Welcome to the 3rd Society for Acute Medicine Webinar

Wednesday 3 June 2020

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How to ask a question

Select the Q&A option from the webinar menu found at the bottom of your zoom window

Type your question here

Press send to submit your question

Your submitted questions will appear here

Use this check box to ask a question anonymously

- Your questions will be answered live by the panellists during the Q&A sections of each presentation
- You can comment on other questions by selecting the comment button
- You can upvote questions using the thumbs up icon
But first, we’d like you to complete a few questions..

Select your responses

Press the submit button to complete the survey
Presentation 1
Tom Knight

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INSIGHTS FROM ICNARC AND ISARIC

Observational data for front door decision makers

Dr Tom Knight
Clinical Research Fellow
Sandwell and West Birmingham NHS Trust
University of Birmingham
CONTENTS

• ISARIC/ICNARC
  • Who they are and what they are about
  • Most recent reports
• What does it mean for acute medicine?
• Local data from SWBH
• Shaping the research agenda
• Network of researchers across 110 countries
• Established 2011
• Platform for data-collection in outbreak prone infections
• Primed infrastructure
• Focus on clinical characterisation and natural history of disease
• Proven or high likelihood of SARS-CoV-2 infection
• Aggregated weekly data
1) Lots of compatible symptoms

2) Typically not in isolation
- In hospital mortality at least 26%
- ICU/HDU admission rate 17.7% (ICU mortality 32%)
- High flow oxygen 55%
- No major co-morbidity 22.5%
- Commonly associated comorbidity
  - Chronic cardiac disease 30.9%
  - Uncomplicated T2DM 20.7%
  - COPD 17.7%
SUMMARY OF ICNARC DATA COLLECTION

Data collection point 1
Demographic characteristics

Data collection point 2
Summary of physiology

Data collection point 3
Summary of admission

Data collection point 4
Outcome
• Case Mix Programme (Excludes ICUs in Scotland)
• 289 units
• 12,086 admissions (28 May 2020) (9347 individual patients)
• Confirmed COVID-19
• Outcomes reported 8062
• Comparisons
  • non-COVID viral pneumonia
  • census data 2011
• ICU mortality 43.2% (n = 3483)
• Median age 60
• Median LOS survivors 11 days (IQR 4 - 22)
• 72.7% received advanced respiratory support
• Median duration 12 days
• Evidence of inequality
Disparities in the risk and outcomes of COVID-19

Protecting and improving the nation’s health
SUMMARY OF ICNARC AND ISARIC

DO WE NEED MORE

- **ISARIC** -> case definition and symptomatology
- **ICNARC** -> severe disease and organ support
- Not conceived with front door decision making in mind
- Unsurprisingly not optimised for this purpose
- Analysis restricted to confirmed patients
  - Risk stratification and prognostication
  - Tailor interventions
  - Identify efficiencies in the process of care
Risk stratification: Severity assessment vs prognostication

A New Predictor of Disease Severity in Patients with COVID-19 in Wuhan, China

Ying Zhou, Zhen Yang, Yanan Guo, Shuang Geng, Shan Gao, Shenglan Ye, Yi Hu, Yafei Wang
doi: https://doi.org/10.1101/2020.03.24.20042119
COVADA
COronaVirus AuDit and Analysis

- Service evaluation at SWBH
- >1500 patients included thus far
- Inclusive of all patients assessed on the COVID care pathway
- Patients discharged from the ED
- Similar in design to SAMBA
- Evaluate process of care
- 7 day outcomes
Mortality PCR and CXRs

Likelihood of COVID19
- PCR positive (P)
- CXR Probable (C)
- CXR Indeterminate (I)

n = 212
COVID NEWS2 and 7 day mortality

![Graph showing the relationship between NEWS2 and 7 day mortality, with bars representing different NEWS2 values and error bars for the proportion of mortality. The graph includes a legend indicating 'SARSCoV-2 PCR', 'Negative', and 'Positive'.]
Acute admissions from institutional care

- 125 admissions from institutional care
- Median age 82 (IQR 69-95)
- Median CFS 7 (IQR 6-8)
- PCR +ve 68.5%
- 7 day mortality 33.9%
  - +ve 39.8%
  - -ve 24.3%
SUMMARY

- OBSERVATIONAL DATA IS KEY UNDERSTANDING DISEASE
- FIRST PHASE CASE DEFINITION AND OUTCOME
- RISK STRATIFICATION
- TARGETING TREATMENTS
- LONGTERM SEQUALAE
- ACUTE MEDICINE MUST INFORM THE RESEARCH AGENDA
- SAMBA?
Thanks for listening:

- Special thanks
- Dr Sarb Clare (SWBH)
- Professor Dan Lasserson (SWBH)
- The SAM team for inviting me
Presentation 2
Harry Willis

www.acutemedicine.org.uk
Multidisciplinary In-Situ Medical Emergency Simulation in the AMU

Dr Harry Willis
AMU, University Hospitals Birmingham
harry.willis@uhb.nhs.uk

Co-authors:
H Hegarty, C Pascoe, A Westley, R Campbell, B Riley, G Packer
Introduction

- Staff in AMUs must be skilled in managing medical emergencies\(^1\)

- **Adverse events** revealed poor processes and performance

- In-situ simulation:
  - improves **technical and non-technical skills**\(^2\)
  - and reveals **latent errors** in healthcare systems\(^3\)
Methods

• A preliminary survey established demand for multi-disciplinary emergency training

• Three unannounced high-fidelity simulations were run, and systemic issues identified

• Feedback was used to develop a weekly programme of formative in-situ simulation training
Results

• Common themes raised in the preliminary survey (n=59) included:
  • A sense of “panic”
  • Weak team leadership
  • Poor role allocation
  • Unfamiliarity with local equipment
  • Minimal opportunities for multi-disciplinary training

• The unannounced scenarios (27 participants) highlighted:
  • Unavailability of, and lack of familiarity with, critical equipment
  • Poor inter-personal team working
  • Low levels of staff confidence
Results

• Although received positively, unannounced scenarios disrupted clinical work and limit constructive feedback or coaching.

• Following the unannounced scenarios, a formative training programme was developed.

• Formative sessions were associated with increased self-reported confidence in emergencies management.

• Systemic issues have been escalated or addressed locally.
Discussion

• In-situ simulation is a versatile tool in departmental training and risk management

• Unannounced simulations are effective at identifying latent errors in healthcare systems, but are perceived as irritants and can struggle with staff buy-in

• Voluntary sessions increase self-reported confidence, but do not provide objective evidence of improved team performance

• Collateral benefits observed from simulation exposure:
  • Debriefing following emergencies is now commonplace
  • Reporting of perceived systems issues has increased
References


Multidisciplinary In-Situ Medical Emergency Simulation in the AMU

Dr Harry Willis
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Co-authors:
H Hegarty, C Pascoe, A Westley, R Campbell, B Riley, G Packer
Presentation 3
Kelham Slinger

www.acutemedicine.org.uk
AMU Socially DistancEd

Presented by:
Dr Kelham Slinger, AIM Registrar & Wessex Medical Education Fellow
University Hospitals Southampton NHS Foundation Trust
kelham.slinger@gmail.com

@Slinger2904
Why?

• Covid-19 pandemic prompting cancellation of educational programs
• Enthusiasm for teaching & learning

Two key features:
• Accommodate social distancing
• Maintain workforce presence
What?

- Educational display plus WhatsApp group discussion
- Weekly rota
- Weekly online feedback
Evidence?

- Constructivist social learning theory¹
- Near-peer learning²³
- Flattened hierarchy⁴
- Self-directed study and adult learning theory⁵
- Prospective continuous evaluation⁶

For those that aren’t... here it is.

As you suggest a score >6 should heighten your suspicion for nec fasciitis.

What do you all think about that?

I haven’t heard of it before, but it looks like it’s a marker of general illness severity, rather than anything specific, which makes sense.

It’s interesting that the MDCalc link tells you not to even calculate LRINEC if you’re clinically suspicious, but to get on.

CRP (mg/L)

0.8

WBC (x10^9/L)

12.5

Hb (g/dL)

13.6

Hematocrit

42.1

Albumin (g/L)

31.0

Creatinine

0.9

Calcium

2.2

For this patient, the CRP is elevated and the WBC is also increased, which suggests inflammation. The Hb and hematocrit are within normal limits, indicating no anemia. The albumin and creatinine are also within normal ranges, with the creatinine being slightly elevated. The calcium level is slightly decreased, which might be a concern.

It’s important to consider the clinical picture alongside these laboratory results.
Initial conclusions...

- Engaging displays
- Competitive
- Formal feedback for juniors
- WhatsApp discussion successful...kind of
- Survey fatigue
- Incorrect information
- Sustainability
Next...

