QI @ NGH: The role of the Chief Registrar

Dr Amy Webster, Chief Registrar and Haematology trainee

Quality Improvement @ NGH

The Trust's Patient Safety Strategy was first launched in 2012 and has since been further developed and updated by The Patient Safety and Quality Improvement (QI) team. As part of the campaign, we have pledged to:

- put safety first
- continue learning
- be honest and transparent with patients, staff and the public
- collaborate internally and externally to participate in innovative approaches.
- be supportive when errors occur

The QI team

The team consists of both clinical and non-clinical staff who are all dedicated to quality improvement. The team has recently moved into a dedicated QI HUB, intended to be a focal point where all staff (including junior doctors) can attend for advice and support on QI projects.

Opportunities for medical staff

The QI team run 3 dedicated programmes to engage medical staff in QI. From these there are currently **37** active QI projects being supported. The programmes include:

1. *Junior doctor safety board*: Open to any grade of junior doctor. Weekly education sessions and ongoing support for active QI projects.

2. *Registrar management programme*: Nine week modular course where registrars are encouraged to challenge and question the safety principles and processes in place and lead on a project that demonstrates their understanding of how to implement a quality improvement project.

3. *Aspiring to excellence programme*: Bespoke two week course to 5th year medical students that teaches the fundamentals of safety science . The students receive a series of lectures and interactive sessions on a number of aspects of a project theme and QI methodology as well as including patient experience.

Projects are regularly submitted for presentation at national and international conferences, with **24** submissions to the 2017 International Forum on Quality and Safety in Healthcare.

The Role of the Chief Registrar

QI is fundamental to improving patient care and a vital tool for all medical leaders. At NGH, the chief registrar has been enveloped into the QI team with active support and mentoring on successful QI methodology. This includes supervision of junior staff and regular involvement in the weekly team 'Look Forward/Look Back' meetings to share QI work.

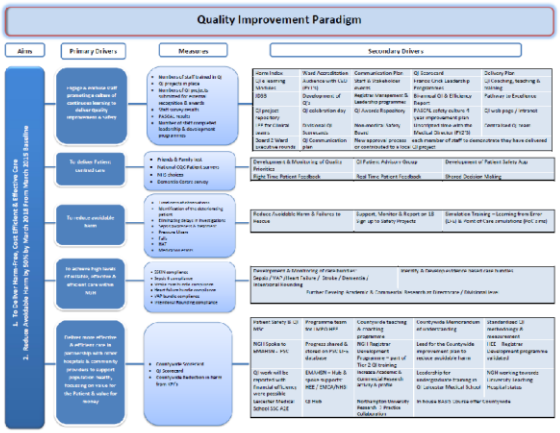


Image: Driver diagram for QI @ NGH – how we aim to deliver harm-free, cost efficient and effective patient care

My current QI projects

Patient blood management (PBM) and reducing unnecessary blood transfusions:

- PBM is defined as "a multidisciplinary, evidence based approach to optimising the care of patients who may require a blood transfusion"[1]. Local data highlights that 75% of emergency admissions with anaemia result in red cell transfusion, of which 54% were felt to be inappropriate based on national indication codes.
- QI projects are focused on highlighting investigations for reversible causes of anaemia, raising awareness of transfusion indication codes and increasing availability of IV iron as a transfusion alternative

Improving Haematology resources and access to clinical advice

- A survey of junior doctors highlighted inadequate resources available to investigate abnormal bloods results, which was causing a large volume of additional work for the haematology medical team.
- Algorithms have been produced and made available online to secondary and primary care. Data collection on their impact is ongoing.

Improving ambulatory management of patients with suspected pulmonary embolism (PE)

- Audit data showed poor compliance with the NICE clinical guideline on venous thromboembolic disease with regards to PE management[2].
- An updated ambulatory pathway in currently in progress to address these issues and avoid unnecessary admissions for PE investigation.

References:
1. NHS National Blood Transfusion committee, Patient Blood Management recommendations 2014
2. Venous thromboembolic disease: diagnosis, management and thrombophilia testing. NICE clinical guideline 144; published 2012

Please see the following webpage for more information: www.northamptongeneral.nhs.uk/QI/Patient-Safety-and-Quality-Improvement.aspx

With special thanks to Sid Beech, Jane Bradley and all of the NGH QI team!

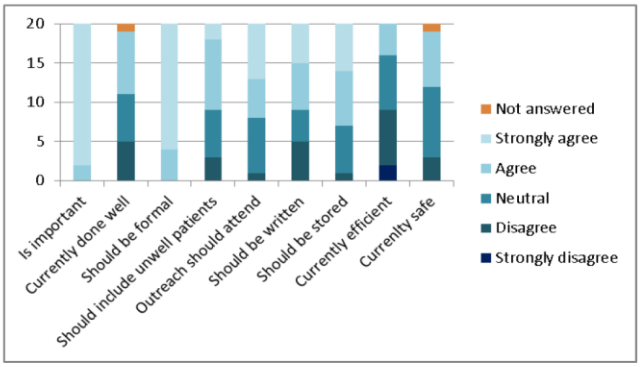
Implementing a hospital-at-night meeting: The experience of a UK district general hospital

Alexandra E Ewence, John M Seymour
Frimley Park Hospital, Frimley Health NHS Foundation Trust, Surrey, UK

Background and Objectives

With 75% of the year 'out of hours'[1] it is essential to provide safe care at night; this necessitates a robust handover.

