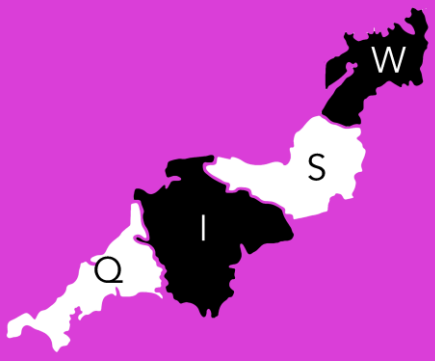
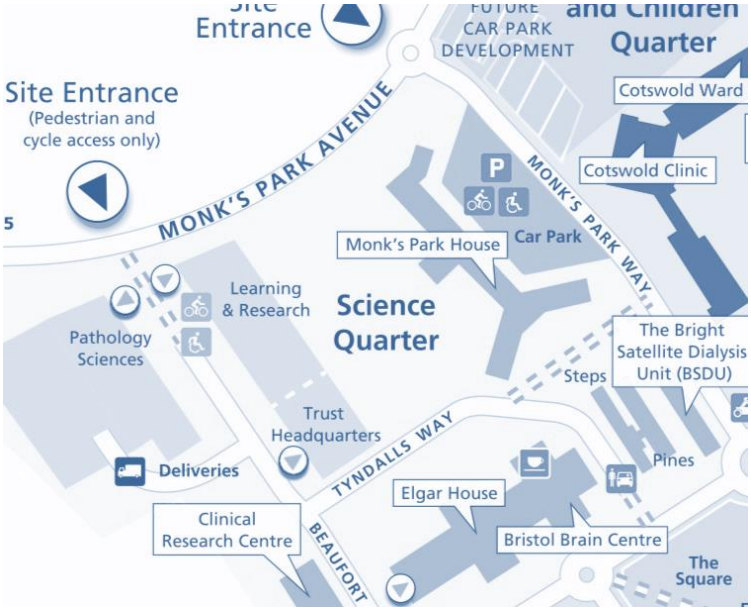
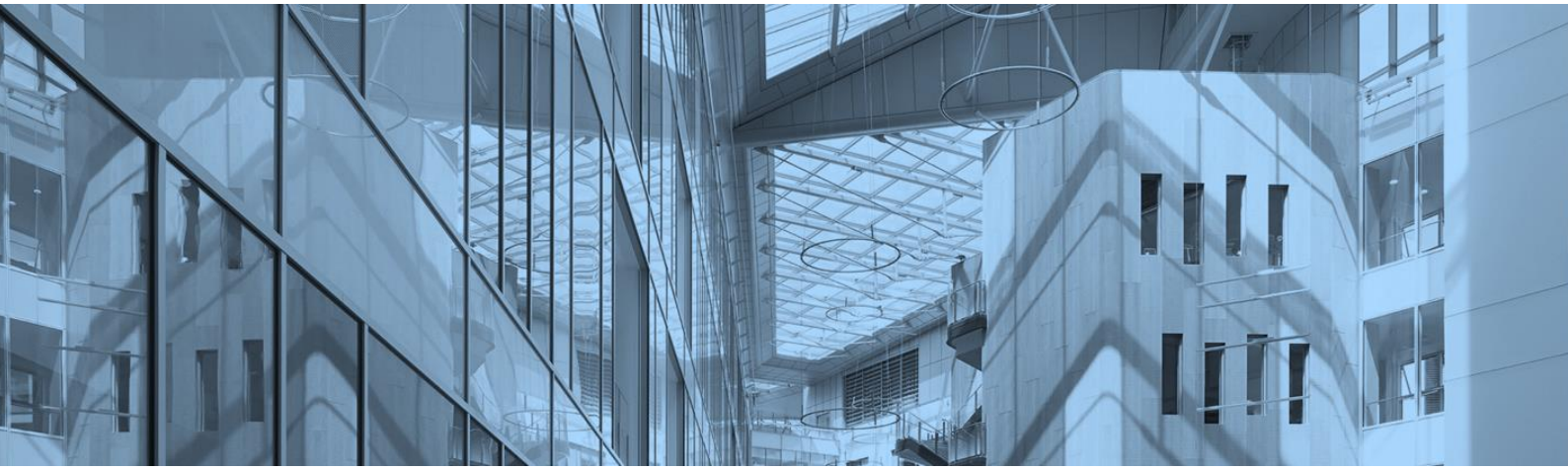
QISW
WINTER CONFERENCE 2020



[Learning and Resource Building
Southmead Hospital
Southmead Road
Westbury-On-Trym
BS10 5NB]

[17th Jan 2020]





Intro

07:30-09:30	Registration and poster display
09:30-10:30	Initial poster reviews and selection of top 10 posters
10:30 - 10:45	**Chairs -**Opening remarks
10:45 - 11:45	**Prof Peter Brennan** - HF in healthcare to improve safety: the art of applying common sense.
11:45 – 12:30	**Ms Helen Crisp** – Keynote Speech
12:30 – 13:00	Lunch Break
13:00 - 13:30	**Mr Dimitri Pournaras** - Treating obesity as a disease
13:30 - 14:00	**Dr Denise Chaffer** – Learning from claims , improving safety, reducing harm and subsequent claims
14:00-14:30	**Dr Bryan Jones** – The Health Foundation
14:30-15:00	Break and Top 10 poster judging for 5 prizes
15:00 – 16:00	4 x 15 mins prize oral presentations
16:00 – 16:20	**Ms Anne Pullyblank** - Intro to the AHSN
16:20 – 16:40	Prize Giving
16:40 - 16:45	Closing Remarks and Thanks

Conference Chair Mr Michael Okocha

Any event of this scale should always start with gratitude. On behalf of the committee I would like to say a huge thank you to Donna Paddon and the medical education team at North Bristol NHS Trust. Without your help this conference would not have been possible.

Thank you to our conference chairs, inspiring speakers, and to Dr Srivastava for putting together our senior faculty; an MDT of talented and enthusiastic representatives from all different disciplines.

This conference was started by the curiosity of foundation trainees and medical students. They asked questions such as:

"What is Quality Improvement and why does it matter?"

Today I hope that we answer these questions and you leave ***inspired*** to ***engage*** in patient safety, and ***empowered*** to be

the force that drives change.

Meet The Speakers

1/3

PROFESSOR PETER BRENNAN

A consultant oral and maxillofacial surgeon at QAH, Portsmouth with an interest in head and neck oncology and reconstruction. He has a personal chair in surgery in recognition of his research and education profile, publishing over 420 papers to date and an editor of 4 textbooks.

Professor Brennan is the youngest President of the British Association of Oral and Maxillofacial Surgeons. He is the Intercollegiate Chairman for MRCS and DOHNS examinations, He is the Editor in Chief of the Journal of Oral Pathology and Medicine. He is a strong advocate of providing the highest level of care for patients, and uses his work on human factors to promote safe surgery and team-working in head and neck cancer.

EDITOR-IN-CHIEF HELEN CRISP

Editor-in-Chief of BMJ Open Quality, an online open access journal which publishes reports of quality improvement in action. She also runs her own company, Crisp QI Ltd, supporting quality improvement in healthcare through strategic consultancy, training and research.

Helen has over twenty years' experience of working in the field of quality improvement in health care, as a practitioner, advisor and evaluator. This has included developing the quality standards and peer review visit methodology; service review projects and evaluation.

Her previous experience includes eight years as Assistant Director of Research at the Health Foundation, where she managed a £4 million per year grants programme for research into patient safety, quality improvement methods and improvement science.

Oral Prize session

Abstract 1. Oral

Title

Storytelling from inpatient psychiatry ward admission: Sharing stories from service users of their experiences of being admitted to acute general adult psychiatry inpatient wards.

Authors

David Martin (AWP), Ginevra Read (AWP), Thanos Tsapas (AWP)

Background

Storytelling in healthcare is a longstanding tool used to enhance empathy and compassion in healthcare providers through the process of developing narrative competence in the listeners. Stories are able to retain and hold values, emotions, and complex information. Storytelling in healthcare can engage with the empathy, compassion and imagination of professionals.

Aims

• Supporting service users to share stories from their own experience
• Evoke the empathy, compassion and imagination of the listeners
• Stimulate the generation of ideas for the future development of inpatient wards or the wider trust
• Recognise and celebrate stories of where more humanistic care has been achieved

Methods

Following the guidance of the PDSA model, we aim to co-design the project in how we will gather stories from service users and decide on a suitable way to re-tell these stories for an audience, using a variety of techniques; such as digital storytelling, short films, podcasts or theatre.

Results and Discussion

We will collect qualitative data from the listeners of the stories told using questionnaires and focus groups to explore reflection on the process, including themes of empathy and ideas to improve patient care in the hospital and wider trust services.

Understanding how patients experience their care is becoming more important as a means of improving healthcare by providing a form of inquiry to capture and name the barriers to humanistic healthcare. As well as uncovering stories where changes and shifts towards more humanistic care have been achieved successfully.
Storytelling can be used to promote cultural change, and is more effective than information based interventions for changing attitudes. The use of digital stories has been shown to be an effective and far-reaching medium for promoting behaviour change.

We aim to use storytelling to improve patient care on AWP inpatient psychiatry wards.

Title

Saving the Planet: Reorganising Renal Transplant FoI Saving the Planet: Reorganising Renal Transplant Follow-up

Authors

S. Williams (Bristol medical student), J Fallon (transplant spr), J Morgan (transplant consultant)

Background

Renal transplantation is increasing in the UK, demand on the follow-up system will expand. Our protocol is 12 clinic follow-ups within month one, 36 in the first year. The travel distance and carbon footprint of the patients to attend clinics is not considered.

Aims

In an era of climate change and the need for sustainability, improvements must be sought.

Methods

We analysed the environmental impact of our services' follow-up, the changes implemented and the possibilities for the future to reduce the carbon footprint of renal transplant follow-up.

Results and Discussion

123 patients from Bristol, Dorset or Gloucester regions over 18 months from January 2018 who received renal transplants in Southmead Hospital were analysed. Carbon footprint was calculated for each patient travelling to clinic visits, giving kilograms of carbon dioxide emissions (kgCO2e). We assess the KgCO2e of all the clinic visits, the improvement made be repatriation and the possible reductions for the future.

For the first month, our 35 Dorset patients averaged 176 miles per clinic, 52 kgCO2e per patient, per clinic visit (pp/pc). Since the protocol changed a 75% reduction (6402 KgCO2e) in emissions from 10 patients follow-up locally in the first month; annual reduction of 14,040 KgCO2e. If our 16 Gloucester patients received local follow-up it would be a 74% reduction (6521 kgCO2e). Our 72 patients 'local' to Bristol travelled on average 28 miles pp/pc, 8 kgCO2e pp/pc, a total of 22,657 kgCO2e.

The Dorset change has reduced environmental impact and hidden costs such as fuel or time off work for the patient and relatives. NHS England advises tranplant units to "consider local blood tests and telephone follow-up in addition to clinic visits". We have seen GP compliance blood tests for transplant patients in Bristol was 90.9%. Thus modifications could be made to produce a hybrid of telephone and clinic follow-up reducing the burden on clinic, patients and the planet which could be extrapolated across NHS England.

Title

Reduce PPH – A multi-disciplinary project to reduce the incidence of Postpartum Haemorrhage (PPH) at a large obstetric unit

Authors

Ben Ballisat (North Bristol NHS Trust) and the Reduce MatNeoSIP team

Background

Postpartum haemorrhage (PPH) is defined as bleeding associated with childbirth. In this country, PPH is a major cause of maternal morbidity and mortality (MBRRACE-UK, 2017). There are a wide range of intrapartum, maternal and obstetric factors that influence the likelihood of PPH.

At our institution, the incidence of PPH is higher than other comparable centres. We commenced this QI project to learn why the rate is high and to reduce the incidence using a collaborative, multi-disciplinary approach to this complex problem. This project forms part of the national Maternal and Neonatal Safety Improvement Programme and is supported by NHS Improvement.

Aims

Our overarching aim: To reduce rate of postpartum haemorrhage (1500ml and over) in all women who deliver at North Bristol NHS Trust by 30% by May 2020. This will result in a reduction from our current rate of 4.9% to 3.4% or below.

Methods

To achieve this, we will ensure:
- Wide engagement of maternity staff with the project
- Introduce a risk assessment and structured management tool
- Two healthcare professionals attend births
- Reduce delay in administering prophylactic oxytocic medication
- Use of weighed blood loss measurement rather than visual estimation

Process measures:
These are typically recorded on a weekly basis to allow frequent PDSA cycles to occur. Current process measures demonstrate the following:
- >85% of women undergo risk assessment
- >80% of women have weighed blood loss measurement
- >90% of women have two healthcare professionals present for birth
- >90% of delivery suite staff have attended a ‘tea trolley’ engagement event

Results and Discussion

After commencing the project the rate of >1500ml PPH increased, this may be due to better detection of blood loss. The rate has now fallen and is currently below the 2018-19 average (see chart).

Experiencing a postpartum haemorrhage can have a significant effect on both physical and psychological wellbeing of a mother. This project’s key aim is to reduce the incidence of PPH through adopting a collaborative QI approach. To achieve this, the improvement team includes staff from all relevant disciplines (Midwifery, Obstetrics and Anaesthesia) who are working in conjunction with delivery suite staff. This phase of the project will continue until May 2020, however, early results show that we are achieving our aims for the process measures and this should ensure the overall PPH rate continues to improve in the longer term.

Abstract 4. Oral

Title

Implementing and Improving Digital Microbiology Requesting at Southmead Hospital

Authors

Dr Matt Smallbones (North Bristol NHS Trust), Miss Natasha Alford (University of Bristol Medical School), Mr Michael Okocha (North Bristol NHS Trust)

Background

Previous near-miss events at Southmead Hospital have highlighted that errors in paper requesting can lead to significant patient harm. In previous paper systems, error rate has been documented as high as 87% in theatre samples. With growing modernisation of NHS systems, digital requesting can improve the speed, organisation and safety of a routine clinical process. In the sixth cycle of this QI project, we continue evidence the superiority of digital laboratory requesting - serving as an example for other hospitals nation-wide.
Previous cycles: This is the sixth cycle of this ongoing Quality Improvement Project, with a 29-member multi-disciplinary leadership team. In the first four cycles, digital requesting was implemented for histology samples, with step-wise interventions resulting in 95% uptake with 0% error rate in digital forms. Due to noticable improvements attributed to this system, the fifth cycle aimed to bring similar digital requesting to the microbiology department.

Aims

Improve the uptake and compliance with microbiology digital requesting, previously implemented in cycle 5.
Monitor the accuracy of information provided to the microbiology department in digital versus paper requesting.

Methods

Multi-departmental education led by members of the MDT leadership team, including nurses and matrons, theatre co-ordinators, surgical consultants, junior doctors and pathology staff. Further to this, an educational trust-wide email was sent, which included an educational video for training purposes.

Data collection: Analyse microbiology requests from a 2-week period to assess uptake of digital requesting systems, with identification of departments or hospital areas with poor compliance

Results and Discussion

94 microbiology requests performed during study period

Primary outcome - Uptake of Digital Requesting:

- 72% uptake of digital requesting systems, improving from 26% on previous cycle
- 12 paper forms from Medi Rooms
- 8 paper forms from Theatres
- 5 paper forms from Wards
- 2 paper forms from Outpatients

Secondary outcome - Error Rate in Completed Paper Forms:

- No forms contained errors in patient details
- 69% error rate in clinician details
- 78% error rate in clinical details
- Overall, 92% of paper forms were not completed correctly

Paper requests continue to have high error rate (92%), predisposing to unsafe clinical practice and increasing the risks to patient care. Following multi-disciplinary education and provision of online training material, digital ICE requesting uptake has significantly increased from 26% to 72%. Medi Rooms have the poorest compliance with digital systems, and would be a suitable target for future localised interventions.

