Royal College of Physicians and Society of Physicians in Wales

Improving general internal medicine (GIM) patient care and clinical practice

Abstracts

November 2020

In collaboration with:

Addysg a Gwella Iechyd Cymru (AaGiC)
Health Education and Improvement Wales (HEIW)
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Introduction

Due to the 2020 COVID-19 pandemic, we were unable to hold the Royal College of Physicians (RCP) and Society of Physicians in Wales (SoPW) joint annual update in acute and general internal medicine.

However, the RCP, SoPW and Health Education and Improvement Wales (HEIW) were keen to give trainees the opportunity to showcase their projects.

This booklet contains abstracts shortlisted for presentation on our virtual platform, along with those that were highly commended by our judges.

We would like to thank HEIW for supporting the RCP and SoPW with this initiative and for providing funding for the prizes awarded, the RCP college tutors and postgraduate centres for helping to promote the poster competition, and finally all the entrants for taking the time to submit and share their work.

If you would like information about next year’s RCP–SoPW joint annual conference and would be interested in entering a future poster competition, please contact:

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The following abstracts were selected for presentation to our panel of judges on Friday 27 November 2020.

**Introduction of ward-based non-invasive respiratory support to a district general hospital during the COVID-19 pandemic**

Authors: Dr Victoria Lewis, Dr Joy Creaser-Thomas, Marian Davies, Kelly Goddard, Dr Mani Dharmalingham, Dr Carol Llewellyn-Jones
Glangwili General Hospital

**Background**

Non-invasive ventilation (NIV) is an effective form of treatment for patients with type 2 respiratory failure.\(^1\) The British Thoracic Society (BTS) has issued guidelines on delivery of acute NIV.\(^1\) Case reports, professional forums and BTS guidelines advocate continuous positive airway pressure (CPAP) as an effective treatment for hypoxaemic patients with COVID-19,\(^2\)\(^-\)\(^4\) while NIV remains effective for COVID-19 patients with hypercapnic acute on chronic ventilatory failure.\(^4\) Previously in Glangwili General Hospital (GGH), NIV and CPAP could only be facilitated in the emergency department (ED), intensive care unit (ICU) or coronary care unit (CPAP only) in open bays. As the outbreak of COVID-19 developed, it became apparent that CPAP and NIV would need to be delivered in appropriate ward-based settings.

**Objectives**

1. Train allied healthcare staff on indications and contraindications of CPAP and NIV for non-COVID-19 and COVID-19 patients.
2. Train staff in basic CPAP and NIV competencies.
3. Initiate ward-based CPAP and NIV protocols.
4. Establish non-invasive respiratory support units.

**Method**

1. Small group teaching sessions delivered across specialties and disciplines.
2. Multimedia tools to support training, including instructional videos and posters.
3. Introduction of CPAP and NIV protocols and flowchart to aid treatment decision making.

**Results**

<table>
<thead>
<tr>
<th></th>
<th>CPAP</th>
<th>NIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>79</td>
<td>16</td>
</tr>
<tr>
<td>Nurses</td>
<td>247</td>
<td>94</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>410</strong></td>
<td><strong>160</strong></td>
</tr>
</tbody>
</table>

Table 1: Allied healthcare staff trained in respiratory support measures March–May 2020

92% described training as either ‘extremely useful’ or ‘very useful’. 87% of doctors used the flowchart and 83% accessed the training videos. CPAP and NIV protocols are in use. Non-invasive respiratory support units have been established with appropriately trained staff.
Conclusion
During the COVID-19 pandemic, ward-based non-invasive respiratory support measures were successfully introduced to GGH in specially designated units. In 3 months, large numbers of staff were trained in CPAP and NIV. The use of multimedia tools supported training. Feedback has highlighted demand for further training.

References
The DAPT study: do all patients receive appropriate treatment?

Authors: Dr Matthew Goss, Dr Holly Morgan, Dr Tom Kinnaird
University Hospital of Wales

Introduction

Dual antiplatelet therapy (DAPT) duration is an important clinical decision. A balance must be sought between reducing further ischaemic events and haemorrhagic risk. A 12-month course is used for the majority of patients undergoing coronary angioplasty for acute coronary syndrome (ACS); 6 months for those with stable coronary artery disease (CAD).\(^1\) Emerging evidence suggests that DAPT should be individualised. Non-inferiority of 3 vs 12 months DAPT has been shown in the OPTIMIZE trial in stable CAD.\(^2\) Conversely the PEGASUS and COMPASS trials have shown that prolonged DAPT (>15 months) reduces mortality in high-risk patients.\(^3,4\) Scoring systems have been developed, including the DAPT score,\(^5\) to aid such decision making.

Methods

A single-centre, retrospective analysis of patients who had undergone percutaneous coronary intervention (PCI) in a 6-month period was conducted. The interventional database and electronic patient notes were reviewed. Data collected included PCI indication, initial DAPT recommended, actual DAPT duration received and reasons for alterations. Other variables included left ventricular function, further ischaemic events and any bleeding issues or admissions. The actual DAPT duration was compared to recommended duration based on DAPT scores and bleeding risk.

Results

400 patients were included in the study (Table 1). Only seven patients had evidence of an individualised antiplatelet regime. Of note, there were 26 significant bleeding events recorded. Based on patients’ treatment recommendation using the DAPT score, 46% had an appropriate duration, 44% may have benefited from a prolonged course and 10% a shorter one.

Conclusions

The individualisation of DAPT using a combination of scoring systems and clinical acumen can enable patients to receive vital antiplatelet treatment while minimising risks. Furthermore, it can provide a framework for clinicians providing local follow-up outside the centre where the intervention may have been performed. Subsequently we have added the DAPT score (Fig 1) to interventional procedure reports and plan to re-audit patients’ DAPT duration.

<table>
<thead>
<tr>
<th>Patient demographics</th>
<th>Gender</th>
<th>Age</th>
<th>Indication</th>
<th>Smokers</th>
<th>DAPT</th>
<th>DAPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male 301 (75%)</td>
<td>Range 30–92 years</td>
<td>ACS 310 (78%)</td>
<td>Current/Ex 222 (55%)</td>
<td>Planned</td>
<td>Changed</td>
</tr>
<tr>
<td></td>
<td>Female 99 (25%)</td>
<td>Mean 63.9 years</td>
<td>Stable CAD 90 (22%)</td>
<td>None 178 (45%)</td>
<td>12 months 316 (79%)</td>
<td>Shortened 12 (27%)</td>
</tr>
</tbody>
</table>

Table 1. Patient demographics and DAPT treatment summary.
Fig 1. The DAPT score.\(^5\)

References


Improving wellbeing among UK doctors redeployed during the COVID-19 pandemic

Authors: Dr Ryan Faderani, Dr Massimo Monks, Dr David Peprah, Dr Lowri Allen, Dr Amy Colori, Dr Alexander Amphlett, Dr Martin Edwards

AUniversity Hospital of Wales; B Royal Free Hospital; C University College London Hospital

Background

In response to the COVID-19 pandemic, the NHS has implemented significant workforce changes to manage the increased and changing demand on healthcare services. These changes include redeployment of doctors into COVID-19-specific roles, reduction in activity of all non-urgent specialties, and altering working patterns. We aimed to investigate the impact of such changes on the wellbeing of redeployed doctors, as well as highlighting the key concerns they may have.

Methods

We conducted an online survey at three NHS trusts (Cardiff and Vale University Health Board, The Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust) over 2 weeks during the peak of the pandemic, asking redeployed doctors to rate their morale, work–life balance, perceived support and safety, and to voice concerns.

Results

172 redeployed doctors responded to the survey. On exploring morale, 114 (66.3%) respondents felt confident in their new role, 113 (65.7%) felt satisfied or neutral with their new role and only 54 (31.4%) felt stressed at work. 114 (66.3%) doctors felt valued by their team and 136 (79%) felt valued by the general public. When asked about work–life balance, 111 (64.5%) had noticed an increase in the length of breaks and 153 (89%) felt that their rota provided sufficient respite. The majority of respondents (n = 95; 55.2%) did not feel confident in the Public Health England / Wales’ personal protective equipment (PPE) guidance and similarly 94 (54.7%) did not feel safe while wearing PPE. The three most common concerns were training opportunities – 105 (61%), PPE – 99 (57.6%) and family health – 95 (55.2%).

Conclusion

Our findings suggest that, among the doctors surveyed, morale is higher than might be expected, with doctors feeling valued, confident and well rested in their new role. Concerns about training opportunities/career progression, PPE and family safety need to be addressed to minimise the adverse effects on doctor’s wellbeing due to redeployment.
A faceless service: human implications of PPE and social distancing in the hospital setting

Authors: Dr Katey Beggan, Dr Aine Jones, Dr Gary Constable
Princess of Wales Hospital

Introduction

The World Health Organization declared SARS COVID-19\(^1\) a pandemic on 11 March 2020.\(^2\) NHS services changed radically in response to the evolving crisis, and infection prevention and control (IPC) subsequently mandated the use of personal protective equipment (PPE)\(^3\) for all patient contact, as well as social distancing\(^4\) for staff. These changes have impacted the wellbeing of both patients and staff in many ways, and we were particularly interested in understanding the effects of PPE on patient experience.

Objective

Assess the impact of IPC strategies on the mood and wellbeing of hospitalised patients during the COVID-19\(^1\) pandemic.

