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Strategy 432444/9

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AIMS AND OBJECTIVES
To review and analyse current preceptorship programmes within NHS trusts in the North West of England. To evaluate the pedagogic rigour of the programme and suggest recommendations to inform the future design of preceptorship programmes.

BACKGROUND
Enhancing the retention of newly qualified staff is of particular importance given that the journey from a new registrant to a competent healthcare professional poses a number of challenges, for both the individual staff member and organisations.

DESIGN
A mixed methods evaluative approach was employed, using online questionnaires and content analysis of preceptorship documentation.

METHODS
Forty-one NHS trusts across the North West region employing newly qualified nurses were invited to participate in the completion of an online questionnaire. In addition, preceptorship programme documentation was requested for inclusion in the content analysis. This study utilised the SQUIRE (Standards for Quality Improvement Reporting Excellence) guidelines.

RESULTS
The response rate for the questionnaire was 56.1% (n=23). Eighteen trusts (43.9%) forwarded their programme documentation. Findings highlighted the wide variation in preceptorship programmes across the geographical footprint.

CONCLUSION
There were instances of outstanding preceptorship and preceptorship programmes where there was a clear link between the strategic vision, i.e., trust policy, and its delivery, i.e. preceptorship offering. There was no one framework that would universally meet the needs of all trusts, yet there are key components which should be included in all preceptorship programmes. Therefore, we would encourage innovation and creativity in preceptorship programmes, cognisant of local context.

RELEVANCE TO CLINICAL PRACTICE
The significant shortage of nursing staff in England is an ongoing issue. Recruitment and retention are key to ameliorating the shortfall, and formal support mechanisms like preceptorship, can improve the retention of newly qualified staff. Understanding current preceptorship programmes is an important first step in establishing the fundamental building blocks of successful preceptorship programmes and enabling the sharing of exemplary good practice across organisations. This article is protected by copyright. All rights reserved.

2. Improving the identification of patients with delirium using the 4AT assessment.

Authors
Bearn, Amelia; Lea, William; Kusznir, Jennie

Source
Nursing older people; Nov 2018

Publication Date
Nov 2018

Publication Type(s)
Journal Article

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30426731

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Available at Nursing older people from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).
Available at Nursing older people 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
Delirium is a common neuropsychiatric disorder that all those working with older people will have encountered at some stage. Delirium is often poorly identified in hospital settings and therefore not optimally managed. After data collection on the acute medical unit in an acute hospital trust in the UK it was evident that patients with signs of delirium were not being formally assessed and therefore not appropriately managed in many cases. A quality improvement project introduced the 4AT delirium assessment tool to try to ensure that patients with delirium were being identified. The project team carried out several plan-do-study-act cycles to bring about our changes, which included a 4AT assessment sticker for nursing staff to complete and teaching for all healthcare staff. Through involvement of all members of the multidisciplinary team and ongoing feedback and changes we were able to increase assessment of delirium from 0% to 64%. There is ongoing work to be done to continue to improve delirium management, but by initially improving the assessment and identification of delirium we will make a difference to these patients' outcomes.

Authors
Doran, Natasha J; Bethune, Rob; Watson, Joanne; Finucane, Katherine; Carson-Stevens, Andrew
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Journal Article
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30425133
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 Available at Postgraduate medical journal from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information
 Local Print Collection [location]: UHL Libraries On Request (Free).
 Available at Postgraduate medical journal from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information

Abstract
AIMTo explore how the South-West Foundation Doctor Quality Improvement programme affected foundation year 1 (F1) doctors' attitudes and ability to implement change in healthcare.METHODS:Twenty-two qualitative interviews were carried out with two cohorts of doctors. The first F1 group before and after their participation in the QI programme; the second group comprised those who had completed the programme between 1 and 5 years earlier. Qualitative data were analysed using thematic analysis techniques. RESULTS: Prior to taking part in the QI programme, junior doctors' attitudes towards QI were mixed. Although there was agreement on the importance of QI in terms of patient safety, not all shared enthusiasm for engaging in QI, while some were sceptical that they could bring about any change. Following participation in the programme, attitudes towards QI and the ability to effect change were significantly transformed. Whether their projects were considered a success or not, all juniors reported that they valued the skills learnt and the overall experience they gained through carrying out QI projects. Participants reported feeling more empowered in their role as junior doctors, with several describing how they felt 'listened to' and able to 'have a voice', that they were beginning to see things 'at systems level' and learning to 'engage more critically' in their working environment.CONCLUSIONS:Junior doctors are ideally placed to engage in QI. Training in QI at the start of their medical careers may enable a new generation of doctors to acquire the skills necessary to improve patient safety and quality of care.

4. Laparoscopic specimen retrieval and attitudes towards morcellation: a questionnaire survey of gynaecology consultants in the United Kingdom.
Authors
Sankaran, Sridevi; Brown, Anna; Kent, Andrew; Odejinmi, Funlayo
Source
Journal of obstetrics and gynaecology: the journal of the Institute of Obstetrics and Gynaecology; Nov 2018 ; p. 1-4
Publication Date
Nov 2018
Publication Type(s)
Journal Article
PubMedID
30422794
Database
Medline
Available at Journal of obstetrics and gynaecology: the journal of the Institute of Obstetrics and Gynaecology from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information
 Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.
The aim of this study was to evaluate the practices of laparoscopic specimen retrieval among Gynaecologists in the United Kingdom and to determine any variation in practice. A survey of Consultant Gynaecologist members of the British Society of Gynaecological Endoscopy (BSGE) was conducted using Survey Monkey™. Of the 460 registered consultants, 187 (40%) responded to the questionnaire. Sixty-two percent (62%) of the respondents considered themselves to be advanced laparoscopic surgeons whilst 34% considered themselves to be intermediate laparoscopic surgeons. The umbilical port was the most commonly used port for specimen retrieval and it was used to remove 49% of ectopic pregnancies, 43% of ovarian cysts and 43% of endometrioma. Most respondents would not insert an extra port or extend the existing port just for the retrieval of a specimen. The level of laparoscopic experience and the gender did not affect the method of specimen retrieval in cases of ectopic pregnancies, endometrioma and ovarian cysts (p value >.05, not significant). The majority of respondents used power morcellation for a laparoscopic myomectomy (85% of respondents) and laparoscopic subtotal hysterectomy (93% of respondents), despite the recent concerns surrounding power morcellation. Impact statement What is already known on this subject? There is a paucity of literature regarding laparoscopic specimen retrieval in gynaecology. In view of recent controversy pertaining to the potential upstaging of leiomyosarcoma with morcellation, other methods of specimen retrieval are gaining an importance. What do the results of this study add? This study shows that the umbilical port is the most commonly used port for specimen retrieval among UK gynaecologists and that most gynaecologists would not insert an additional port purely for specimen retrieval. Most respondents would still use power morcellation for a laparoscopic myomectomy and subtotal hysterectomy, despite the recent concerns over morcellation and its safety. What are the implications of these findings for clinical practice and/or further research? This paper demonstrates the need for development of a database of morcellation practices to enable analysis of both benefits and potential adverse outcomes. This paper will also encourage future research and the audit of specimen retrieval.

5. Improving care at scale: process evaluation of a multi-component quality improvement intervention to reduce mortality after emergency abdominal surgery (EPOCH trial).

