

Better risk assessment tools are desperately required, otherwise, future national campaigns would add significant pressures to already overstretched colorectal units.

REFERENCE

- 1 Taylor M, COI, Radford G, Network. AC. Evaluation of the Bowel Cancer Awareness Pilot in the South West and East of England 31 January to 18 March 2011. Department of Health UK.; 2012

Disclosure of Interest None Declared.

PTH-074 TRANSFORMING WARD ROUNDS

V Krishnan*, D Kejarawal. *Gastroenterology, University Hospital of North Durham-NHS, Durham, UK*

10.1136/gutjnl-2014-307263.520

Introduction Medical 'ward round' (WR) is a complex clinical process and a key component of daily hospital activity. Despite this, there is a clear paucity of quality indicators and evidence base for best practice for WR with considerable variability in the efficiency and quality.

This prompted us to devise and implement a ward round checklist (WRC) based on the Royal College of Physicians (RCP) and Nursing (RCN) [1] to improve quality of inpatient care.

Methods We developed the WRC (Figure 1) for a comprehensive patient review, got approved by the hospital health records committee and used as a sticky note in clinical notes.

The WRC was designed to be used as a memory aid and not to limit critical clinical thinking.

This was piloted in a medical ward and used during every WR.

Results We collected data over a week on ward A (pilot medical ward) and a comparator medical ward (ward X –where WRC was not used).

Among patients in ward A, a subgroup of patients in whom WRC was not used were analysed as a separate sub-group.

Total of 45 patients were assessed during the period, 28 patients from ward A, 19 patients from ward X.

Venous Thrombo-Embolism assessment and action was done in 96.4% (27/28) in ward A (100% in WRC used WR) whilst it was 73.6% (14/19) in Ward X.

Resuscitation and escalation of care decision was made in 67% (19/28) in ward A (93.3% in WRC used WR). It was done only in 31.3% (6/19) of patients in Ward X.

Antibiotic stop date was mentioned in 68.7% (11/16) in ward A (100% – 7/7 in WRC used WR). It was done in 22.2% (2/9) in Ward X.

Abstract PTH-074 Figure 1

WR by	Reviewed
Observation chart	Y N NA
Fluid balance and Nutrition	Y N NA
VTE risk assessment	Y N NA
Drips and catheter needed	Y N NA
Antibiotics- appropriate/stop date	Y N NA
Drugs chart review	Y N NA
Scans and results	Y N NA
Resus/ceiling of care/MET call	Y N NA
Discharge plan	Y N NA
Patient awareness	Y N NA

Expected Day of Discharge was mentioned in 65.2% (15/23 – 5 patients were very unwell to comment on EDD) in ward A (76.5% – 10/13 in WRC used WR). It was done in 53.8% (7/13) of the ward X.

Conclusion A recent NEJM article² evaluating the use of checklists for high-fidelity crisis simulation showed an impressive difference in missing critical steps, 6% with checklists vs 23% without checklists.

The WHO has already recognised and introduced the surgical safety checklist to reduce morbidity and mortality.

We believe that checklists have the potential to improve patient outcomes by ensuring that all patients receive evidence based best practices and safe high quality care. This allows physicians to concentrate on the higher thinking in WR and WRC to ensure that basics are covered.

REFERENCES

- 1 RCP, RCN. Ward rounds in medicine: principles for best practice. London: RCP, 2012
- 2 Arriaga AF, Bader AM, et al. A simulation-based trial of surgical-crisis checklists. *N Engl J Med* 2013;368:246–53. DOI: 10.1056/NEJMsa1204720

Disclosure of Interest None Declared.

PTH-075 'ASCITES CLINIC': AN OUTPATIENT SERVICE MODEL FOR PATIENTS REQUIRING LARGE VOLUME PARACENTESIS

¹WJ Gashau*, ¹G Samra, ²J Gasser, ¹M Rolland, ²P Sambaiah, ¹C Shorrock. ¹*Gastroenterology, Blackpool, UK;* ²*Blackpool Teaching Hospitals Foundation Trust, Blackpool, UK*

10.1136/gutjnl-2014-307263.521

Introduction A retrospective profile of medical readmissions within 30 days of discharge (September 2011–December 2011) from a busy district teaching hospital highlighted that a small proportion of patients (12%) with recurrent ascites accounted for 68% of readmissions. Most required large volume paracentesis (LVP) with a mean length of stay of 4 days. We aimed to determine if a viable, safe model for large volume paracentesis (LVP) in an outpatient setting is feasible.

Methods Changes included identifying motivated liver specialist nurses to lead the ascites clinic service, detailed development of local policy and in-patient referral systems for patients appropriate for the service. Patients are initially reviewed in face-to-face clinics allow comprehensive history, examination and augmentation of information to empower individuals to self-monitor and self-refer based on weight and abdominal girth. These are run in tandem with a consultant led hepatology clinic for senior medical support. Where appropriate, follow up can occur by telephone. If necessary, facilitation of same day elective admission for LVP can be arranged. Competent gastroenterology trainees in the day-case endoscopy unit to carry out LVP with same day patient discharge

Results From September 2012 to May 2013, 68 LVPs have been performed in 12 patients. Complications have been few with only one patient having been admitted twice overnight for ongoing large volume paracentesis. Emergency readmissions for LVP have fallen from 68% to 13% over the corresponding period 12 months earlier with an improved patient experience.

Conclusion The 'Ascites Pathway' allows safe, effective outpatient LVP with increased patient satisfaction. We feel therefore that LVP is best managed in an outpatient setting with a dedicated nurse-led, medically supported ascites service.

Disclosure of Interest None Declared.