Method

A qualitative study of patient experience during the COVID-19 pandemic in the Princess of Wales Hospital. A questionnaire focused on IPC strategies was developed for the purpose of the study. In total, 20 adult patients and 25 staff were surveyed on both COVID and non-COVID wards over a 2-week period in May 2020. Patient wellbeing was defined using the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS).\(^5\)

Results

Both patients and healthcare workers recognise the negative impact of PPE – particularly the effects on communication. Based upon WEMWBS, 30% of patients were experiencing anxiety or depression. Staff reported communication problems and the inability to provide close personal care and reassurance, the most important factors influencing patient experience. Patients, however, identified separation from family, lack of stimulation, impaired communication and isolation as the most important factors affecting wellbeing.

Conclusion

Evidently, IPC strategies affect wellbeing, which contributes to a greater risk of anxiety and depression in patients. Healthcare workers feel that they cannot provide the same reassurance and personal care to patients and have difficulties with communication. Patients are unable to recognise individuals caring for them. Masks in particular remove facial expression, obscure identity and cause difficulties with communication. Boredom and isolation from families, however, have greater impact on patient wellbeing than IPC measures.

References


‘MicroTeach’ – focused teaching on an acute medical unit: a novel approach to case-based acute medical teaching during the COVID-19 pandemic

Authors: Dr Alice Hoole, Dr Richard Marsh

University Hospital of Wales; University Hospital Llandough

Introduction

During the COVID-19 pandemic, we successfully delivered six short, highly interactive and clinically relevant teaching sessions to small groups of doctors (up to 15) while maintaining social distancing rules.

Background

The COVID-19 pandemic presents numerous logistical challenges, not least to trainee doctors trying to access teaching opportunities. There has been an upsurge in use of telecommunications to deliver meetings and teaching; however, this does present educational difficulties in terms of audience engagement and the delivery of clinically relevant case-based teaching. We aimed to create a positive face-to-face learning environment in the context of the pandemic.

Method

After selecting a topic relevant to the acute medical intake, we performed a literature search on PubMed and UpToDate to produce clinically accurate teaching material using a small, cleanable, portable whiteboard. We delivered 10-minute teaching sessions in an empty ‘surge capacity’ area within the department and, once embedded in routine, encouraged trainee doctors to participate in providing teaching themselves. We notified trainee doctors electronically via a mobile messaging application and collected feedback via online questionnaires.

Results/benefits

The sessions were well received by trainee doctors in attendance, who appreciated the focused and interactive nature of the sessions. Trainees photographed the teaching material (Figs 1 and 2) to support their reflective practice and to upload onto their training portfolios. Additionally, speakers were able to collect feedback in support of their own personal and professional development and were provided with individualised certificates.

Conclusions

We have demonstrated a safe way to deliver enjoyable, accurate and clinically relevant teaching material during a pandemic which does not significantly impact on the daily workload of junior doctors, jeopardise patient safety or service demands, or breach social distancing or workplace regulations.

Reference

Fig 1. MicroTeach session 2 – Headache – delivered by a specialty trainee.

Fig 2. MicroTeach session 3 – Hypercalcaemia – delivered by a foundation year 2 doctor.
Developing a multi-platform simulation-based education tool for internal medicine trainees

Authors: Dr Sharon Esther Weinberg, A Dr Oliver Graham Davies, B Dr Michael Shiel, B Dr Patrick Paul Tabet, C Dr Craig Dyer

A Wythenshawe Hospital; B Morriston Hospital; C Royal Preston Hospital

Introduction

Simulation-based education (SBE) refers to using artificial representations of real-life processes to achieve educational goals through experiential learning. The Joint Royal Colleges of Physicians Training Board (JRCPTB) encourages SBE to support doctors in internal medicine training (IMT). SBE allows doctors to enhance their skills and build confidence in practical procedures, without compromising patient safety. There is no standard approach to SBE teaching methods and limited resources are available outside normal working hours. In Morriston Hospital, we have filled this curriculum gap by creating a procedural skills educational syllabus and multimedia toolkit.

Objective

To create a procedural skills educational syllabus and multimedia toolkit for IMT trainees to increase confidence and competency in undertaking procedural skills.

Method

Surveying junior doctors revealed areas of weakness in performing procedural skills. A syllabus of SBE classes covering key clinical skills was taught weekly over 2-hour periods, supported by structured reference documents. Our syllabus is based on the IMT curriculum with content written by a team of trainees using academic literature, reviewed by consultants before integration. An accompanying mobile and web-accessible app was developed using the C# programming language on the Unity framework. The app provides easy access to the structured documents, and is frequently updated with the latest guidelines and supportive management.

Results

Sixteen core medical trainees and IMTs participated in the simulation training. Student confidence levels and ability to achieve core curriculum requirements before and after SBE are shown in Fig 1.

Conclusions

This programme dramatically improved trainees’ confidence in performing clinical skills, with positive end-of-year feedback. This project will be expanded by producing a video for each procedure. We believe that it will become an essential learning and reference tool in the modern workplace and support safer patient care.

Reference

**Fig 1.** Student confidence levels and ability before and after SBE.
Trainee-initiated All-Wales virtual teaching programme for gastroenterology registrars during COVID times

Authors: Dr Lavanya Shenbagaraj, A Gastric-C (Gastroenterology Trainees Research Collaboration Cymru), A Dr Jeff Turner, A Dr Andrew Yeoman, B Dr Sunil Dolwani, A Dr Hasan Haboubi

A University Hospital Llandough; B Royal Gwent Hospital

Background

The COVID-19 pandemic has had an unprecedented impact on all aspects of clinical work, including junior doctors’ clinical training and teaching. Although seemingly minor in the context of the global pandemic, it raises the question of how to adapt to these changes and make training COVID-proof for the future.

Training for gastroenterology specialty registrars (SpRs) in Wales is usually delivered annually by the deanery as a 1-week teaching programme. This was cancelled this year due to the COVID-19 pandemic.

Objective

We aimed to develop trainees’ driven fortnightly virtual regional teaching programme in gastroenterology for 12 months. This is an ongoing quality improvement project (QIP), started in July 2020 and planned to run until June 2021. We also compared the effects of COVID-19 on SpRs’ teaching across all medical specialties in Wales.

Methodology

Results

Gastroenterology SpRs survey results:
• 66.6% wanted to continue virtual teaching.
• 50% rated the sessions as excellent, 33.3% as good.
• 83.3% wanted to continue via TEAMS online platform.
• 66.6% prefer to have the deanery-delivered 1-week SpR teaching virtually as well.

Medical SpRs survey results:

• Most of the training days were cancelled.
• 87.7% wanted to have virtual teaching.
• Oncology and palliative care trainees continued to have regular teaching virtually during COVID.
• Many trainees felt that a blend of virtual and face-to-face teaching is needed for continued learning and networking.

Conclusion

The pandemic has brought to light new ways of learning in medical education. Going forward, the key skills likely to be needed are adaptability, technology incorporation, innovative strategies and remote collaborative skills. We believe this project would act as a pioneer for a similar trainee-initiated teaching programme in response to COVID in the UK.
Flash glucose monitoring: Impact on markers of glycaemic control and patient-reported outcomes in individuals with type 1 diabetes mellitus in the real-world setting

Authors: Dr Sacha Moore,^A^ Dr Eshen Ang,^B^ Dr Zong Xuan Lee,^B^ Dr Melanie Nana,^A^ Rao Bondugulapati^C^  
^A^Royal Gwent Hospital;  
^B^University Hospital of Wales;  
^C^Wrexham Maelor Hospital

**Introduction**

The introduction of FreeStyle Libre flash glucose monitoring system (FGM) which measures interstitial glucose levels in real time has demonstrated positive impact on glycaemic control, particularly in adults with type 1 diabetes mellitus (T1DM).

**Objective**

We aimed to evaluate both glycaemic parameters and patient-reported outcomes in patients prescribed FGM based on the local criteria at Wrexham Maelor Hospital.

**Methods**

This retrospective observational study included patients aged >18 years with a diagnosis of T1DM who were prescribed FreeStyle Libre FGM from May 2018 to February 2019 (n = 90). Quantitative data on glycaemic parameters was collected pre- and post-initiation of FGM in addition to patient-reported outcome measures (PROMs). The primary outcome was change in pre- and post-FGM levels of glycosylated haemoglobin (HbA\text{1c}).

**Results**

There was a mean reduction in HbA\text{1c} of $-7.29 \pm 10.76$ mmol/mol (p<0.001, 95% confidence interval (CI95%) 4.94--9.64 mmol/mol) sustained to the latest reading. There was also a mean reduction in the number of hypoglycaemic episodes per week of 3.20 (percentage reduction 51.86%, p<0.001, CI95% 1.64--4.77). Mean reduction in self-monitoring of blood glucose per day was 6.15 (p<0.001, CI95% 4.97--7.32) after initiation of FGM. 70.6% of the individuals using FGM in our study self-reported an improved awareness of hypoglycaemia since commencing FGM. A significant improvement in quality of life scores was noted in all five domains of the abbreviated Diabetes Distress Score between before and after starting FGM (p<0.001). Key themes highlighted in inductive content analysis include ‘life-changing’, ‘positive experience’ and ‘convenient’.

