Assessing the Quality of E-learning Modules in Medical Education

Dr Alice Crabtree, Dr Louise Anning and Dr Katherine Mellor
Torbay and South Devon NHS Foundation Trust
Aim

- To improve the teaching experience of Core Medical Trainees (CMTs) at Torbay and South Devon NHS Foundation Trust by introducing a weekly teaching programme incorporating e-learning modules.
Methods

• Introduction of weekly teaching sessions for the CMTs
  • Mixture of formal teaching and e-learning
  • E-learning completed as a group, facilitated by Consultant or Registrar.

• Topics:
  • Difficult to sign off on the e-portfolio curriculum clinically
  • Emergency presentations

• Evaluation of 3-4 different modules from each 3 online platforms:
  • BMJ Learning
  • Doctors.net
  • e-Learning for Healthcare

• Modules assessed on Likert scale for:
  1. Utility in curriculum sign off
  2. Utility of content in progression of knowledge
  3. Knowledge level
  4. Ease of use of the module
Results
Comparison of the different E-learning modules

Did this e-learning module help you sign off a curriculum learning point?

How useful was the content?

- e-LfH
- Doctors.net
- BMJ
Results
Comparison of the different E-learning modules

Was the knowledge level pitched appropriately for your training?

Was it easy to use?
Discussion

• 100% of trainees felt that these teaching sessions improved the quality of their training experience.

• Challenges in implementing a new teaching programme:
  • Trainee awareness of sessions happening (communication platform).
  • Attendance limited by work pressures making it difficult to leave wards
  • Availability of consultant/registrar.

• Once the programme was set up to occur on a regular basis these problems improved and 83% of trainees attended regularly.

• Small study – 10 CMTs in total but variable attendance.
Take-home messages

• E-Learning modules are a useful tool to promote training when used within a training programme.

• Modules provided by BMJ learning are the most user friendly and have most appropriate knowledge level for core medical training.

• Consultant/Registrars enjoy these sessions for promoting their own learning/CPD and because they don’t require prior preparation.

References - www.e-lfh.org.uk, www.doctors.net.uk, learning.bmj.com
The Benefits of Embedded Specialist Palliative Care Nursing in the Acute Medical Unit
Aim

• What benefits come from having embedded Specialist Palliative Care on AMU?

• Will it improve the identification and appropriate care of patients in the last year of life?
Method

• Macmillan funded 2 year Project
• 2 Band 7 Specialist Nurses
• Relationship building
• Education and use of SPICT
• Patient identification
• Rapid response to identification
Further, before the Macmillan project commenced in July 17 the average 30 day readmission rate for all palliative care patients was 36.1%, this has now reduced to 30.6%. For patients within the Project, the re-admission rate is 10%.
Results

Estimated Number of Bed Days Saved (July 2017 - July 2018)
194 Estimated Saving £95,642

Avoided Admissions (July 2017 - July 2018)
9 Estimated Saving £16,560

Total £112,202
Discussion

Specialist Palliative Care embedded in-reach to AMU gives:

• Reduced number of bed days and readmission rates
• Improved patient care
• Reduced use of acute care resources
• Saves money!
Take back to AMU message

• Try this in your AMU
• Talk to your Specialist Palliative Care Team and Macmillan
• Potential to transform service

Thank you.

helen.harris@cht.nhs.uk
Nurse-led screening of acute medical admissions: right-siting and re-admissions
AIM

To establish if a nurse-led screening protocol is as accurate and safe as screening done by physicians.
Methods

• Sampling:
  • Anonymised patient data from the hospital’s electronic databases and AIMS manual logs
• Duration:
  • 4 months: from 9 December 2017 to 28 March 2018 (both dates inclusive)
• Statistics:
  • Descriptive statistics and the $\chi^2$ test on Microsoft Excel™ 2010
Results

A total of 274 patients were screened. 173 (63.1%) were reviewed by physicians and 101 (36.9%) by AIMS nurses.

