Treat the Cause

A review of the quality of care provided to patients treated for acute pancreatitis

NCEPOD

Improving the quality of healthcare

Summary

Guidelines for the management of acute pancreatitis have existed for many years; the British Society of Gastroenterology guidelines were last updated nearly 10 years ago. The latest International Association of Pancreatology & American Pancreatic Association guidelines were published in 2012. However, audits of guideline use in acute pancreatitis have often shown poor compliance. The proposers of the study felt that despite the existence of management guidelines the care of these patients was variable nationwide.

Therefore NCEPOD was asked to assess the quality of care given to patients with acute pancreatitis. 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 14,479 patients with acute pancreatitis during a six month period from 1st January 2014. From these we selected a group of 8,925 patients who had either stayed in hospital three or more nights, gone to critical care or died. From a random sample, 712 patients underwent hospital clinician review and 418 patients had external peer review.

Overall, we found that there was room for improvement in care in 50% of patients with acute pancreatitis. 21% of patients in the study had one or more previous episodes of acute pancreatitis, 93% of those for the same cause. Case reviewers felt that efforts to prevent recurrent episodes due to gallstones and alcohol were inadequate. Clinicians reported that the date of first definitive treatment for gallstones was not acceptable in nearly one third of cases.

Aspects of general care where improvements could be made include avoidance of inappropriate antibiotic prescription; 1/5 of patients were being given antibiotics unnecessarily. The use of an early warning score was omitted in 31% of emergency department admissions and appropriate investigations were omitted in 22% of cases. We also found that 21% of patients who did not have an ultrasound had no reason identified to omit this, potentially missing cases of gallstones.

We recommend that clinicians fully investigate patients for the cause of acute pancreatitis. They should ensure early treatment for patients with gallstones and alcohol cessation advice where indicated. We recommend the judicious use of antibiotics as most patients with acute pancreatitis do not require them.

The organisation of care should be improved. Hospitals should develop standardised early warning scoring systems which are used throughout the hospital and commenced in the emergency department. At a regional and national level, the processes of care for patients with acute pancreatitis need to be reviewed. The development of better networking arrangements and regional pancreatitis units, with shared management guidelines, is essential to improve the co-ordination of care.

Principal recommendations

Definitive eradication of gallstones prevents the risk of a recurrent attack of acute pancreatitis. This usually involves cholecystectomy and ensuring that no stones remain in the bile duct. For those patients with an episode of mild acute pancreatitis, early definitive surgery should be undertaken, either during the index admission, as recommended by the International Association of Pancreatology (IAP), or on a planned list, within two weeks. For those patients with severe acute pancreatitis, cholecystectomy should be undertaken when clinically appropriate after resolution of pancreatitis. *(Clinical Directors and All Clinicians)*

Given the increasing complexity of the management of acute pancreatitis and its multidisciplinary nature, formal networks should be established so that every patient has access to specialist interventions, regardless of which hospital they present to and are initially managed in. Indications for when to refer a patient for discussion with a specialist tertiary centre and when a patient should be accepted for transfer, should be explicitly stated. Management in a specialist tertiary centre is necessary for patients with severe acute pancreatitis requiring radiological, endoscopic or surgical intervention. *(Medical Directors and Clinical Directors)*

For all early warning scores and as recommended by the Royal College of Physicians of London for NEWS - all acute hospitals should have local arrangements to ensure an agreed response to each trigger level including: the speed of response, a clear escalation policy to ensure that an appropriate response always occurs and is guaranteed 24/7; the seniority and clinical competencies of the responder; the appropriate settings for ongoing acute care; timely access to high dependency care, if required; and the frequency of subsequent clinical monitoring. *(Medical Directors and Clinical Directors)*

Antibiotic prophylaxis is not recommended in acute pancreatitis. All healthcare providers should ensure that antimicrobial policies are in place including prescription, review and the administration of antimicrobials as part of an antimicrobial stewardship process. These policies must be accessible, adhered to and frequently reviewed with training provided in their use. *(Medical Directors, Clinical Directors, Medical Microbiology Directors, Clinical Pharmacy Lead and All Clinicians)*