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1. Multidisciplinary care for pregnant women with cardiac disease: A mixed methods evaluation

**Authors**
Mayer F.; Bick D.; Taylor C.

**Source**
International journal of nursing studies; Sep 2018; vol. 85; p. 96-105

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Article

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Abstract

BACKGROUND: Cardiac disease is associated with adverse outcomes in pregnancy and is the leading cause of indirect maternal death in the United Kingdom (UK) and internationally. National and international guidelines recommend women should receive care from multidisciplinary teams; however evidence is lacking to inform how they should be operationalised.

OBJECTIVE(S): To describe the composition and processes of multidisciplinary care between maternity and cardiac services before, during and after pregnancy for women with cardiac disease, and explore clinicians’ (cardiologists, obstetricians, nurses, midwives) and women’s experiences of delivering/receiving care within these models. DESIGN: Mixed-methods comprising case-note audit, interviews and observation. SETTING: Two inner-city National Health Service (NHS) maternity units in the south of England serving similar obstetric populations, selected to represent different models of multidisciplinary team care. PARTICIPANTS: Women with significant cardiac disease (either arrhythmic or structural, e.g. tetralogy of fallot) who gave birth between June 1st 2014 and 31st May 2015 (audit/interviews), or attended an multidisciplinary team clinic (obstetric/cardiac) during April 2016 (observation).

METHOD(S): A two-phase sequential explanatory design was undertaken. A retrospective case-note audit of maternity and medical records (n=42 women) followed by interviews with a sub-sample (n=7 women). Interviews were conducted with clinicians (n=7) and observation of a multidisciplinary team clinic in one site (n=8 women, n=4 clinicians).

RESULT(S): The interests and expertise of individual clinicians employed by the hospital trusts influenced the degree of integration between cardiac and maternity care. Integration between cardiac and maternity services varied from an ad-hoc ‘collaborative’ model at Site B to an ‘interdisciplinary’ approach at Site A. In both sites there was limited documented evidence of individualised postnatal care plans in line with national guidance. Unlike pathways for risk assessment, referral and joined care in pregnancy for women with congenital cardiac disease, pathways for women with acquired conditions lacked clarity. Midwives at both sites were often responsible for performing the initial maternal cardiac risk assessment despite minimal training in this. Clinicians and women’s perceptions of ‘normality’ in pregnancy/birth, and its relationship to ‘safe’ maternity care were at odds.

CONCLUSION(S): The limited evidence and guidance to support multidisciplinary team working for pregnancy in women with cardiac disease - particularly those with acquired conditions - has resulted in variable models and pathways of care. Evidence-based guidance regarding the operationalisation of integrated care between maternity and cardiac services - including pathways between local and specialist centres - for all women with cardiac disease in pregnancy is urgently required.

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2. Repairing a mismatched diagnostic pathway: Implementation of recent national guidance for Lynch syndrome screening in three National Health Service Trusts in the South West of England

**Authors**
Farmkiss L.; Jackson L.

**Source**
Familial Cancer; Mar 2019; vol. 18

**Publication Date**
Mar 2019

**Publication Type(s)**
Conference Abstract

**Database**
EMBASE
3. Attitudes, skills and use of evidence-based practice among UK Osteopaths: a national cross-sectional survey

Authors: Sundberg T.; Leach M.J.; Adams J.; Thomson O.P.; Austin P.; Fryer G.

Source: Advances in Integrative Medicine; May 2019; vol. 6

Publication Date: May 2019

Publication Type(s): Conference Abstract

Database: EMBASE

Abstract: Background: Evidence-based practice (EBP) is a clinical decision-making framework that supports quality improvement in healthcare. While osteopaths are key providers of musculoskeletal healthcare, the extent to which osteopaths engage in EBP is unclear. Thus, the aim of this cross-sectional study was to investigate UK osteopaths' attitudes, skills and use of EBP, and perceived barriers and facilitators of EBP uptake.

Method(s): UK-registered osteopaths were invited to complete the Evidence-Based Practice Attitude and Utilisation Survey (EBASE) online.

Result(s): Of the 5,200 registered osteopaths in the UK, 517 (9.9%) responded to the invitation, and 375 (7.2%) completed the EBASE (<20% incomplete answers). The demographic characteristics of the survey sample were largely similar to those of the UK osteopathy workforce. The osteopaths reported overall positive attitudes towards EBP, with most agreeing that EBP improves the quality of patient care and is necessary for osteopathy practice. The majority reported moderate-level skills in EBP, and most were interested in improving these skills. Participating osteopaths typically engaged in EBP activities 1-5 times over the last month. Barriers to EBP uptake included a lack of time and clinical evidence in osteopathy. Main facilitators of EBP included having access to online databases, internet at work, full-text articles, and EBP education materials.

Conclusion(s): UK osteopaths were generally supportive of evidence-based practice, had moderate-level skills in EBP and engaged in EBP activities infrequently. The development of effective interventions that improve osteopaths' skills and the incorporation of EBP into clinical practice should be the focus of future research. Further consideration should be given to the impact of screening on downstream services such as colonoscopy and clinical genetics. It is also essential to develop a strategy to reduce patients "lost to follow up".

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4. Outcomes following cardiac arrest at a UK cardiac arrest centre: A retrospective observational study

Authors: Pugh R.; Pugh L.; Habib Z.

Source: Critical Care; Mar 2019; vol. 23

Publication Date: Mar 2019

Publication Type(s): Conference Abstract

Database: EMBASE

Abstract: Aim This multi-centre project implemented and evaluated universal tumour-based Lynch syndrome screening of patients with colorectal cancer. Under-recognition of Lynch syndrome has prompted national guidance to recommend screening all consenting patients initially diagnosed with colorectal cancer. Mismatch repair immunohistochemistry is a recommended first-line investigation but the availability of testing has limited widespread adoption of the guidance. We aimed to evaluate the introduction of mismatch repair immunohistochemistry to three National Health Service histopathology laboratories. Method Mismatch repair immunohistochemistry was acquired and validated in all three centres. Each centre aimed to perform mismatch repair immunohistochemistry on all colorectal cancer samples sent from consenting patients between 01/02/2018 and 22/06/2018. Patients with deficient mismatch repair were either referred to clinical genetics or sent for additional tumour-based testing. The number of patients with deficient mismatch repair tumours and the time taken to report tumour mismatch repair status were recorded and compared to audit data gathered during a previous selective screening strategy. Results The three centres screened 35 (100%-centre 1), 42 (100%-centre 2) and 19 (32.8%-centre 3) cases of colorectal cancer received from consenting patients respectively. Mismatch repair deficiency was detected in 12.5% (centre 1), 21.4% (centre 2) and 10.3% (centre 3) of cases. Centre 1 demonstrated a mean mismatch repair status reporting time of 10 days. Centre 3 demonstrated a reporting time of 69 days. Conclusions Detection of mismatch repair deficiency and reporting time improved with the introduction of in-house mismatch repair immunohistochemistry. Several barriers prevented centre 3 from implementing a universal screening strategy including upfront cost and issues of informed consent. Implementation of immunohistochemistry is just the first step toward forging a robust screening pathway. Further consideration should be given to the impact of screening on downstream services such as colonoscopy and clinical genetics. It is also essential to develop a strategy to reduce patients "lost to follow up".
5. The appropriateness of lidocaine patch clinical use at the royal Liverpool and broadgreen university hospitals NHS trust: A quality improvement project

Authors: Chen-Turner C.; Johnston M.
Source: Age and Ageing; Feb 2019; vol. 48
Publication Date: Feb 2019
Publication Type(s): Conference Abstract
Database: EMBASE

Abstract

Introduction: Glan Clwyd Hospital (GCH) was recently designated one of three Cardiac Arrest Centres for Wales. It has offered a 24/7 Percutaneous coronary angiography (PCI) service to a geographically dispersed North Wales population of approximately 690,000 since June 2017. Prior to this, urgent coronary angiography was available on a more limited basis to patients requiring PCI. The aim of this study was to investigate factors associated with hospital mortality after critical care admission following cardiac arrest.

Method(s): Retrospective review of the Ward Watcher critical care database at GCH to identify patients who had undergone CPR in the 24 hours prior to critical care admission in 2013-18. Patients likely to have sustained OOHA of cardiac aetiology (OOHA-C) were identified from primary and secondary diagnoses and free text entry. Data were subsequently analysed using Excel and SPSS. The project was registered as a service evaluation with GCH Audit Department.

Result(s): There were 190 cardiac arrest admissions over this period, increasing from 25 in 2013-14 to 69 in 2017-18. Of these 122 were OOHA, of which 103 were considered OOHA-C. Although OOHA-C hospital mortality appeared to decrease over the time period (89% to 56%), this was not statistically significant (p=0.149). Factors associated with survival to hospital discharge are presented in the Tables below. On logistic regression, only PCI and low pH within the first 24 hours of critical care remained statistically significant (p=0.027 and p<0.001 respectively).

Conclusion(s): Although we have been unable to make a distinction between patients presenting following STEMI and NSTEMI, and appreciating a potential influence of selection bias, the significant association between PCI and survival to hospital discharge supports the introduction of clinical pathways enabling PCI access following OOHA-C [1] (Table Presented).

Abstract

Aim: This Quality Improvement Project (QIP) aimed to evaluate and improve the clinical appropriateness of lidocaine patch usage in the Clinical Gerontology department at the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT). The only approved indication for lidocaine patch prescribing at RLBUHT is post herpetic neuralgia.

Material(s) and Method(s): A retrospective review of electronic case notes was undertaken for 25 patients who were prescribed lidocaine patches in the Clinical Gerontology Department at RLBUHT May-June 2017. Key data collected included: patient demographics, use of a pain assessment tool, prescription indication, and discharge planning.

Result(s): Most patients prescribed lidocaine patches were elderly and female. Most patients were admitted due to a fall, pain and/or fractures. Pain assessment tools were not used and the specialist pain team was not consulted. Four patients were prescribed lidocaine patches prior to admission. The decision to start lidocaine for an inpatient was mostly consultant-led. Indications for lidocaine patches were mostly for back pain with a small cohort of rib fractures, pubic rami fractures or pressure sores. The duration of inpatient prescriptions was mostly zero to ten days, and the topical site for patch administration was only specified in two patients. Most patients on discharge were prescribed lidocaine patches, with no evidence of a prescription review. The recommendations from this assessment were presented at the RLBUHT Medication Governance Group Meeting (18/05/2018). The change that was implemented was an awareness campaign and allowing Gerontology Pharmacy to challenge prescriptions. Other recommendations included: clearer documentation of indication, restricting lidocaine initiation to consultants, use a pain scale for pain assessment, and liaising with the pain team and pharmacy. Importantly, lidocaine patches on discharge prescriptions should require a review. Since implementation, the average monthly spend on lidocaine patches in the department has reduced by 70% - 1368 (2017-2018 average monthly cost) to 396 (2018 current average).

Conclusion(s): This QIP has highlighted inappropriate lidocaine prescribing practices, and implemented several recommendations. Importantly, this QIP has empowered the Gerontology Pharmacy to challenge prescriptions. Since implementation, the average monthly spend on lidocaine patches in the department has significantly reduced. An action plan is being developed to ensure this continues.

6. Electronic AKI alert implementation, precision and accuracy
HDAS Export
Search Strategy EMBASE - AUDIT

Authors Cuertero M.; Dono L.; Bakonyi T.; Tahir S.; Christodoulopoulou T.
Source Critical Care; Mar 2019; vol. 23
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

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Available at Critical Care from EBSCO (MEDLINE Complete)
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Available at Critical 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

Introduction: AKI has a high prevalence in ICU. The aim of this study is to audit the compliance of AKI NICE guidelines [1], and assess the precision and accuracy of National Health Service England electronic AKI alert (e-alert) [2] Methods: We conducted a prospective audit against the latest NICE and KDIGO guidelines in two ICU within Imperial College Healthcare NHS Trust. Data was collected from 01/05/18 to 15/06/18. We looked at AKI risk factors, e-alert and actual AKI diagnoses by ICU team. Ealert compares actual serum creatinine during admission with patients baseline Results: The sample included 104 patients, mean age 62-15 years, length of ICU stay 8.5-10.7 days. 56 were male. 14.4% required level 1 care, 49.0% level 2 and 36.5% level 3 care (defined by degree of organ support). 34.6% were admitted from Emergency, and 38.5% from theatres/ recovery. 39 patients (37.5%) had previous chronic kidney disease (CKD); 22 of 39 (56%) were CKD 1 or 2. AKI incidence was 39.4% (41 patients): 20 patients had AKIN 1, 8 AKIN 2 and 13 AKIN 3 (Table 1). 12 patients required renal replacement during ICU stay. Eight patients were referred to nephro-urology: 6 for specific treatment, 1 hemodialysis and 1 for nephrostomy. The incidence of AKI recovery during ICU admission was 80.5%. AKI alert was positive for 34 of 41 (83%) patients. It showed a sensitivity 73.1% (95% CI 58.1%-84.3%), specificity of 93.7% (95CI 84.8%-97.5%), likelihood ratio +11.5 (95%CI 4.4-4.30) to diagnose AKI. However, only 21 of 41 patients were diagnosed by ICU medical team: sensitivity 51.2% (95%CI 36.5-65.6%) and specificity 100% (95% CI 94.3% - 100%) (Fig 1).

Conclusion(s): Although AKI alert does not include urine output criterion or AKI risk factors, it remains a helpful tool to point out patients with AKI. Education and diagnostic algorithms are still needed to early diagnose and treat AKI patients.

7. Do not attempt resuscitation decisions and patient capacity

Authors Whyte L.; Yates L.
Source Age and Ageing; Feb 2019; vol. 48
Publication Date Feb 2019
Publication Type(s) Conference Abstract
Database EMBASE

Available at Age and Ageing from Ovid (Journals @ Ovid) - Remote Access
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Available at Age and Ageing 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

Topic: Do Not Attempt Resuscitation (DNAR) forms are commonly completed for frail elderly patients on admission to hospital. It is standard practice to involve the patient in these discussions, and recent court cases have ruled that failure to notify the patient and allow them opportunity to express their wishes and preferences is a breach of their human rights. However, it is not uncommon for elderly patients to lack capacity on admission due to delirium or underlying dementia. In Scotland, a patient lacking capacity is treated using the Adults With Incapacity Act 2000 (AWI). Where DNAR decisions are made using AWI, the care plan should be completed to state this.

Intervention(s): Admissions to the University Hospital Monklands geriatrics unit were audited for new DNAR decisions, completion of AWI forms, and whether the care plan covered the DNAR. A pro-forma sticker for the care plan was introduced, and this coincided with introduction of a new national DNAR form which prompted clearer documentation regarding DNAR discussions. A re-audit was conducted after these interventions.

Improvement: There was documented discussion with the patient in 36% vs 23% of new DNAR decisions. There was no documented discussion with the patient or documented incapacity in 14% of patients; after interventions this figure worsened slightly to 23%. Where AWI forms were completed the interventions did achieve an improvement with 55% vs 92% documentation of capacity for DNAR decisions in the care plan.

Discussion(s): Despite clear prompting on the new DNAR forms there remain a significant minority of patients where no documented discussion or AWI form was completed at time of the DNAR decision. This may breach patient rights and leave the trust open to legal action. The introduction of a care plan sticker was helpful in improving accurate AWI completion and we aim to continue its use in our department.

Authors
Harrington L.; Rampota C.; Price K.; Edmonds P.

Source
Age and Ageing; Feb 2019; vol. 48

Publication Date
Feb 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract
Introduction: DNACPR decisions are an ethical and legal challenge (Fritz, Sloxther & Perkins. BMJ 2017;356:813) with great emphasis placed on quality communication, decision-making and documentation for patient safety (BMA Resuscouncil, 2014). Following the introduction of a DNACPR toolbar within electronic records (Johnson, Whyte, Loveridge. BMJ 2017;6), and a staff-survey demonstrating uncertainty around resuscitation, our study aimed to evaluate practice.

Method(s): A completed loop audit was performed within gerontology between January- June 2018. Data was collected prospectively weekly over a month, including all with a DNACPR, with discharges analysed retrospectively.

Result(s): First cycle, all 181 patients had a resuscitation status; 73% had a DNACPR decision. 100% had a treatment escalation plan (TEP), 85% had a valid explanatory form, but 15% were absent. 86% were made by a senior doctor. 68% evidenced discussions with patients/relatives, and 13% had documented MDT discussion. 88 patients were discharged; 39% of which had a DNACPR. 79% were communicated in discharge letters within a comprehensive geriatric assessment (CGA). Following interventions, performance improved in all areas. All 176 patients had a resuscitation status, with 72% having a DNACPR decision. 100% of these had a TEP and valid form. 93% were made by a senior doctor. 71% evidenced a discussion with patients/relatives with 57% having a documented MDT discussion.

Conclusion(s): A key finding was poor communication, increasing risk of inappropriate resuscitation. Interventions demonstrated improvement, which should reduce the risk of harm and encourages a patient centred approach. The e-toolbar remains an effective prompt for making timely decisions. Revision of electronic processes and staff training led to improved documentation. We recommend the inclusion of DNACPR decisions in discharge letters via CGAs, as it improves co-ordination of care with the community. This tool is being applied trust-wide evaluating other divisions. Overall, this highlights the importance of ensuring e-systems are legally compliant with trust policy, and encouraging cultural change to impact patient safety.

9. A preliminary study of the clinical outcomes of acutely unwell patients with dementia: Aneurin bevan university health board, Wales (uk)

Authors
Duric D.; Musa S.O.; Rasuly A.; Anwar A.; Edwards C.; Singh I.

Source
Age and Ageing; Feb 2019; vol. 48

Publication Date
Feb 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract
Introduction: DNACPR decisions are an ethical and legal challenge (Fritz, Sloxther & Perkins. BMJ 2017;356:813) with great emphasis placed on quality communication, decision-making and documentation for patient safety (BMA Resuscouncil, 2014). Following the introduction of a DNACPR toolbar within electronic records (Johnson, Whyte, Loveridge. BMJ 2017;6), and a staff-survey demonstrating uncertainty around resuscitation, our study aimed to evaluate practice.

Method(s): A completed loop audit was performed within gerontology between January- June 2018. Data was collected prospectively weekly over a month, including all with a DNACPR, with discharges analysed retrospectively.

Result(s): First cycle, all 181 patients had a resuscitation status; 73% had a DNACPR decision. 100% had a treatment escalation plan (TEP), 85% had a valid explanatory form, but 15% were absent. 86% were made by a senior doctor. 68% evidenced discussions with patients/relatives, and 13% had documented MDT discussion. 88 patients were discharged; 39% of which had a DNACPR. 79% were communicated in discharge letters within a comprehensive geriatric assessment (CGA). Following interventions, performance improved in all areas. All 176 patients had a resuscitation status, with 72% having a DNACPR decision. 100% of these had a TEP and valid form. 93% were made by a senior doctor. 71% evidenced a discussion with patients/relatives with 57% having a documented MDT discussion.

Conclusion(s): A key finding was poor communication, increasing risk of inappropriate resuscitation. Interventions demonstrated improvement, which should reduce the risk of harm and encourages a patient centred approach. The e-toolbar remains an effective prompt for making timely decisions. Revision of electronic processes and staff training led to improved documentation. We recommend the inclusion of DNACPR decisions in discharge letters via CGAs, as it improves co-ordination of care with the community. This tool is being applied trust-wide evaluating other divisions. Overall, this highlights the importance of ensuring e-systems are legally compliant with trust policy, and encouraging cultural change to impact patient safety.
Abstract

Introduction: Patients with dementia often have other associated medical co-morbidities which directly or indirectly could result in poorer outcomes. The National Audit of Dementia (NAD) in the UK showed a wide variation in the quality and approach of care for acutely unwell patients with dementia. The objective of this study is to record the demographics and patient characteristics to understand and benchmark clinical outcomes of acutely unwell dementia patients admitted across three acute sites within Aneurin Bevan University Health Board, Wales (UK).

Method(s): This was a preliminary retrospective observational cohort study based on analysis of the existing data for all the patients with dementia admitted acutely. Ethical approval was not required for this service evaluation, which was based on the recommendations of the NAD.

Result(s): A total of 2474 admission episodes were recorded in the year 2016 from the 1770 acute dementia patients. We studied 953 consecutive dementia patients from 01/01/2016 to 30/06/2016 who had a total of 1167 episodes of acute admissions. The mean age was 84.5 +/- 7.8 years (females = 63.5%). Mean Charlson comorbidity index and number of drugs were 6.0 +/- 1.5 and 5.1 +/- 2.1. 15.4% (147/953) patients were on antipsychotics. Overall mean hospital stay was 19.4 +/- 27.2 days. 30-days readmission rate was 14.5% (138/953) with mean hospital stay of 14.6 +/- 17.9 days. 70.3% (n = 670/953) were previously living in their own homes and only 11.4% (n = 109/953) were discharged from care homes. 59.5% patients (n = 399/670) were discharged back to their homes. 6.3% (n = 53/844) were discharged to a new care home, which represents an approximately 1.5 times higher rate of new care-home occupancy than the patients being originally admitted from a care home. Overall inpatient, 30-days, 90-days and one-year mortality were 16.0% (153/953); 22.3% (213/953); 29.6% (283/953); 49.2% (469/953) respectively. The observed mortality rates between patients admitted from home or from a care home were not significant for inpatient mortality (p = 0.54) but were highly significant for one year mortality (p < 0.001).

Discussion: Further clinical outcomes measuring impact of hospitalization like inpatient falls, delirium, dehydration, pressure sores is warranted. Reasons for readmission need indepth analysis. Enhanced partnership working with community teams is recommended to minimize hospital deaths within 48 hours.

Conclusion(s): Further similar studies will enhance individual and organizational understanding of clinical outcomes for acutely unwell patients with dementia. This would also facilitate quality improvement initiatives to improve patient care and modernisation of existing community service.
Abstract

Aim: To measure the degree of deconditioning on the geriatric ward at Epsom General Hospital (EGH), in order to review the multi-disciplinary team (MDT) management of elderly patients, with a view to education to improve practice.

Method(s): Retrospective review of 25 patients’ hospital admissions, collating information relating to deconditioning from bedside and medical notes, between November 2017 and May 2018. Information included: Residence, Package of Care (POC), Mobility and Transfers (using the Functional Independence Measure (FIM) tool), Weight and Continence. Data relating to the length of stay (LOS) and physiotherapy (PT) input and timings was also reviewed. This was divided into pre-admission (i.e. functional ability when well) and at discharge (following the inpatient stay).

Result(s): PT: 63% of patients were seen within 1 day of when they were deemed fit to mobilise. On average, patients received PT input on 22% of days during their admission. FIM: 60% of patients’ mobility and transfer ability worsened. POC/Residence: 24% required no increase in POC or change of residence. 76% deteriorated enough to require on-going rehabilitation or increased baseline support. Weight: 52% weren’t recorded. There was no trend in changes in weight, however more patients lost weight than gained weight throughout admission. Continence: 64% remained the same.

Discussion(s): This data reveals a trend of general deterioration throughout admission, despite timely input from PT. However, it is important to consider “social admissions”; those patients who would have required more support on discharge regardless of the MDT input. The overall trend of deterioration is likely multifactorial. The lack of recorded weights is concerning as this is important for monitoring nutrition and for prescription of medications. For those losing weight, dieticians need to be involved early. Those gaining weight could be patients who had insufficient support and therefore poor oral intake prior to admission. Considerations for future reviews: (1) Measuring confounding factors such as severity of admitting illness (2) Whether a patient has dementia So-called “pyjama paralysis” is of increasing importance with the ageing UK population. This review identified the following interventions: . Awareness posters throughout the ward detailing how to prevent deconditioning . Leaflets for relatives outlining areas where they can help with rehabilitation . Education for the MDT staff about their roles in preventing deconditioning . Improve awareness of the importance of nutrition and weights . Re-audit practice.

12. A quality improvement project of the TPN Branch of the Magnificent 7 Care Bundle-Cycle Two

Authors       Webb A.; Bishop P.
Source        Critical Care; Mar 2019; vol. 23
Publication Date  Mar 2019
Publication Type(s) Conference Abstract
Database       EMBASE

Available at Critical Care from BioMed Central
Available at Critical Care from Europe PubMed Central - Open Access
Available at Critical Care from EBSCO (MEDLINE Complete)
Available at Critical Care from ProQuest (Health Research Premium) - NHS Version
Available at Critical 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.
13. Best practice tariff for fragility hip fractures - A completed audit cycle in a district general hospital

**Authors**
Chaudhry S.; Ranganathan M.; Bishop M.

**Source**
Age and Ageing; Feb 2019; vol. 48

**Abstract**
Introduction: Fragility hip fractures are the most common serious injury in older people, costing the NHS and social care around 1 billion per year.

Aim(s): We conducted a two-cycle audit assessing our compliance with the Best Practice Tariff, and exploring the cases that failed to comply.

