Strategy 432444/8

#	Database	Search term	Results
8	Medline	(((audit* OR "quality improvement*").ti,ab OR exp "CLINICAL AUDIT"/ OR exp "QUALITY IMPROVEMENT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/)) [Since 26-Feb-2019]	41

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Results 41 of 41 results on Medline - (((audit* OR "quality improvement*").ti,ab OR exp "CLINICAL AUDIT"/ OR exp "QUALITY IMPROVEMENT"/) AND ((NHS OR england OR UK OR "united kingdom" OR "national health service").ti,ab OR exp "UNITED KINGDOM"/)) [Since 26-Feb-2019]

1. The London memory service audit and quality improvement programme.

Authors Cook, Laura D; Nichol, Katie E; Isaacs, Jeremy D
Source BJPsych bulletin; Mar 2019 ; p. 1-6
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30898180
Database Medline
Available at BJPsych bulletin from Europe PubMed Central - Open Access
Available at BJPsych 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).

Abstract Aims and methodMemory services have expanded significantly in the UK, but limited performance data have been published. The aim of this programme was to determine variation in London memory services and address this through service improvement projects. In 2016 London memory services were invited to participate in an audit consisting of case note reviews of at least 50 consecutively seen patients. RESULTS: Ten services participated in the audit, totalling 590 patients. Variation was noted in neuroimaging practice, neuropsychology referrals, diagnosis subtype, non-dementia diagnoses, waiting times and post-diagnostic support. Findings from the audit were used to initiate four service improvement projects.Clinical ImplicationsMemory services should consider streamlining pathways to reduce waiting times, implementing pathways for patients who do not have dementia, monitoring appropriateness of neuroimaging, and working with commissioners and primary care to ensure that access to post-diagnostic interventions is consistent with the updated National Institute for Health and Care Excellence (NICE) dementia guideline.Declaration of interestJ.D.I. received an honorarium from Biogen for an advisory board. He has been Principal Investigator in clinical trials sponsored by Roche, Merck and Lupin pharmaceuticals. He was a member of the 2018 NICE dementia clinical guideline committee.

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

Authors Jones, Lorelei; Pomeroy, Linda; Robert, Glenn; Burnett, Susan; Anderson, Janet E; Morris, Stephen; Capelas Barbosa, Estela; Fulop, Naomi J
Source BMJ quality & safety; Mar 2019; vol. 28 (no. 3); p. 198-204
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30381330
Database Medline
Available at BMJ quality & safety from BMJ Journals - NHS

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

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

Authors Engelhardt, T; Ayansina, D; Bell, G T; Oshan, V; Rutherford, J S; Morton, N S; APRICOT Group of the European Society of Anaesthesiology Clinical Trial Network
Source Anaesthesia; Mar 2019; vol. 74 (no. 3); p. 300-311
Publication Date Mar 2019
Publication Type(s) Multicenter Study Journal Article Observational Study
PubMedID 30536369
Database Medline
Available at Anaesthesia from Wiley
Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract The anaesthesia practice in children observational trial of 31,127 patients in 261 European hospitals revealed a high (5.2%) incidence of severe critical events in the peri-operative period and wide variability in practice. A sub-analysis of the UK data was undertaken to investigate differences compared with the non-UK cohort in the incidence and nature of peri-operative severe critical events and to attempt to identify areas for quality improvement. In the UK cohort of 7040 paediatric patients from 43 hospitals, the overall incidence of peri-operative severe critical events was lower than in the non-UK cohort (3.3%, 95%CI: 2.9-3.8 vs. 5.8%, 95%CI: 5.5-6.1, RR 0.57, p < 0.001). There was a lower rate of bronchospasm (RR 0.22, 95%CI: 0.14-0.33; p < 0.001), stridor (RR 0.42, 95%CI: 0.28-0.65; p < 0.001) and cardiovascular instability (RR 0.69, 95%CI: 0.55-0.86; p = 0.001) than in the non-UK cohort. The proportion of sicker patients where less experienced teams were managing care was lower in the UK than in the non-UK cohort (10.4% vs. 20.4% of the ASA physical status 3 and 9% vs. 12.9% of the ASA physical status 4 patients). Differences in work-load between centres did not affect the incidence and outcomes of severe critical events when stratified for age and ASA physical status. The lower incidence of cardiovascular and respiratory complications could be partly attributed to more experienced dedicated paediatric anaesthesia providers managing the higher risk patients in the UK. Areas for quality improvement include: standardisation of serious critical event definitions; increased reporting; development of evidence-based protocols for management of serious critical events; development and rational use of paediatric peri-operative risk assessment scores; implementation of current best practice in provision of competent paediatric anaesthesia services in Europe; development of specific training in the management of severe peri-operative critical events; and implementation of systems for ensuring maintenance of skills.

4. Evaluation of the Collaborative Use of an Evidence-Based Care Bundle in Emergency Laparotomy.

Authors Aggarwal, Geeta; Peden, Carol J; Mohammed, Mohammed A; Pullyblank, Anne; Williams, Ben; Stephens, Timothy; Kellett, Suzanne; Kirkby-Bott, James; Quiney, Nial; Emergency Laparotomy Collaborative
Source JAMA surgery; Mar 2019 ; p. e190145
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30892581
Database Medline
Available at JAMA surgery from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Abstract ImportancePatients undergoing emergency laparotomy have high mortality, but few studies exist to improve outcomes for these patients.ObjectiveTo assess whether a collaborative approach to implement a 6-point care bundle is associated with reduction in mortality and length of stay and improvement in the delivery of standards of care across a group of hospitals.Design, Setting, and ParticipantsThe Emergency Laparotomy Collaborative (ELC) was a UK-based prospective quality improvement study of the implementation of a care bundle provided to patients requiring emergency laparotomy between October 1, 2015, and September 30, 2017. Participants were 28 National Health Service hospitals and emergency surgical patients who were treated at these hospitals and whose data were entered into the National Emergency Laparotomy Audit (NELA) database. Post-ELC implementation outcomes were compared with baseline data from July 1, 2014, to September 30, 2015. Data entry and collection were performed through the NELA.InterventionsA 6-point, evidence-based care bundle was used. The bundle included prompt measurement of blood lactate levels, early review and treatment for sepsis, transfer to the operating room within defined time goals after the decision to operate, use of goal-directed fluid therapy, postoperative admission to an intensive care unit, and multidisciplinary involvement of senior clinicians in the decision and delivery of perioperative care. Change management and leadership coaching were provided to ELC leadership teams.Main Outcome and MeasuresPrimary outcomes were in-hospital mortality, both crude and Portsmouth Physiological and Operative Severity Score for the enumeration of Mortality and morbidity (P-POSSUM) risk-adjusted, and length of stay. Secondary outcomes were the changes after implementation of the separate metrics in the care bundle.ResultsA total of 28 hospitals participated in the ELC and completed the project. The baseline group included 5562 patients (2937 female [52.8%] and a mean [range] age of 65.3 [18.0-114.0] years), whereas the post-ELC group had 9247 patients (4911 female [53.1%] and a mean [range] age of 65.0 [18.0-99.0] years). Unadjusted mortality rate decreased from 9.8% at baseline to 8.3% in year 2 of the project, and so did risk-adjusted mortality from a baseline of 5.3% to 4.5% post-ELC. Mean length of stay decreased from 20.1 days during year 1 to 18.9 days during year 2. Significant changes in 5 of the 6 metrics in the care bundle were achieved.Conclusions and RelevanceA collaborative approach using a quality improvement methodology and a care bundle appeared to be effective in reducing mortality and length of stay in emergency laparotomy, suggesting that hospitals should adopt such an approach to see better patient outcomes and care delivery performance.

5. Routine use of fluoroscopic guidance and up-front femoral angiography results in reduced femoral complications in patients undergoing coronary angiographic procedures: an observational study using an Interrupted Time-Series analysis.

Authors Castle, Emily V; Rathod, Krishnaraj S; Guttmann, Oliver P; Jenkins, Alice M; McCarthy, Carmel D; Knight, Charles J; O'Mahony, Constantinos; Mathur, Anthony; Smith, Elliot J; Weerackody, Roshan; Timmis, Adam D; Wragg, Andrew; Jones, Daniel A

Source Heart and vessels; Mar 2019; vol. 34 (no. 3); p. 419-426

Publication Date Mar 2019

Publication Type(s) Journal Article Observational Study

PubMedID 30264266

Database Medline

Available at Heart and vessels 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 Transradial access is increasingly used for coronary angiography and percutaneous coronary intervention, however, femoral access remains necessary for numerous procedures, including complex high-risk interventions, structural procedures, and procedures involving mechanical circulatory support. Optimising the safety of this approach is crucial to minimize costly and potentially life-threatening complications. We initiated a quality improvement project recommending routine fluoroscopic guidance (femoral head), and upfront femoral angiography should be performed to assess for location and immediate complications. We assessed the effect of these measures on the rate of vascular complications. Data were collected prospectively on 4534 consecutive patients undergoing femoral coronary angiographic procedures from 2015 to 2017. The primary end-point was any access complication. Outcomes were compared pre and post introduction including the use of an Interrupted Time-Series (ITS) analysis. 1890 patients underwent angiography prior to the introduction of routine fluoroscopy and upfront femoral angiography and 2644 post. All operators adopted these approaches. Baseline characteristics, including large sheath use, anticoagulant use and PCI rates were similar between the 2 groups. Fluoroscopy-enabled punctures were made in the 'safe zone' in over 91% of cases and upfront femoral angiography resulted in management changes i.e. procedural abandonment prior to heparin administration in 21 patients (1.1%). ITS analysis demonstrated evidence of a reduction in femoral complication rates after the introduction of the intervention, which was over and above the existing trend before the introduction (40% decrease RR 0.58; 95% CI: 0.25-0.87; P < 0.01). Overall these quality improvement measures were associated with a significantly lower incidence of access site complications (0.9% vs. 2.0%, P < 0.001). Routine fluoroscopy guided vascular access and upfront femoral angiography prior to anticoagulation leads to lower vascular complication rates. Thus, study shows that femoral intervention can be performed safely with very low access-related complication rates when fluoroscopic guidance and upfront angiography is used to obtain femoral arterial access.

