other life threatening conditions at the same time. Thus, many acute presentations of chest pain can be missed or not receive the necessary treatment on time, in a busy, understaffed department. This significantly increases the mortality and future morbidity due to delays in the healthcare service provision to the patient.

One way to mitigate this is by training healthcare workers like Nurses, paramedics and other emergency healthcare staff to appropriately categorise a patient with chest pain as emergent and requiring ECG, so that the investigations needed can be carried out before the physician is able to clerk the patient.

This project was carried out in a tertiary care centre in Bangalore Urban, Karnataka India. First, the number of patients presenting with chest pain to the emergency department in a one-week setting were reviewed according to severity of symptoms using a 1–10 pain scale, other associated symptoms and presence of comorbidities or risk factors for Heart and lung diseases. The response time of the emergency staff to the patient from entry to the facility until appropriate management (shift to Intensive care unit, higher center referral, immediate prophylaxis, discharge) given was measured. A teaching session was conducted by emergency physicians involving all emergency staff following this. Using the data collected, a simple algorithm was devised to help staff make decisions regarding the treatment protocol. Training regarding reading an ECG, immediate prophylaxis for STEMI/NSTEMI patients and respiratory causes of chest pain was given to Nurses and senior Emergency non-medical staff.

Leading innovation and improvement

114 AMBULATORY EMERGENCY CARE UNIT (AEC) IN PATIENTS' AND HEALTHCARE PROFESSIONALS' EYE

Zakariya Abdulazeez, Uyen Tran. *Department of Acute Medicine, Medway Maritime Hospital, Kent, UK*

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Aim Assess the understanding of ambulatory emergency care between health care professionals and patients, in-line with ambulatory emergency care guide published by NHS Improvement June 2018. Also to highlight the teamwork, leadership and the bespoke improvements carried out to improve the service.

Methods A survey data collection with two separate questionnaires; one for patients with 4 questions, and another for healthcare professionals with 6 questions. Questionnaire forms were handed to patients who were waiting to be seen in Ambulatory Emergency Centre (AEC), also some healthcare professionals including GPs around Medway area, MedOCC, nursing staff and different grade doctors at Medway Hospital over the period of May 2019. Similar survey was carried out after 6 months of the improvement.

Results The initial survey showed misconception of the AEC services. Patients' survey showed 49% considered AEC as an outpatient clinic, 53% expected to stay less than one hour in AEC. Initial healthcare professionals' survey showed that 11% thought that patients with NEWS score 5 could be seen

in AEC. More than half (65%) were unaware of the AEC service. After the implementation of improvements and change the name of the service to Same Day Emergency Centre (SDEC), a second survey was carried out that showed improvement in patients' conception of SDEC services with only 1% considered SDEC as walk in clinic, 84% expected to stay less than 24 hours at SDEC. The second healthcare professionals' survey also showed great improvement with 92% of professionals knew the services provided by SDEC, and all healthcare professionals knew the referral criteria and the referral system.

Conclusions Team work is the key to make a change happens, and leadership is important factor for success. Response to issues regarding patients' safety is required from healthcare professionals to improve the service provided.

115 COMMUNICATION, PROFESSIONAL DEVELOPEMENT, DATA DRIVEN DECISION MAKING

Martin Ezequiel Cohn*, Stella Barnass. *Hillingdon Hospital, The Hillingdon Hospitals NHS Foundation Trust, UK*

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Hand in hand with the COVID-19 pandemic, new processes were put in place to address such disease. The implementation of a structured and reliable process for swabbing of potential COVID-19 infected patients became critical. Nevertheless, this process did not come without problems in practice.

Around mid-March, it was noticed that over 10% of swab samples collected at Hillingdon Hospital were being rejected for analysis. A root-cause analysis through questionnaires and objective data sampling was conducted with support of internal stakeholders to explore the problem. Practical issues in sample handling linked to inadequate communication and training were identified as the main cause for sample rejection.

By the third week of March (i.e. one week in the project), an immediate approach was taken. With support from senior nursing staff, the team created an open space during hand-overs for the discussion of concerns and issues around sampling and technique. Ward specific figures and details were handed over to the ward sisters to inform each team.

During the second stage of interventions, in collaboration with several members of the multidisciplinary team, multiple scripts for an educational video were developed. Several video versions were released based on feedback and following updates from national guidelines. With support of Silver Command, the videos were distributed through the daily email communications and in the Trust's homepage. The actions implemented had an immediate effect in the overall sample rejection rate, reaching about 5% a month in the project, and dropping to less than 2% in later months.

The project improved communication within the teams and cooperation between the multidisciplinary team, highlighting the importance of continuous professional development. In moments of crisis, this union led to further support and reliability on leadership who was trying to promote safety among staff and patients during this difficult time.