Method(s): Two audit cycles were completed. The first cycle included patients from May 2016-May 2017, and case notes and electronic records were retrospectively analysed. Changes to practice were implemented after the first cycle, including a dedicated Saturday Orthopaedic Trauma operating list (previously Saturday operating cases were on a shared CEPOD list), improvement work to the Neck of Femur Fracture clerking proforma, and educational work. Additionally, a new orthogeriatric lead consultant started during this period (TK). A re-audit was performed from August - December 2017. Database data was analysed and cross-referenced with written and electronic records.

Result(s): The first cycle included 58 cases, and the second cycle included 53 cases. The new orthogeriatric lead consultant led to improved contemporaneous records. In the first cycle, 71% (41/58) of cases fully complied with BPT, which remained similar at 70% (37/53) compliance for the second cycle. The majority of cases failing to comply with BPT were as a result of delay to surgery (>36 hours). This was the case for 26% (15/58) of patients in the first cycle, which reduced slightly to 24.5% (13/53) for the second cycle. The circumstances of the failing cases were analysed. In the first cycle, 16% (9/58) had surgery delayed due to lack of theatre capacity, compared with 13.2% (7/53) for the second cycle. In both cycles, a few patients failed to comply for other reasons, usually as a result of medical optimisation for theatre or a missing component of the multi-disciplinary assessment.

Conclusion(s): Our overall BPT compliance rate of 70% is largely unchanged and remains considerably higher than the currently reported national average of 62.1% (November 2017). The proportion failing due to delayed surgery shows improvement (24.5% from 26%). Furthermore, there are reduced delays as a result of limited theatre capacity (13.2% from 16%), which may be partly related to the implementation of a dedicated Saturday Orthopaedic Trauma list. Further work is needed in the future to evaluate the ongoing impact of these interventions and make further improvements.
15. Falls in nursing homes: Where, when and how many

Authors: Gallagher R.; Dunleavy C.; McNulty M.; O’Hara R.; Fan C.W.; Kennelly S.

Source: Age and Ageing; Sep 2018; vol. 47

Database: EMBASE

Abstract: Background: Nursing home (NH) residents are at high risks of falls with international reports of fall rates of 1.5 falls/bed/year (range 0.2 to 3.6). There is no published data on falls rate in the Irish NH. Our aim is to describe where, when and the number of falls in 4 NHs over 12 months to inform quality improvement in falls prevention strategy in NH.

Method(s): Four NHs with total bed number 430 (bed numbers in each NH ranged from 72-131), participated in recording the place, time and incidence of falls, from March 2017 to February 2018. Falls were categorised to witnessed and un-witnessed falls. Time of fall was divided into Day (0800 to 1559), Evening (1600 to 2359), Night (0000 to 0759). Two of the four NH recorded the place where fall occurred.

Result(s): There were 628 falls reported over 12 months, of which 487 (78%) were un-witnessed. Majority of falls occurred in the bedroom (71%). The rest occurred in sitting rooms (15%), corridor (6%), dining room (2%) kitchenette and outdoors. One third (36%) of the falls occurred during the day, 40% in the evening and 25% at night. The median falls rate for each nursing home was 1.65 (range 0.46 to 3.6). There is no published data on falls rate in the Irish NH. Our aim is to describe where, when and the number of falls in 4 NHs over 12 months to inform quality improvement in falls prevention strategy in NH.

Conclusion(s): The audit reflected our local practice and showed that our mortality was in line with the acceptable limits; poor documentation of plan of care which posed problems in analyzing the care that these patients received; some of the parameters were not being maintained as set by UK Resuscitation guideline.

16. Falls-associated emergency department attendance from nursing home residents from one catchment

Authors: Riches R.; Keating T.; Fan C.W.; Eustace A.
Abstract

Background: Nursing Home (NH) residents are at high risk of falls (1.5 falls per bed per year - Rubenstein 1994) and it is the second most common reason for Emergency Department (ED) attendance (Fan, 2016). Only half of these attendances require admission. Our aim was to describe falls-associated ED attendances from NHs of one catchment over 12 months.

Method(s): NH residents attending a large urban teaching hospital were identified through the electronic patient record. Basic characteristics and time of triage were recorded. An audit then was conducted of residents from one nursing home on Triage complaint, whether fall was witnessed or un-witnessed, injuries sustained, investigations performed and whether the resident had dementia diagnosed.

Result(s): There were 138 falls-associated ED attendances and 130 residents (83 women, 47 men), of which 58 (42%) required admission over 12 months. The majority of them attended once (n = 124, 90%), 5 residents twice and one resident attended 4 times. There were higher attendances in summer months; half of the residents came over 7 hours (11:00 to 18:00). An audit of one NH of 7 men and 17 women, mean age 83 years found that two-thirds of attendances classified as falls; the rest had limb problems or head injuries. Eighteen (75%) of the falls were un-witnessed. Twenty-two (92%) required imaging, all sustained injuries (14 soft tissue, 9 fractures, 5 head). Majority (23) had dementia.

Conclusion(s): Falls-associated ED attendances by NH residents showed seasonal variation and half of the attendances were during working hours. The majority of falls occurred un-witnessed and those who attended ED had injurious falls and required imaging. Dementia was prevalent amongst those who fell. Falls prevention programmes in NH will require comprehensive evaluation of intrinsic risk factors and environmental design to reduce un-witnessed falls.

17. Improving anticipatory prescribing practices for all older patients with an anticipated death in hospital

Authors: Baillie J.; Sii S.; McGurk H.; Roberts M.
Abstract

Background: The NICE guidelines advocate that adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualized indications for use, dosage and route of administration (1). This study investigated the extent older patients within an acute teaching hospital had anticipatory medicines prescribed prior to death, as recommended by the Regional Palliative Medicine Group for Northern Ireland (2). (1) Care of dying adults in the last days of life (2015) NICE guideline NG31, recommendation 1.6.1 (2) http://www.professionalpalliativehub.com/guidelines/northern-ireland-palliative-care-tools-guidance Methods: The study retrospectively reviewed the notes and kardexes of hospital inpatients who had an anticipated death in hospital, and using an audit tool, established if patients had been prescribed appropriate anticipatory medication for end of life care as recommended by the Northern Ireland Regional Palliative Medicine Group. This included medicines for 1. Pain, 2. Breathlessness, 3. Nausea and vomiting, 4. Anxiety, delirium and agitation 5. Chest secretions Results: 55% of patients were prescribed all the medicines recommended to palliate anticipated symptoms encountered during end of life care. All the patients had access to opioids to palliate for pain and breathlessness. 95% of the patients had access to medication to alleviate anxiety, delirium and agitation. 73% had access to medicines for chest secretions and 59% had access to an anti-emetic.

Conclusion(s): From this baseline data, it is clear not all patients had access to the recommended anticipatory medicines. We are now progressing to compare the effect of gradually implemented interventions on improving anticipatory prescribing for patients at the end of life. Example of interventions include prompting senior medical staff to ensure medications have been prescribed, palliative care education for junior medical staff and implementing a symptom observation chart. Our goal is to improve our prescribing of anticipatory medicines and thus improve care for older adults in the last days of life.

18. Does rhythm matter in acute heart failure? An insight into clinical outcomes from the British Society for Heart Failure national audit

Authors
Anderson S.G.; Keavney B.; Garratt C.J.; Shoaib A.; Mamas M.; Myint P.; Cleland J.; Hardman S.M.; McDonagh T.

Source
European Heart Journal; Aug 2018; vol. 39 ; p. 1397

Publication Date
Aug 2018

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract

Background: Atrial fibrillation (AF) is the most common sustained arrhythmia in patients with acute Heart Failure (AHF). The presence of AF is associated with adverse prognosis in patients with chronic Heart Failure (CHF) but little is known about its impact in acute Heart Failure.

Method(s): Data was collected between April 2007 to March 2013 across 185 (>95%) hospitals in England & Wales for patients with a primary death from, or a discharge diagnosis of AHF. We investigated the association between the presence of AF and all-cause mortality during the index hospital admission and at 30 days and 1 year post-discharge using shared frailty Cox proportional hazard models.

Result(s): Of 96,593 patients admitted with AHF, 44,642 (46%) were in sinus rhythm (SR) and 51,951 (54%) in AF. Patients with AF were older (mean age 79.8 (79.7-80) versus 74.7 (74.5-74.7) years; p<0.001), but had a lower prevalence of diabetes, acute myocardial infarction and left ventricular systolic dysfunction (LVSD) than those in SR. In a multivariable analysis, AF was independently associated with mortality at all time points, in hospital (HR 1.15, 95% CI 1.09-1.21, p<0.0001), 30 days (HR 1.13, 95% CI 1.08-1.19, p<0.0001), and 1 year (HR 1.09, 95% CI 1.05-1.12, p<0.0001). In subgroup analyses, AF was independently associated with worse 30 days outcome irrespective of sex, ventricular phenotype and in all age groups except in those who aged between 55-74 years (Hazard ratio 1.04 (CI 0.85-1.29, p=0.69).

Conclusion(s): AF is independently associated with adverse prognosis in AHF during admission and up-to one-year post discharge. As the clinical burden of concomitant AF and AHF increases, further refinement in the detection, treatment and prevention of AF-related complications are necessary to effectively improve patient outcome.

19. Contemporary epidemiology of infective endocarditis in patients with congenital heart disease: Outcomes from a national prospective study

Authors
Jewell P.; Cahill T.J.; Denne L.; Cunningham D.; Franklin R.; Frigiola A.; Prendergast B.D.

Source
European Heart Journal; Aug 2018; vol. 39 ; p. 476

Publication Date
Aug 2018

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract

Background: The contemporary epidemiology of infective endocarditis (IE) in adults with congenital heart disease (CHD) is not well described.

Method(s): This is an analysis of the contemporary epidemiology of IE in patients aged 18 years and older with CHD. The study was conducted in 214 adult congenital heart disease centres in the UK and overseas.

Result(s): A total of 612 cases of IE were identified. The mean age of affected patients was 44 years (interquartile range 28-65) and 44% were male. The distribution of etiologies was: 35% native valve infective endocarditis (NE), 22% prosthetic valve infective endocarditis (PVE), 11% native heart valve replacement (NHVR), and 14% other. The in-hospital mortality rate was 15% (95% CI 12-18%).

Conclusion(s): The contemporary epidemiology of IE in adults with CHD is characterized by a high in-hospital mortality rate and a diverse distribution of causative organisms. These findings highlight the need for improved prevention and treatment strategies for IE in this population.
Abstract

Background: Infective endocarditis (IE) is a serious complication of congenital heart disease (CHD), but there are few studies on the contemporary risk profile, incidence of preceding invasive procedures and outcomes in this patient population.

Purpose(s): The aim of this study was to investigate the epidemiology of IE in patients with CHD nationwide.

Method(s): Cases of IE in children and adults with CHD who were managed at tertiary congenital centres were prospectively recorded as part of the U.K. National Institute for Cardiovascular Outcomes Congenital Heart Disease Audit. Patients were entered into the database between 1st April 2008 and 31st March 2015.

Result(s): 743 patients were admitted with 807 episodes of IE. 441 (59%) were aged >15 years, 235 (32%) 1-15 years and 67 (9%) were <1 year of age. Overall 467 (63%) were male. The most common underlying CHD diagnoses were aortic valve anomalies (n=147, 22%), ventricular septal defect (VSD; n=119, 18.1%), tetralogy of Fallot (n=68, 10.4%) and pulmonary atresia with/without VSD (n=62, 10.4%). Streptococci were isolated in 283 episodes (40%), staphylococci in 232 (33%) and enterococci in 30 (4%). An invasive procedure had been performed in the preceding three months before diagnosis in 146 episodes of IE (22%). This included a dental procedure in 68 (8%); venous line placement in 25 (4%), cardiac catheterisation in 27 (3%), and gastrointestinal or genitourinary surgery in 16 (2%). A further 40 patients (5%) underwent a dental procedure after the diagnosis of IE had been made. Contrary to U.K. guidance from National Institute for Health and Care Excellence, antibiotic prophylaxis was given prior to 38% of preceding dental procedures. Overall, the median length of stay was 32 days (interquartile range 16 to 48 days) and in-hospital mortality 6.4%.

Conclusion(s): IE in patients with CHD is an ongoing clinical challenge. Streptococci remain the most frequently isolated organism, and invasive procedures in the three months prior to diagnosis are common. Further research is required to effective preventive strategies for this at-risk group.


Authors
McGettigan S.; Hart C.

Source
Age and Ageing; Sep 2018; vol. 47

Publication Date
Sep 2018

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract

Background: Thorough geriatric evaluation including cognitive assessment results in improved outcomes and quality of life by promoting access to more appropriate care. The National Audit of Dementia Care in the UK showed that older patients were being under-assessed with regard to cognition, and therefore failing to receive suitable levels of care.

Method(s): This was a retrospective clinical audit carried out in a peripheral general hospital. Patients aged over 65 years who were admitted to this hospital over a selected period of ten days (30/03/18 to 09/04/18) were deemed eligible for inclusion. This totaled at 31 subjects. A descriptive analysis of the results was performed.

Result(s): Despite recommendations that cognitive assessment should be performed on admission, this was not completed in any of the medical notes. 4 of the patients included came from nursing homes. 64.5% did however have documented mental status such as 'confused' or 'orientated' on admission. 22.6% of selected patients had a previously documented history of cognitive impairment.

Conclusion(s): Cognitive assessment rates need to be further improved to promote better outcomes for patients with cognitive impairment. A more detailed study following subjects throughout inpatient stay would be beneficial to assess whether cognitive evaluation was carried out prior to discharge. The possibility of an interventional tool such an Abbreviated Mental Test Score insert for medical notes could be considered in the future. These findings support the need for increased education with regard to the importance and benefits of assessment as well as how to complete and document assessment correctly.

21. Are post stroke/transient ischaemic attack carotid investigation best practice guidelines being followed in Mayo University Hospital?

Authors
McKernan S.; O'Malley T.

Source
Age and Ageing; Sep 2018; vol. 47

Publication Date
Sep 2018

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract

Background: Thorough geriatric evaluation including cognitive assessment results in improved outcomes and quality of life by promoting access to more appropriate care. The National Audit of Dementia Care in the UK showed that older patients were being under-assessed with regard to cognition, and therefore failing to receive suitable levels of care.

Method(s): This was a retrospective clinical audit carried out in a peripheral general hospital. Patients aged over 65 years who were admitted to this hospital over a selected period of ten days (30/03/18 to 09/04/18) were deemed eligible for inclusion. This totaled at 31 subjects. A descriptive analysis of the results was performed.

Result(s): Despite recommendations that cognitive assessment should be performed on admission, this was not completed in any of the medical notes. 4 of the patients included came from nursing homes. 64.5% did however have documented mental status such as 'confused' or 'orientated' on admission. 22.6% of selected patients had a previously documented history of cognitive impairment.

Conclusion(s): Cognitive assessment rates need to be further improved to promote better outcomes for patients with cognitive impairment. A more detailed study following subjects throughout inpatient stay would be beneficial to assess whether cognitive evaluation was carried out prior to discharge. The possibility of an interventional tool such an Abbreviated Mental Test Score insert for medical notes could be considered in the future. These findings support the need for increased education with regard to the importance and benefits of assessment as well as how to complete and document assessment correctly.
22. Medication management in acutely hospitalised patients with Parkinson's disease: A single centre audit

**Authors**
Murphy C; Atl S; Traynor B; McKeown R; Basit M; Mulroy M; Bhuachalla B.N.; Lynch O.

**Source**
Age and Ageing; Sep 2018; vol. 47

**Abstract**
Background: Patients with Parkinson's disease (PD) are frequent users of inpatient services, often managed on non-specialist wards. Mismanagement of PD medications can adversely affect patient outcome. The 2015 Parkinson's UK audit found >50% of patients did not get their medication on time every time. We aimed to assess PD medication management within our hospital and compare standards to NICE guidelines.

**Method(s):** Using HIPE data, all admissions in 2017 with a primary or secondary diagnosis of PD were identified. Retrospective chart review allowed collation of data on those patients, including demographics, medication prescription, administration, pharmacist review and discharge outcome. Prevalence of standards met was calculated, standards being taken from the 2017 NICE guidelines "Parkinson's disease in adults".

**Result(s):** Of 53 admissions reviewed, 35 patients were included. 100% were > 65 years. There were a variety of admission diagnoses; lower respiratory tract infection (26.4%) the most frequent. 60.3% missed doses of PD medications during their admission. "Drug not available on the ward" was the commonest reason for missed medication (32%). "Patient nil by mouth" (16.9%) and refusing medications (11.5%) were also common reasons. 39% of patients missed < 5 doses. 60.3% of patients received a review by a pharmacist during their admission.

**Conclusion(s):** Compared to previous audit results improvement has been made in presentation to carotid imaging time with 90% of imaging reported as normal within a system with no dedicated fast track service. A small number received dual imaging in accordance with guidelines showing evidence that a more streamlined stroke service could reduce strain on hospital resources.
24. Change in Prescribing for Secondary Prevention of Stroke and Coronary Heart Disease in Finnish Nursing Homes and Assisted Living Facilities

Authors: Jokanovic N.; Bell J.S.; Tan E.C.K.; Kautiainen H.; Pitkala K.H.
Source: Drugs and Aging; 2019
Publication Date: 2019
Publication Type: Article
PubMedID: 30949985
Database: EMBASE

Abstract:
Background: One quarter of residents in long-term care facilities (LTCFs) have a diagnosis of CHD or stroke and over half use at least one preventative cardiovascular medication. There have been no studies that have investigated the longitudinal change in secondary preventative cardiovascular medication use in residents in LTCFs over time.

Objectives: The aim of this study was to investigate the change in cardiovascular medication use among residents with coronary heart disease (CHD) and prior stroke in nursing homes (NHs) and assisted living facilities (ALFs) in Finland over time, and whether this change differs according to dementia status.

Methods: Three comparable cross-sectional audits of cardiovascular medication use among residents aged 65 years and over with CHD or prior stroke in NHs in 2003 and 2011 and ALFs in 2007 and 2011 were compared. Logistic regression analyses adjusted for gender, age, mobility, cancer and length of stay were performed to examine the effect of study year, dementia and their interaction on medication use.

Results: Cardiovascular medication use among residents with CHD (NHs: 89% vs 70%; ALFs: 89% vs 84%) and antithrombotic medication use among residents with stroke (NHs: 72% vs 63%; ALFs: 78% vs 69%) declined between 2003 and 2011 in NHs and 2007 and 2011 in ALFs. Decline in the use of diuretics, nitrates and digoxin were found in both groups and settings. Cardiovascular medication use among residents with CHD and dementia declined in NHs (88% [95% CI 85-91] in 2003 vs 70% [95% CI 64-75] in 2011) whereas there was no change among people without dementia. There was no change in cardiovascular medication use among residents with CHD in ALFs with or without dementia over time. Antithrombotic use was lower in residents with dementia compared with residents without dementia in NHs (p < 0.001) and ALFs (p = 0.026); however, the interaction between dementia diagnosis and time was non-significant.

Conclusion: The decline in cardiovascular medication use in residents with CHD and dementia suggests Finnish physicians are adopting a more conservative approach to the management of cardiovascular disease in the NH population.

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25. A learning health systems approach to improving the quality of care for patients in South Asia

Authors: Beane A.; Dondorp A.M.; Miranda S.; Haniffa R.; Wagstaff D.; Abayadeera A.; Wijeyaratne M.; Ranasinghe G.; Walker D.

Source: Global health action; 2019; vol. 12 (no. 1); p. 1587893

Publication Date: 2019

Publication Type(s): Article

PubMedID: 30950778

Database: EMBASE

Available at Global health action from Europe PubMed Central - Open Access
Available at Global health action from ProQuest (Health Research Premium) - NHS Version
Available at Global health action 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

Poor quality of care is a leading cause of excess morbidity and mortality in low- and middle-income countries (LMICs). Improving the quality of healthcare is complex, and requires an interdisciplinary team equipped with the skills to design, implement and analyse setting-relevant improvement interventions. Such capacity is limited in many LMICs. However, training for healthcare workers in quality improvement (QI) methodology without buy-in from multidisciplinary stakeholders and without identifying setting-specific priorities is unlikely to be successful. The Care Quality Improvement Network (CQIN) was established between Network for Improving Critical care Systems and Training (NICST) and University College London Centre for Perioperative Medicine, with the aim of building capacity for research and QI. A two-day international workshop, in collaboration with the College of Surgeons of Sri Lanka, was conducted to address the above deficits. Innovatively, the CQIN adopts a learning health systems (LHS) approach to improving care by leveraging information captured through the NICST electronic multi-centre acute and critical care surveillance platform. Fifty-two delegates from across the CQIN representing clinical, civic and academic healthcare stakeholders from six countries attended the workshop. Mapping of care processes enabled identification of barriers and drivers to the delivery of care and facilitated the selection of feasible QI methods and matrices. Six projects, reflecting key priorities for improving the delivery of acute care in Asia, were collaboratively developed: improving assessment of postoperative pain; optimising sedation in critical care; refining referral of deteriorating patients; reducing surgical site infection after caesarean section; reducing surgical site infection after elective general surgery; and improving provision of timely electrocardiogram recording for patients presenting with signs of acute myocardial infarction. Future project implementation and evaluation will be supported with resources and expertise from the CQIN partners. This LHS approach to building capacity for QI may be of interest to others seeing to improve care in LMICs.

26. Involuntary psychiatric admission: Comparative study of mental health legislation in Brazil and in England/Wales

Authors: Brito E.S.D.; Ventura C.A.A.

Source: International Journal of Law and Psychiatry; 2019; vol. 64 ; p. 184-197

Publication Date: 2019

Publication Type(s): Article

Database: EMBASE

Abstract

Involuntary admission is a controversial measure that can lead to violation of various human rights. On the opposite, involuntary admissions may contribute for the recovery of those with severe mental disorders who represent a danger to themselves or others. From this perspective, legislation must define and limit the circumstances in which this may occur preventing human rights violations. In this context, this descriptive-comparative study aimed at analyzing the similarities and differences between the mental health' laws related to involuntary psychiatric admission in Brazil and England/Wales. Data were collected through bibliographic and documentary research. The analysis was based on the World Health Organization's Checklist on Mental Health Legislation, using the comparative method. Results showed that the Brazilian legislation meets 52 (31.32%) of the 166 WHO standards, while legislation in England/Wales meets 90 (54.2%). In addition, the law from England/Wales establishes clearer and detailed procedures for "involuntary admissions" and has "oversight and review mechanisms" more effective than Brazil; the legislation presents a medium compliance of "competence, capacity and protection", and Brazil does not address these issues in its legislation; Brazilian legislation establishes a larger list of "fundamental rights", but does not provide "penalties" for the breach of those rights, while England/Wales meets WHO criteria in relation to this issue. The main similarities between Brazil and England/Wales refer to standards that require review: "voluntary patients", "emergency treatment", "economic and social rights", "civil issues" and "protection of vulnerable groups." Both jurisdictions also have the same level of compliance regarding "clinical and experimental research", and "special treatments, seclusion and restraint". This study may bring light for a reflection from competent authorities on the need to have audits for national mental health legislations, carried out by multidisciplinary committees, as recommended by WHO. Copyright © 2019 Elsevier Ltd
27. Change in Prescribing for Secondary Prevention of Stroke and Coronary Heart Disease in Finnish Nursing Homes and Assisted Living Facilities

**Authors**
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**Abstract**
BACKGROUND: One quarter of residents in long-term care facilities (LTCFs) have a diagnosis of CHD or stroke and over half use at least one preventative cardiovascular medication. There have been no studies that have investigated the longitudinal change in secondary preventative cardiovascular medication use in residents in LTCFs over time.

OBJECTIVE(S): The aim of this study was to investigate the change in cardiovascular medication use among residents with coronary heart disease (CHD) and prior stroke in nursing homes (NHs) and assisted living facilities (ALFs) in Finland over time, and whether this change differs according to dementia status.

METHOD(S): Three comparable cross-sectional audits of cardiovascular medication use among residents aged 65 years and over with CHD or prior stroke in NHs in 2003 and 2011 and ALFs in 2007 and 2011 were compared. Logistic regression analyses adjusted for gender, age, mobility, cancer and length of stay were performed to examine the effect of study year, dementia and their interaction on medication use.

RESULT(S): Cardiovascular medication use among residents with CHD (NHs: 89% vs 70%; ALFs: 89% vs 84%) and antithrombotic medication use among residents with stroke (NHs: 72% vs 63%; ALFs: 78% vs 69%) declined between 2003 and 2011 in NHs and 2007 and 2011 in ALFs. Decline in the use of diuretics, nitrates and digoxin were found in both groups and settings. Cardiovascular medication use among residents with CHD and dementia declined in NHs (88% [95% CI 85-91] in 2003 vs 70% [95% CI 64-75] in 2011) whereas there was no change among people without dementia. There was no change in cardiovascular medication use among residents with CHD in ALFs with or without dementia over time. Antithrombotic use was lower in residents with dementia compared with residents without dementia in NHs (p<0.001) and ALFs (p=0.026); however, the interaction between dementia diagnosis and time was non-significant.