A survey of medical doctors' opinion on handover conducted at our hospital showed that all felt handover was important and all felt it should follow a formal, reproducible process. Only 40% felt it was currently being done well. Only 20% felt that it was currently efficient. Only 35% felt it was currently safe.



We theorised our hospital would benefit from a nightly hospital-wide meeting, that would bring together all adult on-call teams at the start of their shifts. An audit of junior doctors showed 50% felt a hospital at night meeting would make their job easier; 50% were neutral; non disagreed.

We set-out to introduce a hospital at night meeting with attendance from medical, surgical, intensive care (ICU) and site teams. The aims: to improve patient safety, communication and support between teams during the night shift.

Measurement

A survey of doctors' opinions on the meeting, its benefits and limitations will be conducted and compared to a previous survey on handover. The number of emergency calls throughout the hospital will be reviewed before and after implementation of this new meeting.

Method of intervention

A meeting was agreed by the heads of all adult specialty departments.

- To take place at 2200 hrs and last 15 minutes. The most senior representative on site from each team will attend (SpR or Consultant). The medical consultant or medical SpR will lead the meeting, supported by the site manager.

A written agenda was designed and turned into a laminated poster for permanent reference during every meeting. It includes:

- Bed and hospital status, specialty team updates including staffing issues and any unwell patients requiring cross-specialty input.

A written attendance register was created to be signed by all attendees at each meeting.

A location for the meeting was secured.

- The ED seminar room is quiet, private, away from busy clinical areas and offers a table, chairs and essential IT resources.

A daily reminder for the meeting was created.

- Switchboard ensures that all on-call bleeps will broadcast a spoken instruction to attend the meeting 5 minutes before the meeting starts.

The meeting was advertised .

- Via E-mail to all junior doctors
- Via each departmental head to their department leads, consultants and juniors
- One-on-one with each medical registrar
- At foundation doctor and medical junior doctor inductions

Progress

The meeting began in August 2016. Initial attendance was good for medicine, surgical and site teams (80-100%). Attendance from ICU and orthopaedics however was low at 33% and 47% respectively.

A period of further advertising and education was conducted. Despite this, ICU and orthopaedic attendance remained poor (15 and 11% respectively). Surgical attendance fell to 48%.

A further survey of junior doctors' opinions demonstrated that all felt the meeting was clinically relevant to them; 66% felt that it gave them a better understanding of hospital/team pressures and that it helped them in their job, but only 33% felt it was currently working well or was currently improving patient safety.

After further consultation with each specialty department, the meeting start time was changed to 2130 to improve attendance. The ED consultant was also invited to attend to engage senior input. Initially these changes boosted attendance (to 40-100%) from previously poorly attending teams. Unfortunately, this improvement has not continued.

Through further consultation with senior clinicians we plan to increase consultant engagement and increase attendance.

Once universally well attended and running, we hope the benefits of this meeting will become apparent to individual clinicians and the hospital as a whole.

References:

1. Dominik Shaw, Associate Professor, University of Nottingham
2. RCP Acute Care Toolkit 1: Handover and 8: The medical registrar on call

Acute Hospital at Home

Developing the vision of the Future Hospital: A Chief Registrar project

Judy Martin, Linsey Davis, Jordan Bowen, Daniel Lasserson, Sudhir Singh and James Price

Oxford University Hospitals NHS Foundation Trust

1 BACKGROUND

- Removing barriers between the acute hospital and the community is key to the delivery of the Future Hospital.
- An Acute Ambulatory Unit (AAU) was set up at the John Radcliffe Hospital, Oxford 12 months ago.
- An Acute Hospital at Home (AHaH) service has more recently been introduced to support ambulatory working.
- The AHaH service provides elements of care in a patient's own home that traditionally would have required a hospital admission.
- The aims of the service are to
    1. Reduce admissions to hospital
    2. Reduce length of stay in hospital
    3. Improve patient experience

2 CHIEF REGISTRAR

- I was appointed as Chief Registrar at Oxford University Hospitals NHS Foundation Trust in November 2016.
- Developing the capacity and capability of the AHaH service is one of my key goals. The specific aims are to:
    1. Increase the number of patients managed under the care of the AHaH service.
    2. Measure outcomes in clinical efficacy, patient safety and patient experience.
    3. Explore the use of new technologies in ambulatory care.
    4. Develop multi-disciplinary ambulatory pathways for specific conditions such as heart failure and COPD.
    5. Develop the medical support to the AHaH service.

