Individuals within an organisation will have differing expectations of the shop floor leader depending on how they are positioned within the organisation. The purpose of this study is to explore what team members within a single organisation, perceive to be good clinical shop floor leadership through semi-structured interviews.

**Method and results** Purposive, convenience sampling was used to find 12 subjects willing to undergo a semi-structured interview. The intention was to interview a cross-section of members of the Emergency Department team, regarding what they understand by good shop floor leadership and exploring what are the perceived challenges for shop floor leadership.

A crib of questions was used but this was not strictly adhered to, to allow exploration of themes not predefined by the primary researcher.

The interview audio was transcribed and an iterative thematic analysis was then undertaken, with no predefined coding framework. Each transcript was analysed for themes and emergent patterns of commonality.

**Conclusions** The theme of clinical leadership was explored, and the breadth of expectation placed on clinical leaders was evident. The importance of role modelling and credibility were highlighted. Clinical leaders described their strategy for shop floor leadership, and those who were led on the shop floor highlighted factors they valued, in particular education and teaching. The tensions between conflicting demands on the shop-floor leaders were demonstrated. The output from the interview enabled recommendations to be made regarding shop floor leadership for the organisation.

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**Abstract 030**

**ARE STAFF RECORDED PAIN SCORES A ‘GOLD STANDARD’ FOR ED PAIN RESEARCH?**

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10.1136/emermed-2019-RCEM.30

**Background** Relief of pain is a key activity of emergency medicine, however pain is often poorly monitored. As part of the evaluation of an electronic patient pain score recording device we needed to smooth a time series of pain scores in order to minimise ‘noise’ and false readings. In order to evaluate different methods we used the staff recorded pain score as a reference standard.

Patients used an electronic pain recording device containing buttons set out in the same way as a pain visual analog scale. The button corresponding to the currently level of pain was pressed in response to an audible prompt every 15 minutes. Pain scoring by ED staff continued in the normal way, recorded in the electronic health record.

Smoothing was undertaken using 20 and 30 minute bins, with either the median or the maximum patient recorded score being calculated for each bin. The staff recorded pain score nearest to 2 hours was paired with the patient recorded score in the same time window.

For each smoothing method a Bland-Altman plot was made of the paired results and Spearman’s correlation coefficient calculated.

There was little difference between the smoothing methods (table 1). However the most striking finding was that ED staff overall record a lower pain score (by 1 to 2 points) than is self-reported by patients. There were also very wide limits of
agreement - implying variation between patient recorded and staff recorded pain scores (figure 1).
Better understanding of the dynamic of the interaction between patient and ED staff, including staff perceptions, is important in managing pain in emergency care. Our (perhaps naive) initial presumption that a staff recorded score forms a ‘reference standard’ may not be valid.

### Abstract 030 Table 1

<table>
<thead>
<tr>
<th>Method</th>
<th>Bias</th>
<th>Limits of Agreement</th>
<th>Spearman’s Rho</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-minute bin interval, median score</td>
<td>-0.67</td>
<td>-5.97</td>
<td>4.63</td>
<td>0.64</td>
</tr>
<tr>
<td>20-minute bin interval, maximum score</td>
<td>-1.48</td>
<td>-7.07</td>
<td>4.11</td>
<td>0.55</td>
</tr>
<tr>
<td>30-minute bin interval, median score</td>
<td>-0.70</td>
<td>-5.56</td>
<td>4.16</td>
<td>0.68</td>
</tr>
<tr>
<td>30-minute bin interval, maximum score</td>
<td>-1.54</td>
<td>-6.94</td>
<td>3.86</td>
<td>0.58</td>
</tr>
</tbody>
</table>

Background
Patient flow is crucial for patient safety, and for health services and the emergency departments (ED) within them to function. Poor patient flow is associated with increased mortality and morbidity. However, the concept of patient flow was not previously formally taught to all health care professionals (HCP) in our organisation. We developed a fun educational resource to be used with multidisciplinary groups to demonstrate the principles and pitfalls of patient flow in a hospital system.

**Method and results**
Our board game is a collaborative team game for 2–10 players and consists of a hospital with an ED, medical ward, surgical ward and intensive care. The game lasts around 45 minutes, during which the team aims to play through 24 hours in the hospital. The aim is to end the game with fewer patients in the hospital than at the

### Abstract 031 Figure 1

![Image 1](image1)

### Abstract 031 Figure 2

![Image 2](image2)