6. Paired surveys for patients and physiologists in echocardiography: a single-centre experience.

Authors Roshen, Michael; John, Sophia; Ahmet, Selda; Amersey, Rajiv; Gupta, Sandy; Collins, George
Source Echo research and practice; Mar 2019; vol. 6 (no. 1); p. 1-6
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30540562
Database Medline
Available at Echo research and practice from Europe PubMed Central - Open Access
Abstract The British Society of Echocardiography (BSE) highlights the importance of patient questionnaires as part of the quality improvement process, To this end, we implemented a novel system whereby paired surveys were completed by patients and physiologists for transthoracic echocardiography scans, allowing for parallel comparison of the experiences of service providers and end users. Anonymised questionnaires were completed for each scan by the patient and physiologist for outpatient echocardiographic scans in a teaching hospital. In 26% of the responses, patient found the scans at least slightly painful, and in 24% of scans physiologists were in discomfort. The most common reason given by physiologists for technically difficult or inadequate scans was patient discomfort. In 38% of the scans at least one person (the patient or the physiologist) was in at least some discomfort. Comparative data showed that the scans reported as most painful by patients were also reported by the physiologists as difficult and uncomfortable. In summary, these results demonstrate the feasibility of implementing paired surveys. Patient information leaflets by the BSE and National Health Service (NHS) describe echocardiography as painless but the results here indicate this is not always the case.

7. The impact of a combinatorial digital and organisational intervention on the management of long-term conditions in UK primary care: a non-randomised evaluation.

Authors Lugo-Palacios, David G; Hammond, Jonathan; Allen, Thomas; Darley, Sarah; McDonald, Ruth; Blakeman, Thomas; Bower, Peter
Source BMC health services research; Mar 2019; vol. 19 (no. 1); p. 159
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30866917
Database Medline
Available at BMC health services research from ProQuest (Hospital Premium Collection) - NHS Version
Available at BMC health services research from BioMed Central
Available at BMC health services research from Europe PubMed Central - Open Access
Available at BMC health services research from EBSCO (MEDLINE Complete)
Abstract BACKGROUNDBetter management of long-term conditions remains a policy priority, with a focus on improving outcomes and reducing use of expensive hospital services. A number of interventions have been tested, but many have failed to show benefit in rigorous comparative research. In 2016, the NHS Test Beds scheme was launched to implement and test interventions combining digital technologies and pathway redesign in routine health care settings, with each intervention comprising multiple innovations to better realise benefit from their 'combinatorial' effect. We present the evaluation of one of the NHS Test Beds, which combined risk stratification algorithms, practice-based quality improvement and health monitoring and coaching to improve management of long-term conditions in a single health economy in the north-west of England.METHODSThe NHS Test Bed was implemented in one clinical commissioning group in the north-west of England (patient population 235,800 served by 36 general practices). Routine administrative data on hospital use (the primary outcome) and a selection of secondary outcomes (data from both hospital and primary care) were collected in the intervention site, and from a comparator area in the same region. We used difference-in-differences analysis to compare outcomes in the NHS Test Bed area and the comparator after initiation of the combinatorial intervention.RESULTSTests confirmed the existence of parallel trends in the intervention and comparator sites for hospital outcomes for the period April 2016 to March 2017, and for some of the planned primary care outcomes. Based on 10 months of post-intervention secondary care data and 13 months post-intervention primary care data, we found no significant impact on primary outcomes between the intervention and comparator site, and a significant impact on only one secondary outcome.CONCLUSIONA combinatorial digital and organisational intervention to improve the management of long-term conditions was implemented across a whole health economy, but we found no evidence of a positive impact on health care utilisation outcomes in hospital and primary care.

8. The current status of clinical trials in emergency gastrointestinal surgery: A systematic analysis of contemporary clinical trials.

Authors Milton, Amelia; Drake, Thomas M; Lee, Matthew J
Source The journal of trauma and acute care surgery; Mar 2019; vol. 86 (no. 3); p. 524-531
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30399137

Database Medline
Available at Journal of Trauma and Acute Care Surgery from Ovid (Journals @ Ovid) - Remote Access
Available at Journal of Trauma and Acute Care Surgery from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Abstract BACKGROUNDEmergency gastrointestinal surgery (EGS) conditions represent a significant healthcare burden globally requiring emergency operations that are associated with mortality rates as high as 80%. EGS is currently focused on quality improvement and internal audits, which occurs at a national or local level. An appreciation of what EGS trials are being conducted is important to reduce research wastage and develop coordinated research strategies in surgery. The primary aim of this study was to identify and quantify recent and active trials in EGS. The secondary aim was to identify conditions of interest and which aspects of care were being modified.METHODSA systematic search of WHO, UK, US, Australian, and Canadian trials databases was undertaken using broad terms to identify studies addressing emergency abdominal surgery and specific high-risk diagnoses. Studies registered between 2013 and 2018 were eligible for inclusion. Data on study topic, design, and funding body were collected. Interventions were classified into "perioperative", "procedural", "postoperative", "non-surgical", and "other" categories.RESULTSSearches identified 5603 registered trials. After removal of duplicates, 4492 studies remained and 42 were eligible for inclusion. Almost 50% of trials were located in Europe and 17% (n = 7) in the United States. The most common condition addressed was acute appendicitis (n = 11), with the most common intervention being procedure based (n = 23). Hospital-based funding was the most common funder (n = 30).CONCLUSIONThere is large disparity in the number of surgical trials in emergency surgery, which are primarily focused on high-volume conditions. More research is needed into high-mortality conditions.LEVEL OF EVIDENCESystematic review, level III.

9. Patient perspectives on a national multidisciplinary team meeting for a rare cancer.

Authors Bate, Jessica; Wingrove, Jane; Donkin, Alexandra; Taylor, Rachel; Whelan, Jeremy
Source European journal of cancer care; Mar 2019; vol. 28 (no. 2); p. e12971
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30507003
Database Medline
Available at European journal of cancer care from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at European journal of cancer care from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract Multidisciplinary team meetings (MDTM) provide a regular forum for cancer teams to convene and discuss the diagnostic and treatment aspects of patient care. For some rare cancers, MDTMs may also occur at national level to pool expertise and to ensure more consistent decision-making. One such national MDTM exists in the UK for patients with a diagnosis of Ewing's sarcoma of the bone-the National Ewing's MDT (NEMDT). This study explored the patient perspective of this rare cancer national MDTM using focus group and survey methodology. Study participants used their experience to provide several recommendations: that their views should always inform the decision-making process, these views should be presented by someone who has met them such as a specialist nurse, MDT recommendations should be provided to them in plain English, and tools to improve patient choice and enhance communication should be implemented. These patient-centred recommendations will be used to improve the NEMDT but may be valid to inform quality improvement processes for other similar national panels.

10. Hospital Readmissions Among Post-acute Nursing Home Residents: Does Obesity Matter?

Authors Cai, Shubing; Wang, Sijiu; Mukamel, Dana B; Caprio, Thomas; Temkin-Greener, Helena
Source Journal of the American Medical Directors Association; Mar 2019
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30853424
Database Medline
Available at Journal of the American Medical Directors Association from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVESTo explore profiles of obese residents who receive post-acute care in nursing homes (NHs) and to assess the relationship between obesity and hospital readmissions and how it is modified by individual comorbidities, age, and type of index hospitalizations.DESIGNRetrospective cohort study.SETTING AND PARTICIPANTSMedicare fee-for-service beneficiaries who were newly admitted to free-standing US NHs after an acute inpatient episode between 2011 and 2014 (N = 2,323,019).MEASURESThe Minimum Data Set 3.0 were linked with Medicare data. The outcome variable was 30-day hospital readmission from an NH. Residents were categorized into 3 groups based on their body mass index (BMI): nonobese, mildly obese, moderate-to-severely obese. We tested the relationship between obesity and 30-day readmissions by fixed-effects logit models and stratified analyses by the type of index hospitalization and residents' age.RESULTSForty percent of the identified residents were admitted after a surgical episode, and the rest were admitted after a medical episode. The overall relationship between obesity and readmissions suggested that obesity was associated with higher risks of readmission among the oldest old (≥85 years) residents but with lower risks of readmission among the youngest group (65-74 years). After accounting for individual co-covariates, the association between obesity and readmissions among the oldest old residents became weaker; the adjusted odds ratio was 1.061 (P = .049) and 1.004 (P = .829) for moderate-to-severely obese patients with surgical and medical index hospitalizations, respectively. The protective effect of obesity among younger residents reduced after adjusting for covariates.CONCLUSIONS/RELEVANCEThe relationship between obesity and hospital readmission among post-acute residents could be affected by comorbidities, age, and the type of index hospitalization. Further studies are also warranted to understand how to effectively measure NH quality outcomes, including hospital readmissions, so that policies targeting at quality improvement can successfully achieve their goals without unintended consequences.