(1) Right-siting

- 79 (78.2%) of the patients screened by nurses were suitable for admission to AIMS and 69 (87.3%) were right-sited.
- 156 (90.2%) of the patients screened by physicians were admitted, and 139 (89.1%) were right-sited.
- No significant difference between nurse-led and physician-led screening rates at the 0.01 level (p=0.25).
(2) Re-admissions

- 78 (98%) patients were admitted to AIMS using a nurse-led screening process and 1 (2%) patient was re-admitted within 30 days.
- 173 patients screened and admitted to AIMS by the physicians, 7 (4%) patients were re-admitted.
- No significant difference between nurse-led and physician-led re-admission rates at the 0.01 level ($p=0.24$).
Discussion

The study suggests that a nurse-led screening protocol results in right-siting and re-admission rates comparable to a physician-led process.
Take-away Message

• With training and clear processes in place, nurses can be empowered to assess and independently admit patients to an acute medical unit.

• Potential benefits include reduction in delays to admission, prompt, focused nursing care, relief of physician burden, expansion of nursing skill sets and capabilities, increase in self-confidence, and a development of a much stronger professional identity.
HIV Screening in Acute Medical Unit at Queen Elizabeth Hospital Birmingham

Kay Thi Kyaw
Specialty Registrar

Supervisor: Dr Adam Seccombe
Background

• Late HIV diagnosis is a major cause of morbidity and mortality

• NICE (NG60) recommends the following:
  In areas of high prevalence, offer and recommend HIV tests “to everyone who has not previously been diagnosed with HIV and who is undergoing blood tests for another reason”
Background

• Late HIV diagnosis is a major cause of morbidity and mortality

• NICE (NG60) recommends the following:
  In areas of high prevalence, offer and recommend HIV tests “to everyone who has not previously been diagnosed with HIV and who is undergoing blood tests for another reason”

• Routine HIV testing for all Acute Medical admissions was agreed at Queen Elizabeth Hospital Birmingham
Aim

• Assess the proportion of patients in CDU who are screened for HIV
• Use a PDSA approach to test measures to improve the rate of HIV screening
Method

• Audit population: all adult patients who attend AMU

• Three periods of data were requested retrospectively from the QEHB Informatics service for all admissions:

1. **8th May to 31st August 2017** (pre-implementation)
2. **2nd October to 31st December 2017** (following personal and e-mail communication)
3. **1st March to 31st May 2018** (following additional educational sessions and reminder posters)
The percentage of patients receiving an HIV test throughout the process

- E-mail communication
- Educational sessions & reminder posters

No Data
Results

• The proportion of patients who were screened for HIV increased from ~2% to ~10%

• A follow-up survey of junior doctors was performed to explore the ongoing barriers to performing an HIV test

• Three themes emerged:
  1. Forget to do it
  2. Assumed patients need to be formally counselled
  3. Scared in case an HIV test wasn’t appropriate
Take-home messages

• Routine HIV testing should be performed in high prevalence areas (>2 per 1,000 people aged 15-59 years)

• There is no need to counsel patients for HIV testing

• Implied consent in Acute Medical admissions is a valid approach for routine HIV testing
The Utility of AMB, mAMB & GAP Scores in Predicting Admission or Discharge

Katherine Ashcroft
Aims

• In 2016, there were 23.57 million attendances to EDs across England, a number that is increasing year on year. 
  • NHS resources are currently stretched thin.

• In order to streamline the Emergency Department, a scoring-system could be introduced to predict the outcome of each patient.

• Three potential options:
  • Glasgow Admission Prediction (GAP) score
  • Ambulatory Care (AMB) score
  • Modified AMB score (mAMB)
Methods

• Data from 1000 patients presenting to the ED of Salford Royal Hospital between 2\textsuperscript{nd} – 14\textsuperscript{th} April 2018 inclusive was collected.

