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Book of Abstracts

Contents

CQ - Clinical Quality - CQ - Patient Safety [Poster]

1201 Improving Documentation of Bowel Movements by the Medical and Nursing Teams on a Department of Medicine for the Elderly Ward

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Background
Not a normal part of ageing, constipation disproportionately affects the elderly population and a cycle of untreated constipation predisposes to further constipation. Resulting in increased morbidity, mortality, prolonged hospital admissions and institutionalisation clinicians have a duty to identify and treat constipation before these negative outcomes arise.

Local problem
In our Trust, we observed a need for improved identification of constipation in geriatric patients. Nursing and clinician documentation of bowel movements were not meeting the trust standard of daily documentation. Our aim was to achieve 100% bed days with appropriate documentation by the nursing and medical teams, and appropriate laxative prescription.

Methods
Data was collected retrospectively on a DME ward over 7 days for all patients with length of stay greater than 2 days, and recorded per patient per bed day. Outcome measures were the percentage of bed days with complete, incomplete and no documentation by medical and nursing teams, and with laxatives prescribed (P), required (R) and not required (NR). Baseline data collection and two 'Plan Do Study Act' (PDSA) cycles were completed.

Interventions

The first interventions were multidisciplinary team education and posters displayed on the ward as visual cues. For the second PDSA cycle, a ward round checklist and observation stickers were introduced for medical documentation.

Results
Following both rounds, complete documentation by nursing staff improved from 27.6% to 75.3% whilst complete documentation by doctors improved from 4.1% to 70.7%. However, appropriately prescribed laxatives remained unchanged: R at baseline was 24.5% and after round 2 was 20.4% .

Conclusions
Whilst easy to implement and effective at improving documentation, MDT education and visual cues did not translate to appropriate treatment of constipation. We would advise further investigation into utilising novel technology: for example, 'eObservations' system alerts or 'ePrescribing' cues to review laxatives in all geriatric patients.

Improving Documentation of Bowel Movements by the Medical and Nursing Teams on a Department of Medicine for the Elderly (DME) Ward

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NHS

East Sussex Healthcare

NHS Trust

Background

Constipation disproportionately affects the elderly population, but is not a normal part of ageing; it is multifactorial with a vicious cycle of untreated constipation predisposing to further constipation. As a cause of morbidity, prolonged hospital admissions, institutionalisation and even mortality, clinicians have a duty to identify and treat constipation.

Local problem

We observed a Trust-wide risk from constipation to the geriatric patient group; the Trust standard stating bowel movements should be documented for 100% of nursing shifts was not being met. An equivalent standard should be expected of the doctors caring for these patients. Consequently, our aim was to achieve 100% bed days with appropriate documentation of bowel movements by the nursing and medical teams, and appropriate laxative prescription.

Methods

Over 1 week data was collected retrospectively for all patients with length of stay greater than 2 days at time of collection on a 28 bedded DME ward. Documentation was recorded per patient per bed day on the ward. Outcome measures were the percentage of total bed days with complete, incomplete and no documentation by medical and nursing teams. Additionally the percentage of bed days with laxatives prescribed (P), not prescribed but required (R) and not prescribed not required (NR) was measured. Baseline data collection and two 'Plan Do Study Act' (PDSA) cycles were completed.

Interventions

The first interventions were multidisciplinary team education and a poster displayed on the ward as a visual cue (centre left). For the second PDSA cycle, a ward round checklist (centre right) and observation stickers were introduced for medical documentation.


Results

Following both rounds, complete documentation by nursing staff improved from 27.6% to 75.3%; bed days without any documentation decreased from 68.4% to 22.6% (right top). Complete documentation by doctors improved from 4.1% to 70.7% whilst incomplete documentation decreased to 2.7% and absent documentation fell to 26.7% (right middle).

However, appropriately prescribed laxatives remained unchanged: patients without laxatives prescribed who required laxatives (NR) at baseline was 24.5% and after round 2 was 20.4% (right bottom).

