Leading innovation and improvement

49 THE USE OF PERSONALISED BEDSIDE BOARDS TO IMPROVE PATIENT-CENTERED CARE IN PAEDIATRIC INTENSIVE CARE UNITS

¹Martina Spazzapan*, ¹Byrave Vijayakumar, ²Claire Stewart. ¹King's College London, GKT School of Medical Education, London, UK; ²PICU, St. Mary's Hospital, Imperial College Healthcare NHS Trust, London, UK

10.1136/leader-2018-FMLM.47

Aim To assess whether the introduction of a board for non-medical information in each bedspace on the Paediatric Intensive Care Unit (PICU) can help provide health care professionals (HCPs) with a better insight into what those they care for are like as children not just patients, thereby improving patient-centred care.

Method A series of consultations with PICU staff, parents and patients in PICU at St Mary's Hospital in London led to a proposal of the 'A Bit About Me' board layout. This preliminary design was reassessed by staff and families, and later finalised by the senior leadership team in PICU. HCPs and parents of children also completed a seven-part questionnaire quantitatively assessing on a scale of 1–10 how well HCPs knew their patients before and after introducing the boards. Different versions of the questionnaire were created for parents and each healthcare specialty involved in patient care.

Results 38 and 36 questionnaires were collected pre- and post-intervention respectively, and were analysed using unpaired t-tests. Statistically significant improvements ($p < 0.005$) were recorded in five of the items assessed, including nurses' understanding about what comforts their patients, nurses' knowledge of their patients' favourite toys and doctors' ability to recognise their patients outside the hospital. Qualitative feedback about the boards has been positive and recognised from families.

Conclusion Patient-centred leadership is essential for effective quality improvement in clinical environments. We demonstrated how individualised care can be promoted by using boards in bedspaces where parents and children can share non-medical information about who they are and what they like. HCPs who know their patients better as children can personalise their care accordingly, and better appreciate what their baseline is. This is a simple, cost effective and sustainable intervention, which can lead to valuable improvements in family experiences.

50 PLANTING THE 'SEED'

Eilidh Dempster*, Kirsty Short, Joanna Short. Emergency Department, The Sutherland Hospital, South Eastern Sydney Local health District, Australia

10.1136/leader-2018-FMLM.48

We established an ultrasound (US) faculty and teaching programme at an Australian urban district emergency department (ED).

Background It is expected ED consultants will be proficient in Point of Care Ultrasound (PoCUS), however there is no

formal training programme or assessment of trainees prior to completing training. Although optional, the benchmark is for consultants to attain their Certificate in Clinician Performed Ultrasound (CCPU) or equivalent credentialing. US training provided is departmental specific and of variable standard.

There was no US programme or quality improvement initiatives in our ED prior to intervention. <10% of consultants had attended a recent credentialed course; most were not confident with PoCUS and only 1 maintained a logbook.

Intervention: The programme was initiated by an ED consultant with a special interest in US. She developed the faculty with interested ED staff and the Sonographer Educator in ED (the SEED). This is an experienced general sonographer whose role is to teach consultants PoCUS modules and facilitate skills maintenance through one to one sessions.

The faculty organised an accredited course for all consultants. A google form was developed to assist logbook keeping. To communicate US updates to staff, we introduced a newsletter, messaging group and PoCUS section integrated into the department teaching website.

Results 95% of consultants in our ED have now completed a credentialed US course. Logbook compliance has increased 7 fold. The consultant body hold 13 CCPU modules (3 pre-intervention). We have implemented a daily US cleaning rota which has shown increasing monthly compliance.

Conclusion Our ED is recognised as a department that champions US. We have considerably increased consultant engagement and proficiency with PoCUS. The success of our intervention is attributed to a combination of enthusiasm and determination from the faculty with supportive ED management and receptive, interested colleagues.

Leadership and teaching

51 DOCTOR(NOUN, LATIN), TO TEACH; TRANSFORMING A WORKING WEEK INTO A TEACHING WEEK

¹Ahmed Chilmeran*, ²Alexandros Rampotas, ¹Mustafa Agbna, ¹Sathianathan Panthakalam. ¹East Sussex Healthcare NHS Trust, UK; ²Oxford Health NHS Foundation Trust, UK

10.1136/leader-2018-FMLM.49

Aims One of the prerequisites to successfully complete Core Medical Training in the UK is to acquire the Membership of the Royal College of Physicians (MRCP) title by passing the Practical Assessment of Clinical Examination Skills (PACES) exam. Due to work pressures and time limitations, little teaching had been taking place locally at Eastbourne District General Hospital (EDGH). Prior to this, PACES teaching was mainly delivered externally by expensive courses, online resources and books. Given the plethora of patients in a familiar environment of a National Health Service (NHS) hospital, we established that this provided an ideal combination for PACES teaching.