• Each patient’s GAP, AMB, and mAMB scores were calculated, then compared to the actual results of their presentation (discharged or admitted).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1 point per decade</td>
</tr>
<tr>
<td>NEWS</td>
<td>1 point per point on NEWS score</td>
</tr>
<tr>
<td>Triage category:</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>2 (or 3+)</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Referred by GP</td>
<td>10</td>
</tr>
<tr>
<td>Arrived in ambulance</td>
<td>5</td>
</tr>
<tr>
<td>Admitted &lt;1 year ago</td>
<td>5</td>
</tr>
</tbody>
</table>

NEWS, National Early Warning Score.

Figure 1: Glasgow Admission Prediction score\textsuperscript{1}

Table 1: Ambulatory Care score\textsuperscript{2}

<table>
<thead>
<tr>
<th>Factor</th>
<th>Score (1 = applicable, 0 = non-applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sex?</td>
<td></td>
</tr>
<tr>
<td>Age &lt;80</td>
<td></td>
</tr>
<tr>
<td>Patient has access to personal or public transport</td>
<td></td>
</tr>
<tr>
<td>IV treatment not likely to be required</td>
<td></td>
</tr>
<tr>
<td>Patient is not acutely confused</td>
<td></td>
</tr>
<tr>
<td>MEWS score = 0</td>
<td></td>
</tr>
<tr>
<td>Patient not discharged from hospital within last 30 days</td>
<td></td>
</tr>
<tr>
<td>Total AMB Score</td>
<td></td>
</tr>
</tbody>
</table>
Results

• AMB and mAMB score were compared. Both are reliable systems, but mAMB found to be slightly more accurate in predicting discharge within 12 hours.
  • Cut-off determined to be a score of 5

• GAP was found to be more accurate than AMB and mAMB, but calculates the likelihood of patient admission rather than discharge.
  • Cut-off determined to be a GAP score of 20
Discussion

• The results from this study showed a strong relationship between the GAP, AMB and mAMB scores and the number of patients admitted into hospital after presenting to Salford Royal ED.

• Limitations: retrospective study, only in adults, only medical patients, scores required clinical judgement and patient honesty, no Triage score
Conclusion

• Scores showed significant positive predictive value in previous studies.
  • In our study, they did not give us absolute cut-offs in predicting admissions or discharge for the cohort of patients.

• The scores do have the potential to identify patients suitable for AEC (thereby increasing our AEC workload).

• As we use a consultant-led ‘pull model’ from ED, the combination of these scores will be evaluated prospectively for their decision-making capability using an Artificial Intelligence (AI) based model which has been created using a combination of the parameters included in the GAP, AMB scores to try and predict more accurately admissions as well as discharges.
Bibliography


Staff Engagement on the Acute Medical Unit

Lorraine Carlin

AMU Ward Sister
Why bother with staff engagement?

• 2017/18 was a challenging year for acute medicine
• SAM president, Nick Scriven, said he was “concerned” for the “health and sanity” of “overstretched and unloved staff” who were “worn out”
• The NHS staff survey 2017 reported nearly 40% of staff feeling stressed due to work
• Local issue with reduced staff satisfaction scores in the 2017 staff survey and individual cries for help
Aim of project

• Assess the mood of the acute medical unit team
• Identify influencers of mood
• Improve feeling of staff having control over their work and workplace
• Focus on a bottom-up approach to improvements and unit development
• Improve mood
Rough and ready methods

Penny for your Thoughts

Little Box of Bothers and Bright Ideas
### Sharing Feedback

<table>
<thead>
<tr>
<th>You said….</th>
<th>We are doing….</th>
<th>Benefits for patients…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can we have criteria for admission to AMU?</td>
<td>Admission criteria drawn up and agreed with the Emergency Department and copies with the nursing and medical staff.</td>
<td>Avoids multiple moves, makes them feel safe and welcome on arrival to AMU</td>
</tr>
<tr>
<td>Can the latest patient admission sheet be on the top of the clipboard</td>
<td>Implemented and in use for the last week</td>
<td>Reduce risk of patients having delay in arrival observations or review</td>
</tr>
<tr>
<td>Can we improve communication of the action plan?</td>
<td>If nurse unavailable, trial of using a ‘nursing job box’</td>
<td>Avoids delayed stat doses of medications. Initial nursing feedback positive.</td>
</tr>
</tbody>
</table>
Results