11. Human metapneumovirus in paediatric intensive care unit (PICU) admissions in the United Kingdom (UK) 2006-2014.

Authors Barr, Rachael; McGalliard, Rachel; Drysdale, Simon B
Source Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology; Mar 2019; vol. 112 ; p. 15-19
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30669024
Database Medline
Available at Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology 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 BACKGROUNDHuman metapneumovirus (HMPV) is a pneumovirus known to cause respiratory disease in children. It was identified as a pathogen in 2001 and its healthcare burden and associated costs are not fully understood.OBJECTIVESThis study aimed to assess the clinical characteristics of children with HMPV infection admitted to paediatric intensive care units (PICUs) across the United Kingdom (UK) over a nine-year period and to estimate the associated costs of care.STUDY DESIGNData were collected from the UK paediatric intensive care audit network (PICANet) and costs calculated using the National Health Service (NHS) reference costing scheme.RESULTSThere were 114 admissions in which HMPV was detected. The number of admissions associated with a code of HMPV rose steadily over the study period (three in 2006 to 28 in 2014) and showed significant seasonal variability, with the peak season being from November to May. Children required varying levels of intensive care support from minimal to complex support including invasive ventilation, inotropes, renal replacement therapy and extracorporeal membrane oxygenation (ECMO). HMPV was associated with five deaths during the study period. The associated costs of PICU admissions were estimated to be between £2,256,823 and £3,997,823 over the study period, with estimated annual costs rising over the study period due to increasing HMPV admissions.CONCLUSIONSHMPV is associated with a significant healthcare burden and associated cost of care in PICUs in the UK.

12. Preventing Future Deaths from Medicines: Responses to Coroners' Concerns in England and Wales.

Authors Ferner, Robin E; Ahmad, Tohfa; Babatunde, Zainab; Cox, Anthony R
Source Drug safety; Mar 2019; vol. 42 (no. 3); p. 445-451
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30298309
Database Medline
Available at Drug safety from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract INTRODUCTIONCoroners inquire into sudden, unexpected, or unnatural deaths. We have previously established 99 cases (100 deaths) in England and Wales in which medicines or part of the medication process or both were mentioned in coroners' 'Regulation 28 Reports to Prevent Future Deaths' (coroners' reports).OBJECTIVEWe wished to see what responses were made by National Health Service (NHS) organizations and others to these 99 coroners' reports.METHODSWhere possible, we identified the party or parties to whom these reports were addressed (names were occasionally redacted). We then sought responses, either from the UK judiciary website or by making requests to the addressee directly or, for NHS and government entities, under the Freedom of Information Act 2000. Responses were analysed by theme to indicate the steps taken to prevent future deaths.RESULTSWe were able to analyse one or more responses to 69/99 cases from 106 organizations. We analysed 201 separate actions proposed or taken to address the 160 concerns expressed by coroners. Staff education or training was the most common form of action taken (44/201). Some organisations made changes in process (24/201) or policy (17/201), and some felt existing policies were sufficient to address some concerns (22/201).CONCLUSIONSCoroners' concerns are often of national importance but are not currently shared nationally. Only a minority of responses to coroners' reports concerning medicines are in the public domain. Processes for auditing responses and assessing their effectiveness are opaque. Few of the responses appear to provide robust and generally applicable ways to prevent future deaths.

13. Patterns of Use of Heated Humidified High-Flow Nasal Cannula Therapy in PICUs in the United Kingdom and Republic of Ireland.

Authors Morris, Jenny V; Kapetanstrataki, Melpo; Parslow, Roger C; Davis, Peter J; Ramnarayan, Padmanabhan
Source Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies; Mar 2019; vol. 20 (no. 3); p. 223-232
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30395107
Database Medline

Abstract OBJECTIVESTo 1) describe patterns of use of high-flow nasal cannula therapy, 2) examine differences between patients started on high-flow nasal cannula and those started on noninvasive ventilation, and 3) explore whether patients who failed high-flow nasal cannula therapy were different from those who did not.DESIGNRetrospective analysis of data collected prospectively by the Paediatric Intensive Care Audit Network.SETTINGAll PICUs in the United Kingdom and Republic of Ireland (n = 34).PATIENTSAdmissions to study PICUs (2015-2016) receiving any form of respiratory support at any time during PICU stay.INTERVENTIONSNone.MEASUREMENTS AND MAIN RESULTSEligible admissions were classified into nine groups based on the combination of the first-line and second-line respiratory support modes. Uni- and multivariate analyses were performed to test the association between PICU and patient characteristics and two outcomes: 1) use of high-flow nasal cannula versus noninvasive ventilation as first-line mode and 2) high-flow nasal cannula failure, requiring escalation to noninvasive ventilation and/or invasive ventilation. We analyzed data from 26,423 admissions; high-flow nasal cannula was used in 5,951 (22.5%) at some point during the PICU stay. High-flow nasal cannula was used for first-line support in 2,080 (7.9%) and postextubation support in 978 admissions (4.5% of patients extubated after first-line invasive ventilation). High-flow nasal cannula failure occurred in 559 of 2,080 admissions (26.9%) when used for first-line support. Uni- and multivariate analyses showed that PICU characteristics as well as patient age, primary diagnostic group, and admission type had a significant influence on the choice of first-line mode (high-flow nasal cannula or noninvasive ventilation). Younger age, unplanned admission, and higher admission severity of illness were independent predictors of high-flow nasal cannula failure.CONCLUSIONSThe use of high-flow nasal cannula is common in PICUs in the United Kingdom and Republic of Ireland. Variation in the choice of first-line respiratory support mode (high-flow nasal cannula or noninvasive ventilation) between PICUs reflects the need for clinical trial evidence to guide future practice.

14. Risk factors for surgical site infections in neurosurgery.

Authors Patel, S; Thompson, D; Innocent, S; Narbad, V; Selway, R; Barkas, K
Source Annals of the Royal College of Surgeons of England; Mar 2019; vol. 101 (no. 3); p. 220-225
Publication Date Mar 2019
Publication Type(s) Journal Article

PubMedID 30698457
Database Medline
Available at Annals of the Royal College of Surgeons of England from Ovid (Journals @ Ovid) - Remote Access
Available at Annals of the Royal College of Surgeons of England from EBSCO (MEDLINE Complete)
Available at Annals of the Royal College of Surgeons of England from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Annals of the Royal College of Surgeons of England from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract INTRODUCTIONSurgical site infections (SSIs) are of profound significance in neurosurgical departments, resulting in high morbidity and mortality. There are limited public data regarding the incidence of SSIs in neurosurgery. The aim of this study was to determine the rate of SSIs (particularly those requiring reoperation) over a seven-year period and identify factors leading to an increased risk.METHODSAn age matched retrospective analysis was undertaken of a series of 16,513 patients at a single centre. All patients who required reoperation for suspected SSIs within a 7-year period were identified. Exclusion criteria comprised absence of infective material intraoperatively and patients presenting with primary infections. Clinical notes were reviewed to confirm presence or absence of suspected risk factors.RESULTSOf the 16,513 patients in the study, 1.20% required at least one further operation to treat a SSI. Wound leak (odds ratio [OR]: 27.41), dexamethasone use (OR: 3.55), instrumentation (OR: 2.74) and operative duration >180 minutes (OR: 1.85) were statistically significant risk factors for reoperation.CONCLUSIONSThis is the first UK study of such a duration that has documented a SSI reoperation rate in a cohort of this size. Various risk factors are associated with the development of SSIs, making it essential to have robust auditing and monitoring of high risk patients to ensure excellent standards of healthcare. Departmental and public registers to record all SSIs may be beneficial, particularly for those treated solely by general practitioners, allowing units to address potential risk factors prior to surgical intervention.

15. Alcohol Screening and Brief Advice in NHS General Dental Practices: A Cluster Randomized Controlled Feasibility Trial.

Authors Ntouva, Antiopi; Porter, Jessie; Crawford, Mike J; Britton, Annie; Gratus, Christine; Newton, Tim; Tsakos, Georgios; Heilmann, Anja; Pikhart, Hynek; Watt, Richard G
Source Alcohol and alcoholism (Oxford, Oxfordshire); Mar 2019
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Available at Alcohol and alcoholism (Oxford, Oxfordshire) 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 AIMTo assess the feasibility and acceptability of screening for alcohol misuse and delivering brief advice to eligible patients attending NHS dental practices in London.METHODSA two-arm cluster randomized controlled feasibility trial was conducted. Twelve dental practices were recruited and randomized to intervention and control arms. Participants attending for a dental check were recruited into the study and were eligible if they consumed alcohol above recommended levels assessed by the AUDIT-C screening tool. All eligible participants were asked to complete a baseline socio-demographic questionnaire. Six months after the completion of baseline measures, participants were contacted via telephone by a researcher masked to their allocation status. The full AUDIT tool was then administered. Alcohol consumption in the last 90 days was also assessed using the Form 90. A process evaluation assessed the acceptability of the intervention.RESULTSOver a 7-month period, 229 participants were recruited (95.4% recruitment rate) and at the 6 months follow-up, 176 participants were assessed (76.9% retention rate). At the follow-up, participants in the intervention arm were significantly more likely to report a longer abstinence period (3.2 vs. 2.3 weeks respectively, P = 0.04) and non-significant differences in AUDIT (44.9% vs. 59.8% AUDIT positive respectively, P = 0.053) and AUDIT C difference between baseline and follow-up (-0.67 units vs. -0.29 units respectively, P = 0.058). Results from the process evaluation indicated that the intervention and study procedures were acceptable to dentists and patients.CONCLUSIONSThis study has demonstrated the feasibility and acceptability of dentists screening for alcohol misuse and providing brief advice.