Methods We started a team of PACES positive trainees who were interested in teaching; this team would deliver bedside PACES teaching at least twice a week. A weekly timetable

Abstracts

Abstract 51 Table 1 Example of the weekly timetable

Monday	14:00 Dr Panthakalam clinic (station 5) Tod
Tuesday	17:00 Alex (bedside teaching) All
Wednesday	
Thursday	09:00 Mr Kashani clinic (fundoscopy) Sushma
Friday	17:00 Mustafa (bedside teaching) All

Abstract 51 Figure 1 Confidence levels before starting our teaching programme

Abstract 51 Figure 2 Confidence levels after completing the first diet of our teaching programme

Abstract 51 Figure 3 Satisfaction with PACES teaching at EDGH prior to starting our teaching programme

Abstract 51 Figure 4 Satisfaction with PACES teaching at EDGH after completing the first diet

Abstract 51 Figure 5 How a structured teaching programme was thought to increase chances of passing (prior to starting our programme)

Abstract 51 Figure 6 How structured bedside sessions helped the candidates prepare for PACES (after the first diet)

with specified PACES teaching was created (e.g table 1). This included some specialised clinics that were consultant led (rheumatology and ophthalmology) aimed at providing consultant led teaching to PACES candidates. One PACES candidate was allocated to each clinic day providing 1-to-1 focused teaching, while the bedside sessions were open for everyone. A WhatsApp group was also created consisting of all candidates preparing for PACES and instructors, which encouraged all members to share interesting cases deemed good for PACES teaching and also facilitated organising unscheduled teaching.

	1	2	3	4	5	TOTAL	SCORE
Practising on hospital patients under supervision	60.00% 3	0.00% 0	20.00% 1	0.00% 0	20.00% 1	5	3.80
Attending a commercial course	0.00% 0	60.00% 3	0.00% 0	40.00% 2	0.00% 0	5	3.20
Reading from textbooks	50.00% 3	16.67% 1	16.67% 1	16.67% 1	0.00% 0	6	4.00
Online videos (e.g PASTEST)	0.00% 0	0.00% 0	60.00% 3	20.00% 1	20.00% 1	5	2.40
MRCP website example scenarios (stations 2, 4 and 5)	0.00% 0	16.67% 1	0.00% 0	16.67% 1	66.67% 4	6	1.67

What did you find most useful when preparing for PACES?

Answered: 6 Skipped: 0

Abstract 51 Figure 7 Showing what was found useful by candidates when they were preparing for their PACES (after the first diet)

Results and conclusion The feedback from all candidates has been very positive so far. We have significantly improved confidence levels (figures 1 and 2) and most candidates are currently satisfied with the current PACES teaching structure at EDGH (figures 3 and 4). In addition, most candidates found that supervised bedside practice is one of the top two useful methods to prepare for PACES (figure 7).

Leading innovation and improvement

52 IMPROVING THE EXPERIENCE AND MORALE OF THE JUNIOR DOCTOR WORKFORCE

Ruwani Rupasinghe*, Lisa Smith, Russell Helms. *York Teaching Hospital NHS Foundation Trust, UK*

10.1136/leader-2018-FMLM.50

Introduction Our region has low junior doctor fill rates. The Junior Doctor Forum (JDF), led by our Guardian for Safe Working, decided to use the Faculty of Medical Leadership and Management (FMLM) publication ‘Eight

high impact actions to improve the working environment for junior doctors’ to develop an action plan addressing each of the highlighted areas. The overall goal is to make the Trust an employee of choice in the region by giving junior doctors a positive experience during their time here.

Method Data from multiple sources such as exception reports and national surveys was reviewed which demonstrated low morale locally. The FMLM publication was used to generate an action plan under the eight themes. A JDF member has been assigned to lead each strand and junior doctors are encouraged to contribute to the development and implementation of each. Projects are discussed and monitored via monthly JDF meetings as the action plan is a standing agenda item.

Projects, some of which are on-going, include:

1. Ensuring provision of rest facilities
2. 24 hour access to hot food and drinks
3. Signposting to wellbeing services and sharing coping strategies
4. Extra training for educational and clinical supervisors
5. Establishing junior doctor awards
6. Bridging manager–doctor divide via Paired Learning scheme.