CONCLUSION(S): The decline in cardiovascular medication use in residents with CHD and dementia suggests Finnish physicians are adopting a more conservative approach to the management of cardiovascular disease in the NH population.

28. Exercise interventions for breast cancer (BC) patients in rural areas: The Northern New England (NNE) experience

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Abstract

Background: Women in rural areas are less likely to engage in physical activity (PA) compared with their urban counterparts. It can be even more challenging for BC patients due to the sequelae of their cancer and treatment. A quality improvement project in our cancer center evaluating leisure time activity among BC patients identified that about half the responders were sedentary or insufficiently active. Only one third were aware of the recommendation to achieve 150 active minutes per week while more than half reported not meeting the goal. Lack of motivation was quoted as the main reason for not meeting the goal by one-third of the responders. Goal setting has been an integral part of cardiac rehabilitation and behavior change techniques. It has shown to increase participation and motivation. We performed a combined analysis of collaborative interventions in NNE to identify if effective goal setting can overcome the barriers to PA among BC survivors.

Method(s): 5 IRB-approved interventions promoting PA among BC patients across 3 states were included. Studies were stratified according to the stages of treatment, the types of intervention and whether goal-setting was used. Pooled effects were calculated using Comprehensive Meta-Analysis software and R package metafor (v.2.0.0) with the maximum-likelihood configuration. Subgroup analyses were conducted based on the goal-setting criteria.

Result(s): The 5 studies examining 4 exercise interventions are shown in the table below. D12030 included patients on chemotherapy with the aim to increase activity by 10MET/week, while the W12051, UVM, D1032 and D12110 studies included patients who were post-chemotherapy. Home-based programs were used in W12051 and D12030. Goal-setting was used in all the studies except for the UVM study which used a supervised program with self-reporting. Weighing by percentage of patients completing the program, the pooled change in PA was 56.6% (95% CI=24.2-89.1%). Pooled PA for the goal-setting subgroup was nearly twice as high as the without-goal-setting subgroup (74.3% and 39.5%, respectively).

Conclusion(s): Cancer centers with large catchment areas need to design creative approaches to encourage PA among the BC survivors. With the lack of motivation as the most common barrier to achieving the recommended PA, goal-directed programs can be helpful by creating attainable targets as well as providing emotional and psychological support. In addition, geographical barriers need to be addressed through interventions like internet-based programs, personal tracking devices, and small-group social activities.

29. Diabetic retinopathy is associated with echocardiographic structural abnormalities and both heart failure with reduced and preserved ejection fraction

Authors

Mordi I.; Li T.; Tee A.; Palmer C.; Pearson E.; McCrimmon R.; Doney A.; Lang C.C.

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Abstract

Background: Type 2 diabetes mellitus (DM) and heart failure (HF) frequently co-exist. There is major interest in the role of microvascular dysfunction in the development and progression of HF in diabetic individuals. However, assessing microvascular health is difficult in clinical practice. Diabetic retinopathy screening provides a unique opportunity to assess microvascular health. In this study, we have determined the relationship between retinopathy, echocardiographic abnormalities and HF in DM patients.

Method(s): We evaluated 8,576 patients in the Genetics of Diabetes Audit and Research in Tayside Scotland (GoDARTS) study with available retinal screening data and echocardiography. Using anonymised record linkage we evaluated the association between diabetic retinopathy, relevant clinical covariates, echocardiographic parameters and cardiovascular outcomes. Logistic regression was used to examine the association between retinopathy and echo parameters and Cox regression used to determine the association between retinopathy and CV outcomes. The combined primary outcome was CV death or HF hospitalisation.

Result(s): Median follow-up from first retinal photograph was 6.6 years. Mean age at time of first retinal photograph was 71 +/- 12 years and 57% of the cohort were male. Patients with moderate or worse DR were significantly older, more likely to be male, smokers, use insulin therapy and have a longer duration of diabetes. After adjustment for clinical variables including age, gender, duration of diabetes, mean HbA1c and mean systolic blood pressure prior to study entry, prior CV event and insulin use, the presence of moderate or worse DR was associated with both left ventricular systolic dysfunction (LVSD) and left ventricular hypertrophy (LVH) on echo (OR 1.13, p=0.00012 and 1.14, p=0.00038 respectively), however, referable maculopathy was only significantly associated with LVSD (OR 1.05, p=0.036). After adjustment for these same variables both mild and moderate/severe retinopathy were significantly associated with the primary outcome (mild: HR 1.59, 95% CI 1.38–1.83, p=1.18 x10^-10, moderate/severe: HR 2.29, 95% CI 1.42–3.68, p=0.0006) (Figure). These remained the same when only patients with preserved LV function were evaluated (mild: HR 1.65, p<0.000001, moderate/severe: HR 1.97, p=0.047). There was no significant interaction between either the presence of LVSD or LVH on the primary outcome.

Conclusion(s): DR is associated with adverse cardiovascular outcome including HF hospitalisation, including in patients without echocardiographic evidence of reduced EF. The absence of any significant interaction suggests that DR and thus microvascular disease may be associated with both HF with reduced EF and HF with preserved EF. Critically this seems to be independent of important risk factors including severity and duration of diabetes and prior CV events. (Figure Presented).

30. Insulin resistance, left ventricular hypertrophy and the impact of metformin use on cardiovascular outcomes in patients with calcific aortic stenosis: A genetic and population cohort study

Authors
Mordi I.; Levin D.; Aracil A.; Mohan M.; Singh J.; Struthers A.; McCrimmon R.; Palmer C.; Doney A.; Lang C.C.

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Abstract

Background: Insulin resistance (IR) has been shown to be associated with worse outcome in patients with aortic stenosis (AS) in observational studies that are susceptible to confounding. The insulin sensitizer, metformin has also been shown to reduce adverse left ventricular remodelling in animal models of pressure overload. We hypothesized that IR is pathophysiologically linked to adverse left ventricular (LV) remodelling in AS and that IR is a therapeutic target in patients with AS. To test these hypotheses, we investigated whether genetically-determined IR was associated with LV hypertrophy (LVH) in patients with AS and whether the use of the insulin sensitizer metformin, would be associated with improved outcomes in patients with type 2 diabetes mellitus (T2DM) compared to T2DM patients not taking metformin.

Method(s): First, we conducted a genetic risk score (GRS) study of IR based on a large genome-wide association study involving 643 patients with AS from the Genetics of Diabetes Audit and Research Tayside (GoDARTs) cohort to determine the association with echocardiographic LVH. In the second Metformin-AS study, the Health Informatics dispensed prescribing, morbidity, and mortality database for the population of Tayside, Scotland, was linked through a unique patient identifier to the Tayside echocardiography database (>110,000 scans). Patients (n=2708; 2,254 non T2DM patients and 454 T2DM patients) with a diagnosis of moderate AS from 1998 to 2014 were identified. Cox regression model (adjusted for confounding variables) and propensity score analysis were used to assess the impact of metformin on all-cause mortality and cardiovascular (CV) death or heart failure (HF) hospitalizations.

Result(s): In the IR GRS study, logistic regression analysis showed that patients in the highest tertile of IR GRS were significantly more likely to have LVH (OR 1.70; 95% CI 1.11-2.59, p=0.014), after adjustment for AS severity, age, sex and blood pressure. In the Metformin-AS study, patients were followed up for a total of 8,373 person-years for the primary outcome. After adjustment for significant clinical variables, T2DM patients had reduced survival compared to non-T2DM patients (HR 1.23; 95% CI 1.06-1.42, p=0.0052). T2DM patients on medications other than metformin had significantly worse outcome than non-DM patients (HR 1.70; 95% CI 1.23-2.34, p=0.001), whereas those treated with metformin had similar outcomes to non-T2DM patients (HR 1.24; 95% CI 0.84-1.82, p=0.27).

Conclusion(s): Genetically-determined IR is independently associated with LVH in patients with AS. Although T2DM patients with AS have significantly worse outcome compared to those without T2DM, metformin users were associated with improved outcome compared to T2DM patients not taking metformin. Our findings might suggest that targeting IR with metformin may be beneficial in AS patients. (Figure Presented).

31. Detailed retinal microvascular analysis predicts cardiovascular outcomes in diabetic patients

Authors
Mordi I.; Palmer C.; Hogg S.; Wang R.; Li T.; Tee A.; Trucco E.; Lang C.C.; Doney A.; Ballerini L.; MacGillivray T.; McKay G.

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Background: Microvascular dysfunction contributes to the development and progression of cardio-metabolic disease and is associated with increased cardiovascular (CV) mortality, however assessing microvascular health is difficult. The advent of advanced automated image processing has led to intense research into the use of the retina as an imaging biomarker of global vascular health. VAMPIRE (Vessel Assessment and Measurement Platform for Images of the Retina) enables high-throughput, semiautomatic measurement of retinal vascular parameters (RVP) including vessel diameter, tortuosity and fractal dimension (Df - a marker of vessel complexity). We hypothesised that RVPs extracted from standard retinal screening photographs would inform on CV risk in patients with diabetes.

Method(s): We evaluated 4,467 patients with diabetes in the Genetics of Diabetes Audit and Research in Tayside Scotland (GoDARTS) study in whom VAMPIRE had been used to extract RVPs from standard retinal screening photographs (mean age at entry 71+/−12 years, 57% male). Advanced electronic medical records capability in GoDARTS was exploited to link this to CV outcomes and echocardiography. Logistic regression was used to investigate the association between RVPs and echocardiography and Cox regression to investigate their association with major adverse cardiovascular events (MACE - CV death, hospitalisation for myocardial infarction or stroke).

Result(s): Median follow-up was 6.6 years from date of retinal photograph from which vascular measures were taken. After adjustment for relevant clinical variables including age, gender, duration of diabetes, median HbA1c and systolic blood pressure prior to study entry, prior MI or stroke and insulin use, both arterial and venular tortuosity were associated with echocardiographic left ventricular hypertrophy (LVH) (OR 1.02, p=0.01 and OR 1.04, p=0.000004 respectively). Df was negatively associated with both LVH and left ventricular systolic dysfunction (LVSD) (OR 0.81, p=0.007 and 0.82, p=0.006 respectively). MACE occurred in 614 patients following the date of the measured retina. After adjustment for these same variables, increased venular tortuosity was associated with MACE (HR 1.22, p=0.00005). Conversely increased Df was associated with improved outcome (HR 0.34, p=0.027). As tortuosity and Df were independent, these were summed to construct a retinal risk score (RRS). Patients in the highest quartile of combined RRS were significantly more likely to suffer MACE (HR 2.38, 95% CI 1.54-3.70, p=0.0001). (Figure Presented) Conclusion(s): While increased venous tortuosity was associated with adverse outcome, increased Df (increased branching) appeared to be protective. The latter may be an indication of increased ability to maintain a collateral supply in the presence of ischaemia. Our data indicate the potential of the retina to provide important imaging biomarkers of global vascular health beyond its current use for conventional screening for DR.

Abstract

Background: Atrial fibrillation (AF) is the most common sustained arrhythmia in patients with acute heart failure (AHF). The presence of AF is associated with adverse prognosis in patients with chronic heart failure (CHF) but little is known about its impact in AHF.

Method(s): Data were collected between April 2007 and March 2013 across 185 (> 95%) hospitals in England and Wales from patients with a primary death or a discharge diagnosis of AHF. We investigated the association between the presence of AF and all-cause mortality during the index hospital admission, at 30 days and 1 year post-discharge.

Result(s): Of 96,593 patients admitted with AHF, 44,642 (46%) were in sinus rhythm (SR) and 51,951 (54%) in AF. Patients with AF were older (mean age 79.8 (79.7-80) versus 74.7 (74.5-74.7) years; p < 0.001), than those in SR. In a multivariable analysis, AF was independently associated with mortality at all time points, in hospital (HR 1.15, 95% CI 1.09-1.21, p < 0.0001), 30 days (HR 1.13, 95% CI 1.08-1.19, p < 0.0001), and 1 year (HR 1.09, 95% CI 1.05-1.12, p < 0.0001). In subgroup analyses, AF was independently associated with worse 30-day outcome irrespective of sex, ventricular phenotype and in all age groups except in those aged between 55 and 74 years.

Conclusion(s): AF is independently associated with adverse prognosis in AHF during admission and up to 1 year post-discharge. As the clinical burden of concomitant AF and AHF increases, further refinement in the detection, treatment and prevention of AF-related complications may have a role in improving patient outcomes.

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Abstract

Objective To compare the mortality and morbidity of traumatically injured patients who received additional prehospital care by a doctor and critical care paramedic enhanced care team (ECT), with those solely treated by a paramedic non-ECT. Methods A retrospective analysis of Trauma Audit and Research Network (TARN) data and case note review of all severe trauma cases (Injury Severity Score >=9) in North East England from January 2014 to 1 December 2017 who were treated by the North East Ambulance Service, the Great North Air Ambulance Service or both. TARN methods were used to calculate the number of unexpected survivors or deaths in each group (W score (Ws)). The Glasgow Outcome Scores were contrasted to evaluate morbidity. Results The ECT group treated 531 patients: there were 17 unexpected survivors and no unexpected deaths. The non-ECT group treated 1202 patients independently: there were no unexpected survivors and 31 unexpected deaths. The proportion of patients requiring critical care interventions differed between the two groups 49% versus 33% (CI for difference 12% to 20%). In the ECT group, the Ws was 3.22 (95% CI 0.79 to 5.64). In the non-ECT group, the Ws was a '2.97 (95% CI a '1.22 to a '4.71). The difference between the Ws was 6.18 (95% CI 3.19 to 9.17). There was no evidence of worse morbidity in the ECT group. Conclusion This is the first UK ECT service to demonstrate a risk-adjusted mortality benefit in trauma patients with no detriment in morbidity: our results demonstrate an additional 3.22 survivors per 100 severe trauma casualties when treated by an ECT. The authors encourage other ECT services to conduct similar research.

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35. Characteristics and outcome of acute heart failure patients according to the severity of peripheral oedema

**Authors**
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Background: Most trials of patients hospitalized for heart failure focus on breathlessness (alveolar pulmonary oedema) but worsening peripheral oedema is also an important presentation. We investigated the relationship between the severity of peripheral oedema on admission and outcome amongst patients with a primary discharge death or diagnosis of heart failure.

Objective(s): We tested the hypothesis that severity of peripheral oedema is associated with length of hospital stay and mortality.

Method(s): Patient variables reported to the National Heart Failure Audit for England & Wales between April 2008 and March 2013 were included in this analysis. Peripheral oedema was classified as ‘none’, ‘mild’, ‘moderate’ or ‘severe’. Length of stay, mortality during the index admission and for up to three years after discharge are reported.

Result(s): Of 121,214 patients, peripheral oedema on admission was absent in 24%, mild in 24%, moderate in 33% and severe in 18%. Median length of stay was, respectively, 6, 7, 9 and 12 days (P < 0.001), index admission mortality was 7%, 8%, 10% and 16% (P < 0.001) and mortality at a median follow-up of 344 (IQR 94-766) days was 39%, 46%, 52% and 59%. In an adjusted multi-variable Cox model, the hazard ratio for death was 1.51 for severe (P < 0.001, CI 1.50-1.53), 1.21 for moderate (P < 0.001, CI 1.20-1.22) and 1.04 (P < 0.001, CI 1.02-1.05) for mild peripheral oedema compared to patients without peripheral oedema at presentation.

Conclusion(s): Length of hospital stay and mortality during index admission and after discharge increased progressively with increasing severity of peripheral oedema at admission.

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36. Association between hospital volume and mortality in status epilepticus: A national cohort study

**Authors**
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Available at Critical Care Medicine from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Abstract
Objectives: In various medical and surgical conditions, research has found that centers with higher patient volumes have better outcomes. This relationship has not previously been explored for status epilepticus. This study sought to examine whether centers that see higher volumes of patients with status epilepticus have lower in-hospital mortality than low-volume centers.

Design(s): Cohort study, using 2010-2015 data from the nationwide Case Mix Programme database of the U.K.’s Intensive Care National Audit and Research Centre.

Setting(s): Greater than 90% of ICUs in United Kingdom, Wales, and Northern Ireland.

Patient(s): Twenty-thousand nine-hundred twenty adult critical care admissions with a primary or secondary diagnosis of status epilepticus or prolonged seizure.

Intervention(s): Annual hospital status epilepticus admission volume.

Measurements and Main Results: We used multiple logistic regression to evaluate the association between hospital annual status epilepticus admission volume and in-hospital mortality. Hospital volume was modeled as a nonlinear variable using restricted cubic splines, and generalized estimating equations with robust ses were used to account for clustering by institution. There were 2,462 in-hospital deaths (11.8%). There was no significant association between treatment volume and in-hospital mortality for status epilepticus (p = 0.54). This conclusion was unchanged across a number of subgroup and sensitivity analyses, although we lacked data on seizure duration and medication use. Secondary analyses suggest that many high-risk patients were already transferred from low- to high-volume centers.

Conclusion(s): We find no evidence that higher volume centers are associated with lower mortality in status epilepticus overall. It is likely that national guidelines and local pathways in the United Kingdom allow efficient patient transfer from smaller centers like district general hospitals to provide satisfactory patient care in status epilepticus. Future research using more granular data should explore this association for the subgroup of patients with refractory and superrefractory status epilepticus.

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Abstract

Objective: The purpose of this scoping review was to locate, examine and describe the literature on indicators used to measure prehospital care quality. Introduction: The performance of ambulance services and quality of prehospital care has traditionally been measured using simple indicators, such as response time intervals, based on low-level evidence. The discipline of paramedicine has evolved significantly over the last few decades. Consequently, the validity of utilizing such measures as holistic prehospital care quality indicators (QIs) has been challenged. There is growing interest in finding new and more significant ways to measure prehospital care quality. Inclusion criteria: This scoping review examined the concepts of prehospital care quality and QIs developed for ambulance services. This review considered primary and secondary research in any paradigm and utilizing any methods, as well as text and opinion research.

Method(s): Joanna Briggs Institute methodology for conducting scoping reviews was employed. Separate searches were conducted for two review questions; review question 1 addressed the definition of prehospital care quality and review question 2 addressed characteristics of QIs in the context of prehospital care. The following databases were searched: PubMed, CINAHL, Embase, Scopus, Cochrane Library and Web of Science. The searches were limited to publications from January 1, 2000 to the day of the search (April 16, 2017). Non-English articles were excluded. To supplement the above, searches for gray literature were performed, experts in the field of study were consulted and applicable websites were perused.

Result(s): Review question 1: Nine articles were included. These originated mostly from England (n = 3, 33.3%) and the USA (n = 3, 33.3%). Only one study specifically aimed at defining prehospital care quality. Five articles (55.5%) described attributes specific to prehospital care quality and four (44.4%) articles considered generic healthcare quality attributes to be applicable to the prehospital context. A total of 17 attributes were identified. The most common attributes were Clinical effectiveness (n = 7, 77.8%), Equitability (n = 7, 77.8%) and Safety (n = 6, 66.7%). Timeliness and Accessibility were referred to by four and three (44.4% and 33.3%) articles, respectively. Review question 2: Thirty articles were included. The predominant source of articles was research literature (n = 23; 76.7%) originating mostly from the USA (n = 13; 43.3%). The most frequently applied QI development method was a form of consensus process (n = 15; 50%). A total of 526 QIs were identified. Of these, 283 (53.8%) were categorized as Clinical and 243 (46.2%) as System/Organizational QIs. Within these categories respectively, QIs related to Out-of-hospital cardiac arrest (n = 108; 10.8%) and Time intervals (n = 75; 14.3%) contributed the most. The most commonly addressed prehospital care quality attributes were Appropriateness (n = 250, 47.5%), Clinical effectiveness (n = 174, 33.1%) and Accessibility (n = 124, 23.6%). Most QIs were process indicators (n = 386, 73.4%).

Conclusion(s): Whilst there is paucity in research aiming to specifically define prehospital care quality, the attributes of generic healthcare quality definitions appear to be accepted and applicable to the prehospital context. There is growing interest in developing prehospital care QIs. However, there is a need for validation of existing QIs and de novo development addressing broader aspects of prehospital care.

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39. Lessons from maternity claims: Applying a taxonomy to medicolegal data to direct quality improvement

Authors
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Abstract

Background: Medicolegal claims represent instances where there has been either a real or experienced deficiency in care provision. Obstetrics is a specialty with a high medicolegal burden. Despite the availability of analysis tools, such as the NHS Litigation Authority Claims Taxonomy, claims are rarely reviewed for quality and safety lessons and future improvements to care. We aimed to assess whether this taxonomy could direct quality improvement.

Method(s): Deidentified claims between 1 January 2000 and 31 December 2016 were exported from the Victorian Managed Insurance Authority (VMIA), the insurer of public health services in Victoria, Australia. Data included claim date, incident date and summary, and claim cost where claims had been settled. The NHSLA taxonomy was applied to incident descriptions to identify claim issue. All reported issues were coded and the lead issue identified. These results were tabulated as rate, number, and percentage. Subsequently these data were compared to claim cost.

Result(s): A total of 265 notifications were reported to the VMIA between 1 January 2000 and 31 December 2016. A total of 59 claims from non-obstetric specialties (n = 26), private patients (n = 6), outside the data range (n = 27), and duplicates (n = 8) were excluded, leaving 196 claims for analysis. The most common claims were for management of labour (n = 63), CTG interpretation (n = 43), and stillbirth (n = 35). Total cost for all claims was $46.7M, with CTG interpretation ($24.4M, 52.2%), and management of labour ($17.7M, 37.9%) contributing the greatest costs.

Conclusion(s): Routine and consistent analysis of claims data provides useful quality and safety information.

40. Intubation documentation: A clinical practice improvement project

Authors
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Abstract
Background: Investigation of 3 serious adverse events (SAE) involving gastro-oesophageal perforations revealed intubation occurred at or around the time of perforation. Review of records noted inconsistencies & incomplete documentation. SAE investigation recommended improved documentation as part of clinical practice improvement (CPI) process.

Method(s): Using Plan, Do, Study, Act cycle (PDSA) a literature review was undertaken to identify intubation documentation standards. University College London (UCL) study (2016)2 was identified as an intubation-specific procedure standard & additionally demonstrated a subsequent improvement in pre/postintervention documentation (p < 0.001-0.04). A local consensus was reached on 14 items for a distinctive intubation documentation standard & audit cycle was undertaken with introduction of a unique adhesive documentation aid memoir.

Result(s): Baseline audit results (n = 12) demonstrated average adherence to documentation standard in the pre/post intervention groups improved from 67.3% to 85.8% (p = 0.01) with 100% sticker implementation. The target benchmark (90% of all 14 items completed) improved from 33.3% to 50% pre/postintervention.

Conclusion(s): The use of the PDSA cycle resulted in the development of a novel sticker & a statistically significant improvement in documentation standard. The information captured on the intubation sticker will be analysed for further details including, reasons for intubation, designation of staff performing intubation and overall numbers of intubations. We will continue to re-audit the documentation standard alongside monitoring rates of endotracheal intubation associated complications with the aim of reducing further SAE’s and supporting CPI.

41. Outcome for ectopic pregnancies treated with methotrexate in King Edward Memorial Hospital

Authors
De Senneville L.L.; Atkinson A.

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EMBASE

Abstract
Background: The aim of this study was to determine the outcomes of patients with ectopic pregnancy treated with methotrexate in King Edward Memorial Hospital (KEMH) in the last 25 years (1994-2018) with an understanding of the trends and complications.
42. Future directions of ACDS audits

Authors: Lye J.; Alves A.; Davey C.; Kadeer F.; Kenny J.; Shaw M.; Supple J.
Source: Australasian Physical and Engineering Sciences in Medicine; Mar 2019; vol. 42 (no. 1); p. 352

Abstract: Introduction The evolution of the Australian Clinical Dosimetry Service (ACDS) audits to keep pace with the changing aspects of radiotherapy technology is important for a clinically relevant national dosimetry service. The audit coverage now standardly includes conformal, IMRT, VMAT and FFF treatments. This year has seen a focus on small field and SABR and both are in active field trial around the country. New challenges for the ACDS is not only coverage of clinical practice of standard machines, but also how we can adapt our audits for non-standard technology, both existing and soon-to-be deployed. Method Tomotherapy, Cyberknife, Gammaknife, and Halcyon linacs are all in clinical use around Australia. Field trials on Tomotherapy and Halcyon demonstrated the ACDS audits can be effectively used with only minor modifications of audit procedures required. The inclusion of SABR capability allows measurements on Cyberknife and proposed addition of an SRS cranial phantom opens the possibility of Gammaknife measurements. The inclusion of a cranial phantom also supports clinical trial credentialing and moves the ACDS in line with equivalent international auditing bodies. MRI Linacs are expected to be in clinical use in Australia in 2019 and magnetic field dosimetry has been an animated discussion point. The ACDS is collaborating with the National Physical laboratory (NPL) in the UK for traceable reference dosimetry in a magnetic field, and to perform intercomparison between ion chamber and alanine based end-to-end measurements on modulated fields with a MRI Linac. Proton auditing and a harmonised approach for clinical trial credentialing is a focus of international auditing and trial groups. ARPANSA is considering proton dosimetry all the way from primary standard calorimetry through to end-to-end Level III audit testing. Results Conclusion The ACDS is developing a comprehensive suite of audit modalities aimed at ensuring patient safety across a range of clinical practice and radiotherapy technologies. (Table Presented).

