

Nursing

PMO-001 **THE ROLE OF THE SPECIALIST SCREENING PRACTITIONER WITHIN THE BOWEL SCREENING WALES PROGRAMME**

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Introduction Bowel Screening Wales (BSW) was launched nationally in October 2008. With its launch came the introduction of a unique, autonomous nursing role which is placed at the interface of secondary and primary care.

Methods Specialist Screening Practitioners (SSPs) are based at all BSW Local Assessment Centres (LACs) throughout Wales. The original sixteen SSPs employed prior to the inception of the BSW programme had diverse clinical backgrounds and all underwent a 4-week induction programme. On returning to their local areas, SSPs were supported by a programme of clinical induction which incorporated an understanding of agreed competencies. During the initial induction phase SSPs were mentored by the Regional Nurses and Lead Screening Colonoscopists. The role of the SSP is multi faceted. They apply advanced expert clinical knowledge and experience alongside evidence based decision making skills to support participants who have received a positive faecal occult blood test and have consented to speak to a SSP. Each practitioner has their own participant caseload for which they are accountable. They assess participants' fitness to undergo a colonoscopy, arrange the colonoscopy, consent the participants prior to the colonoscopy and are present during the colonoscopy. They also give results, ensure that the participants are placed on the routine recall or surveillance pathway, refer to and attend Multi Disciplinary Team meetings following a participant's diagnosis of cancer. Many participants require considerable support from their SSP due to their medical history which may include mental health issues, the presence of comorbidity and social problems. As the role of SSP is an advanced nursing role all practitioners are required to possess or be working towards a Degree. BSW has collaborated with Cardiff University to develop a MSc module. All Wales SSP network meetings are held twice per year and offer educational and peer support. SSPs employed since the autumn of 2008 undergo a programme of induction based on their educational needs.

Results As a result of the support given by SSPs, participants are well informed about the procedure. Compliance with bowel preparation is high as is evidenced by the low numbers of incomplete colonoscopy. There is a very low rate of participants who do not attend for colonoscopy.

Conclusion Over the last 3 years the role of the SSP has continually evolved. The role can be further developed by sharing knowledge and good practice on a UK wide basis.

Competing interests None declared.

Service development I

PMO-002 **EVALUATION OF A NURSE AND DIETETIC LED FOLLOW-UP SERVICE FOR PATIENTS WITH AN UPPER GASTROINTESTINAL MALIGNANCY**

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Introduction The Clinical Nurse Specialist Team developed a nurse and dietetic led follow-up service. Is the service effective and does it meet patient's needs?

Methods The team devised a questionnaire for both the patients and the clinicians. All patients who had attended the clinic and the three surgical consultants were sent questionnaires. Exclusions were duplicates and those deceased. A total of 100 patient and three clinician questionnaires were sent. The patients and clinicians were asked to return the questionnaires to a Clinical Governance support officer who collated the results. In total the team received 89 responses from patients and two from clinicians equating to a 74% return rate.

Results The majority of patients responded favourably to the nurse and dietetic led service, with only 2% of respondents preferring a consultant led service. Neither of the responding clinicians felt that the service needed to change. 80% of respondents felt the length of their appointment was adequate. The majority of patients responded favourably to the nurse and dietetic led service, with only 2% of respondents preferring a consultant led service. Neither of the responding clinicians felt that the service needed to change. 80% of respondents felt the length of their appointment was adequate.

Conclusion One follow-up clinic per week has streamlined the workload ensuring an equitable, appropriate service. It has also supported the continued professional development of the CNS team/Dietetic team and a more productive workforce. This has highlighted the value of the role of the CNS and Dietetic Team. The Nurse and Dietetic Led service provides the opportunity for patients to have a longer, in depth consultation meeting the recommendations of the Supportive and Palliative Care Guidance Holistic Needs Assessment.

Competing interests None declared.