Authors Stephens, T J; Peden, C J; Pearse, R M; Shaw, S E; Abbott, T E F; Jones, E; Kocman, D; Martin, G; EPOCH trial group

Source Implementation science : IS; Nov 2018; vol. 13 (no. 1); p. 142

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

BACKGROUND Improving the quality and safety of perioperative care is a global priority. The Enhanced Perioperative Care for High-risk patients (EPOCH) trial was a stepped-wedge cluster randomised trial of a quality improvement (QI) programme to improve 90-day survival for patients undergoing emergency abdominal surgery in 93 hospitals in the UK National Health Service. METHODS The aim of this process evaluation is to describe how the EPOCH intervention was planned, delivered and received, at both cluster and local hospital levels. The QI programme comprised of two interventions: a care pathway and a QI intervention to aid pathway implementation, focussed on stakeholder engagement, QI teamwork, data analysis and feedback and applying the model for improvement. Face-to-face training and online resources were provided to support senior clinicians in each hospital (QI leads) to lead improvement. For this evaluation, we collated programme activity data, administered an exit questionnaire to QI leads and collected ethnographic data in six hospitals. Qualitative data were analysed with thematic or comparative analysis; quantitative data were analysed using descriptive statistics. RESULTS The EPOCH trial did not demonstrate any improvement in survival or length of hospital stay. Whilst the QI programme was delivered as planned at the cluster level, self-assessed intervention fidelity at the hospital level was variable. Seventy-seven of 93 hospitals responded to the exit questionnaire (60 from a single QI lead response on behalf of the team); 33 respondents described following the QI intervention closely (35%) and there were only 11 of 37 care pathway processes that > 50% of respondents reported attempting to improve. Analysis of qualitative data suggests QI leads were often attempting to deliver the intervention in challenging contexts: the social aspects of change such as engaging colleagues were identified as important but often difficult and clinicians frequently attempted to lead change with limited time or organisational resources. CONCLUSIONS Significant organisational challenges faced by QI leads shaped their choice of pathway components to focus on and implementation approaches taken. Adaptation causing loss of intervention fidelity was therefore due to rational choices made by those implementing change within constrained contexts. Future large-scale QI programmes will need to focus on dedicating local time and resources to improvement as well as on training to develop QI capabilities. EPOCH TRIAL REGISTRATION ISRCTN80682973 https://doi.org/10.1186/ISRCTN80682973 Registered 27 February 2014 and Lancet protocol 13PR7/7655.


Authors Vail, Emily A; Harrison, David A; Wunsch, Hannah
Source Intensive care medicine; Nov 2018
Publication Date Nov 2018
Publication Type(s) Journal Article
PubMedID 30421257
Database Medline

Abstract

PURPOSE Many diagnostic and therapeutic interventions for critically ill adult patients are not performed according to patient size, but are standardized for an idealized 1.74-m cm (ideal body weight 70 kg). This study aims to determine whether critically ill patients with heights significantly different from a standardized patient have higher hospital mortality or greater resource utilization. METHODS Retrospective cohort study of consecutive patients admitted to 210 intensive care units (ICUs) in the United Kingdom participating in the Intensive Care National Audit and Research Centre’s Case Mix Programme Database from April 1, 2009, to March 31, 2015. Primary outcome was hospital mortality, adjusted for age, comorbid disease, severity of illness, socioeconomic status and body mass index, using hierarchical modeling to account for clustering by ICU. Data were stratified by sex, and the effect of height was modeled continuously using restricted cubic splines. RESULTS The cohort included 233,308 men and 184,070 women, with overall hospital mortality of 22.5% and 20.6%, respectively. After adjustment for potential confounders, hospital mortality decreased with increasing height; predicted mortality (holding all other covariates at their mean value) decreased from 24.1 to 17.1% for women and from 29.2 to 21.0% for men across the range of heights. Similar patterns were observed for ICU mortality and several additional secondary outcomes. CONCLUSIONS Short stature may be a risk factor for mortality in critically ill patients. Further work is needed to determine which unmeasured patient characteristics and processes of care may contribute to the increased risk observed.

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

Authors Devi, Reena; Meyer, Julienne; Banerjee, Jay; Goodman, Claire; Gladman, John Raymond Fletcher; Dening, Tom; Chadborn, Neil; Hinsliff-Smith, Kathryn; Long, Annabelle; Usman, Adeela; Housley, Gemma; Bowman, Clive; Martin, Finbarr; Logan, Phillipa; Lewis, Sarah; Gordon, Adam Lee
Source BMJ open; Nov 2018; vol. 8 (no. 11); p. e023287
INTRODUCTION
This protocol describes a study of a quality improvement collaborative (QIC) to support implementation and delivery of comprehensive geriatric assessment (CGA) in UK care homes. The QIC will be formed of health and social care professionals working in and with care homes and will be supported by clinical, quality improvement and research specialists. QIC participants will receive quality improvement training using the Model for Improvement. An appreciative approach to working with care homes will be encouraged through facilitated shared learning events, quality improvement coaching and assistance with project evaluation.

METHODS AND ANALYSIS
The QIC will be delivered across a range of partnering organisations which plan, deliver and evaluate health services for care home residents in four local areas of one geographical region. A realist evaluation framework will be used to develop a programme theory informing how QICs are thought to work, for whom and in what ways when used to implement and deliver CGA in care homes. Data collection will involve participant observations of the QIC over 18 months, and interviews/focus groups with QIC participants to iteratively define, refine, test or refute the programme theory. Two researchers will analyse field notes, and interview/focus group transcripts, coding data using inductive and deductive analysis. The key findings and linked programme theory will be summarised as context-mechanism-outcome configurations describing what needs to be in place to use QICs to implement service improvements in care homes.

ETHICS AND DISSEMINATION
The study protocol was reviewed by the National Health Service Health Research Authority (London Bromley research ethics committee reference: 205840) and the University of Nottingham (reference: LT07092016) ethics committees. Both determined that the Proactive HEAlthcare of Older People in Care Homes study was a service and quality improvement initiative. Findings will be shared nationally and internationally through conference presentations, publication in peer-reviewed journals, a graphical illustration and a dissemination video.

Authors  
Owen, Jonathan
Source  
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Authors  
Milton, Amelia; Drake, Thomas M; Lee, Matthew J
Source  
The journal of trauma and acute care surgery; Nov 2018
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Available at The journal of trauma and acute care surgery from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).
BACKGROUND Emergency gastrointestinal surgery (EGS) conditions represent a significant healthcare burden globally requiring emergency operations that are associated with mortality rates as high as 80%. EGS is currently focused on quality improvement and internal audits, which occurs at a national or local level. An appreciation of what EGS trials are being conducted is important to reduce research wastage and develop coordinated research strategies in surgery. The primary aim of this study was to identify and quantify recent and active trials in emergency gastrointestinal surgery. The secondary aim was to identify conditions of interest, and which aspects of care were being modified.

METHODS A systematic search of WHO, UK, US, Australian and Canadian trials databases was undertaken using broad terms to identify studies addressing emergency abdominal surgery and specific high-risk diagnoses. Studies registered between 2013-2018 were eligible for inclusion. Data on study topic, design, and funding body were collected. Interventions were classified into ‘peri-operative’, ‘procedural’, ‘post-operative’, ‘non-surgical’ and ‘other’ categories.

RESULTS Searches identified 5603 registered trials. After removal of duplicates, 4492 studies remained and 42 were eligible for inclusion. Almost 50% of trials were located in Europe and 17% (n=7) in the USA. The most common condition addressed was acute appendicitis (n=11), with the most common intervention being procedure based (n=23). Hospital based funding was the most common funder (n=30).

CONCLUSION There is large disparity in the number of surgical trials in emergency surgery, which are primarily focused on high-volume conditions. More research is needed into high-mortality conditions.

