Trauma

77 SILVER TRAUMA PATHWAY: A NEW GOLD STANDARD IN ELDERLY TRAUMA CARE

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The elderly are increasingly represented in trauma. Low level falls are the leading cause of injury. Special attention should be paid to their altered physiological reserve and increased comorbid disease. The Whittington Hospital is a Trauma Unit in London.

A team of junior doctors, led by a senior trainee, conducted a retrospective audit. Using SMART framework, our goal was improving care of elderly trauma patients, measured against elderly trauma guidelines (2017). It was believed better compliance with the guidelines, particularly holistic aspects of elderly care, was achievable and realistic given available resources. The timeframe for our study was 10 months.

108 elderly trauma patients attended the Emergency Department (ED). Forty-six (43%) were admitted. Three patients received full trauma team assessment. While most received ECG, blood tests and imaging, 53% received a cognitive assessment, and few had assessment of anti-coagulation, movement status or treatment escalation plans (TEP). During inpatient stay, 38% had a tertiary survey, which led to 4 missed injuries. Excellent involvement of the multidisciplinary team (MDT) was noted. The results were presented to the Acute Medical Board, ED, the Frailty Group, and Trauma Rehab Group. Input was sought from the MDT to find solutions to issues raised. The results were presented to all stakeholders.

A new 'Silver Trauma Pathway' was initiated, which highlights undertaking a primary and secondary survey in low level trauma, and prompts assessment of features specific to elderly care: cognition, anticoagulation status, TEP and frailty. In addition, an inpatient pathway has been developed. Though uptake was slow, illustrating the difficulty in changing organisational culture, re-audit has shown improvement in elderly trauma care and clinician documentation. Our pathway was presented at the London Trauma Symposium, where it was awarded first prize for innovation, illustrating the power of a collaborative approach.

Leading innovation and improvement

78 CHANGING MINDS, SAVING LIMBS; REFORMING REFERRAL PATHWAYS IN CRITICAL LIMB ISCHAEMIA

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Background Critical limb ischaemia (CLI) is a limb and life-threatening condition. Current NHS guidelines suggest that suspected CLI patients should be assessed by a vascular nurse practitioner (VNP) within 7 days of GP-presentation. Any indicated procedure should then be performed within the

following 6 weeks. Retrospective review of patient records (n=9) at this Trust showed that mean time from GP presentation to VNP review was 8.1 ± 3.1 weeks, with a subsequent procedure requiring further 15.8 ± 5.2 weeks.

Aim To design referral pathways that the Trust believes will lead to CLI patients receiving vital treatment sooner.

Methods Baseline surveys were obtained from 14 stakeholders to assess perceptions of current referral pathways. Our survey comprised 10 questions, assessed using a five-point Likert scale (maximum score 50), with a higher score indicating greater confidence in the system. We also designed new pathways in conjunction with a new tiered scoring system to assess disease severity. Using Plan-Do Study-Act (PDSA) cycles, we then presented these to the same stakeholders, and further reformed our pathways based on feedback. Overall, we completed 2 PDSA cycles, presenting to a senior VNP, and then to the vascular multidisciplinary team meeting.

Results We designed 3 new referral pathways, 'red', 'amber' and 'green'. Each pathway had a different proposed timeline corresponding to patient disease severity, as assessed using our tiered scoring system. Baseline mean survey score was 25.4 ± 2.3 , and final mean score was 33.9 ± 5.2 . This represented a significant improvement in stakeholder confidence (Wilcoxon Signed-Ranks test, $p=0.003$).

Conclusions Improving perceptions of necessary change is an important step to implementing such change. It is necessary to build a culture of improvement prior to implementing any. We have designed new CLI referral pathways that are perceived to be superior to the current pathways. Although further refinement is likely necessary, we believe these pathways are suitable for implementation in the near future.

Leadership development

79 THE OXFORD EMERGING LEADERS PROGRAMME: DEVELOPMENT AND EVALUATION

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Background Leadership is a core competency of medical professionals, including junior doctors.

In junior doctor representative committees at Oxford University Hospitals (OUH):

1. Motivation for engagement has historically dropped throughout the year
2. There is a perceived lack of formal leadership development opportunities available
3. There is an appetite for leadership training

To address these concerns the Oxford Emerging Leaders' Programme (ELP) was developed.

Development The programme was developed from existing resources at OUH through interviews with potential participants.