Conclusions

Whilst easy to implement and effective at improving documentation, education and visual cues /aids did not translate to appropriate treatment of constipation. We would advise further investigation into utilising novel technology: for example alerts from eObservations systems when patient bowels haven't opened for 3 days or ePrescribing systems cueing doctors to review laxatives in all geriatric patients.

Documentation of Bowel Movements by Nursing Staff as a Percentage of Bed Days by Round of Data Collection
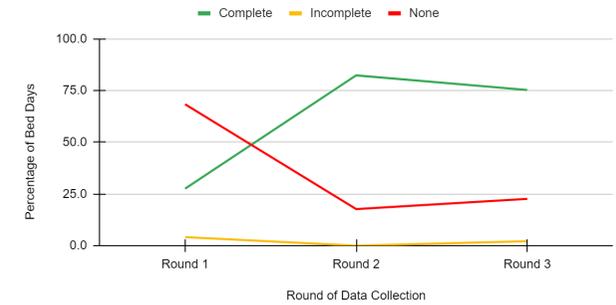
Documentation of Bowel Movements by Doctors as a Percentage of Bed Days by Round of Data Collection
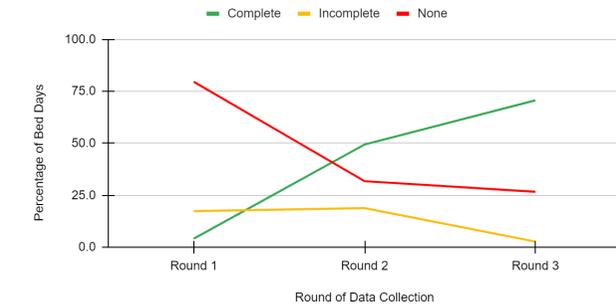
Laxative Prescription as a Percentage of Bed Days by Round of Data Collection
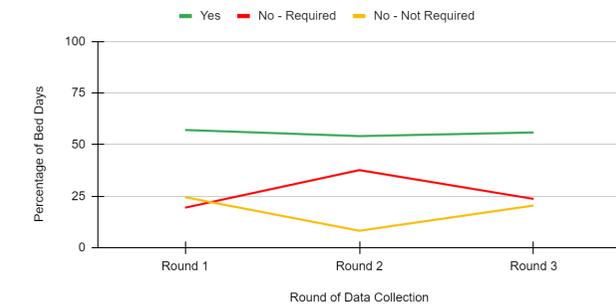
CQ - Clinical Quality - CQ - Patient Centredness [Poster]

1250 Laxatives prescription monitoring for an overlooked problem

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Introduction:
Constipation is a common among hospitalised patients. It results in considerable morbidity, healthcare utilization and economic burden.   Laxatives are prescribed to treat constipation but poorly monitored due to benign side effect perception.

Aim:

We undertook a review to examine the quality of laxative prescribing and their monitoring among hospitalised patients, and proposed new standards:
- Medication review at least once weekly
- Documented rationale for choice of medication used
- A specified timeframe for review and outcome documented for new laxatives

Method:
Patient notes and medication charts were reviewed across medical wards in Trafford General Hospital, Manchester. Data was collected on types of laxatives, reason for prescription, date of review, length of course, compliance and effect of laxatives. Two rounds of audit were performed 6 months apart, with an interim intervention of staff education and local introduction of a new constipation management guideline. The guideline consisted of decision algorithm and suggested treatment.

Results:
47 individual prescriptions were audited in round 1 and 72 prescriptions in round 2, this represented 23 and 32 patients respectively. Across two rounds of audit, review of medications within first week of prescription improved from 17% to 83.7%. Documentation of constipation diagnosis improved from 52.2% to 97.2%. There were large percentage improvements in documentation of specified treatment outcomes across all audited fields, despite overall poorer medication compliance in round 2 (56.9% versus 66% in round 1). Documentation of laxative review improved from 28% to 81.9%. Record of constipation resolution improved from 59.6% to 72%.

Conclusion:

Staff education and implementation of treatment guidelines make a substantial improvement to the medical management of constipation in hospitalised patients.