EVIDENCE LEVEL 1a (oxford).

10. Are there patients missing from community heart failure registers? An audit of clinical practice.

Authors Cuthbert, Joseph J; Gopal, Jayanthi; Crundall-Goode, Amanda; Clark, Andrew L

Source European journal of preventive cardiology; Nov 2018; p. 2047487318810839

Abstract BACKGROUND General practitioners in the UK are financially incentivised, via the Quality Outcomes Framework, to maintain a record of all patients at their practice with heart failure and manage them appropriately. The prevalence of heart failure recorded in primary care registers (0.7-1.0%) is less than reported in epidemiological studies (3-5%). Using an audit of clinical practice, we set out to investigate if there are patients ‘missing’ from primary care heart failure registers and what the underlying mechanisms might be.

DESIGN The design of this study was as an audit of clinical practice (n = 9390).

METHODS Audit software (ENHANCE-HF) was used to identify patients who may have heart failure via a series of hierarchical searches of electronic records. Heart failure was then confirmed or excluded based on the electronic records by a heart failure specialist nurse and patients added to the register. Outcome data for patients without heart failure was collected after two years.

RESULTS Heart failure prevalence was 0.63% at baseline and 1.12% after the audit. Inaccurate coding accounted for the majority of missing patients. Amongst patients without heart failure who were taking a loop diuretic, the rate of incident heart failure was 13% and the rate of death or hospitalization with heart failure was 25% respectively during two-year follow-up.

CONCLUSION There are many patients missing from community heart failure registers which may detriment patient outcome and practice income. Patients without heart failure who take loop diuretics are at high risk of heart failure-related events.

11. The use of an electronic health record system reduces errors in the National Hip Fracture Database.

Authors Lawrence, John E; Cundall-Curry, Duncan; Stewart, Max E; Fountain, Daniel M; Gooding, Christopher R

Source Age and ageing; Nov 2018

Abstract BACKGROUND General practitioners in the UK are financially incentivised, via the Quality Outcomes Framework, to maintain a record of all patients at their practice with heart failure and manage them appropriately. The prevalence of heart failure recorded in primary care registers (0.7-1.0%) is less than reported in epidemiological studies (3-5%). Using an audit of clinical practice, we set out to investigate if there are patients ‘missing’ from primary care heart failure registers and what the underlying mechanisms might be.

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CONCLUSION There are many patients missing from community heart failure registers which may detriment patient outcome and practice income. Patients without heart failure who take loop diuretics are at high risk of heart failure-related events.
13. Improving the personalisation of care in a district nursing team: a service improvement project.

**Authors**
McKendry, Mandy; Green, Helen

**Source**
British journal of community nursing; Nov 2018; vol. 23 (no. 11); p. 552-558

**Abstract**
Aim: to compare the validity of data submitted from a UK level 1 trauma centre to the National Hip Fracture Database (NHFD) before and after the introduction of an electronic health record system (EHRS). Patients and methods: a total of 3224 records were reviewed from July 2009 to July 2017. 2,133 were submitted between July 2009 and October 2014 and 1,091 between October 2014 and July 2017, representing data submitted before and after the introduction of the EHRS, respectively. Data submitted to the NHFD were scrutinised against locally held data. Results: use of an EHRS was associated with significant reductions in NHFD errors. The operation coding error rate fell significantly from 23.2% (494/2133) to 7.6% (83/1091); P < 0.001. Prior to EHRS introduction, of the 109 deaths recorded in the NHFD, 64 (59%) were incorrect. In the EHRS dataset, all the 112 recorded deaths were correct (P < 0.001). There was no significant difference in the error rate for fracture coding. In the EHRS dataset, after controlling for sample month, entries utilising an operation note template with mandatory fields relevant to NHFD data were more likely to be error free than those not using the template (OR 2.69; 95% CI 1.92-3.78). Conclusion: this study highlights a potential benefit of EHR systems, which offer automated data collection for auditing purposes. However, errors in data submitted to the NHFD remain, particularly in cases where an NHFD-specific operation note template is not used. Clinician engagement with new technologies is vital to avoid human error and ensure database integrity.

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

**Authors**
Morris, Jenny V; Kapetanstratakis, Melpo; Parslow, Roger C; Davis, Peter J; Ramnarayan, Padmanabhan

**Source**
Pediatric critical care medicine : a journal of the Society of Critical Care Medicine and the World Federation of Pediatric Intensive and Critical Care Societies; Nov 2018

**Abstract**
Objectives: To 1) describe patterns of use of high-flow nasal cannula therapy, 2) examine differences between patients started on high-flow nasal cannula and those started on noninvasive ventilation, and 3) explore whether patients who failed high-flow nasal cannula therapy were different from those who did not. Design: Retrospective analysis of data collected prospectively by the Paediatric Intensive Care Audit Network. Setting: All PICUs in the United Kingdom and Republic of Ireland (n = 34). Patients and methods: Admissions to study PICUs (2015-2016) receiving any form of respiratory support at any time during PICU stay. Interventions: None. Measurements and main results: Eligible admissions were classified into nine groups based on the combination of the first-line and second-line respiratory support modes. Uni- and multivariate analyses were performed to test the association between PICU and patient characteristics and two outcomes: 1) use of high-flow nasal cannula versus noninvasive ventilation as first-line mode and 2) high-flow nasal cannula failure, requiring escalation to noninvasive ventilation and/or invasive ventilation. We analyzed data from 26,423 admissions; high-flow nasal cannula was used in 5,951 (22.5%) at some point during the PICU stay. High-flow nasal cannula was used for first-line support in 2,080 (7.9%) and post-extubation support in 978 admissions (4.5% of patients extubated after first-line invasive ventilation). High-flow nasal cannula failure occurred in 559 of 2,080 admissions (26.9%) when used for first-line support. Uni- and multivariate analyses showed that PICU characteristics as well as patient age, primary diagnostic group, and admission type had a significant influence on the choice of first-line mode (high-flow nasal cannula or noninvasive ventilation). Younger age, unplanned admission, and higher admission severity of illness were independent predictors of high-flow nasal cannula failure. Conclusion: The use of high-flow nasal cannula is common in PICUs in the United Kingdom and Republic of Ireland. Variation in the choice of first-line respiratory support mode (high-flow nasal cannula or noninvasive ventilation) between PICUs reflects the need for clinical trial evidence to guide future practice.
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Available at [British Journal of Community Nursing](#) from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

**Abstract**

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


**Authors**

Turo, Rafal; Horsu, Seth; Broome, James; Das, Sanjay; Gulur, Dev Mohan; Pettersson, Bo; Doyle, Gerard; Awwase, Ninanad

**Source**

Turkish journal of urology; Nov 2018; vol. 44 (no. 6); p. 478-483

**Publication Date**

Nov 2018

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Journal Article

**PubMedID**

30395796

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Medline

Available at Turkish journal of urology from Europe PubMed Central - Open Access

**Abstract**

OBJECTIVE Percutaneous nephrostomy (PCN) is one of the commonest procedures performed. There are currently no European recommendations on the accepted rate of complications. The aim of the present study is to report the complication rate of PCN with the specific emphasis on sepsis and septic shock, the causative organisms, sensitivities to antibiotics, and associated risk factors.

MATERIAL AND METHODS Retrospectively collected data on patients undergoing acute or elective PCN at the Department of Radiology, Countess of Chester Hospital (COCH), in the UK between January 2014 and December 2016 were analyzed after the study was approved by Local Audit Department at COCH.

