

Methods A retrospective review for our local maternity services was done for use of intravenous iron involving 24 pregnant women with iron deficiency anaemia. Cost of treatment was provided by the local business authority and the NHS Prescription Cost Analysis 2012 database.

Results 80% of patients received oral iron as the first line. However, there was inadequate evidence of antenatal counselling and checking compliance.

15 patients were treated with Monofer at a cost of £847 per patient. 9 patients were treated with Venofer at a cost of £2721.74 per patient.

On average women received Monofer later in pregnancy, 36 weeks compared to 31 weeks. In a small group of patients, mild adverse effects such as flushing and headache were seen with Monofer. However, these were self-limiting. Only one had severe HSR which was successfully managed.

No adverse reactions were seen in the Venofer group.

Conclusion Monofer replenishes iron stores faster than Venofer, offering a safe, convenient, cost-effective, single-dose therapeutic treatment for iron deficiency anaemia in pregnancy. However, it is not commonly used in pregnancy due to fear of hypersensitivity reaction. Simple adverse effects are mislabelled as hypersensitivity reactions. A management flow chart has been suggested after a multidisciplinary discussion to guide in case of such events.

There is a scope to improve detection of anaemia as well as the use of oral iron. To improve detection and management of iron deficiency anaemia, we have also introduced a simple flow chart for doctors and midwives to follow in hospital and community.

This study highlights being innovative, proactive and execution of ideas within wider multidisciplinary teams in community and hospital to improve patient experience, safety and management.

Think sugar

24 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 following:

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

25 THE COVID JUNIOR SUPPORT TEAM (CJST)

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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 transferable 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

empowered by senior medical leaders to work autonomously and to develop solutions, whilst ensuring they had clear and direct access to senior support. Shielding trainees may continue to part of the medical workforce for some time as we approach recovery. Our intervention shows these trainees can gain skills and experience from being involved in leadership and management roles out with the clinical environment. They can be utilised to enhance services if given autonomy and support to do so.

Enhancing your leadership and management skills

26 ENHANCING MY LEADERSHIP AND MANAGEMENT SKILLS BY COMPLETING A MASTER'S IN BUSINESS ADMINISTRATION DEGREE

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10.1136/leader-2020-FMLM.26

Context I am a pre-speciality UK NHS doctor with a keen interest in emerging technologies in healthcare. Aspiring to be an NHS hospital consultant but also functioning as a chief clinical information officer (CCIO). To develop my leadership and management skills, I set myself the following objectives in 2018.

Objectives

- develop critical insights into organisational, management and leadership development theory.
- develop a greater understanding of the private-sector organisations selling healthcare technology to the NHS.
- develop a network of contacts in the healthcare technology sector.

Assessment of objectives The overall purpose of these objectives was from an early stage to build the management knowledge and network of commercial contacts to perform effectively as a CCIO and NHS consultant.

Intervention I felt that a higher degree in leadership and management would help me achieve my full set of objectives in a single move. In 2018 I embarked upon the University of Manchester's master's in business administration (MBA) course; designed to teach how to manage organisations and their resources.

Impact Soft skills gained: New team working and communication skills. Developed different perspectives and approaches to complex ambiguous problem-solving.

Hard skills gained: Learning to apply change management frameworks to transformational projects in healthcare. Learning to apply project management methodologies for organising, tracking and managing quality improvement projects. Learning to critically appraise research in healthcare management.

Lessons applied Two examples of NHS leadership projects which I have contributed to outside the MBA course which enabled me to convert knowledge into practical experience are as follows:

- Junior doctor representative at executive-level strategy planning meetings.
- Quality improvement project to design a remote induction package for newly starting A&E doctors.

Quality improvement project

27 THINKING DELIRIUM: IMPROVING DETECTION AND DIAGNOSIS IN A LOCAL, ACUTE GENERAL HOSPITAL IN NORTHERN IRELAND

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Background Delirium is a complication that presents a frequent challenge on our inpatient wards. Early recognition, detection and diagnosis of delirium can improve patient outcomes. The 4 'A's Test (4AT) is a validated, rapid initial assessment tool that is a sensitive and specific method of screening for delirium in hospitalised patients.

Aims To determine the prevalence of use of the 4AT and to reveal if increasing staff awareness yielded improvement in use of the 4AT and detection of delirium.

Methods Initial data collection analysed inpatient notes on our rehabilitation (rehab) ward and medical assessment unit (MAU), for any terminology suggestive of an underlying delirium. Rehab ward nursing staff had already received training on delirium detection. Following this, formal teaching was delivered to junior doctors, and 4AT lanyard cards were distributed. One month later, another round of data collection was undertaken. Throughout the year, nurses in MAU were educated on delirium. Further data was collected 1 year later.

Results Baseline data analysis showed use of the 4AT on the rehab ward (75%) was significantly greater than MAU (20%). This was associated with increased detection/diagnosis of delirium on the rehab ward (75% diagnosed, 100% concordance with 4AT use) compared to MAU (20%). After 1 month, use of the 4AT improved dramatically on MAU (50%) and remained high on the rehab ward, improving to 87.5%. Results at 1 year show use of the 4AT continues to remain high on the rehab ward (75%) in at-risk patients. In addition, there remains a sustained improvement in 4AT use on MAU (40%) compared to baseline data (20%). Diagnosis and recording of delirium continues to improve on MAU (100% of suspected patients diagnosed), and remains high (75%) on our rehab ward.

Conclusion Our findings support the continued use of the 4AT screening tool and ongoing staff education and training in order to improve knowledge and confidence in detecting signs of delirium.

28 THINKING DELIRIUM: IMPROVING DETECTION AND DIAGNOSIS IN A LOCAL, ACUTE GENERAL HOSPITAL IN NORTHERN IRELAND

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Background Delirium is a complication that presents a frequent challenge on our inpatient wards. Early recognition, detection and diagnosis of delirium can improve patient outcomes. The 4 'A's Test (4AT) is a validated, rapid initial