- Sharing of practice
- Consider sustainability
- Address survey fatigue
- Improving materials
- Formal peer review?
Presentation 4
Noamaan Wilson-Baig

www.acutemedicine.org.uk
Conscious Proning during COVID 19

Presented by:

Noamaan Wilson-Baig, ST6 Academic Trainee in Anaesthesia
Wythenshawe Hospital, Manchester Hospitals Foundation Trust
Conscious Proning - itinerary

• Background
• Physiology and Rationale
• Evidence to date
• ICS Guidelines
• North West Audit (CoPro-COVID)
• Summary
• References
Background – Brief pathophysiology

ARDS traditional model

Insult

- Increased permeability

- Amplified forces

- Increased strain

- Reduced ventilatable lung

- Lung oedema

- Increased lung weight

- Lung collapse (atelectasis)
ARDS COVID19

Hypoxaemia

**L-Phenotype**
- Dysregulation of pulmonary perfusion – Atypical ARDS
- Low elastance
- Low V/Q
- Low recruitability
- Low PEEP response
- Pulmonary microthrombosis

**H-Phenotype**
- Pulmonary oedema – Typical ARDS
- High lung elastance
- Higher recruitability
- High R → L shunt/Deadspace
- Higher PEEP response

Background - COVID19 v Non-COVID mortality

<table>
<thead>
<tr>
<th></th>
<th>Basic Respiratory Support</th>
<th>Advanced Respiratory Support</th>
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<tbody>
<tr>
<td><strong>COVID 19 pneumonia</strong></td>
<td>20%</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Non-COVID pneumonia</strong></td>
<td>11%</td>
<td>34%</td>
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</tbody>
</table>

Physiology of proning

Benefit and rationale for proning

• Recruitment of collapsed alveoli in the posterior lung

• Improved secretion clearance

• Improved ventilation perfusion
Evidence for proning- PROSEVA⁴

• PROSEVA⁴
  • Primary outcome: all cause mortality at 28-days
  • 16% in prone vs. 32.8% in supine (P<0.001)
    • adjusted odds ratio 0.42 (0.26-0.66)
• Bottom Line - Proning in severe ARDS reduces mortality without an increase in adverse outcomes

Limited Evidence Base for Conscious Proning

• Scaravilli V et al 2015\(^5\)
  • Prone positioning improves oxygenation in spontaneous breathing non-intubated patients with hypoxemic acute respiratory failure: A retrospective study

• Ding et al 2020\(^6\)
  • Efficacy and safety of early prone positioning combined with HFNC or NIV in moderate to severe ARDS: a multi-center prospective cohort study

• Sun et al 2020\(^7\)
  • Lower mortality of COVID-19 by early recognition and intervention: experience from Jiangsu Province

• Caputo et al 2020\(^8\)
  • Early self-proning in awake, non-intubated patients in the emergency department: A single ED’s experience during the COVID-19 pandemic
ICS guidelines\textsuperscript{9,10}

Table 1 - Timed position changes for patients undergoing conscious proning process

Timed Position Changes:
If patient fulfills criteria for proning ask the patient to switch positions as follows. Monitor oxygen saturations 15 minutes after each position change to ensure oxygen saturation has not decreased. Continue to monitor oxygen saturations as per the National Early Warning Score (NEWS)

- 30 minutes to 2 hours lying fully prone (bed flat)
- 30 minutes to 2 hours lying on right side (bed flat)
- 30 minutes to 2 hours sitting up (30-60 degrees) by adjusting head of the bed
- 30 minutes to 2 hours lying on left side (bed flat)
- 30 minutes to 2 hours lying prone again
- Continue to repeat the cycle......
Audit – North West, CoPro-COVID

• Prospective audit examining the effect of conscious proning in patients admitted with respiratory deterioration due to COVID19

• Outcomes
  • The primary outcome is the rate of avoidance for intubation.
  • Secondary outcome measure is the reduction in basic respiratory support and FiO2 required
  • Safety outcomes for conscious proning is the time duration (tolerance) for each proning position session.

• Currently ongoing – 70 patients recruited so far

• Another study – ProCov11
  • Prone Positioning in Spontaneously Breathing Non-intubated Covid-19 Patient: a Pilot Study (ProCov)
Summary

• Proning is already established in critical care – ARDS
• Rationale and physiology – relevant to non-intubated patients
• Early evidence – improves oxygenation
  • Uncertain about sustainability when supine
• Further studies needed
• Beyond COVID
Acknowledgements

• I would like to thank Dr Andrew Bentley, Consultant Intensivist and Respiratory Physician, Wythenshawe Hospital, for kindly reviewing the slides for this presentation.