• Immediate positive staff buzz
• Large numbers of ideas and issues shared

Staff survey highlights:
• 100% staff knew of the bothers/ideas box and felt able to share their thoughts
• 89% felt their voice was now heard by seniors
• 50% confident of change, 40% unsure, 10% not confident
• 40% had already seen change based on Little Box ideas
Next Steps

• Consider Fab-O-Meter app for real-time measurement of mood
• Build confidence that staff ideas can become actions: change to “We Said, We Did” posters
• Support from organisational development/QI team for facilitated team development discussions
• Linking staff engagement feedback with patient feedback
• Roll-out to other wards/units
Delayed patient’s length of stay: Results from the London Day of Care Survey (DoCS)

Milka Marinova, Lauren McKenzie Bell, Derek Bell
Introduction

➢ ‘Delayed transfers of care’ (DTOC’s)\(^1\), occur when a patient is ready to leave hospital care but is still occupying an acute hospital bed and awaiting discharge home or another facility.

➢ Discharge bottlenecks lead to fewer beds, increased occupancy rates with associated costs, longer waiting times and poorer patient/staff satisfaction\(^2\).

➢ NHSI is focussing on delays > 21 days but this may miss bigger picture as highlighted by DoCS, which reviews whole-hospital delays.

➢ This large study describes length of stay (LOS) of delayed patients and highlights patients’ optimal place of care.
Method

➢ Using DoCS$^3$, inpatient delays were assessed in 23 of 27 London hospitals over two weeks in October-November 2017.

➢ Patients who did not meet criteria for inpatient care were identified; their LOS, reason for delay and alternative place of care recorded.

➢ Surveys were carried out by trained reviewer teams at each site between 8 and 10am and taking 1 to 3 hours for completion.

➢ Data was checked and entered anonymously, with site reports with recommendations produced.
Results 1

➢ Of 9004 beds surveyed, 7856 patients were included → 24% (1919) delayed

Length of stay for all patients (met or not met criteria) in London Day of Care Survey

- 32% (2502) of patients had LOS of 1-3 days
- 26% (2075) of patients had LOS >14 days
Results 2

Patients not meeting criteria by LOS group, as a % of all patients who did not meet criteria

47% of patients not meeting criteria have LOS of over 14 days, category which is familiar.

Importantly, a significant proportion of patients not meeting criteria have shorter stays: 18% LOS 0-3 & 35% LOS 4-14 days, which may be unfamiliar.

Alternative place of care for delayed patients was ‘at home’ for 56% (range 33-72%) and ‘non-acute area of care’ for 41% (range 24-64%).
Conclusion

- This data suggests NHSI strategy may be misplaced and hospitals must get upstream in LOS by identifying patients at point of entry, within the AMU, to minimise longer admissions and DTOC’s.
- Shifting focus to delayed patients with LOS 1-3 may provide better results for patients and reduce occupancy.
- As 56% could receive care at home, hospitals should better understand needs of this patient group and consider whether they could be served with expedited, simple packages across the working week.
References


Thank you!

Please visit our posters:

➢ Delayed patient’s length of stay: Results from London Day of Care Survey: A&QI 25

➢ Pan-London Day of Care Survey; common reasons for hospital delays: A&QI 59
“A touch of colour:”
Addressing inter-professional grade recognition of Doctors with coloured lanyards

Dr Ellie Hall (FY2) and Dr Lucy Whitton (CT2)
Dr Sara Williams (FY2), Dr Mary Fenton-Jones (FY2)
Dr Jon Downing (ST5 Acute Medicine)
The Problem