RESULTSA total of 66 patients underwent 90 acute or elective PCNs. Three patients developed major post-PCN complication (two patients developed septic shock and the third suffered a hemorrhagic episode requiring blood transfusion). Nephrostomy tube complications (blockage, leaking, fracturing and kinking of the catheter) occurred in 4 patients. Complications were more common when the PCN was performed out of working hours (71.4% [10/14], and 17.3% [9/52] for PCNs performed within, and out of working hours, respectively: p<0.001). The age of the patients did not seem to correlate with the development of complications (p<0.001). Of all 25 patients, in whom septicemia was diagnosed prior to PCN tube insertion, 12 developed septic shock and 13 had signs of sepsis for longer than 24 h. Fifteen patients had positive urine cultures. The most common organism isolated was Escherichia coli. Blood culture isolates included: Escherichia coli, Enterococcus, Proteus mirabilis, Pseudomonas aeruginosa and Streptococcus pneumoniae.

CONCLUSION Our complication rates were within United States proposed target ranges. Our data may help to serve as a baseline for outcome targets in the European centres.


**Authors**

Patani, N; MacAskill, F; Eshelby, S; Omar, A; Kaura, A; Contractor, K; Thiruchelvam, P; Curtis, S; Main, J; Cunningham, D; Hogben, K; Al-Mufti, R; Hadjiminas, D; Leff, D R

**Source**

The British journal of surgery; Nov 2018; vol. 105 (no. 12); p. 1615-1622

**Publication Date**

Nov 2018

**Publication Type(s)**

Journal Article

**PubMedID**

29993125

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Available at The British journal of surgery from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).
Abstract

BACKGROUND Surgical subspecialization has resulted in mastitis and breast abscesses being managed with unnecessary admission to hospital, prolonged inpatient stay, variable antibiotic prescribing, incision and drainage rather than percutaneous aspiration, and loss to specialist follow-up. The objective was to evaluate a best-practice algorithm with the aim of improving management of mastitis and breast abscesses across a multisite NHS Trust. The focus was on uniformity of antibiotic prescribing, ultrasound assessment, admission rates, length of hospital stay, intervention by aspiration or incision and drainage, and specialist follow-up.

METHODS Management was initially evaluated in a retrospective cohort (phase I) and subsequently compared with that in two prospective cohorts after introduction of a breast abscess and mastitis pathway. One prospective cohort was analysed immediately after introduction of the pathway (phase II), and the second was used to assess the sustainability of the quality improvements (phase III). The overall impact of the pathway was assessed by comparing data from phase I with combined data from phases II and III; results from phases II and III were compared to judge sustainability.

RESULTS Fifty-three patients were included in phase I, 61 in phase II and 80 in phase III. The management pathway and referral pro forma improved compliance with antibiotic guidelines from 34 per cent to 58·2 per cent overall (phases II and III) after implementation (P = 0·003). The improvement was maintained between phases II and III (54 and 61 per cent respectively; P = 0·684). Ultrasound assessment increased from 38 to 77·3 per cent overall (P < 0·001), in a sustained manner (75 and 79 per cent in phases II and III respectively; P = 0·894). Reductions in rates of incision and drainage (from 8 to 0·7 per cent overall; P = 0·007) were maintained (0 per cent in phase II versus 1 per cent in phase III; P = 0·381). Specialist follow-up improved consistently from 43 to 95·7 per cent overall (P < 0·001), 92 per cent in phase II and 99 per cent in phase III (P = 0·120). Rates of hospital admission and median length of stay were not significantly reduced after implementation of the pathway.

CONCLUSION A standardized approach to mastitis and breast abscess reduced undesirable practice variation, with sustained improvements in process and patient outcomes.

16. POINT: podiatry for international diabetic foot teams.

Authors Van Acker, K; Garoufalis, M; Wilson, Pauline
Source Journal of wound care; Nov 2018; vol. 27; p. 1-32
Publication Date Nov 2018
Publication Type(s) Journal Article
PubMedID 30398395
Database Medline

Available at Journal of wound care from MAG Online Library Please log in before trying to access articles. Click on 'SIGN IN' and then on 'SIGN in via OPENATHENS'. You probably won't need to put your Athens details in again.

Available at Journal of wound care from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).

Available at Journal of wound 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

FOREWORD

The Point Project is an initiative between the two organisations: D-Foot International and the International Federation of Podiatrists (FIP-IFP). Both organisations promote the role of evidence-based foot care for patients with and at risk of diabetes. This collaborative work highlights the podiatric skills needed in order to deliver comprehensive evidence-based care to patients with diabetic foot disease. The statements along with the relevant skills and behaviours are based upon the guidance documents produced by the International Working Group on the Diabetic Foot (IWGDF), thus meaning while this is a consensus document it is also evidence-based. Representatives from both organisations with a multidisciplinary membership met early in 2017 to discuss the different areas of practice and to define which skills and behaviours were required at different levels of practice. Using the TRIEpodD-document (UK) and IWGDF guidance as the basis for discussion, the team identified which knowledge, skills and behaviours could be considered podiatric in nature. Once identified as podiatric, we discussed at which level of podiatric practice they could apply. The members of the team came from a variety of locations which represented practice at the different levels. Following the initial meeting, further discussions took place via email in order to consolidate initial discussions and complete the document. Cognisant of the large volume of guidance in relation to all areas of practice, this document is aimed to assist clinicians by pointing them in the direction in which they need to develop services rather than being a set of rules which must be followed. The POINT team feels that this document supports clinicians globally on three levels: As a benchmarking tool for existing teams to critically reflect upon their practice and identify where quality improvements can be made As a tool for clinicians who wish to establish a diabetic foot team to highlight the skills needed in order to provide care across the breadth of diabetic foot practice highlighting the specific roles in which podiatrists can help For national and local decision makers, to identify which skills can be provided by podiatrists to promote the development of the profession. While this is a consensus relating to podiatric skills, the team is aware that, in the absence of podiatrists, skills will be provided by other health professionals. We support this practice and while such professionals can not be considered podiatrists, they are providing podiatric skills to the diabetic foot team. The delivery of the relevant skill to the patient is the important factor, not the health professional is delivering it. The development of this document is merely the first step to identifying areas where skills need to be developed. Both D-Foot and FIP-IFP are committed to developing podiatric skills further across the globe. The aims and objectives of the two organisations are mutually beneficial to those suffering from diabetic foot disease. People with diabetes deserve the best care that they can receive, irrespective of the resources available. By working together we have been able to identify the podiatric knowledge, skills and behaviours required to provide evidence-based care. The next step is to work together to ensure consistent delivery of these globally for the benefit of those suffering the debilitating consequences of diabetic foot disease.


Authors

Marshall, Martin; Pfeifer, Nadine; de Silva, Debi; Wei, Li; Anderson, James; Cruickshank, Lesley; Attreed-James, Kieran; Shand, Jenny

Source

Journal of the Royal Society of Medicine; Nov 2018; vol. 111 (no. 11); p. 414-421

Publication Date

Nov 2018

Publication Type(s)

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PubMedID

30235053

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Available at Journal of the Royal Society of Medicine from EBSCOhost EJS


Abstract

OBJECTIVE

A growing proportion of older people live in care homes and are at high risk of preventable harm. This study describes a participatory qualitative evaluation of a complex safety improvement intervention, comprising training, performance measurement and culture-change elements, on the safety of care provided for residents. DESIGNA participatory qualitative study. SETTING Ninety care homes in one geographical locality in southern England. PARTICIPANTSA purposeful sample of care home managers, front-line staff, residents, quality improvement facilitators and trainers, local government and health service commissioners, and an embedded researcher. MAIN OUTCOME MEASURES Changes in care home culture and work processes, assessed using documentary analysis, interviews, observations and surveys and analysed using a framework-based thematic approach. RESULTS Participation in the programme appears to have led to changes in the value of the commitment among care home staff to address the problem of preventable harm. Mobilisation of this commitment appears to benefit from external facilitation and the introduction of new methods and tools. CONCLUSIONS An evidence-based approach to reducing preventable harm in care homes, comprising an intervention with both technical and social components, can lead to changes in staff priorities and practices which have the potential to improve outcomes for people who live in care homes.
18. Loop colostomies are safe in anorectal malformations.

