(OOH) endoscopy (3). We present data from our service in the UK involving inter-hospital transfer of patients.

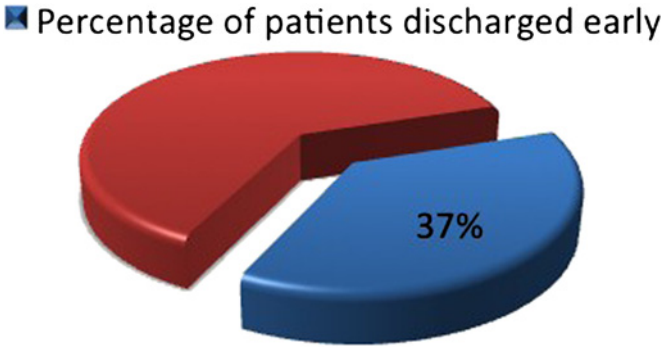
Methods We pooled resources of two neighbouring general hospitals, just North of London: Emergency endoscopy is performed at start of the list followed by elective endoscopy in the endoscopy unit on Saturday and Sunday morning. From Friday evening until Sunday morning, patients admitted to Queen Elizabeth II (QEII) Hospital are medically stabilised and transferred to Lister Hospital by ambulance (13 miles apart, fast freeway).

Results A total of 240 endoscopies were performed OOH from December 2007 to March 2011. Of these, 54 patients were transferred: nine had emergency endoscopy at QEII as they were medically unstable; eight of the patients transferred required therapeutic intervention for active bleeding. The mean pre-endoscopy Rockall score of those transferred was 2.5 (range 0–6). We examined the medical records of 51 (of 54) of the patients transferred. There were three deaths within 30 days of endoscopy, but these were not associated with the transfer process. A total of 19 (37%) of patients had reduced hospitalisation after having their endoscopy at the weekend, as opposed to waiting for endoscopy on Monday.

Conclusion The introduction of the OOH endoscopy service has had multiple benefits.

- Patients consistently receive timely emergency endoscopy.
- Patients may be discharged earlier once they have had the endoscopy.
- There is significantly reduced disruption to emergency operating theatres.
- Participation of endoscopy nurses ensures a better and safer experience for the patients, and better endoscopy decontamination.
- Routine elective weekend endoscopy has reduced waiting lists and generated revenue for the hospitals, justifying the cost of setting up the service.

We suggest that our model is safe and it is feasible for other small units wishing to set up their own OOH endoscopy service to adopt.



Abstract PMO-006 Figure 1

Abstract PMO-006 Table 1 Breakdown of endoscopies performed December 2007–March 2011

		Lister	
	QEII	Transfer from QEII	Admitted to Lister
Saturday	5	24	90
Sunday	4	30	87

Competing interests None declared.

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PMO-007 IS PRE-ASSESSMENT PRIOR TO COLONOSCOPY USEFUL?

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Introduction In 2009, the National Patient Safety Agency issued a Rapid Response Report alerting healthcare providers to the potential risk of harm from using oral bowel cleansing agents (OBCA). Our Trust decided the most robust method of protecting patients was for nurses to see patients in clinic to fully pre-assess them.

Methods Prospective data were collected from the pre-assessment records. The information was then collated and tabulated. The time period covered is from July to the end of December 2011.

Results

Abstract PMO-007 Table 1

	July	August	September	October	November	December	Total
Number	3	53	90	133	130	106	515
Did not attend	0	0	1	4	3	0	8
eGFR/U&E abnorms*	0	4	6	7	6	9	32
Extra prep†	0	4	4	7	7	5	27
TCI‡	0	6	5	4	13	4	32
Declined	0	1	3	3	1	0	8
Stop medication	0	4	2	7	5	2	20
Cons. review§	0	0	6	7	11	3	27

Miscellaneous findings at pre-assessment included:
Patients with pacemakers (4)
A wish to be referred to Help2quit (4)
Requirement to refer back to GP for review [not to do with colonoscopy] (3)
Able to cancel a TCI as not needed (2)
Postponed procedure due to other issues (3)
January–July 2011: Total colons this period: 1196
Total failed: 37=3.09%
Due to poor prep: 10=0.84%
August–December 2011: total colons this period: 795
Total failed: 24=3.02%
Due to poor prep: 4=0.5%
*eGFR or urea and electrolyte abnormalities which required discussion with gastroenterologist and potential further action of
A repeat blood test on the day of procedure
To come into hospital (TCI) for observation of hydration while taking bowel preparation
To temporarily stop certain medication.
†The patient is prescribed additional OBCA because factors have been revealed that influence its effectiveness.
‡TCI means "to come in" to hospital prior to the procedure for bowel preparation.
§The patient has been referred back to their own consultant for various issues found at pre-assessment.

Conclusion During the time period under review 507 patients were pre-assessed.
6.31% had an abnormal eGFR or urea and electrolytes (u & e).
5.33% required further OBCA to be prescribed.
6.31% needed to come in for their bowel preparation.
1.58% of those patients declined the procedure.
3.94% were asked to stop medications in preparation for the test.
Consultants were asked to review 5.33% of these patients.
The trend for failed procedures due to poor bowel preparation has begun to fall.
Pre-assessment is ensuring problems are being addressed in advance of the procedure. Patients are being protected and list efficiency is maximised.

Competing interests None declared.

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