy remains the mainstay of preventative measures for WSBs. Workplace stresseswill always be present, and efforts tominimize these through team support and checking procedures should be perused.Understanding of human factors in avoiding errors is essential.

87. Implementation of a novel continuous scoring system for blunt chest trauma patients to monitor effectiveness of analgesia interventions and improve outcomes in a UK MTC

Authors Qureshi A.; Beckett E.
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Abstract Background and Aims: The Royal Victoria Infirmary is a UK level one trauma centre receiving severe blunt chest trauma patients. The overall mortality in rib fractured patients is approximately 10%, and 13% of these experience complications, primarily respiratory. Regional anaesthetic techniques (paravertebral catheters) are offered to rib fracture patients at our centre. We set out to implement a system to allow us to a) prioritise these pain referrals b) monitor effectiveness of physiotherapy/ analgesic interventions and c) improve overall outcomes of this patient group. In March 2018 we implemented a modified version of a continuous scoring system for chest trauma (PIC Scoring) originally developed by WellSpan York Hospital, York, Pennsylvania, USA (a Level One Trauma Center). Methods: Patients underwent PIC scoring four times daily. This involved recording of: 1. dynamic chest pain score (0-10) 2. inspiratory capacity, assessed against patient specific volumes for ALERT and GOAL 3. cough strength A combined score of 5 or less prompted the nursing team to discuss the patient with a physician to review and arrange for any necessary intervention. Scores were used by pain nurses to assess requirement for regional technique. Results: Published USA data demonstrated reduced lengths of stay, unplanned ICU admissions, pneumonia rates and mortality. PIC scoring is being audited and data from the Trauma Audit Research Network is being collated. Current patient outcomes will be compared to patients prior to implementation to evaluate any change in these outcomes. Conclusions:We anticipate by September 2018wewill be able to demonstrate improvements in aforementioned outcomes as well as respiratory function in those receiving regional anaesthetic techniques. (Figure Presented).

88. Radiation exposure in patients undergoing procedural interventions for pain relief

Authors Misurati M.; Rajdev B.; Puttappa A.
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Abstract Background and Aims: There is an increase in the number of procedures being performed for pain management. Large proportion of patients are subjected to higher and repeated exposure to radiation. There is no National Guidelines for Pain procedures and Radiation exposure in UK. The aims of our audit were to investigate the radiation exposure to patients undergoing Lumbarmedial branch blocks, to measure radiation parameters{Screening time and Dose area product (DAP) values)},to find variation in practice between consultants and compare with published data (reference level). Methods: A retrospective study across 2 hospital sites for 6 months looked at radiation exposure in patients undergoing bilateral L3, L4, L5 medial branch blocks performed by 5 pain consultants (A, B, C, D, E).We took reference value as DAP- 2.5 $Gy.cm^2$ and screening time - 60 sec Results: Data collected from 40 patients showed screening time < 60 seconds in all, DAP <2.5 $Gy.cm^2$ in 32 patients and DAP >2.5 $Gy.cm^2$ in 8 patients. Conclusions: Screening time for 100% of our patients and DAP value for 80% of our patients were below reference level. Our recommendations were to limit radiation exposure in patients to reference values and aim for local guidance until national guidelines available. (Table Presented).

89. Current perioperative use of gabapentinoids, a multi hospital audit-part of gabacute project

Authors James A.P.P.; Kapila R.; Raithatha B.; Bhayani S.; De Souza R.; Alva S.; Rilesh Nanda L.; Chablani M.
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Abstract Background andAims: Gabapentinoids can be used in the multi-modalmanagement of postoperative pain. This audit was part of the national UK multicentre project - GABACUTE, co-ordinated by PAIN TRAIN, which includes trainees interested in pain management. This audit would help us understand and improve the perioperative use of gabapentinoids. Objectives included: - To assess frequency of prescribing perioperative gabapentinoids - To elucidate the beliefs of anaesthetists regarding the benefits and safety of perioperative gabapentinoids Methods: This audit was conducted in four hospitals - Nottingham City, Leicester General, Glenfield and Pilgrim Hospitals, located across the East Midlands region, UK. Patient notes were reviewed in theatre recovery area over two separate 24 hours periods and a survey of the anaesthetistsworking on those two days was also conducted. Results: This audit included 289 patients, undergoing either elective or emergency surgery. Ten (3.4%) patients received pregabalin in the perioperative period. Nine (3.1%) patients received gabapentin perioperatively. 125 anaesthetists were surveyed in this audit, of which 73 (58.4%) were consultants, 39 (31.2%) were anaesthetic trainees, 10 (8%) were SAS doctors and 3 (2.4%) were Physician Assistants. In the survey regarding the reason for not using perioperative gabapentinoids, 59 (47.2%%) anaesthetists quoted unfamiliarity as the reason, 32 (25.6%) - lack of access, 26 (20.8%) - felt there was no benefit, 16 (12.8%) anaesthetists did not use them due to the possibility of sedation. Conclusions: A hospital-based guideline for specialty/surgery specific analgesic pathway which includes the use of gabapentinoids would help in the education and use of gabapentinoids in the perioperative period.