Laxative Prescription Monitoring For An Overlooked Problem

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Introduction

Constipation is a common among hospitalised patients. It results in considerable morbidity, healthcare utilisation and economic burden[1]. While approaches like patient education, exercise, behaviour and dietary changes might be an option in healthy individuals, however such approaches have limited outcome in elderly, unwell patients in hospital.

Laxatives are prescribed to treat constipation, but their use is poorly monitored due to benign side effect perception. National guidance regarding the treatment of constipation is vague regarding laxative choice or dosage[2], and the ultimate prescription of a given laxative varies widely between different clinical practitioners.

Aims and Objectives

We sought to examine the quality of laxative prescription at our hospital against established standards of good prescribing practice[3] and to produce a local guideline on constipation management.

We undertook a review to examine the quality of laxative prescribing and their monitoring among hospitalised patients. Standards for review:

1. Medication review at least once weekly
2. Documented rationale for medication and reason for choice
3. A specified timeframe for review and outcome documented for new laxatives .

Method

Patient notes and medication charts were reviewed across medical wards in Trafford General Hospital, Manchester. Data was collected on types of laxatives, reason for prescription, date of review, length of course, compliance and effect of laxatives. Two rounds of audit were performed 6 months apart, with an interim intervention of staff education and introduction of a new constipation management algorithm (pictured right).
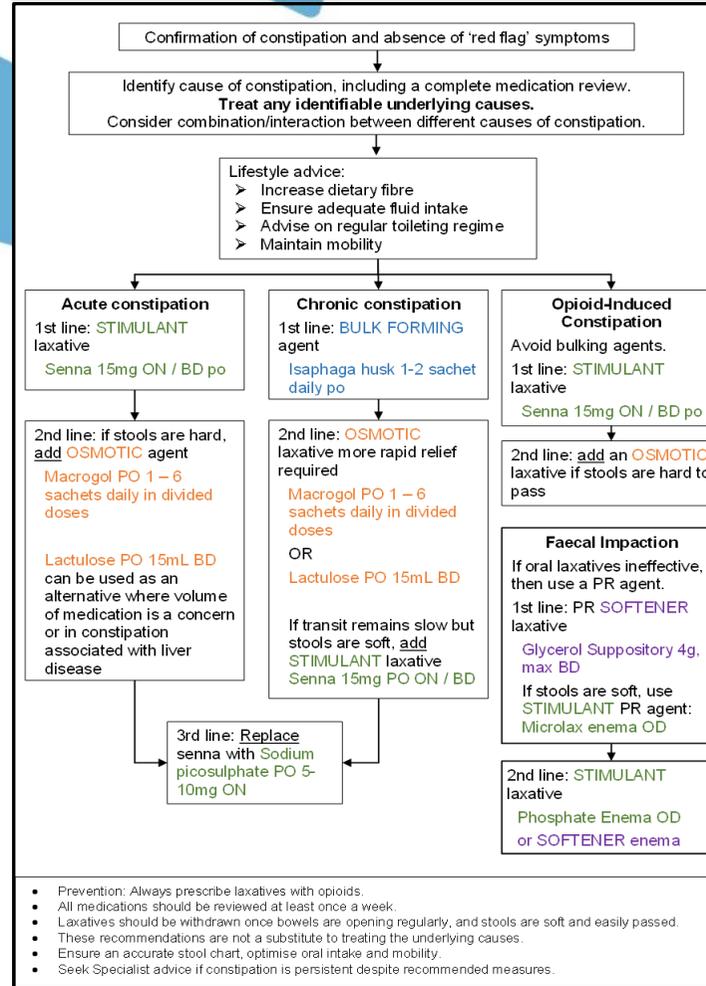
Conclusions

Medical management of constipation in hospital is often overlooked by medical staff, however there is also issue with adherence.

We demonstrated that constipation resolution is greater in patients where there is adherence to treatment. Patients who did not experience resolution of constipation and did not adhere to prescription are also most likely to experience unwanted side effects of their laxatives; regular medication reviews can reduce this issue.

We were able to demonstrate that staff education and enforcement of good prescribing standards in the form of a constipation management guide can vastly improve the quality of laxative prescribing, and hence constipation management.

