OWE-038 NURSE LED VALIDATION OF COLONOSCOPY SURVEILLANCE – QUALITY IMPROVEMENT PROJECT WITH SIGNIFICANT COST SAVINGS

Kevin Yoong*, Jayne Kerrigan. *Mid-Cheshire Hospitals Nhs Foundation Trust, Crewe, UK*

10.1136/gutjnl-2018-BSGAbstracts.7

Introduction Demand in colonoscopy continues to increase with the introduction of bowel cancer screening programme and an ageing population. Evidence shows that between 20%–30% of endoscopy demand is composed of surveillance procedures and that up to 30% of patients undergo surveillance procedures at incorrect intervals or where it is not indicated at all.¹ A nurse lead validation of colonoscopy surveillance was initiated to address this issue.

Methods We developed a protocol for a nurse led review of surveillance colonoscopy. All colonoscopy surveillance referrals to be reviewed by nurse consultant. Relevant referrals were validated with three outcomes;

1. Proceed to colonoscopy
2. Defer colonoscopy to a later date
3. Colonoscopy not indicated

As part of clinical governance, if it was felt that the colonoscopy is no longer indicated, the referral was directed back to the patient's consultant for their agreement.

Results For past 12 months, 521 colonoscopy requests were reviewed. 84 (16%) were not indicated which resulted in cost savings of (84 × £450) £37 800. 96 (18%) were deferred to a later date and 341 (65%) were to proceed as planned. Also out of the 521 patients, 481 patients were thought not to require a pre-colonoscopy assessment slot carried out by a nurse which amounted to cost savings of (521 × £79) £41 159.

Conclusions Our results were consistent with the findings from Hassan et al.¹ This validation process demonstrated that the majority of patients required their surveillance colonoscopy at the correct time. Nurse led validation of colonoscopy request is safe and cost effective and also avoids putting patients through unnecessary risks of colonoscopy and is a way of addressing surveillance colonoscopies that are not indicated.

REFERENCE

1. Hassan C, et al. Post-polypectomy colonoscopy surveillance: European Society of Gastrointestinal Endoscopy (ESGE) guideline. *Endoscopy* 2013;**45**(10):842–864.

OWE-039 NURSE INPATIENT ENDOSCOPY COORDINATOR: INTERIM ANALYSIS OF A QUALITY IMPROVEMENT PROJECT

Sister Rebecca Ullah*, Sampath Kumar, Anuj Gandagule, Simon Everett, Ruchit Sood, Jo Corrigan*. *Leeds Teaching Hospitals NHS Trust, Leeds, UK*

10.1136/gutjnl-2018-BSGAbstracts.8

Introduction The Gastroenterology department at Leeds Teaching Hospitals is large tertiary referral centre with a catchment area of more than 8 00 000 people. Several issues have been identified that have impacted on the timely provision of an inpatient endoscopy service such as incomplete pre-endoscopy ward checklists, incomplete bowel preparation for lower gastrointestinal endoscopy, non-adherence to fasting guidelines and last-minute cancellations as a result.

We introduced a nurse inpatient endoscopy coordinator (NIC) with the aim of improving efficiency and quality of our inpatient endoscopy service.

Methods The quality improvement project (QIP) was conducted at St. James's University Hospital over a 3 month period between November 2017 and January 2018. We collected data for 180 inpatient endoscopy procedures of which 50 were seen by the NIC prior to the procedure. The role of the NIC was to ensure completion of the pre-endoscopy checklist, provision of written information regarding the procedure, ensure patient consent was obtained on the ward, and provide guidance to the ward staff with regards to fasting and/or bowel preparation if indicated.

Results Data was collected for 180 inpatient procedures. The table shows the comparison of the quality assessment outcomes if seen by the NIC compared with when the patient was not seen by the NIC.

Abstract OWE-039 Table 1

	Was the pre-endoscopy checklist complete?	Was the sedation option explained to the patient?	Was consent signed prior to arrival in the endoscopy department?	Was IV access obtained on the ward (if indicated)?
Seen by NIC	49/49	49/49	49/49	43/43
Not seen by NIC	97/130	83/130	67/130	92/123
p-value	<0.01	<0.01	<0.01	<0.01

There were 7 procedures cancelled after arrival in the endoscopy department when not seen by the NIC versus no procedures cancelled when seen by the NIC (p=0.19). One procedure was cancelled by the NIC prior to arrival in the endoscopy unit as they were deemed too unwell to have the procedure undertaken.

A patient satisfaction questionnaire showed that 100% of patients seen by the NIC were 'very satisfied' in several aspects of their care, such as provision of verbal and written information, in being well informed about their procedure and that their procedure was completed in a timely manner.

Conclusion This QIP has shown that the introduction of a NIC can have a significant impact on improving efficiency and quality in an inpatient endoscopy service.