• I would like to thank the North West Research and Audit Group (NWRAG), and the Intensive Care Society, Dr Andrew Bentley, Dr Andrew Martin, Dr Kamal Berechid, Dr Darren Green, Dr Shond Laha, Jane Dean, Dr Peter Bamford, Dr David Whitmore
References


10. Proning the Conscious Patient https://www.youtube.com/watch?v=IhYsVc78UME

Presentation 5
Alpha Madu

www.acutemedicine.org.uk
Education and Training as Key Drivers for Improving Fluid Balance Monitoring and Documentation: findings from a Quality Improvement Project

Presented by:
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Kettering General Hospital NHS Foundation Trust
alpha.madu@nhs.net

Co-authored by:
Harshini Asogan, Ajmal Raoof
• Rationale: inadequately and poorly filled fluid balance charts, making interpretation difficult and affecting clinical practice and patient safety

• Aims and objectives:
  • To assess how accurately and completely fluid balance charts are recorded in the hospital.
  • To assess if health care staff are properly trained in recording fluid balance charts
  • To assess if health care staff face any challenges in completing fluid balance charts
  • To make recommendations where necessary, for improved clinical practice in fluid balance monitoring in the hospital.
Methodology: Simultaneous PDSA Cycles

- Data tools
- Data collection
- Interventions
### Data Collection

<table>
<thead>
<tr>
<th><strong>Accuracy</strong></th>
<th><strong>Completeness</strong></th>
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</table>
|  - Are measurements accurate?  
  - Summed up correctly?  
  - Totaled for the day?  |  - Fluid monitoring prescribed?  
  - Time of entry?  
  - All input and output recorded?  
  - Legible?  |
Results

Challenges reported by health staff (Nurses and HCAs)

• Over-use of fluid balance charts
• Poor staff training
• Poor communication among health staff
• Difficulty in tracking intake and output of ambulatory independent patients
Strategy

• PDSA Cycle 1: Over-use of fluid balance charts: We discussed with the doctors to indicate which patients needed fluid monitoring.

• PDSA Cycle 2: Training and Education: We held one-on-one training sessions with healthcare staff on proper documentation and distributed posters and handbills in the ward.

• PDSA Cycle 3: We ensured weighing scales were provided in the wards to estimate the quantity of urine in wet incontinence pads.

• PDSA Cycle 4: We advised that ambulatory patients be asked to record their own intakes and outputs.
HOW TO PROPERLY COMPLETE A FLUID BALANCE (FLUID MONITORING) CHART

- Ensure fluid monitoring has been requested by the doctor. Do not routinely start a fluid chart for all patients unless this has been requested. If unsure, ask the Doctor or Nurse-in-charge.

- Record clearly. USING ONLY FIGURES, on the fluid balance chart. Do not record entries such as 'wet pad', 'pu'd', 'pu'd-in-toilet' in the chart.

- For patients wearing a pull-up, estimate the quantity of urine in a wet pull-up by weighing it. 1g = 1ml

- For patient's on catheter, record the quantity of urine whenever the bag is emptied.

- For ambulatory patients, offer them a container to pass urine. Estimate the quantity of urine in the container by weighing it, before discarding.

- Estimate quantity of fluid in oral intakes (water, juice, tea, coffee etc) and record it.

- Add up the inputs and outputs using a calculator. At the end of the day calculate the sum total and the difference between the input and output.

### Daily Fluid Record

<table>
<thead>
<tr>
<th>Time</th>
<th>INPUT (ml)</th>
<th>OUTPUT (ml)</th>
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<td>IV</td>
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**Total Intake**

**Total Output**

**Balance +ve or -ve**

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<tr>
<th>Practitioner Name</th>
<th>Practitioner Signature</th>
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If on IV Fluids / Medications consider use of an electronic device.
RESULTS

- Accurately measured?
- Correctly summed up?
- Daily totals and balances correctly recorded?
- Clinically indicated/prescribed?
- Entry times indicated?
- All intakes and losses recorded?
- Legibility

Pre-Intervention
Post-intervention 1
Post-intervention 2
Presentation 6
Zeeshan Javaid

www.acutemedicine.org.uk
HIV INFECTION MASQUERADING AS CONNECTIVE TISSUE DISEASE

Presented by:
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Co- authored by:
Babitha Mekkayil, Anupam Paul
Case history