16. Awareness of alcohol marketing, ownership of alcohol branded merchandise, and the association with alcohol consumption, higher-risk drinking, and drinking susceptibility in adolescents and young adults: a cross-sectional survey in the UK.

Authors Critchlow, Nathan; MacKintosh, Anne Marie; Thomas, Christopher; Hooper, Lucie; Vohra, Jyotsna
Source BMJ open; Mar 2019; vol. 9 (no. 3); p. e025297
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Abstract OBJECTIVESTo explore awareness of alcohol marketing and ownership of alcohol branded merchandise in adolescents and young adults in the UK, what factors are associated with awareness and ownership, and what association awareness and ownership have with alcohol consumption, higher-risk drinking and susceptibility.DESIGNOnline cross-sectional survey conducted during April-May 2017.SETTINGThe UK.PARTICIPANTSAdolescents and young adults aged 11-19 years in the UK (n=3399).MAIN OUTCOME MEASURESAlcohol Use Disorders Identification Test-Consumption (AUDIT-C) (0-12) and indication of higher-risk consumption (>5 AUDIT-C) in current drinkers. Susceptibility to drink (yes/no) in never drinkers.RESULTSEighty-two per cent of respondents were aware of at least one form of alcohol marketing in the past month and 17% owned branded merchandise. $\chi 2$ tests found that awareness of marketing and ownership of branded merchandise varied within drinking variables. For example, higher awareness of alcohol marketing was associated with being a current drinker ($\chi 2=114.04$, $p<0.001$), higher-risk drinking ($\chi 2=85.84$, $p<0.001$), and perceived parental ($\chi 2=63.06$, $p<0.001$) and peer approval of consumption ($\chi 2=73.08$, $p<0.001$). Among current drinkers, multivariate regressions (controlling for demographics and covariates) found that marketing awareness and owning branded merchandise was positively associated with AUDIT-C score and higher-risk consumption. For example, current drinkers reporting medium marketing awareness were twice as likely to be higher-risk drinkers as those reporting low awareness (adjusted OR (AOR)=2.18, 95% CI 1.39 to 3.42, $p<0.001$). Among never drinkers, respondents who owned branded merchandise were twice as likely to be susceptible to drinking as those who did not (AOR=1.98, 95% CI 1.20 to 3.24, $p<0.01$).CONCLUSIONSYoung people, above and below the legal purchasing age, are aware of a range of alcohol marketing and almost one in five own alcohol branded merchandise. In current drinkers, alcohol marketing awareness was associated with increased consumption and greater likelihood of higher-risk consumption. In never drinkers, ownership of branded merchandise was associated with susceptibility.

17. An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences.

Authors Tyler, Nichola; Miles, Helen L; Karadag, Bessey; Rogers, Gemma
Source Social psychiatry and psychiatric epidemiology; Mar 2019
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30903239
Database Medline

Abstract PURPOSEEpidemiological data on the mental health needs of prisoners are essential for the organisation, planning, and delivery of services for this population as well as for informing policy and practice. Recent reports by the National Audit Office and NICE call for new research to provide an updated picture of the mental health needs of men and women in prison in the UK. This study aimed to measure the prevalence and comorbidity of mental health needs across a representative sample of both men and women across 13 prisons in one UK region.METHODParticipants completed a standardised battery of psychometric assessments which screened for a range of mental health difficulties including: mental disorders, personality disorder, and substance misuse.RESULTS469 participants were included in the final sample (338 males, 131 females). A high number of participants reported having had previous contact with mental health services and/or a pre-existing diagnosis of a mental disorder. High rates of current mental disorder were detected across the range of disorders screened for. Levels of comorbidity were also high, with nearly half of participants screening positive for two or more types of mental disorder. Gender differences were noted in terms of previous contact with mental health services, having a pre-existing diagnosis, prevalence of current mental disorder, and levels of comorbidity; with women reporting higher rates than men.CONCLUSIONSRates of pre-existing and current mental illness continue to be high amongst prisoners. Women report significantly higher levels of mental health need compared to men.

18. Assessing the deprivation gap in stillbirths and neonatal deaths by cause of death: a national population-based study.

Authors Best, Kate E; Seaton, Sarah E; Draper, Elizabeth S; Field, David J; Kurinczuk, Jennifer J; Manktelow, Bradley N; Smith, Lucy K
Source Archives of disease in childhood. Fetal and neonatal edition; Mar 2019
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Available at Archives of Disease in Childhood: Fetal and Neonatal Edition 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 Archives of Disease in Childhood: Fetal and Neonatal Edition 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 OBJECTIVETo investigate socioeconomic inequalities in cause-specific stillbirth and neonatal mortality to identify key areas of focus for future intervention strategies to achieve government ambitions to reduce mortality rates.DESIGNRetrospective cohort study.SETTINGEngland, Wales, Scotland and the UK Crown Dependencies.PARTICIPANTSAll singleton births between 1 January 2014 and 31 December 2015 at ≥24 weeks' gestation.MAIN OUTCOME MEASURECause-specific stillbirth or neonatal death (0-27 days after birth) per 10 000 births by deprivation quintile.RESULTSData on 5694 stillbirths (38.1 per 10 000 total births) and 2368 neonatal deaths (15.9 per 10 000 live births) were obtained from Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK). Women from the most deprived areas were 1.68 (95% CI 1.56 to 1.81) times more likely to experience a stillbirth and 1.67 (95% CI 1.48 to 1.87) times more likely to experience a neonatal death than those from the least deprived areas, equating to an excess of 690 stillbirths and 231 neonatal deaths per year associated with deprivation. Small for gestational age (SGA) unexplained antepartum stillbirth was the greatest contributor to excess stillbirths accounting for 33% of the deprivation gap in stillbirths. Congenital anomalies accounted for the majority (59%) of the deprivation gap in neonatal deaths, followed by preterm birth not SGA (24-27 weeks, 27%).CONCLUSIONSCause-specific mortality rates at a national level allow identification of key areas of focus for future intervention strategies to reduce mortality. Despite a reduction in the deprivation gap for stillbirths and neonatal deaths, public health interventions should primarily focus on socioeconomic determinants of SGA stillbirth and congenital anomalies.

19. The effect of a multidisciplinary co-management program for the older hip fracture patients in Beijing: a "pre- and post-" retrospective study.

Authors Wu, Xinbao; Tian, Maoyi; Zhang, Jing; Yang, Minghui; Gong, Xiaofeng; Liu, Yishu; Li, Xian; Lindley, Richard I; Anderson, Melanie; Peng, Ke; Jagnoor, Jagnoor; Ji, Jiachao; Wang, Manyi; Ivers, Rebecca; Tian, Wei
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Available at Archives of osteoporosis 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 Hip fracture becomes a major public health issue with the growing aging population. This study evaluated a multidisciplinary co-management program for older hip fracture patients and found it significantly improved the best practice indicators. It provided preliminary evidence to support the use of such intervention in hip fracture management.PURPOSE/INTRODUCTIONHip fracture leads to high morbidity and mortality in older people. A previous study found a significant disparity in hip fracture management in Beijing Jishuitan Hospital (JSTH) compared to best practice care in the United Kingdom (UK). Following this audit, JSTH launched a multidisciplinary co-management care plan for older hip fracture patients. This study aims to evaluate the effect of this program on the six standards recommended in the UK hip fracture best practice guidelines.METHODSIn this retrospective study, electronic medical record data were collected before and after the intervention. Eligible patients were aged ≥ 65 years, had X-ray confirmed hip fracture, and were admitted to JSTH within 30 days of injury. Patient demographic information, time from emergency department presentation to admission, time from admission to surgery, pressure ulcers, osteoporosis assessment, and falls prevention were collected. Multivariable logistic and median regression models were used for binary and continuous outcomes respectively. Segment regression was also performed for time-related outcomes.RESULTSA total of 3540 eligible patients were identified. After the intervention, half of the patients who received co-management received surgery within 48 h of ward admission compared to 6.4% previously, 0.3% (vs 1.4%) developed pressure ulcers, and 76% (vs 19%) received osteoporosis assessment. No significant differences were observed in fall assessment rates. However, there was a higher rate of ward admission within 4 h of arrival in emergency for patients admitted pre-intervention (61% vs 34%).CONCLUSIONSThe introduction of the co-management model significantly reduced the time from admission to surgery and improved other practice outcomes. A multicenter randomized controlled trial is needed to evaluate the impact of this model on patient health outcomes.

