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

80 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.

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

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10.1136/leader-2018-FMLM.79

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

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estimate staff engagement and facilitate ideas for next planning phase.

Results The initial survey (1 st phase) was analysed to obtain a needs analysis based on response. 44 NCHD's (excluding interns) responded to the survey showing 100% of respondents willing to engage in proposed interview skills sessions.

It was very evident that we successfully identified a gap in our NCHD's career development that we can fill and use as a point of contact to engage our NCHD cohort. With only 4.55% (n=2) NCHD reporting that some form of interview skills was provided by their department and only 2.27% (n=1) reporting that their affiliated training body has provided them with this a skill base.

Post survey analysis 3 interview sessions were organized for St. James's NCHD's to attend based on a first come first served bases and 2 sessions for Intern group. Funding was negotiated for and generously provided by St. James's HR and Trinity College Dublin.

Separate interview sessions were organized for the intern group to address different interview skills needs based on planed interview types.

A total of 47 attended with 10 doctors per session lasting 2 hours duration each.

Post event survey was conducted to estimate the relevance and content of the training in NCHD's opinion. 96% (n=45) of NCHD's strongly agreed that the content covered and time allocated to the sessions was relevant. 96% of NCHD's also a strongly agreed that it was a worthwhile event to continue as part of NCHD engagement and training.

Phase 3: A staff engagement survey was conducted several weeks post event date to request feedback for future events and comments on any developments that should be taken into view for the incoming year.

Conclusion In conclusion we can see that the success and over subscription to our events was a combination of early planning, effective communication and an enthusiastic group of receptive NCHD's.

Enhancing your leadership skills

82 BRINGING CLINICAL MEDICAL EDUCATION ON A PAPERLESS JOURNEY: MAKING EVERY PATIENT CONTACT COUNT

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10.1136/leader-2018-FMLM.80

Introduction Hospital based medical education is the pivotal point of knowledge and skills transfer to our medical students, who, not before long will join us as colleagues on the wards. St. James's hospital in Dublin 8 is the biggest teaching university hospital in Dublin and home to 1,010 acute patient hospital beds.[1 2]

Early and effective contact to the clinical world is important in motivating and stimulating medical student interest in clinical work, which is why having access to difficult patient cases of interest is so important in ensuring knowledge acquisition at an early stage in clinical teaching.[3]

Making every patient contact count towards education regardless of where they are seen within the hospital system using electronic patient record (EPR) is vital for a more holistic approach to clinical teaching.[4]

Aims

1. To make every patient contact count as a valuable teaching resource.
2. To give NCHD's the opportunity to identify patient cases with interesting signs in any clinical setting and make it easily available to the lecturing staff.

Current practice Teaching staff and NCHD's flag patients with interesting signs on wards for teaching purposes using patient lists and waiting lists.This is very time consuming and can be facilitated by creating a better electronic function that all staff can use.

Planned future practice and design Electronic patient record (EPR) is the current system being used to capture patient information in St. James's hospital and is being used in all specialties in different levels.

Design encompassed an easily accessible tab for physicians to comment on the reason for patient case inclusion, the sign and symptoms of interest, what kind of contact is the patient was willing to facilitate and if the patient is willing to take part in clinical exams.

Outcomes anticipated

1. A higher yield of specific patient cases can be accumulated to facilitate teaching in a more organised fashion.
2. Lecturing staff will have easy access to specific patient cases that can augment their teaching and learning outcomes for specific teaching seminars without looking though numerous patient lists.

Next step forward Ensure all NCHD's are aware of the new medical education electronic function built into EPR at induction in July.

Monitor number of NCHD's contributing to it and feedback during ground rounds on the type of cases and numbers that have been submitted, to allow teams to see progression in case load contribution.

Audit lecturers experience with new system.

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Developing effective leaders

83 HOW DO MEDICAL STUDENTS VIEW LEADERSHIP? A NATIONAL CURRICULUM ANALYSIS AND SURVEY

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10.1136/leader-2018-FMLM.81

This project, conducted by the FMLM Medical Student Group, was the first national analysis of UK medical students' access to medical leadership and management (MLM) teaching, within the undergraduate curriculum, and their opinions regarding this.

Timetables (2014/15) from 16 Medicine (A100) courses were analysed to identify data surrounding MLM sessions.

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