**Authors**
Mullassery, Dhanya; Iacona, Roberta; Cross, Kate; Blackburn, Simon; Kiely, Edward; Eaton, Simon; Curry, Joe; De Coppi, Paolo

**Source**
Journal of pediatric surgery; Nov 2018; vol. 53 (no. 11); p. 2170-2173

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

**Abstract**
AIM OF THE STUDY
Divided colostomy (DC) has been recommended in anorectal malformations (ARMs) with previously reported advantages of decreasing overflow into the distal limb and urinary tract infections (UTIs). Skin bridge loop colostomy (LC) is a technically easier alternative without an increase in these complications. We report our institutional experience of LC in ARM.

**METHODS**
Retrospective study (Institution-approved Clinical Audit) reviewing the clinical records of all patients with ARM undergoing stoma formation in a single UK tertiary pediatric surgical center (2000-2015). Data collected included type of ARM, associated anomalies, type and level of colostomy, time to stoma closure, complications and UTIs.

**RESULTS**
One hundred and eighty-two (95 female) patients underwent colostomy formation for ARM. The vast majority (171/94%) underwent LC; 9 (5%) had a divided colostomy (DC) and 2 (1%) had no available data. The spectrum of defects in girls included rectovestibular (62/65%), rectovaginal (4/4%) and cloaca (29/31%). In boys, 71 (82%) had a fistula to the urinary tract and 16 (18%) presented with a perineal fistula. Urological abnormalities coexisted in 87 (47.8%) patients. Thirty five (21%) patients developed UTIs. Among the 19 girls who developed UTI, 8 had rectovestibular fistula and 11 had cloaca. Of the 16 boys who developed UTI, 14 had a fistula to the urinary tract and 11 had an independent urological abnormality. The mean time from stoma formation to stoma closure was 10 (3-52) months. Complications were reported in 22 (12%) LCs. Fifteen patients (9%) developed a stoma prolapse following LC with 10 (6%) requiring surgical revision.

**CONCLUSION**
This is the largest reported series of outcomes following LC for ARM. LC is easier to perform and to close, requiring minimal surgical access, with comparable complications and outcomes to those published for DC.

**TYPE OF STUDY**
Retrospective comparative study.

**LEVEL OF EVIDENCE**
III.

19. The detection of significant fractures in suspected infant abuse.

**Authors**
Raynor, Emma; Konala, Praveen; Freemont, Anthony

**Source**
Journal of forensic and legal medicine; Nov 2018; vol. 60; p. 9-14

**Publication Date**
Nov 2018

**Publication Type(s)**
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**PubMedID**
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Available at Journal of forensic and legal 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

OBJECTIVESkeletal survey is a commonly used means of detecting fractures in infants, and is used as a screen in suspected cases of physical abuse. It is recognised that in live infants, a repeat survey some days after a suspected episode of injury will detect more fractures than one taken shortly after the suspected injury, indicating that the latter lacks sensitivity. In infants who die soon after a suspected episode of physical abuse, the managing clinicians do not have the option of a second survey; however there is the opportunity for the microscopic examination of bones removed at autopsy. Increasingly Osteoarticular Pathology at the Manchester University NHS Foundation Trust (MFT) is being sent samples of bones from infants suspected of inflicted injury for histological examination, both from bones with fractures detected at autopsy or skeletal survey and from posterior ribs and long bone metaphyses (sites of significance in assessing for abusive injury) when there is no evidence of fracture on skeletal survey or autopsy. Here we report the results of an audit of the anonymised data from a series of such cases, to establish the sensitivity of skeletal survey (SS) to detect fractures and to define the medico-legal value of submitting bones for histological examination.METHODSThis was an audit of skeletal injuries in 38 infants aged <18 months presenting to MFT for specialist histopathological evaluation of suspected non-accidental fractures between January 2011 and June 2017. Histopathological examination was performed on all bones submitted and compared with contact radiography of isolated bones and post-mortem skeletal surveys undertaken by specialist paediatric or musculoskeletal radiologists for the presence of fracture. RESULTS A total of 318 fractures were detected histologically; of these, 178 (56%) were of the ribs, 119 (37.5%) were of major limb long bones, 10 (3%) were of the skull, and 11 (3.5%) were recorded as ‘other’. Excluding fractures, skeletal survey detected 54% of the fractures recorded histologically. No fractures were detected radiologically that were not seen histologically. Generally, for skeletal survey, detection rates improved with the age of the lesion, and rib fractures were more difficult to detect than long bone fractures. Ribs 5-8 were the most frequently fractured ribs, and metaphyses around the knee accounted for most metaphyseal limb long bone fractures undetected by SS. CONCLUSION In infants coming to post-mortem, histopathology is more sensitive than SS for the detection of clinically significant fractures. In children suspected of non-accidental injuries but with negative or equivocal SS, sampling of the anterior and posterior end of ribs 5-8 and the bones around the knee for histological examination could reveal clinically unsuspected fractures and significant evidence of physical abuse. 71% of infants showed evidence of old fractures typical of non-accidental injury.

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

Authors
Bhaduri, Sumit; Curtis, Hilary; McClean, Hugo; Sullivan, Ann K

Source
International journal of STD & AIDS; Nov 2018; vol. 29 (no. 11); p. 1146-1150

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

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

Authors
Bhaduri, S; Curtis, H; McClean, H; Sullivan, A K; National Audit Group of the British Association for Sexual Health and HIV

Source
International journal of STD & AIDS; Nov 2018; vol. 29 (no. 11); p. 1142-1145
Abstract

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

22. Primary repair versus surgical and transcatheter palliation in infants with tetralogy of Fallot.

Authors

Dorobantu, Dan M; Mahani, Alireza S; Sharabian, Mansour T A; Pandey, Ragini; Angelini, Gianni D; Parry, Andrew J; Tulloh, Robert M R; Martin, Robin P; Stoica, Serban C

Source

Heart (British Cardiac Society); Nov 2018; vol. 104 (no. 22); p. 1864-1870

Abstract

OBJECTIVES Treatment of infants with tetralogy of Fallot (ToF) has evolved in the last two decades with increasing use of primary surgical repair (PrR) and transcatheter right ventricular outflow tract palliation (RVOTd), and fewer systemic-to-pulmonary shunts (SPS). We aim to report contemporary results using these treatment options in a comparative study.

METHODS This a retrospective study using data from the UK National Congenital Heart Disease Audit. All infants (n=1662, median age 181 days) with ToF and no other complex defects undergoing repair or palliation between 2000 and 2013 were considered. Matching algorithms were used to minimise confounding due to lower age and weight in those palliated.

