Abstracts from the Society for Acute Medicine: Spring meeting

A pilot of Consultant presence in the admission area between 1700 and 2100

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Introduction

We have successfully been running with a Consultant presence in day-time (0900-1700) in the admissions area for a number of years. The recent NCEPOD report – an Acute Problem, criticised the lack of Consultant input into care of patients being transferred to Critical care areas out of hours. The DoH Hospital at Night project has suggested extending the normal working day into the twilight shift.

Method

We piloted the extended presence of Consultant Physicians in our admission area to 12 hours to include 1700-2100 for a two-week period in December 2005.

The Consultant Physician's role in the evening included continuous senior review of all admissions and ensuring effective management plans were in place; active bed management and facilitating rapid ward transfers; expediting discharges; providing leadership to the admission area in the evening.

Results

A number of variables around the admission process and patient journey were measured. The median time from admission to clerking was reduced from 72 minutes (range 15 to 300) to 45 minutes (range 30 to 270) during the twilight shift but was not statistically significant (p=0.6). The median numbers of admissions per day was similar for the two-week baseline (39.5, range 32 to 44) and pilot (42, 33 to 54), p=0.45. There were significantly more discharges within 24 hours of admission during the twilight pilot (17, range 10 to 23) compared to baseline (12.5, range 7-18), p=0.03.

During the study, there was a variable number of medical beds closed due to viral gastroenteritis. Calculating virtual outliers if no beds were closed showed no significant difference between baseline (median 0, range –20 to +4) and pilot (median 5, range –2 to 7), p=0.3.

Feedback from Consultants who worked the twilight shift suggested that the main benefits were related to the training of Junior Doctors and ensuring effective Bed Management. Five Consultants felt that an experienced SpR could have performed the same role, whereas two felt that they couldn't. Efficient Consultant Physician working was hampered by lack of Investigation results and difficulty with evening discharges when the patient was frail/elderly or in need of transport.

Given that our Trust has 24.5 wte Consultants on the rota and that out of hours work after 7pm counts as 1.3, the potential costs in Consultant PA's required to cover the twilight shift all year round would be one PA per month per Consultant.

Conclusion

In conclusion, whilst there were some objective benefits obtained from Consultant presence in the evening such as facilitating rapid discharge and subjective benefits around training, the potential costs are high for a year round service. Concerns around the skills and competencies of trainee doctors under Modernising Medical Careers may result in Consultant presence becoming inevitable.

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Innovative practice: Implementing nurse led discharge in an acute/general medical ward

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Aim

To create an innovative system of nurse led care and discharge within an acute medical unit supported by dedicated holistic care team.

Method

The 18 bedded ward received patients from the emergency department, medical assessment unit and an acute medicine short stay ward. Patients were selected using set criteria and were predominantly undifferentiated acute medical cases. Target length of stay was less than 1 week. Key processes implemented included a transfer of care procedure between medical and nursing teams, daily nurse led ward rounds, a proactive discharge planning policy and integration of a dedicated interdisciplinary team with weekly review meetings. This was supported by a staff development package. Discharges were performed by all grades of nursing staff. Initial data was gathered during the first 4 weeks of project implementation and continues to be benchmarked.

Primary Outcome Measures

75% successful nurse led discharges, 79% appropriate admissions and 44% achieving length of stay less than 1 week. Secondary outcome measures were readmission rate, patient satisfaction using focus group analysis and rate of clinical adverse event reporting.

Results

Over initial 4 week period (Table 1)

Conclusion

Initial results support the concept that implementation of nurse led care and discharge can be achieved on an acute / general medical ward. Using agreed admission criteria, a transfer of care procedure, nurse led ward rounds and a proactive discharge policy the target length of stay was successfully applied in the majority of cases. Further data analysis and re-audit is underway.

	ALL	APPROPRIATE	NOT APPROPRIATE
Total number of patients	102	**75%**	24%
Mean LOS (days)	3.9	3.5	5.6
% LOS <7days	**84%**	92%	73%
TIme to nurse led care (days)	2.3	2.1	7
Discharged	75%	87%	39%
Nurse lesd discharge	**75%**	79%	44%

Table 1.

The use of echocardiography service by acute medicine in an acute general hospital

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Background

An echocardiogram (echo) is commonly requested for patients with an acute medical admission to hospital. Properly performed, an echo is time consuming and requires highly trained staff to perform and interpret.

Objective

To audit the use of the echo service for inpatients by general physicians in a large acute hospital.

Method

A retrospective audit of 5637 in-patient echoes performed 2002 – 2005 in The Hull and East Yorkshire hospital NHS Trust.