Meet The Speakers

2/3

MR DIMITRI POURNARAS

Upper GI, Bariatric & Metabolic Surgeon at North Bristol NHS Trust. National leader in patient outcomes in obesity. Graduating from the Aristotle University of Thessaloniki, Greece, Mr Pournaras undertook all his postgraduate training in the UK, and was awarded a Research Fellowship by the Royal College of Surgeons of England to conduct research on obesity, diabetes and metabolic surgery. He completed his PhD at Imperial College London.

He is on the editorial board of journals Obesity Surgery and Clinical Obesity and has authored more than 50 peer reviewed publications, including articles in the Lancet, the Annals of Surgery, the British Journal of Surgery and the British Medical Journal. He is an international profile and patient advocate in the surgical

DR DENISE CHAFFER

Director of Safety and Learning at NHS Resolution, Dr Denise Chaffer is a registered nurse and midwife. Her PhD is in health care leadership and she has a master's degree in management and social care. Dr Chaffer is a professional clinical nursing leader with years of executive board experience.

Dr Chaffer has been an executive Director of Nursing in two acute trusts and Director in a Primary Care Trust commissioning organisation. She led on patient safety across the London region and is recognised at an international level for her work on major change and reconfiguration initiatives.

Denise published a book in 2016; 'Effective Leadership, A Cure for the NHS?' which draws on the personal experiences of a range senior health care leaders.

Poster submissions

Abstract 5. Poster

Title

Monitoring of Renal Function in Patients taking SGLT-2 Inhibitors

Authors

Jennifer Reid; Francesca Da Costa; Alice; Andrew Hughes; James; Joseph; Ketan Singh; Luca; Matthew; Michael Lewin – Cardiff University Y5 Medical Students

Background

SGLT-2 inhibitors are a class of medications that are used in the treatment of T2DM and work by acting on sodium-glucose co-transporter 2. Due to their dependency on glomerular filtration of glucose load, these medications are known to be less effective in patients with impaired kidney function. As per BNF guidelines, renal function should be assessed before SGLT-2i initiation.

If pre-treatment eGFR is persistently < 60, then this medication class should be avoided. Moreover, the three licensed medications in this class – Canagliflozin, Dapagliflozin and Empagliflozin – have individualised dose reduction regimes in accordance with eGFR as per the BNF, which were all taken into account.

Aims

- To establish how the renal function of patients on SGLT-2i was being monitored within GP surgeries and whether this corresponded with national guidelines
- To establish whether NICE guidance on dose reduction and/or drug cessation in the case of worsening renal function was being appropriately applied

Methods

The GP records of known T2DM patients from 8 GP surgeries in South Wales were used to conduct individualised searches based on 3 search domains: patients currently taking an SGLT-2i, patients taking an SGLT-2i with a recorded eGFR < 60 and patients taking an SGLT-2i with no recorded eGFR.

Results and Discussion

Across the 8 GP surgeries, there were 402 patients taking an SGLT-2i as an adjunct for their T2DM control. Of these, 35 had a recorded eGFR of less than 60. 9 individuals had a persistently low eGFR, which had been combatted in 6 patients with appropriate dose reduction as per national guidance. However, in 3 patients, a medication review was arranged due to incorrect dosing as per their renal function. Finally, there was one patient who had zero evidence of in-practice monitoring, with one previous eGFR recorded in hospital in 2018, so were invited in for a medication review.

This project highlighted that, in most cases, there is high vigilance when monitoring the renal function of this cohort, ensured by a multidisciplinary approach involving GPs, pharmacists and diabetic nurse specialists. However, the highlighted errors evidenced that prescribing errors were still being made, which could be enhanced by direct education to awareness of evolving guidelines. This project further paves the way for larger studies to aid in demonstrating the need for prescribing diligence, which can be reinforced by software investment to electronically highlight monitoring requirements regularly. This allows for further focus on dischpatient safety.

Abstract Accepted for Presentation at QISW National Conference 2020

Title

Improving discharge summary timeliness in general surgery

Authors

Dr Perry Maskell FY2, Dr Meical Povey JCF, Dr Fraser Cameron JCF, Mr Michael Johnson Cons

Background

The electronic discharge summary (eDS) aims to support a safe, comprehensive and instructive handover to primary care, ensuring well-organised follow up and investigations if required. National guidance advises a 100% completion rate of the eDS within 24 hours of patient discharge (1,2), however, our general surgery department only achieved 80%.

Aims

Using quality improvement methodology, we aim to improve the 24-hour eDS completion in our department to the national target of 100%.

Methods

We have implemented three 3-week improvement cycles. Cycle 1 included raising awareness of eDS targets, with cycle 2 initiating the role of eDS co-ordinator within the team. A third cycle has been focussed around a change to the formal on-call handover process, whereby an outstanding eDS list for the consultant on-call is printed and discussed every handover, to facilitate eDS completion within 24 hours.

Results and Discussion

Cycles 1&2 resulted in a 3% increase to the monthly 24-hour completion rate compared to the previous 3 months. Following PDSA cycle 3, completion rates have continued to increase to 85% completion. We estimate this overall 5% completion has led to 15 more patients benefiting from a timely discharge summary per month, as well as an estimated 2 hours saved by preventing junior doctors having to complete 15 less late discharge summaries further down the line.

This change is also likely to have positive implications on trust funding through timely clinical coding. Before our interventions, on-call associated discharge summaries accounted for two-thirds of those outstanding, this number has fallen to ~40% following this project.

We have recognised the importance of education and awareness, as well as personnel dependent factors, and consultant liaison and support in our project. Of note, early notification of outstanding discharge summaries to the relevant team has seemingly proved beneficial in our project. Although timely eDS completion is an ongoing, multifactorial challenge, particularly in high-turnover specialities like surgery, we have demonstrated how simple solutions can make a difference in this area.

Our 4th cycle includes improving the take-up of the new handover policy and involves formal teaching for new doctors starting in the department, emphasising the importance of a timely eDS in safe and effective patient care. We hope to continue to improve our completion rate towards the national standard in the coming months.ving discharge summary timeliness in general surgery

Abstract 7. Poster

Title

The use of proformas to improve communication about medication changes during inpatient admissions at the RUH, Bath

Authors

Hennie Helliwell, Danno Turk, Eleanor Lidgate

Background

The Royal United Hospital, Bath, uses electronic prescribing for inpatient medications and TTA's, this can make it difficult to assess what medication changes have occurred, especially if it is not documented in the patient notes. This can cause confusion amongst medical staff, especially out of hours, and one hundred percent of 17 surveyed FY1's had at some point been unsure why a mediation change had happened. In addition, over three quarters had been contacted, either by a GP or a patient, regarding TTA queries after discharge.

Aims

- To improve the accuracy of medication changes on discharge paperwork
- Improve communication between primary and secondary care regarding patients medications
- To improve patient safety and ensure that medications are not missed off

Methods

The number of medication changes documented in the discharge summary and the reasoning was collected from ten sets of patient notes on one ward. A 'pink proforma' (detailing the drug name, the change made and the reasoning), was introduced to the patient notes on the same ward, over a two week period. Patient notes and discharge summaries were audited to assess the process measure (completion of proforma) and outcome measure (accuracy of discharge summary). The use of the 'pink proforma' without the project members on the ward, and following the introduction of an 'education session' was then re-audited.

Results and Discussion

Baseline data collection found that 64.5% of relevant medication changes on discharge were documented in the discharge summary. Of those documented, reasons for change were given for 77.4% of medications. Following the introduction of the 'pink proforma', 88.8% of proformas were completed, and 88.1% of the discharge summaries were accurate. Results from the second cycle, found that only 4.5% of proformas were completed, and that 22% of discharge summaries were accurate.

Use of the 'pink proforma' was found to increase the accuracy of the discharge summary. However, in order for this positive change to be sustainable, stakeholder engagement needs to be higher, as evidenced by the cycle two results. Barriers to completion of the proforma include time and repetition of work. A suggestion to overcome these barriers and improve documentation, would be to integrate it into the existing systems. For example, creating a compulsory box on electronic prescribing to document the reason for the medication change, which would be pulled through to the discharge summary, ensuring improved communication with other healthcare professionals.

Abstract 8. Poster

Title

Remote Psychotropic Medication Advice for General Practitioners: A Quality Improvement Project

Authors

Dr Rosemary King and Dr Emily Rackley

Background

The UK has some of the highest rates of mental disorders in Europe (1), and nearly half of adults think that they have had a diagnosable mental health condition at some point in their life (2). It is estimated that in 2014 12.5% of people report talking to their general practitioner about their mental health, but only 4% were in contact with secondary mental health services (2). In a recent survey of general practitioners by Mind, the mental health charity, it was found that 40% of all appointments now involve mental health (3).

Aims

The Gloucester Recovery Team is part of the 2gether NHS Foundation Trust, and serves a population of roughly 150,000 people. Our first aim was to first find out how confident general practitioners were about referring in to the Gloucester Recovery Team and managing psychotropic medications. Our second aim was to then improve general practitioner's self-rated scores of confidence in managing psychotropic medication whilst also improving general practitioner's satisfaction with waiting times for patient's referred to the Gloucester Recovery Team.

Methods

We planned to introduce an email address for GPs and primary care mental health nurses to use to seek medication and diagnostic advice for patients known to and not known to the Recovery Team. We hoped that this would both improve patient care by improving GP confidence in managing psychotropic medication, and also potentially reduce referrals into the service though this was not directly measured. A similar service runs within the Older Adult Community Mental Health Team for Gloucester which seems to be used effectively, and so it was hoped that this could also be introduced to the Working age team.
We initially introduced this for the 'Team 2' catchment area which consists of five of the practices within Gloucester. These e-mails were then read and replied to by the Team 2 consultant, Dr Ikram, as appropriate.
Following this, a further survey was sent out to the practices. These results provided both quantitative ordinal data through a likert scale, which was then transformed into binomial data, such as those scoring 'extremely confident' 'very confident' 'somewhat confident' vs 'not so confident' and 'not confident at all' which is then compared using relative risk.

Results and Discussion

Our response rate for our initial survey was 8 general practitioners, and for our follow up survey was 1 general practitioner and 2 nurse prescribers. Confidence in continuing psychotropic medications increased from 7 out of the 8 (78%) stating somewhat confident to extremely confident to 3 out of the 3 (100%) after the introduction of the email. This is a relative change of 1.14 (95% confidence interval 0.87-1.48 p=0.318).

Confidence in initiating psychotropic medications increased from 4 out of the 8 (50%) stating somewhat confident to extremely confident to 2 out of the 3 (66%) after the introduction of the email. This is a relative change of 1.33 (95% confidence interval 0.46-3.84 p=0.594). Analysing the qualitative data has shown that the email address was used for a variety of requests and advice including: 1) A capacity assessment, 2) Initiating medications for depression and anxiety, 3) Medications during pregnancy, 4) Medication for those with Intellectual Disability, 5) Switching medication, mainly anti-depressants, 6) Medications for poor sleep and 7) Mood stabilising medication. This change appeared to be well received from the responses gathered; however the response rate was very low which makes full analysis difficult. We also included nurse practitioners working in primary mental health in our second survey, whereas the initial survey was only sent to general practitioners. This initiative was also only started for 5 of the GP practiced within Gloucester, and there may be a different knowledge base/confidence among the other practices in the city.
(abstract penalised 1 points for length)

Abstract 9. Poster

Title

Developmental dysplasia of the hip: a review of the new referral pathway and adherence to Public Health standards at University Hospitals of Leicester.

Authors

Dr Sara Tomassini (University Hospitals of Leicester NHS Trust), Ms Anna Peek (University Hospitals of Leicester NHS Trust)

Background

Developmental dysplasia of the hip (DDH) is a congenital disorder of hip development. Early diagnosis and intervention have been shown to improve long-term outcomes, thus DDH is one of the conditions screened in the Newborn and Infant Physical Examination (NIPE).

The referral process for suspected DDH at University Hospitals of Leicester (UHL) was re-designed in 2018 to better comply with the targets for referral timelines from the Public Health NIPE guidelines. The changes included the introduction of a joint sonographer and consultant clinic and a streamlined referral pathway which was implemented across the Trust and in primary care.

Aims

Our primary aim was to evaluate whether the changes to the referral process led to an improvement in referral times and adherence to NIPE standards for referral and diagnosis. We also wanted to assess any potential pitfalls in the introduction of the new referral pathway.

Methods

Patients were identified retrospectively by searching the Sunquest ICE system for all requests for hip ultrasound scans for babies under 6 months of age between August and October 2018. The electronic record was reviewed. Exclusion criteria were set: born outside of the UK, did not attend appointments, follow-up scans.

Results and Discussion

Data was analysed for 326 babies. Patients were allocated to 4 groups: positive NIPE at birth, risk factors, positive NIPE at the 6-8-week check and clicky hips.
Overall, there was a marked improvement in the adherence to NIPE standards since the implementation of the new referral pathway (from 38% to 77% of patients). However, some delays in referral persisted. These were mostly observed in the positive NIPE at birth group (20% met NIPE standards) and in the NIPE positive at 6-8 weeks group (48% met NIPE standards). In the latter group 94% of babies were referred via the incorrect pathway.

We identified two factors affecting referral timeline. Firstly, the publication of the pathway on the GP referral system was delayed, contributing to incorrect referrals. Secondly, some delayed assessments were associated with extreme prematurity and a prolonged intensive care stay. Referral in such cases was made when clinically feasible. However, it is difficult to accurately analyse the results from the positive NIPE at birth group because of a small sample size (n=4).

In conclusion, the revised referal pathway has improved adherence to NIPE targets. It needs to be widely disseminated to clinical staff in primary care, maternity and neonatology to further improve performance.

Title

Improving the use of medical photography in reconstructive surgery - A closed loop audit

Authors

Conrad Charlton, Max Denning

Background

Oncoplastic breast reconstruction guidelines from the Association of Breast Surgery state that medical photography pre- and post-operation should be offered for 100% of oncoplastic reconstruction cases. This should be consented for and if images are to be used for research or education this must also be explicitly consented for. Any photographs taken should be stored digitally on a secure server with limited access.

Aims

This project aimed to assess what proportion of patients were offered, consented for, and received medical photography before and after reconstructive surgery.

Methods

Patients receiving an oncoplastic procedure at Charing Cross Hospital were eligible. Paper and digital notes were checked for 100 consecutive patients from January 2019, to assess whether medical photography had been offered, consented for or performed. Results were presented and barriers to medical photography explored. A new consent form was then introduced. The audit cycle was repeated in July 2019. The number of cases using the new consent form was also recorded and all data was compared to the previous audit.

Results and Discussion

Initially 12% of cases were consented for photography, with 0% having photos available on the digital system. A new consent form was proposed to increase compliance. Following the intervention 8% had photography consented for and 0% of patients had photographs available on the hospital computer system. A slight improvement was seen in those that were consented for photographs that could be used for research and/or education (0% vs 3%). Suggestions for further improvement include: a dedicated digital camera or device for the task and a digital consenting platform e.g. iPad that patients can sign.

A purpose designed consent form lead to improved rates of consent for use of images in research or education but had little effect on overall consent rates. Further interventions to improve compliance with national guidelines may include a dedicated device for photography and digital consent platform.

Abstract 11. Poster

Title

Audit of orthopaedic trauma theatre efficiency: Start on time, save money and work as a team.

Authors

Harris T(2), Stone J(1), Crowley G(1), Okocha M(1), Bott A(1)
1. Trauma and orthopaedic department, Southmead Hospital, North Bristol NHS Trust
2. University of Bristol Medical School

Background

Delays to theatre briefing times are an unnecessary and costly cause of inefficiency. An empty fully staffed theatre costs £25/min. Theatre efficiency is highlighted as requiring improvement in trust directive at North Bristol.

