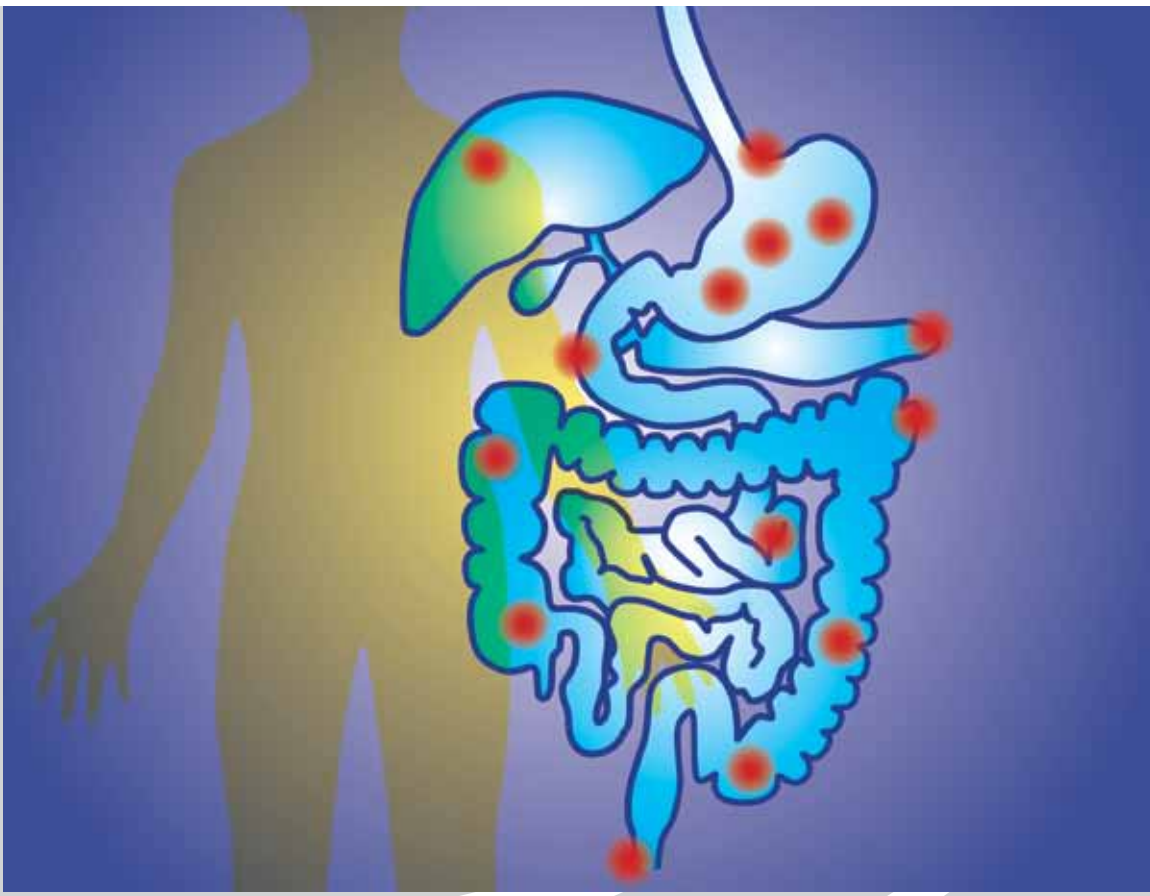
Time to Get Control?

A review of the care received by patients who had a severe gastrointestinal haemorrhage



NCEPOD

Improving the quality of healthcare

Summary

The clinical community looking after patients with gastrointestinal (GI) bleeding have long realised that the care of these patients is less than satisfactory. A number of organisations including NICE, the BSG and SIGN have identified this care as wanting and suggested improvements. There is a belief amongst clinicians that progress remains slow and there is still significant variation in care despite recommendations and advances.

It is with this background that NCEPOD was asked to assess the quality of care given to patients with gastrointestinal bleeding. To do this we used our standard method of assessment of all hospitals in our study. This included assessment of care at an organisational level, clinical level within hospitals and external peer review of selected cases. We identified 31,412 patients who had experienced a gastrointestinal bleed during a 4 month period from 1st January 2013. We decided to look at a group of patients with more severe bleeding and found that 15% of patients received 4 or more units of blood. From these we selected a random sample of 618 patients for hospital clinician review and 485 patients for external peer review.

We found that there are still significant opportunities to improve the care of patients with gastrointestinal bleeding. The most striking findings of this study were that the organisation of GI bleeding services remain patchy and lacks co-ordination. Many hospitals do not have the facilities and / or staffing to deliver comprehensive care both during and out-of-hours. As a result many patients received inappropriate treatment whilst waiting for definitive control of bleeding. For example 9% of patients were given medical treatment that our reviewers felt was unnecessary and 25% were given blood products that could have been avoided.

We recommend that the artificial separation of upper and lower gastrointestinal bleeding should be stopped. To do this each hospital should appoint a Lead Clinician for GI bleeds to take responsibility for the management of patients with upper and lower GI bleeding. This clinician should develop pathways for patients with GI bleeds that identify patients early who require specialist input from GI bleed specialists ensuring timely early investigation and treatment of bleeding. This service should include 24/7 access to a specialist, GI bleed service, endoscopy, IR and surgery. Where deficiencies exist hospitals should develop joint networks with neighbouring hospitals.

Principal recommendations

Patients with any acute GI bleed should only be admitted to hospitals with 24/7 access to on-site endoscopy, interventional radiology (on-site or covered by a formal network), on-site GI bleed surgery, on-site critical care and anaesthesia. *(Medical Directors, Ambulance Trusts and Commissioners)*

Hospitals that do not admit patients with GI bleeds must have 24/7 access to endoscopy, interventional radiology and GI bleed surgery for patients who develop a GI bleed while as an inpatient for another condition by either an on-site service or a formal network. *(Medical Directors, Chief Executives and Trust Boards)*

The traditional separation of care for upper and lower GI bleeding in hospitals should stop. All acute hospitals should have a Lead Clinician who is responsible for local integrated care pathways for both upper and lower GI bleeding and their clinical governance, including identifying named consultants, ideally gastroenterologists, who would be responsible for the emergency and on-going care of all *major* GI bleeds. *(Medical Directors, Clinical Directors)*

All patients who present with a *major* upper or lower GI bleed, either on admission or as an inpatient, should be discussed with the duty or on-call (out-of-hours) consultant responsible for *major* GI bleeds, within one hour of the diagnosis of a *major* bleed. *(All Doctors)*

The ongoing management of care for patients with a *major* bleed should rest with, and be directed by the named consultant responsible for GI bleeds; to ensure timely investigation and treatment to stop bleeding and reduce unnecessary blood transfusion. *(Lead Clinicians for GI Bleeds, Medical Directors, Clinical Directors)*

All patients with a GI bleed must have a clearly documented re-bleed plan agreed at the time of each diagnostic or therapeutic intervention. *(Gastroenterologists, Radiologists and GI Bleed Surgeons)*