90. Development of a pain management pathway for adults with complex acetabular&pelvic trauma, aquality improvement project in a major trauma centre in London

Authors Ma S.; Ranote P.; Ng L.
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Abstract Background and Aims: Evidence suggests that good acute painmanagement in major trauma improves outcome and the converse is also true. Up to 80% of patients will develop chronic pain, which can be prevented by early analgesic intervention in the acute phase; this is true for both surgical and conservative management. Opioid side-effects will affect the quality of patient experience and should be avoided where possible. Regional anaesthesia offers significant benefit to polytrauma patients including reduction of opioid consumption and associated side-effects. The regional block of choice at our institution is Quadratus Lumborum Block (QLB); neuraxial blocks are avoided to allow examination and monitoring of perineal sensation immediately postoperatively. Methods: We standardised analgesic management based on latest evidence and reviewed audit data in order to formulate a multidisciplinary care pathway. The final pathway was produced over several developmental meetings with surgeons, anaesthetists (trauma & pain specialists with acute pain team), physiotherapists and specialist nurses. (Figure Presented) The pathway was made as a checklist. Processes are ticked when completed which avoids overlooking certain steps in the pathway. Results: Our pathway is outlined in Figure 1. Conclusions: NICE (National Institute for Health&Clinical Excellence) guidance for pelvic fractures was published in February 2016. It doesn't specify analgesic regimes in details nor did it extend to beyond the admission period. This work is novel, as it encompasses the pain management through admission, discharge and follow-up. During follow-up, patients with chronic pain will be identified and managed appropriately. This pathway is currently being used and we anticipate that it will be audited the following spring.

91. Outcome after ultrasound guided thoracic paravertebral in rib fractures: A retrospective analysis of 4 years' practice ATA U.K. Major traumacentre

Authors Womack J.; Goodman B.; Stephens N.; Walker I.; Pearson J.
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Abstract Background and Aims: Rib fractures incur significant pain and morbidity. Ultrasound-guided thoracic paravertebral (PVB) analgesia has been described in the management of rib fractures, but little published evidence exists beyond case studies and small case series. Methods: Patients are managed according to a blunt chest trauma protocol which involves anaesthetic review and consideration of PVB. All PVBs are recorded on a database, which includes complications and reasons for removal. This was retrospectively analysed from the 4 years since inception of the database with corresponding national trauma audit (TARN) data from all patients with rib fractures admitted to our institution. Results: A total of 314 consecutive PVB were received by 290 patients. The following complications were observed; 5 patients (1.5%) received ineffective analgesia, 39 catheters (12%) were unintentionally disconnected, 1 infusion was stopped due to metallic taste, 1 inconsequential pleural puncture.Multivariate regression of TARNoutcome data demonstrates a statistically significant reduction in mortality associated with PVB, but this becomes non-significant as a time-dependent covariate. Conclusions: PVB was a safe and effective treatment for rib fractures, but there is insufficient evidence to confirm a mortality benefit.

92. 'stop before you block' re-audit of practice in a London teaching hospital

Authors Woodham V.; Duraisamy K.; Pawa A.
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Abstract Background and Aims: The Stop Before You Block (SBYB) campaign was started in 2011 after 67 incidences of wrong-sided blocks in the UK over a 15-month period. This constitutes a Never Event according to the National Patient Safety Agency and exposes patients to increased risk of nerve injury, local anaesthetic toxicity and wrong-site surgery. Despite a visible campaign in our hospital, there were two wrong-sided blocks in the last two years. The aim of the audit was to assess departmental compliance with SBYB and measure performance against previous results. Methods: Data was collected prospectively by nursing staff on regional nerve blocks preformed over a 3-month period. Data collected included grade of anaesthetist, type of block and whether steps in SBYB were adhered to. This was compared to data collected in 2016. Results: Data was collected for 100 regional nerve blocks. In 76% (vs 93% in 2016) of cases the operative side was confirmed with the patient and consent form prior to the procedure and in 87% (vs 83%) of cases the anaesthetist visualised and exposed the surgical mark prior to prepping the area. However, only 57% (vs 55%) of anaesthetists paused prior to needle insertion. Conclusions: Despite recent wrong-sided blocks and frequent audit, no new interventions have been introduced and there has been no significant improvement in compliance since the last audit. More needs to be done in order to reduce the risk of preventable patient harm. This may require an alternative approach i.e. Mock Before You Block or devoting further resources to the current campaign.

