doctors on a range of topics. Consensus amongst peers was that teaching sessions often were not particularly relevant to the needs of junior doctors.

A peer-to-peer teaching scheme was launched for Foundation Year 1 (FY1) doctors in February 2018. A one-hour session dedicated to peer teaching was allocated once or twice a month within protected teaching time. Three speakers were assigned per session, each delivering a 15–20 minute presentation. Content was left to the discretion of the FY1 doctor presenting, and frequently centred around common on call scenarios.

13 FY1 doctors presented topics within the peer teaching programme in the remaining 6 months of the Foundation Year 1. An end-of-year evaluation survey showed that feedback of the scheme was largely similar to regular teaching sessions, with a higher overall rating.

Reflecting on our positive feedback, going forward we ensured that the programme continued to be offered to the FY1 doctors starting in August 2018, and expanded the programme to FY2 doctors.

Acting upon feedback, the presentation time was lengthened to 30 minutes for the FY2 programme in order to allow the speaker to explore their chosen topic in more depth. We also developed a teaching syllabus based on the core medical/surgical curriculum to encourage teaching tailored towards membership exams.

Compared to last year's FY1 programme, we have seen an increase of nearly 40% in teaching participation this year with 18/54 FY2 doctors presenting topics.

We believe the positive uptake of the peer teaching programme reflects a positive engagement of junior doctors in their education, which we hope will carry through to their clinical work on the wards.

56 DIGITAL PATIENT INFORMATION LEAFLET : AN INNOVATIVE APPROACH

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10.1136/leader-2019-FMLM.56

Issue Non availability of paper leaflets for patients for sexual health conditions and contraception in our clinic due to the lack of logistics necessitated to start a quality improvement project.

Innovative idea proposed Newer generation smart phones have camera with built in QR code scanner and does not require an App to scan the QR code. We utilized this opportunity for our innovation.

Project journey A survey was conducted among sexual health clinic staffs on tools used for distribution of patient information leaflets and acceptability of QR code and short url for usage. Survey findings were presented and discussed at a departmental educational meeting. QR codes linking to official BASHH and FPA online patient information leaflets were created from trust Microsoft word software and displayed as small stickers at clinic rooms for usage. Feedback from users was obtained after 6 months. On the second stage of the project, bit.ly codes were created for different clinic sites and were incorporated to the second version of QR codes. It was exceptionally approved by clinic staff for usage with good positive usage feedback.

Technical knowledge of team members and patients were initial challenges, but it did not create a big hurdle as many of our patients are youngsters and Londoners. The total budget for this low carbon project was zero. It solved our clinic logistics requirement at no extra cost.

Lessons learnt Innovative approaches works and encouraging team members and supporting them during innovations can bring positive improvement to the service. Changes can be proposed and implemented as early as possible if it is of no harm to patients and staffs. Team involvement and communication are essential for a successful project.

57 EXPLORING THE FUNCTIONS OF AN E-PRESCRIBING SYSTEM TO REDUCE PRESCRIBING ERRORS AND IMPROVE INPATIENT MEDICATION RECORD KEEPING

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10.1136/leader-2019-FMLM.57

The e-prescribing system at the Great Western Hospital offers a note taking system that pharmacy uses to record a 24-hour drug history and allows users to add notes clarifying any changes.

A QI project aimed to reduce near-misses caused by pre-prescribing errors by increasing the utilisation of the 24-hour drug history and note system. This was done via education targeted at the primary users of the system using pre-existing channels in the trust. Three cycles of interventions were implemented: teaching the prescribers how to use the system during teaching sessions, increasing publicity via posters in clinical areas and trust mailing lists, and making a version of the guide available on the trust intranet.

The primary measure was the number of near-misses identified from pharmacy phone calls to the medical team in a 24-hour period, which fell from 22 to 10 to 8 to 7. Secondary measures were the percentage drug histories being 'read', which improved from 12.77% to 23.26% initially but fell to 2.38% and 4.65%; and the percentages of drug charts with notes clarifying discrepancies which changed little despite intervention from 18.92% to 28.00% to 33.33% to 29.54%.

