

## Neurology

## 93 INPATIENT MANAGEMENT OF PARKINSON'S DISEASE MEDICATIONS

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An audit was conducted at Ashford and St Peters Hospital (ASPH) by the neurology department to assess management of Parkinson's Disease (PD) medications amongst hospital inpatients suffering from idiopathic PD.

Recent increase in inpatient admissions of PD patients to hospital has led to an increase in incidence of medication errors, missed doses, delayed administration of doses and or prescription of contraindicated medications. The National Patient Safety Agency identified PD medications as critical, with omissions or delays in medication administration being classified as a patient safety incidence. The 'Get it on time' campaign launched in 2016 provided set standards for PD medication administration. This audit was conducted to assess management of PD medications amongst hospital inpatients with the aim of analysing types of medication errors and impact on patient care.

A retrospective case record review was conducted with data collected from a neurology referral database for all inpatients referred to the neurology team at a general district hospital with a confirmed diagnosis of idiopathic PD in 2016. Data was assessed to confirm most up-to-date medication regimen and compared against set standards.

Final population sample was 52 patients. 60% of patients missed a dose, with the average number of doses missed being five. The top three reasons for missing doses were unable to take, nil by mouth, and unspecified reason. 23% of patients were potential candidates for the rotigotine patch, yet only 15% were prescribed a patch with half of those patients receiving the wrong dose. Contraindicated drugs were documented on the drug chart of 40%, and a single patient was found to have been prescribed contraindicated drugs. 65% of patients experienced some form of medication error with 68% subsequently suffering an adverse outcome and 18% a delay in discharge.

Proposed changes included delivery of training to frontline healthcare professionals in basic PD medication management, promote a patient-led attitude, promote improvement in pharmacy stock on the ward and recruit PD nurse specialists to further improve medication management of patients.

The results were presented at the ASPH grand round, as well as the St Georges Hospital regional neurosciences meeting leading to recruitment of PD nurses at both trusts. Results were also sent to all ward sisters and pharmacy to raise awareness of medication errors made in management of PD medications. Training sessions are regularly held on basic PD medication management. A re-audit will be performed using similar methodology to assess the impact of changes made, with an anticipated reduction in medication errors particularly following recruitment of PD nurse specialist. This will provide both a patient benefit by reducing negative health impact from medication errors, as well as an institutional benefit through avoidance of delayed discharge.

## Junior doctor engagement

## 94 BRIDGING THE DIVIDE: SENIOR MANAGERS AND JUNIOR DOCTORS WORKING TOGETHER

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**Introduction** The relationship between junior doctors and senior management deteriorated since the 2016 contract dispute. These feelings spilt over to local management, leading junior doctors to feel undervalued and not listened to. This is further compounded by a rise in admissions and workload and rota gaps. Junior doctors often do not have contact with decision makers and are unable to raise their concerns in the same manner as permanent staff.

**Methods** A group of senior executive attended compulsory foundation year 1 and 2 (FY1/2) doctor teaching. Each executive took part in four or five 10 min roundtable discussions with 7–10 trainees, each had a provocative question. Once all executives have met the whole group, a round up session summarising the most important issues was led by the foundation programme director. The issues highlighted were then sent the executive to action and report back. This event was jointly organised between junior doctors and executives.

**Results** Junior doctors were surveyed about their perception of hospital management before the session and afterwards. Using a 1–10 Likert scale, there was an improvement on all outcomes measured. They felt they got to know senior management (2.6 vs 8.1), that they were involved in decision making (3.8 vs 7.0), that managers acted on feedback (4.0 vs 7.2), were transparent (4.4 vs 6.7) and committed to patient safety (6.0 vs 7.7). There was also a rise in juniors recommending the trust as a place to work (7.5 vs 8.8). The two sessions were rated 4.1–4.4 out of 5 with numerous favourable comments, making it one of the most popular sessions on the teaching calendar. Executives are currently being surveyed. Anecdotally they have enjoyed the sessions, felt they gained new insights and the ability to improve the working conditions of junior doctors.

**Discussion** This project bridged the gap between junior doctors and senior managers, allowing them to discuss their working conditions in a frank and open manner. These were then acted on by the executives who took prompt action, leading to the high satisfaction scores. This closed loop of feedback fosters trust and increases further cooperation leading to improved services overall for patients. The popularity of the sessions shows the effectiveness of bringing together the front liner with senior decision makers.

**Conclusion** Junior doctors are an invaluable source for quality improvement and strong advocates for improving patient safety. Providing them with a forum to openly discuss issues affecting the frontline with senior decision makers is a powerful tool for improving their working conditions and morale, but ultimately patient safety.