This project has informed development of new Trust guidance on medical constipation management in adult patients, which contains our treatment algorithm, further information on laxative classes and treatment information.

Constipation Management Algorithm (part of new Trust-wide Constipation Management Guideline produced by the authors)
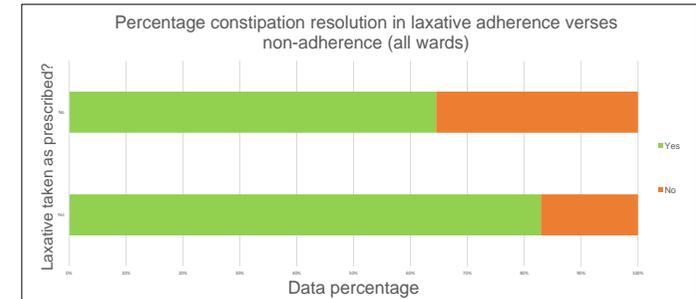
Confirmation of constipation and absence of 'red flag' symptoms

Identify cause of constipation, including a complete medication review.
Treat any identifiable underlying causes.
Consider combination/interaction between different causes of constipation.

Lifestyle advice:
➢ Increase dietary fibre
➢ Ensure adequate fluid intake
➢ Advise on regular toileting regime
➢ Maintain mobility

Acute constipation
1st line: STIMULANT laxative

Senna 15mg ON / BD po

2nd line: if stools are hard, add OSMOTIC agent

Macrogol PO 1 – 6 sachets daily in divided doses

Lactulose PO 15mL BD can be used as an alternative where volume of medication is a concern or in constipation associated with liver disease

3rd line: Replace senna with Sodium picosulphate PO 5-10mg ON

Chronic constipation
1st line: BULK FORMING agent

Isaphaga husk 1-2 sachet daily po

2nd line: OSMOTIC laxative more rapid relief required

Macrogol PO 1 – 6 sachets daily in divided doses
OR
Lactulose PO 15mL BD

If transit remains slow but stools are soft, add STIMULANT laxative
Senna 15mg PO ON / BD

Opioid-Induced Constipation
Avoid bulking agents.
1st line: STIMULANT laxative

Senna 15mg ON / BD po

2nd line: add an OSMOTIC laxative if stools are hard to pass

Faecal Impaction
If oral laxatives ineffective, then use a PR agent.
1st line: PR SOFTENER laxative

Glycerol Suppository 4g, max BD

If stools are soft, use STIMULANT PR agent:
Microlax enema OD

2nd line: STIMULANT laxative

Phosphate Enema OD or SOFTENER enema

- Prevention: Always prescribe laxatives with opioids.
- All medications should be reviewed at least once a week.
- Laxatives should be withdrawn once bowels are opening regularly, and stools are soft and easily passed.
- These recommendations are not a substitute to treating the underlying causes.
- Ensure an accurate stool chart, optimise oral intake and mobility.
- Seek Specialist advice if constipation is persistent despite recommended measures.

Audit Results

Standards	Compliance (%)	
	Round 1 (n = 47)	Round 2 (n = 72)
1. Medications should be reviewed at least once weekly whilst a patient is in hospital Laxative prescriptions reviewed within 1 week	17%	83.7%
2. Documented rationale for medication Documented diagnosis of constipation	52.2%	97.2%
3. A specified outcome should be documented for new laxatives Constipation resolution	59.6%	72.0%
3. A specified outcome should be documented for new laxatives Documentation of laxative reviewed at any time within clinical notes or medication chart	28%	81.9%

Average length of laxative use across laxative classes (days)

	Round 1	Round 2
Osmotic	14.6	15.9
PR laxative	10.7	4.0
Softener	23.2	26.0
Stimulant	20.0	15.3
Average	18.6	16.4

Percentage constipation resolution in laxative adherence verses non-adherence (all wards)

Laxative taken as prescribed?

Data percentage

■ Yes
■ No

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3. General Medical Council. Good practice in prescribing and managing medicines and devices. [Online] April 2021, https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices.

