

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

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**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

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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

importance of leadership and why good initiatives can fail without it. To establish long-term change, we must involve a member of staff with a permanent position in that environment, a leader.

## Leading innovation and improvement

### 103 EXPLORING THE TEACHING AND TRAINING NEEDS OF STUDENTS AND CLINICIANS IN DIGITAL HEALTH

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10.1136/leader-2020-FMLM.103

There has been exponential growth in technology use within the NHS, further accelerated by the Covid-19 pandemic, and video consultations, e-Consults and remote monitoring are now commonplace. However, undergraduate medical education is not keeping up with this pace and medical schools risk producing graduates who are unqualified to work in a digital NHS.

**Assessment** The Medical Education Innovation and Research Centre (MEiC) led two projects exploring views of primary care educators and medical students. MEiC is a translational centre bringing cutting-edge evidence from health, education, community and policy into medical education innovations and research.

Primary care educators attended a digital health workshop where activities included discussing challenges and risks around digital technology. Key challenges identified included digital consultation skills, access, workload, patient safety and ethics.

Third year medical students were invited to enrol on 'Digital Health Futures', a specialty choice module. After the module, students were invited to participate in focus groups to reflect on digital health education. Key themes included lack of preparedness for practice, a call for digital to be fully integrated within the curriculum, and concerns around attitude of the medical school to technology and digital innovation.

**Leadership** Implementing curricular improvement requires strong leadership; and close collaborations and consultation with students and educators is vital. This must be an ongoing and iterative process due to the nature of technological development. Aligning the curriculum to the Topol Report and NHS Long Term plan is key for student learning and ultimately patient care.

MEiC's dedicated leadership in this area has demonstrated the need for curricular reform at undergraduate, postgraduate and continuing professional development level. This emerging and urgent priority must be tackled across the whole medical education spectrum.

## Leading innovation and improvement

### 104 SERVICE DEVELOPMENT PROJECT: CREATING A TRUST LEVEL MENTAL CAPACITY ACT AWARENESS WEEK

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10.1136/leader-2020-FMLM.104

**Aim** To improve the understanding and confidence of clinical staff working in forensic services in applying Mental Capacity Act (MCA) legislation.

**Method** A multidisciplinary group including a psychiatrist, psychologist, social worker and mental health law expert developed a MCA Awareness Week. This included a two hour workshop repeated across three forensic directorates. The workshop featured large and small group activities based on frequently arising scenarios. Workshop attendees were asked to complete a pre and post workshop questionnaire.

**Results** The workshops were fully booked with 80 staff members attending from all clinical specialities including: nurses (33), psychologists (8), healthcare assistants (7), doctors (7), occupational therapists (6), social workers (5), pharmacists (3) and clinical managers (3). 90% of participants completed both the pre and post workshop questionnaires. The mean usefulness score of the workshop was 8.8/10. There was a statistically significant increase (at the 0.05 level) in mean scores across all four measures, including: understanding capacity (26.7% increase), confidence in assessing capacity (29.3%), confidence in being a decision maker (31.6%) and awareness of the principles of capacity (35%). Qualitative feedback was that participants valued having face-to-face learning and group discussions allowed staff to share their views and experiences from the perspective of their disciplines.

**Conclusions** The project was developed in response from the feedback and recommendations of a Care Quality Commission inspection. This meant that senior sponsorship was provided for initiating the project. The multidisciplinary collaboration behind the project also ensured that the service was valued and attended across the disciplines.

The emergence of COVID-19 raises the issue of whether it is viable to adapt a service to an online medium when it is valued for its face to face and group component.

## Cardiology

### 105 STANDARDISING INPATIENT MANAGEMENT OF NON-ST ELEVATION ACUTE CORONARY SYNDROME

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**Aims** To standardise the inpatient management of Non-ST elevation acute coronary syndrome (NSTEMI-ACS) in our tertiary cardiology centre by developing an innovative pathway that integrates care from all members of the multi-disciplinary team (MDT) involved in the patient journey.

**Methods** We retrospectively collected data on all cardiology admissions from January 2020 to April 2020 with a discharge diagnosis of NSTEMI-ACS. We collected informal feedback from representatives of the MDT involved in all stages of the patient journey.

**Results**

- 21% and 33% of patients were screened for diabetes and dyslipidaemia, respectively.
- 84% of patients who underwent coronary angiography met the ESC criteria for high-risk NSTEMI-ACS. Gold standard