NICE National Institute for Health and Care Excellence

NICE quality standard

Acute upper gastrointestinal bleeding in adults

Quality standard

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This standard is based on CG141.

This standard should be read in conjunction with QS11, QS15, QS96, QS112 and QS152.

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Quality statement 1: Risk assessment

Quality statement

People with acute upper gastrointestinal bleeding receive a risk assessment using a validated risk score.

Rationale

The prognosis for people with acute upper gastrointestinal bleeding can vary so it is important to carry out a risk assessment using a validated risk score. This can inform the best course of further treatment, and in some instances can identify people for whom early discharge or outpatient endoscopy are appropriate.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with acute upper gastrointestinal bleeding receive a risk assessment using a validated risk score.

Data source: Local data collection.

Process

Proportion of people with acute upper gastrointestinal bleeding who receive a risk assessment using a validated risk score.

Numerator – the number of people in the denominator who receive a risk assessment using a validated risk score.

Denominator – the number of people with acute upper gastrointestinal bleeding.

Data source: Local data collection. The British Society of Gastroenterology's UK comparative audit of upper gastrointestinal bleeding and the use of blood (2007) asks, 'Does your hospital routinely calculate and document a risk score (for example, Rockall or Blatchford scores) for patients with suspected upper GI bleeding?'

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with acute upper gastrointestinal bleeding to receive a risk assessment using a validated risk score.

Healthcare practitioners give people with acute upper gastrointestinal bleeding a risk assessment using a validated risk score.

Commissioners ensure that they commission services that give people with acute upper gastrointestinal bleeding a risk assessment using a validated risk score.

People with acute upper gastrointestinal bleeding have an assessment of their risk of more bleeding or complications, using an accepted scoring system.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendations 1.1.1 (key priority for implementation) and 1.1.2

Definitions of terms used in this quality statement

Risk assessment

NICE's guideline on acute upper gastrointestinal bleeding suggests the following approach for risk assessment:

Use the following formal risk assessment scores for all patients with acute upper gastrointestinal bleeding:

- the Blatchford score at first assessment, and
- the full Rockall score after endoscopy.

Consider early discharge for patients with a pre-endoscopy Blatchford score of 0.

[NICE's guideline on acute upper gastrointestinal bleeding, recommendations 1.1.1 and 1.1.2]

Quality statement 2: Immediate endoscopy for people who are haemodynamically unstable

Quality statement

People with severe acute upper gastrointestinal bleeding who are haemodynamically unstable are given an endoscopy within 2 hours of optimal resuscitation.

Rationale

In most cases, endoscopy diagnoses the cause of bleeding, provides information about the likely prognosis and facilitates delivery of a range of haemostatic therapies. People who are haemodynamically unstable should be given an endoscopy within 2 hours of optimal resuscitation because their condition means they need urgent investigation and treatment.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable are given an endoscopy within 2 hours of optimal resuscitation.

Data source: Local data collection.

Process

Proportion of people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable who receive endoscopy within 2 hours of optimal resuscitation.

Numerator – the number of people in the denominator who receive endoscopy within 2 hours of optimal resuscitation.

Denominator – the number of people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable to be given an endoscopy within 2 hours of optimal resuscitation.

Healthcare practitioners perform an endoscopy within 2 hours of optimal resuscitation in people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable.

Commissioners ensure that they commission services that give an endoscopy within 2 hours of optimal resuscitation to people with severe acute upper gastrointestinal bleeding who are haemodynamically unstable.

People withsevereacuteuppergastrointestinalbleedingwhoseblood pressure and/or pulse isunstable are given an endoscopy (a procedure using a narrow, flexible tube that is swallowed and has a very small camera at its tip) within 2 hours of being resuscitated.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.3.1 (key priority for implementation)

Definitions of terms used in this quality statement

Within 2 hours

The 2-hour timeframe was derived from expert consensus.

[Expert opinion]

Haemodynamically unstable

People who are haemodynamically unstable are those with active bleeding whose blood pressure or pulse cannot be normalised or who need rapid intravenous fluids to maintain haemodynamic stability.