**Conclusion**

FGM is associated with significant improvement in HbA\text{1c} and, while limited by the self-reported nature of data collection, is also associated with clinically significant reduction in hypoglycaemic episodes to a mean follow-up of 4.6 months. Additionally, patients reported positive experiences of FGM with significant improvement in all aspects of a focused Diabetes Distress Score.
Shielding behaviour of patients with multiple sclerosis in Cardiff during the COVID-19 pandemic

Authors: Dr Rebecca Jane Beesley, Dr Emma Tallantyre, Dr Neil Robertson

*A Glan Clwyd Hospital; B University Hospital of Wales

Introduction

In March 2020 the UK government publicised public health guidance for people with chronic conditions including multiple sclerosis (MS) to shield from COVID-19.1

Objective

To evaluate patterns of shielding behaviour in people with MS (pwMS) and the impact of COVID-19 on patients’ treatment and employment.

Method

A postal survey gauging perceived vulnerability to COVID-19, isolation behaviour and employment status during COVID-19 was sent to 1,528 pwMS in Cardiff in March 2020. Current data on age, disability (Expanded Disability Status Scale, EDSS) and disease-modifying therapy (DMT) were retrieved from an existing MS database. Contemporary data on cumulative COVID incidence were obtained from Public Health Wales.2

Results

Survey responses were received from 721 (47%) recipients. Of 721 respondents, 222 (31%) reported social distancing, 357 (50%) reported ‘self-isolating’ and 124 (17%) reported ‘shielding’ during lockdown. Timing of shielding behaviour coincided with the initial surge of cases (Fig 1). Those on high-efficacy DMT felt most vulnerable (p=0.08) and were most likely to shield (p<0.01). Patients with more advanced disability also felt more vulnerable (p<0.01); the mean EDSS of those social distancing vs self-isolating vs shielding was 3.4 vs 4.9 vs 5.7. 47% of patients on high-efficacy DMT had their DMT interrupted, compared with 5% of pwMS on moderate-efficacy DMT. Most (84%) pwMS felt vulnerable. Of those still able to work during the pandemic, 19% of pwMS working in their usual environment were dissatisfied with their current working arrangement, compared with 3% dissatisfaction amongst those pwMS working from home. Change in working arrangement was not associated with current DMT or disability.

Conclusion

Patients on high-efficacy DMT or with advanced EDSS felt more vulnerable and were more likely to shield; however, DMT and disability were unrelated to new working arrangements. There was significant disruption to treatment for pwMS on high-efficacy DMT.
Fig 1. Number of pwMS in Cardiff isolating against time compared with cumulative incidence of COVID-19 in Cardiff on viral RNA swab testing.

References
Are DNACPR discussions undertaken for patients with terminal illness prior to hospice transfer?

Authors: Dr Corinne Dignan, Dr Kimberley Richardson, Dr Siwan Seaman

Royal Gwent Hospital; Royal Glamorgan Hospital; Marie Curie Hospice

Introduction

The aim of the quality improvement project (QIP) was to increase the number of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions taking place with patients prior to their admission to the Marie Curie Hospice Cardiff and the Vale. As there are no advanced resuscitation facilities at the hospice, proactive DNACPR discussions prior to transfer enable patients to make informed choices regarding their future care.

Objective

To increase the number of patients offered DNACPR discussions in hospitals and the community prior to transfer to the hospice.

Method

An initial audit of admissions was carried out using data collected through the electronic patient record software EMISweb in January and February 2019. Data collected included demographics, diagnosis, DNACPR status and presence of documented DNACPR discussions. Once the results were processed, an updated ‘liaison form’ for admissions to the hospice was integrated into the referral process, with a section to be completed about DNACPR discussions. We then re-audited the admissions between December and February 2020.

Results

There was a 15% increase in the total number of patients who had been invited to take part in DNACPR discussions prior to transfer to the hospice, a 7% increase in patients transferred from hospital and an 18% increase in patients admitted from home. In terms of patients admitted for end-of-life care, we found an 11% total increase in discussions for these patients following the liaison form introduction. However, we found that only one in three referrers were completing the DNACPR section on the liaison form and that 35% of patients were still being referred with neither a DNACPR discussion nor a liaison form (Table 1).

<table>
<thead>
<tr>
<th>Results</th>
<th>Jan - Feb 2019</th>
<th>Dec - Feb 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total admissions</td>
<td>69</td>
<td>122</td>
</tr>
<tr>
<td>No discussion</td>
<td>38%</td>
<td>23%</td>
</tr>
<tr>
<td>Transfer without discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>26%</td>
<td>19%</td>
</tr>
<tr>
<td>Community</td>
<td>45%</td>
<td>27%</td>
</tr>
<tr>
<td>EOL care admission without discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>24%</td>
<td>13%</td>
</tr>
<tr>
<td>- Hospital</td>
<td>50%</td>
<td>17%</td>
</tr>
<tr>
<td>- Community</td>
<td>50%</td>
<td>83%</td>
</tr>
<tr>
<td>Liaison form uptake</td>
<td></td>
<td>34%</td>
</tr>
<tr>
<td>No liaison form or discussion</td>
<td></td>
<td>35%</td>
</tr>
</tbody>
</table>

Table 1. Comparison of pre- and post-intervention data.
Conclusion

This QIP suggests that the implementation of the liaison form for referrers to the hospice has led to a significant increase in the number of patients given the opportunity to discuss resuscitation prior to admission.
Cardiac arrest during COVID-19: a multidisciplinary simulation-based approach

Authors: Dr Joy Creaser-Thomas,\textsuperscript{A} Dr Paulina Suszczynska,\textsuperscript{B} Dr Victoria Lewis,\textsuperscript{C} Dr Jonathan Dauncey,\textsuperscript{B} Dr Alistair Gales,\textsuperscript{D} Dr Stuart Gill,\textsuperscript{B} Dr Andrew Workman\textsuperscript{C}

\textsuperscript{A}Morriston Hospital; \textsuperscript{B}Glangwili General Hospital; \textsuperscript{C}Royal Gwent Hospital; \textsuperscript{D}University Hospital of Wales

Introduction/background

Simulation-based training is an exciting and dynamic medical education tool recognised globally.\textsuperscript{1} It tests clinical knowledge in addition to utilising team working and situational awareness skills.

The COVID-19 pandemic proved an evolving and challenging time for the NHS. With large numbers of unwell patients predicted and rapidly changing clinical guidance, staff training and education needed to be addressed. Training objectives included revision and application of updated adult life support (ALS) guidance and appropriate use of personal protective equipment (PPE).

Objective

Develop a multidisciplinary simulation centred around addressing updated ALS guidelines, appropriate use of PPE and improving interdisciplinary communication.

Methods

At Glangwili General Hospital, we developed a simulation centred around a suspected COVID-19 patient found in cardiac arrest by a junior doctor. Participants were allocated time slots and roles prior to the scenario and two facilitators were appointed. Scenarios were run as realistically as possible, with aids of a mannequin and an automated external defibrillator (Fig 1). Simulation focused on communication, PPE and implementation of updated ALS algorithm, guided by a simulation checklist. A debrief took place following the scenario cessation to solidify training objectives.

Fig 1. Real-time cardiac arrest simulation, with facilitator far right.
Results

72 doctors across various specialties attended, ranging from consultant to F1 level. Specialties included medicine (36), surgery (2), anaesthetics (21), orthopaedics (8) and emergency medicine (5). 45 participants completed online feedback, with improved knowledge regarding PPE and updated ALS guidelines reported by 100%. This simulation-based training led to overall improved confidence in managing cardiac arrest (3.2/10 to 7.7/10) and 100% reporting it a useful training tool.

Conclusions

This MDT-based simulation tool proved effective in illustrating updated clinical guidance, improving communication and confidence among doctors of various grades and specialties during the COVID-19 pandemic.

Reference

Call the Medical Reg 2020: How COVID-19 did NOT affect junior doctors’ training

Authors: Dr Kate Edwards, A Dr Melanie Nana, B Dr Holly Morgan, B Dr Ruth Alcolado C
A Nevill Hall Hospital; B Royal Gwent Hospital; C Royal Glamorgan Hospital

Introduction/background

When the World Health Organization (WHO) declared the COVID-19 outbreak on 30 January as a Public Health Emergency of International Concern, it sent a cohort of junior doctors into a state of uncertainty with regards to their current training.

Objective

For several months, many training opportunities ceased to allow junior doctors to respond to the evolving COVID-19 pandemic. Despite this, junior doctors were still progressing into higher training grades over the coming months. This inspired the Call the Medical Reg team to pursue delivery of this course via an online platform to help prepare trainees for that transition to the middle-grade role.

Method

An itinerary for the virtual course was designed to encourage interaction with attendees using smaller break-out sessions to reflect a traditional face-to-face course.

Within days of the course being advertised, over 200 doctors had requested to attend the event. Given this, Health Education and Improvement Wales (HEIW) provided IT personnel support and use of Blackboard Collaborate as a virtual learning platform. The course was run over 1 day, aimed at doctors stepping into a middle-grade role.

Results

The course was attended by 175 junior doctors from across the UK. Overall, 98% rated the course organisation as excellent or good, and 95% rated Blackboard Collaborate as being user-friendly as a means of learning virtually. Qualitative feedback included ‘Brilliant organisation and facilitation of the teaching. Excellent topics and speakers. Interactive despite the large numbers’ and ‘Great course, great pace. Did not feel like I missed out on anything whilst attending virtually’.

Conclusions

As medical trainees, we appreciated how important it was for doctors to continue learning despite the ongoing COVID-19 pandemic. The 2020 Call the Medical Reg course was proof that high-quality learning can be achieved with large audiences, particularly as this means of learning is likely to continue for the foreseeable future.