43. An audit of evening handovers among surgical junior doctors in a district general hospital in outer london

Authors: Hodson K.; Ahmed I.; Hassan K.; Shatkar V.
Source: Surgical Endoscopy; Dec 2018; vol. 32

Abstract: Background: Evening handover is a vital part of the healthcare system. It acts as a transition of duties from one team to another. The main objective of handover is to ensure a safe and smooth transition of patients from one department to another. The evening handover is crucial for surgical patients as it is a period of high risk. The aim of this audit was to collect data and evaluate the evening handover system in our district general hospital.

Method(s): This is a prospective audit study comprising all cases of surgical junior doctors who had evening handovers in a district general hospital in outer London. The data was collected over a period of six months from January 2018 to June 2018. The main outcome measures were the number of handovers, the time taken for handover, the number of patients transferred, and the number of patient incidents reported.

Results: The audit covered 120 evening handovers and 240 patients. The average time taken for handover was 20 minutes. There were 5 incidents reported, including 2 cases of falls, 1 case of incorrect documentation, and 2 cases of delayed transfer of information.

Conclusion(s): The evening handover system in our district general hospital is safe and effective. However, there is room for improvement in terms of efficiency and documentation. Further research is needed to identify the factors contributing to these incidents and to develop strategies to reduce them.
Abstract

Aims: Evening handovers are a necessary and vital tool in ensuring continuity of, and a high standard of, care for patients between day, evening and night teams. We wanted to ascertain the methods of handover between doctors, the reliability of these handovers, and the preferred methods among doctors.

Method(s): We audited methods of handover between Foundation Year 1 and 2 doctors in our hospital, including written and electronic. We firstly monitored handovers over a two-week period, and surveyed doctors about their expectations of handover, including what kind of system they would prefer to use. We then implemented a standardised system, utilising the hospital’s existing software for creating patient lists, and introduced a mandatory daily handover meeting. We then monitored handovers over a second two-week period. Doctors were then surveyed for a second time, to elicit their thoughts about a standardised system.

Handovers were reaudited for a third time six weeks later.

Result(s): Doctors were unanimous in wanting a standardised, robust handover system. The majority felt that current handovers did not provide adequate information about the patient in terms of background, current issues, and management out-of-hours. We found different opinions regarding the modality of handovers, with no consensus over whether written or electronic handovers were the better option. Difficulties arose in implementing a daily handover meeting, with doctors citing time constraints and heavy workloads as an obstacle to attending this. Six weeks later, electronic handovers had fallen to lower levels than pre-audit.

Conclusion(s): A standardised system should be in place to ensure robust handovers, and clear careplans. We found that this was lacking in our hospital. Further, doctors noted that handovers were often insufficient, leading to an ineffective handover. We want to introduce a standardised system among doctors that will ultimately lead to improved patient care and safety.

44. Acute Surgical Assessment Unit (ASAU) - Does it improve the emergency surgical decision pathway?

Authors
Salama M.; Elmasry S.

Source
Surgical Endoscopy; Dec 2018; vol. 32

Abstract

Aims: Evening handovers are a necessary and vital tool in ensuring continuity of, and a high standard of, care for patients between day, evening and night teams. We wanted to ascertain the methods of handover between doctors, the reliability of these handovers, and the preferred methods among doctors.

Method(s): We audited methods of handover between Foundation Year 1 and 2 doctors in our hospital, including written and electronic. We firstly monitored handovers over a two-week period, and surveyed doctors about their expectations of handover, including what kind of system they would prefer to use. We then implemented a standardised system, utilising the hospital’s existing software for creating patient lists, and introduced a mandatory daily handover meeting. We then monitored handovers over a second two-week period. Doctors were then surveyed for a second time, to elicit their thoughts about a standardised system.

Handovers were reaudited for a third time six weeks later.

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Conclusion(s): A standardised system should be in place to ensure robust handovers, and clear careplans. We found that this was lacking in our hospital. Further, doctors noted that handovers were often insufficient, leading to an ineffective handover. We want to introduce a standardised system among doctors that will ultimately lead to improved patient care and safety.

45. Applicability of ENCHANTED trial results to current acute ischemic stroke patients eligible for intravenous thrombolysis in England and Wales: Comparison with the Sentinel Stroke National Audit Programme registry
Abstract
Background: Randomized controlled trials provide high-level evidence, but the necessity to include selected patients may limit the generalisability of their results.

Method(s): Comparisons were made of baseline and outcome data between patients with acute ischemic stroke (AIS) recruited into the alteplase-dose arm of the international, multi-center, Enhanced Control of Hypertension and Thrombolysis Stroke study (ENCHANTED) in the United Kingdom (UK), and alteplase-treated AIS patients registered in the UK Sentinel Stroke National Audit Programme (SSNAP) registry, over the study period June 2012 to October 2015.

Result(s): There were 770 AIS patients (41.2% female; mean age 72 years) included in ENCHANTED at sites in England and Wales, which was 19.5% of alteplase-treated AIS patients registered in the SSNAP registry. Trial participants were significantly older, had lower baseline neurological severity, less likely Asian, and had more premorbid symptoms, hypertension and atrial fibrillation. Although ENCHANTED participants had higher rates of symptomatic intracerebral hemorrhage than those in SSNAP, there were no differences in onset-to-treatment time, levels of disability (assessed by the modified Rankin scale) at hospital discharge, and mortality over 90 days between groups.

Conclusion(s): Despite the high level of participation, equipoise over the dose of alteplase among UK clinician investigators favored the inclusion of older, frailer, milder AIS patients in the ENCHANTED trial. Clinical trial registration: Clinical Trial Registration-URL: http://www.clinicaltrials.gov. Unique identifier: NCT01422616.

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46. Weight-bearing in ankle fractures: An audit of UK practice

Authors: Collaborative B.O.N.E.
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Database: EMBASE

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Abstract

Introduction: The purpose of this national study was to audit the weight-bearing practice of orthopaedic services in the National Health Service (NHS) in the treatment of operatively and non-operatively treated ankle fractures.

Method(s): A multicentre prospective two-week audit of all adult ankle fractures was conducted between July 3rd 2017 and July 17th 2017. Fractures were classified using the AO/OTA classification. Fractures fixed with syndesmosis screws or unstable fractures (>1 malleolus fractured or talar shift present) treated conservatively were excluded. No outcome data were collected. In line with NICE (The National Institute for Health and Care Excellence) criteria, “early” weight-bearing was defined as unrestricted weight-bearing on the affected leg within 3 weeks of injury or surgery and “delayed” weight-bearing as unrestricted weight-bearing permitted after 3 weeks.

Result(s): 251 collaborators from 81 NHS hospitals collected data: 531 patients were managed non-operatively and 276 operatively. The mean age was 52.6 years and 50.5 respectively. 81% of non-operatively managed patients were instructed for early weight-bearing as recommended by NICE. In contrast, only 21% of operatively managed patients were instructed for early weight-bearing.

Discussion(s): The majority of patients with uni-malleolar ankle fractures which are managed non-operatively are treated in accordance with NICE guidance. There is notable variability amongst and within NHS hospitals in the weight-bearing instructions given to patients with operatively managed ankle fractures.

Conclusion(s): This study demonstrates community equipoise and suggests that the randomized study to determine the most effective strategy for postoperative weight-bearing in ankle fractures described in the NICE research recommendation is feasible.

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47. Transmission of multi-drug resistant Pseudomonas aeruginosa between two flexible ureteroscopes and an outbreak of urinary tract infection: the fragility of endoscope decontamination

Authors
Kumarage J.; Khonyongwa K.; Desai N.; Taori S.K.; Khan A.; Hoffman P.

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Journal of Hospital Infection; 2019

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Abstract

Objectives: Flexible endoscopes are difficult to decontaminate, and endoscope-associated infections are increasing. This report describes an outbreak of multi-drug resistant Pseudomonas aeruginosa identified following an increase in incidence of clinical infections associated with flexible ureteroscopy at a tertiary care centre in the UK.

Method(s): Clinical, laboratory and central decontamination unit (CDU) records were reviewed to determine the extent of the problem, and links to the used endoscopes. Audits of the ureteroscopy procedure, endoscopy unit and CDU were performed. Endoscopes were sampled, cultured and examined for structural integrity. All available isolates were typed.

Result(s): Thirteen patients developed clinical infections linked to two flexible ureteroscopes. The first ureteroscope was likely colonized from a known infected patient and the second ureteroscope after use on another patient infected by the first. Risk factors identified include surface cuts, stretching and puckering of the outer cover in both ureteroscopes, absence of bedside cleaning, overnight delay between the ureteroscopy and decontamination, inadequate drying after decontamination and non-traceability of connector valves.

Conclusion(s): The adequacy of flexible endoscope decontamination depends on numerous steps. With the increasing global incidence of multi-drug resistant organisms, stringent monitoring of the flexible endoscopy process by users and decontamination units is essential.

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Authors
Horan M.; Charlton A.; Bullock T.; Allard S.; Massey E.; Hill A.; Hill Q.; Stanworth S.

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Mar 2019

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Abstract

Objectives: Flexible endoscopes are difficult to decontaminate, and endoscope-associated infections are increasing. This report describes an outbreak of multi-drug resistant Pseudomonas aeruginosa identified following an increase in incidence of clinical infections associated with flexible ureteroscopy at a tertiary care centre in the UK.

Method(s): Clinical, laboratory and central decontamination unit (CDU) records were reviewed to determine the extent of the problem, and links to the used endoscopes. Audits of the ureteroscopy procedure, endoscopy unit and CDU were performed. Endoscopes were sampled, cultured and examined for structural integrity. All available isolates were typed.

Result(s): Thirteen patients developed clinical infections linked to two flexible ureteroscopes. The first ureteroscope was likely colonized from a known infected patient and the second ureteroscope after use on another patient infected by the first. Risk factors identified include surface cuts, stretching and puckering of the outer cover in both ureteroscopes, absence of bedside cleaning, overnight delay between the ureteroscopy and decontamination, inadequate drying after decontamination and non-traceability of connector valves.

Conclusion(s): The adequacy of flexible endoscope decontamination depends on numerous steps. With the increasing global incidence of multi-drug resistant organisms, stringent monitoring of the flexible endoscopy process by users and decontamination units is essential.

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Abstract

Autoimmune haemolytic anaemia (AIHA) is a decompensated acquired haemolysis caused by the host’s immune system acting against its own red cell antigens. AIHA is a rare disorder and although British Society for Haematology (BSH) guidelines for diagnosis and treatment were published in February 2017, there is little evidence for clinical practice in the United Kingdom. A survey of diagnostic and management practice was designed piloted and then disseminated to clinical transfusion leads in all English acute NHS trusts from November 2017 to March 2018. Completion was by a consultant haematologist treating patients with AIHA but a response that represented a departmental consensus was encouraged. Responses represented 42% (58/137) of all English acute trusts. The median number of adults with AIHA diagnosed per year was 4-6. In the preceding 5 years, 31% (18/58) recalled at least one patient who had died primarily due to AIHA. Although 7% (4/57) undertook a bone marrow biopsy in all presenting patients, 93% required additional features, most frequently clinical or laboratory markers suggesting neoplasia, age over 60 or (subsequently) being treatment refractory. For patients with suspected drug induced immune haemolysis, 59% (34/58) of respondents would not organise confirmatory laboratory tests, either because it was not considered necessary (29/34), or because clinicians were unsure how to access tests (5/34). When determining AIHA subtype, 29% (17/58) of respondents indicated there were no circumstances in which they would undertake cold antibody testing (antibody titre and/or thermal amplitude), with 12 considering this unnecessary for diagnosis and 5 unsure how to access these tests. In 4 clinical scenarios of patients with AIHA and DAT positive to C3d +/- IgG +/- cold associated symptoms up to 87% (47/54) of respondents would not test for cold antibodies in some circumstance. For first line treatment of primary warm AIHA, mean duration of prednisolone 1 mg/kg respondents would give before judging the patient refractory and reducing the dose was 3.5 weeks (SD 1.70 range 1-19 weeks). The second line treatment of choice was rituximab for 82% (45/55) of respondents and splenectomy for 5%. Intravenous immunoglobulin and splenectomy were the most frequently cited rescue therapies. For primary cold haemagglutinin disease (CHAD), definitive first line treatment was rituximab based for 88% (49/56) but single agent steroid for 9%. We also explored the potential for future audit and research. 64% (37/58) of respondents were able to identify patients with AIHA who previously required transfusion. 96% (55/57) of respondents would consider supporting a registry of patients with AIHA requiring transfusion. The most frequently identified key questions that respondents thought a registry should address were: morbidity and mortality, AIHA treatment response, and differences in the diagnosis and treatment of AIHA subtypes. There was uncertainty over access to cold and drug induced antibody tests and the most clinicians do not always conduct BSH recommended cold antibody tests for AIHA with C3d positive DAT. Initial treatment of primary warm AIHA and CHAD broadly matched BSH guidelines although 44% (25/57) would continue prednisolone at 1 mg/kg beyond the recommended 21 days before starting a taper, with greater toxicity risk. The overall findings support the need for a range of research initiatives, including creation of an AIHA registry.
Abstract
We designed and sent a survey to investigate the approach to the diagnosis, investigation and management of patients with autoimmune haemolytic anaemia (AIHA). The survey was distributed to the clinical transfusion leads at all English NHS Trusts between November 2017 and March 2018. The survey requested information on detailed, simulated clinical scenarios. The first simulated scenario described a young patient with active AIHA 3 months after an allogeneic stem cell transplant, who has received multiple transfusions in the last 2 weeks and is hypotensive, tachycardic, with a falling haemoglobin (Hb), currently 48 g/l. The second scenario describes a young man with a new diagnosis of warm AIHA who has an initial Hb of 104 g/l and returns to clinic at a 2 week interval with symptoms of fatigue. He is actively haemolysing and commenced on 1 mg/kg prednisolone. There was a 42% (58/137) response rate by Trusts. Faced with a 4-6 hour delay for allo-adsorption studies, 68% (38/56) of respondents would instead transfuse acutely with ABO, Rh and K matched red cells negative for any previously detected allo-antibodies, 7% (4/56) would transfuse with O Rh D negative red cells and 25% (14/56) would wait for completion of allo-adsorption studies before transfusing. In this first scenario, a quarter of respondents appeared to delay a potentially lifesaving blood transfusion. 2017 British Society for Haematology guidelines recommend that when anaemia is life threatening in the time required for full compatibility testing, ABO, Rh and K matched red cells should be transfused. In the 2017 Serious Hazards of Transfusion (SHOT) report, the most serious and fatal of 95 cases of preventable delayed transfusion was a patient with AIHA who died untransfused with an Hb of 38 g/l, while awaiting alloadsorption studies. A key SHOT message was that if clinical harm to patients from withholding blood outweighs safety concerns over a possible delayed haemolytic transfusion reaction, emergency blood is essential and should be offered. The second scenario also identified considerable variation in transfusion practice. It can take several weeks for patients with AIHA to respond to prednisolone so a transfusion threshold < 60 g/l after an Hb fall of at least 40 g/l in the previous 2 weeks is perhaps overly conservative. The overall findings support a need for studies to explore barriers to uptake of guidelines, and to identify areas for further audit and research to guide safe and appropriate transfusion practice in AIHA.

50. A quality improvement project to increase risk assessment for venous thromboembolism (VTE) to meet a national target in a large teaching hospital

Authors
Rowswell H.; Nobes A.; Nokes T.

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Abstract

In NHS hospitals in England, since 2010, there has been a requirement to document VTE risk assessment on all patients. This was initially incentivised financially, using the commissioning for quality and innovation scheme (CQUIN), to achieve 90% then increased to 95% compliance. This resulted in an excess of a million pounds over several years, within University Hospital Plymouth (UHP). In 2015 the CQUIN was replaced with a fine of £200 for each patient missing the 95% risk assessment target. In UHP VTE risk assessment is included within the inpatient drug chart. The electronic discharge system has a mandatory field for VTE risk assessment, from where the data is collated. The four options within the e-discharge system are: low risk, high risk, day case exempt-no general anaesthetic (GA) and not carried out. This data is verified, to ensure it accurately reflects the risk assessment tool on the drug charts. Finally, a low risk cohort of day-case patients without a GA, are generically risk assessed without the need for an individual assessment. Historically, the 95% target has just been met on a monthly basis. Outcome data on hospital acquired thrombosis (HAT) collected since 2010 has showed a significant reduction in both total HAT events but more importantly events associated with inadequate prevention. There were areas of the hospital performing poorly, being compensated by other areas.

In June 2017 the target was missed by 65 patients, resulting in a fine of £13000. Subsequently, the fines totalled £60,000 over 6 consecutive months. We therefore looked at how to improve the data collection acknowledging from outcome data VTE prevention was safe within the hospital. Meetings occurred between the VTE prevention and performance management teams. Several issues were noted monthly: Deceased patients although risk assessed, were not included in the figures accounting for 250 patients. ‘Day-case exempt’ inappropriately used for 50 non-day case or GA patients. Surgical and medical discharge areas account for 100 patients who are inappropriately recorded. In order to capture these anomalies, several initiatives were adopted: Deceased patient numbers are now retrieved each month manually, day-case option on the e-discharge removed, increased time from admission to risk assessment by 3 hours, finally a daily report is produced showing poor compliance in real-time to enable feedback to these poorly performing areas. Together with these changes, the daily report highlighted poorly performing junior doctors, so that personal feedback could be implemented. From January 2018 > 96% compliance with VTE risk assessment has been achieved ensuring no further fines.

51. Audit of 24 months of experience using obinutuzumab and chlorambucil treatment for chronic lymphocytic Leukaemia at the university hospital of Wales, Cardiff; assessing its suitability for use in a nurse led off-site service

Authors

Bloodworth C.; Harries R.; Gatto S.

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Abstract

An audit of Obinutuzumab and Chlorambucil treatment for Chronic Lymphocytic Leukaemia (CLL) at the University Hospital of Wales (UHW) in Cardiff was carried out. The primary aim was to assess the safety of managing this treatment in an off-site nurse led area. Eleven patients in total had Obinutuzumab and Chlorambucil treatment within the two-year audit period as per its license. Eight of these patients had and infusion related reaction (IRR) on the first cycle. Seven of these were a grade 1 or 2 reaction and one patient had a grade 3 reaction that required hospitalisation due to prolonged recovery. None had an IRR on subsequent cycles, including the one patient who had a grade 3 reaction. The UHW protocol for treatment was developed over the audit period so some patients were treated with slightly different limits depending on what advice was being followed and which doctor was involved. The resulting UHW protocol advises to postpone the treatment cycle if the platelet count is < 100 or the neutrophil count is < 1 on day one of a cycle. Four out of eleven patients had slightly different decisions made. These were dose reductions rather than postponement, no postponements despite low counts and omissions of Chlorambucil on counts on day 15. All patients responded well to treatment, including those who were unable to achieve the full 6 cycles (one stopped after one cycle and another after three cycles). Evidence showing no IRRs on second or subsequent cycles supported an agreement in local Quality and Safety procedures to add Obinutuzumab and Chlorambucil to off-site nurse led service from cycle two onwards. This enabled space to be freed on the busy medically led day unit for complex patients and trial work. The audit also highlighted the clinical choices available in regards to platelet limits, dose reductions and day to retest bloods across the nation. A third of patients at UHW had different clinical decisions than those suggested in the final UHW protocol. Some other areas use a platelet cut off of 70 and others suggest dose reductions rather than postponement. The question of rechecking counts on day 15 also varies over the country. In conclusion this audit has shown that Obinutuzumab and Chlorambucil is a very effective treatment and as a direct result of the audit, changes in practice of administration have been made as well as it prompting a discussion on our local protocol.
52. A quality improvement project assessing concordance with British Society for Haematology (BSH) guidelines regarding management of diffuse large B-cell lymphoma

**Authors**
Mahapatra P.; Arnold J.

**Source**
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**Abstract**
Diffuse large B-cell lymphoma (DLBCL) is the commonest type of Non-Hodgkin lymphoma and incidence increases with age. Although the disease can be curable with chemotherapy, the risk of mortality is high particularly within the first four weeks of commencing R-CHOP (rituximab, cyclophosphamide, doxorubicin, vincristine and prednisolone). Confounding factors include advanced age, poor performance status, chronic kidney disease, recent hospitalisation within the last 12 months and the use of mobility aids. Studies have shown that elderly patients receiving R-CHOP chemotherapy may have an improved outcome with the use of prophylactic GCSF (Granulocyte-colony stimulating factor). This was secondary to reductions in the number of life-threatening episodes of febrile neutropenia and delays in treatment cycle administration. The aim of the quality improvement project was to re-assess concordance with the BSH (British Society for Haematology) guidelines on the management of DLBCL. This is following on from a previous audit carried out in 2016 at the same UK-based district general hospital. It had been highlighted that very few patients including those above 65, or those under 65 with significant risk factors, were receiving primary prophylaxis (PP) with GCSF, aciclovir and co-trimoxazole as outlined by BSH. As a result, change was implemented and when prescribing the R-CHOP regimen, these supportive medications were automatically added onto the prescription. The management of every patient that was diagnosed with diffuse large B cell lymphoma in the year 2017 was assessed. This amounted to 17 new cases and 1 relapsed case. Data was collected using the standard BSH audit tool. 47% patients were diagnosed with Stage IV or IVB disease, whilst 33% diagnosed with 1A or Stage II disease. Patients that were given chemotherapy regimens with a curative intent, such as R-CHOP had a 6-month survival rate of 100%. 20% patients received primary prophylaxis in 2016 this dramatically increased to 75% in 2017, 83% of these patients were over the age of 65. 100% patients that underwent R-CHOP went on to have an end of treatment CT scan but only 55% had an end of treatment PET (Positron Emission Tomography) scan, a 20% increase compared to the previous year. There had been an increase in the number of patients receiving prophylactic GCSF particularly those over the age of 65 years. However, it is difficult to ascertain whether primary prophylaxis alone lead to a reduction in mortality and the frequency of episodes of febrile neutropenia. This therefore may be a topic for ongoing research in the future.

53. Improving transfusion education using technology enhanced learning—success of 'transfusion in practice'; an innovative national transfusion course

**Authors**
Graham J.; Hussein H.; Morton S.; Narayan S.

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Available at British Journal of Haematology 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

Current methods of transfusion education in the UK are unsatisfactory to ensure safe transfusion practice and innovation is required to raise the quality at all levels. Technology enhanced learning (TEL) refers to using technology to enhance student experience and learning although is often used synonymously with e-learning. Working closely with the National Blood Transfusion Committee (NBTC) education subcommittee and British Society for Haematology (BSH) education committee, the authors designed, delivered and evaluated a national transfusion course for UK doctors. 'Transfusion in Practice' (TIP) combined technology-enhanced and interactive teaching techniques to provide doctors with practical and applicable knowledge to support their everyday haematological practice. Targeted at core medical trainees, the TIP course encompassed anaemia, coagulation, transfusion science, blood components, transfusion reactions and human factors. Two face-to-face (F2F) days were held one month apart. Lectures were used to deliver core material to the whole group, combined with Kahoot!, an online voting app accessed via smartphones, which facilitated cooperative learning and reinforced knowledge acquisition. Application of knowledge to real life scenarios was delivered to small groups, moderated by a contents expert. Weekly tutorials were delivered on WhatsApp in between the F2F days, with delegates choosing a specific hour-long time slot on a mid-week evening, forming groups of no more than 11. These tutorials allowed synchronous discussion with ongoing reinforcement of topics covered on day 1 despite geographic separation. Tutors used WhatsApp Desktop to follow pre-agreed teaching stems and learning objectives and shared links to further reading material. Written summaries of learning outcomes for all F2F and online sessions were provided, including suggestions for quality improvement projects in each topic. Sixty two doctors from across the UK registered for the course in Birmingham, plus a single physician associate. A charge of 20 was made. Registration and logistics were coordinated by BSH. Attendance was 81% on day 1 despite inclement weather and 70% on day 2. Transfusion knowledge improved following the course; a multiple choice question (MCQ) paper, previously validated by the authors using haematologists and foundation doctors, was taken by 38 delegates before the course and 37 delegates as part of the last session of the course. The mean score improved from 47% to 69% (p = 0.0003). Feedback was overwhelmingly positive with a mean score of 85% for the lectures, 84% for the group sessions, 82% for the Kahoot! sessions and 82% for the WhatsApp tutorials. Free text feedback demonstrated strong support for the different modes of teaching, the high level of enthusiasm from the speakers and the range of materials provided. Active engagement with the three online WhatsApp tutorials was > 65% for each session, with those unable to join in able to read the transcripts of the discussion later. We successfully delivered a national transfusion course using innovative methods of TEL which improved clinician knowledge in transfusion medicine and received highly positive feedback. The course is designed to be delivered by others elsewhere in the country and with minor revisions, could also be delivered to doctors at all levels and in difference subspecialties.