Endoscopy is associated with complications. These are uncommon when it is used for diagnosis in relatively fit people, but are relatively common in people who are actively bleeding, and may be life threatening in people with comorbidities whose condition is unstable.

NICE's full guideline on acute upper gastrointestinal bleeding states that, whenever possible, endoscopy should not be undertaken until cardiovascular stability is achieved. However, it is recognised that for people who are haemodynamically unstable it will not be possible to achieve full resuscitation, therefore attempts should be made to optimally resuscitate before endoscopy to minimise the risk of complications. The risks of endoscopy for people whose condition is unstable should be balanced against the risks of delaying endoscopy.

Clinical judgement should be used to determine whether people who are haemodynamically unstable have achieved their optimal level of resuscitation.

Quality statement 3: Endoscopy within 24 hours for people who are haemodynamically stable

Quality statement

People admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable are given an endoscopy within 24 hours of admission.

Rationale

In most cases, endoscopy diagnoses the cause of bleeding, provides information about the likely prognosis and facilitates delivery of a range of haemostatic therapies. People admitted to hospital who are haemodynamically stable should be given an endoscopy within 24 hours of admission. This will help to avoid re-bleeding, and can reduce the length of their hospital stay.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable are given an endoscopy within 24 hours of admission.

Data source: Local data collection.

Process

Proportion of people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable who receive endoscopy within 24 hours of admission.

Numerator – the number of people in the denominator who receive endoscopy within 24 hours of admission.

Denominator – the number of people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable.

Data source: Local data collection.

Outcome

Length of hospital stay for people with acute upper gastrointestinal bleeding who are haemodynamically stable.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people admitted to hospital with acute upper gastrointestinal bleeding who are haemodynamically stable to be given an endoscopy within 24 hours of admission.

Healthcare practitioners perform endoscopy within 24 hours of hospital admission in people with acute upper gastrointestinal bleeding who are haemodynamically stable.

Commissioners ensure that they commission services that give an endoscopy within 24 hours of hospital admission to people with acute upper gastrointestinal bleeding who are haemodynamically stable.

People withacuteuppergastrointestinalbleedingwhose blood pressure and pulse are stable and who are admitted to hospital are given an endoscopy (a procedure using a narrow, flexible tube that is swallowed and has a very small camera at its tip) within

24 hours of admission.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.3.2 (key priority for implementation)

Definitions of terms used in this quality statement

Haemodynamically stable

People who are haemodynamically stable have stabilised blood pressure and pulse.

Quality statement 4: Endoscopic treatment for non-variceal bleeding

Quality statement

People with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage are offered endoscopic treatments (combination or a mechanical method).

Rationale

Endoscopic treatment of non-variceal acute upper gastrointestinal bleeding can control active bleeding, reduce the rate of re-bleeding and the need for blood transfusion.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage are offered endoscopic treatments (combination or a mechanical method).

Data source: Local data collection.

Process

Proportion of people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage who receive endoscopic treatments (combination or a mechanical method).

Numerator – the number of people in the denominator who receive endoscopic treatments

(combination or a mechanical method).

Denominator – the number of people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage.

Data source: Local data collection. The British Society of Gastroenterology's UK comparative audit of upper gastrointestinal bleeding and the use of blood (2007) asks, 'Were any therapeutic endoscopic procedures undertaken?'

Outcome

a) Proportion of people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage who have uncontrolled bleeding or re-bleeding within 48 hours.

Data source: Local data collection.

b) Proportion of people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage who need rescue therapies.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage to be offered endoscopic treatments (combination or a mechanical method).

Healthcare practitioners offer endoscopic treatments (combination or a mechanical method) to people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage.

Commissioners ensure that they commission services that offer endoscopic treatments (combination or a mechanical method) to people with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage.

People with acute upper gastrointestinal bleeding caused by stomach or duodenal ulcers are offered treatment using an endoscope (a narrow, flexible tube that is swallowed and has a very small camera at its tip).