CQ - Clinical Quality - CQ - Patient Centredness [Poster]

1252 Investigating inpatient management of bladder and bowel health to ascertain workload on staffing and inpatient experience.

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Incontinence and care dependence threatens patient dignity. There are widespread concerns about a lack of attention to the dignity of older people who need assistance with toileting or bladder and bowel care in health or social care settings.(1).   In a large UK city hospital we set out to investigate our inpatient management of bladder and bowel health to ascertain need, workload on staffing and the experience of our patients.

Methods
Patient interview +/- case note review was carried out across 17 wards by 7 independent interviewers. Interview was modelled on the ICIQ-SF questionnaire(2). Interview was adapted to include faecal incontinence(FI) and made applicable to inpatients. Data collected prospectively.

Results
84 interviews +/- case note reviews completed. 52/84 female, all >65 years.   52%(43/83) had been incontinent of urine(UI), of which 33%(14/43) were newly incontinent since admission. 72%(21/29) of those with pre-existing UI had not been referred to a continence service previously. 33%(28/84) had been incontinent of bowels(FI), of which 32%(9/28) were newly incontinent since admission. 76%(63/83), could indicate where the toilet was on the ward. 69%(57/83) needed assistance to toilet   28%(23/83) reported an incident of incontinence when waiting on assistance to toilet during this admission. On Quality of life(QoL) measurement using a 1-10 scale, patients with new UI reported a mean impact score 6.6/10. Whereas people with pre-existing UI reported lower scores, mean 4.5/10. Contrasting this, people with FI reported a higher impact on QoL regardless of whether the FI was new or pre-existing.

Conclusions
The vast majority of our inpatients are incontinent and need assistance to toilet, 69% (57/83). This represents a significant workload on nursing staff that is under-recognised. Due to staffing pressures we evidenced dignity with toileting had been compromised. The vast majority of incontinent patients have never been assessed previously. FI causes more distress than urinary incontinence.

Investigating inpatient management of bladder and bowel health to ascertain impact on staff workload and inpatient experience.

There is widespread concern about a lack of attention to the **dignity** of older adults who need assistance with toileting, bowel and bladder care, in health and social care settings.[1]

Aim
What is the patient experience of bowel and bladder care in our department?

Our department cares for over 160 older adults in hospital but we had an inadequate understanding of the patient experience of continence whilst in our wards - and the staff resource needed to deliver continence care reliably.
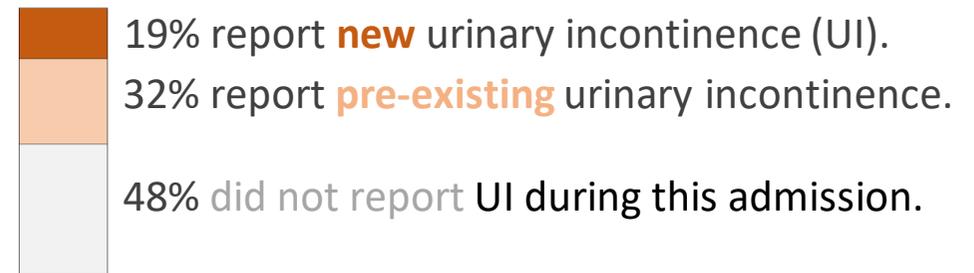
Method
84 patient interviews were conducted across medicine for the elderly wards within a large city hospital and 2 rehab hospitals, Feb-Mar 22.

Interviews were modelled on ICIQ-SF questionnaire[2] – adapted for the inpatient setting and supplementary questions on bowel care.

Case note review and carer responses were used to support those answering with impaired capacity.

1. Ostaszkiewicz, J. et al. A concept analysis of dignity-protective continence care for care dependent older people in long-term care settings. BMC Geriatr 20, 266 (2020).
2. Avery K et al. ICIQ: a brief and robust measure for evaluating the symptoms and impact of urinary incontinence. Neurourol.Urodyn. 2004.

Results

19% report **new** urinary incontinence (UI).

32% report **pre-existing** urinary incontinence.

48% did not report UI during this admission.