93. The utility of ICU readmission as a quality indicator and the effect of selection

Authors Maharaj R.; Vlachos S.; Terblanche M.
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Available at Critical Care Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Objectives: Intensive care readmission rates are used to signal quality, yet it is unclear whether they represent poor quality in the transition of care from the ICU to the ward, patient factors, or differences in survival of the initial admission. This study aims to measure the selection effect of surviving the initial ICU admission on readmission rates. Design: Retrospective cohort study of adult patients admitted to ICUs participating in the Case Mix Program database from the Intensive Care National Audit Research Centre. Settings: The study includes 262 ICUs in the United Kingdom. Patients: The study includes 682,975 patients admitted to ICUs between 2010 and 2014. Interventions: None. Measurements and Main Results: The study includes 682,975 patients admitted to ICUs in the United Kingdom. There were 591,710 patients discharged alive, of which 9,093 (1.53%) were readmitted within the first 2 days of ICU discharge. Post-ICU admission hospital mortality and ICU readmission were poorly correlated (r = 0.130). The addition of a selection model resulted in a weaker correlation (r = 0.082). Conclusions: ICU readmission performed poorly as a performance metric. The selection process by which only patients who survive their index admission are eligible for readmission has a significant effect on ICU readmission rankings, particularly the higher ranked ICUs. Failure to consider this selection bias gives misleading signals about ICU performance and leads to faulty design of incentive schemes.

94. Variation in the perioperative care of women undergoing abdominal-based microvascular breast reconstruction in the United Kingdom (The optiFLAPP Study)

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Abstract Introduction: Abdominal-based microvascular breast reconstruction constitutes approximately one-fifth of reconstructions following mastectomy for breast cancer. Enhanced recovery after surgery (ERAS) protocols have been implemented to improve patient care. The aim of this project was to identify variation in the perioperative care of women undergoing microvascular breast reconstruction to inform development of an ERAS protocol. Methods: Surveys were developed for plastic surgeons, anaesthetists and the lead clinician for breast reconstruction at each unit. These assessed most aspects of perioperative care. A team of medical student collaborators was identified. This team created a list of surgeons and anaesthetists in the United Kingdom by unit. REDCap was used to record their responses. Results: Nineteen (19/39, 49%) lead clinicians, 83 (83/134, 62%) plastic surgeons and 71 (71/100, 71%) anaesthetists from units across the UK completed the surveys. Marked variation was identified in the clinician responses when compared with the national and international guidelines. This variation covered many aspects of patient care including antibiotic and fluid prescribing, surgical technique, post-operative care and recording of patient outcomes. Conclusions: The optiFLAPP national practice survey has demonstrated variation in the perioperative care of women undergoing abdominal-based microvascular breast reconstruction. We propose a large prospective audit to assess current protocols and support development of randomised controlled trials.

95. Medicines reconciliation in primary care: A study evaluating the quality of medication-related information provided on discharge from secondary care

Authors Shah C.; Hough J.; Jani Y.
Source European Journal of Hospital Pharmacy; 2018
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Database EMBASE

Abstract Objectives: Medicines reconciliation is an effective way of reducing errors at transitions of care. Much of the focus has been on medicines reconciliation at point of admission to hospital. Our objective was to evaluate medicines reconciliation after discharge from hospital by assessing the quality of information regarding medicines within discharge summaries and determining whether the information provided regarding medicines changes were acted on within 7 days of receiving the discharge information. Methods: A retrospective collaborative evaluation of medicines-related discharge information by Clinical Commissioning Group (CCG) pharmacists using standardised data collection tools. Outcomes of interest included compliance with national minimum standards for medication-related information on discharge summaries, such as allergies, changes to medication regimen, minimum prescription standards, for example, dose, route, formulation and duration, and medicines reconciliation by the primary care team. Data were analysed centrally. Results: 43 CCGs covering each of the four National Health Service regions in England participated in the study and submitted data for 1454 patients and 10 038 prescribed medicines. The majority of medication details were stated in accordance with standards with the exception of indication (11.7% compliance), formulation (60.3% compliance) and instructions of ongoing use (72.5% compliance). Documentation about changes was poor: 1550/3164 (49%) newly started medicines, 186/477 (39%) dose changes and 420/738 (57%) stopped medicines had a reason documented. Changes were not acted on within 7 days of receiving the discharge information for 12.5% of patients. Conclusions: Our evaluation revealed overall good compliance with discharge medication documentation standards, but a number of changes to medicines during hospitalisation were not fully communicated or documented on the discharge summary or actioned in the general practice after discharge.