20. Severity and Outcome Assessment score: a useful tool for auditing orthognathic surgery.

Authors Geddes, A; Laverick, S; McBride, A; McIntyre, G T
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Available at British Journal of Oral and Maxillofacial 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 Many indices and scoring systems exist for assessing skeletal patterns and malocclusion but none have been universally adopted by teams providing orthognathic surgery in the UK. Using a standardised objective measure of a patient's condition is important both for service provision, treatment allocation, and other clinical governance domains. The Severity and Outcome Assessment tool (SOA) developed by the British Orthodontic Society (BOS) and British Association of Oral and Maxillofacial Surgeons (BAOMS) provides a standardised method of assessing patients throughout the orthognathic pathway and lends itself to case selection, resource allocation and auditing treatment outcomes. The SOA uses 7 cephalometric skeletal, dental and soft tissue measures to produce an overall score.The SOA has been used by the current NHS Tayside orthognathic team since August 2006 to audit treatment outcomes. While we recognise that cephalometric analysis forms only one part of orthognathic treatment we believe that having an objective measure on which to assess treatment is useful. We present our experience of using this quick, simple and reproducible tool in auditing orthognathic treatment outcomes.

21. Giant cell arteritis in patients of Indian Subcontinental descent in the UK.

Authors Tan, N; Acheson, J; Ali, N
Source Eye (London, England); Mar 2019; vol. 33 (no. 3); p. 459-463
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Available at Eye (Basingstoke) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDGCA in the Indian Subcontinent (ISC) is rare. Our centre in London, UK, serves an ethnically diverse population, including a significant population of patients of ISC descent. We hypothesise that patients of ISC descent are no less likely than others to present with symptoms suggestive of GCA and therefore to undergo temporal artery biopsy (TAB).METHODA retrospective audit of all TABs performed at our institution over an 8 year period, to identify ethnicity (white, black, ISC, other, unknown) and biopsy result. We compared the proportion of all patients of ISC descent attending the ED to the proportion of ISC patients undergoing TAB. We compared the proportion of positive TABs among ISC patients with positive TABs among white patients. We also compared the proportion of TAB in ISC patients with all non-ISC ethnicities combined.RESULTSThe proportion of patients undergoing TAB who were of ISC descent (16.3% of 92) was comparable to the proportion of A&E attendances made up by ISC patients [p = 0.1339]. 3.8% (1/26) of positive biopsies were among patients of ISC descent. White patients were significantly more likely to have a positive biopsy than patients of ISC ethnicity (33% of 61 white patients vs. 7% of 15 ISC [p = 0.0456]), as were patients of non-ISC ethnicity (32.5% of 77 non-ISC patients vs. 7% of 15 ISC patients [p = 0.0464]).DISCUSSIONAt our centre, biopsy proven GCA occurs in patients of ISC descent, but rarely. Full investigation for GCA continues to be appropriate where it is suspected, regardless of ethnicity.

22. Traumatic Renal injury in a UK Major Trauma Centre - Current Management strategies and the role of early re-imaging.

Authors Aldiwani, M; Georgiades, F; Omar, I; Angel-Scott, H; Tharakan, T; Vale, J; Mayer, E
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Publication Type(s) Journal Article
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Available at BJU international from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVESTo analyse the contemporary management of renal injuries in a UK Major Trauma Centre and to evaluate the utility and value of re-imaging.MATERIALS AND METHODSThe prospectively maintained Trauma Audit and Research Network (TARN) database was interrogated to identify patients with urinary tract injuries between January 2014 and December 2017. Patients' records and imaging were reviewed to identify injury grades, interventions, outcomes and follow up.RESULTSRenal injury was identified in 90 patients. Male to female ratio was 79:11. The average age was 35.5 years (SD 17.4, Range 1.5-94). The majority of renal trauma were caused by blunt mechanisms (74%). The overall severity of injuries were: 18 (20%) grade I, 19 (21%) grade II, 27 (30%) grade III, 22 (24%) grade IV and 4 (4%) grade V. Most cases (84%) were managed conservatively. Early intervention (<24 hours) was performed in 14 cases (16%) of renal injury. The majority of these cases were managed by interventional radiology(IR) techniques (9/14). Only two patients required emergency nephrectomy, both of whom died from extensive polytrauma. 19 patients underwent laparotomy for other injuries and did not require renal exploration. Overall 30-day mortality was 13%. Re-imaging was performed in 66% of patients at an average time of 3.4 days from initial scan. The majority of re-imaging was planned (49 patients) and 12% of these scans demonstrated a relevant finding (urinoma, pseudo-aneurysm) which altered management in 3/49 patients (6.1%).CONCLUSIONNon-operative management is the mainstay for all grades of injury. Haemodynamic instability and persistent urine leak are primary indications for intervention. Open surgical management is uncommon. Repeat imaging after injury is advocated for stable patients with high grade renal injury (Grade III-V) although more research is needed to determine the optimal timing. This article is protected by copyright. All rights reserved.

23. Safety of meningococcal group B vaccination in hospitalised premature infants.

Authors Kent, Alison; Beebeejaun, Kazim; Braccio, Serena; Kadambari, Seilesh; Clarke, Paul; Heath, Paul T; Ladhani, Shamez; National Neonatal Audit Network
Source Archives of disease in childhood. Fetal and neonatal edition; Mar 2019; vol. 104 (no. 2); p. F171
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Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Available at Archives of Disease in Childhood: Fetal and Neonatal Edition from Unpaywall

Abstract OBJECTIVESTo assess the risk of significant adverse events in premature infants receiving the novel 4-component group B meningococcal vaccine (4CMenB) with their routine immunisations at 2 months of age.PARTICIPANTS, DESIGN AND SETTINGIn December 2015, Public Health England requested neonatal units across England to voluntarily participate in a national audit; 19 units agreed to participate. Anonymised questionnaires were completed for infants receiving 4CMenB alongside their routine immunisations. For comparison, a historical cohort of premature infants receiving their primary immunisations without 4CMenB or paracetamol prophylaxis was used.MAIN OUTCOME MEASURESParacetamol use; temperature, cardiovascular, respiratory and neurological status before and after vaccination; and management and investigations postvaccination, including serum C reactive protein levels, infection screens and antibiotic use.RESULTSComplete questionnaires were returned for 133 premature infants (<35 weeks' gestation) who received their first dose of 4CMenB at 8 weeks of age, including 108 who received prophylactic paracetamol according to national recommendations. Overall, 7% (8/108) of infants receiving 4CMenB with paracetamol had fever (>38°C) after vaccination compared with 20% (5/25) of those receiving 4CMenB without paracetamol (P=0.06) and none of those in the historical cohort. There were no significant differences between cohorts in the proportion of infants with apnoea, bradycardia, desaturation and receiving respiratory support after vaccination.CONCLUSIONS4CMenB does not increase the risk of serious adverse events in hospitalised premature infants. This audit supports the current national recommendations to offer 4CMenB with other routine vaccinations and prophylactic paracetamol to premature infants at their chronological age.

24. Ethnic-specific mortality of infants undergoing congenital heart surgery in England and Wales.

Authors Knowles, Rachel L; Ridout, Deborah; Crowe, Sonya; Bull, Catherine; Wray, Jo; Tregay, Jenifer; Franklin, Rodney C G; Barron, David J; Parslow, Roger C; Brown, Katherine
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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 PURPOSETo investigate ethnic differences in mortality for infants with congenital heart defects (CHDs) undergoing cardiac surgery or interventional catheterisation.DESIGNObservational study of survival to age 1 year using linked records from routine national paediatric cardiac surgery and intensive care audits. Mortality risk was investigated using multivariable Poisson models with multiple imputation. Predictors included sex, ethnicity, preterm birth, deprivation, comorbidities, prenatal diagnosis, age and weight at surgery, preprocedure deterioration and cardiac diagnosis.SETTINGAll paediatric cardiac surgery centres in England and Wales.PATIENTS5350 infants with CHDs born from 2006 to 2009.MAIN OUTCOME MEASURESurvival at age 1 year.RESULTSMortality was 83.9 (95% CI 76.3 to 92.1) per 1000 infants, with variation by ethnic group. Compared with those of white ethnicity, infants in British Asian (Indian, Pakistani and Bangladeshi) and 'all other' (Chinese, mixed and other) categories experienced significantly higher mortality by age 1 year (relative risk [RR] 1.52[95% CI 1.19 to 1.95]; 1.62[95% CI 1.20 to 2.20], respectively), specifically during index hospital admission (RR 1.55 [95% CI 1.07 to 2.26]; 1.64 [95% CI 1.05 to 2.57], respectively). Further predictors of mortality included non-cardiac comorbidities, prenatal diagnosis, older age at surgery, preprocedure deterioration and cardiac diagnosis. British Asian infants had higher mortality risk during elective hospital readmission (RR 1.86 [95% CI 1.02 to 3.39]).CONCLUSIONSInfants of British Asian and 'all other' non-white ethnicity experienced higher postoperative mortality risk, which was only partly explained by socioeconomic deprivation and access to care. Further investigation of case-mix and timing of risk may provide important insights into potential mechanisms underlying ethnic disparities.

25. A multicentre audit of the use of bronchoscopy during open and thoracoscopic repair of oesophageal atresia with tracheo-oesophageal fistula.