Aims

To quantify delays to theatre start times, identify reoccurring causes and implement changes to reduce delays

Methods

Cycle 1 was a three week prospective data collection exercise, recording WHO briefing time and patient arrival time in two trauma theatres at Southmead hospital. We implemented an alarm in trauma meeting and a phone call to theatres. We then conducted a second audit cycle for two further weeks

Results and Discussion

Cycle 1: Delays for theatres A&B respectively: Average brief delay 10 mins, 15 mins; total brief delay 2 hours 44 mins, 3 hours 33 mins; average transit delay 28 mins, 23 mins; total transit delay 7 hours, 6 hours. Total estimated cost of delays was £28, 925 (£501,367 annually).

Cycle 2: Delays for theatres A&B respectively: Average brief delay 8 mins, 15 mins; total brief delay 1 hour 5 mins, 1 hour 58 mins; average transit delay 23 mins, 48 mins; total transit delay 3 hours, 6 hours 22 mins. Total estimated cost of delays was £18,625 (£484,350 annually).

The introduction of an alarm in trauma meeting and a phone call to theatres with the details of the first patient on the list led to reduced delays in theatre start times. Our estimates predict that this could save over £17,000 annually.

Abstract 12. Poster

Title

Reducing pain with distraction therapy and pre-attendance analgesia in small acute paediatric burns

Authors

Howard Chu, Clinical Fellow Registrar, Sankhya Sen, Consultant Burns Surgeon, Plastic Surgery Department, North Bristol NHS Trust

Background

The development of acute outpatient clinics has enabled burns services to assess the majority of smaller paediatric burns the day after injury. This event can be distressing and it is therefore important to ensure that children are initially assessed in an optimal environment.

Aims

1. To understand how small acute paediatric burns are managed across the British Isles
2. Implementation of a standardised analgesia guideline within our burns unit at Bristol Children's Hospital
3. To investigate the effect that distraction therapy has on pain scores in small acute paediatric burns

Methods

Seventeen paediatric burns services within the British Isles were contacted. Following verbal consent, questions were asked to ascertain their pre-attendance analgesia regimen for small acute burns presenting to their outpatient burns service.

This gave guidance for implementation of a defined standard within our unit, stating that all outpatient paediatric burns should be advised to take Paracetamol 60 minutes prior to their allocated outpatient appointment.

The final part of our study recruited all patients who had taken analgesia prior to their appointment time, and collating their pain scores at the start, during the dressing change and at the end. We compared pain scores in two subgroups: those with and those without distraction therapy. Results were analysed and statistically evaluated

All seventeen paediatric burns services agreed to partake within the survey. On average it was recommended that Paracetamol should be taken 48 minutes prior to their appointment time.

Results and Discussion

In the first loop of our audit 44% of patients/ carers received analgesia advice. Following intervention this increased to 80%.

A total of 50 patients were recruited into our study for distraction therapy and it was found that larger burns are more painful, Paracetamol reduces pain by 18% and distraction therapy reduces pain by 23%.

Following a national survey of all paediatric burns services it is recommended that Paracetamol should be taken 60 minutes prior to allocated outpatient appointment time.

We are continuing to improve this standard through nurse education, revision of referral documentation and dissemination of information within the department.

It has been shown in this project that it is important to provide adequate pre-attendance analgesia and distraction therapy within clinic to reduce patient distress.

Abstract Accepted for Presentation at QISW National Conference 2020

Abstract 13. Poster

Title

Visibility for All: Improving the Inpatient Inter-specialty Referral System

Authors

Authors: Michelle Akhunbay-Fudge, Dowan Kwon, Won Young Moon, Brandon Pieters, Jeni Pillai, Charles Wilson, Jo Morrison. Affiliations: Taunton and Somerset NHS Foundation trust

Background

The inter-specialty referral system within Musgrove Park Hospital, also known as the red top referral system (RTRS), is an electronic referral system where a referral is only visible to a sender and designated recipients. The lack of visibility of the referrals to the other members of the sender and recipient teams means that patient care is often delayed or periodically missed especially when other members of the team who cannot see the referral take over the care of the patients.

Aims

We identified Epro, a current electronic patient record system, as a new way of sending referrals.

We aimed to increase the visibility of inter-specialty communication and improve patient care by transferring RTRS to Epro, where every referral can be sent electronically, saved in patient records and visible to all staffs who have access to patient records.

Methods

We conducted a survey to enquire staffs their views on current RTRs and transferring referrals to Epro. The new referral system was trialled in the pilot group of 6 F1 doctors from March 2019 to May 2019. The number of referrals visible on Epro before and after trial was recorded.

Results and Discussion

68% of the survey population (n=55) replied that the visibility of the current RTRS was inadequate and 94% said that RTRS would be better-served on Epro. The visibility of referrals (n= 360) on EPro from August 2018 to February 2019 was between 0-19% per month. Following the change in platform within our pilot group, more than 94% of referrals sent were visible on Epro each month. Less than 7% of replies to referrals were visible from August 2018 to February 2019. Following the change, the visibility of responses to referrals increased to 57%.

The survey illustrated that most staffs agreed that the lack of visibility of current RTRS is a problem and the change should be introduced. Epro has been used for electronic patient records in our hospital but it has not been utilised for sending referrals prior to the project. Our trial of new referral system highlighted that sending referrals via Epro improved visibility of both referrals and response to referrals. We have begun adopting new referral system in August 2019.

The transfer of RTRS to Epro has made communication between specialties more visible which will help improving patient care.

Abstract 14. Poster

Title

Importance of correct microbiology sample labelling.

Authors

Barlow E, Harding E and Gwilym B. University Hospital of Wales (UHW), Cardiff.

Background

Correct sample labelling is vital to providing safe and effective patient care. Incorrect labelling can lead to wrong patient identification and negatively affect microbiology advice regarding ongoing treatment. It was noted that the number of rejected microbiology samples was increasing on the Vascular ward at the University Hospital of Wales (UHW), Cardiff, which was subsequently having an effect on the clinical management of certain patient conditions.

Aims

The aim of this audit was to reduce the rate of rejected samples, raise awareness regarding the importance of correct sample labelling and provide teaching on this issue.

Methods

Data was collected retrospectively for ward inpatients. All microbiology samples sent within a 4-week period were identified. Data was recorded regarding the sample type, whether it was accepted or rejected, and the reason for acceptance/rejection. Implementations were then made based on these initial results.

Results and Discussion

The initial percentage of rejected samples was 17%. This was mainly found to be due to insufficient clinical details being provided on the request form. These results were highlighted to all staff at the ward's daily 'board-round' and teaching provided on sample labelling.

Posters were also created and put up around the ward to remind staff to check samples are collected and labelled in the correct manner prior to sending them. Following this a re-audit was undertaken. This showed a decrease in the percentage of rejected samples to 7%.

Rejected samples due to incorrect labelling lead to delays in the availability of microbiology results and sensitivities to antibiotics. Consequently, this leads to delays in patients receiving the most appropriate treatment. Furthermore, it affects the clinician's ability to prescribe and rationalise antibiotics based on culture sensitivities, something that is increasingly important due to antibiotic resistance.

This project is a good example of a simple yet effective measure that can lead to improvements in patient care. However, we need to continue raising awareness of this issue and provide ongoing teaching as this can be and should be improved further.

Abstract Accepted for Presentation at QISW National Conference 2020

Abstract 15. Poster

Title
Pre-Op Group and Saves – Who really needs them?

Authors

Dr Fraser Todd, Dr Deepika Bhojwani, Mr Michael Okocha

Background

NICE and MBOS provide guidance on which elective surgeries require pre-operative 'group and save' samples. This list is extensive but historical.

Several studies have questioned the need for routine pre-op group and saves in accordance with current guidelines. It has been suggested that these tests are not justified as they do not alter the management of post-operative bleeding[1] and most patients are unlikely to require a transfusion [2].

Aims

1. To assess compliance with guidance for pre-operative group and save samples at our major trauma centre (Southmead Hospital).
2. To identify how many patients who had group and saves also had blood products issued to them.

Methods

This was a prospective data collection study in a major trauma and pan-specialty tertiary referral centre with 27 active operating theatres. 445 cases were reviewed from operating lists across all specialities during one week in May 2019 and cross referenced with the ICE investigation reporting system.

Results and Discussion

Of the 445 cases: 18 were breast, 34 colorectal, 43 neurosurgery, 74 plastics, 11 spinal, 20 transplant and endocrine, 39 upper GI, 71 urology, 11 vascular, 122 trauma and orthopaedics and 2 general medicine. 129 patients had group and saves in line with MBOS guidance. Only 20 patients required blood products, all of who had valid group and save samples taken pre-operatively.

84.5% of group and saves were unnecessary highlighting a need to revise current guidance. At an estimated cost of £20 per group and save[3] an update in selection guidance could have saved £2080 and a potential £100,000 per year on blood tests alone.

None of the patients lacking a pre-op group and save required blood products in the post-operative period. This demonstrates that clinicians are already self-selecting to an extent which patients a group and save may be appropriate for and are accurately able to those that identify high risk for bleeding.

Ending routine group and saves would therefore the avoid discomfort and inconvenience of extra blood tests for most patients without compromising their safety.

Abstract Accepted for Presentation at QISW National Conference 2020

Abstract 16. Poster

Title

Increasing completion of Treatment Escalation Plan (TEP) forms of patients on a medical ward in a District General Hospital

Authors

Dr Christopher Roberts. Great Western Hospital

Background

DNACPR forms are designed to provide immediate guidance to healthcare professionals in the event of cardiac arrest. The majority of trusts expand these to include escalation to critical care. Discussions of this nature can be difficult for medical staff and perceived to be distressing to patients. This can result in forms not being completed and therefore futile or inappropriate CPR being attempted. It is recommended that decisions of this nature are made by the most senior member of the medical team and discussed with the patient and family at the earliest appropriate opportunity.

Aims

1. To increase completion of treatment escalation plans (TEP) forms to avoid inappropriate resuscitation attempts and to ensure these are discussed with patients and family.
2. To empower junior and nursing staff to help facilitate discussions with patients and senior staff.

Methods

This project involved education of junior medical staff including foundation doctors, core trainees and nurse practitioners and the MDT. This consisted of teaching at meetings and discussions at handover. A ward round checklist was utilised to act as a reminder. TEPs were reviewed before the intervention and one month after.

Results and Discussion

This project was completed between October and November 2018. Initial results before the intervention showed that only 12 of 28 (43%) patients had a TEP form completed or a documented discussion regarding escalation plans following admission to the ward. After the intervention, the completion of forms increased to 19 of 28 (68%).

The above shows that with simple, low cost interventions such as a checklist and staff education, there was a significant increase in the number of completed TEPs. Education encouraged involvement from the wider MDT and resulted in more forms being completed. This was thought to be due to staff feeling more comfortable regarding discussions.

A ward round checklist ensured that senior staff such as consultants were part of discussions as it meant these issues were highlighted on ward rounds. It aimed to ensure that standards were retained after the initial intervention period as the checklist will continue to be used.

Abstract 17. Poster

Title

The Role of a Bespoke Clinical Teaching Fellow at Prospect Hospice: Improving Student Satisfaction for Bristol 5th Year Medical Students - a Quality Improvement Project

Authors

Annabelle Mondon-Ballantyne, Great Western Hospital Swindon, Prospect Hospice and Bristol Medical School

Background

Previous years feedback related to palliative care teaching and hospice experience showed that students did not feel supported at the hospice and were unclear of learning opportunities available at the hospice.

New 50:50 CTF role in palliative medicine was funded between Aug-December 2019, the project would aim to prove this role was useful to students and could be justified whilst financially viable and improve student satisfaction.

Aims

1. Improve medical student satisfaction and learning outcomes during their placement at Prospect Hospice.
2. Justify implementation of new palliative care clinical teaching fellow (CTF) role.
3. Produce a validated teaching plan that can be used by future CTFs for students rotating through the hospice setting.
4. Baseline data collection of hospice experience, aims and anxieties.

Methods

- Designated CTF supported students
- Feedback collected using standardised form.
- PDSA1 –Tour of hospice and ward round
- PDSA2 –Above & patient clerking and presentations for CBDs instead of ward round.
- PDSA3–Above & syringe driver/opioid teaching
- PDSA4 –Above & virtual reality experience

Results and Discussion

- Quantitative data showed student satisfaction was maintained, ranging from 4.7-5/5.
- Qualitative data confirmed learning objectives were met and improved throughout the project. Students recognised the value of the teaching fellow commenting they ‘Felt uplifted and energised by this day of teaching’, ‘appreciated the structured plan to the day’ and ‘Best day of my module’. Comments improved with each PDSA cycle.
- Results of balancing measures (looking at staff perception of the value of the CTF and impact on overcrowding on the unit and patient fatigue) showed that repeated interventions and PDSA cycles did not have a perceived negative impact.

Students and staff benefited from having a CTF at the hospice. A CTF enhances students’ learning opportunities and experience from the hospice by providing a structure for the day and minimises anxiety around being in the hospice. Students found bedside teaching particularly useful to their learning. Students’ benefited from the experience seeing patients using and to be able to use VR headset when learning about non-pharmacological methods of managing pain. It has not been seen to have had a negative impact on over-crowding on the unit or on staff perception of patient fatigue when looking at balancing measures.

Title

Is Your Operation Costing You More Than You Think? **– Winner of the MoneyJar Health Prize**

Authors

Mr Nick Rees, Dr Deepika Bhojwani, Miss Tejas Netke, Mr Michael Okocha

Background

NHS departments across the country are overstretched and underfunded. Given the current financial climate, fair allocation of resources is imperative. This can be achieved through tackling inaccuracies in clinical coding.

Aims

- To compare theatre listing to operation notes within our major trauma centre at North Bristol Trust.

Methods

Data was collected prospectively in a major trauma and pan-specialty tertiary referral centre with 27 active operating theatres. 445 cases were reviewed from operating lists across all specialities during one week in May 2019.

Results and Discussion

Of the 445 cases: 18 were breast, 36 colorectal, 43 neurosurgery, 74 plastics, 11 spinal, 20 transplant and endocrine, 39 upper GI, 71 urology, 11 vascular, 122 trauma and orthopaedics. 36 operations were coded incorrectly. No obvious patterns were identified to link the errors to a particular specialty or procedure.

8% of the operations were not fairly reimbursed due errors in clinical code. Whilst errors may be multifactorial, clinicians have a responsibility to ensure that surgical documentation is clear and complete[1] .

Based on the results of this audit, the trust could forfeit compensation for an estimated 1,872 procedures per annum resulting in unnecessary and significant financial losses.

References:
[1] The increasing importance of clinical coding. (2008). British Journal of Hospital Medicine, 69(7), pp.372-373.

Abstract 19. Poster

Title

"Visual Abstract"- Style Posters Improve Compliance with BOAST-12 Ankle Fracture Guidelines

Authors

Dr Hashim Al-Musawi and Dr Conor S Jones

Background

The appropriate management of ankle fractures aims to optimise functional recovery and reduce the risk of post-traumatic arthritis. The British Orthopaedic Association Standards for Trauma (BOAST) guidelines provide a gold-standard for such management.

Aims

- We therefore aimed to assess and improve our adherence to guidelines outlined in BOAST 12.

Methods

A retrospective audit of all patients with closed ankle fractures, admitted and treated in our center over a three-month period, was conducted (n=33). Particular deficiencies were highlighted in documentation of post-reduction neurovascular status and VTE prescribing. Guidelines were incorporated into the departmental teaching programme and "visual abstract" laminated posters were hung in the junior doctor office. The audit was repeated five months after the intervention. Quality Improvement and patient Safety department assisted in analyzing the audit results. The audit loop was presented in the clinical governance meeting.

Results and Discussion

Twenty-two patients met the inclusion criteria of the second audit cycle. Documentation of post-reduction neurovascular status and VTE prophylaxis improved from 17% to 63% and from 81% to 94% respectively. Small improvements were also seen in the documentation of injury mechanism, skin integrity, pre-reduction neurovascular status and comorbidities (each >90% completion).

