

were prospectively studied. The following groups of patients were excluded: non-english speaking patients; patients with previous experience of the procedure; sedated patients as the sedation might have impaired mental recall: and inpatients because of possible confounding comorbidity. An abbreviated previously validated consent questionnaire was used (the QuIC questionnaire),<sup>2</sup> with specific reference to the overall understanding of the test, risk/benefits and alternatives. The significance of observed differences were statistically assessed by the Student's t-test.

**Results** Patients were consented by either their named nurse or the doctor carrying out the procedure. All nurses trained in consent participated in this study, 10 staff nurses and two sisters. Doctors who participated in this study were four consultant gastroenterologists, three gastroenterology registrars, two consultant surgeons and one elderly care consultant. Questionnaires were completed for 65 nurse consent and 47 doctor consents. Patients had a better understanding of the alternatives to having the procedure when consented by a nurse ( $p < 0.03$ ). Patients understood the risks, discomfort, benefits and the overall procedure equally whether consented by a nurse or doctor.

**Conclusion** This study has shown that nurse consent in our unit was more thorough than doctor consent. Patients who were consented by a nurse showed greater understanding of the alternative options to having the endoscopy. There was equal understanding of the risks, discomfort, benefits and overall procedure whether consented by a nurse or a doctor. Based on these results, endoscopy units should consider adopting nurse led consent into their daily working practice.

**Competing interests** None declared.

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**OC-004 ASSISTANT PRACTITIONERS IN ENDOSCOPY: INNOVATIVE PRACTISE**

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**Introduction** New roles are being introduced within the NHS to utilise knowledge and skills to offer value for money services. Assistant Practitioners were introduced into the endoscopy unit and an innovative service was set up to improve the patient management for pre surveillance colonoscopy screening.

**Methods** A telephone assessment was implemented by an Assistant Practitioner (band 4) to ascertain whether this could be offered as an alternative to the current pre endoscopy clinic led by a band 5 to ensure the patient was safe to proceed with bowel preparation and investigation.

**Results** 68 patients were booked onto the Assistant Practitioner (AP) telephone clinic over a 10-week period. Out of these 20 DNA'd the appointment and 48 were assessed via the telephone consultation. Out of the 48 patients assessed the AP was able to decide if the patient was fit to proceed without seeking further advice. Forty-one patients were deemed suitable to advance to colonoscopy and agreed a date to attend. Seven patients chose to be discharged.

**Conclusion** Hospital attendance is not always required to adequately assess the suitability for bowel preparation and colonoscopy. For a cohort of patients this can be done by a telephone consultation. This has advantages both for the user, in that they are not required to attend with all the difficulties associated with hospital visits, and

the provider for adequate use of resource and capacity available. It is acknowledged that there may be a proportion of patients identified that require a face to face assessment at a higher level and those can be given a date to attend a nurse led clinic at the time of telephone consultation. This method is more cost effective due to the higher numbers of consultations on a telephone assessment clinic compared to face to face clinic and the associated salaries of the band of the practitioner undertaking the session.

**Competing interests** None declared.

**OC-005 AN EXPLORATION OF THE HEALTH AND SOCIAL NEEDS OF PEOPLE LIVING WITH INFLAMMATORY BOWEL DISEASE: A METASYNTHESIS**

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**Introduction** The Inflammatory Bowel Disease Questionnaire and the Rating Form for IBD patient's Concerns, are widely used measures in IBD but fail to capture the essence of living with IBD from the patient's perspective. To deliver patient centred care it is imperative that we have an understanding of the experience of living with IBD. This study aimed to synthesise the findings of qualitative papers that explored the health and social needs of patients living with IBD.

**Methods** A systematic literature search was conducted in MEDLINE, PsychInfo, EMBASE, CINAHL, British Nursing Index via the OVID platform to August 2010. Search filters developed by the Hedges database, McMaster University Health Information Research Unit and Kathryn Nesbit, Edward G Milner Library, University of Rochester, were adapted to aid the search. 1395 papers were generated by the preliminary search. Qualitative studies which explored the phenomena of living with IBD, English language and sample population adults >16 years were included. Study eligibility judgements and data extraction were independently completed by the authors. The papers were quality appraised using the Critical Appraisal Skills Programme. Synthesis was achieved by comparing the themes and findings of each study with one another to identify 1st order constructs. Repeated comparison between the papers revealed the similarities and differences, which led to 2nd order constructs and the new interpretation of the synthesised studies.

**Results** Six papers and one unpublished thesis were included, all from Western countries, one study included patients from an immigrant background. Combined sample of the studies was only 86 patients to describe the phenomena of living with IBD. First iteration of synthesis identified 16 themes, 2nd iteration synthesised these into three main constructs: "detained by the disease"; "living in a world of disease"; "wrestling with life". "Detained by the disease" is the fear of incontinence, and the behaviour the patients displays as a result of this. Social isolation and missing out on life events all serve to "pull" the patient back from normal living. "Living in a world of disease" is living with the fear of a long term condition. "Wrestling with life" is the "push" to continue normal living.

**Conclusion** People with IBD endure many daily challenges, stress, pain, fighting for control. The combined impact of living with IBD is the tension they live with. The value of metasynthesis is the interpretation of all of the synthesised studies to provide a global representation of living with IBD: "Pushed and pulled: a compromised life", people living with IBD experience a constant conflict throughout their lives, they push to be normal but IBD pulls them back.

**Competing interests** None declared.