with data from a previous audit conducted between 2016 and 2017.

Methods 208 patients with DR were identified on EMIS between 2018 and 2019. They were then classified according to DR grade and time from last screening to most recent follow-up eye examination within 12 months, 3–6 months, 4 weeks, and 1 week. Moreover, data is shown for HbA1c value and type of diabetic treatment.

Positive results:

1. Did-Not-Attend numbers for DRSS decreased significantly since last audit.
2. All patients were seen within the appropriate time scale for retinal screening/hospital review.

Negative results:

1. For those who DNA, there were no reasons noted on EMIS and no communication between the Practice and DRSS to clarify the reason.
2. 67% of patients with DR had poor diabetic control and needed up-titration of their treatment or to start on insulin.

Conclusion Results show that changes in clinical practice are needed to ensure proper follow-up of patients with DR. Changes recommended focus on better communication and more efficient and effective time spent on Diabetes management. A few solutions include:

1. Phone calls between the practice and DRSS to clarify reasons for DNA
2. More frequent visits (3–6 months) for patients with uncontrolled HbA1c
3. Up-titration of treatment over the phone without the need of a GP appointment for patients not on maximum number and dose of oral medications.
4. Patients to be reminded during their Diabetic Annual Review to book for retinal screening.

Quality improvement

101 INNOVATING TO IMPROVE: REDESIGNING EMERGENCY ORTHOPAEDIC FRACTURE CARE DURING A GLOBAL PANDEMIC

Thomas Cash, Nastaran Sargazi, Cefin Barton, Nicholas Boyce-Cam. *Mid Cheshire Hospitals NHS Foundation Trust, UK*

10.1136/leader-2020-FMLM.101

Aims The COVID-19 pandemic has changed the delivery of emergency orthopaedic fracture care, with focus on avoiding hospital admissions and minimising nosocomial virus transmission. We set out to reconfigure our service to best meet the needs of patients.

Methods Prior to the pandemic, patients with displaced fractures requiring manipulation routinely received treatment in the operating theatre. The pandemic posed several challenges to the continued delivery of this service following a reduction in theatre capacity. After discussion with multidisciplinary team members, it was agreed that where possible manipulations would be performed in fracture clinic at the point of the presentation. To facilitate this, the trust's mini c-arm (fluoroscopy) was relocated. A standard operating procedure (SOP) was written to guide safe administration of analgesia for adults

and children. Essential resuscitation equipment and airway trained doctor support were made available to ensure patient safety. Data was collected prospectively over a 28-day period and compared to the same period in 2019.

Results The mini c-arm was used on 34 patients in the fracture clinic setting. 82.4% patients received definitive treatment and 44.1% avoided admission for theatre. There were no adverse events. Compared to 2019, the number of patients undergoing fracture manipulation in theatre decreased by 66.7%. NHS reference costs were used to estimate a £8445 saving over the 28-day period.

Leadership Lessons The nature of the global pandemic required swift action to be taken to adapt our service to meet the needs of patients. We used the PDSA (plan, do, study, act) framework to implement this change. After discussion of the findings at our quality improvement meeting, an SOP has now been written to guide the continued running of the service. We wish to highlight this model of emergency orthopaedic fracture care to other trusts for use in the COVID-19 pandemic and beyond.

Quality improvement

102 IMPLEMENTING POSITIVE CHANGE TO THE PRESCRIBING SYSTEM ON THE RENAL WARD IN NINEWELLS HOSPITAL

Carina Banziger*, James Noyes. *NHS Tayside, UK*

10.1136/leader-2020-FMLM.102

Introduction Staff on the renal ward in Ninewells Hospital have highlighted multiple prescribing errors affecting haemodialysis inpatients. Currently, they have two drug charts; one for the acute hospital admission and another for dialysis medications. Concerns were highlighted after duplicate antibiotic doses were administered out of hours, due to confusion surrounding two drug charts. The aim of this project was to reduce the number of drug chart errors by 50% departmentally, in keeping with the World Health Organisation 'Patient Safety Challenge'.

Method Over three weeks the number of prescription chart errors were recorded, which included errors on personal details, allergies and antibiotic prescribing. Vancomycin and gentamicin are the most common antibiotics given on dialysis in NHS Tayside for line sepsis. Our proposed method of change introduced vancomycin and gentamicin stickers for the ward prescription chart, highlighting antibiotics given on dialysis. Medical staff were informed to utilise them in a departmental meeting. Thereafter, the prescription charts were re-audited over three weeks.

Results 86% of drug charts contained errors in week one. In weeks two and three, 100% and 50% of charts had discrepancies respectively. After the implementation, week one showed no errors on the drug charts. In weeks two and three, 20% and 60% of the charts showed mistakes respectively. There was a 66% overall decrease in drug chart errors. Nevertheless, week three showed an increase errors on charts.

Conclusion Although initial improvement was seen, the project 'fizzled' to an end as the junior doctors rotated. Due to the nature of four month rotations, it is difficult for positive change to be sustained. We consider this project highlights the