Authors Ahmad, Nargis S; Dobby, Nadine; Walker, Eleanor; Sogbodjor, L Amaki; Kelgeri, Nivedita; Pickard, Amelia; Burrows, Tom; Nicholson, Katy E; Green, Alice; Shepherd, Liz; Thornley, Helen; Wolfe-Barry, Juliet A; Parker, Beverley J; Childs, Sophie L; King, Rumiko G; Mele, Sara; Krishnan, Prakash
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Available at Paediatric 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 BACKGROUNDOesophageal atresia with tracheo-oesophageal fistula is usually repaired in the neonatal period. Preferential ventilation through the fistula can lead to gastric distension. Bronchoscopy has a role in defining the site and size of the fistula and may be carried out by the surgeon or the anaesthetist. The use of bronchoscopy varies across different institutions.METHODSThis is a multi-centre case note review of infants with oesophageal atresia with tracheo-oesophageal fistula who underwent surgery between January 2010 and December 2015. This retrospective audit aims primarily to document the use of bronchoscopy during open and thoracoscopic repair at a selection of United Kingdom centres. We also note details of respiratory complications, i.e. relating to airway management, the respiratory system and difficulty with ventilation; at induction and during surgery. The range of techniques for anaesthesia and analgesia in these centres is noted.RESULTSBronchoscopy was carried out in 52% of cases. The incidence of respiratory complications was 7% at induction and 21% during surgery. Thoracoscopic repair usually took longer. One centre used High Frequency Oscillatory Ventilation, on an elective basis during thoracoscopic repair, to facilitate surgical access and address concerns about hypoxemia and hypercarbia.CONCLUSIONUse of bronchoscopy varies considerably between institutions. Infants undergoing tracheo-oesophageal fistula repair are at risk of peri-operative respiratory morbidity. The advent of thoracoscopic repair has introduced further variation. This article is protected by copyright. All rights reserved.

26. Reducing Trainee Service Provision Burden: An Audit of Cardiac Surgical Follow-Up.

Authors Jones, Siôn Gwyn; Russell, Glenn N; Oo, Aung
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Available at Journal of surgical education 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 OBJECTIVETo standardize the discharge policy for outpatient appointments and reduce the burden of service provision placed on trainee surgeons.DESIGNRetrospective audit of practice followed by a prospective audit following our intervention.SETTINGCardiac surgery outpatient clinic at Liverpool Heart and Chest Hospital, a large tertiary cardiothoracic center in the United Kingdom.PARTICIPANTSAll patients (total 1002) attending postcardiac surgery follow-up appointments in the periods January to March 2015 (n = 428), February to March 2016 (n = 250), and February to March 2017 (n = 324).RESULTSIntroduction of departmentally agreed guidelines on discharge from follow-up reduced the number of inappropriate recalls among patients attending their first postoperative appointment (4.6% vs 17.6%; p < 0.001), which was maintained at 1 year (4.5% vs 17.6%; p < 0.001). In the initial cohort, a significantly higher proportion of patients were inappropriately recalled if they were seen by registrars who were not from the operating consultant's team (11.7% vs 24.1%; p = 0.007); this was not apparent after the guidelines were introduced (5.4% vs 3.8%; p = 0.62). There was no increase in the number of patients referred back to the cardiac surgical department after introduction of the guidelines (0.71% vs 2.8%; p = 0.078). We calculated an annual cost saving of £3841 ($5377). There was a significant increase in the number of new patients seen by trainees in each clinic (0.15 vs 0.38, p = 0.04).CONCLUSIONImplementation of a discharge guideline decreased the number of unnecessary attendances at the outpatient clinic without an increase in subsequent re-referrals and was cost neutral. Trainees were able to assess more new referrals, increasing the educational value of the clinics.

27. British Society of Interventional Radiology Iliac Angioplasty and Stent Registry: fourth report on an additional 8,294 procedures.

Authors Miller, C; Frood, R; See, T C; Hammond, C J
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Available at Clinical Radiology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
Available at Clinical Radiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract AIMTo provide an update of current practice in iliac artery intervention in the UK.MATERIALS AND METHODSNinety-nine interventional units across the UK completed online submission forms for iliac angioplasty and stent procedures between 2011 and 2014 (inclusive) for the British Iliac Angioplasty and Stenting (BIAS) IV registry.RESULTSData for 8,294 procedures were submitted during the study period. A total of 12,253 iliac segments were treated in 10,311 legs. The commonest indication was claudication (n=5219, 64.4%). Of the cases performed, 6,582 (80.8%) were performed electively with 3,548 (44.8%) of the procedures performed as a day-case and 6,586 (54%) of the lesions were treated with stents. Successful endovascular intervention (residual stenosis ≤49%) was achieved in 11,847 (97%) of treated segments, with residual stenosis in 1.5%. One point five percent of lesions could not be crossed with a wire. Limb complications were recorded in 366 (3.5%), resulting in 141 patients undergoing an unplanned intervention and 173 (2.2%) patients had a systemic complication. There were 84 deaths prior to discharge, of which 13 (15%) were procedure related. Both systemic and limb complication rates were higher in patients undergoing treatment for critical ischaemia.CONCLUSIONIliac stenting and angioplasty are associated with high technical success with a low complication rate. These data provide up-to-date statistics for patient information and future audit and benchmarking purposes.

28. Exploring organizational support for the provision of structured self-management education for people with Type 2 diabetes: findings from a qualitative study.

Authors Carey, M E; Agarwal, S; Horne, R; Davies, M; Slevin, M; Coates, V
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Available at Diabetic medicine : a journal of the British Diabetic Association from Wiley Online Library Medicine and Nursing Collection 2018 - NHS
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Abstract AIMTo explore the organizational context in which Type 2 diabetes structured group education is provided.METHODSFour Clinical Commissioning Groups in England providing Type 2 diabetes structured self-management education participated in a qualitative study exploring the context for provision of that education. Using UK Diabetes Audit returns, two Clinical Commissioning Groups were selected that had non-attendance rates of ≤25%, and two that had non-attendance rates of ≥50%. Between May 2016 and August 2017, 20 interviews were conducted with Clinical Commissioning Group staff including: commissioners, healthcare professionals, managers, general practitioners and diabetes educators. Data gathering was prolonged as it proved challenging to engage with healthcare staff as a result of frequent local restructuring and service disruption.RESULTSLocal audits revealed discrepancies in basic data such as referral and attendance numbers compared with national audit data. There was a commonality in the themes identified from interviews: diabetes education was rarely embedded in service structure; where education uptake was poor, a lack of central support to delivery teams was noticeable; and where education uptake was positive, delivery teams were actively engaged, sometimes relying on enthusiastic individuals. Both situations put the local sustainability of diabetes education at risk.CONCLUSIONSThere appears to be a link between attendance rates and organizational issues, therefore, when considering how to increase attendance rates, the state of the diabetes education infrastructure should be reviewed. Good uptake of diabetes education can be too reliant on the enthusiastic commitment of small teams or individuals delivering the education. This article is protected by copyright. All rights reserved.

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

Authors Trethewey, Samuel P; Edgar, Ross G; Morlet, Julien; Mukherjee, Rahul; Turner, Alice M
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Abstract INTRODUCTIONNon-invasive ventilation (NIV) is recommended for treatment of acute hypercapnic respiratory failure (AHRF) in acute exacerbations of COPD. National UK audit data suggests that mortality rates are rising in COPD patients treated with NIV.OBJECTIVETo investigate temporal trends in in-hospital mortality in COPD patients undergoing a first episode of ward-based NIV for AHRF.METHODSRetrospective study of hospitalised COPD patients treated with a first episode of ward-based NIV at a large UK teaching hospital between 2004 and 2017. Patients were split into two cohorts based on year of admission, 2004-2010 (Cohort 1) and 2013-2017 (Cohort 2), to facilitate comparison of patient characteristics.RESULTSIn total, 547 unique patients were studied. There was no difference in in-hospital mortality rate between the time periods studied (17.6% vs 20.5%, P = .378). In Cohort 2 there were more females, a higher rate of co-morbid bronchiectasis and pneumonia on admission and more severe acidosis, hypercapnia and hypoxia. More patients in Cohort 2 had NIV as the ceiling of treatment. Patients in Cohort 2 experienced a longer time from AHRF diagnosis to application of NIV, higher maximum inspiratory positive airway pressure, lower maximum oxygen and shorter duration of NIV. Finally, patients in Cohort 2 experienced a shorter hospital length of stay (LOS), with no differences observed in rate of transfer to critical care or intubation.CONCLUSIONIn-hospital mortality remained stable and LOS decreased over time, despite greater comorbidity and more severe AHRF in COPD patients treated for the first time with ward-based NIV.