Those in the **new** UI group reported **poorer negative impact scores** (mean 6.6 /10) than the **pre-existing** UI (mean 4.5) group.

Almost ¾ of those with **pre-existing** UI had **never** previously accessed continence services in the community.

69% patients required staff assistance to toilet.

28% reported an incidence of **incontinence whilst waiting on assistance** to toilet during this admission.

Conclusions
High proportion of the patient group were dependent on staff for toileting. However, many are experiencing distressing episodes of avoidable incontinence in the context of depleted nursing capacity.

Also, existing continence assessment pathways are failing to capture most of this frail older population – better referral routes are needed between specialist community teams and secondary care.

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CQ - Clinical Quality - CQ - Clinical Effectiveness [Poster]

1253 Urinary Incontinence - Getting Back to BASICS

C Quirie1; S Keir1; J Mair1; A Sanderson1

Medicine of the Elderly; Western General Hospital, Edinburgh

Urinary incontinence (UI) is a common, but often overlooked problem. The initial assessment for new UI in NHS Lothian is BASICS, with both a paper and online version. It guides the user through a bladder diary (B), a physical exam (A), symptom profile (S), infection (I), constipation (C), bladder scans (S). My aim was to increase the use of BASICS assessment for new UI up to 50%. Baseline measurement was gathered for current practice in relation to use of BASICS across all six MOE wards, and whether online or paper form was used. I completed qualitative analysis, with a survey of junior doctors and MOE nurses on the barriers to completion of BASICS. Following unanimous feedback from the qualitative survey, we switched the entire department to paper BASICS forms. BASICS was amended to simplify those areas done poorly. A box was added to prompt diagnosis making. I engaged junior doctors in teaching about UI. 152 patients were included in the results, of which 32 had new UI. There was a 13.1% increase in the use of BASICS, with 50% of those appropriate having an assessment started. There were improvements across all components – 21.9% had a bladder diary complete (+17.1%); PV exam improved by 24.7% to 61.1%; symptom profile improved to 43.8% (+15.2%); and bladder scan jumped to 78.1% (+21%). Pleasingly 50% of patients were given a diagnosis for the new UI (+ 11.9%), and 43.8% had a patient specific management plan made, a jump of 10.7%. We have improved our assessment, diagnosis and management of new UI across the department. Listening to staff feedback and switching to universally paper forms in an ever increasingly technological ward has had positive outcomes. The next step is continuing momentum in the department, of which staff education is key.

Urinary Incontinence – Getting Back to BASICS

C Quirie[1], S Keir[1], J Mair[1], A Sanderson[1]

Medicine of the Elderly, Western General Hospital, Edinburgh[1]

Introduction and Aims

Urinary incontinence (UI) is a common, but often overlooked problem, especially in elderly patients.

The initial assessment for new UI in NHS Lothian is via a BASICS checklist, with both paper and online versions available. It guides the user through a **B**ladder diary, **A** physical exam, **S**ymptom profile, **I**nfection, exclude **C**onstipation, bladder **S**cans.

My aim was to increase the use of BASICS in assessment of new UI to 50% across the MOE department.

Methods

Baseline data was gathered for current practice in relation to the use of BASICS across all six MOE wards at WGH (144 patients). 23.8% of patients with new UI had a BASICS started, with pockets of good practice.

I completed qualitative analysis, with a survey of junior doctors and MOE nurses on their barriers to the completion of BASICS assessments. Following unanimous feedback from the qualitative survey, we switched the entire department to paper BASICS forms only.

BASICS (figure 1) was amended to simplify those areas done poorly – the most important of which was the addition of the symptom profile questions to the back of BASICS form. A box was also added to prompt and encourage diagnosis of subtype of UI.

I engaged junior doctors in teaching about UI

The new updated BASICS was "launched" at the Department teaching in Feb 2022.

Figure 1

Results

152 patients were included in the results, of which 32 had new urinary incontinence and were appropriate for BASICS (deemed as being in a steady state for 7 days).

There was a 26.2% increase in the use of BASICS across the department, with 50% of those appropriate having an assessment started.

