

This included: duration, format, title, and year of study, of any MLM components in the timetable. We also launched an anonymous online survey for medical students to determine their perceptions of MLM teaching in the curriculum.

Across the timetables, 892 (range, 8–141) MLM teaching sessions were identified. Of these, 64.9% took place during clinical years. 644 medical students from 30 universities completed our survey. 88.3% agreed that MLM skills are important for junior doctors and 87.4% agreed that MLM is relevant to their education. Despite 57.5% agreeing that there should be specific standards set for graduating medical students, only 8.9% were aware of the Medical Leadership Competency Framework, and 17.1% felt that MLM is taught effectively in their curriculum. Students' preferences for teaching and assessment of MLM were not in line with the distribution of teaching sessions identified in our analysis, indicating that there are future challenges in matching student's expectations towards developing leadership capabilities with formalised undergraduate curricula.

Medical students' teaching experience varies widely between universities, but the majority recognise the importance of MLM in their education and their future roles as junior doctors. This research provides novel insight into the national delivery of MLM within undergraduate medical schools, alongside important commentary on students' preferences for curriculum delivery. We anticipate that this research will be used to enhance teaching delivery and hope that this data is useful in supporting the leadership development of future doctors.

## Reducing waste

### 84 REDUCING WASTE AND IMPROVING PATIENT SAFETY: INTRODUCTION OF THE ON-CALL DOCTOR'S BAG

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We introduced an on-call doctors bag for the Foundation Year One (FY1) doctor's on-call medical ward cover at Wexham Park Hospital. These on-call shifts are extremely busy with the FY1 covering 14 different wards. Time is wasted locating essential equipment on unfamiliar wards. Literature over the last 5 years has calculated that junior doctors spend on average 29 hours accessing treatment room and approximately 4 working days collecting equipment over a year.<sup>1</sup> These delays can compromise patient safety in emergencies as well as contributing to daily inefficiency and lower job satisfaction.

A pre-intervention questionnaire using a 5-point Likert Scale identified 90% of FY1 respondents (n=22) at felt that significant time was wasted looking for equipment on unfamiliar wards.

A paramedic sling-bag (£90) was purchased as an on-call doctors bag. The bag was stocked with the relevant equipment and was made available to all FY1s for their medical on-call. The bag was restocked by the ward manager at the end of each shift.

A post-intervention questionnaire was distributed to FY1 doctors. 100% of respondents (n=20) agreed the on-call bag helped them to be more efficient. 100% of respondents

agreed less time was spent collecting equipment on the wards with the bag. 95% of respondents stated that they will continue to use the on-call bag.

10 simulated trials were performed comparing the time taken to collect equipment on 8 different wards. 6 volunteer final year medical students unfamiliar with the hospital environment were asked to collect equipment for four common on-call tasks (ABGs, cannulas, phlebotomy and blood cultures) on 8 different wards with and without the on-call bag. In every trial performed, the student with the on-call bag obtained the equipment faster than the student without the bag. The median time saved across all procedures and wards was 3 min 26 s (range 57 s – 7 min 29 s).

The on-call doctor's bag is invaluable in reducing waste and increasing the number of on-call jobs that can be completed per shift. It reduces the time wasted in collecting essential equipment when treating the unwell or deteriorating patient.

## REFERENCE

1. Karapinar Y, Habib A, Sawyerr H. Improving time efficiency gathering equipment in the treatment room. *BMJ Open Quality* 2017;6.

## Radiology report alert systems

### 85 RADIOLOGY REPORT ALERTS! ARE EMAIL 'FAIL-SAFE' ALERTS ACKNOWLEDGED AND ACTED UPON?

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**Background** After identifying failure to act on radiology reports as a cause of patient safety incidents, The Royal College of Radiologists and National Patient Safety Agency released guidelines stipulating that it is incumbent on radiology departments to use 'fail-safe alert' systems to communicate critical and significant unexpected results. Electronic systems are preferred, to reduce errors, increase workflow efficiency and improve auditability. A paucity of evidence exists on the effectiveness of such systems.

**Aim** To assess i) acknowledgment of email radiology report alerts by clinical referrers and ii) where indicated, whether follow-up imaging was performed.

**Methods and Materials** A full-cycle audit conducted at a tertiary referral centre in London, which uses the email-based 'RadAlert' system (Rivendale Systems, UK). All cases on the RadAlert database between 5th February 2017 and 31st July 2017 were audited in cycle 1 and, following departmental educational meetings, the first 100 cases during Sept 2017 in cycle 2. The target compliance for acknowledgment of alerts was 100%.

**Results** In cycle 1, 39% (154/390) alerts were 'accepted', 55% (213/390) 'abandoned', 5% (21/390) 'declined' and 1% (2/390) 'cancelled'. In a sample of 'abandoned' alerts, follow-up imaging (where deemed indicated based on the report) was still performed for 76% (19/25).