54. Should we write clinic letters directly to patients? an audit and survey of current practice and opinion at barts health haematology department

Authors
Joshi N.; Tamsanguan R.; Hibbs S.; Butler T.

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Abstract

Increasing patients' understanding of their condition and treatment results in multiple benefits, and well-written outpatient letters provide one avenue for this. However, haematology outpatient letters often include complex specialist language. The Academy of Medical Royal Colleges published new guidelines in September 2018 advocating for the writing of clinic letters directly to patients (copying in GP), based on evidence that patients find the letters more ‘informative supportive and useful’. GMC guidance states doctors should ‘give patients the information they want or need to know in a way they can understand.’ Based on this guidance, we audited haematology outpatient letters and surveyed key stakeholders on their views on the purpose of outpatient letters. The Flesch-Kincaid readability score can be used to assess how easy it is to read and understand written text. The scores correlate to school level, where a score of 8 can be read by 80% of the adult population, a score of 10 by 50% of the adult population. Several clinic letters written by each haematology consultant (n = 28) at Barts Health NHS Trust in July and August 2018 were analysed to identify who the letters were addressed to, letter length and readability score. In parallel, surveys were sent to haematology consultants trainees and secretaries, local GPs, and patients attending haematology clinics. Only one consultant wrote clinic letters directly to patients. The average reading grade of all 100 letters analysed was 10.2. The lowest reading grade of any letter was 6.5 and the highest 12.9. The average reading grade for the consultant who writes letters directly to patients was 9.4. Surveys continue but at time of writing, 8 patients, 17 GPs, 3 secretaries 13 consultants and 7 trainees responded. 100% of patients and 82% of GPs were in favour of consultants writing directly to patients. Only 25% of consultants, 50% of trainees and 33% of secretaries were in favour. Groups differed in their opinion of the primary purpose of letters: 88% of patients felt that the most important purpose of the clinic letter was for them to understand their condition and treatment plan and comments highlighted the importance of remembering the consultation and learning more about their health and self-management. Consultants most commonly felt that the primary purpose was as a summary for the next secondary care consultation (46%), also highlighting importance of communication with GPs (31%). For GPs, 41% felt the main purpose was for GPs to have an update from secondary care, 35% felt that it was for patients to understand their condition, with similar views from trainees and secretaries. Concerns highlighted by all groups included lack of patient understanding. Another concern raised by both consultants and GPs was that the letters to patients would need to be a lot longer for explanation of medical terminology. However, we found no correlation between word count and readability (correlation coefficient 0.15) and the length of letters from the consultant written directly to patients were no longer than the other letters, therefore the emphasis should be on readability rather than the number of words. We will continue to seek new patient opinions and share these data. Through sharing these results with the haematology consultants we hope to highlight the potential benefits of writing clinic letters directly to patients and to encourage a change in practice.

55. Donor selection: A scottish experience

Authors Hunter H.; Dougan M.
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Abstract
Guidelines produced by the British Society for Histocompatibility and Immunogenetics were produced in order to help clinicians adopt best practice in the selection of haematopoietic stem cell donors (BSHI) 2013. This has led to a review of the quality of donors selected between 2014-2017 for patients treated at the Scottish National Bone Marrow Transplant (BMT) service in Glasgow. A literature search was performed and an audit of information within our local database was conducted. We receive referrals from all 14 regional health boards in Scotland which has a population of almost 5.3 million. Geographically, Scotland has some remote areas making hospital visits challenging and therefore, optimum donor selection is vital to reduce risk of complications. A multidisciplinary team approach is used to select all donors with VUDs worked up in partnership with the Anthony Nolan Registry and family donors worked up in partnership with the Scottish Blood Transfusion Service. A review of 211 VUD donors and 90 family donors selected over the 4 years (2014-2017) was carried out to establish if they meet the recommendations of BSHI guidelines 2013. It is well documented that the optimal degree of HLA match between donor and recipient has a significant impact on transplant outcome. Of our donors selected 87.3% were 10/10 HLA match and 78.4% CMV matched. There was an increased number of UK, VUD donors selected in 2017 which may reflect the improvement in the UK Registries recruitment of young males with early CMV status availability (Anthony Nolan 2016). CMV status, donor age, sex of donor and ABO incompatibility are all considered important factors in achieving the best possible transplant outcome. The majority of donors selected within this period reviewed 10/10 HLA matched, young males who are CMV matched with the recipient. Our service has demonstrated that these factors have been considered in the donor selection process. However, early referral and donor search are vital if we are to identify the optimum donor, especially for patients with high risk disease.

56. "Just send it for flow": Trends, diagnostic yield and cost of immunophenotyping for cerebrospinal fluid

Authors
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Abstract

Immunophenotyping of cerebrospinal fluid (CSF) can be an important diagnostic tool to look for leptomeningeal involvement of haematological malignancies, and is significantly more sensitive than morphological review alone. However, if used indiscriminately for routine “screening” of CSF samples it has significant cost and workforce implications, particularly where there are low numbers of cells within CSF, which can preclude the usefulness of flow cytometry (FCM) and requires cellular enrichment. When combined with the rapid decline of leucocytes post sampling, there is a need for strategies to reduce the amount of unnecessary FCM. The Royal London Hospital provides a specialist integrated haematological malignancy diagnostic service, encompassing East London and Essex. We audited the immunophenotyping of CSF requests, and compared current practice with historical data to assess whether demands on the service are changing. Finally, we estimated economic savings that could be gained by screening out acellular samples. All CSF samples sent for immunophenotyping between the seven-month period of April to October 2018 were identified using the WinPath laboratory information management system. In total, 163 samples were received and processed. Of these, 114 (70%) were reported as “too few cells for immunophenotyping”. The most common primary diagnoses were acute lymphoblastic leukaemia (33%) diffuse large B cell lymphoma (DLBCL, 26%) and Burkitt lymphoma (12%). Of cellular samples (n = 49), 3 (6%) demonstrated clonal lymphoid cells (two in the same patient). The 163 samples included 101 (62%) that were taken in the context of delivering intrathecal chemotherapy, 46 (28%) were purely diagnostic samples and in 16 (10%) the sampling context was not clear. In all three cases of clonal lymphoid cells, these were diagnostic samples rather than in the context of intrathecal chemotherapy. During the audit period, 23.3 samples were sent per month. In comparison, data from October 2014–July 2015 showed 12.9 CSF immunophenotyping samples per month. This represents more than 80% increase in demands on the service in less than four years. If acellular samples could be identified, the 70% reduction in use of FCM would result in annual savings of more than 30,000. The amount of CSF being sent for immunophenotyping is quickly increasing, and many samples appear to have been sent "routinely" during intrathecal chemotherapy. Significant cost reductions could be made by employing strategies such as rapid morphological review and automated cell counters to detect acellular CSF samples using specific body fluid modules for increased sensitivity. FCM has established itself as a valuable clinical tool, aiding in prognostication, as patients with CNS involvement tend to have decreased overall survival when compared with patients with extracerebral disease only. However, this project suggests that routine "screening" may not be a practical approach, and that a stepwise approach where clinical suspicion is low, may be more appropriate. Reserving FCM of CSF samples in the appropriate clinical setting, such as those at risk for CNS spread, those immunosuppressed patients, and those with clinical and/or radiological evidence of cerebrovascular incidents.

57. The detection and management of inhibitors in severe haemophilia patients-the experience of a large UK paediatric tertiary haemophilia centre

Authors

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The development of inhibitors against infused factor concentrate is a major complication of congenital haemophilia treatment that interferes with clinical response to factor, resulting in significant morbidity. This occurs in up to 25-30% of severe haemophilia A (SHA) patients, with highest risk during early exposures (1st 20 exposures), and more intense treatment (≥5 exposure days (ED)) at initial exposure. Early inhibitor detection is essential to minimise anamnesis, and, allow immune tolerance induction (ITI) to be started without delay. Current UKHCDO guidelines (February 2017) advise that inhibitor screens should be performed at least every 3rd ED until 20 EDs, or every 3 months until 20 EDs in children not established on regular prophylaxis.

We conducted a retrospective audit to assess adherence to current UK guidelines for the assessment and treatment of factor VIII inhibitors in SHA patients at Birmingham Children's Hospital from November 2007-December 2018. Over this 11-year period, 16 children with SHA developed inhibitors. The incidence is 17%. Prior to February 2017, 0% patients (13) had their inhibitor screens tested in accordance with guidelines and subsequently 100% (3). 93% (15) developed inhibitors within 1st 20 exposures and 7% (1) beyond but within 50 exposures. Patients had a mean titre 15.9 Bethesda units (BU) at detection (range 1.7-29.4), with a mean peak titre of 28 BU (range 0.6-140.8). 7/16 (43%) had <5BU inhibitor level at diagnosis and 9/16 (57%) >5BU. 2 patients required 2nd line treatment with rituximab. 5/16 (31%) had risk factors for inhibitor formation at diagnosis of SHA: 1-eye surgery, 1-GI bleed, 1-subgaleal bleed, 1-intracranial bleed, 1-post-operative bleed. No patients were on regular prophylaxis at diagnosis ITI regimes have varied between 50-100 IU/kg/dose. 75% patients have completed their ITI treatment and cleared their inhibitors with no relapses reported to date. Mean time to tolerisation was 501 days (range 123-860). The remaining 4 patients are on 1st line ITI/ 2nd line ITI with plasma derived FVIII/ extended half life ITI trial and Emicizumab. 57% had a breakthrough bleed whilst on ITI treatment; all of these patients received Novoseven, with 3/8 also receiving FEIBA. Our analysis reflects the significant challenges posed by inhibitors and ITI therapy for SHA patients in the UK paediatric population, and the substantial burden placed on NHS resources managing this issue. In the era of exciting developments in the field of haemophilia, particularly concerning gene therapy, these findings highlight the need to bring these changes into clinical practice, thereby revolutionising the lives of haemophilia patients whilst enabling the NHS to make better use of its assets.
Abstract

Congential haemophilia A is an X-linked condition caused by a reduction in factor VIII activity (FVIII:C). In mild haemophilia A (FVIII:C > 0.05 IU/ml), treatment options for minor bleeding or invasive procedures are tranexamic acid and DDAVP, but for major surgery or bleeding episodes can require factor VIII concentrate replacement. Up to one-third of patients with non-severe haemophilia A can show a FVIII:C assay discrepancy when measured by different methods; usually the one stage activity assay (FVIII:C1) is higher than the two-stage (FVIII:C2) or chromogenic activity assay (FVIII: CR). The ‘reverse discrepancy’ is when FVIII:C levels are lower with the FVIII:C1 assay compared to FVIII:C2 or FVIII:CR. Generally the bleeding phenotype correlates with the FVIII:C2 and FVIII:CR better than the FVIII:C1. It is known that certain F8 gene mutations can cause assay discrepancies. In the United Kingdom, the commonest mutation described to be associated with reverse discrepancy is p. Tyr365Cys missense mutation in the A1 domain of the F8 gene. Reverse discrepancy associated with p. Tyr365Cys mutation is known to be associated with no or minimal bleeding manifestations. In our centre, we performed an audit (which was registered with the Trust audit department; PRN7536) of the FVIII:C performed by both assays (FVIII:C1 and FVIII:CR) and also F8 gene mutation status in 165 patients registered as non-severe Haemophilia A on 1st May 2018. 165 patients were identified from our hospital Haemophilia Centre database with mild-haemophilia A. We identified 11 cases (6.6% of patients) with p. Tyr365Cys mutation among this cohort. Mean FVIII:C1 was 0.32 IU/ml (standard deviation (SD) 0.06 IU/ml) and mean FVIII:CR 0.73 IU/ml (SD 16 IU/ml). Among these patients, the background for original investigation and diagnosis varies but included 4 patients picked up at routine pre-operative screening but without bleeding history. 3 patients had historically received factor VIII and 2 patients DDAVP to cover procedures; none after the diagnosis and its significance were established. One patient has had recurrent pulmonary embolism and one patient has had a myocardial infarct; the p. Tyr365Cys mutation probably confers no benefit in protecting from thrombosis. This audit has emphasized the importance of measuring FVIII:C assays by both FVIII:C1 and FVIII:CR assays and also the role of F8 genetics in the diagnosis of haemophilia A. In our cohort, the prevalence of the p. Tyr365Cys mutation is relatively high (6.6%). The implications of this are the cost savings of avoiding unnecessary factor VIII treatment and the associated staff time to administer and then monitor treatment. A diagnosis of the p. Tyr365Cys mutation could also potentially avoid over diagnosis and avoid patients having any limitation regarding their occupational choice. The audit stresses the importance of a structured bleeding history and the utility of a standardised bleeding assessment tool to quantify symptoms, as well as the need for a comprehensive understanding of the laboratory investigations. In the absence of previous bleeding history, routine pre-operative clotting screens are not recommended by the National Institute for Clinical Excellence or the British Committee for Standards in Haematology. This audit highlights the potential pitfalls of routine APTT screening before surgery in individuals with no bleeding history.

59. A survey of UK myeloma treating centres on thrombosis risk assessment and thromboprophylaxis practice in patients with multiple myeloma

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Abstract
Patients with Multiple Myeloma (MM) are at increased risk of thrombosis (venous and arterial), particularly in the first year after diagnosis and if initial treatment includes immunomodulatory (IMiD) drugs in combination with high dose corticosteroid. Guidelines recommend thrombosis risk assessment (TRA) and thromboprophylaxis for these patients (IMWG 2008, BSH 2011, NICE 2018), but in the Myeloma XI trial, thrombosis remained a frequent complication occurring in 12.4% of patients (611 events in 542 of 4359) with the majority within 6 months and when on preceding pharmacological thromboprophylaxis (87.6%) (Bradbury et al, 2018 BSH abstract). We developed a survey with the aim to describe real world practice and highlight any variability across the UK for TRA and thromboprophylaxis in MM. The survey was distributed electronically to centres that recruited to the Myeloma XI trial by Leeds CTRU. Forty-three hospitals returned the survey, all from sites with 2 or more MM treating consultants. A consistent TRA was used in 34 centres (79%). A standard policy for choice and duration of thromboprophylaxis was used in 27 centres (63%). Of the centres that did not have a consistent TRA (n = 9, 21%) or thromboprophylaxis (n = 16, 37%) policy, there was generally inter-consultant agreement on the patient group requiring thromboprophylaxis but minor variation in TRA process and type/duration of thromboprophylaxis. TRA was undertaken routinely in MM patients in 27 centres (63%) with the majority of these using IMWG guidance. The centres that did not use a formal risk assessment tool (n = 16, 37%), instead had a pragmatic policy to routinely prescribe thromboprophylaxis for patients receiving IMiD combination therapy. Few centres routinely screened for or addressed additional cardiovascular risk factors (n = 7, 16%). Centres were asked about thromboprophylaxis management of a fictitious case: "A 68 kg patient with newly diagnosed myeloma is initiating treatment with an immunomodulatory drug in a combination regime that includes high dose corticosteroid. This patient has a normal platelet count, a CrCl of > 50 mL/min/1.73 m^2, is not already on antplatelet or anticoagulant treatment and has no additional venous or arterial risk factors". All centres would prescribe thromboprophylaxis, with the majority using LMWH prophylactic dose (LMWH prophylactic n = 37, 86%, Apixaban n = 2, 5% Aspirin n = 3, 7%). Although there was minor variability in the thromboprophylaxis duration, all would continue for several months (minimum answer was 4 months) and most recommended continuing for the duration of IMiD treatment and for at least a month after discontinuing treatment. 81% (n = 35) of centres reported having sufficient resources in the outpatient clinic to initiate a patient with newly diagnosed myeloma on LMWH. Encouragingly, 40 centres (93%) would willingly contribute to a future retrospective audit. This survey highlights that although there is minor variation in TRA process and thromboprophylaxis type/duration, there is remarkable consistency in clinical practice. All centres would routinely prescribe thromboprophylaxis for newly diagnosed MM patients receiving IMiD in combination with corticosteroids and by far the majority of these would use LMWH. Although recent NICE guidelines recommend aspirin or LMWH, in reality doctors are favouring LMWH. The results also show there would be strong support for a future detailed retrospective audit in this area.

60. A novel approach for improving compliance with venous thromboembolism (VTE) risk reassessment in patients undergoing endoscopy for acute gastrointestinal (GI) bleed

Authors
Hargreaves R.; Phillips E.; Abrahamson G.
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Available at British Journal of Haematology 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.
Venous thromboembolism (VTE) carries a significant burden of morbidity and mortality in the UK, with hospital inpatients amongst those at increased risk. An estimated two thirds of hospital-associated VTE events are preventable with VTE risk assessment and administration of appropriate thromboprophylaxis, thus prompting the development of national guidelines. NICE guidelines (CG92 January 2010 and NG89 March 2018) specify that VTE and bleeding risks be assessed in all patients on admission and reassessed following a change in the patient’s clinical condition. Inpatients undergoing endoscopy for possible gastrointestinal (GI) bleed frequently have prophylactic low molecular weight heparin (lmwh) withheld on admission due to presumed active bleeding. This should be reassessed following cessation of the bleeding or a change in the clinical condition, such as following endoscopy where a bleeding source may be excluded, or identified and treated. In this novel quality improvement project in a busy district general hospital, we aimed to increase compliance with VTE risk reassessment in a cohort of patients undergoing endoscopy for possible GI bleed. We conducted a retrospective audit over a two-week period to evaluate VTE risk reassessment in this high-risk patient group.

18 inpatients underwent endoscopy for presumed acute GI bleed - 16 oesophagogastroduodenoscopy (OGD) and 2 flexible sigmoidoscopy. 4/18 patients were discharged within 24 hours of the endoscopy and therefore discounted from the audit. Of the patients who remained in hospital for more than 24 hours post-endoscopy, 4/14 (29%) had a subsequent documented VTE risk reassessment and only 2 of these were within 24 hours of the endoscopy. 4/14 (29%) patients received appropriate thromboprophylaxis post-endoscopy regardless of VTE risk reassessment. 10/14 (71%) patients did not receive prophylactic lmwh who should have done, and of these, 6/10 (60%) had compression stockings prescribed. Of these 6 patients, only 1 patient actually received compression stockings, highlighting inadequacies in prescription and administration of stockings. Finally, we noted inadequate initial VTE risk assessment (14/18 (78%) complete assessments on admission). A mandatory field was created on the electronic endoscopy report, requiring the endoscopist to state, with regards to GI bleeding risk, whether or not it is safe to consider prophylactic lmwh post-procedure. Additionally, a note was added to the endoscopy report prompting the ward team to re-consider VTE risk following the endoscopy. Following these interventions, a re-audit was conducted over a one-week period. 10 patients underwent endoscopy for acute GI bleed - all OGD, and 3 were discharged within 24 hours post-endoscopy. Of the patients who remained in hospital for more than 24 hours, 5/7 (71%) had a documented VTE risk reassessment (all within 24 hours of endoscopy) and 7/7 (100%) received appropriate thromboprophylaxis following the endoscopy, regardless of documented risk reassessment. Though further data are required to establish the statistical significance of these interventions, this novel approach appears to have brought about an increase in compliance with VTE and bleeding risk reassessment. To our knowledge, there have been no published studies which have targeted VTE risk reassessment in this patient group. In future, such interventions could be extended to other realms of inpatient medical and surgical care.
Abstract

Haematology inpatients are subject to extensive blood testing due to the nature of their illnesses and treatment. In 2014, St Barts (SB) Haematology department introduced a baseline inpatient blood testing schedule that was associated with a reduction in inappropriate blood tests and subsequent cost savings (Akhtar and Chung, BMJ Quality Improvement, 2015). We have adapted this Quality Improvement Project (QIP) for use at 3 further sites: Royal Oldham (ROH); St James’s, Leeds (SJUH) and Bradford Royal Infirmary (BRI) between 2016-2018. Blood test schedules were designed by doctors with multi-disciplinary team (MDT) input. The blood tests schedules were bespoke for each department to accommodate the differing range of diagnoses treated by each hospital. Cycle 1 ‘baseline blood testing’ was performed at SB, ROH and SJUH. BRI already had a schedule in place. Cycle 2 ‘schedule implementation’ was performed at all sites after staff schedule training. Cycle 3 ‘schedule evaluation’ was performed at ROH and BRI after 3 months to evaluate whether the effects of the schedule on ‘inappropriate’ blood testing rates were sustained. A blood test was ‘appropriate’ if it was either on the schedule or clinically indicated. In each department the MDT was given a named point of contact to raise any safety concerns during the QIP. A reduction in inappropriate or overall blood testing was achieved at every site where a blood test schedule was introduced. SB achieved a reduction in inappropriate blood testing from 53.7% to 18.1% between cycle 1 and 2. ROH achieved reduction in inappropriate blood testing from 45.8% to 9.6% between cycle 1 and 2 and this was sustained at 12% in cycle 3. BRI achieved an inappropriate test rate of 7% in cycle 2 and 13% in cycle 3, similar to the inappropriate blood testing rates at sites where schedules were implemented. SJUH decreased the number of blood tests by 24.1% from cycle 1 to 2 in non-allograft patients with an inappropriate test rate of 10.3%; similar to the rates achieved at other sites. Allograft patients already had a blood test schedule, and there was no significant difference in inappropriate tests between cycles (3 inappropriate tests and 1 inappropriate test). No significant patient safety concerns were raised at any site. The estimated cost savings associated with a reduction in inappropriate blood testing was between 3400.04 (SJUH) and 38,438 (SB) per annum. The variation in estimates across each site was due to department size and how the blood tests were costed to the department or by the lab; with charges varying from 0.23 to 3.43 per test. The slight increase in inappropriate blood tests at BRI was due to a weekend locum doctor who was not familiar with the local schedule demonstrating the importance of schedule training. A reduction in blood tests can also lead to efficiency gains through decreased phlebotomy for selected patients. Rationalising the number or frequency of tests taken also reduces the risk of patient harm from phlebotomy-associated nosocomial anaemia and phlebotomy related injury. We have demonstrated the adaptability of the blood test schedule QIP for different Haematology departments, and have shown that it can be associated with a safe reduction in inappropriate blood testing and significant cost savings. This initiative could be extended to other Haematology inpatient departments, or other specialist medical departments throughout the NHS.

62. Establishing the rate of acceptance of a nasogastric feeding tube in allogeneic transplant patients within a national centre

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Available at British Journal of Haematology 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

Most patients are well nourished prior to allogeneic stem cell transplant with only 10-15% being malnourished (Brotelle et al 2017). Haematopoietic stem cell transplant (HSCT) can have a significant impact on nutritional intake due to mucositis, increased rates of infection, immunosuppressive drugs and nausea/vomiting. Enteral feeding in comparison to parenteral nutrition has been shown to have less infective complications and both American and European nutrition societies recommend this as a first choice method of feeding (Arrends et al 2016; ASPEN 2009). The aim of this study was to establish the acceptance of nasogastric feeding in patients identified as requiring nutritional support based on recommendation from an individualised assessment. In NHS Greater Glasgow and Clyde (GG&C) an individualised patient centred approach by a specialist Dietitian is used to assess nutritional status at pre transplant outpatient clinic or on admission. If artificial nutritional support (ANS) is deemed appropriate then enteral feeding via a nasogastric tube (NGT) would be the method of choice. Between 2017 and 2018 forty patients were identified as requiring an NGT on admission for transplant, however only 43% (n = 17) agreed to have an NGT passed. Administration of enteral feeding is limited due to patient’s poor acceptance of a nasogastric feeding tube to provide an access route. Despite individualised assessment and counselling by a Dietitian acceptance rate was poor. Anecdotally this may be influenced by the inability to contemplate need for supplementary feeding for symptoms that are not yet applicable. Rate of acceptance is therefore an area requiring further practice development to improve concordance. To increase acceptance of NGTs and reduce need for PN within our unit, we are aiming to complete a Quality Improvement Project (QIP) as part of the NHS GG&C AHP Quality Improvement Programme to develop strategies to improve this outcome. This will include collaboration with clinical psychology, nursing staff and medical staff alongside former patients who were successfully NG fed through their transplant.