What grade are they?
Aims

1) Explore

2) Produce

3) Collect

4) Evaluate
Method
Pre

• 96% doctors and 93% nurses - important to know doctors grades

• 91% of doctors - grade being mistaken

• 5% doctors and nurses – always knowing the grade of a doctor

Post

• 97% of doctors better able to identify grades

• 97% of doctors also felt an improvement in role recognition
Not sure what the grade of Dr you’re talking to is? Simple lanyard solution from John Downing & team - best project I saw at the @RUHBath QIP evening. Has made a real difference to me as Med SpR in emergency situations being able to tell what experience my team has @acutemedicine


An Evaluation of the Function of our MSSU, and Validation of the Ability of the MSSU Score to Identify Patients Suitable for MSSU Care

Dr Alexander Moffat  FY2 - Worcestershire Royal Hospital
Dr Emily Woods  FY2 - Worcestershire Royal Hospital
Dr Jennifer Gwyn  StR - Acute Medicine & Intensive Care Medicine, West Midlands Deanery

Session 6.3 – Wee Shortys: Improving Service Organisation & Design in the AMU
Overview & Aims

Aims

1) **Evaluate the functioning of our MSSU**, looking at characteristics of patients admitted and retrospectively assessing their suitability

2) **Validate the usefulness and accuracy of the MSSU score** in predicting a LOS ≤/>3 days (by comparing actual LOS between score-appropriate and score-inappropriate patients)

3) **Introduce the MSSU score to our hospital for a trial period**, with subsequent re-audit to see results

The MSSU score 2

<table>
<thead>
<tr>
<th>MSSU Score (Powter et al, 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ≥5 regular medications</td>
</tr>
<tr>
<td>2. ≥80 years of age</td>
</tr>
<tr>
<td>3. Confusion (new/old)</td>
</tr>
<tr>
<td>4. Previous hospital admission in last 4 wks.</td>
</tr>
</tbody>
</table>

One point is scored for each variable

MSSU score 0 or 1 = admit to MSSU
MSSU score ≥2 = not appropriate for MSSU


*Wee Shortys: Validating the MSSU Score*
Retrospectively collected a range of data pertaining to admission of 100 patients admitted to our MSSU in November 2017 from electronic hospital records.

Determined appropriateness of MSSU admission, based on:
   i) their duration of admission (appropriate = LOS ≤72hrs), and;
   ii) their retrospective MSSU score (appropriate = 0/1)

The scoring system was then introduced to guide MSSU admissions for a seven day trial period in April 2018, with subsequent reaudit.
Results – Part 1

Nov ’17 (pre-score introduction)  \( (n = 100 \text{ patients}) \)

Of the 100 patients admitted to MSSU in the initial period, only 35% of patients had a total hospital LOS ≤3 days, with 62% of patients ‘score-appropriate’

Of 35 patients with LOS ≤3 days, 30 of them (86%) had score of 0/1
**Results – Part 2**

**Apr ’18 (post-score introduction)  \( (n = 26\) patients)**

Of the **26** patients admitted to MSSU in the trial period, only **27%** of patients had a total hospital LOS \( \leq 3\) days, with **50%** of patients ‘score-appropriate’

After our trial, paradoxically proportionally **more score-inappropriate patients** were admitted (**50%** vs. **38%**), and a **lesser proportion of admissions** were \( \leq 3\) days LOS (**27%** vs. **35%**)
Discussion

- Of 126 total patients, 75 patients (60%) had a score of 0/1 (score-appropriate), with 34 of these patients (45%) having a LOS ≤3 days.
- Of the 51 score-inappropriate patients, only 8 patients (16%) had a LOS ≤3 days.
- The MSSU score thus worked to some extent, with a greater proportion of ‘score-appropriate’ patients (score 0/1) having an admission of duration ≤3 days, compared to ‘score inappropriate’ patients (45% vs. 16%).