30. The use of IVIg in the treatment of inflammatory polyneuropathies and myasthenia gravis at The Walton Centre.

Authors Kimyongur, Selim; Hywel, Brython; Holt, James
Source The journal of the Royal College of Physicians of Edinburgh; Mar 2019; vol. 49 (no. 1); p. 5-11
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Abstract BACKGROUNDImmunoglobulin is a blood product used in a variety of medical disorders, usually delivered intravenously (IVIg). Neurology patients, particularly those with inflammatory polyneuropathy, utilise a lot of IVIg. There is a national shortage of immunoglobulin and, thus, pressing need to ensure minimum effective dosing as well as rigorous outcome assessments to assess benefit at treatment start and subsequently, as placebo effects can be strong.METHODSSerial audit of IVIg use at The Walton Centre against national guidelines was carried out through analysis of clinical notes of day unit patients. Review of the national immunoglobulin database and of neurology outpatient notes to benchmark our practice and provide some comparison with the wider nation was also performed.RESULTSSerial audit led to improved adherence to guidelines, and analysis of practice identified wide variation in IVIg use.CONCLUSIONLocal audit and benchmarking of practice can be used to promote quality and consistency of IVIg use across the NHS.

31. The Impact of an Electronic Patient Bedside Observation and Handover System on Clinical Practice: Mixed-Methods Evaluation.

Authors Lang, Alexandra; Simmonds, Mark; Pinchin, James; Sharples, Sarah; Dunn, Lorrayne; Clarke, Susan; Bennett, Owen; Wood, Sally; Swinscoe, Caron
Source JMIR medical informatics; Mar 2019; vol. 7 (no. 1); p. e11678
Publication Date Mar 2019
Publication Type(s) Journal Article
PubMedID 30839278
Database Medline
Available at JMIR medical informatics from Europe PubMed Central - Open Access

Abstract BACKGROUNDPatient safety literature has long reported the need for early recognition of deteriorating patients. Early warning scores (EWSs) are commonly implemented as "track and trigger," or rapid response systems for monitoring and early recognition of acute patient deterioration. This study presents a human factors evaluation of a hospital-wide transformation in practice, engendered by the deployment of an innovative electronic observations (eObs) and handover system. This technology enables real-time information processing at the patient's bedside, improves visibility of patient data, and streamlines communication within clinical teams.OBJECTIVEThe aim of this study was to identify improvement and deterioration in workplace efficiency and quality of care resulting from the large-scale imposition of new technology.METHODSA total of 85 hours of direct structured observations of clinical staff were carried out before and after deployment. We conducted 40 interviews with a range of clinicians. A longitudinal analysis of critical care audit and electronically recorded patient safety incident reports was conducted. The study was undertaken in a large secondary-care facility in the United Kingdom.RESULTSRoll-out of eObs was associated with approximately 10% reduction in total unplanned admissions to critical care units from eObs-equipped wards. Over time, staff appropriated the technology as a tool for communication, workload management, and improving awareness of team capacity. A negative factor was perceived as lack of engagement with the system by senior clinicians. Doctors spent less time in the office (68.7% to 25.6%). More time was spent at the nurses' station (6.6% to 41.7%). Patient contact time was more than doubled (2.9% to 7.3%).CONCLUSIONSSince deployment, clinicians have more time for patient care because of reduced time spent inputting and accessing data. The formation of a specialist clinical team to lead the roll-out was universally lauded as the reason for success. Staff valued the technology as a tool for managing workload and identified improved situational awareness as a key benefit. For future technology deployments, the staff requested more training preroll-out, in addition to engagement and support from senior clinicians.

32. Successful second language learning is tied to robust domain-general auditory processing and stable neural representation of sound.

Authors Kachlicka, Magdalena; Saito, Kazuya; Tierney, Adam
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Abstract There is a great deal of individual variability in outcome in second language learning, the sources of which are still poorly understood. We hypothesized that individual differences in auditory processing may account for some variability in second language learning. We tested this hypothesis by examining psychoacoustic thresholds, auditory-motor temporal integration, and auditory neural encoding in adult native Polish speakers living in the UK. We found that precise English vowel perception and accurate English grammatical judgment were linked to lower psychoacoustic thresholds, better auditory-motor integration, and more consistent frequency-following responses to sound. Psychoacoustic thresholds and neural sound encoding explained independent variance in vowel perception, suggesting that they are dissociable indexes of sound processing. These results suggest that individual differences in second language acquisition success stem at least in part from domain-general difficulties with auditory perception, and that auditory training could help facilitate language learning in some individuals with specific auditory impairments.

33. Quality of handwritten surgical operative notes from surgical trainees: a noteworthy issue.

Authors Nzenza, Tatenda C; Manning, Todd; Ngweso, Simeon; Perera, Marlon; Sengupta, Shomik; Bolton, Damien; Lawrentschuk, Nathan
Source ANZ journal of surgery; Mar 2019; vol. 89 (no. 3); p. 176-179
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Available at ANZ journal of surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract BACKGROUNDSurgical operation notes are crucial for medical record keeping and information flow in continued patient care. In addition to inherent medical implications, the quality of operative notes also has important economic and medico-legal ramifications. Further, well-documented records can also be useful for audit purposes and propagation of research, facilitating the improvement of delivery of care to patients. We aimed to assess the quality of surgical operation notes written by junior doctors and trainees against a set standard, to ascertain whether these standards were met.METHODWe undertook an audit of Urology and General Surgery operation notes handwritten by junior doctors and surgical trainees in a tertiary teaching hospital over a month period both in 2014 and 2015. Individual operative notes were assessed for quality based on parameters described by the Royal College of Surgeons of England guidelines.RESULTSBased on the Royal College of Surgeons of England guidelines, a significant proportion of analysed surgical operative notes were incomplete, with information pertaining to the time of surgery, name of anaesthetist and deep vein thrombosis prophylaxis in particular being recorded less than 50% of the time (22.42, 36.36 and 43.03%, respectively).Overall, 80% compliance was achieved in 14/20 standards and 100% compliance was attained in only one standard.CONCLUSIONSThe quality of surgical operation notes written by junior doctors and trainees demonstrated significant deficiencies when compared against a set standard. There is a clear need to educate junior medical staff and to provide systems and ongoing education to improve quality. This would involve leadership from senior staff, ongoing audit and the development of systems that are part of the normal workflow to improve quality and compliance.

34. Study protocol for a multicenter prospective cohort study on esophagogastric anastomoses and anastomotic leak (the Oesophago-Gastric Anastomosis Audit/OGAA).

Authors Evans, R P T; Singh, P; Nepogodiev, D; Bundred, J; Kamarajah, S; Jefferies, B; Siaw-Acheampong, K; Wanigasooriya, K; McKay, S; Mohamed, I; Whitehouse, T; Alderson, D; Gossage, J; van Hillegersberg, R; Vohra, R S; Griffiths, E A
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Available at Diseases of the esophagus : official journal of the International Society for Diseases of the Esophagus 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 Esophagectomy is a mainstay in curative treatment for esophageal cancer; however, the reported techniques and outcomes can vary greatly. Thirty-day mortality of patients with an intact anastomosis is 2-3% as compared to 17-35% in patients who have an anastomotic leak. The subsequent management of leaks postesophagectomy has great global variability with little consensus on a gold standard of practice. The aim of this multicentre prospective audit is to analyze current techniques of esophagogastric anastomosis to determine the effect on the anastomotic leak rate. Leak rates and leak management will be assessed to determine their impact on patient outcomes. A 12-month international multicentre prospective audit started in April 2018 and is coordinated by a team from the West Midlands Research Collaborative. This will include patients undergoing esophagectomy over 9 months and encompassing a 90-day follow-up period. A pilot data collection period occurred at four UK centers in 2017 to trial the data collection form. The audit standards will include anastomotic leak and the conduit necrosis rate should be less than 13% and major postoperative morbidity (Clavien-Dindo Grade III or more) should be less than 35%. The 30-day mortality rate should be less than 5% and the 90-day mortality rate should be less than 8%. This will be a trainee-led international audit of esophagectomy practice. Key support will be given by consultant colleagues and anesthetists. Individualized unit data will be distributed to the respective contributing sites. An overall anonymized report will be made available to contributing units. Results of the audit will be published in peer-reviewed journals with all collaborators fully acknowledged. The key information and results from the audit will be disseminated at relevant scientific meetings.

35. Evidenced-based radiology? A single-institution review of imaging referral appropriateness including monetary and dose estimates for inappropriate scans.

Authors Ryan, James W; Hollywood, Aoife; Stirling, Aaron; Glynn, Martina; MacMahon, Peter J; Bolster, Ferdia
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Available at Irish journal of medical science from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract BACKGROUNDThere has been a year on year increase in imaging requests at our academic institution. The iRefer guidelines are produced by the Royal College of Radiologists in the UK and are designed to prevent inappropriate imaging and radiation exposure. They have been available to general practitioners and hospital physicians in Ireland since March 2015.AIMSOur aims were to determine the proportion of inappropriate imaging referrals pre- and post-guideline introduction and to calculate the cost and dose estimates for inappropriate scans.METHODSA retrospective review of 1124 radiographs was performed with reference to a validated audit template. Emergency department, in-patient, and general practitioner referrals were reviewed. Cost and cumulative dose estimates were calculated for inappropriate referrals taking into account salaries, average time spent performing/reporting radiographs, and median effective dose values.RESULTSThe introduction of the iRefer guidelines has not significantly affected the proportion of inappropriate radiograph referrals at our institution, 42% pre-introduction and 43% post-introduction. We identified 784 inappropriate referrals across 6 radiograph subtypes, imparting a total median effective dose of 65.1 mSv to patients. The time spent performing inappropriate abdominal and spinal radiographs in 2017 yielded an estimated cost of €8036.40.CONCLUSIONA significant amount of inappropriate radiographs continue to be requested and performed, exposing patients to needless ionizing radiation and wasting staff members time at a financial cost. Interventions are needed to decrease inappropriate referrals.

