**PTH-132** IRON DEFICIENCY ANAEMIA NURSE LED CLINIC: AUDIT OF 1ST YEAR

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Introduction Iron deficiency anaemia accounts for 4–13% of gastrointestinal referrals occurring in 2–5% of adult men and post menopausal women. Current guidelines suggest that the work up of asymptomatic anaemia remains incomplete and often inappropriate with important diagnoses of malignancy and malabsorption being missed. In an effort to improve our handling of these patients from primary care and reconfigure services, a nurse led clinic was established in 2009 with the aim to provide rapid access to appropriate investigations and management.

Methods All clinic patients between 01/06/2009–05/07/2010 were included in the study. Patients were triaged into the clinic via the GP referral letter. End points examined were: patient demographics, anaemia, microcytosis and iron deficiency, whether oral iron preparations were being used, investigations (OGD/colonoscopy), wait times for investigations and pathology identification. Data were collected using patient notes, pathology results database, clinic letters and endoscopy reports. Anaemia was classified as an Hb of < 11.5g/dL.

Results 110 patients were included (no exclusions); 81 female and 29 male (73.6%,42.3%). Age range 21–90yrs, mean 57yrs, median 58yrs. 62% were made up of men (29) and post-menopausal women (47); 33% (13) menstruating females with GI symptoms and 46% (21) menstruating females without GI symptoms. 62% were in receipt of oral iron supplementation at referral. 66% of referrals included the blood results revealing 92% anaemic; 54% microcytic; 50% iron deficient. This compared to 68% of patients anaemic bled in the clinic of whom 20% were not anaemic but on iron supplementation leaving 12% neither anaemic nor on iron supplements. Of those not on iron (42–15 men, 29 women) 21% had renal disease (GRF < 60), 12(29%) were iron deficient, 10(24%) were iron deficient and anaemic. A total of 61 patients underwent endoscopic investigation (47 post menopausal and male group; 6 menstruating females with GI symptoms and 8 menstruating females without GI symptoms). We identified 4 malignancies; 3 polyps, 3 colitics, 9 upper GI pathologies (GAVE, varices, ulcers, small bowel Crohn’s). With GI symptoms and 8 menstruating females without GI symptoms.

Conclusions A high percentage of patients seen at A&E ≥ 5 were flagged to the Alcohol Liaison Service. Similarly, a high percentage of patients seen in A&E were screened by the nurses, given extended brief advice, and offered referral to Specialist Alcohol Worker (SAW).

All patients seen by SAW and by Alcohol Clinical Nurse Specialist (ACNS) over a 6 week period were given a questionnaire and sealed envelopes, to be returned anonymously.

Results 95 questionnaires were distributed by the ACNS, and 79 were returned (return rate 83%). 10 questionnaires had technical printing errors, so were excluded from final analysis, so the ITT return rate was 75%. 32 questionnaires were distributed by the SAW, with a 100% return rate.

The first 3 questions dealt with quality of the service, and were numerically scored from 1–4, with 1 being poor, and 4 being excellent. When asked ‘How would you rate the quality of the service you have received?’ 97% answered 3 or 4 (good or excellent). When asked if the service had met their needs, 88% of clients stated that it had. The remainder of the questionnaire dealt with acceptance of the service, and whether the service would be recommended to peers. When asked whether clients would recommend a friend to the service, 90% responded positively.

The scores for the SAW were even better, with positive responses (outcome 3 or 4 on questionnaire) 100% of the time.

Conclusion This work illustrated the acceptance and value of the ALS to service users admitted acutely. Furthermore, free text responses received were overwhelmingly supportive and positive towards the service.

Disclosure of Interest None Declared.

REFERENCES
1. Alcohol-use disorders: preventing the development of hazardous and harmful drinking, NICE Public Health Guidance 24, June 2010
2. The AUDIT (Alcohol Use Disorders Identification Test), World Health Organisation, 2001

**Disclosure of Interest** None Declared.

**PTH-133** PATIENT SATISFACTION WITH A NURSE-DELIVERED ALCOHOL LIASON SERVICE IN A GENERAL HOSPITAL SETTING

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Introduction Transnasal endoscopy (TNE) is performed with an ultrathin endoscope via the nasal passages. It has been available for over a decade and is widely used in Japan but use is variable in Europe and there is very little data on extent of use in the UK. It is recommended to have superior patient tolerability and satisfaction and there is emerging evidence that it causes significantly less cardiovascular upset. Anecdotally we perceive this method to be rarely used in our region and we performed a survey to assess extent of its use.

Methods This survey was to assess the availability of and opinion of TNE in the Northern region. The survey was circulated via email to the lead endoscopist in each of the 10 hospital trusts in the northern region. Opinion was sought on quality of views and biopsy samples and also perceived advantages and disadvantages of TNE.

Disclosure of Interest None Declared.