- The score may have performed better in predicting an admission >3 days (in patients with score >1), and therefore identifying patients inappropriate for admission to MSSU:
  - 43 of 51 score-inappropriate patients (score >1, 84%) had LOS >3 days
  - 34 of 75 score-appropriate patients (score 0/1, 45%) had LOS ≤3 days
Conclusions & Take-Home Messages

✓ Our MSSU is **not functioning** as intended
✓ The **MSSU score shows some promise** in predicting LOS, and seems **better at predicting LOS >3 days** in our study
✓ **All levels of staff** need to be involved and onboard if a score to guide MSSU admissions is to be used
✓ It remains **extremely difficulty to accurately predict LOS**, even with a scoring system which brings some benefit
✓ Perhaps the **place for an MSSU** in our hospital should be questioned…

References

Wee Shortys: Validating the MSSU Score
Pooled data:

<table>
<thead>
<tr>
<th></th>
<th>Of ALL patients (n = 126)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean LOS in hospital, of all MSSU admissions</td>
<td>8.79</td>
</tr>
<tr>
<td>Median LOS in hospital, of all MSSU admissions</td>
<td>6</td>
</tr>
<tr>
<td>Range of LOS in hospital, of all MSSU admissions</td>
<td>1.48</td>
</tr>
<tr>
<td>Standard deviation of LOS in hospital, of all MSSU admissions</td>
<td>8.13</td>
</tr>
<tr>
<td>Mean LOS in hospital, of appropriate MSSU admissions</td>
<td>7.69</td>
</tr>
<tr>
<td>Median LOS in hospital, of appropriate MSSU admissions</td>
<td>4</td>
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<tr>
<td>Range of LOS in hospital, of appropriate MSSU admissions</td>
<td>1.33</td>
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<tr>
<td>Standard deviation of LOS in hospital, of appropriate MSSU admissions</td>
<td>8.75</td>
</tr>
<tr>
<td>Mean LOS in hospital, of inappropriate MSSU admissions</td>
<td>10.18</td>
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<tr>
<td>Median LOS in hospital, of inappropriate MSSU admissions</td>
<td>9</td>
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<tr>
<td>Range of LOS in hospital, of inappropriate MSSU admissions</td>
<td>1.28</td>
</tr>
<tr>
<td>Standard deviation of LOS in hospital, of inappropriate MSSU admissions</td>
<td>6.94</td>
</tr>
</tbody>
</table>

References

Wee Shortys: Validating the MSSU Score
Impact of Social Media on the Promotion of Acute Internal Medicine

Damian Dooey, Anika Wijewardane and Naina Mohan
takeAIM Fellows
Aim/Method

• We use Twitter, Facebook, Instagram and our newly re-designed website to promote AIM.

• We reviewed analytics over a 6 month period, for these platforms. We examined the number of new followers that joined us and looked at the website, as well as the number of impressions of our posts.
Twitter

• New followers: 172 - total of 833 followers
• Tweeted 87 times which managed to gain 162,000 impressions
• takeAIM twitter profile @take__AIM was visited 3885 times, with @take__AIM being mentioned by other people 398 times.
• 123 new ‘friends’ to the page.
• Used Facebook to advertise the upcoming conference in Cambridge – 10\textsuperscript{th} November
• During our last campaign we reached 13,875 profiles, with 50,733 impressions. The advert was clicked 163 times.

• We have 126 followers with our pictures getting an average of 14 likes.
• We use Instagram to promote upcoming regional events and national conferences by using photos and adverts.
We launched our brand new redesigned website in April 2018, we use it to promote our regional events, national conferences, as well as promotion of acute medicine. Since the launch we have had 1253 new users with 1831 sessions on the website. 56.42% of people used a desktop, with 40.36% using a mobile phone and the rest a tablet. 311 users were from outside the UK, we had contact from users in America asking about Acute internal medicine.
Conclusion

• Our social media platforms are expanding to help promote AIM. We will continue to use them to promote our national and regional events. A social media calendar has been devised to aid in our engagement and we aim over the next 6 months to increase our reach to promote and raise awareness of AIM.
Improving care for patients who may have clinical uncertainty of recovery: the lens acute admissions

Susanna Shouls
Authors and acknowledgements

Authors: Shouls S\textsuperscript{1,4}, Connolly V\textsuperscript{2}, Hayes A\textsuperscript{1}, Hopper A\textsuperscript{4}, Cooper M\textsuperscript{1}, Davies F\textsuperscript{2}, Fagge S\textsuperscript{2}, Goodburn L\textsuperscript{1,3}, Hayle C\textsuperscript{5}, Henry, C\textsuperscript{1}