Source guidance

Definitions of terms used in this quality statement

Endoscopic treatments (combination or a mechanical method)

NICE's guideline on acute upper gastrointestinal bleeding states: do not use adrenaline as monotherapy for the endoscopic treatment of non-variceal upper gastrointestinal bleeding.

It recommends using 1 of the following endoscopic treatments:

- a mechanical method (for example, clips) with or without adrenaline
- thermal coagulation with adrenaline
- fibrin or thrombin with adrenaline.

The full guideline concludes that each of these approaches can control active bleeding, reduce the rate of re-bleeding and need for blood transfusion compared with not receiving endoscopic therapy. Trials have failed to show superiority of any single approach.

[NICE's guideline on acute upper gastrointestinal bleeding, recommendation 1.4.1, 1.4.2 and full guideline]

Quality statement 5: Treatment of non-variceal bleeding after first or failed endoscopic treatment

Quality statement

People with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable are given interventional radiology treatment.

Rationale

Sometimes endoscopic therapy is technically difficult and the endoscopist cannot achieve or secure haemostasis, or bleeding recurs despite full or maximal endoscopic treatment. One additional therapeutic option is interventional radiology (embolisation), which can identify and treat the bleeding point. This can be preferable to surgery, because postoperative mortality is high for this group of patients, most of whom are extremely ill at the time of surgery.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable are given interventional radiology treatment (embolisation).

Data source: Local data collection.

Process

Proportion of people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable who receive interventional radiology treatment (embolisation).

Numerator – the number of people in the denominator who receive interventional radiology treatment (embolisation).

Denominator – the number of people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable.

Data source: Local data collection. The British Society of Gastroenterology's UK comparative audit of upper gastrointestinal bleeding and the use of blood (2007) shows the proportion of people having either surgery or radiological intervention.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable to be given interventional radiology treatment.

Healthcare practitioners give interventional radiology treatment to people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable.

Commissioners ensure that they commission services that give interventional radiology treatment to people with non-variceal acute upper gastrointestinal bleeding who continue to bleed or re-bleed after endoscopic treatment and who are haemodynamically unstable.

People with acute upper gastrointestinal bleeding from the stomach or duodenum who continue to bleed or re-bleed after endoscopic treatment and whose blood pressure or pulse is unstable are given interventional radiology treatment. A long narrow plastic tube called a catheter is inserted into an artery in the groin and, under X-ray guidance, is then

steered to the site of bleeding. After a small injection of X-ray dye to confirm that the tube is in the right place, the bleeding artery is blocked off to stop the bleeding. A CT scan may be needed beforehand to guide treatment if endoscopy has not identified the site of bleeding.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.4.7 (key priority for implementation)

Definitions of terms used in this quality statement

NICE's guideline on acute upper gastrointestinal bleeding, recommendation 1.4.7, states that if interventional radiology is not promptly available people should be referred urgently for surgery.

Quality statement 6: Prophylactic antibiotic therapy for variceal bleeding

Quality statement

People with suspected or confirmed variceal acute upper gastrointestinal bleeding are given antibiotic therapy at presentation.

Rationale

People with variceal acute upper gastrointestinal bleeding are prone to infection. Infection has adverse effects on renal function and commonly precipitates hepatorenal failure, characterised by oliguria, sodium and fluid retention and death. Early antibiotic therapy reduces these risks.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with suspected or confirmed variceal acute upper gastrointestinal bleeding are given antibiotic therapy at presentation.

Data source: Local data collection.

Process

Proportion of people with suspected or confirmed variceal acute upper gastrointestinal bleeding who receive antibiotic therapy at presentation.

Numerator – the number of people in the denominator who receive antibiotic therapy at

presentation.

Denominator – the number of people with suspected or confirmed variceal acute upper gastrointestinal bleeding at presentation.

Data source: Local data collection.

Outcome

Rates of sepsis in people with suspected or confirmed variceal acute upper gastrointestinal bleeding.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with suspected or confirmed variceal acute upper gastrointestinal bleeding to be given antibiotic therapy at presentation.

Healthcare practitioners give antibiotic therapy at presentation to people with suspected or confirmed variceal acute upper gastrointestinal bleeding.