There were improvements across all components (*figure 2)*, with the most notable being a 17% increase in completion of bladder diary; near 25% improvement in PV exams, and 15% increase in symptom profile completion.

Pleasingly, 50% of patients were given a diagnosis for the type of UI they had (+11.9%), and 43.8% had a patient specific management plan created, a jump of 10.7%.
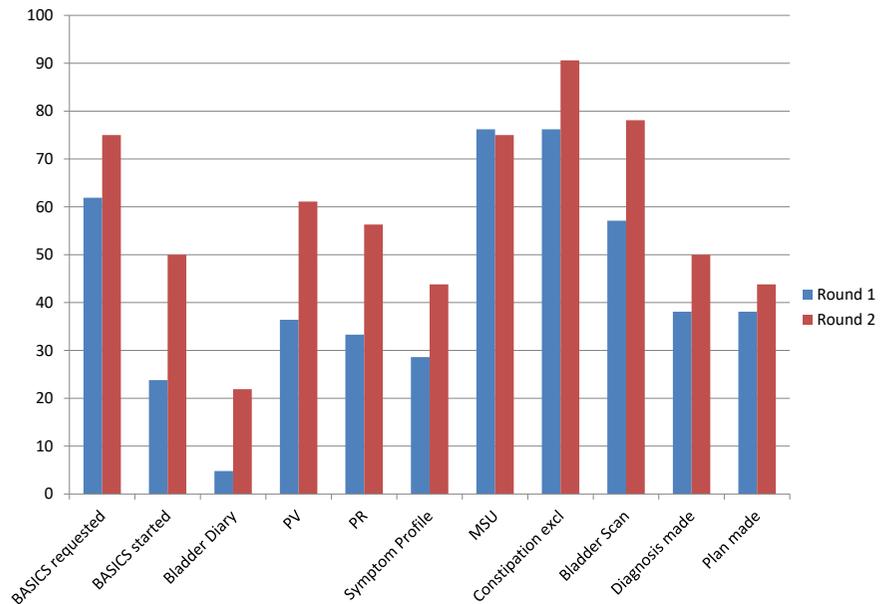
Figure 2

Conclusions

We have improved our assessment, diagnosis and management of new UI across the department.

Listening to staff feedback and switching to universally paper BASICS in an ever increasingly technological ward has had positive outcomes.

The next step is continuing momentum in the department, of which staff education is key. It has been added to the rolling junior doctor audit cycle, to keep highlighting UI and keep people talking about BASICS.

CQ - Clinical Quality - CQ - Clinical Effectiveness [Poster]

1254 Is there a problem with how we quantify stool amount on a patient's bowel chart?

S Coombes1; E Burn1; MD Patel1; D Samani1.

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Introduction
Documenting a patient's bowel movement, including type and quantity, is essential for identifying, preventing and managing constipation. Within University Hospitals of Leicester (UHL), the electronic stool chart prompts for stool type but stool quantity is optional free text and '+' is used or not at all. At UHL, constipation was in the top 4 reasons why patients were re-admitted. Our aim is to review current documentation of stool quantity and collect staff perception; therefore enabling us to develop a more specific electronic tool to aid documentation and therefore treatment of constipation.

Method
Snapshot analysis of electronic patient records across 3 care of the elderly wards over 1 week. Survey of health care professionals to accurately classify type of stool as per the Bristol Stool Chart (BSC). Using modelling clay to be able to identify quantity as per the King's Stool Chart (KSC) formula using '+ ' or our new fruit analogy method (<100g =smaller than a plum, 100g = plum, 200g = apple, 300g = grapefruit, >300g = larger than a grapefruit).

Results
Data from 60 patients showed 306 motions recorded over 1 week, of which 51% had quantity recorded using '+' for most. We noted 51% were on medications that can cause constipation, 48% had laxatives prescribed pre-admission and 68% had medication regime adjusted due to constipation. Out of 30 staff members surveyed, 67% could not identity stool type accurately using BSC. However 30% did accurately quantify stool amount using the KSC formula with '+' or our fruit method, with more formed stool being better quantified.