- 56 years old female, house-keeper
- Gradual onset of erythematous reticular rash on lower limbs started 6 months ago
- Chronic intermittent symptoms of recurrent oral ulcers, dry mouth and eyes, paraesthesias in both feet, arthralgias and low mood over the past one year
- No systemic or inflammatory joint symptoms
- Non-smoker and Non-alcoholic
- Single at the time of presentation with 3 children
- Independent with day to day activities
- No family history of cancer, rheumatic or connective tissue diseases
Examination

• Weight 58.5 and BMI of 22
• BP 146/73 mm Hg
• Livedo reticularis rash on both legs upto knees and on both elbows
• Nodal osteoarthritis both hands
• No peripheral joint synovitis
• Rest of cardiovascular, respiratory, abdominal and neurological examination unremarkable
• Urine dipstick showed a trace of leucocytes, positive nitrates, positive trace for protein and blood +++ (MSU- E.coli for which she was treated)
Investigations

- Mild Anemia (Hb 113), Lymphopenia (1.3), Thrombocytopenia (Platelets 123)
- Positive Direct Antiglobulin test and Increased Serum Haptoglobin
- Normal Iron studies, Vitamin B12, Folate,
- ESR of 77, CRP < 5
- Hypergammaglobulinemia, Serum Protein Electrophoresis showed Polyclonal pattern
- Urine Protein Creatinine Ratio raised at 28.3 (Normal <20)
- Low C4 (0.13)
- ENA (Autoimmune) screen Positive with Positive ANA (initially 1:160, later came up to 1:320 on subsequent visit), Positive anti-RNP antibody and Equivocal anti-SM antibody
- Schirmer’s Test was Positive
- NCS showed mild axonal sensory motor neuropathy with absent or reduced amplitude
- Normal Electrolytes, Bone chemistry, Glucose, Urate, CK, Renal and Liver function
- Imaging including Chest X-Ray and Echo were unremarkable
Impression, Initial Management Plan and Clinical Outcome

• Likely diagnosis of Mixed Connective Tissue disease. (SLE-like clinical features and haematological abnormalities, Strongly Positive ANA, Positive anti-RNP and equivocal anti-SM antibodies, though no features of Myositis or Scleroderma)

• Hydroxychloroquine commenced but she stopped it shortly after she developed floaters in her left eye.

• DepoMedrone (Methylprednisolone) injection given

❖ 4 months later, No improvement in her symptoms after getting DepoMedrone injection.

❖ Further 3 months later, Progressive worsening of discomfort in her feet with burning and tingling, significant fatigue and being tearful. Neurologist reviewed and suggested she had Peripheral Neuropathy. Occupational therapist referral done for fatigue management.

❖ 7 months later, Repeat bloods showed Anemia at 111, ESR of 112, CRP < 5, eGFR reduced to 49 with Creatinine of 108, ALP of 425 and ALT normal. Urine dipstick done showed a trace of leucocytes, positive nitrates, positive trace for protein and blood +++.
Clinical deterioration, Further Work-up and Final Outcome

- **Further 3 months later**, She developed symptoms of weight-loss (almost 11 kg in 10 months), intermittent loose stools and abdominal pain for which she was referred to Gastroenterologist
- OGD showed candida esophagitis, gastric and duodenal ulcer
- **Further 2 months later** she was admitted to the hospital due to pyrexia, worsening lethargy, poor appetite and weight loss. She was found to be Pancytopenic and was treated for Neutropenic Sepsis
- CT Thorax, Abdomen & Pelvis showed mesenteric lymphadenopathy and multiple hyperdense liver lesions.
- Further Work-up done, Liver Biopsy showed anaplastic large cell lymphoma
- HIV test Positive and CD4 count measured was 9.
- Diagnosed with advanced HIV disease, continued to deteriorate with neutropenic sepsis, developed multi-organ failure and unfortunately passed away during the same admission
Conclusion

• Human immunodeficiency virus (HIV) infection shares many clinical manifestations with connective tissue diseases, including musculoskeletal symptoms such as myalgia, arthralgia/arthritis, skin rashes, lymphadenopathy and organ involvement, such as kidneys, heart, lungs and central nervous system. They also have several common laboratory findings such as anemia, leukopenia, lymphopenia, thrombocytopenia and hypergammaglobulinemia.