RESULTS Patients underwent PrR (n=1244), SPS (n=311) or RVOTd (n=107). Mortality at 12 years was higher when repair or palliation was performed before the age of 60 days rather than after, most significantly for primary repair (18.7% vs 2.2%, P<0.001), less so for RVOTd (10.8% vs 0%, P=0.06) or SPS (12.4% vs 8.3%, P=0.2). In the matched groups of patients, RVOTd was associated with more right ventricular outflow tract (RVOT) reinterventions (HR=2.3, P=0.05 vs PrR, HR=7.2, P=0.001 vs SPS) and fewer pulmonary valve replacements (PVR) (HR=0.3 vs PrR, P=0.05) at 12 years, with lower mortality after complete repair (HR=0.2 versus PrR, P<0.09).

CONCLUSIONS We found that RVOTd was associated with more RVOT reinterventions, fewer PVR and fewer deaths when compared with PrR in comparable, young infants, especially so in those under 60 days at the time of the first procedure.

23. Barriers to implementation of a healthy canteen policy: A survey using the theoretical domains framework.

Authors

Reilly, Kathryn; Nathan, Nicole; Grady, Alice; Wu, Jason H Y; Wiggers, John; Yoong, Sze Lin; Wolffenstein, Luke

Source

Health promotion journal of Australia : official journal of Australian Association of Health Promotion Professionals; Nov 2018

Abstract

OBJECTIVES Treatment of infants with tetralogy of Fallot (ToF) has evolved in the last two decades with increasing use of primary surgical repair (PrR) and transcatheter right ventricular outflow tract palliation (RVOTd), and fewer systemic-to-pulmonary shunts (SPS). We aim to report contemporary results using these treatment options in a comparative study.

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Authors: Visokiene, Z., Narkauskaitė-Nedzinskienė, L., Puronaitė, R., Mikaliūkštienė, A.
Source: Health and quality of life outcomes; Nov 2018; vol. 16 (no. 1); p. 206
Publication Type(s): Journal Article
Publication Date: Nov 2018
PubMedID: 30382867
Database: Medline

Abstract:
BACKGROUND Currently there is no diabetes-specific quality of life (QOL) instrument available in Lithuanian language. We aimed to develop a Lithuanian version of a widely-used individualised instrument - the Audit of Diabetes Dependent Quality of Life questionnaire (ADDQOL-19) and assess the validity and reliability in patients with type 1 and type 2 diabetes mellitus (DM).

METHODS This study was conducted at the Primary Care and Endocrinology Outpatient Clinics in Vilnius. The ADDQOL was translated from the original English (UK) into Lithuanian using a standardized methodology of forward and back translation. After cognitive "debriefing" the validity and reliability of LT-ADDQOL questionnaire were assessed in a sample of 138 diabetes patients. Cronbach's alpha coefficient, factor analysis, independent t tests and ANOVA were used.

RESULTS There were 106 participants with type 2 and 32 with type 1 DM included in the study with a mean age of 55.5 ± 14.5 years and 56.2% women. The Cronbach's alpha coefficient was 0.908 and most of the items loading values onto one single factor were larger than 0.40 (varied from 0.41 to 0.77), indicating good internal consistency and reliability of instrument.

CONCLUSIONS We developed the Lithuanian version of ADDQOL-19 which is a valid and reliable instrument to measure impact of diabetes on QOL. It could be further used by clinicians and researchers for comprehensive assessment of QOL in adults with diabetes.


Source: Eye (London, England); Nov 2018; vol. 32 ; p. 8-23
Publication Date: Nov 2018
Publication Type(s): Journal Article
PubMedID: 30390025
Database: Medline

Abstract:
ISSUE ADDRESSED Improving implementation of school healthy canteen policies requires a comprehensive understanding of implementation barriers. Therefore, the aim of this study was to assess a range of barriers, as reported by canteen managers, using a quantitative survey instrument developed based on a theoretical framework. METHODSA cross-sectional survey of primary school canteen managers from the Hunter New England region of New South Wales was conducted of eligible schools in the study region identified as having an operational canteen. Survey items assessed canteen manager employment status, canteen characteristics and potential barriers to healthy canteen policy implementation, aligned to the 14 domains of the Theoretical Domains Framework via a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Canteen manager mean domain scores were calculated, less than four indicating the canteen manager considered the domain was a barrier. Canteen managers were also asked to provide a current canteen menu for audit by a dietitian.

RESULTS Of the 184 participants, 20% (n=36) were assessed as having menus compliant with the state policy. The five most common domains identified as potential barriers to policy implementation were behaviour regulation (n=117, 65%), skills (n=105, 57%), beliefs about capabilities (n=100, 55%), reinforcement (n=95, 52%) and goals (n=95, 52%). Canteen managers who reported optimism as a barrier had significantly lower odds of having a menu compliant with the state policy (OR=0.39; 95% CI 0.16-0.95, p=0.038)

CONCLUSIONS This study provides further evidence of perceived and actual barriers that canteen managers face when attempting to implement a healthy canteen policy, and highlights the need to address differences in canteen characteristics when planning implementation support. SO WHAT?: For public health benefits of nutrition policies within schools to be realised, the barriers to implementation need to be identified and used to help guide implementation support strategies. This article is protected by copyright. All rights reserved.
26. Proceedings from 'Clinical Audit in Retina 2017': summaries and discussion: Crowne Plaza, Birmingham City Centre, UK; Wednesday 28 June 2017.

Source: Eye (London, England); Nov 2018; vol. 32; p. 2-7
Publication Date: Nov 2018
Publication Type(s): Journal Article
PubMedID: 30390026
Database: Medline


27. Audit of COPD exacerbations in secondary care.

Source: Drug and therapeutics bulletin; Nov 2018; vol. 56 (no. 11); p. 129
Publication Date: Nov 2018
Publication Type(s): Journal Article
PubMedID: 30297447
Database: Medline


Authors: Berni, Ellen; Murphy, Daniel; Whitehouse, James; Conway, Pete; Di Maggio, Paola; Currie, Craig J; Poole, Chris
Source: Current medical research and opinion; Nov 2018; vol. 34 (no. 11); p. 2001-2008
Publication Date: Nov 2018
Publication Type(s): Journal Article
PubMedID: 29995455
Database: Medline

Abstract: OBJECTIVE: Rifaximin-α 550 mg twice daily plus lactulose has demonstrated efficacy in reducing recurrence of episodes of overt hepatic encephalopathy (OHE) and the risk of hepatic encephalopathy (HE)-related hospitalizations compared with lactulose alone. This analysis estimated the cost effectiveness of rifaximin-α 550 mg twice daily plus lactulose versus lactulose alone in United Kingdom (UK) cirrhotic patients with OHE. METHOD: A Markov model was built to estimate the incremental cost-effectiveness ratio (ICER). The perspective was that of the UK National Health Service (NHS). Clinical data was sourced from a randomized controlled trial (RCT) and an open-label maintenance study in cirrhotic patients in remission from recurrent episodes of OHE. Health-related utility was estimated indirectly from disease-specific quality of life RCT data. Resource use data describing the impact of rifaximin-α on hospital admissions and length of stay for cirrhotic patients with OHE was from four single-center UK audits. Costs (2012) were derived from published sources; costs and benefits were discounted at 3.5%. The base-case time horizon was 5 years. RESULT: The average cost per patient was £22,971 in the rifaximin-α plus lactulose arm and £23,545 in the lactulose arm, a saving of £574. The corresponding values for benefit were 2.35 quality adjusted life years (QALYs) and 1.83 QALYs per person, a difference of 0.52 QALYs. This translated into a dominant base-case ICER. Key parameters that impacted the ICER included number of hospital admissions and length of stay. CONCLUSION: Rifaximin-α 550 mg twice daily in patients with recurrent episodes of OHE was estimated to generate cost savings and improved clinical outcomes compared to standard care over 5 years.
29. The colorectal surgeon’s personality may influence the rectal anastomotic decision.