REFERENCES

1. **The Department of Health.** *A Policy Framework for Commissioning Cancer Services. A Report By The Expert Advisory Group On Cancer To The Chief Medical Officers of England and Wales.* London. 1995.
2. **The Department of Health.** *The NHS Cancer Plan. A Plan For Investment. A Plan For Reform.* London. 2000.
3. **The Department of Health.** *National Surveys of NHS patients: Cancer National Overview 1999-2000.* London. 2002.
4. **The Department of Health.** *Cancer Reform Strategy.* London. 2007.
5. **The Department of Health.** *National Cancer Survivorship Initiative.* London. 2008.
6. **National Institute for Clinical Excellence.** *Improving Supportive and Palliative Care For Adults.* London. 2004.

PMO-003 **EFFECT OF MRI AND VARIABLE STIFFNESS COLONOSCOPES ON CAECAL INTUBATION RATES BY EXPERIENCED ENDOSCOPISTS**

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Introduction Magnetic endoscopic imager (MEI) and variable stiffness colonoscopes (VSC) have been shown to improve caecal intubation rates in trainees. Many trained endoscopists in our department prefer to perform colonoscopies with them rather than without. The aim of this study was to assess colonoscopic performance data in experienced endoscopists, with and without the use of MEI and VSC, in our endoscopy department.

Methods Our endoscopy department uses Olympus VSC with MEI in two theatres and standard Pentax colonoscopes with no variation in stiffness or 3D imaging, in our two other theatres. All equipment was purchased in 2009. Experienced endoscopists use both Olympus and Pentax equipment. We have conducted a retrospective case note analysis to assess caecal intubation rates, terminal Ileum intubation rates, polyp detection rates and sedation used, by individual endoscopists.

Results We reviewed 3984 procedures, performed by 16 experienced endoscopists between September 2009 and November 2011. 2598 colonoscopies used Olympus VSC with MEI and 1386 with Pentax equipment. Caecal intubation rate (CIR) was higher in 13/16

endoscopists when using MEI and VSC than without. The total CIR for all colonoscopies was greater using VSC with MEI than without (89.9% vs 87.1%, $p=0.0153$). There was no significant difference in TI intubation rate, polyp detection rate or sedation used.

Conclusion Although most endoscopists prefer to use MEI and VSC when performing colonoscopy, our data suggests that the difference in caecal intubation rates with experienced endoscopists is small. However, our observed difference in CIR of 2.8% would equate to about 168 colonoscopies in our unit completed, per year that would be otherwise incomplete.

Competing interests None declared.

PMO-004 DO WE NEED PROPOFOL SEDATION AND A CYTOLOGIST PRESENT DURING ENDOSCOPIC ULTRASOUND? INITIAL EXPERIENCE FROM A UK CENTRE

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Introduction Endoscopic ultrasound (EUS) is a prolonged procedure using endoscopes nearly twice the diameter of a standard gastro-scope and relies on a compliant still patient to obtain images and fine needle aspiration (FNA) samples. Propofol or anaesthetic delivered sedation is used to ensure procedure success and tolerability in many international centres with in-room cytology expertise to optimise the yield of FNA. This practice is potentially costly and labour intensive. We retrospectively and prospectively examined tolerability, completion and FNA accuracy in a recently expanded EUS centre in the UK using midazolam and fentanyl sedation only and no in room cytologist.

Methods Electronic array radial and linear ultrasound scopes with FNA procedures were available to our centre from July 2010. A cytology processing methodology was used with complete expulsion of FNA material into a "cytorich red" medium with no in room slide processing or viewing. A standard three FNA passes was used for pancreatic masses (20 ml suction) and lymph nodes (0–10 ml suction). Accuracy was calculated with follow-up of patients for >3 months for specimens. Also from this time analysis of sedation used, procedure success and any reversal agent/respiratory support required was documented. From 1 September 2011 patients undergoing EUS and gastroscopy examinations were invited to complete questionnaires to score pain during the procedure.

