Introduction/Rationale

The aim and objectives of the audit is to compare alcohol-related liver disease admissions of outcomes and complications at University Hospital of Leicester NHS Trust since the introduction of daily in-reach Gastroenterology and out of hours GI bleed services, Liver and Medical High Dependency Units within the University Hospital of Leicester NHS Trust against the key recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2013 report.

Methodology/Data Source

Patients were identified from clinical coding on HISS. Altogether there were 90 patients identified to be suitable for auditing. These were patients admitted to UHL with a diagnosis of alcohol-related liver disease. There were 54 case notes examined between 1st July 2012 – October 2012 and 36 case notes examined between 1st July 2013 – October 2013 respectively. Health care records, laboratory, radiological and clinical management were data utilised in the clinical audit. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Data Collection Tool were used for data collection. Data analysis was carried out using MS Excel (NCEPOD) 2013 report.

Results (NCEPOD 2013 recommendations)

1. Time between admission to UHL and Liver ward transfer

Mean time = 9 days, Median time = 10 days

2. Advice sought from specialist Gastroenterology/Hepatology

- Consultant hepato-gastroenterologist (HGS) and HGS nurse consultant
- Consultant liver medicine
- Consultant intensive care medicine
- Consultant medical high dependency unit

3. In patients with decompenated ALD, blood culture included as initial investigations on admission to hospital

Patients were identified from clinical coding on HISS.

4. Ascites tap performed as initial assessment if ascites present. Coagulopathy is not a contra-indication

5. Liver screen performed as soon as possible after admission to hospital

6. Adequate alcohol history documentation on admission

7. Appropriate location where patient was first admitted into hospital according to Level 0, 1, 2 and 3

8. Appropriate triage and treatment plan for patients with alcohol-related liver disease who deteriorate acutely and whose background functional status is good. There should be close liaison between the medical and critical care teams when making escalation decision

9. In patients with decompensated alcohol-related liver disease and deteriorating renal function, diuretics should be stopped and intravenous fluid administered to improve renal function even if the patient has ascites and peripheral oedema

10. Deterioration in renal function in patients with liver disease should not be assumed to be due to HRS, as other potential indications are often present and should be actively excluded

11. Escalation of care should be actively pursued for patients with alcohol-related liver disease who deteriorate acutely and whose background functional status is good. There should be close liaison between the medical and critical care teams when making escalation decision

12. A decision not to escalate or to actively withdraw treatment for a patient with alcohol-related liver disease should be made by a Consultant with specialist training to identify what interventions are likely of benefit to the patient

Conclusions

Patients admitted with alcohol-related liver disease are a group of people who are difficult to help. But they are still entitled to be treated on their clinical merits and given the care that would bring benefits. The illness may be self-inflicted, like so many of the lifestyle diseases that bring patients to their doctors in modern society, and the prospects of a cure for many of these people may not have been propitious for some years. But the present concern about the quality of care delivered in our hospitals is as valid for them as it is for any other group of patients: no decent healthcare system should deliver care. But they are still entitled to be treated on their clinical merits and given the care that would bring benefits. The illness may be self-inflicted, like so many of the lifestyle diseases that bring patients to their doctors in modern society, and the prospects of a cure for many of these people may not have been propitious for some years. But the present concern about the quality of care delivered in our hospitals is as valid for them as it is for any other group of patients: no decent healthcare system should deliver care...