Think sugar-Hyperglycemia management in cardiology

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Introduction • Issue :Lack of awareness for the significance and management of hyperglycaemia in the short and long term for cardiology patients. Data collected from 21 inpatients in Cardiology ward and CCU between May 8th and 24th 2018, and 2nd cycle between 10th July till 30th July 2018.

Results
1. Hb A1C check (1st cycle showed on 33% which rose to 90% in 2nd cycle)
2. Reason for admission 1st and 2nd cycle:The most common reason for admission within the cohort was myocardial infarction.
3. Frequency of blood glucose checked: 1st cycle 67% patients checked 4 times a day. 2nd cycle this rose to 85%
4. Referral to Diabetic specialist team: 38% were referred to the Diabetic inpatient team in first cycle which changed to 75% in the 2nd one.
5. Information given to the patients: 100% patients were given the information leaflet in the second cycle as compared to 42% verbal info in 1st cycle.

• Leadership and innovation: This QIP led to improvement in the understanding of healthcare professionals, about the significance of glycaemic control, patient information and appropriate follow up for it via focusing:
1. Catchy ‘Think sugar’ posters created and put up in cardiology ward and CCU, with literature references as part of evidence based medicine.
2. First initial CBG check documentation was made part of nursing CBG check sheets.
3. Patient information leaflet was created and feedback taken

6) Impact:
• Patient care and hence further admissions improved in terms of both cardiology care and glycaemic control and helped anticipating in reducing the health care burden as well.
• The innovative way of disseminating the knowledge and improving patient care helped health care professionals understand better the significance of good quality control as an integral part of cardiology related medical issues and overall health of the patients.

Enhancing your leadership and management skills

The COVID Junior Support Team (CJST)

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10.1136/leader-2020-FMLM.25

The NHS response to COVID 19 required staff to work very differently as the health service pivoted dramatically. As clinical service models evolved to prepare our hospital for the anticipated wave of COVID patients, a group of junior doctors who were excluded from frontline duties volunteered to contribute by providing office based tasks. The COVID Junior Support Team (CJST) was formed with its main ‘objective’, to support staff in the delivery of effective and high quality patient care. The CJST self-organised its members, taking on specific roles and setting up services tailored to address specific needs identified. Outputs included:

1. Standard Operating Procedures (SOP) for COVID-19 results management for discharged patients
2. Updating clinical guidance
3. Communication cascade
4. Rotas
5. Induction and Training programs for interim FY1’s
6. Mortality Reports
7. Rapid learning reports/literature searches
8. Staff wellbeing survey
9. GP advice service provided by senior trainees and consultants

Our intervention has shown that despite not being able to work in patient facing clinical environments doctors in training have many transferrable skills which can be harnessed to assist front line staff and contribute positively. The CJST provided a unique development opportunity for doctors in training to gain experience of leadership and management across a wide range of activity. The team were