96. Epidemiology and aetiology of paediatric traumatic cardiac arrest in England and Wales

Authors Vassallo J.; Barnard E.B.G.; Smith J.E.; Webster M.; Lyttle M.D.
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Database EMBASE
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Available at Archives of disease in childhood 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 epidemiology and aetiology of paediatric traumatic cardiac arrest (TCA) in England and Wales. Design: Population-based analysis of the UK Trauma Audit and Research Network (TARN) database. Patients and setting: All paediatric and adolescent patients with TCA recorded on the TARN database for a 10-year period (2006-2015). Measures: Patient demographics, Injury Severity Score (ISS), location of TCA ('prehospital only', 'in-hospital only' or 'both'), interventions performed and outcome. Results: 21 710 paediatric patients were included in the database; 129 (0.6%) sustained TCA meeting study inclusion criteria. The majority, 103 (79.8%), had a prehospital TCA. 62.8% were male, with a median age of 11.7 (3.4-16.6) years, and a median ISS of 34 (25-45). 110 (85.3%) had blunt injuries, with road-traffic collision the most common mechanism (n=73, 56.6%). 123 (95.3%) had severe haemorrhage and/or traumatic brain injury. Overall 30-day survival was 5.4% ((95% CI 2.6 to 10.8), n=7). 'Pre-hospital only' TCA was associated with significantly higher survival (n=6) than those with TCA in both 'pre-hospital and in-hospital' (n=1) - 13.0% (95% CI 6.1% to 25.7%) and 1.2% (95% CI 0.1% to 6.4%), respectively, p<0.05. The greatest survival (n=6, 10.3% (95% CI 4.8% to 20.8%)) was observed in those transported to a paediatric major trauma centre (MTC) (defined as either a paediatric-only MTC or combined adult-paediatric MTC). Conclusions: Survival is possible from the resuscitation of children in TCA, with overall survival comparable to that reported in adults. The highest survival was observed in those with a pre-hospital only TCA, and those who were transported to an MTC. Early identification and aggressive management of paediatric TCA is advocated.

97. Newborn hearing screening protocols and their outcomes: A systematic review

Authors Kanji A.; Khoza-Shangase K.; Moroe N.
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Abstract Objective: To conduct a review of the most current research in objective measures used within newborn hearing screening protocols with the aim of exploring the actual protocols in terms of the types of measures used and their frequency of use within a protocol, as well as their outcomes in terms of sensitivity, specificity, false positives, and false negatives in different countries worldwide. Methods: A systematic literature review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis. Electronic databases such as PubMed, Google Scholar and Science Direct were used for the literature search. A total of 422 articles were identified, of which only 15 formed part of the current study. The 15 articles that met the study's criteria were reviewed. Pertinent data and findings from the review were tabulated and qualitatively analysed under the following headings: country; objective screening and/or diagnostic measures; details of screening protocol; results (including false positive and negative findings, sensitivity and/or specificity), conclusion and/or recommendations. These tabulated findings were then discussed with conclusions and recommendations offered. Results: Findings reported in this paper are based on a qualitative rather than a quantitative analysis of the reviewed data. Generally, findings in this review revealed firstly, that there is a lack of uniformity in protocols adopted within newborn hearing screening. Secondly, many of the screening protocols reviewed consist of two or more tiers or stages, with transient evoked otoacoustic emissions (TEOAEs) and automated auditory brainstem response (AABR) being most commonly used. Thirdly, DPOAEs appear to be less commonly used when compared to TEOAEs. Lastly, a question around routine inclusion of AABR as part of the NHS protocol remains inconclusively answered. Conclusions: There is sufficient evidence to suggest that the inclusion of AABR within a NHS programme is effective in achieving better hearing screening outcomes. The use of AABR in combination with OAEs within a test-battery approach or cross-check principle to screening is appropriate, but the inclusion of AABR to facilitate appropriate referral for diagnostic assessment needs to be systematically studied.

98. Making moisture manageable: Introducing a moisture lesion prescription sticker

Authors Sarkar N.
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Available at Wounds UK 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 Patients receiving critical care often go through a period of critical illness, making their skin vulnerable to moisture damage, which in turn can lead to further tissue deterioration. This moisture damage is identified as moisture-associated skin damage, or a moisture lesion. Within Adult Critical Care at Nottingham University Hospitals NHS Trust, variations in moisture lesion practice were identified. At times there was no prescription in place and the course of treatment did not always reflect the Trust's moisture lesions guideline. Therefore, a moisture lesion sticker was designed to standardise current, best practice. As part of the Plan-Do-Study-Act cycle, the sticker was introducted to an adult critical care clinical area, with an audit carried out 3 months after. Following the audit, the sticker was adapted further to improve its impact in clinical practice. The sticker has been well received and is in the process of being rolled out across the Trust.