Conclusions
Using '+' or fruit size alone to help quantify stool amount is inconsistent. However using a combination of both methods improved reliability. We need to improve knowledge of BSC across staff and develop a prompt on the electronic system recording quantity as well as type.

IS THERE A PROBLEM WITH HOW WE QUANTIFY STOOL AMOUNT ON A PATIENT'S BOWEL CHART?

Authors: S Coombes[1]; E Burn[1]; MD Patel[1]; D Samani[1].

[1]Care of the Elderly Department; University Hospitals of Leicester NHS Trust.

INTRODUCTION

Documenting a patient's bowel movement, including type and quantity, is essential for identifying, preventing and managing constipation. Within University Hospitals of Leicester (UHL), the electronic stool chart prompts for stool type but stool quantity is an optional free text and '+' is used or not at all. At UHL, constipation is one of the top 4 reasons for re-admission. Our aim is to review current documentation of stool quantity and collect staff perception; therefore, enabling us to develop a more specific electronic tool to aid documentation and treatment of constipation.

METHOD

Firstly, a snapshot analysis of electronic medical records was undertaken of 60 patients across 3 care of the older person's wards over 1 week. Secondly, a survey of health care professionals, on how accurately they can classify type of stool as per the Bristol Stool Chart (BSC)[2], based on clay models of stool (Figure 1). Thirdly, using the same clay models to be able to identify quantity as per the King's Stool Chart (KSC)[3] formula using '+ ' and our new fruit analogy method (<100g =smaller than a plum, 100g = plum, 200g = apple, 300g = grapefruit, >300g = larger than a grapefruit).

Figure 1 – examples of clay models of stool.
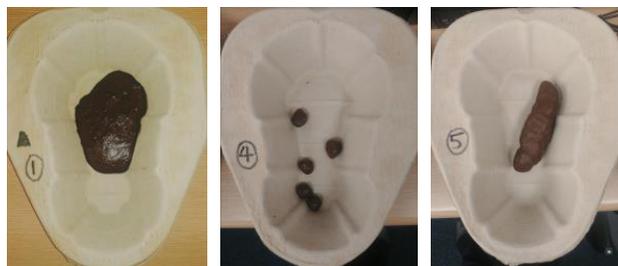
Type 6 ++ (185g)   Type 1 + (50g)   Type 3 +++ (300g)

CONCLUSION

1. Stool amount is not routinely documented.

Using '+' or fruit size alone to help quantify stool amount is inconsistent. However, using a combination of both methods improved reliability.

<100g	+ (plum)
100-200g	++ (apple)
>200g	+++ (grapefruit)

Plum   Apple   Grapefruit

2. Need to improve knowledge of Bristol Stool Chart across all staff groups.

This will allow more accurate documentation.

3. Develop a prompt on the electronic system to record quantity as well as type.

To allow better recognition of constipation and therefore it's treatment.

RESULTS

Data from 60 patients showed 306 motions recorded over 1 week, of which 51% had quantity recorded using '+'. We also noted 51% were on medications that can cause constipation, 48% had laxatives prescribed pre-admission and 68% had medication regime adjusted due to constipation. Out of 30 staff members surveyed, 67% could not identity stool type accurately using BSC. However, 30% did accurately quantify stool amount using the KSC formula with '+' or our fruit method, with more formed stool being better quantified.
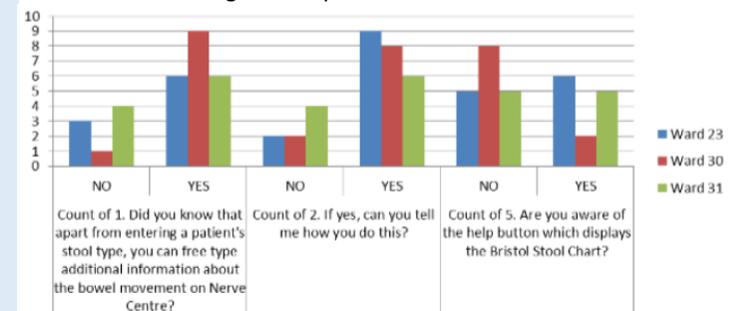
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NHS Trust