Poor documentation of post-reduction neurovascular status has important patient safety and medicolegal implications. Simple educational interventions can be used to improve junior doctor awareness of, and adherence to, related guidelines. The clinical director in the clinical governance welcomed the idea of introducing a tick box in the orthopaedic admission performa.

Abstract 20. Poster

Title

The Hidden Cost of Idiopathic Pancreatitis

Authors

Mr Nicholas Rees[1], Dr Rhiannon Frostick[2&3]; Ms Ffion Dewi [2&3] ; and Mr Okocha, M.[2&3]
[1 University of Bristol, 2 Southmead Hospital, and 3 Severn Deanery]

Background

Hospital admissions with pancreatitis increase annually and a subset of these patients have no identifiable aetiology. These patients suffer repeat investigations and admissions with no management pathway.

Aims

- To establish the number of patients presenting with idiopathic pancreatitis.
- To estimate the 10-year cost of idiopathic pancreatitis.

Methods

Retrospective review of all surgical admissions with pancreatitis between January and June 2019 to a major trauma and tertiary referral centre.

Between January to June 2019, 199 patients were admitted with pancreatitis and of these, 37 with idiopathic pancreatitis.

Results and Discussion

On average, these patients had 2 admissions with pancreatitis (maximum 7), and a 10-year-average of 5 radiological investigations. The average length of hospital stay was 5 days per admission with 3 sets of blood tests. The average cost per patient was calculated to be £4915. The maximal patient cost over 5 years was £16995. Total cost to the NHS over 6 months was £181,855 excluding ITU and emergency admission costs and specialist care.

These patients are difficult to manage and require extensive investigation, input from specialist teams and ITU. These patients have multiple admissions due to the lack of manageable aetiology. We believe that these patients require a national MDT pathway of investigation and management.

Abstract 21. Poster

Title

Improving inpatient referrals in medicine.

Authors

Mehak gupta, Stephen Adeyeye

Background

In Worcester Royal hospital, at the beginning of my rotation in medicine I noticed it was very hard to find out how to do referrals. Different specialities had their own protocols for inpatient referrals ranging from emails to paper referrals.

Due to lack of availability of relevant information, most of our time was spent trying to find out how to do referrals and this would then lead to delay in patient care as referrals were not being sent on time. It also reduced our efficiency as this was time consuming.

We were not given any information during induction about this and hence, we decided to find out if other junior doctors were in a similar situation.

Aims

Our aim was to reduce the amount of time junior doctors spent on finding out how to do referrals by half.

Methods

We devised a questionnaire and administered it to the junior doctors, who had begun working in medicine in August, 2019 to collect our baseline data.

Thereafter, we designed an A4 page with all the referral pathways and these were provided in form of posters in all the medical wards, particularly close to desktop and phones. We also made a soft copy and circulated it to the junior doctors.

Results and Discussion

All junior doctors were informed either verbally or through email/whatsapp groups about this document
Informal feedback was obtained about the pathway from the doctors and similar concerns of small fonts noted by most people, which were corrected with document reprinted in larger fonts for easy visibility.

We then collected our second set of data which showed that 15% of junior doctors were finding it hard to do referrals now compared to 72% initially. Also the time spent on finding out how to do a referral had effectively reduced to half (from >10minutes initially to <5minutes now)

We have achieved our aim of reducing time taken to do a referral by half. Also the feedback we obtained from the doctors about the pathway has been encouraging and this can be demonstrated by our results. We are still working with our IT department to upload the document on the intranet for easy accessibility.

Abstract 22. Poster

Title

Developing Radiology Guidelines to Improve Patient Flow

Authors

Charlotte Browne, James Common, Fraser Merchant, Emma Samouelle

Background

Increasing demand for imaging and interventions is causing unprecedented pressure on radiology departments[(1)]. In our acute trust we observed that uncertainties regarding the requesting and reporting process generates increased workload for both clinicians and radiology - often delaying scan execution and reporting. This contributes to delayed diagnosis, treatment and patient discharge.

We addressed this by developing guidelines to improve junior doctors' knowledge of radiology requesting and thus reduce the number of avoidable interruptions to the duty radiologists - a factor shown to influence the quality and safety of radiologists' output [(2)].

Aims

- To produce radiology requesting guidelines

Methods

We surveyed junior doctors and radiology registrars to establish the most problematic areas of requesting and reporting. We created requesting guidelines in collaboration with the radiology department.

These are going to be publicised by email and at junior doctor teaching. We will then re-survey to measure improvement.

Results and Discussion

Radiology registrars reported that 37% of interruptions during on-call shifts were inappropriate. Junior doctors were least confident at requesting imaging out of hours, requesting interventional radiology and obtaining specialist reviews of scans. 97% felt that requesting guidelines would be useful.

Optimised interaction with the radiology department aids patient flow, ultimately reducing discharge delays. Concise radiology guidelines are an effective and lasting method for achieving this.

References:
[(1)] Care Quality Commission. Radiology Review. July 2018.
[(2)] Bell et al. Reducing interruptions during duty radiology shifts, assessment of its benefits and review of factors affecting the radiology working environment. Clin Radiol. 2018 Aug;73(8):758.e19-759.e25.

Abstract 23. Poster

Title

Patient and Clinician Education to Improve Antibiotic Prescribing

Authors

James Common

Background

Antimicrobial resistant (AMR) infections cause around 700,000 deaths each year globally, due to rise to 10 million by 2050 if no action is taken [(1)]. Around 70% of antibiotic prescriptions occur in primary care and 20% of these are inappropriate [(2,3)]. Improving this is key in the fight against AMR One barrier to appropriate prescribing is patients' expectations of receiving antibiotics [(4)]. I audited and attempted to improve antibiotic prescribing in acute sinusitis at a GP practice in Bristol with >25000 patients.

Aims

- To improve antibiotic prescribing in acute sinusitis at a large GP practice in Bristol.

Methods

Over four weeks consultation records relating to acute sinusitis were audited against NICE and local guidelines. The results, alongside guidance on the management of sinusitis, were presented to practice clinicians. An EMIS template was created to aid decision making and provide information to patients on why antibiotics were not recommended. Re-audit will occur in one month.

Results and Discussion

There were high rates of antibiotic prescribing. 45% of consultations resulted in immediate prescriptions with 77% of these not meeting the criteria for antibiotics. Antimicrobial stewardship in primary care is vital in the fight against antimicrobial resistance. Educating clinicians and patient is simple yet effective method to improve prescribing practice [(5,6)].

References:

(1) Department of Health and Social Care. UK 5-year action plan for antimicrobial resistance 2019 to 2024. 24 January 2019. Available from: https://www.gov.uk/government/publications/uk-5-year-action-plan-for-antimicrobial-resistance-2019-to-2024.

(2) Smieszek T, Pouwels KB, Dolk FCK, Smith DRM, Hopkins S, Sharland M, et al. Potential for reducing inappropriate antibiotic prescribing in English primary care. J Antimicrob Chemother [Internet]. 2018 Feb 27;73(suppl_2):ii36–43. Available from: https://doi.org/10.1093/jac/dkx500.

(3) Nuffield Trust. Antibiotic Prescribing Quality Watch. Last updated 18 July 2019. Available from: https://www.nuffieldtrust.org.uk/resource/antibiotic-prescribing.

(4) Sirota M, Round T, Samaranayaka S, Kostopoulou O. Expectations for antibiotics increase their prescribing: Causal evidence about localized impact. Vol. 36, Health Psychology. Sirota, Miroslav: Department of Psychology, University of Essex, Wivenhoe Park, Colchester, United Kingdom, CO4 3SQ,

Abstract 24. Poster

Title

Does targeted immersive simulation based training improve medical students ability to ‘speak up’

Authors

Dr Kirsty Bates - Avon & Wiltshire Partnership Trust/University of Leicester

Background

Speaking up has the potential to act as an immediate preventative measure to human error resulting in patient safety concerns and facilitates the subsequent identification of process deficiencies. However, in many cases, individuals are reluctant to voice concerns in a pressurized environment, opting to choose the safer action of silence, or if they do speak up, are ignored.

Aims

Second-year medical students at the University of Leicester were enrolled into a novel simulation designed to assess, target and improve the trainee’s ability to speak up about patient safety within the clinical environment.

Methods

Students were randomly assigned to a group (<10 students). Each group participated in three different simulations: a senior-led ward round (WR), a consultant-led Multidisciplinary Team Meeting (MDT), and theatre (T). Simulations are experienced by every group on a rotational basis.

Each simulation incorporated a number of patient safety challenges. Prior to the simulations, students received an introductory briefing to explain their roles as “1st year junior doctors” within the simulations, as well as introducing the overriding themes of preparing for clinical practice, including aspects of professionalism and patient safety. In the theatre Simulation, students were taught about the importance of speaking up to see if this impacted on them highlighting the patient safety issues in the scenarios that followed.

Results and Discussion

238 second year medical students participated in the simulation-based training.
Overall, the students were more likely to identify an error and speak up in the later simulation stations compared to the initial stations: 29% in the 1st station vs. 54% in the 2nd station vs. 66% in the 3rd station, p=0.03.

A total of 174 (74%) trainees completed the post SBT survey. Prior to the SBT 24% either agreed or strongly agreed that they felt confident in speaking up if there was a patient safety issue, compared to 93% following completion of the training episode (p<0.001).

In conclusion, we have shown that Targeted Simulation Based Training is a valuable and effective educational tool in the pre-clinical setting. Further longitudinal studies to show whether training in speaking up translates into behavioral change, initially throughout medical school and onto future clinical practice is required.

Abstract 25. Poster

Title

Foundation Doctors Teach ReSPECT

Authors

M. Monica Haydock (F2) & Andrew Foo (Consultant ICM and Anaesthetics) - Gloucestershire Hospitals NHS Foundation Trust

Background

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process and form has recently been implemented in Gloucestershire Hospitals NHS Foundation Trust along with the South West in October 2019. The ReSPECT process is “a new approach to encourage people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices.” It is slowly being adopted in many hospital trusts and health care providers throughout the UK. Locally, this replaced the Unwell/Potentially Deteriorating Patient (UP) form or ‘Purple’ form.

Aims

- Increase awareness (Phase 1) of the implementation of the ReSPECT process within the trust
- Develop the teaching skills of Foundation Doctors through training and teaching
- Further develop communication skills of Foundation Doctors through the ReSPECT process

Methods

24/108 Foundation Doctors were initially recruited. Online and face to face training were conducted. Through a cascade method of teaching, these doctors will then train and teach peers and ward staff about the ReSPECT process. Online feedback was then collated and returned to foundation doctors for their portfolios. Teachings are are also logged and reported back to the ReSPECT Implementation Group.

Furthermore, ReSPECT communication skills/tiny simulation sessions are underway. These sessions aim to increase the confidence of foundation doctors when having conversations regarding the ReSPECT process. Through these sessions, a ReSPECT “conversation starter” sheet can also be created which would help in further ReSPECT process training.

Results and Discussion

24/108 Foundation Doctors were initially recruited. 8/24 went through training and proceeded to teach in their wards. Since then, there has been 20 training/teaching events reaching 156 staff members.

Confidence levels were assessed after training – 92.3% of responders were confident in finding the ReSPECT forms, 96.1% were confident in identifying which team member to discuss the ReSPECT form with, 92.3% were confident in identifying which patients need a ReSPECT form, 80.7% were confident in discussing the ReSPECT form with patients or their families, 92.3% were confident in filling in the ReSPECT form, and 84.6% were confident in teaching others about the ReSPECT process and form.

The implementation of the ReSPECT process in GHNHSFT increases the safe delivery of healthcare to its patients. The efforts of the foundation doctors through this teaching/training project have contributed in raising awareness (Phase 1) of the implementation process. The results of this project will also contribute to Phase 2 of the implementation process, which is training in having quality conversations and reflective practice/competency.

Another unique aspect of this teaching/training project is that as Foundation Doctors are still in the very early stages of their careers, being exposed to discussions on ceilings of treatment (with senior support), they will be able to develop and hone this skill as they progress throughout their careers.

Meet The Speakers

3/3

DR BRYAN JONES

Improvement fellow at the Health Foundation Bryan Jones is an Improvement Fellow at the Health Foundation. Since joining the Health Foundation in 2013, Bryan has focused in the main on the analysis of quality improvement and improvement capability building efforts within the NHS.

He is the co-author of a number of publications on improvement including the Improvement Journey (2019), How to Get Started in QI (2019), Making the Case for QI (2017), The Challenge and Potential of Whole System Flow(2016) and Building the Foundations for Improvement (2015).

Prior to joining the Health Foundation, Bryan worked in Westminster for an MP on the Health Select Committee and for a number of health related charities. He has a PhD in Social Policy and has been a Labour Councillor in Kent.

MISS ANNE PULLYBLANK

A Consultant Colorectal surgeon appointed to North Bristol NHS Trust in 2003 and was Clinical Director for Surgery from 2010 to 2015. Anne has been involved in medical education as a Clinical Tutor and has an interest in patient safety.

She was chair of the Trust Clinical Risk Committee for 2 years. Anne was part of the Safer Patient's Initiative, working in the peri-operative work stream. She then became faculty for the peri- operative workstream for the South West Safety collaborative.

Anne is now Clinical Director for Patient Safety Collaborative at West of England Academic Health Science Network. Anne was shortlisted for a Health and Social Care Award in 2009 for work on the surgical safety checklist, winner of a National Patient Safety Award in 2011 for work on nasogastric tube safety, shortlisted for a NHS leadership award in 2012 and shortlisted in 2 categories for a national patient safety award in 2014 for work on reducing surgical site infection.

Anne is currently lead for lower gastrointestinal surgery and emergency surgery at North Bristol NHS Trust and is lead for the West of England Emergency Laparotomy collaborative. In 2016, the Enhanced Recovery team won hospital team of the year at the Bristol Evening Post Awards. In 2017 Anne was shortlisted with a team for Cancer Team of the Year at the BMJ Awards for developing an electronic cancer referral system.

Abstract 26. Poster

Title

Improving information available to the On-Call doctor in a rural Scottish hospital through the introduction of a Friday checklist

Authors

Michelle Heelan FY2, Catriona Woodley GPST, Heather Kirkland FY2, Calum Green FY2, David Gregg FY2, Gordon Caldwell Consultant- Lorn & Islands Hospital, Oban, Scotland NHS Highlands

Background

There is an increased rate of adverse events among inpatients over the weekend. Concise documentation from the primary team alongside a clear escalation plan is essential for the on-call team to assess and treat deteriorating inpatients. The introduction of a checklist provides structured documentation, which are proven to reduce morbidity and mortality. On weekends this rural hospital has one consultant and one junior doctor covering the wards and Accidents and Emergency, therefore access to a Treatment Escalation Plan (TEP) and clear documentation from the primary team during the week is crucial to optimise patient safety.

Aims

To survey staff and identify information required by the on-call team to safely treat inpatients. This information will be utilised to create a pro forma, against which all inpatients notes will be audited to assess current documentation. A Friday checklist will be created and re-audit completed to quantify improvement.

Methods

Cycle 1: Staff survey identified information crucial for treatment of inpatients and a pro forma created. All notes from Friday were audited utilising this pro forma.

Cycle 2: A checklist was created for use on Friday ward-rounds. A re-audit was conducted following introduction of the Friday checklist to quantify improvement.

Results and Discussion

Cycle 1 identified TEPs were recorded for 18.75% of patients and a clear weekend plan was recorded for 37.5% of patients. The diagnosis was recorded in 25% of patients' notes. Antibiotic duration was recorded for 33% of patients on current antibiotic therapy. These results were presented at the departmental meeting and the checklist was created for use in Friday ward-rounds.

Cycle 2 showed marked improvement in documentation in all areas. Weekend plan and antibiotic duration were recorded in 100% of notes. TEP use increased to 75%. Diagnosis was recorded all patients.