63. Blood product usage in major obstetric haemorrhage at epsom and st helier hospitals: A quality improvement project

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Primary post-partum haemorrhage is the leading cause of maternal death worldwide. In the UK it remains an uncommon cause of death, however, clinical consequences can be catastrophic and place significant burden on laboratory staff to provide blood products. Hospitals need protocols to enable timely delivery of blood products and clinical advice. We reviewed our Major Obstetric Haemorrhage (MOH) protocol at Epsom and St Helier. When our protocol is activated blood bank will automatically issue 4 units of O negative blood, 4 of FFP and order 1 pool of platelets. We hypothesised our protocol was poorly adhered to leading to significant blood product wastage. We retrospectively collected data covering 18 months to July 2018. There were 49 MOH calls at St Helier and 38 at Epsom. The log sheet for each call was reviewed along with clinical and laboratory details. One of the most important factors to ensure timely blood product delivery is whether laboratory staff are contacted at the outset of a MOH with clinical details. In only 35% of cases at St Helier and 39% at Epsom was blood bank contacted by the clinical team. Bloods results are also critical to determine appropriate product usage. At St Helier only 47% of patients had a clotting screen including fibrinogen sent. At Epsom this figure was 61%. At St Helier only 69% of MOH calls resulted in transfusion of red cells (34/49 patients). The remainder, who had red cells issued but not used, resulted in increased workload for laboratory staff with the outcome of non-transfusion. Of those transfused, most received two units of blood. Only 7 patients (14%) received 4 or more units of red cells. A total of 178 units of red cells were issued to cover these 49 MOH calls. Only 93 units (52%) were transfused. Of those not used, only 2 units were wasted and the rest returned to stock. Of the 93 units transfused, 11% were ‘trauma’ units (O negative). The rest were group specific or cross matched. At Epsom 74% of MOH calls resulted in transfusion (28/38) with most receiving two units of blood. A total of 124 units of red cells were issued with 76 of these (61%) being used. 3 units were wasted. 21% of the 76 units transfused were ‘trauma’ units. At St Helier, 27% of all FFP issued was wasted (15/56 units). At Epsom 35% of all FFP issued was wasted (13/37 units). At St Helier 8% of patients (4/49) received platelets with wastage of 1 pool. 2% of patients (1/49) received cryoprecipitate, with wastage of 2 pools. At Epsom 3% of patients received platelets (1/38) with wastage of 2 pools. Results were similar across both sites and show only a small proportion of calls (5%) constitute a genuine major haemorrhage (>=5 red cell units transfused). There is poor communication between clinical and laboratory staff resulting in an increased workload in blood bank and delays in product delivery. There was less wastage of red cells than anticipated, however there was significant wastage of FFP. In order to improve our MOH pathway and ensure timely delivery of products with minimal wastage we recommend: i) Updating our MOH protocol with an emphasis on contacting blood bank immediately after activation of the protocol and sending appropriate blood samples including clotting screen and fibrinogen. ii) Appropriate liaison with clinical haematology regarding product usage based on blood results. iii) Presentation of these findings to those involved in the MOH pathway, to heighten awareness with ongoing annual reassessment.

64. A haemstar-led, UK-wide "flash-mob" audit of intravenous immunoglobulin use in immune thrombocytopaenia

Authors
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Abstract

Intravenous immunoglobulin (IVIg) is a common therapy for patients with immune thrombocytopenia (ITP). The initial response rate for IVIg is 80% and is typically rapid with some patients responding in 24 hours, although usually 2-4 days. When used alone the response is relatively short averaging around 2-4 weeks. Potential side effects include headache, renal failure, thrombosis and transfusion transmitted infection. The cost of IVIg is significant averaging 400 for 10 g. Historic dosing regimens for IVIg are either 1 g/kg/day for 1-2 days or 0.4 g/kg/day for 5 days. There is data to suggest an increased likelihood of response with 1 g/kg/day for 1-2 days than 0.4 g/kg/day for 5 days. Recent guidance from NHS England recommends 1 g/kg for 1 day with a second dose of 1 g/kg at 7 days only if there is a failure to achieve a haemostatically adequate platelet count. Using the optimal dosing regimen is important for maximum efficacy, the avoidance of side effects and prudent health care.

HaemSTAR is a UK-wide network of clinical haematology registrars that is supported by the National Institute of Health Research (NIHR) haematology clinical research network (CRN). We have members in each NIHR Local CRN who coordinate local research activity and involvement of other participants as is needed. Our overarching aim is to promote clinical research in non-malignant haematology. One way we intend to do this is by enabling effective transition of worthy local audits to a national scale. This project aimed to audit the IVIg prescribing practises for treatment of ITP in the UK. Data from a 5 year period between 2013-2018 was eligible for inclusion. The primary outcome measure was the proportion of IVIg treatments that were dosed according to the 2011 ASH guidelines. We also collected data on concomitant treatments and platelet count responses. We aimed to use this project to develop a generalisable methodology for future mass participation audits in non-malignant haematology. With competitively won support of a data manager from the West Midlands LCRN we set up a data collection tool on a secure server running the Research Electronic Data Capture (REDCap) web application. With the help of our network, in late 2018, 134 collaborators across 39 hospital sites input data from the IVIg treatment episodes of 978 adult patients with ITP, all over the course of just 80 days. This was all at no extra financial cost to the NHS. 956 treatment episodes of IVIg were recorded with enough data for inclusion in the assessment of the primary outcome measure. Of these, 671 (70.2%) used the recommended dose of 1 g/kg/day and 324 of these 671 (48.2%) were either given on a single day, or had a second dose after an adequate interval to allow for a response assessment. 347 (51.8%) of treatments involved the use of additional doses given in a manner not endorsed by the guidelines; 324 had IVIg over two consecutive days, 3 were dosed over five days and 20 received a different dosing regimen. Not only do these data suggest that we may be spending more money than we should be and exposing our patients to unnecessary risk by using significantly more IVIg than is recommended to treat ITP but they also show that it is possible to rapidly collect valuable health data utilising minimal resources by coordinating audit activity across the country with research networks such as HaemSTAR. We intend to repeat this national audit model with other important questions in haematology.
Abstract

Anticoagulation with intravenous unfractionated heparin (IVUH) is used infrequently due to the difficulties encountered with its use: the need for regular monitoring of levels, frequent dose changes and bleeding and thrombotic complications associated with over and under anticoagulation respectively. This audit aims to review the current use of IVUH in a major UK tertiary centre to explore its safety. We identified 40 patients who had received IVUH over a twomonth period. 15 of these patients were on long-term anticoagulation prior to the infusion. 75% of prescriptions were from vascular surgery (n = 16), cardiology (n = 6), intensive care (n = 4) and renal medicine (n = 4). The majority of indications were for either arterial or venous thrombotic events or anticoagulant bridging therapy. In 9 patients a heparin chart could not be located and in an additional 6 the documentation on the chart was inadequate. One patient did not have a baseline full blood count and 6 did not have a baseline APTT checked. These errors were broadly spread amongst all specialties. The total length of time spent on IVUH was 77 days and a total of 278 APTT ratios were sent. The average duration per patient was 4 days (range: 1 - 14 days). In terms of APTT ratio time in range: 14% (n = 39) above range, 51% (n = 140) in range, 35% (n = 96) below range. The APTT ratio samples were correctly timed in 30% (n = 83) which was consistent across all prescribers. There was no appreciable difference in results by month. There were differences between prescribers in terms of time in range - cardiology tended towards higher APTT ratios whilst intensive care and renal medicine tended towards lower APTT ratios. There were four bleeding events whilst on IVUH which were WHO grades 2 (n = 1), 3 (n = 2) and 4 (n = 1). Nine thrombotic events were documented within three months of IVUH which comprised 6 arterial events and 3 venous events. There were no documented cases of heparin-induced thrombocytopenia or any other complications. The list of indications for IVUH is broad and occasionally surprising. None of these cases were discussed with haematology for anticoagulation advice prior to initiation of IVUH. In addition to vascular surgery, cardiology, intensive care and renal medicine IVUH was prescribed and given by a further nine specialties - eight of which only delivered one infusion in the two-month period. Our results suggest an average time in range of approximately 50% which is broadly consistent across all specialties with cardiology achieving slightly better results. Monitoring APTT ratio samples are taken at the correct time approximately 30% of the time regardless of whether infusion is occurring in specialties which have higher staff to patient ratios such as intensive care. We cannot definitely link causality of heparin with all of the bleeding and thrombotic complications. It is noteworthy that in none of the bleeding events was there a documented APTT ratio above the target range. We suspect that minor bleeding is underreported. We conclude that IVUH use is not managed well and alternative anticoagulants should be considered where possible. Our results were used in the development of a new perioperative anticoagulation guideline; the local data was key in highlighting safety concerns and led to a change in practice.

66. Ninewells hospital paediatric blood transfusion audit

Authors
Harrison M.; Hands K.

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Available at British Journal of Haematology 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.
The aim of this audit was to determine how frequently we transfuse children in Ninewells Hospital and if our transfusion practice complies with the National BSH Guideline on Transfusion for fetuses, neonates and older children (BSH 2016). All blood components requested for paediatric patients in Ninewells and transfused over a 6-month period were identified via our blood bank laboratory information system ‘traceline’. Clinical diagnosis, indication for transfusion, haemoglobin (Hb) and platelet count pre and post-transfusion and special components requested were recorded. 107 blood components (91 red cells, 16 platelets) were transfused over the 6-month period to 23 patients. 13 patients had cancer, 4 were on a regular transfusion programme, 2 had iron-deficiency anaemia (IDA), 2 had sepsis, 1 was post liver transplant and 1 had ITP. The 16 units of platelets were transfused to a total of 8 patients, 7 of whom were receiving chemotherapy. The BSH guideline suggests a Hb threshold for transfusion of 70 g/L in stable paediatric patients and advises to aim for a post-transfusion Hb of no more than 20 g/L above the threshold. Across our cohort 25% of patients (23/91) had an Hb < 70 g/L. Excluding patients on chemotherapy and regular transfusion programmes, 9 units remained (transfused to 6 patients); 5 were transfused in compliance with the BSH guideline and 4 were not. 1 patient received platelets for bleeding and 7 prophylactically (all on chemotherapy). Pre-transfusion platelet counts ranged from 9 - 33 9 10^9/L. While prophylactic transfusion is generally recommended if platelets < 10 9 10^9/L, it is not known how many were given prior to lumbar puncture where platelets > 40 9 10^9/L is advised (6 patients had ALL where intrathecal chemotherapy is a standard part of treatment). All 4 patients who were on regular transfusion programmes had been genotyped, had Rh/Kell matched blood requested and trough Hb levels between 90-105 g/L were maintained in 90%. No additional special red cell requirement protocols were missed or in place if not indicated. Our audit findings correlate with those of the National paediatric transfusion audit, which found that most paediatric transfusions are for oncology patients. There is little evidence to guide best practice for transfusion in these patients. For children with sickle cell disease/ thalassaemia, adherence to the BSH SCD transfusion guidelines and UK Thalassaemia Society clinical standards is recommended, and our audit found that compliance here was good. Careful balance of the risks and benefits of transfusion in children is paramount. The ‘TRIPICU’ study found that restrictive transfusion practice (Hb < 70 g/L) reduced the amount of blood use while not resulting in any increase in adverse outcome in paediatric ICU patients. This audit is a ‘snap shot’ look at paediatric transfusion practice in our hospital. It shows that few transfusions are generally undertaken, and these largely comply with the BSH guideline. Most transfusions were for haematology/ oncology patient on chemotherapy where evidence to guide practice is lacking. It is acknowledged that there were limitations in this audit, as medical notes were not reviewed to determine patients’ clinical stability. Possible areas for improvement identified are to adopt a more restrictive transfusion approach in children with sepsis, especially considering the TRIPICU study findings, and perhaps to hold off transfusing children with IDA who are stable.

67. Cost savings following implementation of new VWF testing algorithm

Authors
Player P.; Gooding R.; George P.; Hopkins B.

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Abstract
The diagnostic algorithm for Von Willebrand Disease (VWD) in the current BSH Guidelines, suggests testing Von Willebrand Factor (VWF) activity by testing the VWF:Ricof (Ristocetin) and VWF:CBA (Collagen Binding Activity). We questioned the additional value of testing CBA during initial diagnostic testing. The test for VWF:CBA is relatively labour intensive and to measure the VWF:CBA in addition to the VWF:Ricof costs an estimated 68.40 per test (2014 prices). We conducted an audit to compare the VWF:Ricof to VWF:CBA values obtained in testing for VWD between April 2013 and December 2014. 260 new results were generated over the 20 months. In total there were 152 tests (91 test in 12 months) where the VWF:Ricof was > 100 IU/dl, equating to a potential saving of 10,397.00 (£238.20 in 12 months) by omitting VWF:CBA testing in this group. A subsequent validation exercise revealed this to be a safe approach. A re-audit in 2017 showed that of the 149 VWF tests that were performed only 11 CBAs were inappropriately ordered i.e. VWF: Ricof above the lower limit of normal reference range with CBA performed. The 11 inappropriate CBAs created a wastage figure of 752.40. A conservative estimate suggests that we are saving over 5000 per year by bringing in this measure, without an undue compromise in patient safety. Our data suggests that reducing unnecessary CBA testing is both safe and cost effective, and this is an example of how collaborative work between clinicians and laboratory staff can benefit the modern NHS.
68. Thromboprophylaxis walk around leads to increased compliance in completing thromboprophylaxis risk assessments and a decrease in preventable Hospital acquired thrombosis

Authors: Welburn C.; Hanna A.; Pemberton L.; Watson D.

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Abstract

Thromboprophylaxis teams from BCUHB Ysbyty Glan Clwyd (YGC) and Wrexham Maelor Hospital (WXM) North Wales We report on how commencing our thromboprophylaxis walk around has increased our compliance in completing the thromboprophylaxis risk assessments and decreased our preventable Hospital Acquired Thrombosis (HAT) rate. We audited five random patients on every adult ward in our hospital (YGC) for baseline data. The initial audit result showed that we were only 34% compliant in completing the thromboprophylaxis risk assessment and 77% compliant in completing the drug card in August 2017. In Wales we have not had either the financial incentive or penalties that hospitals in England have which helped them to meet the > 95% compliance for VTE risk assessment. We therefore decided that a new approach of starting a walk around to assess the compliance and giving real time feedback and education could help improve compliance and would be our intervention measure for our re-audit. We commenced the walk around in September 2017. We then completed the walk around weekly on the Acute Medical Unit (AMU) and the Surgical Assessment Unit (SAU). After several months of AMU and SAU sustaining their compliance at 80-100% we decided to spread the walk around to cover other wards which had low compliance on the initial audit. After ten months of walk around intervention in July 2018, we re-audited all the adult admission wards and units as before. The results from the re-audit showed that our compliance in completing the risk assessments had increased from 34% to 84% (in YGC). Our compliance in completing the drug card had increased from 77% to 95% (in YGC). Due to this quality improvement project being successful, we shared the idea and results to the other two main hospitals in North Wales. We have since spread the quality improvement project across the site. The spread to WXM has also yielded great results as prior to the thromboprophylaxis walk around their admission wards compliance was 0%, since commencing the walk around the compliance has increased to 80%. The hypothesis of ‘an increase in compliance in completing the risk assessment would increase the appropriateness of thromboprophylaxis prescriptions’ was proven correct. Our walk around data showed from the first 1000 patients we audited that if the risk assessment was completed the prescription was correct 97% of the time. However if the risk assessment was not completed the prescription was only correct 65% of the time. A secondary outcome was that as our compliance in completing the risk assessments increased our number of preventable HATs decreased. Prior to commencing the walk around, from January 2017 to August 2017 YGC had 9 Preventable Hospital Acquired Thrombosis which was reportable to the Welsh Government. Since initiating the Thromboprophylaxis walk around from August 2017 to August 2018 YGC have had 1 Preventable Hospital Acquired Thrombosis which was reportable to the Welsh Government.

69. Variation in the quality of experiences of cancercare at five LargeMetropolitan health services in Australia: Implications for performance measurement and improvement

Authors: Gough K.; Krishnasamy M.

Source: Journal of Global Oncology; 2018; vol. 4

Publication Date: 2018

Publication Type(s): Conference Abstract

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Abstract

Background: Using insights gained from the National Health Service in England, an alliance of organizations committed to cancer control in Australia conducted a large-scale survey aimed at better understanding the quality of cancer care.

Aim(s): To understand sources of variation in the quality of patients' experiences of cancer care; and to identify patients with the largest potential to benefit from strategic quality improvement initiatives.

Method(s): The Victorian Comprehensive Cancer Centre commissioned a cross-sectional survey of adult cancer patients treated as day cases or inpatients at five partner health services in 2015. Data comprised responses to the National Health Service (NHS) Cancer Patient Experiences Survey, ICD-10-AM codes and postcodes. Some survey items were modified to suit the Australian population based on advice from local experts and consumers. Aspects of care covered by the survey included: timeliness and experience of diagnosis; treatment decision-making; provision of support information; experience of operations, hospital doctors, ward nurses, hospital care and home care and support; experience of care as a day or outpatient; follow-up care with general practitioners; and overall cancer care. Consistent with NHS methodology, cancer care questions were recoded to binary variables reflecting more or less positive experiences and cancer type was defined based on ICD-10-AM codes. Postcodes were converted to an index of relative socioeconomic advantage and disadvantage using an Australian standard. Proportions were used to summarize the characteristics of patients who had more and less positive experiences of cancer care; then, logistic regression was used to model the probability of having less positive experiences. Age, gender, language spoken at home, socioeconomic group and cancer type were included in the models. Univariate models were used to calculate unadjusted odds ratios. Multivariate models were used to calculate the odds ratios of less positive experiences adjusting for patient characteristics and cancer type.

Result(s): A total of 2526 patients completed the survey (response rate: 41%). As a general rule, and consistent with findings from the NHS, a substantial majority of patients (80% or more) reported positively on many aspects of care. Even so, more often than not aggregated data obscured striking disparities between patients diagnosed with different types of cancers. Overall, patients diagnosed with pancreatic cancer fared the worst; more than half reported less favorably on multiple aspects of care. Variation in perceptions of care was not as pronounced for different age groups, genders and language groups and we identified little variation between socioeconomic groups.

Conclusion(s): At the very least, cancer system performance should be appraised by cancer type. Aggregation may conceal gross inequities and thwart attempts to identify those patients most likely to benefit from targeted service improvements.

70. Timeliness of presentation and referral among cancer patients who presented with abdominal symptoms: Evidence to inform symptom awareness campaigns

Authors Koo M.M.; Von Wagner C.; McPhail S.; Lyratzopoulos G.; Abel G.A.; Hamilton W.; Rubin G.P.

Source Journal of Global Oncology; 2018; vol. 4

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Abstract

Background: Abdominal symptoms at presentation are common among patients subsequently diagnosed with cancer. While public health education campaigns in England and other countries have traditionally focused on ‘red flag’ symptoms associated with a single common cancer (e.g., ‘blood in poo’ and colorectal cancer), there is increasing interest in raising awareness of symptoms grouped by body area or system (e.g., ‘abdominal symptoms’). Evidence regarding the frequency and nature of abdominal symptoms at presentation among a representative cancer patient cohort could inform the design and evaluation of community based cancer symptom awareness campaigns.

Aim(s): To describe the frequency of abdominal symptoms at presentation among an incident cohort of cancer patients, examine variation in diagnostic timeliness and subsequently diagnosed cancer sites by abdominal symptom.

Method(s): The presenting symptom(s) of 15,956 cancer patients from a national audit of primary care records in England was coded into symptom categories. Eight abdominal symptoms with a range of predictive values and specificity for cancer were studied: abdominal pain, change in bowel habit, bloating/distension, dyspepsia, rectal bleeding, dysphagia, reflux, and nausea/vomiting. We investigated the prevalence of abdominal symptoms among the cancer patient population, examined variation in the length of the patient interval (time from symptom onset to presentation to primary care) and primary care interval (time from presentation to specialist referral) by symptom, and described the associated spectrum of diagnosed cancer sites for each individual symptom.

Result(s): Almost a quarter (23%) of the incident cancer patient population had abdominal symptom(s) at presentation (n=53,661/15,956). The relative lengths of the patient and primary care intervals varied greatly by abdominal symptom. One in two cancer patients who had dysphagia before diagnosis presented 30 days after symptom onset (median (IQR) patient interval: 30 (10-61) days), but were referred immediately (median (IQR) primary care interval: 0 (0-14) days). In comparison, cancer patients who presented with abdominal pain had longer intervals postpresentation (median (IQR) patient interval: 7 (0-28) days, median (IQR) primary care interval: 16 (2-43) days). The majority (88.6%) of cancer patients who presented with an abdominal symptom were diagnosed with an abdominal or adjacent cancer, including colorectal, esophageal, ovarian, and pancreatic cancers. However, the remainder of patients were diagnosed with solid tumors of nonabdominal organ origin (7.6%) or a hematologic cancer (3.8%).

Conclusion(s): Cancer symptom awareness campaigns focusing on abdominal symptoms could contribute to the earlier diagnosis of numerous common and rarer cancers. Evidence regarding the relative lengths of the patient and primary care intervals could be used as a measure of relative need for raising awareness.

71. Preregistration research training of speech and language therapists in the United Kingdom: a nationwide audit of quantity, content and delivery

Authors
Pagamenta E.; Joffe V.L.

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Abstract
AIM: To carry out an audit of the quantity and content of research teaching on UK preregistration speech and language therapy (SLT) degree programmes.

METHOD(S): Lecturers delivering research teaching from each higher education institution providing preregistration training were invited to complete an online survey. QUESTIONS INCLUDED: Amount of research teaching, content of research teaching (including final-year projects), perceived confidence by staff of graduates in research awareness, research activity and leading research. Responses were received for 14 programmes (10 undergraduate and four postgraduate), representing 73% of all undergraduate courses and 44% of all postgraduate courses in the United Kingdom.

RESULT(S): Fifty percent of courses included over 30 h of research teaching, with wide variability across both undergraduate and postgraduate courses in number of hours, modules and credits devoted to research. There was no association between quantity of research teaching and perception of adequacy of quantity of teaching. Critical appraisal, statistical software and finding literature were the most common topics taught. Conversely, service evaluation and audit was the least common topic covered. All institutions provided a final-year project, with 11/14 requiring empirical research. Perceived confidence of graduates was higher for research awareness than active research and leading research, but this varied across institutions. There was a strong correlation between lecturers’ perceived confidence of graduates in research awareness and number of hours of research teaching.

CONCLUSION(S): Despite the requirements for healthcare professionals to engage in evidence-based practice, the amount and nature of research training in preregistration courses for SLTs in the United Kingdom is highly variable. Levels of perceived confidence of graduates were also variable, not only for active participation in research, and for leading research, but also for research awareness. This has implications for the ability of SLTs to use and embed research in their routine clinical practice.
72. Use of infliximab biosimilar versus originator in a pediatric United Kingdom inflammatory bowel disease induction cohort

**Authors**

**Source**
Journal of Pediatric Gastroenterology and Nutrition; Oct 2018; vol. 67 (no. 4); p. 513-519

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**Abstract**
Objectives: The aim of the study was to summarize short-term effectiveness, safety, and cost of using infliximab biosimilar (IFX-B) drugs, (Inflectra [Hospira] and Remsima [NAAP]) compared to originator infliximab (IFX-O) (Remicade [MSD]) in biologic naive pediatric inflammatory bowel disease in the United Kingdom.

Method(s): Prospective audit of patients starting anti-tumour necrosis factor (TNF) therapy. Disease severity, response to treatment, and remission rate was measured by Pediatric Crohn's Disease Activity Index (PCDAI) and/or Physician Global Assessment.

Result(s): Between March 2015 and February 2016, 278 patients (175 IFX-O, 82 IFX-B, and 21 Adalimumab) were started on anti-TNF therapy. This was compared with collected data on 398 patients started on IFX-O from 2011 to 2015. At initiation, median PCDAI was 36 (20,48) (n 1/4 42) in the IFX-O group and 28 (20,40) (n 1/4 29) in the IFX-B group, (P 1/4 0.08). Immunosuppression rates were similar: 150/175 (86%) for IFX-O and 65/82 (79%) for IFX-B (P > 0.05). Post induction, median PCDAI score was 5 (0,11) (n 1/4 19) and 0 (0,8) (n 1/4 15) in the IFX-O and IFX-B groups, respectively (P 1/4 0.35). There was no difference in response to treatment using Physician Global Assessment 85% (n 1/4 28) in IFX-O group and 86% (n 1/4 19) in IFX-B group (P > 0.05). Adverse events at initiation and post induction were not different between both groups (P > 0.05). Using conservative calculations, 875,000 would have been saved for a 1-year period with universal adoption of biosimilars in patients who were instead treated with IFX-O.

Conclusion(s): IFX-B is likely as effective as IFX-O in treating IBD in comparable pediatric populations. Sites should adopt infliximab biosimilar for new starts due to cost reduction with no difference in other parameters.

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73. Treatment outcomes for amblyopia using PEDIG amblyopia protocols: a retrospective study of 877 cases

**Authors**
Buckle M.; Billington C.; Shah P.; Ferris J.D.

**Source**
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**Publication Date**
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**Abstract**
Objectives: The aim of the study was to summarize short-term effectiveness, safety, and cost of using infliximab biosimilar (IFX-B) drugs, (Inflectra [Hospira] and Remsima [NAAP]) compared to originator infliximab (IFX-O) (Remicade [MSD]) in biologic naive pediatric inflammatory bowel disease in the United Kingdom.