Commissioners ensure that they commission services that give antibiotic therapy at presentation to people with suspected or confirmed variceal acute upper gastrointestinal bleeding.

People with acute upper gastrointestinal bleeding known or suspected to be caused by enlarged veins are given antibiotics when they first see a healthcare professional.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.5.2 (key priority for implementation)

Quality statement 7: Band ligation for oesophageal variceal bleeding

Quality statement

People with acute upper gastrointestinal bleeding from oesophageal varices are given band ligation.

Rationale

The use of bands for oesophageal bleeding will stop the bleeding and has significant benefits over the alternative of injection sclerotherapy. The benefits include: improved mortality and a reduction in re-bleeding, numbers of additional procedures needed to control bleeding, total units of blood transfused and number of sessions of treatment needed to eradicate varices.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with acute upper gastrointestinal bleeding from oesophageal varices are given band ligation.

Data source: Local data collection.

Process

Proportion of people with acute upper gastrointestinal bleeding from oesophageal varices who receive band ligation.

Numerator – the number of people in the denominator who receive band ligation.

Denominator – the number of people with acute upper gastrointestinal bleeding from oesophageal varices.

Data source: Local data collection. The British Society of Gastroenterology's UK comparative audit of upper gastrointestinal bleeding and the use of blood (2007) shows the number of endoscopic therapeutic procedures, which includes banding.

Outcome

Rates of uncontrolled bleeding in people with upper gastrointestinal bleeding from oesophageal varices.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with acute upper gastrointestinal bleeding from oesophageal varices to be given band ligation.

Healthcare practitioners perform band ligation in people with acute upper gastrointestinal bleeding from oesophageal varices.

Commissioners ensure that they commission services that give band ligation to people with acute upper gastrointestinal bleeding from oesophageal varices.

Peoplewith acute upper gastrointestinal bleeding caused by enlarged veins in the oesophagus (gullet) are given band ligation, a type of elastic band that helps to stop the bleeding.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.5.3

Quality statement 8: N-butyl-2-cyanoacrylate for gastric variceal bleeding

Quality statement

People with acute upper gastrointestinal bleeding from gastric varices are given an endoscopic injection of N-butyl-2-cyanoacrylate.

Rationale

Endoscopic injection of N-butyl-2-cyanoacrylate can obliterate gastric varices, whereas attempts at banding are likely to be unsuccessful for these varices.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with acute upper gastrointestinal bleeding from gastric varices are given an endoscopic injection of N-butyl-2-cyanoacrylate.

Data source: Local data collection.

Process

Proportion of people with acute upper gastrointestinal bleeding from gastric varices who receive endoscopic injection of N-butyl-2-cyanoacrylate.

Numerator – the number of people in the denominator who receive endoscopic injection of N-butyl-2-cyanoacrylate.

Denominator – the number of people with acute upper gastrointestinal bleeding from gastric varices.

Data source: Local data collection.

Outcome

Rates of uncontrolled bleeding in people with acute upper gastrointestinal bleeding from gastric varices.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with acute upper gastrointestinal bleeding from gastric varices to be given an endoscopic injection of N-butyl-2-cyanoacrylate.

Healthcare practitioners give an endoscopic injection of N-butyl-2-cyanoacrylate to people with acute upper gastrointestinal bleeding from gastric varices.

Commissioners ensure that they commission services that give an endoscopic injection of N-butyl-2-cyanoacrylate to people with upper gastrointestinal bleeding from gastric varices.

People withacuteuppergastrointestinalbleedingcausedbyenlargedveinsinthestomach are given an injection of N-butyl-2-cyanoacrylate, a substance that helps to stop the bleeding. This injection is given using an endoscope (a narrow, flexible tube with a camera at its tip).

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141

(2012, updated 2016), recommendation 1.5.5

Quality statement 9: Management of variceal bleeding using transjugular intrahepatic portosystemic shunts (TIPS)

Quality statement

People with uncontrolled acute upper gastrointestinal bleeding from varices are given transjugular intrahepatic portosystemic shunts (TIPS).