This QIP identified the variance that exists in medical note taking and highlighted the importance of easily accessible and concise notes for the On-Call team. The introduction of a standardised checklist provided a tool for structured documentation. This prompted junior members of the team to clarify the weekend plan with the primary team on the Friday ward round. This ensured crucial information was documented and was readily available to the on-call team when required, ultimately optimising patient safety.

Abstract 27. Poster

Title

Improving the quality of Foundation Year 1 induction through increased focus on near-peer teaching

Authors

Dr Michal Woyton (FY2 Salford Royal Foundation Trust), Dr Sofia Arkhipkina (FY2 Salford Royal Foundation Trust)

Background

Changeover time in August is a stressful time for new Foundation Year 1 (FY1) doctors. The period has also been associated with an increased risk to patient safety, with higher mortality rates and reduced efficiency.
In 2012 Health Education England (HEE) introduced a compulsory 4-day induction period for newly-appointed FY1s. With no national curriculum, Trusts design locally-tailored programmes for this period. HEE 2014 guidance stressed the aim of the induction was familiarising FY1s with local working environment to maximise patient safety. Until this year planning of the FY1 induction programme at Salford Royal Hospital had no input from foundation doctors.

Aims

- Restructure the Trust's FY1 induction programme to provide teaching on key topics identified by outgoing FY1s as relevant
- Shift the focus of induction towards familiarising FY1s with Trust protocols and improving their confidence prior to starting work as doctors
- Include near-peer teaching sessions within induction
- Maximise patient safety during changeover time

Methods

We surveyed outgoing FY1s on their experiences of the induction process. Based on the feedback, we redesigned the Trust's FY1 induction programme to include more small-group near-peer teaching workshops delivered by outgoing FY1s, with an increased focus on patient safety. We surveyed incoming FY1s before and after teaching workshops.

Results and Discussion

Feedback from the outgoing FY1 cohort identified near-peer teaching delivered by outgoing FY1s as an effective method of passing on job-specific information. The feedback also highlighted essential topics to cover as part of induction incl. management of the acutely unwell patient, prescribing tasks on the Trust's computer system, task prioritisation, introduction to on-calls, and sessions on documenting discharges safely.

96.3% of FY1s found the newly introduced near-peer teaching workshops helpful in familiarising them with the work of FY1s in the Trust. There was improved self-perceived confidence/familiarity for all the topics covered (highest: 88.9% increase in familiarity with the on-call system).

The restructured induction programme improved self-perceived confidence of new FY1s in the topics covered by the near-peer teaching workshops. Teaching by outgoing FY1s provided a relevant insight into the FY1 role within the trust, valued by incoming FY1s. The small-group format allowed plenty of time for FY1s to ask tutors questions and clarify specific concerns about their new jobs. Familiarising new FY1s with Trust protocols whilst providing plentiful opportunity to answer their queries is likely to increase their confidence and therefore improve patient safety at changeover time.

We recommend this method of induction to maximise the FY1's readiness prior to starting their new jobs.

Abstract 28. Poster

Title

Oxygen Prescribing Practices at Royal Surrey County Hospital

Authors

Aleksandra Kotwica

Background

Oxygen is a drug and needs to be prescribed. British Thoracic Society Guidelines 2017 state that the best practice is to prescribe a target range for all hospital patients at the time of admission. This is to ensure that appropriate oxygen therapy can be started in the event of unexpected clinical deterioration with hypoxemia. (3). Patient at risk of type 2 respiratory failure should have a target set at 88-92%. The rest of the patients should be targeted between 94 – 98%. This audit aims to identify current practice at the Royal Surrey County Hospital, compared to the BTS National Audit in 2013 and the British National Guidelines for oxygen use in adults in healthcare emergency settings in 2017.

Aims

We wished to evaluate:

A. A correct prescription was filled out for patients receiving oxygen therapy in the hospital
B. In the patients with COPD oxygen saturation was maintained at 88% - 92%
C. Oxygen target saturations have been prescribed to all of the patients on the medical wards

Methods

1st audit cycle: On a single day in April 2019 all patients on medical wards were observed for supplemental oxygen therapy.

2nd audit cycle: We have used both, active and passive interventions to meet the BTS standards. The active interventions included presentation of the results at weekly teaching for junior doctors and direct education of all junior doctors on the medical wards. The passive interventions included the labels on the drug charts and posters.

Results and Discussion

1st audit cycle: Out of a total of 180 patients seen, 45 (25%) only had their oxygen prescribed. Nineteen (10.5%) of the 180 patients were on oxygen. Of these 6 (13%) patients had the oxygen prescribed correctly. Twenty-two patients on the wards had a known diagnosis of COPD and two-bronchiectasis. In only 12 of these patients (50%) was oxygen target saturations have been prescribed.

2nd audit cycle: Out of total 172 patients seen, 97% had their oxygen target saturations prescribed. Twenty (12%) of these patients have been on oxygen with 18 (90%) patients having had their oxygen prescribed. In all of the patients prescribed and receiving the oxygen the target saturation have been prescribed correctly.

The 1st audit cycle highlighted significant gaps in oxygen prescribing at Royal Surrey County Hospital. Almost half of COPD patients on the medical wards were at risk of oxygen toxicity.

Following the implementation of the passive and active recommendations the oxygen prescribing practices have meet the National Standards.
Education of doctors and nurses on the accurate oxygen prescription should be reinforced regularly.

Abstract 29. Poster

Title

Safe Handover, Saves Patients

Authors

Siya Lodhia; Joseph Lalor; Nadine McCauley

Background

The surgical senior house officer (SHO) covers Urology out of hours at Lister hospital in Stevenage. With frequent changeover of staff, the quality of handover can vary, resulting in the possibility of patients being missed on ward rounds, compromising patient safety. This audit set out to evaluate the standard of handover compared to the Royal College of Surgeons' guidelines.

Aims

To change the handover method to make it compliant with guidelines.

Methods

A total of 34 patients handed over by the surgical SHO to the Urology team, over a 30-day period in the month of October, were included in the audit. After auditing the handover for two weeks, we designed our own proforma to be used as part of the handover. Factors included were based on parameters from the Royal College of Surgeons guidelines. We then re-audited the handover using our proforma.

Results and Discussion

The results demonstrate an overall increase in the amount of information handed-over. We have summarised the largest increases observed when comparing the data obtained before and after using the proforma. The recording of:

- patient name increased from 76% to 100%;
- date of birth and hospital number increased from 59% to 95%;
- consultant responsible increased from 0% to 91%; and
- location of patient increased from 24% to 95%.

The introduction of the Urology admissions handover sheet increased recording of all factors and brought awareness to those taking the handover to pass on helpful information they otherwise would not have.

This audit demonstrates that following guidelines to improve communications can help us get it right first time and improve overall patient safety.

Abstract 30. Poster

Title

Increasing Ultrasound availability - a simple way to reduce surgical admissions

Authors

Siya Lodhia; Lydia Earnshaw; Mohammed Fahmy

Background

Ultrasound scanning (US) can be a useful tool for diagnosis in the Emergency setting. General Surgery currently admit around 15 patients a day but only have 4 reserved US slots. We believe more slots would reduce inpatient admissions and improve patient care.

Aims

To reduce US wait times for inpatients and safely discharge patients with urgent OP US scans when required

Methods

We looked at patients that presented over 2 weeks and noted the following:

- differential diagnosis;
- time of request;
- time of US;
- whether definitive diagnosis was reached; and
- if further imaging was needed.

Results and Discussion

Of the 39 patients in our study, only 12 had US scans on the same day and 6 patients had to wait over 24 hours, of which 3 were not seen to for over 48 hours. Subsequently, 14 patients required further investigation which resulted in huge delays with their care.

This audit clearly showed patients were having to wait unacceptable lengths of time for a scan. However, after discussing with the Radiology department we came up with the following interventions:

- A HOT Mobile is to be given to the daily sonographer for quicker communication;
- An additional room will be opened in AMU providing closer access to SAU for additional US scanning. This will increase the number of total slots for the hospital, but the emergency, medical and surgical take patients would in the first instance be scanned here.
- Use of a new ‘urgent’ code created by Radiology when requesting scans for patients that can be discharged safely if they are guaranteed a scan within a few days.

Abstract 31. Poster

Title

Fracture clinic venous thromboembolism (VTE) assessment and prophylaxis for patients with lower limb plaster cast immobilization

Authors

Shady Hermena[1] and Sherif Isaac [2]
[1]Trauma and Orthopedic department, Yeovil District Hospital
[2] Trauma and Orthopedic department, Worcestershire Acute Hospitals NHS Trust

Background

Venous thromboembolic (VTE) is a significant cause of morbidity and mortality. VTE events cost the NHS an estimated £640million a year. Post-traumatic lower limb immobilization causes 2% of all VTE. However, this cause is potentially preventable by identifying the high-risk population and prescribe the suitable pharmacological prophylaxis. The VTE assessment form is an effective tool to identify patients with a high risk to develop VTE. In addition, the NICE guidelines (NG 89) recommends using pharmacological VTE prophylaxis with LMWH or Fondaparinux sodium for people with lower-limb immobilization whose risk of VTE outweighs their risk of bleeding.

Aims

1. Monitor the documented care in fracture clinic in Worcestershire Acute NHS trust against the audit standard (NG 89)
2. Improve the compliance to complete the VTE assessment form and prescribe the required chemoprophylaxis for adult patients with lower limb plaster cast immobilization.

Methods

Inclusion criteria were adult patient with posttraumatic lower limb cast immobilization. Exclusion criteria were patients younger than 16 years old and patients with air boot.28 patients were included in the first audit and 22 patients were included in the second audit. The electronic EZ system used to retrospective notes review.

Results and Discussion

The first loop audit showed that only 21 out of 28 patients (75%) had VTE assessment completed and VTE prophylaxis prescribed. The audit was presented in the trust-wide governance and we introduced a poster in consultation rooms to remind the clinicians to complete the VTE assessment for very patient with lower limb cast immobilization.

Furthermore, we notified the plaster room team not to proceed to do any lower limb plaster cast without a completed VTE assessment form. This was very effective to improve the compliance to (95.45%) in completing the VTE assessment form and prescribing VTE prophylaxis as noticed on closing the audit loop.

VTE is potentially a preventable cause of mortality and morbidity. Lower limb immobilization in plaster cast increases the risk of developing VTE. VTE assessment form is a simple and effective tool to identify high-risk patients for VTE who should receive pharmacological prophylaxis according to the NICE guidelines recommendation.

The audit action plan including the illustrative poster and plaster room team involvement were effective to improve the compliance in Worcestershire Acute Hospitals NHS Trust. However, continuous monitoring of our care is recommended to ensure the standard levels of care are maintained and improved to reach 100% compliance.

Abstract 32. Poster

Title

Post nasal-packing management of epistaxis

Authors

Selda Boztepe and Fenella Shelton

Background

Epistaxis is a common ENT emergency and nasal packing and cautery are common methods used in secondary care to achieve haemostasis. NICE guidance states all patients presenting to primary or secondary care services with epistaxis should have Naseptin® (chlorhexidine and neomycin) prescribed. In addition, it is standard practice within ENT that all patients admitted with epistaxis should be examined, and cautery attempted if a bleeding point is identified, before discharge.

Aims

To assess current practice in the management of epistaxis after the removal of nasal packing at the Royal United Hospital, Bath.

Methods

Retrospective analysis of the electronic drug chart and discharge summary of the last 100 patients admitted with epistaxis at the Royal United Hospital in Bath was undertaken.

Results and Discussion

Notes were assessed for evidence of: post pack removal anterior rhinoscopy or examination, post pack removal cautery and whether Naseptin® cream was prescribed on discharge.The last 100 patients admitted with nasal packing covering an 8 month period (August 2018-April 2019) were looked at, 8 patients were excluded based on the exclusion criteria of the study. Only 41/92 (45%) patients were discharged with Naseptin® cream. 39/92 (42%) patients had no documented attempt at cautery prior to discharge.

The local management of epistaxis following the removal of nasal packing is currently sub-optimal. This has potential implications for further presentations to health care services and re-admission to hospital. A new protocol for management of epistaxis following pack removal has been designed and is currently being delivered as part of training to all ENT clinical staff. Following the implementation of the new epistaxis protocol and allowing for a period of adjustment a second audit will be conducted to complete the cycle.

Abstract 33. Poster

Title

Flooding Theatre: why do we waste so much water while scrubbing? – **Winner of the Health Foundation Prize**

Authors

M Huttman (Med Student), B Turner (Med Student), J Fallon (SpR), A Edwards (Consultant) – North Bristol NHS Trust

Background

Climate change labelled the greatest threat to health in the 21st century, a range of conditions related to heat, cold, extreme weather and air pollution are predicted to rise. It is out duty to optimise all we can to minimise environmental impact of healthcare, which as an industry is monumental.

The WHO recommends that scrubbing take between 2-5 minutes, most of this time is disinfecting with soap/picks/sponges, with minimal time spent rinsing off the disinfectant under running water. It is convention to leave the tap running, but why? This needless water consumption could be reduced conferring both financial and environmental benefits.

Aims

Firstly, to quantify the amount of excess water usage during surgical hand scrubbing, in litres and assess a possible intervention to reduce water consumption during surgical hand scrubbing.

Secondly, to estimate savings, both environmental and financial which could be made by intervening.

Methods

10 surgeons across 5 theatres were observed scrubbing, using a stopwatch to measure the time the tap was running without being used for rinsing. The average 'waste' calculated per scrub across the surgeons from the time the water was needlessly running X flow rate. Tap flow rate calculated by sustainability department (9 litres/min), they also gave an estimate of the cost per litre of water at Southmead (£2.00 per 1000 litres) with a water heating cost of £0.03/minute. This allowed Potential cost savings to be calculated, cost per litre of warmed water x litres wasted during scrubbing.

Results and Discussion

The average extra time taps were running was 1m42s (1.7min) at a flow rate of 9L/min, costing £0.002/L with a heating cost of 3p/min (0.333p/L). We found an average wasted 15.3L of water, costing 5.1p per scrub. As a very conservative estimate a single theatre performs 5 cases per day with a minimum of 3 persons scrubbing that is 230L per day, 1150L per week (£6.13), 59800L per year (£320) and across all NBT theatres (30) 1.8 million litres of water (£9,600), equivalent to 315kg of carbon production!

What has been made clear is there is a significant amount of waste, the monetary cost isn't significant, but in times of a global climate emergency can our trust or the NHS justify this level of waste for such a simple solution. The next step is to place our intervention which is an education poster above each sink to remind people of the significant impact and to simply turn the tap off between rinsing. Once the educational poster has been circulated we can re-audit to assess if such a simple intervention can reduce the impact or trust has on the planet.

Abstract Accepted for Presentation at QISW National Conference 2020

Abstract 34. Poster

Title

Improving the handover process between 4 monthly FY1 roations

Authors

Dr Anisha Mangtani, Dr Rosalind Beckett, Dr Susannah Dabbaj, and Dr Heather Woodcraft
Southmead Hospital, Bristol

Background

A 2009 NHS and wellbeing review found that “organisations that prioritised staff health and well-being performed better…[achieved] better outcomes, higher levels of staff retention and lower rates of sickness absence1.” With this in mind, development of practices improving junior doctor wellbeing should be focussed on as a priority. While current approaches involve reviewing general work practices (e.g. rest breaks2) more specific to foundation programme doctors is the frequent changeovers between hugely varied medical and surgical specialties. Feelings of unpreparedness around changeover were identified as a possible area for improvement by junior doctor’s welfare committee at Southmead (JDAWG).

Aims

Improve the confidence and wellbeing of Foundation Year 1 (F1) doctors starting new rotations at North Bristol trust (NBT) through handover sheets completed by colleagues having done the rotation. Handover sheets aim to provide information relevant to the F1 role in the team, to ease anxiety during the transition period.

Methods

Cycle 1 (baseline), F1 doctors at NBT completed a survey assessing levels of confidence/ preparedness for their second rotation. Proformas were distributed to F1s who completed them based on personal experience of the rotations. This was collated into easy-to-read handover sheets and redistributed back to F1s before Cycle 2.