**Authors**
Moug, S J; Henderson, N; Tiernan, J; Bisset, C N; Ferguson, E; Harji, D; Maxwell-Armstrong, C; MacDermid, E; Acheson, A G; Steele, R J C; Fearnhead, N S; Edinburgh Delphi Collaborative Group

**Source**
Colorectal disease: the official journal of the Association of Coloproctology of Great Britain and Ireland; Nov 2018; vol. 20 (no. 11); p. 970-980

**Publication Date**
Nov 2018

**Publication Type(s)**
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**PubMedID**
29904991

**Database**
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Available at Colorectal disease: the official journal of the Association of Coloproctology of Great Britain and Ireland from Wiley Online Library Medicine and Nursing Collection 2018 - NHS

Available at Colorectal disease: the official journal of the Association of Coloproctology of Great Britain and Ireland from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).

Available at Colorectal disease: the official journal of the Association of Coloproctology of Great Britain and Ireland from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location]: British Library via UHL Libraries - please click link to request article.

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

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

**Authors**
Tsui, Jonathan Jenkin; Davey, Veronica; Colvin, Lesley

**Source**
British journal of pain; Nov 2018; vol. 12 (no. 4); p. 220-229

**Publication Date**
Nov 2018

**Publication Type(s)**
Journal Article

**PubMedID**
30349696

**Database**
Medline

Available at British Journal of Pain from Europe PubMed Central - Open Access

**Abstract**
Background and aimsThe Lothian Chronic Pain Service relocated from a university teaching hospital (Western General Hospital (WGH)) to a community centre (Leith Community Treatment Centre (LCTC)) in 2015. Transportation and geographical location were noted by staff to be potential challenges that could negatively impact on the patient experience. The objective of this study is to evaluate how relocating pain clinic from an urban-based hospital to a peripheral community centre on patient experience. METHODS An assessment and audit of the impact of the relocation on the Patient-Reported Experience Measure (PREM) of pain services was conducted. Using a nationally developed questionnaire, the patient-reported experience from LCTC was prospectively collected in 2016 and was compared to historical data obtained from WGH in 2014 by National Health Service (NHS) Scotland. All patients attending Lothian Chronic Pain Service clinics were deemed eligible for the audit. Patient demographics were compared between the two data sets. The impact of patient deprivation on patient experience was investigated using the Scottish Index of Multiple Deprivation (SIMD16). RESULTS Data from 111 patients from LCTC were compared to 206 patients from WGH. Percentage of patients rating care as ‘excellent’ was found to be significantly greater at LCTC than WGH (0.0049). However, overall patient rating of care from LCTC was not significantly different from WGH data and ratings were higher at LCTC. No correlation was found between patient deprivation and PREM. Conclusion There is no clear evidence that PREM was negatively affected by the move from a university teaching hospital to a community setting. As this only reported experiences of patients who attended the service, further studies may be warranted to investigate the impact of patient nonattendance.

Authors: Khan, Saad U; Bowrey, David J; Williams, Robert N; Soh, Jun Yi; Peleki, Aikaterini; Muhibullah, Nazli; Waterland, Peter W

Source: Annals of medicine and surgery (2012); Nov 2018; vol. 35; p. 67-72

Publication Date: Nov 2018

Publication Type(s): Journal Article

PubMedID: 30294432

Database: Medline

Available at Annals of medicine and surgery (2012) from Europe PubMed Central - Open Access

Abstract

Background Informed consent obtained for day case surgery has been historically incomplete. An assessment of consenting practice for groin hernia was performed relative to existing gold standards and patient’s perception of the consent process was evaluated with a questionnaire. The aim of the study was to identify areas of improvement to comply with best practice.

Methods A retrospective audit of adult patients undergoing groin hernia repair (June-November 2016) at a tertiary care centre was performed. The same cohort of patients was surveyed with a self-administered questionnaire to identify their view on consenting practice.

Results 113 patients were identified who underwent groin hernia repair during the study period. Pre-printed consent templates - stickers (as opposed to hand-written) were used in 53(47%) cases. In 75(66%) cases, there was complete documentation of the risks and benefits of surgery. 81(72%) patients received information about the full benefits of surgery. 27(23%) patients received partial information and 7(6%) patients had no mention of benefit recorded. Postoperative recovery was fully explained to 85(75%) patients. Use of pre-printed templates ensured 100% documentation compared to handwritten consent forms (risks 37%, benefits 47%, and recovery 53%). Preference for the timing of consent was in clinic (64%), day of surgery (25%), 34(56%) felt the choice for the technique and 22(36%) felt the choice for anaesthesia. Satisfaction was non-significantly better in those consented in clinic (87% versus 76% p = 0.74). 49(80%) felt happy with the overall consent process. 57(93%) felt that they received support and advice. 60(98%) responders felt confidence in the National Health Service and 59(97%) would recommend treatment to family and friends.

Conclusions The use of pre-printed consent and discharge summary templates improve compliance with best practice. Whilst patient preference favours consent in the outpatient clinic, satisfaction levels were high wherever consent was obtained. Patients should have more choice.

32. Paediatric intensive care and neonatal intensive care airway management in the United Kingdom: the PIC-NIC survey.

Authors: Foy, K E; Mew, E; Cook, T M; Bower, J; Knight, P; Dean, S; Herneman, K; Marden, B; Kelly, F E

Source: Anaesthesia; Nov 2018; vol. 73 (no. 11); p. 1337-1344

Publication Date: Nov 2018

Publication Type(s): Journal Article

PubMedID: 30112809

Database: Medline

Available at Anaesthesia from Wiley

Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location] : UHL Libraries On Request (Free).

Available at Anaesthesia from Available to NHS staff on request from UHL Libraries & Information Services (from non-NHS library) - click this link for more information Local Print Collection [location] : British Library via UHL Libraries - please click link to request article.
Addiction
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<
years, respectively). SETTINGSouth West
0.24, 95% CI
week). Partner alcohol use
<
0.001; high risk: b
0.10, 95% CI
= = = = = = =
0.001]. The majority of this association was explained through early alcohol initiation
= = = = = = =
0.02, 0.10, P
1.07, 95% confidence interval (CI)
0.01; high risk: b
0.39, 1.22, P
1.07, 2.35, P
0.64, 1.49, P
0.001; high risk: b
1.71, 95% CI
0.07, 0.40, P
0.01; early alcohol initiation/associating with deviant peers (moderate: b = 0.24, 95% CI = 0.07, 0.40, P < 0.01; high risk: b = 0.10, 95% CI = 0.03, 0.16, P < 0.01). There was strong evidence of a remaining direct effect (moderate: b = 0.81, 95% CI = 0.39, 1.22, P < 0.001; high risk: b = 1.28, 95% CI = 0.65, 1.91, P < 0.001). A similar pattern of results was evident for partner alcohol use.CONCLUSIONSYoung adults whose parents have moderate or high-risk alcohol consumption are more likely to consume alcohol than those with parents with lower alcohol consumption. This association appears to be partly accounted for by earlier alcohol use initiation and higher prevalence of association with deviant peers.