Reference

Changing the way we document and provide care: A COVID-19 ward round

Authors: Dr Samuel Telfort, A Dr Charlotte Gilbert, B Dr Devu Nair, C Dr Ruth Williams B
A Glan Clwyd Hospital; B Princess of Wales Hospital; C Prince Charles Hospital

Background

During the height of COVID-19 in a district general hospital, we identified a need early on to standardise care for the high number of patients expected, ensuring that evidence-based medicine and holistic care were delivered to patients who may be cared for under a number of specialties. We designed a COVID-19 proforma to help optimise ward rounds.

Objectives

The most important aspects of a medical ward round were identified in order to effectively care for patients. The proforma needed to have key clinical information and be accessible for use by non-physician doctors caring for patients with COVID-19.

Methods

We completed multiple plan–do–study–act (PDSA) cycles during the first wave of the pandemic. Following initial design and implementation, we sought feedback from the MDT. This, coupled with rapidly changing guidelines, led to the development of multiple versions of the proforma. Feedback forms were distributed to doctors, who used the proforma to identify sections that worked well and aspects that required refining.

Results

92% of doctors agreed that the proforma was more convenient to use than traditional continuation sheets. 100% of doctors agreed that the proforma was invaluable in detailing escalation plans. Additional comments included that traditionally, escalation plans were limited to resuscitation decisions; however, the proforma provided decisions on non-invasive ventilation, Medical Emergency Team calls and frequency of observations. 90% felt the proforma encouraged a more holistic management of patients due to prompts such as diet, bowel movements and family updates. This was important as visitors were not allowed; therefore, families were kept as involved as possible.

Conclusion

The aim of the quality improvement project (QIP) was to design a comprehensive, accessible ward-round proforma (Figs 1 and 2). Through rapid PDSA cycles in the face of an emerging pandemic, we created several versions; however, it still provided an element of stability in a stressful and novel time.
### COVID-19 Ward Daily Checklist V1.6

**Patient Details**

- Date / Time: ____________ __:__
- Doctor Completing: ____________
- Date of Symptom onset: __/__/___
- Date of Positive Swab: __/__/___
- CXR date: __/__/___ findings: ____________

### Problem List

- Current issues: ____________
- Past medical history/social history: ____________

### Escalation of Care Decision

- For ITU: Full intervention with CPR
- Not for ITU or CPR:
  - For NIV/CPAP: 
    - (if unsure discuss with senior / DNAR completed (communicated))
    - Anticipatory medications prescribed
- For best supportive care on ward, NOT ITU, NOT NIV/CPAP:
  - (if unsure discuss with senior / DNAR complete (communicated))
  - Anticipatory medications prescribed
- For rapid response:
  - For observations/NEWS score: ________ Hourly or As Per News

### Breathing

**Targeted saturations:** 88-92% 92-96% (as per current guidelines) ____________

<table>
<thead>
<tr>
<th>Current Oxygen requirement:</th>
<th>Saturations in targeted range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worse Type I Respiratory failure: Increase inspired FiO2 Consider chest physio if retained secretions (needs full PPE) Liaise with ITU (if candidate)</td>
<td>Continue current regime</td>
</tr>
<tr>
<td>Worse Type II Respiratory failure: Controlled oxygen therapy – aim to 92% &gt;7kPa Consider chest physio if retained secretions (needs full PPE) Liaise with ITU (if candidate) If no improvement despite above – consider NIV</td>
<td></td>
</tr>
<tr>
<td>Failure to respond to intervention (if not for ITU) Controlled withdrawal of NIV Ensure anticipatory medications available / consider syringe driver Liaise with patient and next of kin.</td>
<td></td>
</tr>
</tbody>
</table>

### Food & Family

- Is patient meeting nutritional requirements? Y / N Consider supplemental sip feeding (NG feeding contraindicated as aerosol generating)
- Symptomatic constipation? Y / N Consider laxatives (laxaid) 
- Are family updated? Y / N Phone / Skype / Family liaison team / Np patient

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*Fig 1.*
### Drugs & Infection

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swabs sent for COVID?</td>
<td>Consider flu swab if high clinical suspicion</td>
</tr>
<tr>
<td>Review drug chart</td>
<td>LMWH charted / TEDs if LMWH contraindicated</td>
</tr>
<tr>
<td>Evidence of superadded bacterial infection?</td>
<td>Use hospital HAP/CAP guidance</td>
</tr>
<tr>
<td></td>
<td>Especially consider if immunocompromised</td>
</tr>
</tbody>
</table>

### Fluid Management

**Aim to run 'dry' (increased survival from ARDS)**

- Only stop diuretics if AKI / hypovolaemia

**If the patient has ↓ oral intake, persistent pyrexia, prolonged BrV, AKI or SBP<90mmHg; start fluid regime.**

- Assess fluid management and urine output daily

**Suggested fluid regime:**

- 1 L of maintenance fluids - Hartmann’s
  - <45kg over 24 hours
    - (approx. 150ml/hr)
  - 45-70kg over 16 hours
    - (approx. 60ml/hr)
  - >70kg over 12 hours
    - (approx. 75ml/hr)

### Progress

**Is the patient deteriorating despite optimum measures?**

- Switch focus to symptom control
- Ensure anticipatory medications prescribed (may need syringe driver)
- Communicate with family

<table>
<thead>
<tr>
<th>RR</th>
<th>SpO2</th>
<th>BP</th>
<th>HR</th>
<th>T</th>
<th>BM</th>
<th>AVPU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

- Signed

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26
Introducing the BSG/BASL cirrhosis care bundle: improving care in the management of patients admitted to hospital with decompensated liver cirrhosis

Authors: Dr Irfan Ullah, Dr Abdul Wahab Paracha, Dr Sushma Thappa, Dr Sekina Sardar Ghuman
Nevill Hall Hospital

Introduction

Mortality related to liver disease in the UK is rising\(^1\) and admission with decompensated cirrhosis carries an in-hospital mortality of 10–20\%.\(^2\) An NCEPOD report in 2013\(^2\) found that only 47\% of patients admitted to hospital with alcohol-related liver disease received good care. This formulated the basis for the ‘decompensated cirrhosis care bundle’,\(^3\) aiming to reduce mortality and length of stay and improve patient outcomes.

Objective

To determine whether patients admitted to secondary care with decompensated cirrhosis were investigated and managed appropriately within the first 24 hours as per the decompensated cirrhosis care bundle.

Method

A prospective audit was undertaken at our centre, a district general hospital. All patients admitted with decompensated cirrhosis between December 2019 and February 2020 were identified. Data on demographics, investigations, management and length of stay were collected and analysed.

Results

19 patients were admitted; 13 were male and the mean age was 55.9 years. Alcohol intake was documented in only 73.7\%. All had baseline routine bloods but fewer had coagulation (89.5\%), magnesium (57.9\%), calcium/phosphate (73.7\%) or glucose (57.9\%) checked. Only 36.8\% had an ultrasound requested and only 53.8\% underwent ascitic aspiration. Two patients had confirmed spontaneous bacterial peritonitis; both received antibiotics but neither received albumin. Four patients presented with upper gastrointestinal bleeding but only half had appropriate initial management with terlipressin and antibiotics. 75\% had a gastroscopy within 24 hours. All patients admitted during the week received a gastroenterology review within 24 hours. Average length of stay was 10 days and one patient died.

Conclusion

Although some aspects of care were appropriate, there were also deficiencies in the management of patients admitted with decompensated cirrhosis. The care bundle provides a step-wise approach and prompt to ensure that aspects of care are not missed. As a result, an adapted care bundle was successfully introduced into the Medical Assessment Unit with a view to improving patient outcomes.
References


Montgomery consent process for Mohs surgery using a skin surgery risk leaflet

Authors: Dr Andrea Cordaro, Dr Alla Altayeb, Dr John P Wells, Dr Rachel Abbott, Dr Richard Motley

*University Hospital of Wales; Royal Gwent Hospital*

Introduction

The Montgomery ruling of 2015 in the UK states that patients should be informed of material risks of treatment. Informed consent is not just signing a form, but a reflective process on risks and benefits. Information leaflets may lack detailed information about surgical risks.

Objective

This quality improvement project (QIP) aims to assess whether a risk information leaflet improves risk-recall, anxiety, patient satisfaction and understanding before Mohs surgery.

Methods

A prospective QIP of 160 Mohs surgery patients was conducted between January and June 2020. In the first cycle, surgery was discussed in clinic and consent was documented on ‘All-Wales’ consent forms on the day of surgery. In the second cycle, patients were additionally posted a skin surgery risk leaflet developed by the authors 2 weeks in advance of Mohs surgery. The leaflet described minor and major risks of skin surgery and what to expect before, during and after skin surgery. Questionnaires were used to assess risk-recall, anxiety, patient satisfaction and knowledge.

Results

Patients receiving the additional information leaflet were more able to recall risks of surgery (11% in first cycle to 70.7%, p<0.001) and had more knowledge about information on the preoperative, operative and postoperative periods (47.6% in first cycle to 94.3%, p<0.001). In both cycles, patients had normal anxiety levels (p=0.312) and good satisfaction (p=0.122).

