admissions in a large acute hospital serving a catchment of 650,000.

Methods From July 2011 to December 2012, all admissions via the Acute Medical Unit (AMU) were screened using the VitalPAC clinical observation system with a VitalPAC Alcohol Assessment Score (VPAAS) based on the Paddington Alcohol Test. At-risk patients (VPAAS of 6 or more) were referred to the ASNS and an Alcohol Use Disorders Identification Test (AUDIT) performed. Data analysis was performed on patient demographics, unit consumption, diagnosis, mortality and previous ED attendances and admissions.

Results There were 29,361 admissions of whom 28,098 (96%) completed VPAAS alcohol screening. Mean AMU population age was 67.4 years, 52.3% female. Of 1,123 high risk cases, 770 were seen by the ASNS and 636 defined as dependent (AUDIT >20). Compared to the general AMU cohort, the at-risk group had more ED attendances (7.8 vs. 2.9) and hospital admissions (4.8 vs. 3.1) in the previous 3 years and a lower age of death (58.3 vs. 81.5). Dependent women had fewer recurrent attendances and admissions than men but had a higher mortality rate and lower age of death (52.2 vs. 62.4). The maximum AUDIT score of 40 was recorded in 41% of cases seen by the ASNS and this subgroup had a mean age of death of 52.7 with 6.2 admissions and 10.8 ED attendances previously. The most frequent primary diagnoses in those with a VPAAS of 6+ were liver disease, mental health disorders and GI bleeding.

Conclusion Our analysis of over 28,000 admissions demonstrates that screening of all medical patients for alcohol misuse is achievable. We successfully identified a cohort of high risk patients with recurrent admissions and ED attendances, high unit consumption and an elevated risk of liver disease and early death. This cohort can be targeted with interventions to reduce the burden of alcohol related harm.

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OC-053 RESULTS OF THE UK MULTI-REGIONAL AUDIT OF BLOOD COMPONENT USE IN CIRRHOSIS

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Introduction Cirrhosis is a complex acquired disorder of coagulation with a recent paradigm shift in understanding to consider cirrhosis as a pro-thrombotic disorder. It is a frequent indication for transfusion of blood components, both for prophylaxis and for treatment of bleeding, although indications and patterns of blood use are poorly characterised.

Methods All NHS trusts with representation on the BSG membership list were invited to take part in a national audit. Data were collected prospectively on conseutive admissions with a confirmed diagnosis of liver cirrhosis over a 4 week period, with follow up to discharge/death/day 28. Specific information was requested on use of blood components, including indication, type of component and laboratory indices prior to transfusion. Standards were defined against guidelines on the use of red blood cells (RBCs), fresh frozen plasma (FFP), platelets and cryoprecipitate.

Results Data on 1313 consecutive patients with cirrhosis (mean age 58 years, 65% male) were collected from 85 hospitals. The predominant aetiology was alcohol (70%; 921/1313); 74% of admissions were for features of decompensation; and 21% (275/1313) cases had a positive septic screen. 30% (391/1313) of all admissions were transfused a blood component; in 61% (238/391) this was for treatment of bleeding and in 39% (153/391) for prophylaxis. In patients transfused for bleeding (81%, 192/238 for gastrointestinal bleeding), 92% (220/238) received RBCs, 32% (77/238) FFP, 14% (34/238) platelets and 4% (10/238) cryoprecipitate; in patients with bleeding who received RBCs, the Hb threshold was >8 g/dL prior to RBC transfusion in 31% (69/220) cases. For prophylaxis the majority (61%, 94/153) received transfusion in the absence of a planned procedure. In patients transfused for prophylaxis prior to a procedure (59/153): 19% (3/16) received FFP at an INR ≤1.5 for high risk procedures and 33% (6/18) received FFP at an INR ≤2 for low risk procedures; 36% (9/25) received platelet transfusion at a platelet count >50 prior to a procedure. The most frequent procedures resulting in prophylactic transfusion were paracentesis (18/59), surgery (15/59) and endoscopy (10/59). In-hospital venous thromboembolism was documented in 2% (29/1313) cases. Case fatality during follow up was 10% overall (128/1313) with decompensated cirrhosis (41%; 52/128) as the most frequent cause of death.

Conclusion Patients with cirrhosis are frequently transfused during hospitalisation. This audit highlights areas where greater scrutiny of blood component use is required, particularly in the group transfused for prophylaxis of bleeding. Further work is needed to improve patterns of blood use in cirrhosis to ensure patients are not exposed to unnecessary transfusion and its attendant harms.

Disclosure of Interest None Declared.

BSG nurses' association/GIN "Education Day"

OC-054 THE VALUE OF A WARD LIAISON NURSE TO IMPROVE ENDOSCOPY FOR IN-PATIENTS

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Introduction Endoscopy Inpatients are challenging as they tend to be the sickest patients who require procedures urgently. The numbers fluctuate and there is little provision for capacity in a busy day-case endoscopy unit. At the Royal Liverpool there are >2000 in-patient endoscopic procedures per annum and which are served by 9 per week dedicated in-patient lists. However, these lists were poorly utilised at <50% of time this was due to cancellations and poor scheduling. Waiting times for in-patients were unacceptable. The aim was to improve the in-patient experience of endoscopy and improve efficiency of the in-patient lists.