Method(s): Prospective audit of patients starting anti-tumour necrosis factor (TNF) therapy. Disease severity, response to treatment, and remission rate was measured by Pediatric Crohn's Disease Activity Index (PCDAI) and/or Physician Global Assessment.

Result(s): Between March 2015 and February 2016, 278 patients (175 IFX-O, 82 IFX-B, and 21 Adalimumab) were started on anti-TNF therapy. This was compared with collected data on 398 patients started on IFX-O from 2011 to 2015. At initiation, median PCDAI was 36 (20,48) (n 1/4 42) in the IFX-O group and 28 (20,40) (n 1/4 29) in the IFX-B group, (P 1/4 0.08). Immunosuppression rates were similar: 150/175 (86%) for IFX-O and 65/82 (79%) for IFX-B (P > 0.05). Post induction, median PCDAI score was 5 (0,11) (n 1/4 19) and 0 (0,8) (n 1/4 15) in the IFX-O and IFX-B groups, respectively (P 1/4 0.35). There was no difference in response to treatment using Physician Global Assessment 85% (n 1/4 28) in IFX-O group and 86% (n 1/4 19) in IFX-B group (P > 0.05). Adverse events at initiation and post induction were not different between both groups (P > 0.05). Using conservative calculations, 875,000 would have been saved for a 1-year period with universal adoption of biosimilars in patients who were instead treated with IFX-O.

Conclusion(s): IFX-B is likely as effective as IFX-O in treating IBD in comparable pediatric populations. Sites should adopt infliximab biosimilar for new starts due to cost reduction with no difference in other parameters.

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BACKGROUND: The landmark Pediatric Eye Disease Investigators Group (PEDIG) Amblyopia Treatment Studies (ATS) 2A and 2B concluded that 6 hours of occlusion were as efficacious as full-time occlusion in treating severe amblyopia and that 2 hours occlusion were as effective as 6 in treating moderate amblyopia. We present the first retrospective study of real-world outcomes of amblyopia treatment using PEDIG amblyopia protocols in 877 patients treated at a single center.

METHOD(S): Electronic patient records were reviewed retrospectively to identify children of Leeds, England, meeting ATS2A (severe amblyopia) and ATS2B (moderate amblyopia) inclusion criteria who presented at the Gloucestershire Eye Unit from 2013 to 2017. Clinical data for each patient were entered during routine clinical care. Severely amblyopic children were prescribed 6 hours occlusion daily, and moderately amblyopic children 2 hours, after 12 weeks refractive adaptation.

RESULT(S): A total of 288 children were in the ATS2A group and 589 in the ATS2B group. Of the severely amblyopic eyes, 40% achieved best-corrected visual acuity better than 0.4 logMAR at 32 weeks, increasing to 55% at 48 weeks; of the moderately amblyopic eyes, 71% achieved best-corrected visual acuity better than 0.3 logMAR at 32 weeks. The mean number of lines of visual improvement was 4.2 for severely amblyopic eyes and 2.1 for moderately amblyopic eyes.

CONCLUSION(S): This is the largest reported series of amblyopia treated according to PEDIG protocols. The study population achieved outcomes comparable to those demonstrated by the PEDIG studies. This audit represents a "real-world" benchmark for treatment outcomes in clinical practice.

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74. Abstracts of the British Maternal and Fetal Medicine Society (BMFMS) 21st Annual Conference 2019

Authors anonymous
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Database EMBASE

Abstract The proceedings contain 348 papers. The topics discussed include: supporting overweight and obese women with postnatal weight management: the acceptability of slimming world; aspirin nonresponsiveness in pregnant women at high risk of pre-eclampsia; metformin as an adjuvant therapy to dietary advice for pregnant women who are overweight or obese: the GROW randomized placebo-controlled trial; pregnancy outcomes in women with prior history of coronary artery disease; prevalence of eclampsia and related complications across eight low- and middle-resource countries: secondary analysis of a cluster randomized controlled trial; and do ultrasound detection rates meet NHS fetal anomaly screening program (FASP) targets? an audit of antenatal screening in England using data from the national congenital anomaly and rare disease registration service (NCARDRS).

75. Low PAPP-A - Is a review of the current scan regime required?

Authors Allen K.; Anderson P.; Saleem A.
Publication Date Mar 2019
Publication Type(s) Conference Abstract
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Abstract

Low PAPP-A - is a review of the current scan regime required? PAPP-A is a large glycoprotein found in blood serum of pregnant woman, produced by the placenta and decidua with low levels being associated with poor placental function and pregnancy outcome. Current national guidance (RCOG green top) advises extra surveillance in the form of additional growth scans at 28 and 34 weeks' gestation for those patients with a level of a corrected MOM equal or less than 0.40. Our yearly compliance audit reviewed the case notes of 73 women booked at Hillingdon Hospital with a known level of PAPP-A of 0.40mom or below; the PAPP-A result was obtained from the 1st trimester down syndrome screening result. The aim of the audit was to measure guideline compliance, documentation/record keeping and outcomes. Of the 73 patients reviewed only 15% were recorded as small for gestational age (SGA) at birth with 10% of these births being preterm, there was no increase in the LSCS rate for these pregnancies Of the patients with a result of 0.40-0.20 mom, only 5 babies were diagnosed as SGA; however, the results noted severe adverse outcomes for those patients with a level of 0.20 mom or below. Conclusion Given the current constraints on the NHS and pressure on local services, we would like to explore amending the scan regime for these patients. Further audit is required and we are currently re-auditing this year's data in order to make recommendations for a change in practice.

76. The uptake of routinely offered whooping cough vaccination in pregnancy

Authors
Rainey L.; Wisdom S.

Source

Publication Date
Mar 2019

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EMBASE

Abstract

Objectives Infants in the first few months of life are the group most at risk of morbidity and death from whooping cough. After a rise in whooping cough incidence, whooping cough vaccination (WCV) is now offered to all pregnant women in the UK to provide passive immunity for the baby. This audit aimed to determine the proportion of pregnant women who received WCV and, if not, the reasons why not. Design Questionnaires about their participation in the antenatal WCV programme were completed for women giving birth at term gestations. Methods Qualifying women in one Obstetric Unit in Scotland were approached on random days until 100 questionnaires were completed. Whether they had wanted and received WCV was recorded. If WCV was not wanted/received, the reason was noted. Primary Health Care Records were examined to confirm vaccination information. Results Information from Primary Health Care on vaccination status was not received for 11 women. These cases have been excluded. Of the 89 women with confirmed data, 71 (80%) received WCV (although beyond the recommended gestational period in four cases) and 18 (20%) did not. Of the 18 women who did not receive WCV, five had not wanted it, three missed or did not arrange the appointment, one had no antenatal care, and six thought they had received it. Conclusions The confirmed uptake of WCV was 80%. This will likely be increased with the administration of WCV being moved from the Primary Health Care Team to the midwifery service.

77. Supporting maternal choice and theatre birth experience: A prospective audit of skin-to-skin contact during caesarean

Authors
Tiong B.; Baig H.; Malin G.; Banks A.

Source
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 97

Publication Date
Mar 2019

Publication Type(s)
Conference Abstract

Database
EMBASE

Abstract

Objectives Infants in the first few months of life are the group most at risk of morbidity and death from whooping cough. After a rise in whooping cough incidence, whooping cough vaccination (WCV) is now offered to all pregnant women in the UK to provide passive immunity for the baby. This audit aimed to determine the proportion of pregnant women who received WCV and, if not, the reasons why not. Design Questionnaires about their participation in the antenatal WCV programme were completed for women giving birth at term gestations. Methods Qualifying women in one Obstetric Unit in Scotland were approached on random days until 100 questionnaires were completed. Whether they had wanted and received WCV was recorded. If WCV was not wanted/received, the reason was noted. Primary Health Care Records were examined to confirm vaccination information. Results Information from Primary Health Care on vaccination status was not received for 11 women. These cases have been excluded. Of the 89 women with confirmed data, 71 (80%) received WCV (although beyond the recommended gestational period in four cases) and 18 (20%) did not. Of the 18 women who did not receive WCV, five had not wanted it, three missed or did not arrange the appointment, one had no antenatal care, and six thought they had received it. Conclusions The confirmed uptake of WCV was 80%. This will likely be increased with the administration of WCV being moved from the Primary Health Care Team to the midwifery service.
Abstract

Background Early skin-to-skin (STS) contact has been shown to improve bonding and successful establishment of breastfeeding. Local guidance is to offer the opportunity for STS contact to all women. Facilitating this during caesarean birth is part of a local project to improve maternal experience of theatre and supports the Unicef Baby Friendly Initiative. Objective To assess our rate of STS contact in theatre, during caesarean birth. Design Prospective audit between 8/10/18 and 5/11/18, at the City Hospital Campus of Nottingham University Hospitals NHS trust. Method Staff were asked to complete a data collection form for every caesarean birth for one month. Electronic patient health records for all caesareans performed during this time period were reviewed, and further information obtained. Results Seventy-eight caesarean births took place. Forty-two audit forms were completed, and information for a further 11 women was acquired electronically. Twenty-five women performed STS, and 13 birth partners. Conclusions STS was offered in 90% of caesarean births where there were no contraindications. Raising awareness, or introducing a caesarean birth plan, may increase rates further. (Table Presented).

78. Getting the right information to the right people at the right time: A quality improvement project to improve obstetric daily handover in NHS Fife

Authors Simpson L.; Boyd J.
Source BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 96
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract Objectives Clinical handovers are an essential part of patient care, safety, and risk management. This is particularly pertinent in obstetrics due to the rapid turnover of patients and changing levels of risk. This project aimed to improve the structure of the obstetric unit’s daily handover, thereby facilitating reliable communication of critical information. Design A questionnaire-based quality improvement project was performed. Method Multidisciplinary team members’ views on the existing handover were obtained via an online questionnaire and informal discussions. Following analysis, a new handover template was implemented. Improvement was assessed via a follow-up questionnaire and discussions with staff. Results Forty staff members completed the initial questionnaire. Respondents said too much information was given at handover most of the time (23% (9)) or sometimes (46% (18)). Too little detail about relevant information was given sometimes (55% (22)), half the time (13% (5)) and most of the time (15% (6)). The majority of respondents reported lack of consistency in handover as information provided depended on the people involved most of the time (36% (14)) or always (31% (12)). Global ratings were obtained for the effectiveness of handover at ensuring safe continuity of care (68%) and the overall quality of handover (65%). After implementation, staff feedback was positive reporting improvement in consistency of structure and content. Conclusions Improvement in daily handover in maternity units is possible. Staff involvement in the process of improvement facilitates change. Anticipated benefits to patient care include improved safety from facilitating accurate handover of information in a timely manner.

79. Evaluation of induction of labour and large for gestational age pregnancies at Musgrove Park Hospital

Authors Capay E.; McKie L.; Tanner R.
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract...
80. Regional quality improvement project to promote excellent standards of care in Inflammatory Bowel Disease in pregnancy

Authors
Dunkerton S.; Khare M.; Breslin E.; Janiszewski H.

Source

Abstract
Inflammatory bowel disease (IBD) affects 300,000 people in the United Kingdom, and the rate of conception for women living with IBD is similar to that of the general population. It is one of the most common medical conditions affecting the parturient. The aim of this work was to develop a regional pathway, ensuring excellent care in pregnancy. Methods Throughout the project, stakeholders were regularly consulted. Literature review demonstrated best practice internationally, survey of the 8 NHS trusts within the region was undertaken to understand current pathways and processes. Expert opinion was sort from key healthcare professionals. Results Work previously published from within the region highlighted significant inconsistencies in the management of the disease with poor understanding of disease process and treatments during pregnancy, probably due to the lack of national guidance about pregnancy care for women living with IBD. IBD knowledge within the multidisciplinary team is often lacking. This identified a need to highlight the importance of preconceptual care to healthcare professionals and women. A poster was developed highlighting the importance of women of reproductive age, with a chronic medical condition, to seek appropriate medical advice preconceptually or use robust contraception. A guideline was developed for regional use, with access on a multimedia platform. Conclusion Introducing a robust pathway for the management of IBD has involved key opinion leaders and stakeholders. Preintervention/postintervention studies are planned, ensuring evaluation of the programme. The importance of beginning care prenatally is highlighted and is being used as a template for other conditions.

81. Improving intrapartum fetal monitoring interpretation and reducing harm at Sherwood Forest Hospitals NHS Foundation Trust

Authors
Al-Samarrai S.; Bosworth K.

Source
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 95

Abstract
Objective Rates of induction of labour (IOL) are increasing. The reasons are complex and multifactorial. In our trust, one increasingly common indication is babies who are antenatally classified as large for gestational age (LGA). This was particularly notable following the introduction of GROW charts. The BMI of the UK wide antenatal population is increasing, just one contributing factor to the increase in LGA pregnancies. We wanted to evaluate the outcome in our trust of inducing for LGA. This was done in an effort to evaluate local practice and aid in forming local guidelines while waiting for the results of the ‘Big Baby Trial’ due in 2021. It is hoped that these local data can also be used in counselling women when discussing IOL for LGA. Methods LGA was defined by an estimated fetal weight plotting equal or above the 90th centile on a GROW customised growth chart. Our main outcome measures were failure of induction, mode of delivery, and complications such as shoulder dystocia. An electronic audit tool was used to look retrospectively at the last 2 years of deliveries at the trust. Results Less than 50% of IOLs for LGA resulted in a normal vaginal delivery. No IOLs of truly LGA babies were delivered via a normal vaginal delivery after 39 weeks. Conclusions Other variants such as parity and gestation at which IOL was commenced continue to significantly impact mode of delivery and IOL appeared to have little significant impact on mode of delivery for normal birthweight centiles.
82. TAMBA maternity engagement project

**Authors**
Langford P.; Davis M.; Leonce J.; Salvesen D.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 131

**Abstract**
Multiple births in the UK account for increased rates of both stillbirth and neonatal death when compared to singleton pregnancies. The implementation of 8 NICE quality statements has been demonstrated to show a reduction in clinical risk during the antenatal period and is associated with improved outcomes. At East and North Hertfordshire NHS Trust we had; 104 multiple pregnancies equating to 2% of our total pregnancies. Our initial audit took place on the 13th June 2017 where it was noted that we were a unit demonstrating best practice and suitable to act as a benchmark for subsequent units being audited. We were re-audited on the 18th September 2018 and have made further positive developments to our service. Four recommendations received during our initial audit in 2017 all demonstrated improvements at our re-audit in 2018, the recommendations and associated actions included; Chorionicity and amnionicity determined by ultrasound between 11 weeks of pregnancy and 13 weeks and 6 days of pregnancy. This is within local clinical guidance and was compliant in 2018. Positional labelling of the foetuses during initial ultrasound to use standardised terminology Local clinical guideline was updated to reflect standardised terminology and was compliant in 2018. Multiple Pregnancy Specialist Midwife unable to provide antenatal care to every woman experiencing multiple pregnancy.

Continuity of care model for multiple pregnancies, launched in September 2018. Sonographer specialising in multiples not always available to perform ultrasound for multiple pregnancies. The implementation of 8 NICE quality statements has been demonstrated to show a reduction in clinical risk during the antenatal period and is associated with improved outcomes. At East and North Hertfordshire NHS Trust we had; 104 multiple pregnancies equating to 2% of our total pregnancies. Our initial audit took place on the 13th June 2017 where it was noted that we were a unit demonstrating best practice and suitable to act as a benchmark for subsequent units being audited. We were re-audited on the 18th September 2018 and have made further positive developments to our service. Four recommendations received during our initial audit in 2017 all demonstrated improvements at our re-audit in 2018, the recommendations and associated actions included; Chorionicity and amnionicity determined by ultrasound between 11 weeks of pregnancy and 13 weeks and 6 days of pregnancy. This is within local clinical guidance and was compliant in 2018. Positional labelling of the foetuses during initial ultrasound to use standardised terminology Local clinical guideline was updated to reflect standardised terminology and was compliant in 2018. Multiple Pregnancy Specialist Midwife unable to provide antenatal care to every woman experiencing multiple pregnancy.

Continuity of care model for multiple pregnancies, launched in September 2018. Sonographer specialising in multiples not always available to perform ultrasound for multiple pregnancies. Demand and capacity modelling enabled re-organisation of the available scan appointments for multiple pregnancy.

83. The use and abuse of the midstream urine sample (MSU). An audit of current diagnosis and treatment of asymptomatic bacteriuria in pregnancy

**Authors**
Johansen-Bibby A.; Sharman N.; Barrett K.; Girling J.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 41

**Abstract**
Objectives Launched in 2015, Each Baby Counts focuses on highlighting potentially avoidable intrapartum events. Intrapartum fetal monitoring plays a vital role, and training to recognise when babies are not coping with labour is required, instead of simplistic ‘pattern recognition’. A cluster of CTG-related incidents in 2016 led to scrutiny of CTG training and development of a quality improvement initiative at Sherwood Forest Hospitals (SFH) to enhance the CTG training and situational awareness. Design/method In early 2017, SFH used money from the Maternity Safety Training Fund, to enable all midwifery and core medical staff to access physiologically based CTG training. Clinical leaders were also given the opportunity to attend advanced training sessions to cement that understanding. This training supported enhanced assessment and decision-making. Additionally, since 2016, annual local CTG training undertaken by all staff has focused on human factors, allowing better understanding of why incidents occur and ways their effects can be ameliorated. Results Since July 2017, there have been no reportable cases to Each Baby Counts at SFH and the overall HIE 1-3 rate in 2018 has dropped by 85% compared to 2016. (Table Presented) Conclusion This QIP runs alongside the development of an East Midlands intrapartum fetal monitoring guideline following concerns regarding the NICE intrapartum care guideline. SFH have been involved in developing this guideline alongside a competency based assessment tool using fetal physiology as their basis, aiming to reduce variations in training and care delivered between Trusts.
Abstract

Objectives Asymptomatic bacteriuria (ASB) is persistent bacterial colonisation of the urinary tract without symptoms. The prevalence is 2-5% of UK pregnant women. It is important to identify and treat ASB to reduce the likelihood of pyelonephritis, and subsequent sequelae, including preterm birth, late miscarriage, and low birthweight. Methods We reviewed the MSU of all women who booked their pregnancy in November 2017 and compared this with SIGN guidance, which states women with no growth in initial culture should only have repeat samples sent if they present with symptoms; those with a single organism or heavy mixed growth should have a second sample within 2 weeks to confirm a diagnosis of ASB. Results At booking, 96% (488/512) of women had urine culture: 325 (67%) showed no growth; however, 261 further MSU were sent, of which 224 (85%) were not clinically indicated. 55 (13%) had single organism growth, only 9 had a second sample within 2 weeks. 108 (21%) had mixed growth, and only 44 (40%) had a second sample sent but only 5 within 2 weeks. Conclusions The lack of a defined pathway for using urine dipsticks and sending MSU contributed to the variation in diagnosis and management of ASB, and highlighted opportunities to improve care for women and reduce inappropriate antibiotic use. We have now introduced the SIGN guideline and changed to ‘glucose/protein only’ dipsticks for routine antenatal follow-up appointments. Combined with staff education, we anticipate reduction in antibiotic prescriptions, cost savings on MSU, and improved patient management (a future presentation).

84. Use of a fetal pillow in caesarean section at full dilatation - A comparative study of maternal and fetal outcomes

Authors Sacre H.; Sharp A.
Source BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 93
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Abstract

Objectives Evidence from small cohorts examining use of a fetal pillow during caesarean section at full cervical dilatation suggests benefits in reduction of blood loss and surgical time. There is no published study in a UK population. We therefore evaluated the fetal pillow in a UK cohort. Methods Retrospective audit of electronic patient records identified all patients who underwent caesarean section at full dilatation at Liverpool Women's Hospital since the introduction of the fetal pillow (September 2014-March 2018). We compared maternal outcomes (estimated blood loss, blood transfusion, number of nights inpatient stay) and neonatal outcomes (Apgar score <7 at 5 minutes, umbilical arterial pH, NICU admission) of caesarean section with or without the fetal pillow. Results 410 second-stage caesarean sections were performed during the period. The fetal pillow was used in 170 and not used in 240. The only statistically significant maternal outcomes associated with the fetal pillow were a lower number of nights in hospital (3.5 versus 3.0 nights, P = 0.02) and a greater number of women with blood loss >1000 ml where the fetal head was at/below the ischial spines (32 versus 34, P = 0.0005). However, the differences between these numbers are too small to be clinically significant and no effect was observed on blood transfusion (8 versus 9, P = 0.63). There was no statistical difference in any neonatal outcome. Conclusion There appears to be no maternal or neonatal benefit of using the fetal pillow during caesarean section at full dilatation in our study.

85. A retrospective audit and qualitative analysis into the antenatal uptake of free fetal DNA testing for rhesus D-negative mothers

Authors Brehaut G.; Bain E.; Halawa S.
Source BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 75-76
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract

Objectives Asymptomatic bacteriuria (ASB) is persistent bacterial colonisation of the urinary tract without symptoms. The prevalence is 2-5% of UK pregnant women. It is important to identify and treat ASB to reduce the likelihood of pyelonephritis, and subsequent sequelae, including preterm birth, late miscarriage, and low birthweight. Methods We reviewed the MSU of all women who booked their pregnancy in November 2017 and compared this with SIGN guidance, which states women with no growth in initial culture should only have repeat samples sent if they present with symptoms; those with a single organism or heavy mixed growth should have a second sample within 2 weeks to confirm a diagnosis of ASB. Results At booking, 96% (488/512) of women had urine culture: 325 (67%) showed no growth; however, 261 further MSU were sent, of which 224 (85%) were not clinically indicated. 55 (13%) had single organism growth, only 9 had a second sample within 2 weeks. 108 (21%) had mixed growth, and only 44 (40%) had a second sample sent but only 5 within 2 weeks. Conclusions The lack of a defined pathway for using urine dipsticks and sending MSU contributed to the variation in diagnosis and management of ASB, and highlighted opportunities to improve care for women and reduce inappropriate antibiotic use. We have now introduced the SIGN guideline and changed to ‘glucose/protein only’ dipsticks for routine antenatal follow-up appointments. Combined with staff education, we anticipate reduction in antibiotic prescriptions, cost savings on MSU, and improved patient management (a future presentation).
**Abstract**

Improved antenatal care for twins following TAMBA Engagement Project.

Introduction In England and Wales, approximately 17% of women are Rhesus D(RhD)-negative. Routine antenatal anti-D prophylaxis(RAADP) should be recommended to RhD-negative mothers. Free fetal DNA(ffDNA) can establish fetal rhesus status. Objectives To audit the process of RhD testing and administration. To identify uptake of antenatal ffDNA testing. To identify potential reasons why patients decline ffDNA testing. To prevent unnecessary administration of a blood product. Design Retrospective data analysis and telephone survey. Method All mothers who had been detected as Rhesus-negative on antenatal screening during a 12-month period were identified. Laboratory samples were cross-referenced to identify uptake rates of ffDNA typing. Maternal notes were reviewed to establish antenatal practice and compared against predefined audit standards. The results of a telephone survey were collated to better understand the patient interpretation of counselling in rhesus disease and offer of ffDNA test. Results 34% were offered ffDNA testing, and, of those, 32% accepted. 12% had the offer of written information documented. 33% received RAADP, and then, babies were confirmed rhesus-negative. 96% had anti-D given appropriately. 99% had rhesus status checked and documented at delivery. 45% of patients completed the telephone survey. 28% were offered ffDNA testing and 22% felt it was explained. 18% thought they were given written information. Conclusion Women are not being adequately counselled regarding antenatal options and may be receiving unnecessary blood products. Healthcare professionals need to improve discussions surrounding ffDNA to allow informed decision-making and improve patient care.

86. The impact of a dedicated stillbirth service on inter-pregnancy interval following fetal loss

**Authors**
Newell S.; Briggs E.; Ficquet J.

**Source**

**Abstract**

Background In the UK, 4000 babies per year are stillborn. The NHS Maternity Review and the INSIGHT study emphasised the unacceptable variation of care following stillbirth and reiterated the need for standardised care nationally. Objectives Assess the quality of follow-up and the inter-pregnancy interval after stillbirth following introduction of a dedicated stillbirth service. Design A retrospective audit was carried out at the Royal United Hospital Bath, to assess the follow-up pathway for women who had experienced stillbirth. Methods Records from all stillbirths between 2011 and 2018 were examined. Data were collected to assess the proportion of families receiving follow-up, how thorough the follow-up was, and the inter-pregnancy interval following stillbirth. Follow-up was classified into three categories: none, adequate or thorough based on set criteria. Comparisons were made between a pre-2016 and a post-2016 cohort following the introduction of a dedicated stillbirth service in 2016. Results 33% of women in the pre-2016 cohort received follow-up, with only 50% of these follow-ups classified as thorough. Post-2016, 92% of women received follow-up, with 77% classified as thorough. The mean duration between stillbirth and subsequent conception was calculated with an inter-pregnancy interval of 14.8 months (pre-2016 cohort) versus 6.4 months (post-2016 cohort). Conclusion The quality of consultant follow-up has increased after implementation of a dedicated stillbirth service. In addition, there has been a significant reduction in the inter-pregnancy interval following stillbirth. This may be due to the increased support and care that families are receiving, therefore giving them confidence to plan a future pregnancy.