Conclusion

The preoperative leaflet can significantly improve patients’ risk-recall and understanding about the operation and does not significantly affect anxiety or satisfaction. Dermatologists should provide detailed written information about risks prior to skin surgery as a more robust means of consent.
Telemedicine in antenatal diabetes care: a new opportunity for patient engagement? Outcomes from a review of the literature

Authors: Isabella Patterson, Amoy Johnson, Maheen Shukir, Dr Sacha Moore, Dr Melanie Nana

Cardiff University; Royal Gwent Hospital; University Hospital of Wales

Introduction/background

Results from the recent National Pregnancy in Diabetes (NPID) audit revealed that women with diabetes in pregnancy, regardless of aetiology, have poorer outcomes. Patient engagement in this cohort is often challenging. The COVID-19 era has catalysed the adoption of telemedicine and application-based patient engagement.

Objective

We aimed to evaluate the evidence for the adoption of telemedicine in comparison with other patient engagement strategies to improve outcomes in antenatal diabetes care and preconception counselling.

Method

Medline and Embase databases were searched using terms ‘diabetes mellitus’, ‘pregnancy’, ‘antenatal’, ‘preconception’, ‘telemedicine’, ‘smart phone’ and variants, combined using Boolean operators. Article screening was performed by three reviewers independently. The primary outcome was improvement in HbA1c post-intervention, with secondary outcomes including improvement in self-reported knowledge scores.

Results

The search yielded 303 abstracts, with most studies assessing outcomes in gestational diabetes cohorts. Methods of patient educational intervention were varied and included the use of educational DVDs, multidisciplinary team (MDT) meetings, website-based information, group education sessions and mobile applications. Table 1 provides a summary of outcomes from different patient education strategies.

<table>
<thead>
<tr>
<th>Patient education strategy</th>
<th>Summary of study outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational DVD</td>
<td>No difference in pre-and post-intervention HbA1c.</td>
</tr>
<tr>
<td>Multidisciplinary group leadership</td>
<td>Increase in median knowledge score Pre-and post-intervention scores were 8 and 12 respectively (p &lt; 0.001)</td>
</tr>
<tr>
<td>Self-care guide package with face-to-face educational sessions.</td>
<td>No significant difference in infant weight at birth Newborn infant hospitalisation rate higher in control group Lower APGAR scores of neonates in control group Improvement in self-care behaviour in intervention group Oral glucose tolerance test levels lower in intervention group</td>
</tr>
<tr>
<td>Website-based education</td>
<td>Patients more likely to attend clinic appointments (96.2% vs 70.7%, p &lt; 0.001) and lose weight post-partum (90.4% vs 48.3%, p &lt; 0.001) Increase in knowledge scores</td>
</tr>
<tr>
<td>Mobile app</td>
<td>Increase in knowledge scores</td>
</tr>
<tr>
<td>Group education</td>
<td>Improvement in self-care behaviours</td>
</tr>
</tbody>
</table>

Table 1. Summary of intervention strategies and patient outcomes.
Conclusion

Despite heterogeneity in study design and outcome reporting, there is a demonstrable role for telemedicine in the management of patients with diabetes in pregnancy. Satisfaction among those using telemedicine-based services was high, with easier access to healthcare professionals providing greater control and greater use of technology promoting self-management of disease. In the era of COVID-19, the rapid adoption of telemedicine services may work to improve outcomes in this cohort.

References

Tackling a handemic: optimising staff skin health during COVID-19

Authors: Dr Alexandra Phillips, Dr Sanvitti Bengeri, Dr Lucie Olivova, Dr Ana Catarina Lopes Vieira, Dr Inês Ponte Bettencourt dos Reis

University Hospital Llandough; Great Western Hospital

Background

Contact dermatitis (CD) is a common cause of occupational skin disease among healthcare workers. Frequent handwashing is a known risk factor for the development of CD, whereas emollients are effective in its prevention and treatment. As well as negatively impacting the quality of life of affected staff, CD has implications for infection control as damaged skin harbours more micro-organisms and is difficult to clean effectively. With the arrival of COVID-19, increased handwashing could place clinical staff at higher risk of developing CD. It is essential that we understand the scope of the problem and implement measures to alleviate its impact on staff and patients.

Objective

To assess the prevalence of symptoms of hand dermatitis among clinical staff at the Great Western Hospital and implement measures to improve skin health, using plan–do–study–act (PDSA) methodology.

Method

In an ongoing quality improvement project, a paper questionnaire was distributed to clinical staff at random. Change ideas implemented include the provision of moisturiser bottles, fitting of wall-mounted moisturiser dispensers and distribution of information posters. Data collection was performed at 6-week intervals from April to September 2020 (Fig 1).

Results

A total of 300 staff were surveyed over four cycles with an average response rate of 98%. 90% of staff reported symptoms of CD in April 2020, with only 29% retrospectively reporting symptoms pre-pandemic. The self-reported prevalence of CD symptoms had fallen to 42% by September. Staff usage of trust-provided moisturiser increased from 17% in April to 20% in September. The most commonly cited barrier to moisturisation was limited availability of emollients, although the percentage of staff reporting this declined from 66% in April to 58% in September (Fig 2).

Conclusions

This work highlights the significant issue posed by CD among clinical staff in the context of a pandemic and identifies the provision of moisturiser as a potential way of addressing this.

References


SKIN HEALTH DURING COVID-19 PANDEMIC
By completing this questionnaire you are consenting to the use of your anonymous data. Thank you.

Ward/clinical area: ..........................................................

Over the past week, I’ve been cleaning my hands more often/for longer than I was 6 months ago (before pandemic).
☐ Yes  ☐ No

I have had dry, red, cracked or itchy skin on my hands in the past week.
☐ Yes  ☐ No

I had dry, red, cracked or itchy skin on my hands 6 months ago.
☐ Yes  ☐ No

Each day at work, I currently use hand moisturiser:
☐ Less than once  ☐ Once  ☐ Twice or more

The moisturisers I’m using are mostly (please select only one):
☐ Provided by myself/colleagues  ☐ Trust-provided bottles
☐ Hand Medic dispensers

The barriers to me using hand moisturiser more often at work are (select all that apply):
☐ Limited availability  ☐ Feels unpleasant  ☐ Too busy
☐ Doesn’t help  ☐ Inconvenient position within working area

Any other comments? Please write them on the back.

Fig 1. The paper questionnaire administered to ward staff (left) and the information posters put up in clinical areas to raise awareness and encourage staff use of trust-provided moisturiser (right).

Fig 2. Run chart showing the percentage of staff reporting CD symptoms (red), usage of trust moisturiser (blue) and limited availability of moisturiser (yellow). Vertical green lines represent implementation of a change idea.
The impact of an electronic referral system on streamlining endocrine referrals from primary care

Authors: Dr Gloria Singleton, Dr Laura Allen, Professor JS Davies, Professor DA Rees, Dr AJ Lansdown
University Hospital of Wales

Introduction

In October 2016, Cardiff and Vale University Health Board introduced an electronic ‘e-referral’ service for primary care referrals to endocrinology to streamline the referral and triage process.

Objectives

To evaluate the impact of the e-referral service on the triage process, endocrine outpatient activity and advice given to primary care.

Methods

Referral and triage summary outcome reports for endocrinology were analysed from October 2016 to June 2020 (45 months), including the reason for the referral and the end outcome (triaged to clinic, returned to referrer with advice or redirected to another specialty).

Results

Over the 45-month period, a total of 3,100 outpatient endocrinology referrals were received. Over the same time period, 940 referrals (30.3%) were returned to primary care with appropriate advice given. 222 patients (7.2%) were redirected to a more appropriate specialty. Some referrals were redirected to the endocrine nursing team for endocrine testing, such as for performing short Synacthen tests. In total, 1,640/3,100 patients (52.9%) were actually seen in clinic. Consequently, the waiting times for routine new referrals reduced from 37 weeks in July 2016 to zero in February 2017. 16 patients required their referral to be upgraded to urgent, and 148 patients had their referral downgraded to routine. Common themes identified in the referrals returned to primary care included advice on vitamin D, parathyroid hormone (PTH) levels, cortisol results, generalised excessive sweating, hyponatraemia and endocrine prescriptions.

Conclusions

The introduction of the e-referral system has significantly reduced the number of patients requiring outpatient endocrine appointments. It has ensured that patients who require urgent specialist input have been appropriately identified. Common themes of advice to primary care have resulted in the development of protocols to enable GPs to manage some of these patients with more confidence.
A quality improvement project: Improving patient awareness of hypoglycaemia management before getting behind the wheel

Authors: Dr Aliya Mohd Ruslan, Dr Natasha Shrikrishnapalasuriyar, Dr Thinzar Min, Professor Jeffrey W Stephens

Morriston Hospital; Singleton Hospital

Introduction

Hypoglycaemia is a common acute complication of insulin therapy that can negatively affect an individual’s cognitive function, spatial awareness, memory and emotional wellbeing. Drivers with diabetes, particularly patients with insulin-treated diabetes, may have restrictions on their driving. Acute adverse events such as hypo- and hyperglycaemia can occur and are likely to impact a patient’s driving ability.

Method and objective

A questionnaire was conducted in a secondary care setting over a 4-month period to assess whether patients with insulin-treated diabetes are aware of and adhering to the driving regulations. It is imperative that patients have knowledge of the DVLA (Driver and Vehicle Licensing Agency) guidelines with regards to their diabetes.