The 4 month programme included 6 half-day workshops alongside team quality improvement projects (QIPs). 13 participants completed the course.

Guest presentations were given by NHS healthcare leaders and QIPs were mentored by hospital consultants with experience in leadership and quality improvement.

Evaluation Evaluation was conducted with a mixed-methods approach based on Kirkpatrick's framework for evaluation of educational outcomes (Harden, Grant and Buck, 1999; Hammick, Dornan and Steinert, 2010).

- Levels 1 and 2 (Reaction/Learning)
 - Self-assessment questionnaires based on Pendleton and Furnham's Primary Colours model (2016)
- Level 3 (Behavioural Change)
 - Post-course questionnaire; interviews
- Level 4 (System)
 - Quality Improvement Project outcomes.

Results Course participants found the combination of workshops and practical work engaging.

Many participants struggled to arrange their clinical duties to attend all workshops.

Self-assessment results showed an increase in leadership capacity, with statistically significant increases in 50% of domains. There were large increases related to strategy, alignment and relationships with managers.

Confidence, motivation and job satisfaction rose amongst participants.

Objective improvements were demonstrated in 2/4 QIP's.

Conclusions By aligning the programme with organisational goals (Quality Improvement) course faculty were able to access support and development opportunities to the benefit of the organisation, the individuals and their patients.

A solution to workshop timing problems continues to elude faculty.

A longer timeframe could support course outcomes.

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Leading innovation and improvement

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THE ACUTELY UNWELL PATIENT – HOW CAN WE IMPROVE JUNIOR DOCTOR ASSESSMENT AND RECORD-KEEPING TO IMPROVE PATIENT SAFETY

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When patients become acutely unwell on the ward, it is often a Foundation (FY1/2) doctor who assesses initially. Doctors are encouraged to use the 'Airway, Breathing, Circulation, Disability, Exposure' (A-E) approach to assess. The pressured nature of reviewing patients may lead to incomplete assessment.

We aimed to introduce a proforma to improve assessment of unwell patients on orthopaedic wards, based around GMC guidelines for assessment.

Plan-Do-Study-Act (PDSA) cycle 1: Surveyed junior doctors.

50% didn't use an A-E approach when documenting reviews. 63% would use a proforma for documentation. 75% thought it would be useful and increase their confidence communicating with seniors. All believed it would improve documentation.

Cycle 2: Pre-proforma assessment/documentation.

85% were reviewed by FY1/FY2 doctors, with 15% subsequently reviewed by a senior. There was inadequate patient identification in 30%. No contact details were documented in 90%. Reason for review was always documented; A-E approach was used in 55%. Essential aspects were missed (Airway patency – 55%; Heart rate – 50%; chest exam – 30%). Impression was noted in 45%. Reviews were highlighted on ward rounds in 10% of cases and it was never documented that information was given to the patient.

Cycle 3: Post-proforma assessment/documentation.

60% were reviewed by a FY1/FY2, with 80% subsequently reviewed by a senior. Patient identification increased to 100% and documentation of reviewers' contact details to 80%. Use of A-E approach and documentation of impression increased to 100%. Acknowledgment of previous review on ward rounds was 85% and information was provided to the patient in 80%.

Cycle 4: Surveyed doctors.

67% felt the proforma improved assessment, communication with seniors, and identification of patients reviewed during subsequent ward rounds. All felt it improved documentation.

An A-E proforma can improve care and documentation.

We will continue to analyse proforma use at 4 weekly intervals through PDSA cycles.

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THE LITTLE THINGS THAT SHOW WE CARE: STAFF ENGAGEMENT AND CAREER DEVELOPMENT

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Introduction Staff development and engagement is one of the sure ways to ensure you can retain your staff, uplift moral and obtain patient satisfaction.

At the National staff engagement forum in 2016 staff engagement was described as; 'Staff are engaged when they feel valued...and say matters and makes a difference'.

Taking the challenges of busy clinical work, we aimed to provide our cohort of NCHD's the chance to provide us with feedback on a proposed session we deemed to be of interest to NCHD's through a 3 phased survey study.

Aims

- To identify a gap in NCHD's career development and to provide a program to fill this need at no cost to NCHD's.

Methods 3-phased survey was conducted; first phase needs analysis and NCHD requirement of proposed event. Second phase survey is post event evaluation and analysis of event success and relevance. Third phase survey was aimed to