

PTH-024 SELF PROVIDED GUIDED MEDICAL HISTORY IS FAST, COMPLETE AND ACCURATE

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Introduction The medical history is the fundamental basis of diagnosis. Every medical student learns how to take a full history, but in clinical practice the history is often truncated due to pressures of various kinds. Many clinicians use pre-consultation forms to collect relevant history, but these are rigid and cannot include the complete medical history.

Methods We have developed a large database of questions that could be asked during history taking. A computerised algorithm selects the next relevant question depending on the previous answer. A designer interface allows questionnaires to be developed and adjusted readily. The questions are phrased in plain English, but the program translates the answers into medical terminology. The history is then available in PDF format for presentation to the clinician. Patients self completed their history using a touch screen, and checked the results before printing. Comments about the process were recorded from patients and clinical staff. The system was trialled in a hepatitis assessment clinic. Patients are fully informed about this voluntary and secure system prior to use.

Results 443 patients used the touch screen. 12 did not complete their history because of language problems (8) or indifference (3). The average time to complete was 14.7 min (range 7–21 min). 7 patients were identified who were at high risk of hepatitis infection, and a monospot test was offered and accepted in all of these and further serological tests undertaken. 180 patients with known positive serology completed their history.

Conclusion Patients found the touch screen easy to use, and were able to complete their history in the waiting area prior to consultation. They were universally happy to keep a printout of their history. The clinicians were able to spend more time discussing risks and treatment options, and were able to ask supplementary questions rather than repeatedly obtaining basic data. Printouts of the PDF were retained in the notes as part of the medical record. This technology has shown great potential in allowing more new patients to be seen, increasing efficiency in carrying out regular reviews, gathering better clinical information and reducing patient distress when asking sensitive questions. Perceived benefits are – more rapid and thorough clinical assessment; semi-automated follow up; health screening; and patient surveys. There are applications for this technology in many fields of medical practice.

Disclosure of Interest None Declared.

PTH-025 DIETITIAN-LED VIRTUAL COELIAC DISEASE CLINIC RESULTS IN COST SAVINGS AND INCREASED PATIENT SATISFACTION

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Introduction We identified that demand for follow up of adult patients diagnosed with coeliac disease exceeded the capacity of our dietitian-led coeliac annual review clinic. A dietitian-led

virtual coeliac clinic was developed as an efficient and cost effective method of reviewing adults with established coeliac disease.

Methods Patients with established coeliac disease (i.e. a combined histological and serological diagnosis more than 12 months earlier), who were assessed by the dietitian as understanding fully how to adhere to a gluten free diet and who have shown a good symptomatic response were sent the virtual clinic questionnaire. They were also sent a blood form to monitor full blood count, bone biochemistry, ESR, haematinics and tissue transglutaminase in line with the BSG 2010 coeliac guidelines. They were asked to complete and return the questionnaire in a prepaid addressed envelope and have the blood tests undertaken within 4 weeks. The questionnaire responses and blood results were reviewed by a specialist gastroenterology dietitian. The identification of any new abnormal blood results was highlighted to the GP and/or consultant gastroenterologist. If any red flag symptoms (i.e. blood in stools, unintentional weight loss or persistent change in bowel habit) were highlighted on the questionnaire then the patient was telephoned by the dietitian to discuss further before being referred to their GP or gastroenterologist as appropriate.

Results 86 patients were sent the virtual coeliac review questionnaire from May 2012- April 2013. Of these, 81 patients (94.2%) returned their questionnaire and 78 patients (90.6%) had their blood tests undertaken. Of these, 7.4% patients (n = 6) were referred to gastroenterology for abnormal blood results or for the presence of new gastrointestinal symptoms. Only 1 of these patients (1.2%) needed to be seen in the gastroenterology clinic. 6.1% of patients (n = 5) were telephoned by the dietitian for reporting red flag symptoms. After the telephone consultation none of these patients required gastroenterology or dietetic appointments.

80% of patients responded that alternating annually between virtual review and a clinic appointment was preferential to an annual clinic appointment.

Conclusion A virtual review coeliac clinic at the Royal Bournemouth Hospital is a cost effective and patient preferred method of managing adults with established coeliac disease.

REFERENCE

1 The Management of Adults with Coeliac Disease; BSG 2010

Disclosure of Interest None Declared.

PTH-026 EVALUATION OF A SERVICE TO MANAGE INFLAMMATORY BOWEL DISEASE (IBD) IN PREGNANCY

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Introduction Following the publication of a consensus for management of IBD in pregnancy a service was set up in our institution (April 2013) to optimise the management of pregnant women with IBD. Its' aim is to enable multidisciplinary management of patients with a consultant gastroenterologist, consultant obstetrician, colorectal surgeon and IBD specialist nurse. It provides a baseline health check in the early stages of pregnancy, more intensive foetal growth monitoring with additional growth scans at 28 and 32 weeks of pregnancy, discussion of delivery methods and anticipation of potential peripartum problems including liaison with colorectal surgical team. A review of the service was performed after 8 months to provide an overview of management of patients, demand and outcomes following set up of the service.

Methods A retrospective review of medical notes was performed of patients seen in the clinic. Information was gathered on diagnosis, previous surgery for IBD, parity, outcomes of previous pregnancies, medication preconception and during pregnancy, disease activity preconception and during pregnancy and outcome of pregnancy.