Participating Hospitals: George Eliot Hospital NHS Trust, Ipswich Hospital NHS Trust, Isle of Wight NHS Trust, Lewisham and Greenwich NHS Trust, North Middlesex University Hospital NHS Trust, Royal Cornwall NHS Hospital Trust, Shrewsbury and Telford Hospital NHS Trust, University Hospitals of Leicester NHS Trusts
1. Aim

To understand potential missed opportunities for patients who are admitted to hospital in their last months of life to enable honest conversations and shared decision making.
2. Methods:

Activity in this hospital trust in the 90 days before the patients final admission.

Extracted by hospital informatics team

Analysed using excel

<table>
<thead>
<tr>
<th>Does the patient have existing life-limiting condition / frailty?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3 days</td>
<td>Recognition last days of life, quality of care in hospital; opportunity future care planning in the previous three months.</td>
<td></td>
</tr>
<tr>
<td>4-30 days</td>
<td>Recognition clinical uncertainty of recovery and quality of care; future care planning in the previous three months.</td>
<td></td>
</tr>
</tbody>
</table>

Qualitative casefile review deceased patient records
3. Results: quantitative analysis

66% of patients who died had some contact with the same hospital Trust in the preceding 90 days before their final hospital admission.

Mean average: 6 hospitals, n=16,352
4. Results: qualitative casefile review

- recognition of uncertain recovery by one clinician does not always translate to standardised action across the multi-disciplinary team with patients and those important to them
- potential to reduce non-beneficial (?unwanted) treatments / use of acute hospital beds
- terminology used in patient records can be unclear
- little information available for the admitting team about patient preferences as an advance care plan, emergency care treatment plans or community DNA-CPR (2%, 6%, 5% respectively)
5. Discussion

• Recognition with clear standards for action and alert language (eg AMBER care bundle) could reduce non-beneficial and unwanted tests and treatments
• Opportunities to improve future care planning within hospital Trusts
• “Uncertain recovery” means just that – may help overcome some cultural barriers including “waiting to see until things become certain”
• Communication is an active ingredient of care
• Demographic changes means more patients in the future
6. Take away messages

Need early recognition of uncertain recovery across the clinical team with clear standardised actions that include active communication with patients and those important to them

- This may reduce non-beneficial and unwanted tests and treatments / inpatient stays
- There is a cultural aspect – the method we used works as it combines acute, palliative and patient/carer perspectives
References

AMBER care bundle for patients whose recovery is uncertain: www.ambercarebundle.org.uk


Rapid Improvement Guide - Improving end of life care the lens of acute admissions
Introducing Safety Huddles into an Acute Medical Unit

AUTHORS: Peter Siordet Scolding, Diana Newman, Angharad Jenkins
Introducing Safety Huddles into an Acute Medical Unit

AIM: To improve the sharing of safety issues from night- to day-team through a ‘SAFETY HUDDLE’
Introducing Safety Huddles into an Acute Medical Unit

**METHODS:**
QIP: 3 PDSA cycles/ 6 months
No safety issue handover at baseline

**CYCLE I:**
- Doctor-to-doctor handover
- Patient issues

**CYCLE II:**
- Nursing participation
- Situational & material issues

**CYCLE III:**
- Improved recording & allocation of tasks & attendance
Introducing Safety Huddles into an Acute Medical Unit

RESULTS:

CYCLE I:
- 3 patients /day on average (p/DoA)
- <5 mins to complete huddle on average

CYCLE II:
- 2 p/DoA
  - STAFFING: \( \bar{x} \) 2 nurses & 1 doctor short /shift
  - MATERIAL: Faulty blood-gas machine, bleep system crashes, drug shortages
  - SITUATIONAL: Bed flow problems
  - Admission spikes

