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.

**REFERENCES**


**Leading innovation and improvement**

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

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.