Results From 1 July 2010 until 31 December 2011 450 EUS procedures were performed. 11 were incomplete and all due to luminal stricture formation only. FNA was performed in 126 patients. Accuracy for all lesions was 84.9%, and for solid pancreatic tumours 82.4% ($n=68$). Midazolam use ranged from 0 to 10 mg (mean 3.44 median 4) and fentanyl use ranged from 0 to 200 μ g (mean 67.9; median 50). No reversal agent was used and no patients required any assisted ventilation. Prospective recruitment from 1 September 2011 included 49 patients which participated for EUS. The mean procedure time was 19.5 min (range 8–35), mean pain score during the procedure was 2.26/10 (range 0–9 median 2), and the average dose of sedation was 3.45 mg midazolam and 72.8 μ g fentanyl. During the same time period 75 consecutive patients undergoing gastroscopy participated. There was no difference in the average pain score during the procedure compared to EUS: mean=2.6/10 (t test $p=0.36$) (mean procedure time=6.7 min; sedation given in 14/75; mean=3.3 mg midazolam).

Conclusion Despite prolonged procedure duration and large scope diameter, EUS procedures are safely and well tolerated with midazolam and fentanyl sedation. A high FNA accuracy can be achieved without a cytologist present in the room.

Competing interests None declared.

PMO-005 BRIEF INTERVENTION REDUCES FUTURE HOSPITAL ATTENDANCE IN HAZARDOUS ALCOHOL DRINKERS

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Introduction Excessive alcohol consumption is a major health burden facing the NHS. The Fast Alcohol Screening Tool (FAST) is a useful, simple tool to screen for hazardous/harmful drinking. Hazardous drinking is associated with a high risk of psychological or physical problems in the future. In this study, we assess the FAST score in patients attending the Emergency Department (ED) of our hospital. We then evaluate whether brief alcohol intervention on high scorers (hazardous drinkers), in the form of consultation and advice on alcohol related habits, results in fewer future ED attendances.

Methods All those, 18 years and over, attending the ED of Chesterfield Royal Hospital over a 24 h period were asked to take part in this study. All participants were formally consented. Patient demographics were taken, and reason for admission noted. Number of prior ED attendances were noted from hospital records and patient recollection. FAST questionnaires were then filled, followed by a brief intervention [typically lasting 10 min] given to those who scored 3 or above. Investigators had prior training on brief intervention. Frequency of hospital attendance following this episode was then taken from hospital records.

Results 140 patients attended ED, but 25 were excluded (declined participation, life-threatening illness). Therefore, 115 patients participated in the study (60 (52%) female and 55 (48%) male; median age 47). FAST score was 0 in 60 (52%), 1 in 13 (11%), 2 in 19 (17%) and ≥ 3 in 23 (20%) patients. Brief alcohol intervention was carried out in 19 out of 23 patients who scored ≥ 3 (not possible in four who were intoxicated with alcohol). These included 9 (48%) female and 10 (52%) male with median age of 39. In this subgroup of patients, 15 had no previous ED attendances, one attended once, one attended twice and two attended three times each in the prior 6 months. Therefore, four out of 19 (21%) of these patients attended ED on a total of nine occasions over that 6 months. 20 out of 92 patients (22%) of those with FAST score <3 had prior admissions over the same period with a total of 25 attendances. Two out of 19 (10%) patients with FAST score ≥ 3 , who were given brief intervention, re-attended over the following 6 months, on one occasion each (total two attendances). 13 out of 92 (14%) patients with FAST score <3 re-attended over this time period, with total 17 attendances. Brief intervention therefore appeared to reduce future hospital attendance in hazardous alcohol drinkers.

Conclusion Hazardous alcohol drinkers (with FAST scores ≥ 3) make up a large proportion of those attending ED. Brief alcohol intervention for these reduces their re-attendance. We therefore recommend front-line ED staff to be trained in brief intervention.

Competing interests None declared.

PMO-006 OUT OF HOURS GASTROINTESTINAL BLEED SERVICE IN THE UK: INTER-HOSPITAL TRANSFER OF PATIENTS FOR ENDOSCOPY IS SAFE

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Introduction Acute Upper Gastrointestinal Bleeding (AUGIB) results in 25000 in-patient admissions annually in the UK (1). Patients admitted at weekends with AUGIB have significantly increased mortality (2). Current guidelines advise availability of out-of-hours