CYCLE III:
- 1.3 p/DoA
  - STAFFING: Understaffed by doctors 58% vs nurses 42% of time
  - EQUIPMENT & FACILITIES: Bleep system errors
    Broken equipment
    Software crashes, imaging restrictions + 8 more
  - SITUATIONAL: Specific capacity & bed flow issues
Introducing Safety Huddles into an Acute Medical Unit

DISCUSSION:

Well established in safety-conscious industries. In Acute Medicine they:

1. Improve continuity in transition from night- to day-shifts
2. Are an opportunity for any one to raise any safety issue
3. Improve team awareness & co-ordination from the shift start

Support from senior stakeholders (Clinical Director, Matron, Consultants) with influence over working patterns was crucial to changing existing routines i.e. post-take ward round, nurse handover.

Participant dialogue was instrumental in improving the process, proforma and identifying barriers.
Introducing Safety Huddles into an Acute Medical Unit

'**take-back to AMU**’ messages

1. Highly valued once embedded
2. Good QIP
3. Local adaptations through PDSA cycles
4. Needs senior support

Thank you
The 12th International Scientific Conference
The Society for Acute Medicine
Bournemouth International Centre
20 – 21 September 2018

Taking the P...
Urine sampling – choosing the right bottle:
a QIP
(A&QI 78)

Harjinder Kaur Kainth
ST5 AIM/GIM West Midlands

Contributors
Joseph Sturman
Stacey Evans
Background

• Frequent results of rejected urine samples sent from AMU
• Rapid turn over of patients
• Hospital policy – borate container (red-top)
• Evidence suggests that urine collected in borate container reduces false positive MC&S results.

Aims

• Determine the number of urine samples collected for MC&S from AMU, and the proportion of these rejected for being sent in the incorrect container
• Assess knowledge of AMU nursing staff regarding urine sampling
• Assess the impact of a simple intervention on the above
Intervention

**RED TOP BOTTLE**

- Urine culture (more than 5ml volume)

**WHITE TOP BOTTLE**

- Urine legionella antigen
- Urine culture (only if volume less than 5ml)
- Lumbar puncture
- Ascitic fluid
- Pleural fluid
- Urine toxicology screen
## Results - Sampling

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention 1</th>
<th>Post-intervention 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total samples received</td>
<td>111</td>
<td>61</td>
<td>78</td>
</tr>
<tr>
<td>Number of samples rejected</td>
<td>47%</td>
<td>28%</td>
<td>17%</td>
</tr>
<tr>
<td>Rejected due to white top (as % of rejected samples)</td>
<td>75%</td>
<td>35%</td>
<td>31%</td>
</tr>
</tbody>
</table>
## Results – Knowledge

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention (n=12)</th>
<th>Post-intervention (n=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MC&amp;S container</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td>58</td>
<td>100</td>
</tr>
<tr>
<td>White</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td><strong>Minimum volume of urine sample</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3ml</td>
<td>50</td>
<td>0</td>
</tr>
<tr>
<td>5ml</td>
<td>17</td>
<td>100</td>
</tr>
<tr>
<td>10ml</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td><strong>If less than minimum volume</strong></td>
<td>Send in different container</td>
<td>0</td>
</tr>
<tr>
<td>Wait for patient to pass more urine</td>
<td>100</td>
<td>27</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td><strong>Container for legionella antigen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td>33</td>
<td>7</td>
</tr>
<tr>
<td>White</td>
<td>67</td>
<td>93</td>
</tr>
</tbody>
</table>
Discussion

• Labelling is simple and cost-effective
  • Improvement in nursing knowledge of urine sampling
  • Reduction in rejected samples due incorrect container
  • Improvements maintained

• The cost of a rejected sample is £2.97
  • Costs of sampling
  • Delayed diagnosis
  • Prolonged use of broad-spectrum antibiotics
  • Delayed discharge
  • Complications of antibiotic usage
  • Patient distress

• Future use
  • Extend to other types of sampling container and all inpatient wards
  • Similar analyses in hospitals throughout in the West Midlands region, facilitated by WAMC
References