Results

The age range of patients who had in patient echocardiogram was 17 to 101; mean 67 ±17.3 years.

Of the 5637 echoes, 3715 were ordered by non-cardiologist physicians. 2173 (58.5%) came from general physicians, 644 (17.3%) from Care of the Elderly physicians, 417 (11.2%) came from chest physicians, 238 (6.4%) came from gastro-enterologists, 211 (5.7%) from neurologists and 27 (0.7%) from other specialities.

Indications for echocardiography were: assessment of left ventricular function in 1621 (43.4%); possible valvular heart disease in 575 (15.5%); possible infective endocarditis in 498 (13.4%); arrhythmia in 359 (9.7%); possible embolic source in 298 (8%); pericardial effusion in 219 (5.9%); pulmonary hypertension 61 (1.6%) and others 93 (2.5%).

Of the 1621 echoes requested for assessment of LV function by the non-cardiologist physicians, 77.3% had normal LV function and 9.3% had moderate to severe LV impairment. In contrast, of 464 echoes ordered by cardiologists for LV function 54.7% had normal LV function and 29.7% had moderate to severe LV impairment ($P<0.0001$).

Of the 498 patients echoed for suspected endocarditis, 18 (4%) had echocardiographic evidence of vegetation. None of the patients with endocarditis had pre-existing valve disease.

298 patients had echocardiogram for cardiac source of emboli. Only 2% had a source and all of these patients had moderate to severe LV systolic impairment.

Conclusion

The pick up rate for abnormalities on echocardiograms ordered by general physicians is very low. Echocardiography is a scarce resource. Physicians should exercise greater selection over their requests for echoes.

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Case Studies of Transcatheter Embolisation for Upper Gastrointestinal Haemorrhage: A valid alternative when medical management fails

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Introduction

Acute upper gastrointestinal (GI) haemorrhage is common, with an overall annual incidence of 103 patients per 100000 population in the UK. Following resuscitation, strong evidence suggests that endoscopy is the first line management option. However, debate remains as to the best treatment if therapeutic endoscopy fails. Historically, the management of such patients has been surgical. An alternative therapy is transcatheter embolisation (embolotherapy). Although first described over 30 years ago it currently remains an uncommon intervention despite advances that have revolutionised the treatment of refractory upper gastrointestinal bleeding in specialist centres.

We present two complex cases of upper gastrointestinal haemorrhage successfully treated by embolotherapy

CASE 1

A 78-year-old man, on regular non-steroidal anti-inflammatory drugs (NSAIDs) for arthritis, presented with upper GI bleeding. He was on his fifth day of Prednisolone for an exacerbation of chronic airways disease. His exercise tolerance was 25 metres on the flat. He drank 70 units of alcohol per week. An upper GI endoscopy showed two acute duodenal ulcers with a visible vessel but no active bleeding. He continued to bleed despite a total of 3 endoscopies and adrenaline injections. A consultant upper GI surgeon agreed that medical treatment had failed but was concerned about the operative risk. The patient was referred for urgent embolotherapy.

The gastroduodenal artery was embolised and although active bleeding was not idetified his condition stabilised with no further bleeding. He was discharged 4 days later.

CASE 2

A 66-year-old man was self-medicating for 4 days with NSAIDs for a soft tissue injury to his foot. He attended his local Emergency Department and was given low molecular weight heparin for a suspected deep vein thrombosis. Within hours he presented to the medical take with an acute GI bleed. Despite receiving 8 units of blood his haemoglobin fell from 104g/l to 84g/l. At endoscopy his stomach was full of fresh blood but a bleeding point could not be seen. At selective angiography, bleeding points were identified arising from the left gastric and the short gastric arteries. These arteries were embolised. Bleeding ceased and the patient was discharged 5 days later.

Discussion

In both cases the intervention of a vascular radiologist eliminated the need for surgery in 2 patients where laparotomy would have carried a significant risk. They highlight the flexibility of embolotherapy and pose the question of whether embolotherapy should be considered as the gold standard when medical management fails.

Angiography can locate the source of bleeding in some cases where endoscopy has failed. Furthermore, evidence from retrospective studies has shown that embolotherapy is as effective as surgery whilst in addition offering an alternative to patients who are poor surgical risks.

The only obvious drawback is the availability for specialist vascular interventional radiology facilities.

In conclusion, interventional vascular radiology offers an extremely useful treatment modality for patients with GI bleeds. We are convinced that the 2 cases described would have needed surgery, and its inherent risks, without embolotherapy.