Quality improvement

31 IMPROVING ESCALATION PLAN DECISIONS OF PATIENTS: THE IMPLEMENTATION OF A TREATMENT ESCALATION PLAN (TEP) FORM

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Aims Treatment escalation plans (TEPs) ensure patients have ceilings of care considered. They allow staff and patients to be aware of limits of treatments in the event of acute deterioration. In our NHS Trust there is currently no formal TEP document. The aims of our study were a) to evaluate the extent of current TEP decision making and documentation and b) to implement a TEP form and assess its impact.

Methods Utilising PDSA-cycle methodology, we conducted an initial survey of junior doctors and audited ward notes, looking at TEP and DNAR documentation. A TEP form was designed and implemented on these wards and doctors re-surveyed and documentation re-audited.

Results We collected data on 30 patients on three wards. 0% of patients had a TEP form. Only 10% had any TEP documentation. 47% had a DNAR decision. Survey of doctors (n=20) showed 95% thought a TEP form would make the management of patients easier. 90% of junior doctors thought everyone admitted to hospital should have a TEP. Following the implementation of the TEP form, re-audit of ward documentation (n=26) showed 60% of patients had a TEP form and 76% had a DNAR decision. Re-survey of junior doctors (n=17) showed that 100% found it beneficial in managing patients on call. 76% of respondents felt there was a reduction in inappropriate bleeps and medical emergency calls due to the introduction of the TEP form.

Conclusions The TEP form is a useful tool for facilitating ceiling of care decisions and should be considered for every patient admitted to hospital.

32 ADDRESSING EFFICIENCY OF CLINICAL INFORMATION DELIVERY IN CARDIOLOGY WARDS: EXPERIENCE FROM A QUALITY IMPROVEMENT PROJECT ON ECHOCARDIOGRAPHY REPORTING

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Echocardiography is a key diagnostic procedure, but delays or requests overload might compromise its contribution to the clinical decision process.

This project aimed at speeding the availability of echocardiograms results by applying two strategies: 1) Introducing a provisional report (PR) to be delivered immediately to doctors; 2) Reducing the number of referral requests by changing the triage process.

Baseline data were gathered during a 9-week period. The first intervention cycle applied strategy1 by introducing a PR given verbally by echocardiographers to doctors which contained key clinically relevant findings. Rate of uptake of the

PR and time from echocardiogram completion to PR availability were monitored during the following 6 weeks. Strategy2 was implemented 4 weeks after the conclusion of cycle1 and introduced triaging by cardiologists. They determined echocardiogram appropriateness which we expected to reduce the number of overall referrals. Number of requests and time from referral to echocardiogram completion to report availability were monitored during the following 6 weeks. Semi-structured questionnaires proposed at the end of both cycles explored participants' views of the effects of the changes.

Cycle1 resulted in a 78% reduction of the median time used to get relevant information to clinicians. However, PR uptake varied across the observation window reaching at best 40%. Cycle2 resulted in a 40% reduction in the median number of referrals per week and in a 31% reduction of the median time needed from referral to full report. 62% of the doctors reported they noticed improvements in reporting speed after cycle1, which increased to 71% after cycle2. 87% of participants felt strategy1 and 71% felt strategy2 improved patient timely discharge.

Significant improvements in the reporting times of key clinical information can be achieved; however, sustainability and staff engagement are key factors that can influence adherence and long-term outcomes.

Developing effective leaders

33 THE ESSENCE OF CLINICAL LEADERSHIP

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Aims Clinical leadership is an integral part of medicine that is listed as one of the 'Outcomes for Graduates' by the General Medical Council. Studies suggest that there is an underrepresentation of this topic within the medical undergraduate curriculum leading to confusion regarding the responsibilities of clinical leaders and delayed development of leadership skills within junior doctors and medical students. In this review, I aimed to illustrate the true definition of clinical leadership, the benefits of good clinical leadership and the importance of the integration of leadership teaching within the undergraduate curriculum.

Methods A literature review was undertaken using the following databases: Pubmed and Embase. The keywords used were: 'Clinical Leadership' and 'Clinical Management'.

Results To understand the essence of clinical leadership, one must differentiate it from clinical management. The major difference is that leaders bolster change whereas managers stabilize current positions and allocate resources to manage issues. There were numerous instances found where detrimental care was provided in hospital due to poor leadership, further showing the explicit importance of good quality leadership in delivering satisfactory care. Good clinical leadership was shown to provide a higher patient and staff satisfaction, reduced adverse events and an increase in income-per-bed. Early integration of clinical leadership within the undergraduate curriculum was shown to lead to an improved knowledge of leadership roles and more confidence in leading within teams and conflict resolution, both in undergraduate and postgraduate settings.