99. Improved outcomes for hepatic trauma in England and Wales over a decade of trauma and hepatobiliary surgery centralisation

Authors Barrie J.; Jamdar S.; Iniguez M.F.; Bouamra O.; Jenks T.; Lecky F.; O'Reilly D.A.
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Available at European journal of trauma and emergency surgery : official publication of the European Trauma Society from Unpaywall

Abstract BACKGROUND: Over the last decade trauma services have undergone a reconfiguration in England and Wales. The objective is to describe the epidemiology, management and outcomes for liver trauma over this period and examine factors predicting survival.METHODS: Patients sustaining hepatic trauma were identified using the Trauma Audit and Research Network database. Demographics, management and outcomes were assessed between January 2005 and December 2014 and analysed over five, 2-year study periods. Independent predictor variables for the outcome of liver trauma were analysed using multiple logistic regression.RESULTS: 4368 Patients sustained hepatic trauma (with known outcome) between January 2005 and December 2014. Median age was 34 years (interquartile range 23-49). 81% were due to blunt and 19% to penetrating trauma. Road traffic collisions were the main mechanism of injury (58.2%). 241 patients (5.5%) underwent liver-specific surgery. The overall 30-day mortality rate was 16.4%. Improvements were seen in early consultant input, frequency and timing of computed tomography (CT) scanning, use of tranexamic acid and 30-day mortality over the five time periods. Being treated in a unit with an on-site HPB service increased the odds of survival (odds ratio 3.5, 95% confidence intervals 2.7-4.5).CONCLUSIONS: Our study has shown that being treated in a unit with an on-site HPB service increased the odds of survival. Further evaluation of the benefits of trauma and HPB surgery centralisation is warranted.

100. Pediatric Nurses' Perceptions of Medication Safety and Medication Error: A Mixed Methods Study

Authors Alomari A.; Wilson V.; Solman A.; Bajorek B.; Tinsley P.
Source Comprehensive child and adolescent nursing; Jun 2018; vol. 41 (no. 2); p. 94-110
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Abstract This study aims to outline the current workplace culture of medication practice in a pediatric medical ward. The objective is to explore the perceptions of nurses in a pediatric clinical setting as to why medication administration errors occur. As nurses have a central role in the medication process, it is essential to explore nurses' perceptions of the factors influencing the medication process. Without this understanding, it is difficult to develop effective prevention strategies aimed at reducing medication administration errors. Previous studies were limited to exploring a single and specific aspect of medication safety. The methods used in these studies were limited to survey designs which may lead to incomplete or inadequate information being provided. This study is phase 1 on an action research project. Data collection included a direct observation of nurses during medication preparation and administration, audit based on the medication policy, and guidelines and focus groups with nursing staff. A thematic analysis was undertaken by each author independently to analyze the observation notes and focus group transcripts. Simple descriptive statistics were used to analyze the audit data. The study was conducted in a specialized pediatric medical ward. Four key themes were identified from the combined quantitative and qualitative data: (1) understanding medication errors, (2) the busy-ness of nurses, (3) the physical environment, and (4) compliance with medication policy and practice guidelines. Workload, frequent interruptions to process, poor physical environment design, lack of preparation space, and impractical medication policies are identified as barriers to safe medication practice. Overcoming these barriers requires organizations to review medication process policies and engage nurses more in medication safety research and in designing clinical guidelines for their own practice.

Strategy 432448

#	Database	Search term	Results
1	EMBASE	(audit* OR "quality improvement").ti,ab	217423
2	EMBASE	(NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab	309023
3	EMBASE	exp "CLINICAL AUDIT"/	2146
4	EMBASE	exp "UNITED KINGDOM"/	407871
5	EMBASE	exp "NATIONAL HEALTH SERVICE"/	65431
6	EMBASE	(1 OR 3)	217930
7	EMBASE	(2 OR 4 OR 5)	575560
8	EMBASE	(6 AND 7)	19773
9	EMBASE	8 [DT 2018-2018] [Since 18-Sep-2018]	157
10	EMBASE	(audit*).ti,ab	180804
11	EMBASE	(3 OR 10)	181336
12	EMBASE	(7 AND 11)	18283
13	EMBASE	12 [DT 2018-2018]	365