Results

Cycle 1 (baseline) results showed 43% of rotations did not provide handover sheets prior to starting in August. 52% of F1s did not feel prepared prior to starting in August. 43% felt they knew what was expected of them. Of the 48% who felt prepared prior to starting and the 43% who felt they knew what was expected of them prior to starting, 80% were given a written handover sheet beforehand. Furthermore, of those who had not received a handover sheet, 80% answered that they felt it would have reduced feelings of worry/anxiety if they had received one.

Discussion and Conclusion:

These findings show that most F1s at North Bristol trust did not feel prepared prior to their first rotation and that those who did, had received a handover sheet prior to starting, indicating that formal handover sheets could be a significant factor in improving feelings of preparedness. Handover sheets also have the potential to improve wellbeing of F1 doctors by reducing feelings of worry and anxiety prior to switching rotation. This will be assessed in Cycle 2, following the distribution of our handover sheets created in collaboration with current F1s.

References:

1. S Boorman, NHS Health and Wellbeing Report 2009, Commissioned by DoH
2. Rimmer Abi. Doctors' wellbeing: GMC promises action BMJ 2019; 367 :l6484

Abstract 35. Poster

Title

Improving confidence and quality of VTE risk assessment and VTE prophylaxis prescribing

Authors

Sebastian Calloway [1], Ashley Medcalf [2], Bhavi Patel[3], Edward Barton[3], Madeleine Culverhouse-Matthews[3], Simon Williams[3] and Katrina Glaister[3]
[1] North Bristol NHS Trust, [2] Brighton and Sussex University Hospitals Trust, [3] Salisbury NHS Foundation Trust

Background

Venous thromboembolisms (VTE) complicate a patient's hospital stay in a significant proportion of inpatient admissions. (1) As such, VTE risk assessment and subsequent prescription of prophylaxis is paramount to prevent catastrophic consequences for patients which can result in prolonged admission, admission to ITU and even death (2).

While appropriate prescription of VTE risk prophylaxis is to a high standard at Salisbury District General Hospital, the process of VTE risk assessment appeared vague. We aimed to measure the confidence of junior doctors in prescribing pharmacological VTE prophylaxis in accordance with trust and NICE guidance and the new PADUA scoring system (3).

Aims

1. To measure and improve the confidence and safety when prescribing pharmacological VTE prophylaxis.
2. To create a single document that had VTE guidance alongside a checklist that could be used prior to prescribing.

Methods

We used a questionnaire to gather information from junior doctors about confidence and adherence to guidelines when prescribing pharmacological VTE prophylaxis for their patients.
Then we implemented a sticker with the PADUA numerical scoring system, audited the usage of the sticker, and improved compliance with teaching and feedback.

Results and Discussion

Out of the questionnaires received, there was a huge variation in confidence of prescribing VTE, 69% were aware of trust guidance, and of those, only 50% were aware of where to find it.

The two audits of the PADUA sticker are shown below:

	VTE document	First round audit	Second round audit
Compliance (%)	Indications	57.1% (n=12)	79.2% (n=57)
	Contraindications	23.8% (n=5)	51.4% (n=37)
	Dose adjustments	0%	51.4% (n=37)
	Sign and Date	57.1% (n=12)	62.5% (n=45)

Initial results revealed average to poor confidence in prescribing pharmacological VTE prophylaxis. This could have detrimental consequences to patient care. This will also incur increased costs to the department as a result of over-prescription or prolonged hospital stays. The new sticker and PADUA scoring system will aid in limiting the uncertainties that doctors face when prescribing VTE prophylaxis.

Though requiring several further revisions, the new document has already shown an increase in compliance in safety checks.

Abstract 36. Poster

Title

An audit of surveillance mammogram follow-up rates in postoperative breast cancer patients at a regional breast care centre.

Authors

Zoe Bleything, Ariella Levene, and Michael Okocha

Background

Breast cancer is the most common cancer affecting women in the UK and the second most common cause of cancer death. Surveillance mammograms are a key tool in identifying cancer recurrence and as a point of contact ensuring patients are not lost to follow up. NHS guidance advises all patients with breast cancer should be offered annual surveillance mammograms for five years or until they are eligible for the NHS screening programme. Bristol Breast Care Centre protocol complies with NHS guidance and previous local audits have reported completion of 95% of mammograms in first year postoperative patients

Aims

- For 100% of eligible post-operative patients to have year one and year two surveillance mammograms.
- For 100% of patients with abnormal surveillance mammograms to be investigated further if appropriate.

Methods

Retrospective review of surveillance mammogram reports of patients who had cancer removal breast surgery from January 2017 to December 2017. If features suspicious of malignancy were reported, we reviewed further investigations to determine whether a diagnosis of cancer was made. Data collection will continue until the end of December 2019.

Results and Discussion

677 postoperative patients were included who had undergone either mastectomy (187) , wide local excision (136) or wire guided excision (354). Patients who had died or had further breast surgery not relating to malignancies picked up on surveillance scans were excluded. At the time of writing 87% (585) of patients had at least one annual surveillance mammogram and 75% (503) had two. All patients (100%) whose mammogram reports identified suspicious features received further investigation. We identified two confirmed malignancies that had been picked up on surveillance mammograms and three further cases suspicious for malignancy currently under investigation.

The identification of malignancy validates the purpose of the surveillance and also demonstrates an excellent follow up rate for abnormal mammograms. Despite the incompleteness of our data-set at time of writing we tentatively suggest that the data available reflects a drop off in surveillance mammogram completion from the first to second year post-operatively.

We suggest a review of non year one surveillance mammogram requests to clarify rates of booking errors and annual reporting of mammogram uptake to assess whether the rate of drop off increases in later years of surveillance.

Abstract 37. Poster

Title

Establishing a midnight huddle to improve interspecialty working

Authors

Dr Miriam Thake and Dr Mya Dilly, Great Western Hospital, Swindon

Background

Multiple different teams work within hospitals, historically working independently with minimal interaction. Night time working is a key area of stress within the hospital with rising emergency admissions and increasingly frail, complex and multi-morbid patients. There is now truly at 24 hour demand within hospitals. Traditionally specialty teams worked as silos with limited opportunities to highlight areas of risk and provide inter-specialty support. Referrals are often made over the phone between “faceless” doctors, with anecdotal suggestions of occasional conflict.

Aims

- To improve inter-specialty working, focusing on out-of-hours, overnight working, bringing together teams from ED, medicine, surgery, paediatrics, orthopaedics, ITU, Site team and Hospital@Night.
- To encourage situational awareness and team work through communication and problem solving.
- To provide inter-specialty support at times of high pressure or risk.

Methods

Using Langleys PSDA cycles for rapid improvement and assessment, a Midnight Huddle was designed; a short, multidisciplinary briefing in ED, focused on areas or patients that are most at risk. A crib sheet was designed to add structure to the meetings and a feedback form to guide PSDA cycle interventions.

Results and Discussion

The Midnight huddle started on 23/09/2019 in the Emergency department. Attendance from all specialties was generally good and the feedback was positive. Suggestions from the first round of feedback informed improvements. An automated bleep is now sent out at 23.45 to remind participants that the Huddle is about to happen, we have re-promoted the Huddle and successfully secured funds to provide hot drinks and snacks. The second cycle of feedback has been even more positive than the first.

Qualitative feedback from the Midnight Huddles highlights the impact of the Huddle allowing the sharing of ideas between teams, mutual support and the ability of the Huddle to make separate specialities “feel more like a team”.

Using QI methodology to tailor a bespoke Midnight Huddle for the hospital has helped to understand flow and how other specialities are coping within the hospital at night and has improved conversations and inter-specialty working.

Abstract 38. Poster

Title

Appendectomy outcomes in paediatric patients at MCHFT

Authors

SKP Tam, M Iyenkepolor, A Kazem

Background

Appendicectomy is one of the most frequently performed surgical procedures in children.

Aims

The objective of our study was to examine appendicectomy outcomes in paediatric patients at Mid Cheshire hospitals NHS foundation trust (MCHFT) and compare them with the national benchmark. The information gathered from this will enable us to identify areas for quality improvement, and ultimately, to improve patient experience.

Methods

A retrospective audit of all patients less than 16 years old who underwent emergency appendicectomy between 01/04/2016 to 31/03/2019 was carried out. Data was provided by the audit department using OPSC4 codes, ICE system and clinical notes. The main outcomes we looked at were waiting time to surgery, length of stay and 30 days readmission and reoperation rate.

Results and Discussion

A total of 92 paediatric patients were identified, with a median age of 12 years (range 5-16 years). 63% were females and 48% had laparoscopic procedure. The median length of stay was 3 days (range 1- 8 days), this was slightly longer than the national average in England (2 days). However, 47% of our patients stayed less than 2 days. 92% of patients had their operation within 24 hours from admission.

30 days readmission rate was 17.4% (16 patients). Pain, wound infection and postoperative collection were the main reasons for readmission. 3.3% of patients were re-operated on due to post-operative collection. Appendicitis was confirmed on histology in 86% of patients.

Our audit demonstrated that post-operative pain and collection were the most common reasons for hospital readmission. Regular use of pain leaflet on discharge and providing early access for postoperative complications will help to reduce readmission rate.

Abstract 39. Poster

Title

Improving Clinical Induction for Incoming FY1 Doctors

Authors

Arthur Gallimore, Catherine Graham, Gethin Hopkin, Warrington & Halton Foundation Trst

Background

Induction has come to be seen as a key part of the transition from medical student to Foundation doctor (1). However, newly qualified doctors do not feel adequately prepared for their clinical role (2). Often they feel anxious and unprepared not only for clinical skills but also various administrative and non technical skills required in the day to day role (3). The authors undertook a project to help improve induction, by making teaching more tailored to the tasks required of FY1 doctors starting in the following cohort.

Aims

Due to prior inadequate induction for previous incoming FY1 cohorts, this project looked at the induction programme at Warrington and Halton Foundation trust and aimed to improve self-assessed confidence by 20%.

Methods

The first cycle assessed the previous FY1 cohort's perceptions of the previous induction programme. The second assessed incoming FY1 doctors' areas of concern. The incoming FY1s were then given a questionnaire before and after a tailored teaching session that was designed to focus on aspects of the day-to-day job.

Results and Discussion

Following the teaching session the incoming FY1 cohort (n=31) showed an average increase in confidence and self-perceived proficiency in the aspects tested of 20% ($p<0.05$). All aspects tested improved with by between 10-38.6% (IQR 15%, SD 9.96%). Both of the questionnaire cycles from the incoming FY1s showed more confidence than the previous cohort's retrospective questionnaire.

The efficacy of induction can be improved by ensuring that important clinical content that is relevant to the job role as well as tailoring induction to the needs and concerns of those undergoing the induction period.

Note results regarding long term outcomes are still awaited and were not available at time of submission.

Abstract 40. Poster

Title

Bleep Away – Inefficient Task Allocation Out of Hours

Authors

Dowan Kwon, Shriya Kumar and Paul Thorpe; Musgrove Park Hospital, Taunton

Background

Many hospitals still rely heavily on bleeps for communication between healthcare professionals, especially out of hours (OOH). Bleeps are only capable of one-way communication and cannot convey urgency for the receiver. The sheer number of bleeps often means simply answering them takes a significant amount of time away from doctors attending to sick patients. In addition, bleeps may not always be returned in a timely manner, resulting in a loss of communication entirely.

Aims

Our project analysed bleeps junior doctors receive during OOH medical shifts to identify methods to improve efficiency at Musgrove Park Hospital (MPH).

Methods

- To identify the number of bleeps that junior doctors receive during OOH shifts
- To identify the proportion of appropriate and inappropriate bleeps that junior doctors receive during OOH shifts
- To identify OOH shifts that are particularly demanding with higher work load as identified by receiving greater number of bleeps

Results and Discussion

A multi-disciplinary team of healthcare professionals created lists of appropriate and inappropriate jobs junior doctors were frequently bleeped about OOH. Jobs overdue from in-hours and those should be tasked by a different healthcare professional were deemed inappropriate.

The bleeps received by OOH doctors were subsequently assessed according to the lists.

637 bleeps were collected across 42 OOH medical shifts including evening, weekend day, and night shifts, averaging over 1.5 bleeps/hour. 383 (60.1%) of these bleeps were deemed appropriate, 209 (32.8%) inappropriate, and the remaining 45 (7.1%) not reaching successful communication. One incidence of patient safety concern was raised, involving two life-threateningly unwell patients requiring urgent medical attention. This was denied as the duty doctor couldn't answer the bleep without leaving the sick patient they were already with.

Weekday evening shifts (5pm-9pm) were highlighted as the busiest shift with 153 bleeps in 12 shifts, averaging approximately 3.2 bleeps/hour.

Good communication between healthcare professionals and appropriate task allocation play vital roles in patient care. Several trusts have implemented a 'Hospital at Nights' team or a triage nurse whose job is to receive the bleeps prior to allocating each job to the most suitable personnel which MPH are due to trial in due time as a PDSA cycle following the data published from this project.

The number of inappropriate tasks that junior doctors get OOH reduces efficiency and the poor one-way communication system with the lack of function to triage or convey urgency has led to inadequate patient care.

Abstract 41. Poster

Title

Reducing delays in inpatient blood result availability at the North Middlesex University Hospital – **Winner of the Kings Fund Prize**

Authors

Matthew Beresford; North Middlesex Hospital, London

Background

Blood testing is an important aspect of inpatient care which can guide diagnosis, further investigation and treatment. As such, it is important that results are available in a timely manner that matches the workflow of a busy inpatient ward. At the North Middlesex University Hospital, prior to the initiation of this project, doctors regularly raised concerns about delays in access to inpatient results, including regular cases where routine results had to be handed over to the on-call team.

Aims

Our overall aim was to 'Increase the % of inpatient blood results available by 12pm to 50% by June 2019' - at baseline, average performance when judged against this standard was 16%.

Methods

The inclusion of 12pm in our aim statement reflects the opinion of senior clinicians that this enough time for results to be reviewed and acted upon on the same day. We used the Model for Improvement methodology to evaluate and develop solutions to the problem of blood result delays. The specific tools we used included:- Process mapping to evaluate potential sources of delays in the workflow of ward phlebotomists and staff working in the rapid response lab. - Driver diagram to conceptualise the diverse factors contributing to inpatient blood test delays - Rapid tests of change in the form of PDSAs - Run charts to visualise our gathered data and discern meaningful trends

Results and Discussion

Change idea 1: Team Phlebotomy structure. Deployed team of 3 phlebotomists working in tandem (rather than individually) across 6 wards. While there was an improvement in the % of results back by 12pm, there was a negative impact on phlebotomy satisfaction, and the team required additional supervision and portering support. As a result, we decided not to investigate this approach further Change idea 2: Phlebotomy start time moved from 8am to 7:30am. An initial trial on a single day across six wards increased the % of results available by 12pm from 16% to 53% . On the back of this success we conducted a second trial over a week on 4 wards, showing that samples reached the lab , on average, 86 minutes earlier (baseline 11:41 am) and that there was a knock-on improvement in blood result availability (average increased to 57%). The was no significant impact on patient satisfaction as measured by FFT score values. Change idea 3: Verbal handover between phlebotomists and lab reception. We changed the previous process of depositing samples in a receipt box at the lab or leaving samples for porter collection, to a process whereby phlebotomists would hand samples to a member of lab staff with the verbal instruction 'priority inpatient samples'. In a test conducted over a week on 4 wards this produced a further improvement, over and above that produced by the early start rota, with the average in-lab time dropping by a further 46 minutes and the % result availability increasing up to 65% Change idea 2 and 3 had a significant and cumulative positive impact on the in-lab time and that this in turn improved the percentage of results available by 12pm. Surprisingly, a 30 min shift in start time led to a 90 minute improvement in the in-lab time. We believe this may be partly accounted for by fact phlebotomists were delayed less on the ward when starting earlier (this was reported anecdotally during the trial). In addition, involvement in the 'trial' likely served a motivator and improved phlebotomists' productivity.
We believe the success of the verbal handover relates to fact that samples 'dropped off' were previously getting mixed up with outpatient samples, delaying their registration in lab. Verbal handover circumvented this problem. Furthermore, an earlier in-lab time allowed inpatient samples to miss the bottleneck on the analysers created by a deluge of GP samples at around 12pm thus improving lab turnaround time. The two above changes are currently only operating across 6 of 15 wards in the hospital. The next step would be to implement the changes across all wards and assess if the impact was sustained.
(abstract penalised 1 points for length)

Abstract 42. Poster

Title

Good record keeping; a review of surgical notes at Weston General Hospital

Authors

Isla Shariatmadari and Sefa William Canbilen; Weston General Hospital

Background

Throughout the years, there have been many attempts to standardise medical record-keeping in the UK. The Tunbridge report in 1965 highlighted the importance of this, creating standards for hospital record forms. The significance of this has come to light over the years with national audits and notable inquiries that have consistently shown how poor record keeping may contribute to poor patient care. Good and authentic record keeping is a skill every clinician must learn to refine. Not only in terms of supporting direct patient care but also in its secondary function as a medico-legal document.

