INTRODUCTION

Existing evidence shows that many medical errors are avoidable and a systematic approach using safety checks such as the WHO Surgical Safety Checklist can reduce adverse events. Research within high-risk industries has illustrated that errors with significant impact on safety often relate to non-technical skills (NTS) rather than technical ability. By focusing on the key NTS in Endoscopy, we hypothesise that team function will be enhanced, patient safety improved and errors reduced.

METHODS

Current safety practices in Endoscopy were evaluated prospectively via (1) Assessment of current safety checks and (2) Analysis of safety enhancing NTS (ie, behaviours), based on a pilot study. Behaviours deemed to be “safety checks” (SC) that impact positively on patient care were determined by expert consensus. Endoscopists were observed and their checking behaviours assessed by two independent clinical observers: (1) a gold standard SC of “cross checking” with a colleague, and (2) a discernible attempt to perform an SC. Endoscopists NTS were assessed quantitatively (1–4 scale) using a validated framework. In addition any errors, near misses or adverse events (AE) were qualitatively recorded for each procedure.

RESULTS

22 lists were observed and 90 procedures analysed from a representative sample of 16 Endoscopists. In total 1218 opportunities to perform a safety check were identified. The “gold standard check” was only performed in 9% of instances. In 37% of episodes no check was completed. Endoscopists and nurses performed similar checks separately, often without communication. ENTS scores varied, (mode = 3, min = 1, max = 4). Endoscopists scoring higher on NTS were more likely to perform safety checks (correlation coefficient r = 0.82 p = 0.001). 41 safety incidents were observed and 27% occurred in the lists where the Endoscopist scored a gold standard check (SC) that impact positively on safety often relate to non-technical skills (NTS) rather than technical ability. By focusing on the key NTS in Endoscopy, we hypothesise that team function will be enhanced, patient safety improved and errors reduced.

CONCLUSION

This study demonstrates wide variability in safety checks and non-technical skills in Endoscopy. There appears to be a relationship between robust safety checks and good NTS. Further research should focus on the relationship between technical (DOPS) and non-technical (ENTS) skills and whether training in NTS for Endoscopists can reduce adverse events and improve their safety behaviour.

Abstract PTU-224 Figure 1 Endoscopic non-technical skills (ENTS) vs safety check (SC) scores.

Competing interests M Matharoo Grant/Research Support from: This group has received funding from the NHS Bowel Cancer Screening Research Programme for development of non-technical skills awareness & team training. Conflict with: The Freemasons Grand Charity, A Haycock. None declared. N Sevdalis: None declared. S Thomas-Gibson: None declared.

REFERENCES


PTU-225

REFERRAL TO GI ENDOSCOPY FOR ANAEMIA, DOES THE MCV REALLY MATTER?

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INTRODUCTION

Anaemia is a common indication for referral to GI endoscopy services. Appropriate triage of these referrals may be aided by further characterisation of the anaemia and review of iron studies. However, value of the MCV in predicting a positive endoscopic finding has been questioned. Our aim was to determine predictors of positive endoscopic findings in patients referred to a single centre for investigation of anaemia in a 6-month period, in relation to full blood count (FBC), iron studies, and patient age.

METHODS

A retrospective cohort study examining endoscopic procedures performed where anaemia without an obvious cause was the primary indication. Patients with overt GI haemorrhage were excluded. Data were extracted from an electronic database and specific parameters included demographic variables, indication(s) for endoscopy, haematological values, iron studies, and endoscopic findings. Positive endoscopy was defined as a finding considered responsible for the anaemia. Analysis was performed using Graphpad Prism and Microsoft Excel.

RESULTS

A total of 359 endoscopic procedures (210 gastroscopies, 137 full colonoscopies, 12 left colonoscopies) were performed in 245 patients. In 48/245 (20%) patients, a cause for anaemia was found; 10/245 (4%) had malignancy; [5/243 (1%) gastric ca, 7/243 (3%) colorectal ca]. 58/243 (16%) had a non-malignant cause of anaemia, including gastric ulcer 15/243 (6%), angiodyplasia 13/243 (5%) colorectal ca, 9/243 (3%) coeliac disease 2/243 (1%). Endoscopy was normal or revealed incidental findings in the remaining 195/243 (80%) patients. Older age and higher RDW were significantly associated with positive endoscopy overall. (p=0.006, p=0.009 respectively). While the association with lower serum Hb trended towards significance (p=0.07), no association between MCV and positive endoscopy was observed (p=0.87). Low serum ferritin and MCV were significantly associated with malignancy (p=0.05, p=0.05), as was a higher RDW (p=0.03).

CONCLUSION

While a low MCV was significantly associated with malignancy on GI endoscopy, it was not significantly associated with a positive endoscopy overall. RDW is a good predictor of positive endoscopy with regard to both malignant and non-malignant causes of anaemia. Hence, the performance of GI endoscopy can be considered in the context of a normal MCV.

Competing interests None declared.

PTU-226

COLORECTAL CANCER SCREENING IN A MODERATE RISK POPULATION: WHAT IS THE POLYP YIELD AND WHAT IS THE OPTIMUM SCREENING INTERVAL?

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INTRODUCTION

Colorectal cancer (CRC) screening has been shown to reduce mortality from CRC. Many people with a family history of colon cancer are at a higher risk of developing CRC. There is a need for a more precise approach to screening in high-risk populations. The current screening guidelines recommend colonoscopy at 5-year intervals for screening in moderate-risk populations. However, there is a lack of evidence to support these guidelines. Our aim was to determine the polyp yield of colonoscopy in a moderate-risk population and the optimal screening intervals for colonoscopy.

METHODS

Prospective cohort study of colorectal surveillance colonoscopies in a high-risk population. Patients were referred for surveillance colonoscopy at 5-year intervals. Colonoscopies were performed by a single Endoscopist. All polyps were removed at the time of colonoscopy. The polyp yield was determined by the number of polyps found per patient and the number of polyps found per 1000 polypectomies. The optimal screening intervals were determined using the criteria of a positive test result defined as a polyp yield of at least 5%.

RESULTS

A total of 367 surveillance colonoscopies were performed in 318 patients over a period of 5 years. The polyp yield was 5.0% (18/367) with an average of 0.055 polyps/1000 polypectomies. The optimal screening intervals were determined to be 3, 5, and 7 years, with a polyp yield of at least 5%. The test result was considered positive for a polyp yield of at least 5%.

CONCLUSION

The polyp yield of colonoscopy in a moderate-risk population was 5.0% (18/367) with an average of 0.055 polyps/1000 polypectomies. The optimal screening intervals were determined to be 3, 5, and 7 years, with a polyp yield of at least 5%.

Competing interests None declared.