

clinic assessment first. Mean wait on pathway for 2WW 12.4 days (range 4–20), and for 18WW 28.8 days (range 15–42), all breaches by patient choice. This represented a reduction from the normal pathway of 48% (2WW) and 67% (18WW). DNA rate was low at 1% (unit average 7%). Most common diagnoses were polyps (20%), diverticular disease (20%), IBD (9%). 1 patient had colorectal cancer – a further patient was diagnosed with pancreatic cancer on CT pneumocolon following a failed colonoscopy. 13% patients required clinic follow up. An estimated saving of £14156 was made from out-patient clinic slots that were no longer necessary, with cancellation of over seven new out-patient lists.

Conclusion These data suggest that the introduction of a novel pathway for patients with LGI symptoms can produce significant benefits to the patient in terms of time to definitive endoscopic diagnosis. A financial benefit is also clear, as is the opportunity to redeploy clinic doctors elsewhere.

REFERENCE

Wright HL. *Colorectal Dis* 2012;14:10

Disclosure of Interest None Declared.

OC-057 IN. OUT. "NEXT PLEASE!" CAN PERSON-CENTRED CARE BE DELIVERED IN ENDOSCOPY?

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10.1136/gutjnl-2014-307263.57

Introduction In. Out. "Next please!" Is this the image of endoscopy nursing? It can often be difficult to personalise care or care delivery with such a rapid turnover of patients. As registrants we have a duty to deliver safe, effective, person-centred practice (PCP). Staff at the Belfast City Hospital opted to explore this concept further.

Methods In order to understand the nature of PCP we used emancipatory practice development tools, as this is the only service improvement methodology which has the delivery of PCP as the explicit outcome. To increase awareness of "self," staff initially were invited to explore their own inherent values and beliefs, facilitated through a Values Clarification Exercise (VCE) using critical creativity [1]. The VCE helped identify key themes which formed the basis of our visioning statement. We used the *15 Steps Challenge*[2] and Workplace Critical Culture Analysis Tool (WCCAT)[3] to explore the prevailing culture within the department and establish if we were indeed person-centred.

Results Integral to the PCP framework [1] is the therapeutic relationship between service users and care providers. Working on the premise that "first impressions count," the *15 Steps Challenge* was performed by key stakeholders and facilitated by junior nursing staff. Observations were made in four key areas of practice. Feedback was collated and presented to the ward manager and a subsequent action plan created, which included improvements to the reception area. In addition, to further explore the workplace culture, eight observations of practice were undertaken using the WCCAT by a representative staff group. These findings were then presented to the wider team who prioritised areas for action.

Conclusion We believe PCP should not be viewed as a one-time event, but rather a continual process embedded in everyday practice. We are confident that this premise can be extrapolated to any endoscopy unit where staff are empowered to deliver person-centred care. It is our intention to repeat the *15 Steps*

Challenge and WCCAT in late 2014 to demonstrate the continual process of improvement of increasing effectiveness.¹

REFERENCES

- McCormack B, Titchen A. Critical creativity: melding, exploding, blending. *Educational Action Research: an International Journal*. 2006;14(2):239–266
- National Health Service Institute for Innovation and Improvement. *Putting Patients First – The Productive Series*. Coventry: NHS Institute for Innovation and Improvement. 2012
- McCormack B, Henderson E, Wilson V, Wright J. Making practice visible: the workplace culture critical analysis tool (WCCAT). *Practice Development in Health Care* 2009;8(1):28–43
- McCormack B, McCance, T. *Person-Centred Nursing Theory and Practice*. Sussex, Wiley-Blackwell. 2010
- Garbett R, McCormack B. A concept analysis of practice development. *NT Research*. 2002;7(2):87-100

Disclosure of Interest None Declared.

OC-058 AMBULATORY CARE ALCOHOL DETOXIFICATION (ACAD) AT WHITTINGTON HEALTH: A NEW APPROACH !

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10.1136/gutjnl-2014-307263.58

Introduction Alcohol-related harm costs NHS £3.5 billion a year. It has become a "top priority" for the NHS. Alcohol Concern reported 1.2 million alcohol-related admissions in 2011/12, an increase of 135% over the last 10 years, but more people are also seeking and completing treatment. Current standard treatment for those actively withdrawing from alcohol is for inpatient (IP) detoxification and concurrent assessment and intervention by an Alcohol Liaison Nurse (ALN) which usually takes, on average, 5–7 days as an IP.

Methods A care pathway was formulated for inpatients to be referred to the AC service based on strict guideline. The AC centre dedicated 2 appointments daily within working hours (Mon-Fri) for outpatient (OP) detoxification. During each session, the ALN assessed, breathalysed the patient and completed a Clinical Institute Withdrawal Scale (CIWA). The AC doctor then prescribed a daily regimen of chlorthalidone on a symptom-dose basis. A retrospective audit was completed of all patients referred through this pathway.

Results From Jan 13-Dec 13, 19 patients (after medically assessed) were referred for the ACAD after 3 days. 14 patients engaged with the service and completed their AD. 10 male, 4 female, aged 28–68 years. All patients were admitted via Emergency Dept; 8 presented with alcohol withdrawal, 6 with other acute problems but concurrently treated for alcohol withdrawal whilst IP. 10 had physical co-morbidities; 2 had psychiatric co-morbidities. 6 patients had a previous history of seizures. 2/14 patients consumed alcohol during the AD phase of their treatment (noted on breathalysing the patients). These patients were subsequently discharged from ambulatory care and referred to local alcohol services. 1 patient required readmission to hospital for physical concerns relating to diabetes, completing the remainder of the detoxification as an IP. All patients agreed to be followed up in the community and have engaged with community services. The average duration of AD was 5 days. In previous study we have estimated that a 7 day inpatient admission as costing £2183 vs a 3 day admission with 3 follow up ambulatory appointments costing £1352. The potential cost saving is significant once this service is widely used.

Conclusion This small innovative pilot study demonstrates that ACAD can be an effective and safe approach to the managing