Aims

The aim of our quality improvement project was to assess the quality of surgical note keeping within the general surgical department of Weston General Hospital. The objective was to measure note keeping in accordance with published guidelines.

Methods

A concurrent review of surgical inpatient notes was undertaken with standards set at 100%. We delivered a short talk to the surgical department exploring attitudes to medical record keeping. In addition, we utilised visual aids to promote and reinforce our standards.

Results and Discussion

Standards measured following our interventions showed improvement in more than 50% of our parameters, with several of the indicators reaching 100% (time and grade of most senior clinician for example).

Interestingly, our group discussions revealed that more than 60% felt clinical notes primarily served a medico-legal function.

Our findings indicate that clinical note keeping has scope for improvement and that utilising simple measures can improve standards, ultimately leading to improved patient safety. With the increased initiative to computerise medical records across the NHS, there is a concern that not adhering to current standards may translate into the digitalised world.

As clinicians, we must make it a priority to adhere to such standards.

Abstract 43. Poster

Title

Improving day one post-op documentation

Authors

SJ Everett[1], L Hainsworth[2], H Dewaal[1], P Foster[1], and A Stevenson[1]
[1] Musgrove Park Hospital, Taunton and [2]Royal United Hosital, Bath

Background

There are many important checks to be carried out on day one post-operatively. This quality improvement project contained three audit cycles to ascertain the current standard of documentation on day one post-op in orthopaedic patients in a DGH, and then aimed to improve upon and standardise it

Aims

To improve upon and standardise day one post-op documentation.

Methods

Each audit cycle looked at one week of operations. Notes were reviewed at the end of the day. Following the first audit cycle, standards of documentation were agreed within the department and a proforma produced to reflect this. Second and third audit cycles were carried out to review proforma usage.

Results and Discussion

Initial audit of 41 cases revealed inconsistent documentation practices. 29 cases were included in the second audit and the proforma was utilised in only 13.8%. However, in the cases that used the proforma, the standard of documentation was high and all key components of day one post-op review were recorded. The proforma was used in a higher proportion of patients in the third audit cycle, following the intervention of re-education at audit meeting and improved availability of the proforma on ward rounds.

Whilst using a proforma for day one post-op reviews may seem like a “tick-box exercise” it certainly has benefits. This project demonstrates that a proforma helps standardise documentation practice and improves documentation calibre when used.

It serves as a reminder for pertinent issues such as VTE prophylaxis, neurovascular status and antibiotic prescription, amongst others, all of which can be important medico-legally.

Abstract 44. Poster

Title

Evaluation of postoperative plan in lower limb trauma cases clinical audit.

Authors

Shady Hermena [1] and Charles Docker [2]
[1]T&O department Yeovil District Hospital and [2] T&O department Worcestershire Acute Hospitals NHS Trust

Background

Unclear instructions or incomplete postoperative plan could affect the quality of postoperative care. The good surgical practice published by the Royal College of Surgeons of England emphasises the importance of clear post-operative notes and postoperative instructions for every procedure. These notes should accompany the patient into recovery and to the ward and should give sufficient detail to enable continuity of care by the health care team. We completed a closed-loop audit to evaluate and improve the postoperative plan in lower limb trauma patients in Worcestershire Royal Hospital. Furthermore, we introduced a template for the postoperative plan in mnemonic order that is easy to remember and the improvement was measured in the second loop audit.

Aims

Assessment of postoperative plan in the operative notes for lower limb trauma cases that have been done in Worcestershire Royal Hospital against the audit standard: "The good surgical practice" provided by the Royal College of Surgeons of England.

Methods

We included adult patients who had surgery for lower limb trauma. Patients younger than 16 years old were excluded. 50 patients were included in the first audit and 36 patients were included in the second audit. The electronic EZ system used for retrospective notes review. Excel sheet used for data collection.

Results and Discussion

The completed antibiotic plan improved from 14% to 41.93%. The postoperative blood tests clear plan increased from 37.14% to 77.3%. DVT prophylaxis plan was completed in 88.57%. in the second audit compared to 32% in the first audit. Complete Plan for weight-bearing and immobilization rose from 86% to 100%. Complete Plan for post-operative x rays improved from 86.66% to 100%. Removal of clips or sutures clear instructions increased from 86% to 96.77%. Clear follow-up plan dramatically improved from 26% to 90.9%.

The postoperative plan should include clear instructions for Antibiotics, postoperative blood tests, postoperative x rays, weight-bearing status, venous thromboembolism prophylaxis, time for removal of clips or stitches and follow up. The clear postoperative plan is essential for continuity of care.

The mnemonic postoperative plan template could be an easy and effective method to write clear and complete postoperative instructions.

Title

Improving the quality of referrals to Urology

Authors

Jennifer Warner FY2, Emma Papworth ST6, Edward Jefferies Consultant, and Jaspal Phull Consultant

Background

In Bath, requests for a urological opinion are via a referral sent to an email address. It was noted that many referrals contained inadequate information and concerns were identified regarding the safety of this referral method. This project aimed to improve the efficiency of the referral system.

Aims

To improve the efficiency and safety of the referral system

Methods

50 paper referrals collected retrospectively were reviewed against an agreed standard. A standardised template to replace the original referral form was developed, with answers to frequently asked questions, advice on important information to include in a referral, and details of how to contact a Urology doctor more urgently. Then re-audited

Results and Discussion

34% reduction in inappropriate referrals.
29% increase in information provided, meaning improved quality of referrals.
16% reduction in potential patient harm, more appropriate referrals being made via email.
12% reduction in referrals that could have been resolved over the phone.

The aim of this project was to improve the way patients are referred to urology. The changes implemented aimed to minimise email referrals for urgent problems and unwell patients, improve the efficiency of the system for Urology staff, and limit the number of unnecessary referrals. The improvements made resulted in 29% more information to make a decision. Inappropriate referrals reduced by 34% and 16% reduction in potential harm.

Abstract 46. Poster

Title

Patient Involved Goals as Part of a New Enhanced Recovery Pathway in Cystectomy Patients

Authors

Hugh Crawford-Smith & Edward Tudor (Gloucestershire Hospitals NHS Foundation Trust- Urology Department)

Background

Cystectomy is a major surgery to remove the urinary bladder, typically treating muscle-invasive bladder cancer. Once removed, a section of the patient's small bowel is re-purposed to drain urine from the ureters to a stoma (ileal conduit). This surgery has long been associated with extended inpatient stays and complications; however, with new and existing pre- & post-operative techniques, we believe that these issues can be reduced with minimal financial burden. Optimising existing enhanced recovery pathways, as well as developing new and innovative patient directed goal structures, can change culture and outcomes for both healthcare professionals and patients and their families.

Aims

To reduce the length of stay following cystectomy for adult patients in GHNHSFT by 20% in 6 months. To be achieved by standardising care, improving MDT working as well as empowering and educating patients to be an integral part of the pre-operative and recovery process with clearly directed goals.

Methods

We developed novel patient directed goals to centre the pathway around. This allowed a clear recovery journey, motivated the patients and allowed assessment of progress throughout. We adapted enhanced recovery pathways from other units as well as from different specialities within GHNHSFT with 12 key stakeholder departments across the MDT.

Results and Discussion

We performed retrospective analysis of outcomes on cystectomy patients in the 3 months prior to this pathway implementation (n=11), then prospectively gathered the same data as a pilot of our pathway following implementation (n=7). We found a decrease in median inpatient stay from 13 to 7 days (mean 12.5 to 9.1 days) following implementation of patient goal target sheets and enhanced recovery pathway. We interviewed patients who reported great satisfaction with their high involvement with their own care and recovery, and that the target sheets allowed them to perform goal orientated activities that kept them motivated and recorded their progress.

Abstract 47. Poster

Title

Prescription and administration of pre-operative drinks **– Winner of the QISW Prize**

Authors

Sophie McDonald, Rhiannon Frostick, Kueni Igbagiri, Richard Donovan, Tom Murphy, and Sean Duffy
Southmead Hospital, Bristol

Background

Optimisation of preoperative nutrition has been demonstrated to reduce the rate of surgical site infection. Many surgical departments now encourage the routine prescription of pre-operative drinks. Pre-operative drinks contain key electrolytes and protein and crucially are able to pass through the stomach within 2 hours. These drinks can therefore be given early on the morning of surgery. At one major trauma centre, current guidelines required junior doctors to prescribe patients with hip fractures one pre-operative drink the night before surgery and one the morning of surgery.

Aims

- To collect data on current prescribing practice in a major trauma centre
- To see if this can be improved with minimal cost

Methods

We collected data on whether both of the pre-operative drinks were prescribed and if they were given by the nursing staff. We also asked junior doctors if they knew the indication for prescribing pre-operative drinks. We then provided teaching for the juniors on the indication for pre-operative drinks and re-audited.

Results and Discussion

In our initial data collection we found that only 20% of patients had their pre-operative drink prescribed the night before surgery. Only 50% of these patients were actually given their drink by the nursing staff despite it being appropriate to give. 16% of patients had their morning of surgery drink prescribed correctly. However only 2 patients (6%) were given their drink.

None of the junior doctors asked knew that the indication for pre-operative drinks is to try to reduce the rate of wound infection. Following a brief teaching session on the indication, rate of prescribing significantly improved.

The reason doctors gave for not prescribing pre-operative drinks prior to the intervention was time pressure. All reported that if they were not busy during their on call shift then they would have prescribed the drinks.

Following the intervention, the on call shifts have not become less busy, but the rate of prescription has significantly improved. This demonstrates the importance of education on indication.

Future steps include ensuring education is part of induction, educating nurses on when it is appropriate to give and introduction of stickers for quicker prescribing.

Title

A Retrospective Audit of Baseline Monitoring on Initiation of Amiodarone Treatment

Authors

Ee Teng Goh*, Vishal Nainesh Patel*, Afifa Rasoli, Majed Shamat and Sadia Khan.
Chelsea and Westminster Hospital NHS Trust (*Joint first authors)

Background

Amiodarone is a class III antiarrhythmic drug indicated in a range of arrhythmias, especially when other medications have proven ineffective. It has an extensive side effect profile including hepatotoxicity, pneumonitis and thyroid dysfunction. As such, baseline tests including thyroid function (TFT), urea and electrolytes (U&E), liver function (LFT), chest X-rays (CXR) and pulmonary function tests (PFT) are essential along with regular monitoring to minimize risk of adverse effects. A retrospective audit was conducted to investigate local adherence to monitoring recommendations on initiation of amiodarone treatment. Interventions were introduced and a re-audit was carried out for the uptake of said interventions.

Aims

- Improve patient safety by early detection and intervention for adverse effects due to amiodarone
- Improve delivery of healthcare at a lower cost by reducing costs associated with admissions /treatment /compensation due to amiodarone
- Improve coordination of care between providers

Methods

Electronic patient records were reviewed for patients started on amiodarone at an acute NHS hospital from September 2017-2018. Monitoring at baseline and 6 months were reviewed. A checklist was introduced and education carried out post-audit, and a survey was done after 6 months to assess competence and checklist utilisation.

Results and Discussion

Forty-nine patients were included in the study. At baseline, 67.3% had TFTs, 77.6% had LFTs, 83.7% had CXRs and 95.9% had U&Es. None of the patients had PFTs and only one patient had baseline T3 levels checked. Monitoring of digoxin and warfarin levels was suboptimal as well. Less than 50% of patients who continued amiodarone had CXRs, TFTs and LFTs done at 6 months. Post-education and the introduction of the checklist, staff competence improved, especially regarding the need for PFTs and free T3 levels, although still suboptimal. Awareness of the checklist was not universal as well.

This project was designed using basic Plan, Do, Study, Act methodology. Baseline adherence to monitoring recommendations for amiodarone therapy at initiation and at 6 months needed to be improved. The checklist implemented was to be enforced by pharmacists and actioned by prescribers. While significant improvement was seen at 6 months, accessibility and continuity remained an issue.

The next cycle of interventions include formal regular education and integration of the checklist onto the intranet. Patient data one year after the first cycle of interventions will be analysed, and future plans include integrated prescribing caresets once the hospital moves to electronic prescribing.

Abstract 49. Poster

Title

The fear of CST and how to overcome it

Authors

Siya Lodhia and James Schuster Bruce

Background

The ‘F3 year’ is now becoming a more common concept in a doctor’s world, with medical students planning this year outside of training before even starting Foundation.

In 2011, 28.7% of doctors took a year out prior to specialist training, compared to the 62.3% in 20181. However, what are the reasons for this?

Aims

To find out why doctors are not applying to specialist training straight from Foundation years.

Methods

We held a course for doctors interested in Core Surgical Training (‘CST’) . We helped them prepare and asked them why they were debating between taking a year out versus apply directly into specialism. We held a survey before and after the training course and compared the results.

Results and Discussion

Our course results are based on 25 potential trainees. We found that only 20% of the individuals believed they were informed about the application process before the course. However, following the course, this increased to 100%.
The data collected prior to the course showed a score of 2 (out of a 5-point Likerts scale) for confidence of participants in relation to the CST interview. The post-course survey showed a statistically significant increase in their confidence with regards to all stations.

Overall from our pilot study it seems a lack of confidence at interview was a key reason for applicants not feeling ready to apply. Our survey showed that our evening course increased confidence and so, we suggest that medical students/F1s have access to this course earlier on in their career and we would also suggest better access to a surgical mentor.

A combination of these should increase the number of applicants going directly into CST.

Abstract 50. Poster

Title

The Utility Of MRI In Diagnosis Of Acute Occult Scaphoid Fractures And An Assessment Of Its Clinical Practicalities

Authors

Emilie Lostis, Richard Donovan, and Alasdair Bott; North Bristol NHS Trust

Background

Magnetic Resonance Imaging (MRI) Scaphoid' is considered to be the gold standard to investigate suspected occult scaphoid fractures. In May 2018, 68% of surgeons of the British Society for Surgery of the Hand (BSSH) Conference believed that an 'MRI Scaphoid' could be achieved within 2 weeks of request.

Aims

The aim of this study was to audit the time-to-MRI scan for suspected acute scaphoid fractures against a national timeframe discussed at the BSSH conference, and to assess what percentage of acute occult scaphoid fractures can be diagnosed with an early 'MRI Wrist' that were otherwise undetectable on radiographs after two weeks.

Methods

We retrospectively analysed all 'MRI Wrist' requests over a six month period. Inclusion criteria were all MRI requests for a suspected acute occult scaphoid fracture. We excluded MRI requests for other acute, atraumatic, or chronic causes.