• Autoantibodies may be falsely positive in infections e.g. HIV and in malignancy
Learning Points

• Risk factors of HIV infection should be considered during assessment of multisystem diseases like connective tissue diseases particularly prior to immunosuppression.

• Viral screening including HIV test should be considered in all high risk patients and particularly if the symptoms are atypical and do not quite fit well with the diagnosis of connective tissue disease

References

1. BSR and BHPR guideline for the prescription and monitoring of non-biologic disease-modifying anti-rheumatic drugs
2. The British Society for Rheumatology biologic DMARD safety guidelines in inflammatory arthritis
Presentation 7
Allan Xu

www.acutemedicine.org.uk
Improving the Quality of Post Take Ward Round Documentation in the Care of the Older People’s Service

Presented by:
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allan.xu@nhs.net

Co- authored by:
Dr. Li Yuan Chan, Dr. Mohammed Abedin, Dr. Dhanupriya Sivapathasuntharam
Importance of the ‘Post-Take Ward Round’ (PTWR)

• Post-Take Ward Round often first time senior clinician reviews the patient
• Requires high quality documentation of clinical findings and decisions
  - Especially important in older patients with multiple co-morbidities and complex social histories
  - Escalation plans and DNAR status must be carefully documented
• Despite this there is currently no guidance from any Royal College or governing body regarding Post-Take Ward Round Documentation
  - Royal College of Physicians offers guidance on generic ward round documentation
Aims of our Quality Improvement Project

• To assess the quality of documentation in the PTWR
• To standardise the content documented in the PTWR through the development of a PTWR Proforma
• To encourage the initiation of the ‘Comprehensive Geriatric Assessment’
• To improve patient safety and continuity of care
Methodology

• Consultant Geriatricians at our hospital agreed in consensus upon ‘key information’ that should be documented during the PTWR

• PTWR documentation from Monday and Saturday of every week from one month was audited to assess how much ‘key information’ was documented
  - Ensured a variety of consultants’ and juniors’ documentation was sampled
  - To identify any differences between weekday and weekend documentation

• Quality Improvement: A PTWR Proforma was then implemented to improve documentation of ‘key information’
Audit Cycle 1 Findings

- **Total Number of Patients**: 78
  - Median age: 83
  - Male 49%, Female 51%

- **Number of Consultants**: 8

- **Key Findings**:
  - Only 42.3% of patients had escalation plan/status documented
  - Not all PTWR documentation had a named consultant
PTWR Proforma

BDDly Care Consultant Post-Take Ward Round

Name of Consultant:

Presenting Complaint:

Background:
(qualifying data from CFR)

ROCMACOOD CLINICAL REALITY SCORE:
Living situation – own home/sheltered living care home/nursing home
Package of Care? – Y/N
Next of kin –

History:

On Examination:

RR –
SpO2 –
BP –
HR –
Temp –
NEWS Score:

Investigations
Recent Imaging:
Bloods:
ECGs:
Urine:

Comprehensive Geriatric Assessment:
Falls –
Vision –
Hearing –
Nutrition –
Bone Protection –
Continence –
Dementia & Delirium –
Mood –
Medication Review:
CGA Bloods Done? (B12/folate/Vitamin D/TFTs) – Y/N

Patient Safety:
Allergies:
(qualifying data from CFR)
VTE prophylaxis prescribed? Y/N
Lines –
Urinary catheter –
Oxygen prescribed? Y/N
Pressure care (Waterlow score):

Working Diagnosis:

Calling of Care:

Plan:

1)

<name + bleed>
Audit Cycle 2 Findings

- **Total Number of Patients:** 46
  - Median age: 85
  - Male 48%, Female 52%

- **Number of Consultants:** 8

- **Key Improvements:**
  - Named Consultant 91.0% -> 100%
  - Escalation Plan 42.3% -> 84.8%
  - Working diagnosis 70.5% -> 91.3%
Conclusions and next steps

• A Proforma can aid in improving the quality of documentation during the PTWR
  - prompts for information
  - easy to fill in values

• **Next Steps**: Assessing impact on length of stay and patient outcomes
Thank you! Join us again…

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Time – all BST</th>
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| 10 June 2020  | ACP Acute Medical Curriculum  
                COVID-19 in Acute Medicine: Clinical Update | 1900-2100hrs     |
| 17 June 2020  | COVID-19 in Acute Medicine: Implications for Acute Oncology  
                Using Apps in Acute Oncology to Facilitate Early Discharge in Patients | 1900-2100hrs     |

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