Results

A total of 80 patients who took insulin for their diabetes and drove completed the questionnaire. Within this cohort, 50% were over the age of 60 years. 61.3% of patients recognised symptoms of hypoglycaemia most of the time, and at least 15% of these patients had experienced mild hypoglycaemia while driving. Only 52.5% carry a blood glucose testing kit every time they drive, only 50% check their blood glucose before driving, and only 50% always take a break from a long journey to check blood glucose. Only 25% of this cohort were aware of the correct and safe blood glucose level needed prior to getting behind the wheel, while 26.3% stated that they had never received advice about driving.

Conclusions

The results of our survey demonstrated that patients’ awareness and adherence to the DVLA’s regulations were substandard, and there is still considerable room for improvement in their knowledge and adherence to the DVLA guidance. To improve patients’ awareness and knowledge, we have designed a poster which is displayed in the waiting room. All diabetologists should be more proactive in discussing the rules as part of the general diabetes review and we have created a leaflet highlighting the main points of the DVLA guidelines.
Wellbeing: It’s for life, not just for COVID

Authors: Dr Kate Edwards,¹ Dr Madhu Kannan,² Dr Stephanie Gray, Kath Barnes²
¹University Hospital of Wales; ²Nevill Hall Hospital

Introduction/background

The SARS-CoV-2 global pandemic was declared by the World Health Organization 30 January 2020.¹ Our COVID-19 journey at Nevill Hall Hospital (NHH) started on 10 March 2020 with our first positive case. When dealing with challenges like a pandemic, healthcare professionals (HCPs) are at increased risk of moral injury and mental health problems.²

Objective

From the outset, the wellbeing of HCPs was emphasised by employers, educators, healthcare-related organisations, charities, public, colleagues, patients and relatives. It was apparent that we needed a local, focused approach to ensure that staff were aware of resources and supported.

Method

From early in our COVID-19 journey, there were named seniors for HCPs to approach and staff were made aware of wellbeing resources available, along with NHH-specific clinical information, via the widely accessible daily ‘COVID-19 update and quick reference guide’ using WhatsApp®.

Our clinical psychology department offered group/drop-in/telephone sessions, and ad-hoc meetings between seniors and juniors / multidisciplinary team were arranged to discuss issues and to debrief. Welfare of junior doctors was addressed, including arranging flights when relatives were unwell, sensitively altering rotations when needed, organising scrubs/crocs/towels/toiletries, delivering shopping and checking in on doctors who were off sick.

Results

Qualitative ad hoc feedback enabled tailoring of support and indicated that effective communication, including a point of contact, made staff feel informed and valued and provided a sense of belonging. Quantitative surveys showed that the proportion of HCPs needing extra support for mental health and wellbeing increased from 39.6% (57/144) in May 2020 to 61.5% (32/52) in September 2020. 73.2% (30/41) would consider clinical psychology sessions or alternative resources in the future.

Conclusions

Wellbeing of HCPs was quite rightly highlighted by the pandemic. Resources, locally and nationally, intensified and were made more accessible. This focus on wellbeing was valued and extra resources were utilised and are still in demand. Should it be just during a pandemic that we are this mindful of our wellbeing? Or should this be the baseline?

References

The following abstracts were awarded Highly Commended certificates.

**Inter-departmental, multidisciplinary COVID-19 patient simulation exercise, ‘Pandemic plans made at the pub’**

**Authors:** Dr Victoria Lewis, Dr Tom Cairns, Dr Joy Creaser-Thomas, Dr Drew Wokeman, Dr Ling Tan
Glangwili General Hospital

**Background**

On 31 January 2020, Wuhan in China reported a cluster of cases of COVID-19. Discussions with colleagues from medicine, intensive care (ICU) and emergency departments (ED) revealed growing concerns regarding the COVID-19 outbreak and the potential implications for Glangwili General Hospital, a district general hospital in West Wales. We decided to organise a COVID-19 patient simulation scenario, to be run across the ED, medical and ICU departments.

**Objective**

1. To test the COVID-19 policies currently in place.
2. To assess staff awareness of policies.
3. To identify areas for improvement across all departments and disciplines. It was important that this was a multidisciplinary approach to ensure that all aspects of care for a patient and how they impact each other were fully considered.

**Method**

A simulation scenario was designed, involving an unwell patient with risk factors for COVID-19. The simulation began in the ED and involved clerical, nursing, radiology and medical staff, among others. The simulation was run as per real time and included transferring the patient to ICU. The simulation was observed by members of each department and filmed, allowing further departmental review. Formal written feedback was collected. Feedback and learning points were analysed and disseminated to each department separately and presented at the hospital grand round.

**Results**

Feedback highlighted common themes, including:

1. No standardised personal protective equipment (PPE).
2. Unnecessary numbers of staff exposed.
3. Difficulties in communication between staff in COVID-19-exposed ‘dirty’ and non-exposed ‘clean’ areas.
4. Uncertainty regarding how best to safely facilitate investigations, such as chest X-rays and blood gas samples.
Conclusion

The simulation was felt to be a useful exercise by all involved and numerous areas for development were identified, resulting in changes to the ED, medical and ICU departments. The exercise increased staff awareness of current policies and generated discussions for further developments moving forwards.

References

Communication challenges during COVID-19: what can we do better?

Authors: Dr Gwent Cartwright, Dr Ben Pyrke, Dr Katy Figg, Dr Alexander Tuck, Dr Harriet White, Dr Emily Murphy, Dr Badr Abdalla
University Hospital Llandough

Introduction

The COVID-19 pandemic has challenged the way we communicate with patients and families, with more communication being via telephone or virtual methods, rather than face to face. Conversations are often on difficult topics like resuscitation decisions or breaking bad news. Although emphasis is placed on communication skills teaching at medical school, the COVID-19 pandemic has presented new challenges that junior doctors are likely to feel unprepared for. We wanted to identify areas where junior doctors felt that their communication skills could be improved and to implement a teaching programme to address these.

Methods

Questionnaires about communication during the COVID-19 pandemic were distributed to 22 junior doctors working at University Hospital Llandough in June 2020. A teaching session was organised, with input from palliative care, to address topics raised in the questionnaire. A repeat questionnaire was circulated post-teaching to identify the main learning points and assess response from junior doctors.

Results

22 junior doctors completed the pre-teaching survey. 100% reported having difficult conversations by telephone, and 82% had had no formal teaching on phone-based communication skills. 81.8% of doctors surveyed felt that formal teaching on this topic would be helpful. Post-teaching, 12 junior doctors provided feedback, with an average increase in confidence of 37% in undertaking difficult conversations. Written feedback identified the importance of preparing for difficult discussions, regularly updating family members to build trust, and integrating family updates into daily ward life, as key learning points.

Conclusions

The COVID-19 pandemic has placed additional stresses on junior doctors, including communicating with relatives. Lack of face-to-face visitation means that more conversations happen virtually, and it is critical to ensure that junior doctors are well equipped to handle this. Teaching programmes can empower junior doctors to be proactive in involving relatives in day-to-day care during the COVID-19 pandemic and improve confidence in conducting difficult conversations virtually.
Knowledge and self-perception of competence in dermatology among interim foundation doctors in Morriston Hospital

Authors: Dr Kashini Andrew, Dr Mohd Baker
Morriston Hospital

Background

Studies in the UK have shown that about 54% of the population will develop a skin condition in any 12-month period and 63% of them will seek medical attention. This has been associated with a significant reduction in quality of life, significant psychosocial morbidity and mortality.

It is also known that medical students in the UK have only a modest amount of teaching and placements in dermatology and are eventually not very confident in diagnosing and managing common dermatoses.

Objectives

1. To assess the knowledge dermatology amongst Interim foundation doctors in Morriston Hospital.
2. To identify gaps in competence in dermatology among interim foundation doctors and explore solutions.

Method

Our team designed a self-administered questionnaire. This was used to collect information about the knowledge of dermatology and confidence in managing skin conditions among 21 interim foundation doctors. It also assessed their thoughts about how their knowledge gaps could be met.

Results

The most common duration of dermatology placement was 7 days (range 2–21 days; Fig 1). No respondents were confident in diagnosing a skin condition; 56% were neutral, 38% were uncertain and 6% were very uncertain in making a diagnosis. The number of correct responses by junior doctors to a set of 11 images of skin conditions is shown in Fig 2. When asked if a dermatology placement of 2 weeks or less in medical school is adequate preparation for their post, 63% of junior doctors said no.

Conclusion

Most of the respondents had a good knowledge of dermatology and the majority had just a week of dermatology placement. Most respondents felt that a longer placement in dermatology would prepare them better for their roles as junior doctors and this needs to be highlighted to the medical schools in Wales.

References

Fig 1. Duration of dermatology placement.

Fig 2. Number of correct responses by junior doctors to 11 images shown. Images shown were of psoriasis, acne, venous ulcer, arterial ulcers, pressure ulcer, asteotatic eczema, cellulitis, malignant melanoma, basal cell carcinoma, squamous cell carcinoma and actinic keratosis.
Impact of COVID-19 on cardiology services in Nevill Hall Hospital and reimagining the service in new normal

Authors: Dr Saad Hasan, Dr Haseeb Ur Rahman, Dr Anish Patil, Carla Lewis, Dr Ciaran Haye, Samuel Townsend, Dr Stephen Hutchinson

Nevill Hall Hospital

Introduction

The UK government announced a lockdown on 23 March 2020 to slow the spread of COVID-19 and protect NHS capacity, which inevitably had effects on cardiology services in many UK hospitals. Nevill Hall Hospital (NHH) provides an acute cardiology service using six coronary care unit (CCU) and 16 ward beds, non-invasive investigations and clinics. Invasive procedures are undertaken at Royal Gwent Hospital and University Hospital of Wales on a treat and repatriate basis.