Methods In February 2013, an In-patient liaison (B6) was appointed to help coordinate in-patient listing for endoscopy.

This involved the triage of patients (including UGI Bleeds and ERCPs), coordinating with the wards and listing of patients. As the focal point of contact for ward teams, advice is given to teams about preparation of patients, as well as consenting patients on the wards ready for lists. Attending ward rounds on a daily basis to AandE, medical admissions unit and Gastroenterology wards means patients are actively listed. The effect was audited with outcomes of list utilisation, improvement patient waiting times and back-filling of lists.

Results Satisfaction Feedback from the ward staff, doctors and specialist nurses were extremely positive with the role.

ERCPS were managed more effectively with reductions in cancellations of patients that did not require them and effective triage to EUS. Also access of patients needing urgent ERCP was much easier due to the value of coordination.

UGI Bleeds Were managed more effectively which led to a reduction in the patients that required in-hours and out of hours theatre.

Interventional Endoscopy Listing in-patients for complex therapeutic interventions such as stenting and getting tertiary referrals in form other hospitals was significantly improved.

Efficiency The list utilisation improved greatly from 64 to 86% in just 8 months. The waiting times (patient scoped within 24 h of referral) improved by 32% for upper GI endoscopy and by 16% for sigmoidoscopy despite a substantial increase in the number of referral s (OGD increase by 13% and sigmoidoscopy by 20%).

Conclusion An in-patient liaison nurse has been pivotal for improving the quality, and efficiency, of the endoscopy service we offer to in-patients.

Disclosure of Interest None Declared.

OC-055 IBD PASSPORT-DEVELOPING AN EVIDENCE-BASED INTERNET TRAVEL RESOURCE FOR INFLAMMATORY BOWEL DISEASE: A REPORT OF THE INITIAL STAGES OF IMPLEMENTATION

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Introduction Travellers with Inflammatory bowel disease (IBD) are at greater risk of travel-related morbidity [1],with ECCO recommending expert consultation prior to travel, particularly for those on immunosuppression.[2] The travel consult and patients pre-travel preparation have been found to be deficient.[1] Here we present the development of a dedicated IBD travel advice website to enable informed, safe travel with IBD.

Methods We conducted a literature review using Ovid databases and a search of existing online material using major internet search engines to identify existing research and resources regarding IBD and travel. Data was extracted from a recently reported prospective survey[3] of 136 IBD patients which examined pre-travel preparation and experiences of travelling with IBD.

Results The database and Internet search revealed a paucity of research and resources available for IBD patients and professionals regarding travel and IBD. Our survey of 136 patients found 60% [82/136] reported IBD affected travel, however; pre-travel medical advice was only sought by 24% [32/136]. Disease-related travel knowledge was poor with 52% of immunosuppressed patients unaware of the need to avoid live vaccines; only 53/136 (39%) buy travel insurance covering their IBD and the majority of these (70%) pay a premium. 91% (124/136) would find a dedicated IBD travel website useful. As a result of this, IBDPassport™ was developed for both patients and professionals as non-commercial, IBD-specific travel resource, aimed at providing evidence-based information on all aspects of travel and IBD. The functionality of the website includes an interactive map of country specific advice including vaccinations and a 'search and refer' service for IBD professionals to refer to other IBD centres globally. Features also include practical information for travelling with IBD and specific information for the immunocompromised traveller.

Conclusion We present the first comprehensive web-based travel resource created for both IBD patients and professionals to obtain evidence-based IBD and country specific travel information. IBDPassport™ needs to be formally evaluated by patients and healthcare professionals as part of a larger study and to inform further development.

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Disclosure of Interest None Declared.

OC-056 STRAIGHT TO TEST COLONOSCOPY – A VIABLE MEANS OF SHORTENING TIME TO A DEFINITIVE DIAGNOSIS

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Introduction Endoscopy units face an increasing demand on their ability to meet timeliness targets. One way of managing demand is to work differently – and straight to test (STT) offers this. Patients with lower gastrointestinal (LGI) symptoms are telephone triaged by a trained specialist nurse direct to the appropriate endoscopic investigation, rather than attending clinic first. Clear benefits to the patient are a reduction in time to wait until definitive (endoscopic) diagnosis, to the Trust in freeing up out-patient staff to work elsewhere, and finally to the local health economy in terms of reduction in clinic costs

Methods We followed a protocol outlined previously by the Dorset group.[1] Briefly, a specialist nurse assessed patients by phone and completed a symptom questionnaire. Patients were triaged according to symptoms and age; flexible sigmoidoscopy (<40 yrs, anorectal symptoms only) or clinic (>80 yrs and comorbidity, or major co-morbidity) or colonoscopy (everyone else). Appointments occured within 2 weeks for 2WW patients, or within 6 weeks for 18WW patients. The endoscopist was allowed to arrange further clinic review as was seen fit. A prospective database allowed capture of patient outcomes and demographic details, an estimate of financial benefit was made on the basis of standard charges for surgical (£172) or medical (£220) out-patient clinics.

Results 89 patients passed through the pathway in the first three months, 64% female. Mean age 61 (range 32–88) yrs, 76% were on the 2WW pathway. Only 2% of the patients were triaged to flexible sigmoidoscopy, no patients required