## NCEPOD self-assessment checklist

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| **#** | **Recommendations** | **Is it met? Y/N/Partially/Planned** | **Comments (Examples of good practice or deficiencies identified)** | **Action required** | **Timescale** | **Person responsible** |
| **1** | Hospital coders and clinicians should work more  closely together to ensure coding for acute pancreatitis is accurate. This will aid local quality improvement initiatives and national reporting while facilitating the commissioning of services according to the needs of patients. *(Hospital Coders, Professional Association of*  *Clinical Coders, Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **2** | Better management of co-morbidity in patients with acute pancreatitis is needed, especially through the involvement of the relevant specialists, as this represents an opportunity to improve overall outcomes. *(All Clinicians)* |  |  |  |  |  |
| **3** | All patients presenting to the Emergency Department with an acute illness, such as acute pancreatitis, should have physiological parameters recorded as part of their initial assessment. These measurements should form  part of an early warning score, such as the National Early Warning Score (NEWS). *(Emergency Medicine Doctors)* |  |  |  |  |  |
| **4** | An early warning score should be used in the emergency department and throughout the patient’s stay in hospital to aid recognition of deterioration. The score should be standardised within and across hospitals. Use of the National Early Warning Score (NEWS) would facilitate this  standardisation. *(Medical Directors and All Clinicians)* |  |  |  |  |  |
| **5** | 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)* |  |  |  |  |  |
| **6** | Acute Pancreatitis may require input from a number of different specialities. Therefore it should be managed by a multidisciplinary team, comprising all specialities needed to treat the condition as well as the underlying co-morbidities. *(Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **7** | 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)* |  |  |  |  |  |
| **8** | All patients admitted to hospital with acute pancreatitis should be assessed for their overall risk of malnutrition. This could be facilitated by using the Malnutrition Universal Screening Tool (MUST) and provides a basis for appropriate referral to a dietitian or a nutritional support team and subsequent timely and adequate nutrition support. *(Medical Directors, Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **9** | Gallstones should be excluded in all patients with acute pancreatitis including those thought to have an alcohol related acute pancreatitis, as gallstones are common in the general population. Abdominal ultrasound scanning is the minimum that should be performed. *(Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **10** | 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)* |  |  |  |  |  |
| **11** | As recommended by the British Society of Gastroenterology, ERCP services should work collaboratively in a regional or hub-and-spoke model, with simple and rapid referral pathways established. Through this method, facilities for urgent or emergency ERCP should be widely available. *(Clinical Directors and Endoscopy Leads)* |  |  |  |  |  |
| **12** | As previously supported and recommended by NCEPOD, each hospital should have a 7-day Alcohol Specialist Service, to provide comprehensive physical and mental assessments, ‘brief interventions’ and access to services prior to discharge. *(Medical Directors)* |  |  |  |  |  |
| **13** | All patients with suspected alcohol-related acute pancreatitis should be discussed with the hospital alcohol support service at every admission. Efforts to deal with this underlying cause of acute pancreatitis should equal those of gallstone acute pancreatitis. Future clinical guidelines on acute pancreatitis should incorporate this. *(Clinical Directors, All Clinicians, Specialist Associations, NICE, BSG, IAP, APA)* |  |  |  |  |  |
| **14** | 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)* |  |  |  |  |  |
| **15** | The 2012 IAP/APA guidelines provide recommendations concerning key aspects of medical and surgical management of acute pancreatitis based on the currently available evidence. These recommendations should serve  as a reference standard for current management of acute pancreatitis. *(Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **16** | Specialist tertiary centres for acute pancreatitis should be commissioned. A specialist tertiary centre is defined by the IAP as a high volume centre with intensive care facilities, daily access to radiological intervention, interventional endoscopy including EUS and ERCP and surgical expertise in managing necrotising pancreatitis. An example model to base this on from the English Department of Health could be the existing ‘Improving Outcomes Guidance’ compliant hepato-pancreato-biliary cancer units. *(Specialist Commissioners and Medical Directors)* |  |  |  |  |  |
| **17** | NCEPOD supports the IAP recommendation that after excluding the commoner causes of acute pancreatitis, those in whom the cause remains unknown should undergo MRCP and/or endoscopic ultrasonography to detect occult microlithiasis, neoplasms or chronic pancreatitis as well as rare morphologic abnormalities. A CT of the abdomen should also be considered. *(Clinical Directors and All Clinicians)* |  |  |  |  |  |
| **18** | All patient deaths should be discussed at morbidity and mortality meetings and learning should be shared through network meetings and their annual reports. Adequate time for structured assessment of deaths and complications should be provided by hospital Trusts/Boards. *(Medical Directors, Clinical Directors and All Clinicians)* |  |  |  |  |  |

NB: Personnel/organisations listed in italics are who NCEPOD thinks should act on the recommendation, but this is only a guide and not limited to these groups