Rationale

In some cases, variceal bleeding cannot be controlled with endoscopic treatment. In these instances, TIPS can be used to stop the bleeding.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with uncontrolled acute upper gastrointestinal bleeding from varices are given TIPS.

Data source: Local data collection.

Process

The proportion of people with uncontrolled acute upper gastrointestinal bleeding from varices who receive TIPS.

Numerator – the number of people in the denominator who receive TIPS.

Denominator – the number of people with uncontrolled acute upper gastrointestinal bleeding from varices.

Data source: Local data collection.

What the quality statement means for different audiences

Service providers ensure that systems are in place for people with uncontrolled acute upper gastrointestinal bleeding from varices to be given TIPS.

Healthcare practitioners perform TIPS in people with uncontrolled acute upper gastrointestinal bleeding from varices.

Commissioners ensure that they commission services that give TIPS to people with uncontrolled acute upper gastrointestinal bleeding from varices.

People withuncontrolledacute uppergastrointestinalbleedingcausedbyenlargedveins are given a procedure called transjugular intrahepatic portosystemic shunts (also called TIPS). In a TIPS procedure, the veins feeding into the liver and those draining it are connected so that the blood flow is redirected and the pressure in the enlarged veins is lowered.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendations 1.5.4 (key priority for implementation) and 1.5.6

Definitions of terms used in this quality statement

Transjugular intrahepatic portosystemic shunts

In a transjugular intrahepatic portosystemic shunts (TIPS) procedure, the veins feeding into the liver and those draining it are connected so that the blood flow is redirected and the pressure in the enlarged veins is lowered.

Before using TIPS, attempts should first be made to stop bleeding using the alternative

methods described in quality statements 7 and 8. NICE's guideline on acute gastrointestinal bleeding states:

- Consider transjugular intrahepatic portosystemic shunts (TIPS) if bleeding from oesophageal varices is not controlled by band ligation.
- Offer TIPS if bleeding from gastric varices is not controlled by endoscopic injection of N-butyl-2-cyanoacrylate.

[NICE's guideline on acute upper gastrointestinal bleeding, recommendations 1.5.4 and 1.5.6]

Quality statement 10: Continuation on low-dose aspirin

Quality statement

People with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved are advised to continue on low-dose aspirin.

Rationale

Aspirin can cause gastrointestinal ulcers to form and cause pre-existing ulcers to bleed. Clinicians have therefore withheld aspirin at the time of acute gastrointestinal bleeding. However, the antiplatelet effects of aspirin persist for at least 7 days after discontinuation. This means that people with acute upper gastrointestinal bleeding who are already taking low-dose aspirin to prevent further vascular events should be advised to continue taking aspirin if their bleeding has stabilised so that the benefit of taking aspirin can be maintained.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved are advised to continue on low-dose aspirin.

Data source: Local data collection.

Process

Proportion of people with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved who are advised to continue on low-dose aspirin.

Numerator – the number of people in the denominator who are advised to continue on low-dose aspirin.

Denominator – the number of people with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved.

Data source: Local data collection. The British Society of Gastroenterology's UK comparative audit of upper gastrointestinal bleeding and the use of blood (2007) records the drugs taken by people who have acute upper gastrointestinal bleeding.

What the quality statement means for different audiences

Service providers ensure that systems are in place to advise people with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved to continue on low-dose aspirin.

Healthcare practitioners advise people with acute upper gastrointestinal bleeding, who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved, to continue on low-dose aspirin.

Commissioners ensure that they commission services that advise people with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved to continue on low-dose aspirin.

People with acute upper gastrointestinal bleeding who have had a stroke or heart attack, and are taking aspirin to prevent another, are advised to continue on aspirin when their bleeding has stabilised.

Source guidance

Acute upper gastrointestinal bleeding in over 16s: management. NICE guideline CG141 (2012, updated 2016), recommendation 1.6.1

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Society of Gastroenterology
- Royal College of Physicians (RCP)
- Royal College of Radiologists