The interventions show that it is possible to use existing trust education channels to produce a sustainable reduction in near-misses. The reduction in percentage drug histories being 'read', and the lack of change in the percentages of drug charts with notes clarifying discrepancies illustrate the challenges in using an e-prescribing system.

58 HOSPITAL AT WEEKENDS: IMPROVING CONTINUITY OF CARE

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10.1136/leader-2019-FMLM.58

Introduction Maintaining continuity of care at the weekends with a reduced workforce requires effective handover, and robust workforce and task management. In Medway Maritime Hospital, an audit showed that only 50–60% of the weekend

Abstract 58 Table 1

What are we trying to accomplish?	Aim: Improved weekend continuity of care. Objective: Achieve Handover task completion rate (TCR) of 80% in 6 months.
How will we know that a change is an improvement?	Primary measure: Handover TCR, measured via review of medical records. Secondary measure: Perceived effectiveness of weekend handover measured via periodic survey Balancing measure: Number of weekend discharges, collected by the Business Intelligence Department.
What change can we make?	See Driver diagram

Abstract 58 Figure 1

- Non-random variation:
 - Shift
 - Trend
 - Too few runs (≥ 7)

Abstract 58 Figure 2

handover tasks were completed. This Quality Improvement (QI) project demonstrates the value of QI tools in empowering junior doctors as change leaders.

Method The scope of this QI project was defined using the Model for improvement¹ (table 1).

A survey of junior doctors was conducted to investigate the barriers against continuity of care at the weekends and ideas for improvement. The survey result was used to construct a Drivers diagram (figure 1), which outlined the 'theory for change' and identified appropriate interventions.² The key interventions were:

1. Week 3: Introduction of structured handover meeting
2. Week 6: Change to weekend medical staff model to increase the number of doctors on ward cover and providing more senior support for foundation year 1 doctors
3. Week 11: Change to medical registrar rota to enable the weekend ward registrar to lead the handover meeting
4. Week 24: An electronic handover system was developed and piloted from week 24, with full roll out at week 28.

Result At 6 months, the handover TCR improved to 88% (figure 2). The run chart showed shift, trend, and too few runs, indicating non-random variation.³ The perceived effectiveness of weekend handover showed sustained improvement from 7.4/10 to 8.7/10 in the same period. The number of weekend discharges showed only random variation.

Conclusion This QI project improved continuity of care at no additional cost to the hospital. Junior doctors are well placed to offer solutions for challenges in modern healthcare, and QI is increasingly recognised as a core skill for doctors. The Model for improvement, driver diagram, and run charts are accessible QI tools that empower doctors to deliver measurable improvement in care.

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I AM A PATIENT, LET ME OUT OF HERE. A LEADERSHIP INITIATIVE TO IMPROVE PATIENT FLOW AT WEEKENDS

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10.1136/leader-2019-FMLM.59

Background Following the initial successful implementation of weekend discharge ward rounds by a former chief registrar, we reviewed a 2 year period of whether implementing discharge ward rounds is effective for improving patient flow, and has it sustained increasing the number of 'well' patients discharged over weekends/bank holidays.

Methods From 1st April 2017- 31st March 2019, we reviewed the number of medical discharges facilitated by the discharge ward round on weekend/bank holidays, and a mean figure of discharges/day produced. Dates where no named discharge registrar/clinician logged on the trust system have been excluded.

Results Over the time period, mean number of discharges/day was 2.94. Over the winter months November to February, this figure increased to 3.06 discharges/day. Data collected prior to the implementation of the ward round (May-July 2016) was 1.4 discharges/day. This shows the discharges/day more than doubling since implementation. The original data (6 months post initial implementation) showed a discharges rate of 4.625 discharges/day. Therefore over time the effectiveness of the ward round has decreased, however still shows significant improvement.

Conclusions Weekend discharge ward rounds are effective in increasing the number of 'well' inpatients discharged over weekends. This Results in: patients discharged home/to family members; improves patient flow; provides significant savings for the hospital trust. The number of discharges has decreased