Methods

Data were collected on inpatient-occupied bed numbers, number of coronary angiograms, echocardiograms, elective direct current cardioversions (DCCVs) and pacing checks performed and outpatient activity. These data were compared over the same period (23 March to 22 April) in 2019 and 2020.

Results

Average inpatient numbers fell from 21 to 8 (Fig 1), with a fall in all non-COVID presentations.

![Figure 1. Occupied bed days.](image)

Inpatient echocardiograms performed during the period dropped from 144 to 38, while outpatient echocardiograms dropped from 233 to 9.
Other investigation numbers also dropped significantly (Fig 2).

Fig 2. Investigation comparison for 23 March – 22 April 2019/2020

Outpatient clinics are now predominantly telephone consultations.

Discussion

The stark effect on a single hospital unit raises concerns that potentially serious conditions are going untreated. Comprehensive data from Spain showed a marked reduction in interventional cardiology activity during this pandemic.\(^1\) Our findings also build on this worrying trend. Historically, during the 2003 SARS outbreak in Taiwan, fear of catching the virus in hospital had a major impact on visits.\(^2\)

There are major long-term challenges in terms of dealing with the backlog of clinics, investigations, procedures and adapting new working patterns and practices. Telephone clinics have proven popular with patients and their potential should be explored further, in addition to better vetting and triage of patients.

Conclusions

Against this background, the current referral to treatment times are unrealistic, and careful evidence-based planning should be implemented to minimise disruption to patient care.

References


Cheat sheets for medicine – negotiating the challenges of redeployment

Author: Dr Alice Hoole
University Hospital of Wales

Introduction

Redeployment has been a necessity during the COVID-19 pandemic and has resulted in doctors working in medicine for the first time in many years. The ‘cheat sheets for medicine’ provide those redeployed with a portable, digital reminder of how to assess and manage patients with non-COVID-19 medical problems where specialist medical input may be initially unavailable.

Background

The British Medical Association made recommendations to organisations to provide adequate induction and training to redeployed doctors, with specific reference to clinical training.¹

Objective

‘Cheat sheets for medicine’ were designed to provide at-your-fingertips clinically relevant information about medical emergencies to doctors redeployed to medical specialties. The hope was that these cheat sheets would give them knowledge and confidence to commence initial management with an up-to-date evidence base.

Method

Landscape slides were populated with each of nine common medical problems, in addition to a pharmacology and resource list. Each ‘cheat sheet’ included information on clinical features, relevant investigations and first-line management considerations. The completed portfolio was peer reviewed by two consultants and distributed along with induction material.

Results

The ‘cheat sheets’ were universally well received and used by a range of doctors at different levels of training and expertise, described as ‘elegantly designed’ and ‘logical’ in making up a ‘highly valuable guide’ in one testimonial. Doctors felt more confident in managing common medical emergencies. The digital format was accessible for users, in particular was easy to navigate on smartphones to be used whenever and wherever required.

Conclusions

Access to digital resources and telecommunications has been paramount in the challenging context of COVID-19. Providing simple and digestible clinical updates via the ‘cheat sheets for medicine’ equipped redeployed doctors with aide memoires in times of need. Similar interventions could be used for August rotations of foundation doctors in the future.

Reference

The impact of face-to-face pulmonary rehabilitation on the recovery of patients who have been diagnosed with severe COVID-19 requiring non-invasive and invasive ventilation

Authors: Dr Victoria Lewis, Dr Alice Lucey, Sam Jones, Dr Sara Fairbairn
Royal Gwent Hospital

Background

During March–July 2020, in the COVID-19 pandemic, Aneurin Bevan University Health Board reported 2,761 patients diagnosed with COVID-19. Many of those with severe COVID-19 showed persisting fatigue, shortness of breath, muscle mass loss and deconditioning with resultant decreased exercise tolerance, in addition to ongoing psychological and complex health concerns. A bespoke face-to-face COVID-19 pulmonary rehabilitation (PR) programme was set up to maximise recovery, with significant evidence to support PR in other respiratory conditions.

Aim

1. To assess the impact of PR on the Modified Fatigue Impact Scale (MFIS) of patients diagnosed with severe COVID-19.
2. To assess the impact of PR on the 6-minute walk test (6MWT), sit to stand test (STS) and BORG dyspnoea score.
3. To identify patients most likely to benefit from PR in the future.

Method

Patients were identified as having had ‘severe COVID-19’ and referred for PR by consultant case review of patients requiring non-invasive and invasive ventilation in either the respiratory high care unit or intensive care unit. Patients were then assessed by a multidisciplinary team to ensure consent and appropriateness for the programme.

Patients completed MFIS and were assessed on a variety of other physical and psychological measures, including 6MWT, STS and BORG dyspnoea score. During weekly sessions, the patients engaged with a tailored programme of cardio and strengthening exercises as well as pilates. Patients repeated the assessments after 6 weeks.

Results

Total number of patients was 31. 97% of patients attended 80–100% of sessions. The median change in MFIS was −16% (Fig 1). There were also improvements seen in the 6MWT with a median increase of 23%, and STS with a median increase of 36%. Median change in BORG score was −0.5 (−50%).
Conclusion

PR is an effective treatment for patients who have been diagnosed with severe COVID-19 in improving physical abilities and psychological feelings of wellbeing.
A novel approach to an organised teaching programme during the COVID-19 pandemic

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Introduction

Teaching is an integral part of training at all levels to produce competent professionals. One of the most affected domains during the COVID-19 pandemic was regular teachings, at both local and regional levels. Despite the obvious challenges and hurdles during these unprecedented times, cautious steps could be taken to restore normality to some extent. Keeping this in mind, we worked with local tutors to design a weekly teaching programme for fellow junior doctors.

Aims and objectives

The main objectives of the proposed teaching programme are to:

1. restore regular teachings in COVID-19 crisis with adaptation to changing practices
2. design and deliver a teaching programme to ensure learning opportunities
3. provide teaching opportunities to fellow colleagues for their experience and assessments.

Method

The utmost priority was to ensure the safety of participants to make this project successful. Therefore, government guidelines were followed regarding social distancing, small gatherings and other infection control measures. All sessions were planned ahead after collaboration with local tutors to cover unexpected sick leave gaps for smooth progression. A senior was always present to supervise and provide formal teaching feedback.

Results

A total of 13 consecutive weekly sessions were run from May to July 2020. On an average, 10–15 participants attended each session as only limited seating was possible. 10 out of 15 (66.7%) attendees returned the post-programme questionnaire. All of them found it useful and they were satisfied with the safety measures taken. Fig 1 summarises the key benefits.

Fig 1. Key benefits of weekly teaching sessions.
Conclusions

Every challenge we come across in life is a learning opportunity. This pandemic has taught us that we are capable beyond our set boundaries. Adapting to restrictions during crises is imperative for continuity of the healthcare system. The post-programme feedback from attendees summarised this discussion: 90% agreed (80% strongly so) that regular teachings are still possible in this pandemic.
‘Face time’ for the first time – video communication between relatives and junior doctors in the COVID-19 pandemic

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Introduction

Relative visiting restrictions during the COVID-19 pandemic have presented a significant barrier to effective communication between families, patients and staff. Therefore, junior doctors working on COVID-19 wards have had to implement novel methods to overcome these barriers presented by the pandemic, with many turning to technology to offer solutions. Recognising these challenges as an area for improvement on our own ward, we sought to introduce new technologies to improve communication between patients, relatives and staff.

Methods

We identified a cohort of 22 inpatients in University Hospital Llandough in May 2020, and conducted telephone surveys with their nominated next of kin. Opportunities for video-call updates with junior doctors were then offered to families (with patient permission) using accuRx, an NHS-approved video communication software. A post-intervention survey was conducted with families following the introduction of video updates.

Results

Pre-intervention survey results found that 63% of respondents did not feel well informed, with an average understanding of the patient’s clinical plan scored at 5.5/10. 22% of those surveyed had received difficult news over the phone during the COVID-19 pandemic, and 86% felt that video communication would be useful.

Following the introduction of video updates, relatives reported better understanding of the admission, felt less isolated from the patient, and were reassured about the quality of care being received by the patient.

Conclusions

The global COVID-19 pandemic has presented an opportunity to improve the use of technology in facilitating communication between patients, relatives and staff. The introduction of video calls between patients’ relatives and doctors is an ideal method to preserve non-verbal communication within the doctor–relative relationship, as well as improving relatives’ understanding and satisfaction with patient care.
Improving consent form completion for skin surgery

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Introduction

Written consent is a legal obligation if a procedure involves significant risks or consequences for the patient’s personal life. Time pressure, proficiency and legibility can limit the completeness of consent documentation.

Objective

Our aim was to audit our practice in consenting for skin surgery and implement changes to maintain best practice.

Methods

Between March and July 2020, retrospective data from 105 patients in dermatology were reviewed in each audit cycle. Procedures included: benign and malignant skin excisions (42.9%), Mohs surgery (19.1%), curettage and cautery (9.5%), punch biopsy (9.5%), shave biopsy (9.5%) and cryotherapy (9.5%). The standard was 100% completion of key areas of written consent. Consent teaching and a sticker with generic risks for all skin surgery to be attached to consent forms and notes were implemented. Additional risks specific to the patient and the procedure were handwritten. Re-audit was completed.