ADWE-01 THE PREDICTION OF DIMINUTIVE/SMALL POLYP HISTOLOGY USING DIDACTIC VS COMPUTER BASED TRAINING IN GASTROENTEROLOGY TRAINEES

¹Graham Baker*, ²Samuel Smith, ^{2,3}Marietta Iacucci, ⁴John Saltzman, ²Uday Shivaji, ³Brendan Lethebe, ⁵Ayman Bannaga, ⁶Aditi Kumar, ⁵Adam McCulloch, ⁷Beata Polewiczowska, ⁵Daniel Geh, ⁵Faraz Tahir, ⁵Harriet Fowler, ²Joanne O'Rourke, ⁵Maria Qurashi, ⁸Monika Widlak, ⁹Philip Harvey, ⁵Paul Lim, ⁵Sheeba Khan, ⁵Tarun Gupta, ²Subrata Ghosh. ¹New Cross Hospital, Wolverhampton, UK; ²Institute of Translational Medicine, University of Birmingham, UK; ³University of Calgary, Calgary, Canada; ⁴Brigham and Women's Hospital, Boston, USA; ⁵University Hospitals Birmingham, Birmingham, UK; ⁶Russells Hall Hospital, Dudley, UK; ⁷South Warwickshire NHS Foundation Trust, Warwick, UK; ⁸University Hospitals Coventry and Warwickshire, Coventry, UK; ⁹Sandwell and West Birmingham NHS Trust, West Bromwich, UK

10.1136/gutjnl-2018-BSGAbstracts.9

Abstract ADWE-01 Figure 1

Introduction Experts are able to predict and differentiate between neoplastic and non-neoplastic colonic polyps with high accuracy and meet the PIVI (Preservation and Incorporation of Valuable Endoscopic Innovations) thresholds. However, this has not been replicated in non-experts and cannot be currently recommended in clinical practice. The aim of this randomised trial was to establish the optimum method of training to increase the diagnostic accuracy of diminutive/small colonic polyp histological prediction by trainee gastroenterologists.

Methods Gastroenterology trainees from the Midlands, UK, reviewed 78 videos (48 i-Scan-OE+30 NBI) of diminutive/small polyps. Participants were randomised to computer-based learning or didactic training. The 78 videos (randomised order) were re-assessed. The NICE (NBI International Colorectal Endoscopic) classification and SIMPLE (Simplified Identification Method for Polyp Labelling during Endoscopy) classification systems were used to classify diminutive/small polyps (figure 1).

Results 16 trainees (12 gastroenterology trainees and 4 naïve endoscopists) were randomised to receive either self-training (n=8) or didactic training (n=8). A higher proportion of high confidence predictions of polyps were made by the self-training group vs didactic group when using the SIMPLE classification 77.1% vs. 69.9% ($p<0.005$) and using the NICE classification 77% vs. 69.8% ($p=0.006$). When using NICE classification, the sensitivity of the self-training group was 72% vs. 83% $p<0.0005$, and the accuracy 66.1% vs. 69.1%. When using SIMPLE classification the sensitivity was 78% vs. 83% (NS) and accuracy 65.7% vs. 69% (table 1).

Abstract ADWE-01 Table 1 Diagnostic performance to predict colonic polyp histology

		Self-training [95% CI]	Didactic [95% CI]	P-value
SIMPLE	Sensitivity	0.78 [0.73–0.82]	0.83 [0.78–0.86]	0.148
	Specificity	0.51 [0.48–0.57]	0.52 [0.46–0.58]	0.735
	Accuracy	0.66 [0.62–0.69]	0.69 [0.65–0.73]	0.225
NICE	Sensitivity	0.72 [0.69–0.77]	0.83 [0.79–0.87]	0.0005
	Specificity	0.59 [0.53–0.65]	0.52 [0.46–0.58]	0.106
	Accuracy	0.66 [0.62–0.70]	0.69 [0.65–0.73]	0.275

Conclusions Self-learning for the prediction of diminutive/small polyp histology is a method of training that can achieve results similar to the more labour intensive and expensive didactic training. The availability of adequate self-learning teaching modules that teach how to differentiate neoplastic vs non-neoplastic colonic polyps with high accuracy could enable more widespread implementation of optical diagnosis in clinical practice.

ADWE-02 DIAGNOSTIC YIELD AND EARLY DISCHARGE IN GASTROINTESTINAL BLEEDING: COMPARATIVE TRIAL BETWEEN CAPSULE ENDOSCOPY AND GASTROSCOPY

¹Hey-long Ching*, ¹Melissa F Hale, ¹Reena Sidhu, ²Sabina Beg, ²Krish Ragunath, ¹Mark E McAlindon. ¹Royal Hallamshire Hospital, Sheffield, UK; ²Nottingham University Hospitals, Nottingham, UK

10.1136/gutjnl-2018-BSGAbstracts.10