Acute Limb Ischaemia – Info for Local Reporters

Introduction

Acute limb ischaemia (ALI) occurs due to a sudden blockage of blood flow to a limb, leading to a lack of oxygen and potential tissue necrosis. Historically, the most common cause was a blood clot from the heart in patients with atrial fibrillation (AF), but this has decreased with better management of AF. Now, local artery occlusion, often in previously diseased or treated arteries, is more prevalent. Other causes include clots from other sources, cancer, and medical interventions. ALI can also be linked to COVID-19 infection. It is distinct from chronic limb-threatening ischaemia (CLTI).

The precise incidence of ALI is difficult to pinpoint, due to the lack of precise coding for the condition but is suggested to be around 10 per 100,000. The incidence is likely to be higher than estimated and therefore a higher number of patients are potentially coming to harm.

ALI is a limb- and life- threatening emergency with catastrophic ramifications if treatment is delayed. The impacts of ALI on patients, their relatives and health care systems are significant. 10-15% of patients require major amputation and 26% of patients die within 30 days of presentation. Of those patients with amputation, the subsequent loss of function and associated disability often requires intensive therapy, social care and other support. A third of patients who are discharged require ongoing nursing care.

This study will review the care pathway of patients with acute limb ischaemia, looking at factors in the quality of care provided.

Overall aim

To explore current care pathways for patients with acute limb ischaemia; identify remediable clinical and organisational factors that can improve the delivery and quality of the required care.

Objectives

Organisational

To review:

1. Provision of services in “hub” and “spoke” hospitals and their relationship to other hospitals
2. Policies, guidelines, and care pathways relating to ALI
3. Staff availability to treat patients with ALI
4. Theatre/ interventional radiology access and priority for patient with ALI
5. Local capabilities and limitations
6. Learning and network sharing.

Clinical

To identify and examine remediable factors in a cohort of patients with ALI

To explore/map the pathway from admission to discharge (including death)

To review:

1. Pre-hospital care (GP, 111, vascular nurse or other, outpatients), including the referral process, the role of primary care and any delays in presentation
2. Initial emergency department/ hospital assessment, including delays and assessment of risk, causation, and co-morbidity
3. Decision making process: Investigations undertaken and multidisciplinary team involvement
4. Timeliness and documentation of the transfer process
5. Pharmacological/non-pharmacological management including analgesia
6. Quality of peri-operative care
7. The timeliness of any intervention or surgery
8. Quality of the initial treatment provided
9. Management of complications and/or ongoing ischaemia and any further interventions/surgery
10. Discharge planning/follow-up and management of long-term risk factor for recurrent
11. Outcomes from any intervention and/or surgery (including avoidable outcomes)
12. Communication with patients and their families.

Participating hospitals

All acute hospital providers in England, Wales, Northern Ireland and Jersey where patients with ALI might be admitted will be expected to participate in the study.

Method of data collection

Identifying patient population

We will identify a sample of patients who were admitted with ALI to a Vascular Arterial Hub hospital and track them back through their pathway of care.

A spreadsheet will be disseminated to our Local Reporters to populate with basic details about patients who fit the criteria to participate in the study.

Unfortunately, there is currently no specific ICD10 code for ALI to reliably separate it from chronic limb ischaemia. Our scoping work has shown that a set of surrogate codes will identify a sample of patients, in which around one third have ALI. We will therefore need a Local Study Contact to filter through the list of patients initially identified and confirm whether the patient had ALI, and for patients transferred from another hospital, the hospital where they were transferred from.

A maximum of 10 patients will be selected at each vascular specialist hospital to be in the study.

Clinician questionnaire - hospital

Questionnaires will be uploaded to our online system, which Local Reporters can assign to the named vascular surgeon responsible for the patients' care when they were admitted to hospital. Instructions will be provided to pass the questionnaire on to most appropriate clinician (should it not be the named person).

Case note Review – Vascular arterial hub/ spoke hospitals

Case notes will be requested from the Vascular arterial hub hospital for the whole episode as well as from the referring "spoke" hospital for patients who were transferred. Notes requested will include: admission details, emergency department notes investigations, prescription/ drug chart, details of any procedures including operation notes, clinical annotations, nursing notes, discharge summary and correspondence. These will be anonymised and reviewed at meetings of the case reviewer panel where a multidisciplinary, multispecialty group of reviewers will assess the notes and complete the Reviewer Assessment form, which captures their views on the quality of care provided, this group will include vascular surgeons, interventional radiologists, nurses, pharmacists, anaesthetists and emergency medicine physicians and intensive care clinicians.

Clinician questionnaire – primary care

We will also be disseminating questionnaires to the primary care clinician for each patient in the case review, where the patient is identified as having been referred for admission by the GP. NB: Local Reporters will not be required to assign / oversee the completion of these questionnaires

Hospital organisational questionnaire

The questionnaires will collect data on the service provided to patients with acute limb ischaemia. Separate questionnaires for arterial "hub" hospitals and non-specialist "spoke" hospitals will be disseminated via the online questionnaire system and Local Reporters will be able to invite multiple clinicians to complete the questionnaire.

National data opt out: From the 1st August 2022, organisations in England need to comply with the national data opt-out. If you are returning a spreadsheet to NCEPOD after this date, prior to returning the data to us, please check the listed patient NHS numbers against the National spine and remove the details of any patients who have opted out.

PLEASE NOTE, BECAUSE OF GDPR REGULATIONS, WE ARE NO LONGER ABLE TO COLLECT CLINICIAN DETAILS WITHOUT CONSENT. WHEN ENTERING CLINICAL TEAM DETAILS PLEASE DO NOT ENTER CLINICIAN NAMES – PLEASE ONLY USE THE NAME/SPECIALTY OF THE TEAM OR A CLINICIAN CODE (THIS CAN BE A PAS CODE OR ANY OTHER THAT WOULD HELP YOU IDENTIFY THE CLINICIAN AND ALLOW US TO SELECT CASES ACROSS A RANGE OF CLINICIANS).

We would be grateful if you could return the completed password protected patient identifier spreadsheet to ncepod@nhs.net by **11th October 2024**. Please then phone the office with the password to open the spreadsheet on 0207 251 9060.

Further information about the study and the protocol, including frequently asked questions, can be found on our website: https://www.ncepod.org.uk/ali.html or please contact the office on 0207 251 9060 or by email to ali@ncepod.org.uk.