Results

In the first cycle, 83.8% of procedures had written consent, but no consent form had all key areas completed: risks (68.1%), capacity assessment (42.5%), providing additional written information (41%), no abbreviations (43.8%), secure filing (65.8%), providing a copy to the patient (19.2%), clinician (61.6%) and patient details (100%), benefits (85.2%), anaesthetic type (92%). Re-audit showed that 95.2% of procedures had written consent, with all key areas filled at above 80% completion rate.

Conclusion

Consent teaching and skin surgery risk stickers improved the consent form completion rate. Risk stickers can be a useful tool for dermatologists to ensure that all major risks of skin surgery are explained and documented, improving patient safety and clinical governance.
Signed, sealed, delivered; but who’s your doctor?

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Background

The Royal College of Physicians (RCP) standards for medical record keeping state: ‘the name and designation of the person making the entry should be legibly printed against their signature’.\textsuperscript{1} Further, the General Medical Council (GMC) advises accompanying documentation of the doctor’s GMC reference number.\textsuperscript{2} Accurate and legible documentation is vital for maintaining patient safety. We noted that record keeping at the Royal Gwent Hospital often fell below these standards.

Objective

To improve standards of documentation of name and GMC number in medical notes and on prescription charts to reach 90% concordance with RCP and GMC guidance.

Method

Data were collected once weekly for 10 weeks on a 28-bed acute respiratory ward. Legibility of name and GMC number were analysed for each medical entry and prescription across the preceding 7 days.

Plan–do–study–act (PDSA) cycles consisted of:

1. verbal presentation to doctors
2. ward doctors were provided with personalised self-inking stamps displaying their name and GMC number
3. further education and visual examples of stamp use in prescription charts via email.

Result

In total, 1,632 medical entries and 780 prescriptions were analysed. PDSA cycle 1 had limited impact. In medical notes, cycle 2 demonstrated a sustained increase above the median across four consecutive data points for name legibility and five data points for GMC number. The standard of 90% was met twice (Fig 1). Rates in prescription charts remained low throughout the project, despite PDSA cycle 3 having a small impact (Fig 2).

Conclusion

Introduction of self-inking stamps significantly increased the legibility of names and associated GMC numbers in medical notes. This was not replicated in prescription charts. The project was limited by entries made by doctors outside the pilot team and prescription chart design. Funding has been approved to expand our intervention across the health board and we will assess this impact with further PDSA cycles.
Fig 1. Identification standards in medical notes.

Fig 2. Identification standards in prescription charts.

References


A prospective audit on compliance with perioperative safety checklists for venous thromboembolism prophylaxis: a closed-loop audit

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Glan Clwyd Hospital

Introduction

Hospital-acquired thrombosis (HAT) is an avoidable yet common complication in patients undergoing surgery.\(^1\) It is defined as any venous thromboembolism (VTE) that occurs within 90 days of hospitalisation, which comprises up to 60% of all VTE events.\(^1,2\) The World Health Organization (WHO) surgical checklist is implemented to encourage safe surgery and to reduce the risk of such complications.

Objective

Aiming to minimise the incidence of HATs in perioperative patients, we performed a prospective audit assessing compliance rates when completing the WHO/perioperative checklists pertaining to VTE prophylaxis at Glan Clwyd Hospital from November 2017–18 (first audit cycle) and February 2019–20 (second audit cycle).

Method

Upon gaining permission from our local clinical audit and effectiveness team, we developed a data collection proforma and audited approximately five cases from each theatre across all specialties and they were subsequently analysed (51 cases – first audit, 58 cases – re-audit). After review of our VTE prophylaxis process in operative patients, changes were made to specific sections in our local WHO/perioperative checklists and were re-audited.

Results

The total number of postoperative HATs reduced from 60 patients (0.23% (November 2017–18)) to 38 (0.14% (February 2019–20)). Addressing the VTE prophylaxis in each section of the WHO checklist, completion rates increased in sections: ‘Pause’ (26.5% to 94.8%), ‘sign in’ (4.1% to 75.9%), ‘time out’ (69.4% to 93.1%) and ‘sign out’ (0% to 98.3%). Postoperative VTE prophylaxis prescription completion increased from 58.8% to 100%. Completion of VTE risk assessments for preoperative patients also increased from 45.1% to 98.3%.

Conclusions

Postoperative HAT accounts for a significant but preventable complication. Through our revised WHO/perioperative checklists, the total number of HATs decreased and our performance figures for VTE prophylaxis showed notable improvements.

References

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Avoiding overuse of inpatient cardiac telemetry

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Ysbyty Gwynedd

Topic
A quality improvement project to estimate the overutilisation of cardiac telemetry in the inpatient setting.

Introduction
Cardiac telemetry plays a crucial role in acute hospitalisation for cardiac rate, rhythm monitoring, diagnosis of arrhythmias, avoiding sudden cardiac death. The basic idea of telemetry is to closely monitor patients; however, overuse of telemetry evident from several recent studies has had a negative impact on patient care.1–4

Continuous use of telemetry without being periodically reviewed has led to unnecessary stress on the patient as well as healthcare professionals. It adds an extra burden and waste of resources.

Objectives
To study the contributing factors for overutilisation and indication for telemetry in the inpatient setting.

To study who authorised the cardiac telemetry, its duration, documentation in medical notes and its outcome.

Method
Retrospective data were collected for all inpatients who underwent cardiac telemetry during 1 month. Data were collected from case notes and telemetry forms were requested for patients.

Results
A total 36 patients’ data were collected and the most common indication for telemetry was electrolyte correction (Fig 1). The majority of them were requested for an appropriate indication, by doctors of all grades. The average duration was 2 days and about 20% of the patients were monitored for 4–7 days.

None had any significant finding on telemetry, therefore patient management remained unaltered. There was a lack of telemetry finding in medical notes, hence consideration for taking off telemetry was not done on a daily basis.
Fig 1. Indication for cardiac telemetry.

Conclusions

The duration of telemetry was longer than expected due to lack of documentation and review.

**Learning points**

- Telemetry should be requested only for appropriate indications.
- Documentation in notes on a daily basis, review and considering taking telemetry off are appropriate.
- Autodiscontinuation should be applied after 48 hrs of telemetry and requested again, if required, with justification.
- Designing and implementing an authorised form for telemetry would be beneficial.

**References**

A new communication tool introduced on medical wards during COVID-19: a quality improvement initiative

Authors: Dr Lokapriya Ananthan, Dr Andrew Lansdown
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Introduction

Effective communication with family members of hospitalised patients was critical during COVID-19. A lack of an organised method of communication was identified in the COVID wards at the University Hospital of Wales Hospital in March–April 2020. This resulted in miscommunication between medical staff and families of patients. Increased complaints from family members were also witnessed. There was a need for an effective tool to ensure better communication.

Aim

To design and implement a structured tool of communication to ensure safe and effective information on patients being relayed to their family members.

Method

An audit focusing on current practice of communication with family members of the 25 patients on a COVID ward was conducted in April 2020. A weekly communication chart was then introduced on all the COVID wards, with clear roles and responsibilities agreed for the medical doctors around specific documentation requirements. Medical staff were made aware of the changes during board meetings and face-to-face reminders for the first 2 weeks of implementation.

Results

At baseline, only 55% of families were updated in a day and repetitive conversations with the same family members by multiple staff members was 70%. Overall satisfaction of family members was 60% and satisfaction of medical staff was 50%. A re-audit a month after implementation of the new tool showed a 40% improvement in overall satisfaction among both family members and medical staff, and almost a 40% improvement in the total number of families updated per day.

Conclusion

This project demonstrates the use of a simple tool to improve communication between family members and medical staff, especially during unprecedented times. We recommend its use across all clinical areas, including medical admission units and non-COVID medical wards.
Spread the word, not COVID: Communication during a pandemic

Authors: Dr Kate Edwards, Dr Madhu Kannan
Nevill Hall Hospital

Introduction/background

The SARS-CoV-2 global pandemic was declared by the World Health Organization (WHO) on 30 January 2020 as a Public Health Emergency of International Concern (PHEIC). The first positive case in Nevill Hall Hospital (NHH) was reported on 10 March 2020, the start of our COVID-19 journey locally.

Objective

As a junior doctor working within acute secondary care and with COVID-19 guidance changing daily, clearly rapid effective communication to disseminate accurate and appropriate information between all healthcare professionals (HCPs) working locally was required.

Method

The use of an instant messaging service was deemed the most accessible form of communication between a large cohort of HCPs. Due to local policies differing between hospital sites within Aneurin Bevan University Health Board, it was felt appropriate to set up a site-specific communication group.

Results

An end-to-end-encrypted ‘NHH daily COVID updates’ group was established via WhatsApp® to communicate with a large cohort of HCPs locally, by posting the daily ‘COVID-19 update and quick reference guide’. Qualitative feedback received throughout the process allowed administrators to tailor material and delivery for effective use. Formal survey results showed that WhatsApp® was the preferred method of communication (38% (35/92)), and 72.2% (104/144) used the daily update as their source of NHH-specific COVID information. Respondents’ comments included ‘easy to access’, ‘brilliant for clinical info’ and ‘thank you so much’.

Conclusions

The SARS-CoV-2 global pandemic has had a lasting impact on everyone within the NHS. Ensuring that our hospital site had robust lines of communication allowed rapid dissemination of both clinical and non-clinical information, ensuring that staff could work effectively and felt more empowered during a rapidly evolving situation.

Reference