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

Authors
Mahedy, Liam; MacArthur, Georgina J; Hammerton, Gemma; Edwards, Alexis C; Kendler, Kenneth S; Macleod, John; Hickman, Matthew; Moore, Simon C; Heron, Jon

Source
Addiction (Abingdon, England); Nov 2018; vol. 113 (no. 11); p. 2041-2050

Publication Date
Nov 2018

Publication Type(s)
Journal Article

MedlineID
29806869

Database
Medline

Available at Addiction from Wiley Online Library Medicine and Nursing Collection 2018 - NHS Available at Addiction from Available to NHS staff on request from UHL Libraries & Information Services (from NULJ library) - click this link for more information Local Print Collection [location]: UHL Libraries On Request (Free).

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

Authors
Jones, Lorelei; Pomeroy, Linda; Robert, Glenn; Burnett, Susan; Anderson, Janet E; Morris, Stephen; Capelas Barbosa, Estela; Fulop, Naomi J

Source
BMJ quality & safety; Oct 2018

Publication Date
Oct 2018
BACKGROUND Healthcare systems worldwide are concerned with strengthening board-level governance of quality. We applied Lozeau, Langley and Denis’ typology (transformation, customisation, loose coupling and corruption) to describe and explain the organisational response to an improvement intervention in six hospital boards in England.

METHODS We conducted fieldwork over a 30-month period as part of an evaluation in six healthcare provider organisations in England. Our data comprised board member interviews (n=54), board meeting observations (24 hours) and relevant documents.

RESULTS Two organisations transformed their processes in a way that was consistent with the objectives of the intervention, and one customised the intervention with positive effects. In two further organisations, the intervention was only loosely coupled with organisational processes, and participation in the intervention stopped when it competed with other initiatives. In the final case, the intervention was corrupted to reinforce existing organisational processes (a focus on external regulatory requirements). The organisational response was contingent on the availability of ‘slack’—expressed by participants as the ‘space to think’ and ‘someone to do the doing’—and the presence of a functioning board.

CONCLUSIONS Underperforming organisations, under pressure to improve, have little time or resources to devote to organisation-wide quality improvement initiatives. Our research highlights the need for policy-makers and regulators to extend their focus beyond the choice of intervention, to consider how the chosen intervention will be implemented in public sector hospitals, how this will vary between contexts and with what effects. We provide useful information on the necessary conditions for a board-level quality improvement intervention to have positive effects.
BACKGROUND Governing bodies are largely responsible for the monitoring and management of risks associated with a safe playing environment, yet adherence to regulations is currently unknown. The aim of this study was to investigate and evaluate the current status of medical personnel, facilities, and equipment in Rugby Union clubs at regional level in England.

METHODS A nationwide cross-sectional survey of 242 registered clubs was undertaken, where clubs were surveyed online on their current medical personnel, facilities, and equipment provision, according to regulation 9 of the Rugby Football Union (RFU).

RESULTS Overall, 91 (45.04%) surveys were returned from the successfully contacted recipients. Of the completed responses, only 23.61% (n = 17) were found to be compliant with regulations. Furthermore, 30.56% (n = 22) of clubs were unsure if their medical personnel had required qualifications; thus, compliance could not be determined. There was a significant correlation (p = -0.029, r = 0.295) between club level and numbers of practitioners. There was no significant correlation indicated between the number of practitioners/number of teams and number of practitioners/number of players. There were significant correlations found between club level and equipment score (p = 0.003, r = -0.410), club level and automated external defibrillator (AED) access (p = 0.002, r = -0.352) and practitioner level and AED access (p = 0.0001, r = 0.404). Follow-up, thematic analysis highlighted widespread club concern around funding/cost, awareness, availability of practitioners and AED training.

CONCLUSION The proportion of clubs not adhering overall compliance with Regulation 9 of the RFU is concerning for player welfare, and an overhaul, nationally, is required.

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

Authors Christie, Bryan
Source BMJ (Clinical research ed.); Oct 2018; vol. 363 ; p. k4520

39. Effectiveness of Behavioural Interventions to Reduce Urinary Tract Infections and E. coli Bacteraemia for Older Adults Across all Care Settings: A Systematic Review.

Authors Jones, L F; Meyrick, J; Bath, J; Dunham, O; McNulty, C A M
Source The Journal of hospital infection; Oct 2018
40. Genome-Wide Association Study Meta-Analysis of the Alcohol Use Disorders Identification Test (AUDIT) in Two Population-Based Cohorts.

**Authors**
Sanchez-Roige, Sandra; Palmer, Abraham A; Fontanillas, Pierre; Elson, Sarah L; 23andMe Research Team; Substance Use Disorder Working Group of the Psychiatric Genomics Consortium; Adams, Mark J; Howard, David M; Edenberg, Howard J; Davies, Gail; Crist, Richard C; Deary, Ian J; McIntosh, Andrew M; Clarke, Toni-Kim

**Source**
The American journal of psychiatry; Oct 2018; vol. 17 (no. 1); p. 118

**Abstract**
OBJECTIVE: Alcohol use disorders are common conditions that have enormous social and economic consequences. Genome-wide association analyses were performed to identify genetic variants associated with a proxy measure of alcohol consumption and alcohol misuse and to explore the shared genetic basis between these measures and other substance use, psychiatric, and behavioral traits.

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

RESULTS: The GWAS meta-analysis of AUDIT total score identified 10 associated risk loci. Novel associations localized to genes including JCAD and SLC39A13; on the problematic consequences of drinking (AUDIT-P).

41. Talk CPR - a technology project to improve communication in do not attempt cardiopulmonary resuscitation decisions in palliative illness.

**Authors**
Taubert, Mark; Norris, James; Edwards, Sioned; Snow, Veronica; Finlay, Ilora Gillian

**Source**
BMC palliative care; Oct 2018; vol. 17 (no. 1); p. 118
42. Developing an implementation strategy for a digital health intervention: an example in routine healthcare.

Authors
Ross, Jamie; Stevenson, Fiona; Dack, Charlotte; Pal, Kingshuk; May, Carl; Michie, Susan; Barnard, Maria;Murray, Elizabeth

Source
BMC health services research; Oct 2018; vol. 18 (no. 1); p. 794

Abstract
BACKGROUND Evidence on how to implement new interventions into complex healthcare environments is often poorly reported and indexed, reducing its potential to inform initiatives to improve healthcare services. Using the implementation of a digital intervention within routine National Health Service (NHS) practice, we provide an example of how to develop a theoretically based implementation plan and how to report it transparently. In doing so we also highlight some of the challenges to implementation in routine healthcare.

METHODS The implemented intervention was HeLP-Diabetes, a digital self-management programme for people with Type 2 Diabetes, which was effective in improving diabetes control. The target setting for the implementation was an inner city London Clinical Commissioning Group in the NHS comprised of 34 general practices. HeLP-Diabetes was designed to be offered to patients as part of routine diabetes care across England. Evidence synthesis, engagement of local stakeholders, a theory of implementation (Normalization Process Theory), feedback, qualitative interviews and usage data were used to develop an implementation plan.

RESULTS A new implementation plan was developed to implement HeLP-Diabetes within routine practice. Individual component strategies were selected and developed informed by Normalization Process Theory. These strategies included: engagement of local opinion leaders, provision of educational materials, educational visits, educational meetings, audit and feedback and reminders. Additional strategies were introduced iteratively to address barriers that arose during the implementation. Barriers largely related to difficulties in allocating resources to implement the intervention within routine care.

CONCLUSION This paper provides a worked example of implementing a digital health intervention. The learning from this work can inform others undertaking the work of planning and executing implementation activities in routine healthcare. Of particular importance is the selection of appropriate theory to guide the implementation process and selection of strategies; ensuring that enough attention is paid to planning implementation; and a flexible approach that allows response to emerging barriers.
## Search Strategy

### MEDLINE - AUDIT

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