

This study aimed to assess ICU nurses' perception of their ability to assess critically ill patients' nutritional status using the evidence-based guidelines.

**Methods** A cross sectional descriptive design was employed. A total of 190 ICU nurses from two health care sectors in Jordan participated in the study and completed a structured questionnaire prepared to assess nurses' perception of patients' nutritional status.

**Results** Nurses showed greater levels of responsibility for 'preventing complications' and 'evaluation' than 'assessment' and 'identifying goals'. Tube position is still confirmed via unreliable measures such as air bubbling technique (mean 4.00, SD 1.14). The mean for measuring Gastric Residual Volume was above the mid-point (3.70, SD 1.33). However, there was inconsistency in recognising the limit, threshold and frequency of measuring this volume. Diarrhoea is the most frequent complication of enteral nutrition (mean 3.36, SD 1.34) followed by abdominal pain, tube dislodgment, weight loss and uncontrolled blood sugar. Nurses perceived that the incidences of complications are less likely to occur in the presence of evidence-based guidelines than absence ( $\rho = 0.73$ ,  $df = 251$ ,  $p < 0.001$ ).

**Conclusion** Nurses show more concerns about the outcomes of enteral feeding instead of the preliminary assessment. Measuring GRV and confirming tube placement are still deficient and require further attention. EBP is acknowledged by nurses where undertaking such protocols is emphasised.

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**Disclosure of Interest** None Declared.

#### PTH-049 THE SPLIT CLINIC – A PRESCRIPTION FOR EFFICIENCY IN THE GASTROENTEROLOGY OUTPATIENT CLINIC

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**Introduction** Worldwide, healthcare providers are striving to balance escalating costs with the patient's expectation of efficient access to specialist opinion, rapid investigation and treatment. Over the past 65 years, the NHS gastroenterology outpatient journey has remained unchanged. Patients are assessed at the first visit, followed by one or more hospital visits for gastrointestinal investigations and a return hospital visits for final assessment. The split clinic has been designed, wherever possible, to condense the journey from weeks or months to hours.

**Methods** Over a period of three months, each gastroenterology referral letter was previewed four to six weeks prior to the outpatient appointment, and each patient was triaged as "Solution" and "Complex". For the solution cohort, investigations were predicted and booked for the same day as the outpatient visit.

The patients were asked to attend clinic starved and told to expect one or more same day gastrointestinal investigations. On the appointment day, "Solution" patients attended the split clinic for an initial assessment, then proceeded to investigation, returning thereafter to the clinic for feedback.

**Results** Of 174 referrals, 95 patients were triaged from the referral letter as "Solution" patients, and 81 attended the split clinic (7 did not arrive, 4 postponed, 3 direct to surveillance colonoscopy). In those who attended, 46 same day tests were performed (14 upper endoscopies, 11 sigmoidoscopies, 5 barium swallows, 6 Eso Capsule endoscopies, 5 ultrasound scans, 1 electrogastrogram, 2 CT abdomen and 2 CT colonoscopy). Twenty-seven patients (34%) were discharged, and twenty-two (27%) were discharged after a single follow up telephone consultation. Overall, 49 patients designated as "Solution" patients (60%) required only a single hospital visit. Sixteen patients (17%) were re-designated as "Complex" requiring further tests and 3 (3%) were referred elsewhere. Overall, 95 (46 same day tests and 49 return to follow up clinic in old system) return hospital visits were avoided and the attended to discharged ratio was 81:27 (1:0.3).

**Conclusion** Analytical triage of GP referral information allows identification of most gastroenterology "Solution" patients. This facilitates pre-emptive investigation planning and scheduling which, in turn, supports a split clinic designed to condense weeks or months of investigation and follow up into a few hours. The well planned split clinic meets the patient's expectation for an efficient journey, quick diagnosis and reduced number of hospital visits.

**Disclosure of Interest** None Declared.

#### PTH-050 THE IMPACT OF A DEDICATED INPATIENT BLEEDERS ENDOSCOPY LIST IN THE TIMELY MANAGEMENT OF ACUTE UPPER GASTROINTESTINAL BLEEDS

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**Introduction** Acute upper gastrointestinal bleeding (AUGIB) is still a medical emergency with a hospital mortality rate of 10%<sup>[1]</sup>. NICE guidelines recommend that endoscopy is offered to all patients presenting with AUGIB within 24 h<sup>[1]</sup>. In order to improve our waiting times, a week day dedicated Inpatient Bleeders (IB) list was introduced from October 2012 and its impact on time to endoscopy and length of hospital stay monitored through audit.

**Methods** A retrospective audit of all AUGIB in Princess Alexandra Hospital (a district general hospital in Essex) was conducted from April-September 2012 (prior to the introduction of the IB

Abstract PTH-050 Table 1

	Pre-IB (April-September 2012)	Post-IB (January to April 2013)
Total cases	103	88
No of AUGIB (primary reason for admission)	65	60
Days to OGD (mean)	2.15	1.78*
% of OGDs within 24 h	36.9	53.3
Median LOS (days)	5	4*

\*  $p < 0.05$

list) and from January-April 2013 (once IB list established). The IB list set aside 3 slots every Monday-Friday from 8–9 am for inpatient AUGIB. Each week a designated consultant gastroenterologist was responsible for performing endoscopies on the IB list. AUGIB cases were identified from endoscopy indications being 'haematemesis' and/or 'melaena'. Patients who developed AUGIB after admission were excluded. For each patient, the endoscopy date, admission and discharge dates were collected from electronic discharge summaries and patient records. The time (in days) to endoscopy (from admission) and length of hospital stay (LOS) was calculated for all cases.