Results and Discussion

We analysed 200 'MRI Wrist' requests over six months in 2019 at a UK Major Trauma Centre. 134 patients met the inclusion criteria. The mean time-to-MRI was 20.8 days. Four patients (3%) underwent same-day MRIs, 26 patients (19%) had an MRI within 7 days, and 84 patients (63%) achieved MRI within 14 days. Early imaging with MRI detected acute occult scaphoid fractures in 16 patients (12%).

MRI proved to be useful in diagnosis an extra 12% of occult scaphoid fractures in our institution. Roughly two thirds of MRI scans were performed within 14 days of requesting. The development of local/regional protocol-based pathways for performing timely MRIs to diagnose occult scaphoid fractures in those who are clinically symptomatic 14 days post-injury would likely yield a significant proportion of otherwise missed injuries.

Abstract 51. Poster

Title

How much does efficacy of clerking increase with a proforma?: an audit of the Derriford surgical clerking system pre- and post- introduction of an acute surgical clerking proforma

Authors

Michael Foxall-Smith, Matthew Arnaouti, Katy Emslie, and Devender Mittapalli; Derriford Hospital, Plymouth

Background

Admission proformas are used to guide doctors in clerking, ensuring important information relating to the patient is not overlooked. Doctors at Derriford are provided with a blank drug chart and continuation paper. When clerking/ presenting valuable information is overlooked.

Aims

1. Evaluate clerking methods on the Surgical Admission Unit (SAU)
2. Identify whether all the essential information is captured
3. Review the introduction of a surgical proforma to SAU

Methods

A survey was designed to assess competency of the clerking system was, and whether there was any room for improvement. Results identified areas doctors thought important to include when clerking a new patient. These were formally assessed in a spreadsheet. Cycle 1 of the audit looked at 62 patients.

Results and Discussion

- Only 23% of patients had a responsible consultant identifiable implying lack of responsibility for patients with multiple teams working on SAU in a week.
- No formal measurement of co-morbidities or social factors that may affect rehabilitation or length of stay
- Only 30% cases noted allergy status, and 45% noted medications.
- 95% of patients started on treatment, only 71% were given a differential diagnosis.

A clerking proforma was designed and introduced, and the results were re-audited.

Abstract 52. Poster

Title

Introducing an electronic operation note proforma in a Children's hospital – **Winner of the GSQIA Prize**

Authors

A. Hamilton-Baillie, L. Simonca, H. Nicholas, E. Lindisfarne, and S. Lindlay. University Hospitals Bristol

Background

Operation notes at Bristol Children's Hospital are usually hand-written on a blank space page. The Royal College of Surgeons (RCS) provides guidelines for operative notes(1). Accurate and legible operation notes are important for patient safety and communication between the multidisciplinary team. Satisfactory operation notes are also important for accurate coding and tariffs, audits, teaching and e-logbook entries.

Aims

To improve post-operative patient care by introducing an electronic proforma for operation notes.

Methods

A quality improvement project was undertaken using PDSA methodology. Retrospective data collected from fifty operation notes (handwritten and typed) was audited against RCS guidelines. Multi-disciplinary stakeholder consultation was carried out via anonymous surveys. An electronic operation note proforma was introduced. Re-audit will take place in January 2020.

Results and Discussion

43 operation notes were hand written, 7 typed. Total compliance with RCS guidelines was 51% (handwritten) and 64% (typed). Standards often missed in handwritten and typed notes respectively include: time of surgery (8%,0%), tissue removed/added/altered: (11%,28%), prosthesis details: (0%,0%), blood loss: (0%,0%), VTE prophylaxis: (2%,0%).

Questionnaire results: 64% of respondents struggle to read one in two operation notes, 31% have to clarify plans. 100% preferred the electronic operation proforma to the handwritten note. Respondents noted the electronic note improved legibility, understanding of post-operative care and discharge planning. They report that it improves patient safety and facilitates flow and prompt discharge.

Baseline audit and stakeholder consultation demonstrated that operation notes often do not meet RCS standards and this negatively impacts end users including junior doctors, nurses and ward clerks. This may subsequently impact patient safety and patient flow. We therefore developed and introduced an electronic proforma for operation notes based on RCS guidelines. We will re-audit with the aim of improving compliance with RCS guidelines and implementing electronic operation notes as the new standard of care.

Reference:
1. Good Surgical Practice. (2014). London: The Royal College of Surgeons of England.

Abstract 53. Poster

Title

Improving ultrasound waiting times for acute surgical patients at The Great Western Hospital

Authors

Dr Max Roderick, Great Western Hospitals NHS Foundation Trust

Background

Patients attending the surgical assessment unit (SAU) who are not unwell enough to be admitted are often discharged home but asked to return for urgent investigations the next day. Often an ultrasound is performed for abdominal or pelvic pathology. The current system in the trust is for the patient to re-attend SAU in the morning and wait to be called over to the ultrasound department at some point. They then return to SAU for discussion of results and management plan. This process often takes many hours meaning long waiting times for patients but also a delay in important decision making.

Aims

- To reduce patient waiting times for those returning for ultrasound imaging
- To reduce overcrowding in the SAU waiting room
- To ensure important clinical decision making occurs as early as possible

Methods

A new system was introduced where the first three ultrasound slots of the day were reserved for SAU patients. Furthermore, patients attended the ultrasound department first and then came over to SAU for discussion of results and management plan. The time between patient arrival and time of scan was measured both pre and post intervention.

Results and Discussion

The average time between patient arrival and time of scan was calculated for patients before and after the new system was introduced. Patients who had their ultrasound scan after the new system was introduced had shorter waiting times than patients who were scanned under the previous system. In addition, by the time the doctors had finished the post-take ward round many of the scans had been performed and reported, meaning important clinical findings were acted on earlier in the day.

The new system reduced patient waiting times, improved flow through SAU, and meant significant findings were acted on in a timely manner. However, limitations were encountered including difficulty accommodating large numbers of scans, as sonographers run a busy service with a limited number of scans that can be performed each day. Further review of patient data in the coming months will allow us to adapt the new system in the long term, helping to match demand with services available. Given the success of the new system, we hope that surgical departments in other hospitals will consider adopting this approach.

Abstract 54. Poster

Title

Introducing the National Burns Passport – **Winner of the BMJ Open Quality Prize**

Authors

Christopher Lalemi, Thomas Harris, Ariella Levenne, Kate Richardson Michael Okocha, and Catalina Estela

Background

The Burns unit at Southmead assess and treats hundreds of acute burns patients through its ABC clinic yearly. A large number of these treated patients required continued burn wound management post assessment. The vast majority of these patients, if not all were managed with regular wound dressings in the community.
These dressing changes were done either by the patient, their GP practise nurse or by district nurses. The problem stemmed from there not being any real record for the patient and the health professionals in the community to identify the type of dressings used and how often these dressing should be changed.
The idea of this QI project was to firstly identify whether patients were able to remember the dressings they had for their burn, secondly how often they had their dressings changed and lastly whether the introduction of a Burns Passport improved patients record and awareness of their dressings and wound management.

Aims

- to identify what proportion of patients had an accurate idea of dressings used for their burn, how often their dressings were changed and by whom
- to identify whether a burns passport: a booklet with the type of dressings used, how often it needs to be changed, who changed it and any concerns is recorded and kept with the patient.

Methods

Data from over 200 patients with a burn seen in Southmead Hospitals ABC clinc in 2018 was collected. In total 160 patients were included in the initial audit. 40 patients were excluded.
A short questionnaire was conducted by the 160 burns patients asking questions regarding their experience and the dressings that were used as part of their wound management.

We then created a burns passport and gave to every patient who attended ABC clinic over a two week time period in 2019. We later asked these patients the same questionnaire questions as the previous cohort who did not receive a burns passport.

Results and Discussion

98% of patients asked the initial questionnaire didn't know the dressings involved in their wound management.

After implementing the burns passport 100% of patients had a record of the dressings used as part of their wound management

Having a Burns Passport as part of the management of Burn patient showed not only an increase in patient knowledge regarding their dressing regime but also an increase compliance and engagement in their management.

Abstract Accepted for Presentation at QISW National Conference 2020

The BMJ Open Quality journal is dedicated to publishing high quality, peer reviewed healthcare improvement work. Articles covering original research, local, national and international QI projects, value-based healthcare improvement initiatives and educational improvement work are all considered. BMJ Open Quality adheres to the highest possible industry standards concerning publication ethics.

MoneyJar Health provides personal finance and investing guidance for UK health professionals. We run educational workshops and events, one to one coaching and meet ups. We are also very Active one social channel and distribute weekly blogs and video content

The King's Fund is an independent charity working to improve health and care in England. Interested in shaping health and social care policy to improve clinical practices for all. They do this through varied means including relevant and good quality research, education, promotion and networking.

West of England Academic Health Science Network

One of 15 AHSNs across the country, together make up the AHSN Network. Here in the West of England, our AHSN has earned a reputation for its ambitious, joined-up vision for healthcare innovation and transformation. Since their launch, their priority has been to work across organisational and geographical boundaries, to develop and deliver transformation that is based on genuine need and sustainable.

Gloucestershire Safety and QI Academy. Through structured programmes they aim to develop a culture of continuous quality improvement within the trust. Where staff at all levels have the confidence to highlight areas for improvement and then have the skills, knowledge and support to be able to implement improvements.

The Health Foundation

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Highly Commended Abstracts accepted but Withdrawn Due to Work Commitments

Title

TToFFU: Time To First Family Update

Authors

Sangam Malani, Amogh Patil and Sarah Pearse

Background

In 2006/7 NHS organizations received 140,000 complaints. One of the frequent concerns often surrounds a lack of communication and involvement with relative and carers. The report, Caring for Dignity 2006, found that only 55% of the older people surveyed said that they felt involved in their care. It is therefore unsurprising that, a review of patient centred organisations by Health Facilities Scotland– found patient- and family-centred approach to be one of the crucial factors contributing at an organisational level to success. It is this we aim to emulate.

Aims

To assess if the families (NOK) are being given the opportunity to be involved in shared decision making by looking at:

- Whether they received an update
- The time to first family update
- Frequency of updates
- Reason for not being updated

Methods

Our audit looks at the time to first family update and subsequent updates across 2 Care of the Elderly wards. We trialled different interventions across the two, with Ward A receiving a presentation at their local multidisciplinary team (MDT) meeting, and Ward B receiving additional reminders in the form of posters & laptop badges.

Results and Discussion

Ward A: Although they had fewer interventions, the updates from doctors went up as the plans for family discussions were often senior led and made weekly at MDT. The average time for a nursing update stayed at 2 days but the average time to the first doctor's update improved from 2 to 1.4 days, as did the time to each subsequent update from 2 to 1.5 days.

Ward B: The most significant improvement was in the number of nursing updates with 55.2% of families receiving a nursing update in comparison to 32.3% in cycle 1. The average time to the first nursing update improved from 9.4 to 6.8 days (Ward B's nurses updated 16 patients in comparison to 2 on Ward A). The average time for a doctor's update also improved from 4 to 2.9 days but there was an overall drop in the updates given. This was attributed to staff changeover and the consultant being on leave and served as a reminder of how difficult it is to sustain change.

We are currently in the process of pioneering our second intervention which aims to ease documentation. This involves building an i-view component and integrating updates into the dynamic documentation on CERNER, our electronic health record.

Title

Stream Streamlining workup for listing on the national deceased donor renal transplant waiting list

Authors

Katy Saunders and Mr Samuel Turner (Transplant and Endocrine Consultant), North Bristol NHS Trust

Background

Our local waiting time from wait-listing to renal transplantation is just over 3 years, which is over the national average. There are many contributing factors, some of which are outside our control. An analysis of the loco-regional workup network revealed various delays in the pathway, including cardiac investigations and processing time of referral letters, which itself added a median of 17 days.

Aims

- To perform more transplants, faster, with the best experience (regional KQUIP aim).
- To implement changes to shorten the workup process to 18 weeks or less.
- To set up monitoring of the workup process.

Methods

An e-referral for transplantation was created and piloted locally on the ICE system. An existing Excel spreadsheet database was adapted to capture the dates of all appointments and investigations.

Following launch of the ICE e-referral, 16 of a total of 24 referrals were received as e-referrals, the remainder being sent as letters. The time from referral to surgical clinic appointment reduced from 9 weeks to 7 weeks.

Results and Discussion

Reforming a workup pathway is challenging, with many factors contributing, we had to focus on those over which we have control. Introduction of a new e-referral was unpopular with the referring nephrologists and following the pilot it will be necessary for us to demonstrate the advantages in terms of faster access to the national waiting list.

The e-referral form is only a small part of the process of streamlining the pathway, and the project will continue find small improvements where possible.lining workup for listing on the national deceased donor renal transplant waiting list

LIST OF PRIZES

Poster National Prizes	
BMJ Open Quality Prize	For best meaningful involvement of patients and carers in Quality Improvement work
	Acceptance of paper for submission based on the poster, with waiver of £1000 article publication charge
Moneyjar Health Prize	For Best Cost Saving Healthcare Initiative
	Poster displayed on website, an Amazon Echo and free attendance at one of the Moneyjar Health Workshops.
Kings Fund Prize	For best involvement of the multi-disciplinary team
	Winner getting to a day's experience with the team
The Health Foundation Prize	For the best designed poster
	A day's placement in the Improvement team at the Health Foundation in London plus travel and 1 night's accommodation (in line with the Health Foundation's expenses policy). Will likely be tied into a major Health Foundation event.
Gloucestershire Safety and Quality Improvement Academy Prize (GSQIA)	For a most sustainable improvement project
	A place on our Silver – Quality Improvement in Action Programme A poster presentation slot at our next Festival of Quality Improvement , Research & Innovation
Quality Improvement Southwest People's Choice Prize	For best presented abstract according to Junior Committee
Oral National Prize Session	
Academic Health Science Network West of England	1/4 Selected by abstract
	2/4 Selected by abstract
	3/4 Selected by abstract
	4/4 Selected by abstract

Many thanks to
Supporting Chairs:
Ms Anne Pullyblank – Director of AHSN West of England
Dean Claire Van Hammel – Severn Foundation Programme Dean
Dr Chris Burton – Medical Director

Conference Support:
Ms Donna Paddon - Medical Education Manager

Senior Faculty:
Dr Seema Srivastava - Associate Medical Director and Consultant Geriatric Medicine
Ms Vardeep Deogan – North Bristol NHS QI lead
Ms Rebecca Winterborn – Vascular surgeon
Ms Charlotte Munday – Allied Health Professional and Perform Coach
Dr David shipway – Consultant Perioperative Medicine and Geriatric Medicine
Dr Katie Samuel – Consultant Anaesthetist
Ms Helena Burden – Consultant Urologist
Ms Lorraine Motuel - Lead QI and Patient Safety
Ms Jude Clipsom - Patient Safety and QI nurse

Thanks to the Committee

Dr Katherine Saunders – Programme Chair
Thank you for your relentless pursuit of perfection during this process, you have been a tremendous support

Mr Naim Slim – Operations Chair
Thank you for bringing a level of polish to this conference you have been an incredible source of support on this journey

Dr Rhiannon Frostick and Dr Laura Saia – Keynote speakers support team
Both of you have faced incredible challenges during this 6-month process, thank you for helping to secure such great speakers

Miss Emily Farrow – Finance Chair
Thank you for securing these incredible prizes.

Mr Richard Donovan – Abstracts lead
From Dr to Mr during this process, thank you for your help.

Dr Michael Foxall-Smith – Steering Committee
Thank you for being a sounding board throughout this process

Dr Dee Annear – Certification lead
Thank you for sticking with us even through multiple bouts of illness

Dr Ysi Embury-Young – Publicity Chair
Thank you for your thumbs!

Dr Charlotte Bennett – Promotion team
As the most junior member on the team thank you for your help look forward to handing this conference to you next year

Mr James Olivier – Attendee support team lead
Thank you for being a fail-safe and checking to make sure things are done properly

Thank you again to the medical education team, you have been incredible, as always

Kind Regards
Michael Okocha