In cycle 2, 56% (56/100) alerts were 'accepted', 37% (37/100) 'abandoned', 4% (4/100) a 'duplicate record' on the database and 3% (3/100) 'declined'. Of all 'abandoned' alerts, follow-up imaging (where deemed indicated) was still performed for 76% (22/29).

**Conclusion** Acknowledgment of report alerts by referring clinicians may be increased through departmental educational meetings. Radiologists should not rely solely on email alerts however, since a considerable proportion continue to be unacknowledged by the recipient. Appropriate follow-up imaging was undertaken regardless in these cases, suggesting that radiologists continue to also rely on other alert methods despite the introduction of the email based system.

## Patient safety, quality improvement, clinical practice

### 86 MAKING THE RIGHT CALL FOR FALLS' – EVALUATING THE EFFICACY OF A MULTI-FACETED TRUST WIDE APPROACH TO IMPROVING PATIENT SAFETY POST FALLS

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10.1136/leader-2018-FMLM.84

**Introduction** Inpatient falls are the most commonly reported patient safety incidents nationally, and carry a significant burden on resources, morbidity and mortality. Ensuring adequate post falls management of patients by staff is therefore paramount to maintaining patient safety especially in out of hours and resource stretched settings.

**Aims** This quality improvement project (QIP) aims to improve the current practice of falls management and patient safety at Guys and St Thomas Hospital. It also looks to increase junior doctors confidence in managing falls and their use of new intervention guidance protocols. Importantly it highlights the benefits of multi disciplinary collaboration with key stakeholders such as falls, radiology, QIPs and clinical medicine teams to achieve its intended impact.

**Methods** Interventions include:

1. The development of new trust guidelines.
2. The production and distribution of 2000 newly designed lanyard cards amongst ward staff that provide a concise management protocol.
3. Improved fall awareness trust wide through the use of trust media.
4. Implementation formal falls teaching at junior doctor induction.
5. Introduction of a new falls bleep to expedite key imaging.

Qualitative data analysis involved using an established incident database to retrospectively review clinical practice in 145 falls in 2016 pre-intervention as compared to 189 consecutive falls in 2017 post intervention. A separate serious harm database was used to analyse 50 falls from May 2015 to March 2018 to assess the interventions impact on delays to diagnosing serious harm.

Quantitative data analysis assessed junior doctors' confidence in managing falls, their awareness of the impact of falls and the utility of guidelines through pre and post intervention questionnaires.

**Results** The time from fall until harm was detected was statistically significantly lower ( $p=0.044$ ) post intervention. The incidence of significant delays to detecting harm ( $>10$  hours)

also reduced post intervention. Rates of documentation, the time to clinical review and time to order and schedule X rays and Computer Tomography scans all improved in and out of hours. Results showed a statistically significant improvement in overall review time ( $p=0.001$ ), ordering X rays ( $p=0.046$ ) and scheduling CT scans ( $p=0.029$ ) post intervention.

Questionnaire data demonstrated junior doctors' improved awareness of falls, clinical training, utility of guidelines and increased confidence.

**Conclusions** This quality improvement project has shown statistically significant improvements to fall management in a short period of time through a generalisable, multifaceted and multi-disciplinary team approach to a growing major national patient safety issue. Suggested next steps of this project include introducing trust wide fall specific induction sessions. This QIPs' ongoing work hopes to provide a template to help lessen the burden of falls on patients and trusts nationally.

## Enhancing your leadership and management skills

### 87 FROM MEDICAL STUDENT TO PROJECT MANAGER: A LEADERSHIP IN HEALTHCARE EXPERIENCE

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10.1136/leader-2018-FMLM.85

As part of the 70th anniversary celebrations, a Student-led Health Commission was recruited by the Policy Institute at Kings College London. The group, commissioned by the NHS, was tasked to recommend radical changes to the UK National Health Service. The commission was challenged to identify young people's views of what our health and social care system should deliver and envision fundamental changes to healthcare over the next 15 years.

This project improved the commissioners' understanding of health policy process and allowed future health professionals to have hands on experience in health leadership and management, interacting with senior health management and organising an 'unconference'.

Due to varying personal and educational commitments outside of the project, coping mechanisms for time management strategies were developed by all members of the commission. Professionalism was another key learning point throughout the project. We were in continual contact with senior health management, clients and other stakeholders, and a professional attitude was essential. This experience highlights the importance of this type of project for students and alumni, equipping the interns with skills and knowledge that cannot be learned at university while making an impact on the population.

By managing two teams of commissioners, I was able to oversee several tasks informed by external stakeholders, for which we collected data using interviews and were advised by a team of Harvard interns. We engaged healthcare professionals and other young voices by circulating surveys to student networks and healthcare bodies. During our unconference, I presented recommendations to an audience of front-line staff, policymakers, senior managers and students, as well as live-interviewing a senior stakeholder on recommendations implementation.