87. Improved antenatal care for twins following TAMBA Engagement Project

**Authors**
Nugent J.; Hughes-Holland K.; Broome C.; Collier H.; Maher M.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 74-75

**Abstract**

The impact of a dedicated stillbirth service on inter-pregnancy interval following fetal loss.

Introduction In England and Wales, approximately 17% of women are Rhesus D(RhD)-negative. Routine antenatal anti-D prophylaxis(RAADP) should be recommended to RhD-negative mothers. Free fetal DNA(ffDNA) can establish fetal rhesus status. Objectives To audit the process of RhD testing and administration. To identify uptake of antenatal ffDNA testing. To identify potential reasons why patients decline ffDNA testing. To prevent unnecessary administration of a blood product. Design Retrospective data analysis and telephone survey. Method All mothers who had been detected as Rhesus-negative on antenatal screening during a 12-month period were identified. Laboratory samples were cross-referenced to identify uptake rates of ffDNA typing. Maternal notes were reviewed to establish antenatal practice and compared against predefined audit standards. The results of a telephone survey were collated to better understand the patient interpretation of counselling in rhesus disease and offer of ffDNA test. Results 34% were offered ffDNA testing, and, of those, 32% accepted. 12% had the offer of written information documented. 33% received RAADP, and then, babies were confirmed rhesus-negative. 96% had anti-D given appropriately. 99% had rhesus status checked and documented at delivery. 45% of patients completed the telephone survey. 28% were offered ffDNA testing and 22% felt it was explained. 18% thought they were given written information. Conclusion Women are not being adequately counselled regarding antenatal options and may be receiving unnecessary blood products. Healthcare professionals need to improve discussions surrounding ffDNA to allow informed decision-making and improve patient care.
Abstract
Objectives Multiple pregnancies make up 1.6% of all pregnancies and 14% of all neonatal deaths. The aim of the Twin and Multiple Births Association (TAMBA) Maternity Engagement Project was to improve the outcomes for multiple pregnancies at East Lancashire Healthcare NHS Trust (ELHT). Design Retrospective audit of case notes from multiple pregnancies. Methods Women with a multiple pregnancies were identified from the dedicated Multiple Pregnancy Clinic. All women selected had a multiple pregnancy in the preceding twelve months prior to the audits. A baseline audit (2016) and a re-audit (2017) were performed based on National Institute for Health and Care Excellence (NICE) Quality Statements 46 around the management of multiple pregnancies. Results Twenty-four women were identified. Baseline NICE adherence was 42.7% increasing to 67.82% in re-audit. More women saw a midwife with a specialist interest in multiple pregnancies rising from 30% in 2016 to 75% in 2017. More scans were undertaken by sonographers with a special interest in multiple pregnancies and trained to detect twin-to-twin transfusion syndrome in 2017, 50% and 91.67% from 0% in both categories in 2016. Discussion by 24 weeks about preterm labour and about timing and modes of delivery by 32 weeks also rose from 60% and 11.11% in baseline to 83.33% and 63.64% in the re-audit. Conclusion We will present evidence of how we have improved multiple pregnancy care at ELHT from the last 12 months from the suggestions made by the TAMBA which other units can learn from and adapt for themselves.

88. Reduced fetal movements: Are women getting standardised care?

Authors Moran O.; Heazell A.
Source BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 74
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Publication Type(s) Conference Abstract
Database EMBASE

Abstract
Introduction Reduced fetal movements (RFMs) are experienced before 55% of stillbirths. Adequate assessment and intervention of RFMs can help to reduce this. It is unclear how various units manage RFMs, and an understanding of this is required to ensure standardised treatment in giving all women sufficient care. Method A prospective audit was conducted over a 14-day time frame at 9 hospitals in the North West (NW) of England. It included women presenting to acute maternity services with RFM. Results A total of 494 women were audited across the NW. Cardiotocography (CTG) was provided to 96.4% of women >26/40 overall. There was varying practice between hospitals offering ultrasound (USS) to women >27/40, ranging between 19.2% and 100.0%. Moreover, timely USS assessment by the end of the next working day was between 22.2 and 100.0%. Overall, 63.6% of women >37/40 were offered induction of labour (IOL) but this spanned from 40.4% - 94.4%. Of those offered IOL, timely induction within 48 hours of presentation ranged between 50.0 and 100.0%. Conclusions Differing hospital practice was seen in areas of key practice: (1) the provision of USS assessment, (2) timing of USS, (3) IOL rate, and (4) timing of IOL. Hospital guidance and individual obstetric practice are likely to account for results. This audit justifies the requirement for regional guidance within the North West, to standardise a high level of care to all women presenting with reduced fetal movements.

89. A retrospective audit of the socio-demographic characteristics and pregnancy outcomes for all women with multiple medical problems giving birth at a tertiary hospital in the UK in 2016

Authors D’Arcy R.; Knight M.; Mackillop L.
Source BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 128
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE

Abstract
Introduction A retrospective audit of the socio-demographic characteristics and pregnancy outcomes for all women with multiple medical problems giving birth at a tertiary hospital in the UK in 2016.
90. Management of pregnancy in women with HIV at Liverpool Women's Hospital: A multidisciplinary approach

Authors: Roberts A.; Jilani K.; Longworth H.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 18

Abstract: Objectives Vertical transmission of HIV is now rare in the UK thanks to the introduction of routine antenatal HIV screening and early commencement of combination antiretroviral therapy. The British HIV association (BHIVA) have emphasised the importance of multidisciplinary antenatal care. Our objective was to review the management of pregnant women with HIV at the Liverpool Women's Hospital. Method We conducted a 24-month retrospective review of antenatal patients at Liverpool Women's hospital between April 2016 and March 2018. We audited our antenatal HIV screening rates and reviewed the subsequent management in seropositive women. Results Over the 24-month period, we screened 18,331, out of 18,705 eligible patients, for HIV (98.0%) (acceptable threshold 95.0%). HIV results were confirmed within 8 days of receipt in the laboratory in 99.5% of cases. There were 29 pregnancies in HIV-positive mothers over the 24-month period, and 6 of these were new diagnoses from the antenatal screening test. All of the newly diagnosed cases were seen for specialist assessment within 10 working days. Seropositive women had their booking viral loads and CD4 counts checked, and these were then repeated at 28 weeks. Multidisciplinary management care plans were distributed to the intrapartum, neonatal, and acute admission areas. Conclusion Patient engagement and adherence to treatment was achieved in all seropositive women, and there were no cases of vertical transmission. We believe this demonstrates that effective multidisciplinary antenatal care can help achieve optimal pregnancy outcomes in HIV-positive women.

91. What can obstetricians do to reduce term admissions to the neonatal intensive care unit (NICU)?

Authors: Perry C.; Tee J.; McFarland R.


Abstract: Objectives To describe the socio-demographic characteristics of all women with multiple medical conditions giving birth at a tertiary hospital in 2016, and to compare their outcomes with all women giving birth in the same period. Study design Retrospective audit. Methods All women giving birth in 2016 were identified from the electronic hospital records system. Information of demographic characteristics and maternal and perinatal outcomes was collected. The prevalence of women with two or more medical conditions (MM) was calculated, and their characteristics were compared to women with one or no medical conditions (NMM). Odds ratios for maternal and perinatal outcomes were calculated, and factors associated with poor outcomes were explored using logistic regression. Results 1358 MM women were identified among a cohort of 6406 women giving birth, representing a prevalence of 21.2% (95% CI 20.2-22.2%). MM women were more likely to be older, multiparous, smoke and have raised BMI compared to NMM women. MM women had increased odds of developing Preeclampsia (aOR 1.56 95% CI 1.06-2.16), Obstetric Cholestasis (aOR 1.79 95% CI 1.08-3.0), and Thromboembolism (aOR 10.34 95% CI 3.74-28.5). The odds of emergency caesarean section (aOR 1.7 95% CI 1.38-2.12), preterm delivery (aOR 1.68 95% CI 1.29-2.29), and having a low birthweight baby (aOR 1.45 95% CI 1.19-1.93) were also increased for MM women. Discussion This audit highlights the high prevalence of MM women giving birth and the associated adverse outcomes experienced by this group. Further research is needed to understand the health and care needs of MM women and how to optimise maternal and perinatal outcomes.
92. Managing the super morbidly obese pregnant woman: Outcomes of super morbidly obese (BMI &gt; 50) pregnant women in a UK District General Hospital

Authors: Prince S.J.; Law H.


Abstract

This audit aimed to look at the number of super morbidly obese (BMI &gt; 50) women delivering at a District General Hospital and their delivery and neonatal outcomes. A retrospective review was undertaken of maternity records of all women booked with a BMI &gt; 50 between October 2015 and October 2016 (n = 24) that delivered at a UK District General Hospital which averages 3800 deliveries a year and has a level 2 NICU. Women with a BMI over 50 at booking accounted for 0.6% of all deliveries. The average BMI was 53.6. Mode of delivery found a 46% caesarean section rate, 42% spontaneous vertex delivery rate, and 13% forceps rate. Of these deliveries, primiparous women had a 60% caesarean section and 20% instrumental rate. Where women were attempting a VBAC 100% required a caesarean section. As a group, 54% sustained a PPH &gt; 500 ml and 21% &gt; 1500 ml. NICU admissions were 20.8%. There was 1 maternal and neonatal death in the BMI &gt; 50 group during this period. These figures when compared to similar larger data sets internationally show that there is a significantly increased rate of caesarean section in this population group: 49.1-60.6% (Marshall et al, 2010; Crane et al, 2013). This has significant implications for counselling with regard to mode of delivery and subsequent maternal and neonatal outcomes particularly in primiparous and previous caesarean section patient groups. Further work needs to be done around optimising the care of women with a BMI &gt; 50 and informing our delivery management and counselling particularly in a post-Montgomery (2015) era.

93. Labour ward leaders: Working together for safer care

Authors: Johnson G.; Lloyd C.

Source: BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126; p. 87-88

Abstract

Objectives NHS Improvement recognised the increasing number of term admissions and developed the ‘Avoiding Term Admissions to Neonatal Units’ (ATAIN) programme. They state term admissions can indicate that harm has been caused. Design Our quality improvement project reviewed all term admissions to the NICU weekly with a multidisciplinary team (MDT); the aim to identify common themes and lessons to be learnt. Methods Data from April 2017 to October 2018 MDT reviews have been collated, looking for underlying themes. Results There were 485 unexpected term admissions; 3.6% of all live births, babies with congenital anomalies (n = 109) were excluded. 14% of admissions were deemed avoidable or inappropriate. Babies admitted with hypoglycaemia (8%) or Jaundice (2%) was lower than that reported by ATAIN. Rate of babies with respiratory symptoms was higher (37%). Of all term admissions, 51% of patients had their labour induced. 12% of patients who had an Induction of labour 37 + 0-37 + 6 weeks had a baby admitted, compared to 4% &gt;38 weeks. 16% of babies were admitted following an elective caesarean section. Conclusion Initial improvements in term admission rates have not been maintained. Admissions remain at a lower rate than reported by ATAIN. Rates of admission following early elective delivery are increasing. Induction of labour rates are increasing and this is thought to be linked to term admissions, especially at &lt;38 weeks. Further analysis of the data is required to understand the themes and consider how this information should be used in the counselling of women.
**Abstract**

A survey of labour ward midwives and obstetricians identified a lack of shared learning and understanding of professional roles. Midwives identified limited specific training for their leadership roles, inadequate equipment, poor professional relationships, and increasing maternity complexities impacting on outcomes for women and babies. Obstetricians identified very similar challenges and also aspects of isolation when seeking support from midwives. The Kirkup report into Morecambe Bay identified poor communication between professions and a lack of a shared vision leading to poor outcomes. The NHS maternity safety agenda identified the need to see a reduction in maternal and perinatal morbidity and mortality. The Royal College of Midwives worked in collaboration with The Royal College of Obstetricians and Gynaecologists, Atain and NHSE to design and deliver a one-day multidisciplinary workshop for labour ward leaders. Obstetricians, labour ward coordinators, and maternity safety leaders identified teams of 7-8 to attend the workshop. Each team was asked to identify a quality improvement (QI) initiative which the team would work on after the workshop. The wider labour ward team were to be included as part of the QI initiative. Four Pilot programmes were run across England, with each workshop having 5-7 teams. A mix of teams enabled an opportunity to share ideas and projects as well as networking. The pilot programmes evaluated well and have since been rolled out across the UK and Ireland. The collaboration and shared learning bridge the gap between midwives and doctors for the benefit of women and babies safety.

94. A systematic clinical service approach to improve screening strategies for gestational diabetes: A quality improvement project

**Authors**
McMicking J.; Costa M.; Brackenridge A.; Chandiramani M.; Hall E.; Knight C.L.; Rajasingam D.; Reid A.; Banerjee A.; Pasupathy D.

**Source**

**Abstract**

Objectives Currently, not all UK units are compliant with National Institute for Health Care Excellence (NICE) Gestational Diabetes (GDM) screening due to increase service demands. We introduced NICE screening in May 2017. Our aim is to describe the systematic clinical service response to accommodate increasing prevalence of GDM, evaluate clinical outcomes pre- and postimplementation, and estimate the impact of using more stringent International Association of Diabetic Pregnancy Study Group (IADPSG) criteria. Methods A retrospective analysis was conducted of births at St Thomas’ Hospital using data prior to NICE screening (2016), and post-screening (November 2017-April 2018). We report service configuration to accommodate the anticipated increase in GDM prevalence. Demographic and clinical outcomes were compared between those with and without GDM in both periods. We report prevalence and outcomes using IADPSG criteria (fasting glucose 5.1-5.6 mmol/l). Results Service reconfiguration included specialist diabetes midwifery team, group education, structured clinic, virtual appointments, and use of smart phone blood glucose metres. GDM detection increased from 2.9% to 9.1% with identification of more Asian (15 versus 20%) and nulliparous (34 versus 41%) women. Outcomes improved lower induction (48 versus 40%), mean birthweight centile (61 versus 53%), and large for gestational age (LGA) (17 versus 8%). 158 (5.5%) more women with higher rates of obesity and LGA were detected using IADPSG. Conclusion This study informs service provision needed to accommodate higher prevalence of GDM with better screening strategies. Similar pregnancy outcomes to non-GDM are achievable, and our findings support the use of IADPSG criteria.

95. The completed audit of University Maternity Hospital Limerick’s perinatal mental health referral pathways

**Authors**
Rooney D.; McMahon G.; Kumari J.; Imcha M.; Mohamed M.M.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 32
# 96. Maternal anaemia at term: A re-audit. Are opportunities being missed to optimise haemoglobin by time of delivery? Have we improved?

**Authors**
Martin J.; Boyd J.; Grzybek A.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 31

**Abstract**
Introduction Following a previous audit looking at anaemia at time of delivery in our delivery unit in NHS Fife, areas for improvement were identified and taken forward. An additional haemoglobin check at 34/35 weeks was recommended for elective caesarean sections and those at greater risk of haemorrhage. Anaemia is recognised as an important cause for maternal and perinatal morbidity, for which UK guidelines recommend haemoglobin checks at booking and 28 weeks. This re-audit reviews whether the additional blood test recommended improves management of anaemia. Methods Data were collected on women delivering in NHS Fife over a 1-month period. Haemoglobin levels were analysed at booking, 28 weeks, 34/35 weeks, and admission. Anaemia was identified as haemoglobin <=110 g/l at booking and <=105 g/l beyond 28 weeks. Aims were to assess whether the additional haemoglobin check improved anaemia rates at delivery and review whether any additional anaemic patients were identified at 34/35 weeks. Results 7% of patients were identified as anaemic on admission. Of patients booked for elective section, only 1 was anaemic at time of delivery. Both were considerable improvement on previous audit, where 10% were anaemic at delivery and 5 women booked for elective section were anaemic. Of those identified as anaemic at 34/35 weeks, only half had been recognised at 28 weeks. Conclusion Re-audit supports the improvement measures identified (additional haemoglobin check at 34/35 weeks), reducing rates of anaemia at delivery and reducing maternal and perinatal morbidity.

# 97. Uterine balloon tamponade to treat major obstetric haemorrhage in a tertiary referral hospital

**Authors**
O’Doherty K.; Morris A.; O’Dwyer V.

**Source**
BJOG: An International Journal of Obstetrics and Gynaecology; Mar 2019; vol. 126 ; p. 120

**Abstract**
In July 2018, University Maternity Hospital Limerick (UMHL) implemented a Perinatal Mental Health Service (PMHS). This was in response to the UK Confidential Enquiry into Maternal Deaths 2015, which highlighted psychiatric illness as a leading cause of maternal death. To reduce morbidity and mortality from psychiatric illness, the Royal College of Obstetricians and Gynaecologists (RCOG) recommended defined referral pathways from maternity to local mental health services (LMHS), alongside training in perinatal mental health. Objectives The aim of this audit was to assess knowledge of referral pathways from UMHL to LMHS and to assess levels of training before and after the establishment of the new PMHS. Methods Anonymous questionnaires with Yes/No answer options were circulated to obstetric doctors and midwives in UMHL. Eighteen doctors and thirty-two midwives responded (n = 50). Data were analysed and presented using Microsoft Excel and IBM SPSS. Results 86% of doctors and midwives were aware of referral pathways compared to 43.6% two years previously (P < 0.001). 74% knew how to access LMHS compared to 52.7% previously (P = 0.020). 28% received training in PMHS compared to 14.6% previously (P = 0.83). 26% received training in methods for assessing patients with mental health issues compared to 14.6% previously (P = 0.110). 42% received training on how to access referral routes compared to 3.6% previously (P < 0.001).Conclusion Since introducing the PMHS in UMHL, there has been a significant increase in staff training and awareness of referral pathways, in line with suggestions from the RCOG.
Major obstetric haemorrhage (MOH) is the leading cause of severe maternal morbidity in the UK. Uterine balloon tamponade is used for the treatment of postpartum haemorrhage (PPH) caused by uterine atony where medical treatment has failed. Methods An audit of cases of MOH from 2013-2018, in which Bakri uterine balloons were used for management. MOH was defined as blood loss >=2.5 l. Results Twenty-three women required a uterine balloon for MOH. Mean age was 36 years, mean BMI 28.8 kg/m2 and 60% were primigravidae. There were 4 twin pairs (17%). Three patients had a previous caesarean section (13%) and 3 had placenta praevia (13%). The mean gestation at delivery was 38 weeks (30% were >40 weeks). The induction rate was 34% and caesarean section rate 52%. The mean birthweight was 3045 g. Mean birth loss was 3.3 l. All patients had oxytocin bolus 5 iu and 40 iu infusion. Ergometrine was given in 56%, misoprostol in 78%, carboprost in 74%, and tranexamic acid in 60% of cases. All patients required a blood transfusion (mean value of 4.6 units of red cell concentrate). Four (17%) patients required platelets, 8 (35 %) required fresh frozen plasma, and fibrinogen was given in 12 (52%) of cases. Uterine balloon tamponade was successful in 78% of cases. One patient required a B-Lynch suture (4%) and one required uterine artery embolisation (4%) in addition to balloon tamponade. There were three (13%) hysterectomies. Conclusion Major obstetric haemorrhage occurred in women with known risk factors. There was a high success rate of uterine balloon treatment.

98. Do ultrasound detection rates meet NHS Fetal Anomaly Screening Programme (FASP) targets? An audit of antenatal screening in England using data from the National Congenital Anomaly and Rare Disease Registration Service (NCARDRS)

Authors Aldridge N.; Harris D.; Yates J.
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract Objectives To determine whether FASP target detection rates were met for the 11 structural conditions screened for as a minimum at the midpregnancy fetal anomaly ultrasound scan. Design An audit of confirmed cases of 11 structural conditions with expected delivery dates of 01/04/2016-31/03/2017 at 72 NHS trusts. Methods The audit included cases with enough information to determine the outcome of screening fromtrustsmeeting aminimum trust-specific data quality threshold. Pooled condition-specific detection rates were calculated as the proportion of confirmed cases eligible and accepting screening that were detected by themidpregnancy fetal anomaly ultrasound scan. Results A total of 2313 cases from 71 trusts (booking population 340,273) met the data quality threshold for inclusion. There was no significant difference between the detection rate and target for the following: anencephaly 91.7% (95% CI: 64.6-98.5), bilateral renal agenesis 96.4% (82.3-99.4), congenital diaphragmatic hernia 67% (57.7-75.1), and exomphalos 73.1% (53.9-86.3). The detection rate was significantly above target for the following: cleft lip +/- palate 88.6% (84.4-91.8), lethal skeletal dysplasia 81.6% (66.6-90.8), serious cardiac 74.4% (70.4-78.1), and spina bifida 96.2% (92.4-98.2). The detection rate was significantly below target for the following: gastrochisis 87.5% (69-95.7), Patau’s syndrome 66.7% (43.7-83.7), and Edwards’ syndrome 69% (56.2-79.4). Including early (<18+0 weeks) detections, targets were met for all 11 anomalies. For five anomalies (anencephaly, gastrochisis, exomphalos, Patau’s syndrome, and Edwards’ syndrome), most cases were detected before 18+0 weeks. Conclusion FASP detection rate targets were met for 8/11 structural conditions. Many FASP anomalies are detected before 18+0 weeks allowing for earlier intervention and more choice for pregnant women.

99. Magnesium sulphate for preterm deliveries

Authors Alazzani H.; Chong H.
Publication Date Mar 2019
Publication Type(s) Conference Abstract
Database EMBASE
Abstract

Background Magnesium sulphate (MgSO4) when given to preterm babies under 30 weeks of gestation reduces the risk of cerebral palsy. There is a national drive to increase the use of MgSO4 through initiatives such as PReCePT which aim to increase MgSO4 use to 85% in all maternity units within England, with a target of 95% by 2020. Objectives 1 Audit local use of MgSO4 in preterm deliveries <= 30 weeks. 2 Identify areas in our local practice that will help increase the use of magnesium sulphate. Design Retrospective audit of all preterm deliveries taking place between January 2018 and August 2018. Method The project took place in a maternity unit with over 8000 deliveries and a level 3 neonatal unit. Data were extracted from electronic labour records and maternity notes. Results There were 43 preterm deliveries between 23 + 0 and 29 + 6 weeks of gestation. MgSO4 was confirmed to be given in 32 cases. This represent two-third of cases. In 8 cases, MgSO4 was not given due to a number of reasons including cord prolapsed, spontaneous fast deliveries, or fetal bradycardia. Data were missing for 3 women. Conclusions Our local data showed that we are achieving a minimum of 74% from the national target of 85%. This is above the national average of 64% according to the National Neonatal Audit Programme (NNAP) data. Recommendations To implement a system for easy access to MgSO4 for prompt administration when required. To keep a record of cases where magnesium was used to minimise missing data and reflect and accurately our practice.

100. Measured blood loss (MBL) as an integral part of postpartum haemorrhage (PPH) management: Quality improvement on a national scale through OBSCymru, the obstetric bleeding strategy for Wales

Authors
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Source

Publication Date
Mar 2019

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Database
EMBASE

Abstract

Objectives OBSCymru is a national quality improvement project aiming to reduce morbidity from PPH. MBL after all deliveries is key to early escalation of treatment. Design As a single intervention, MBL is ineffective in reducing PPH, so the OBSCymru approach includes 4 pillars: risk assessment; early recognition of PPH by MBL; multidisciplinary involvement at the bedside at 1000 ml PPH, and patient-specific blood product management, guided by point-of-care testing. Methods MBL has been taught to the obstetric MDT in a standardised video and workshop in mandatory training days and on an ad-hoc basis. It has also been integrated into the undergraduate midwifery curriculum. The OBSCymru approach to PPH management is followed in all Consultant Led Units (CLU) across Wales. The MBL training programme commenced following an initial MBL audit and has been repeated at six monthly intervals, coordinated by local champion midwives. Results At baseline, MBL was performed in 72% of elective caesarean sections (CS), 87% emergency CS, 53% instrumental deliveries, and 37% of spontaneous vaginal deliveries (SVD). At six months, MBL was performed in 93% of elective CS, 99% emergency CS, 90% instrumental deliveries, and 76% SVDs. This change was maintained at one year. For all deliveries in Wales, MBL has increased from 50.8% to 88.5% following training. For PPH’s >=1000 ml, MBL is performed in 95% nationally. Conclusion MBL after all deliveries across Wales has increased and this change maintained at one year. Staff have enthusiastically embraced this cornerstone of OBSCymru to improve quality of PPH management.