Results Data was collected on 20 patients. 8 had Crohns disease (CD), 12 had ulcerative colitis (UC). Surgery: In the UC group 3/12 had previous surgery: 2 ileoanal pouch, 1 subtotal colectomy. In CD group 4/8 had an ileocolonic resection. Parity: 5=para 1, 8=para 2, 6=para 3, 1=para 4. Medication: 11/20 were on no medication (6 UC, 5 CD). 3 were on infliximab, last infusion 20/40, 3 were on azathioprine, 5 were on a 5ASA. Disease activity: 19/20 were well preconception, 1 was unwell around time of conception (miscarriage at 11/40). 10/20 had a flare of disease activity during pregnancy: 1 settled with topical treatment, 1 settled with 5ASA, 8 required oral steroids. All 3 patients on infliximab had a flare after stopping it and required oral steroids. 1 of these had a stillbirth shortly after commencing steroids for a flare. Outcomes: 10/20 have not yet delivered, 3 are planned for elective CS (1 perianal disease, 1 previous CS, 1 previous forceps delivery). 3 had CS (2 had ileoanal pouches and 1 had perianal disease), 1 stillbirth, 1 miscarriage, 5 had normal vaginal delivery (NVD). No preterm births or low birth weights reported.

Conclusion Those with ileoanal pouches and perianal disease are being appropriately considered for a planned CS. 50% of our patients have a NVD which as expected is lower than the general population. 50% of our patients had a flare in disease during pregnancy which is higher than literature (30%)¹. 80% required oral prednisolone to settle and both adverse outcomes appear to be related to a flare in disease. Those on infliximab appear to be at high risk of flaring after their last dose around 20 weeks.

REFERENCE

1 Janneke van der Woude *et al.* J Crohns Colitis 2010;4:493–510

Disclosure of Interest None Declared.

PTH-027 ANAESTHESIA-LED PROPOFOL SEDATION FOR COMPLEX ENDOSCOPY: CLIMBING HIGHER

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Introduction NHS indicators for quality improvement (QI) are divided into key domains - safety, experience, outcome and effectiveness. Patient experience has been shown to be positively related to clinical effectiveness and safety and should not be overlooked when assessing the effectiveness of a service. The introduction of a new Anaesthesia-Led Propofol Sedation (ALPS)

Abstract PTH-027 Table 1 Domain and excellence scores over the six-month QI period

	Jan-Mar	Apr-Jun
Outcome score	93%	97%
Experience score	86%	93%
Efficiency score	62%	85%
Excellence score	68%	75%

service in 2012 was pivotal in managing patients undergoing complex endoscopic procedures. Our aim was to establish a continuous quality improvement programme to take an already successful service and pursue excellence.

Methods Measures and scores were agreed within the domains of patient optimisation, outcome and experience, and service efficiency. A composite score was used as an Excellence Score. All patient episodes were scored by the same anaesthetist using a 3-point qualitative scale; fully (>95% complete, 2 points), largely (75–95% complete, 1 point) and partially/not achieved (<75% complete, 0 points). Individual domain scores and the Excellence Score were presented as a percentage, in terms of the current service and “What If” scores to show the impact of changing practice. Patient experience was measured indirectly and with a telephone questionnaire at one-week post-discharge. Results were discussed in an MDT focus group, interventions instigated and the data recollected three months later and re-discussed.

Results 40 consecutive patients attending for complex endoscopic procedures from January to June 2013 were reviewed. Table 1 shows scores during the first three months and the influence of implemented changes. Across all scores, improvement was seen, particularly in the Efficiency Score which increased by 22%.

A patient optimisation score reflected a guideline-compliant service, but was initially low due to a lack of pre-assessment and individualised patient preparation, and sporadic use of an adapted WHO Surgical Safety Checklist. A “What If” score of 82% was presented, showing the potential service gains in the presence of these additions. Consequently managers agreed to fund use of the Hospital Preoperative Assessment Service and clinical staff agreed to implement regular use of an adapted WHO Safe Surgery Checklist.

Conclusion Achieving excellence depends upon acknowledging weaknesses in practice that may already be very good. This study has shown the value of a quality improvement programme in improving a new, innovative service. Often adoption of care elements used routinely elsewhere within the hospital setting can lead to significant improvements in patient care and the efficiency of the service.

Disclosure of Interest None Declared.

PTH-028 ANALYSIS OF QUALITY OUTCOMES FOLLOWING CHANGING BOWEL PREPARATION FOR COLONOSCOPY FROM PICOLAX TO MOVIPREP IN NHS LOTHIAN

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Introduction Using our global rating scale data from 2010 we observed that the quality of preparation for colonoscopy using Moviprep was superior to Picolax. Given this and the National patient safety alert issued in 2009 regarding bowel preparation ¹, we decided to change the default bowel preparation from Picolax to Moviprep in NHS Lothian in 2012.

Methods The aim of this study was to prospectively audit the quality of Moviprep and Picolax preparation for colonoscopy and flexible sigmoidoscopy during two 3 month periods-before (March-May 2012, period 1) and after (November-January 2013, period 2) Moviprep was changed to the default preparation in NHS Lothian for colonoscopy. All patients who attended