36. Histological Aging of Fractures in Infants: a practical algorithm for assessing infants suspected of accidental or non-accidental injury.

Authors Naqvi, Anie; Raynor, Emma; Freemont, Anthony J
Source Histopathology; Mar 2019
Publication Date Mar 2019
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Abstract This study is the first to systematically document histological features of fractures of known age in infants (≦12 months). It has been used to develop a tabulated database specifically to guide histopathologists to age fractures in children considered to have suffered accidental or non-accidental injury (NAI). Currently in the UK there are insufficient pathologists with experience in histological aging of fractures to meet the medicolegal need for this examination. This study provides a practical tool that will allow those skilled paediatric and forensic pathologists currently involved in assessing infants for evidence of accidental or non-accidental injury a basis for extending their assessment into this area of unmet need. 169 fractures of known age at death were obtained from 52 anonymised infants over a period of 32 years (1985-2016 inclusive). Sections stained haematoxylin and eosin (H&E) and Martius scarlet blue (MSB) were used to identify specific histological features and to relate them to fracture age. In 1999 the data were entered into a tabulated database for fractures accumulated between from 1985-1998 inclusive. Thereafter cases were added and at 2 yearly intervals the accumulated data were audited against the previous data base, and adjustments made. This paper describes the final dataset from the 2017 audit. The study was terminated at the end of 2016 as there had been no material changes in the dataset for 3 consecutive audits. This article is protected by copyright. All rights reserved.

37. Patients with in-situ metallic coils and amplatzer vascular plugs used to treat pulmonary arteriovenous malformations since 1984 can safely undergo magnetic resonance imaging.

Authors Alsafi, Ali; Jackson, James E; Fatania, Gavin; Patel, Maneesh C; Glover, Alan; Shovlin, Claire
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Available at The British journal of radiology from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

Abstract OBJECTIVES:To examine the magnetic resonance imaging (MRI) safety of metallic coils and Amplatzer vascular plugs. Currently, concern regarding MR-safety of devices used to treat pulmonary arteriovenous malformations (PAVMs) causes delays in performing emergency MRI in patients presenting with acute neurological symptoms.METHODS:A retrospective audit was performed on all patients who underwent PAVM embolization at our institution between 1984 - 2017. Outcomes of all MRI studies performed at our institution were recorded. In addition, known outcomes of all known MRI studies performed on patients treated with the earliest steel coils (1984 - 1995) were recorded.RESULTS:At our institution, 20 patients underwent 1.5 T MRI after the insertion of 100 steel coils (15.5 - 28.6, median 22 years later), 140 coils designated MR-conditional (0.42 - 12.7, median 9.3 years later), and 54 MRI-conditional Amplatzer vascular plugs (0.17 - 8.0, median 0.75 years later), many in combination. The majority of scans were for cerebral indications, but other body regions scanned included spinal, thoracic, and pelvic regions. No adverse events were reported. Similarly, there were no adverse events in any MR scan known to have been performed in other institutions in seven further patients treated with the earliest steel coils (1984 - 1995). Again, the majority of scans were for cerebral indications.CONCLUSIONS:The findings demonstrate MR safety at 1.5 T of all PAVM embolization devices inserted in a main UK centre since inception in 1984.ADVANCES IN KNOWLEDGE:Magnetic resonance imaging of patients who have had pulmonary AVMs treated by embolization can be implemented without contacting specialist pulmonary arteriovenous malformation treatment centres for approval.

38. Major incident triage and the evaluation of the Triage Sort as a secondary triage method.

Authors Vassallo, James; Smith, Jason
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Available at Emergency medicine journal : EMJ 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 INTRODUCTIONA key principle in the effective management of major incidents is triage, the process of prioritising patients on the basis of their clinical acuity. In many countries including the UK, a two-stage approach to triage is practised, with primary triage at the scene followed by a more detailed assessment using a secondary triage process, the Triage Sort. To date, no studies have analysed the performance of the Triage Sort in the civilian setting. The primary aim of this study was to determine the performance of the Triage Sort at predicting the need for life-saving intervention (LSI).METHODSUsing the Trauma Audit Research Network (TARN) database for all adult patients (>18 years) between 2006 and 2014, we determined which patients received one or more LSIs using a previously defined list. The first recorded hospital physiology was used to categorise patient priority using the Triage Sort, National Ambulance Resilience Unit (NARU) Sieve and the Modified Physiological Triage Tool-24 (MPTT-24). Performance characteristics were evaluated using sensitivity and specificity with statistical analysis using a McNemar's test.RESULTS127 233patients (58.1%) had complete data and were included: 55.6% men, aged 61.4 (IQR 43.1-80.0 years), ISS 9 (IQR 9-16), with 24 791 (19.5%) receiving at least one LSI (priority 1). The Triage Sort demonstrated the lowest accuracy of all triage tools at identifying the need for LSI (sensitivity 15.7% (95% CI 15.2 to 16.2) correlating with the highest rate of under-triage (84.3% (95% CI 83.8 to 84.8), but it had the greatest specificity (98.7% (95% CI 98.6 to 98.8).CONCLUSIONWithin a civilian trauma registry population, the Triage Sort demonstrated the poorest performance at identifying patients in need of LSI. Its use as a secondary triage tool should be reviewed, with an urgent need for further research to determine the optimum method of secondary triage.

39. Rethinking priorities: experience of an educational initiative to change attitudes, behaviours and clinical practice in end-of-life care.

Authors Edwards, Annette; Barros D'Sa, Viv; Hicks, Fiona
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Abstract To implement the National End of Life Care strategy and enable more people to express and achieve their preferences about care at the end of life, senior clinicians outside palliative medicine need to make it a routine part of their practice. However, it is acknowledged that recognising that people are entering the last phase of their illness is not always straightforward, and having conversations about aims of treatment and planning for future care may not be easy. In order to begin to address these challenges, funding was sought from the Yorkshire and the Humber Strategic Health Authority (SHA), and subsequently Health Education England, Yorkshire and the Humber (HEEYH), to pilot a development programme in 2 acute trusts. 2 palliative medicine consultants shared the trainer role at each site, supporting hospital consultants from a range of specialties, with a GP to give a community perspective. The programme involved individual clinicians identifying their own learning needs and specific issues for end-of-life care in their patients. The group met together monthly in action learning sets to discuss issues in a safe yet challenging environment. Following evaluation using a combination of training needs analyses, feedback questionnaires, audits and service evaluations, it was modified slightly and repiloted in 2 further trusts as 'Rethinking Priorities'. This paper describes the programme and its outcomes, especially in relation to participants' learning, service development and leadership. It also highlights the challenges, including different learning styles, the concept of action learning, obtaining funding and dedicated time, and how to evaluate the effectiveness of a programme. Overall, it suggests that an educational initiative based on clinicians identifying their own learning needs, and using an action learning approach to explore issues with other colleagues, with the addition of some targeted sessions, can result in positive change in knowledge, behaviour and clinical practice.

40. Creating sustainable health care systems.

Authors Littlejohns, Peter; Kieslich, Katharina; Weale, Albert; Tumilty, Emma; Richardson, Georgina; Stokes, Tim; Gauld, Robin; Scuffham, Paul
Source Journal of health organization and management; Mar 2019; vol. 33 (no. 1); p. 18-34
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Abstract PURPOSEIn order to create sustainable health systems, many countries are introducing ways to prioritise health services underpinned by a process of health technology assessment. While this approach requires technical judgements of clinical effectiveness and cost effectiveness, these are embedded in a wider set of social (societal) value judgements, including fairness, responsiveness to need, non-discrimination and obligations of accountability and transparency. Implementing controversial decisions faces legal, political and public challenge. To help generate acceptance for the need for health prioritisation and the resulting decisions, the purpose of this paper is to develop a novel way of encouraging key stakeholders, especially patients and the public, to become involved in the prioritisation process.DESIGN/METHODOLOGY/APPROACHThrough a multidisciplinary collaboration involving a series of international workshops, ethical and political theory (including accountability for reasonableness) have been applied to develop a practical way forward through the creation of a values framework. The authors have tested this framework in England and in New Zealand using a mixed-methods approach.FINDINGSA social values framework that consists of content and process values has been developed and converted into an online decision-making audit tool.RESEARCH LIMITATIONS/IMPLICATIONSThe authors have developed an easy to use method to help stakeholders (including the public) to understand the need for prioritisation of health services and to encourage their involvement. It provides a pragmatic way of harmonising different perspectives aimed at maximising health experience.PRACTICAL IMPLICATIONSAll health care systems are facing increasing demands within finite resources. Although many countries are introducing ways to prioritise health services, the decisions often face legal, political, commercial and ethical challenge. The research will help health systems to respond to these challenges.SOCIAL IMPLICATIONSThis study helps in increasing public involvement in complex health challenges.ORIGINALITY/VALUENo other groups have used this combination of approaches to address this issue.

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

Authors Hendra, Louise; Hendra, Tim; Parker, Stephen J
Source World journal of surgery; Mar 2019; vol. 43 (no. 3); p. 798-805
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Available at World journal of surgery from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.

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