Abstract concepts

Following on from the article in the last issue of *Agenda* on 10 Top Tips for writing a clinical quality abstract, we wanted to provide some helpful pointers using the example of a successful abstract from a recent meeting. Writing an abstract is such a great way to share good practice and to provide some recognition for the hard work that goes into these projects.

This is one of the Clinical Quality posters, submitted under the category of patient safety, that was successful this year and was chosen for a platform presentation. You may have seen this at the BGS Autumn Meeting – *Introducing Treatment Escalation Plans (TEP) for older persons; Response to the COVID-19 pandemic* by SJ Woodford and HP Patel.

Why submit an abstract to a BGS meeting?

I'm Rachel, one of the geriatric medicine registrars currently working in Hull. My registrar, Dr Kershaw, and I have been fortunate enough to have our abstract accepted for poster presentation at the BGS Autumn Meeting 2021.

Our project looked at the use of melatonin for sleep disorders in patients with Parkinson's Disease within our region, with the aim of implementing the Parkinson's Disease Sleep Scale as an objective measure.

I found that writing an abstract helped me review the project, recapping what were our main aims and objectives and evaluating whether the project achieved these. It allowed me to reflect on the most relevant and important conclusions that could be drawn. It is easy with a project to get bogged down in the details of the methodology and individual results, but I feel writing an abstract gives the opportunity to review what went well and how to progress the project or what strategies I can take forward to my next quality improvement project. Reading others abstracts and posters is inspiring and encouraging to get even more involved in QI.

Getting started

Firstly, you need to describe your problem and how your proposed change will improve quality. This project was based around an important and clinically-relevant topic. The abstract begins with a clear definition of treatment escalation plans with an emphasis on shared decision making. This demonstrates an understanding of the project focus and relevance to clinicians as well as patients and carers.
"TEP documentation was not standard within our trust up to 2018. We aimed to design and introduce a standardised TEP proforma and evaluate its use in older persons aged ≥80."

The introduction describes a specific and relevant aim. Using the acronym SMART can be beneficial in ensure the aim of the project is specific, measurable, achievable, relevant, and timely.[1]

The project must use quality improvement methodologies with at least one completed PDSA cycle and describe the full cycle where the change has been made and evaluated.

"Data was obtained from patient notes and questionnaires within the Medicine for Older Persons department (MOP) from four PDSA cycles between 2018-2020. Cycle 1 was a service evaluation. Based on this data, a TEP form was created and approved for use in all adult patients. Cycles 2, 3 and 4 evaluated TEP after introduction of the proforma."

As you can see this project had four completed PDSA cycles over a period of two years, but you could submit with one completed cycle. If there is a topic that would be likely to generate learning and discussion, a single audit or survey can be submitted.

Highlighting the interventions of each PDSA cycle and how these were generated and implemented can demonstrate understanding of the progressive and pliable nature of quality improvement.

The results section can be a tricky one to write, the key

Introducing Treatment Escalation Plans (TEP) for older persons: Response to the COVID-19 pandemic

SJ Woolford,[1] HP Patel [2,3,4]

1. Academic Foundation Trainee, University Hospital Southampton, UK; 2. Medicine for Older People, University Hospital Southampton, UK; 3. Academic Geriatric Medicine, Faculty of Medicine, University of Southampton, UK; . NIHR Southampton Biomedical Research Centre, University of Southampton & University Hospital Southampton NHS Foundation Trust, UK

Introduction: TEP detail appropriate ceilings of care and guide treatment of patients based on shared decision making. TEP documentation was not standard within our trust up to 2018. We aimed to design and introduce a standardised TEP proforma and evaluate its use in older persons aged ≥80.

Methods: Data was obtained from patient notes and questionnaires within the Medicine for Older Persons department (MOP) from four PDSA cycles between 2018-2020. Cycle 1 was a service evaluation. Based on this data, a TEP form was created and approved for use in all adult patients. Cycles 2, 3 and 4 evaluated TEP after Introduction: of the proforma.

Results: There was a 239% increase in TEP after Introduction: of the proforma, compared to baseline (cycle 1: n=14/47 [29.8%], cycle 2: n=17/112 [15.2%], cycle 3: n=30/97 [30.9%], cycle 4: n=42/59 [71.2%]). The increase in TEP between cycles 3 and 4 coincided with the COVID-19 epidemic. Clinicians were more confident in actioning TEP based on the proforma, compared to those written in the notes (cycle 2: 83% confidence vs 54%, cycle 3: 100% vs 35%, Cycle 4: 98% vs none written in the notes). An improvement in understanding the purpose, comprehensiveness and location of TEP forms was observed. Feedback suggested TEP provided clear guidance for 1. ceilings of care; especially useful out of hours 2. discussions with critical care and 3. patient handover between staff and successive shifts.

Conclusion: TEP forms offer clear guidance on ceilings of care. Introduction: of the TEP proforma has led to more frequent and proactive discussions with patients on ceilings of care and have facilitated a culture change in the management of older persons. Use of the forms increased during the COVID-19 pandemic but are now viewed as an essential component of patient safety and have been successfully implemented trustwide.

is to get the relevant results across and demonstrate the significance without numerical overload.

This project measured more than just the improved numbers of TEPs so was good to see the process of evaluation in action.

"There was a 239% increase in TEP after introduction of the proforma [...] Clinicians were more confident in actioning TEP based on the proforma, compared to those written in the notes (cycle 2: 83% confidence vs 54%, cycle 3: 100% vs 35%, Cycle 4: 98% vs none written in the notes)."

This demonstrates how the team have considered both the systemic and human factors involved in quality improvement.

As we know quality improvement projects may not 'stick' if there is not a plan to disseminate so it is important to talk about sustainability and spread – even if this hasn't been done you can describe your plan:

"now viewed as an essential component of patient safety and have been successfully implemented trust wide."

The word count can be a challenge so it is important to use the Revised Standards for Quality Improvement Reporting Excellence Guidelines (SQUIRE 2.0) – the link to submitting abstracts can be found here **www.bgs.org.uk/abstracts.**

In conclusion, writing an abstract can give the opportunity to reflect on your project and review the key results and findings. It's something to be proud of, look what you have achieved and be inspired to keep going with QI.

Reference

1. Bjerke M and Renger R (2017) Being smart about writing SMART objectives. Evaluation and Programme Planning. April 61;125-127