**Results** The longest wait to OGD was for patients admitted on a weekend (Friday-Sunday) with a mean waiting time of 3.04 days pre IB list though this figure reduced to 1.88 days with the introduction of the IB list.

**Conclusion** The introduction of the 5 day IB list enabled our gastroenterology service to improve compliance with the NICE guidelines for AUGIB as the mean number of days to OGD decreased from 2.15 to 1.78, with over 50% of patients having an OGD within 24 h under the new system. The median LOS was also reduced from 5 to 4 days with the IB list. We expect that an extension of the IB list from a 5 to 7 day service would further reduce waiting times to OGD and LOS. The use of a dedicated 'bleeders' list prior to the start of elective endoscopy lists is an efficient and safe method of meeting targets in AUGIB and we would recommend its use particularly in a district general hospital setting with limited access to a 24/7 emergency AUGIB endoscopy service.

#### REFERENCE

- 1 Acuteupper gastrointestinal bleeding: management; Issued June 2012; NICE clinical guidance 141; [guidance.nice.org.uk/cg141](http://guidance.nice.org.uk/cg141)

**Disclosure of Interest** None Declared.

#### PTH-051 THE FIRST YEARS OUTCOME DATA FROM IBD-SSHAMP; UK'S FIRST REMOTE WEB-BASED SELF MANAGEMENT PROGRAMME FOR STABLE INFLAMMATORY BOWEL DISEASE PATIENTS

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**Introduction** In February 2012 the Luton and Dunstable University Hospital, became the first hospital in UK to use a remote (web-based) programme to help manage stable inflammatory bowel disease (IBD) patients. IBD-SSHAMP (Supported, Self Help And Management Programme) aimed to transfer the care of stable IBD patients from hospital based outpatient appointments (OPAs), to effective community based monitoring + management, co-ordinated by specialist IBD nurses.

**Objective** To improve cost efficiency by reducing the number of unnecessary routine OPAs + thereby improve OPA waiting times.

**Methods** The LandD manages 2420 active IBD patients, most of which are seen twice a year in routine OPAs. 26 lack mental capacity and 117 do not have internet access. Using Patient Knows Best we developed individualised websites for all of our IBD patients, to offer them a direct communication portal and a symptomatic assessment tool that provides appropriate management advice via a traffic light system. If a patient scores badly, an alert is sent out to the specialist team. The websites have a library of self help advice sheets and upload the patients hospital

results in graphical form. The system can be converted into 6 different languages and has both iPhone or Android apps. Patients can access this service from the comfort of their own homes or (like a health passport) whilst on the move/abroad. A proportion of our more stable patients can be transferred to community based care via IBD-SSHAMP and receive twice yearly virtual (telephone) clinics with blood and faecal (calprotectin) inflammatory marker assessments. By freeing up OPA space we can accommodate emergency patients usually within 24–48 hrs.

**Results** We are steadily inviting the 2,277 IBD patients who have internet access to a personalised website, and have successfully transferred 420 onto IBD-SSHAMP. We plan to transfer a further 400 to community based IBD-SSHAMP by the end of 2014. Confidence is such that this second wave will primarily contain patients stable on immunosuppressants eg. azathioprine. So far IBD-SSHAMP has saved our CCG approx £68,000 (400 × 2 × £85), whilst reducing our OPA waiting times. Only 7 of our IBD-SSHAMP patients have required an emergency hospital OPA. We have received positive feedback from the patients, who feel more supported and appreciate that they are not being discharged.

**Conclusion** IBD-SSHAMP is the UK's first internet based remote management system for managing stable IBD patients. This proof of concept project, has proven to be effective, safe and cost efficient. Our CCG have fully supported the concept and outcome, funding 2 additional IBD nurses to support the system. The Regional CCG are now keen to roll this concept out through the East of England.

**Disclosure of Interest** None Declared.

#### PTH-052 HOW THE NEW INFLAMMATORY BOWEL DISEASE REGISTRY AND PATIENT MANAGEMENT SYSTEM (IBD-R/PMS) HAS HELP DEFINE THE FUTURE OF OUR DISTRICT GENERAL IBD SERVICE

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**Introduction** In 2013 the Luton and Dunstable (LandD) University Hospital, became the first hospital in UK to pilot the new IBD-R/PMS. The PMS was designed by clinicians to be quick and easy to use, at the point of care, to facilitate best clinical practice. The system is live with PAS details, accessible throughout the Trust and provides up-to-date information consolidated in one place with real-time data collection. The IBD-Registry aims to provide the UK with its first ever national IBD statistics, by pooling some of this anonymised data centrally.

**Objective** To reviewed the effects of IBD-R/PMS on a DGH's IBD Service.

**Methods** The LandD looks after 2780 IBD patients. Data from 2571 of these patients has been uploaded, with pre-existing data on 1200 being ported over from an old Rotherham database. The IBD-R/PMS can analyse the service and individuals workloads, to help provide service reports and evidence of self worth for the IBD nurse specialists role. The new National IBD Standards (E2) advocates the use of electronic clinical management systems. When patients phoned up "out of the blue", clinical staff can quickly access clinical summary sheets, just by using a name search. To-date we have had no complaints or concerns about data inputting or security issues. Instead patients felt reassured and confident that staff were well informed about their