**REFERENCES**
1. NICE Guidance has mandated the need to provide an Alcohol Liaison Service (ALS) within all Acute Trusts (1). Within our organisation, we have a mature ALS which provides advice and support to prospectively identified patients admitted to the Acute Medical Service. This audit was undertaken to seek the views of service users, and to ensure that we were fulfilling their needs and expectations, thus allowing feedback on future service development.

Aim To assess the patient acceptance of a Nurse-Led Alcohol Liaison Service.

Methods All patients admitted to Medical Admissions Unit (MAU), had an alcohol assessment using the validated AUDIT (2) nursing questionnaire. Those scoring ≥ 5 were flagged to the Alcohol Liaison Service. Similarly, a high percentage of patients seen in A&E were screened by the nurses, given extended brief advice, and offered referral to Specialist Alcohol Worker (SAW).

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Disclosure of Interest None Declared.
Results Of the 10 surveys sent out all recipients responded. 2
trusts have access to TNE with only one trust having access to a
specific TN service performing approximately 150–200 per year.
The 2 trusts with access to TNE had both received training in TNE
from industry and also in-house training. The trust with a TNE
service had also received training from other endoscopists experi-
enced in TNE and an ENT surgeon. When compared with standard
endoscopy 30% thought views were worse, 60% the same and 10%
unable to comment (due to lack of experience of TNE). 60% thought
biopsy samples were adequate, 20% too small and 20% unable to
comment.

Advantages of TNE: 2 felt unable to comment due to lack of
familiarity with this method. Improved patient tolerance was the
main advantage stated by 7 with improved comfort, less gagging
and reduced sedation requirements, with 1 stating less nursing sup-
port and therefore potential for evening lists and improving capac-
ity issues as the main advantage.

Disadvantages: 2 unable to comment, 2 no disadvantages, 2-
stated cost of set up, 1- failure of nasal passage, 1-narrow channel
limits therapy, 1-prolonged preparation time compared to throat
spray and 1- poor views.7/8 without access to TNE felt a TNE ser-
vise would be beneficial to their trust and 5 would be keen to set it
up in their trust. Reported barriers to set up were cost 6/8 and time
1/8. 6 would be more likely to set up a TNE service if training were
available.

Conclusion TNE is not widely used in our region with only 1 of 10
trusts performing regular TNE lists. It is perceived by the majority
of endoscopists to have significant patient benefit and the majority
are keen to set up a service. The main restriction to use appears to
be the cost of set up despite the opinion that TNE is cost efficient
overall. It is indicated that making TNE training available may
increase its use. This was a regional survey and it would be interest-
ing to see if these results are replicated nationally.

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**REFERENCE**

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**PTH-135** EXAMINING THE ATTITUDES, PERCEPTIONS AND
BARRIERS OF BOWEL SCREENING WALES STAKEHOLDERS
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Introduction Service evaluation is of paramount importance for
the continued improvement and development of any health inter-
vention and there is very little documented evidence that examines
the attitudes and perceptions of Bowel Screening Wales (BSW) stake-
holders. Anecdotal evidence has suggested several factors that con-
tribute towards the uptake of bowel screening in Wales, such as,
lack of understanding around screening, the nature of the test, and
the will to complete the test, but this evidence has not been evalu-
ated or documented.

Methods A qualitative descriptive approach was undertaken and
semi-structured interviews were conducted with stakeholders at the
Royal Welsh Show, Builth Wells, Powys during July 2012 to
gauge their attitudes, perceptions, and barriers towards bowel
screening. Inclusion criteria was for all eligible men and women
aged between 60–74 years who have been invited to be screened.

Results 42 participants agreed to take part in the interview (19 male
and 23 female) of which 31 participants reported completing their
bowel screening test with 12 participants reporting they had not.

The results indicate that participants are aware of cancer and
have a very basic knowledge regarding bowel cancer but are not ne-
necessarily aware of the function of the bowel screening programme. A
content analysis framework was developed (Newell & Burnard,
2006) which identified two major themes; health beliefs and health
behaviour. This service evaluation suggests that participant’s per-
ceived susceptibility influences their decisions to take part. Par-tici-
pants who are not aware of BSW or the risks associated with bowel
cancer will not complete the kit. Furthermore, this service evalua-
tion suggests that participants who do not present with symptoms
are also less-likely to complete their kit. Furthermore, only a very
small number of participants sited fear or anxiety as a contributing
factor for participating even though they were aware that the kit
was to test for cancer. Majority of the participants who declined the
invitation suggested that this was due to dealing with their faecal
matter. It is interesting to note that their reasons for not completing
their kit were lethargy and apathy.

Conclusion Service evaluations are essential in understanding the
attitudes and perceptions of stakeholders. The findings from this ser-
vie evaluation suggest that participants have a limited knowledge of
the risks associated with bowel cancer and know very little about the
programme but perceive screening to be important. However partici-
pants perceived severity and susceptibility are contributing factors
in their participation to accept or decline the invitation to be screened.

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Wales, H. Heard: None Declared