3 PROGRESS

MEDICAL SUPPORT
- Established twice weekly clinical board rounds.

OUTCOMES
- Established monthly M&M meetings.
- Developed patient survey.

TECHNOLOGY
- Developed service evaluation proposal for a pilot of wearable technologies in ambulatory care.

MULTIDISCIPLINARY AMBULATORY PATHWAYS
- Established links with COPD and heart failure teams.
- Progress on developing COPD and heart failure ambulatory pathways.

4 NEXT STEPS

MEDICAL SUPPORT
- Develop job description and business case for increased medical support to allow capabilities and capacity of service to expand.

OUTCOMES
- Roll out patient survey and use results to identify areas for improvement.
- Develop sustainable M&M structure.

TECHNOLOGY
- Pilot of wearable technology in ambulatory care.

MULTIDISCIPLINARY AMBULATORY PATHWAYS
- Implement and develop heart failure and COPD pathways using quality improvement methodology.

5 DISCUSSION

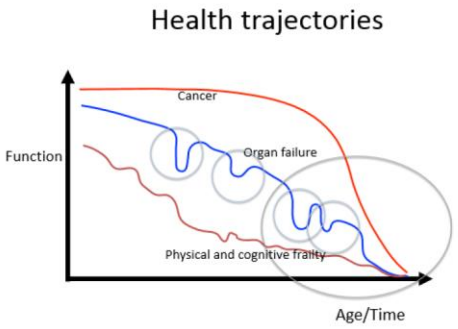
- Over the last 6 months the AHaH service has become established within the hospital and community.
- Potential challenges that will need to be addressed include:
    1. Patient, carer and clinician perceptions on efficacy and safety.
    2. Matching service capacity to patient need.
    3. Developing the capability to manage medically complex and frail patients who, while potentially presenting a greater challenge, may benefit most from care in their own home.

First do no harm: Changing culture surrounding ceilings of treatment in end-of-life care

McNeill S, Toner E, Caskey S, Marley AM, Guy S, Elliott P

Introduction

The NICE Quality Standard for End of Life Care for adults (2011) provides a far reaching vision of how high quality end of life care should appear today. Unfortunately, people approaching the end of life may receive inconsistent care as their condition deteriorates. Failure of the team providing normal medical care to communicate patients' wishes and clearly document a personalised care plan for current and future support and treatment can expose patients to burdensome medical investigations, as well as increasing anxiety among nursing staff and 'on call' medical teams should an acute deterioration occur outside of normal working hours.



Aims

The aim of this project is to test the hypothesis that a pre-emptive ceiling of treatment (COT) form will lead to improved discussion and documentation of prognosis and appropriate treatment options in the context of an end-of-life trajectory.

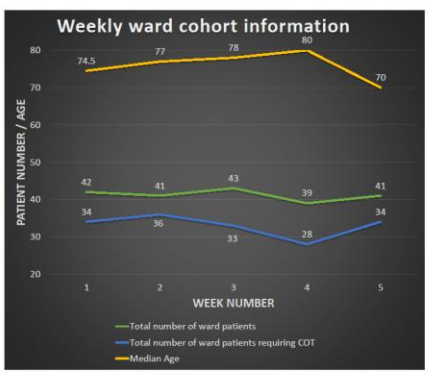
Methods

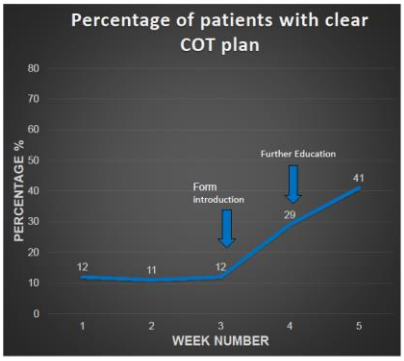
Inpatient notes in the Belfast City Hospital (BCH) Respiratory unit are being reviewed weekly by three senior trainee doctors. ECOG performance status, presenting diagnosis, comorbid disease, and the 'surprise question' are all being used in developing a consensus opinion as to whether a ceiling of treatment plan is important for each patient.

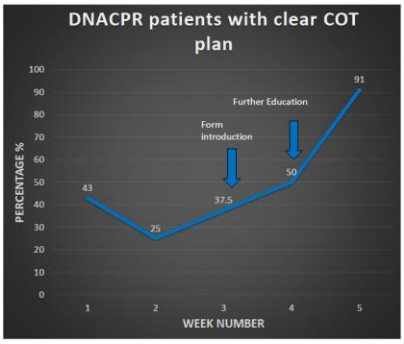
Two online survey tools were administered to examine nursing and doctors' confidence in caring for patients approaching end-of-life care.

Referrals to ICU/ HDU and cardiac arrest calls were retrospectively reviewed for appropriateness.

Initial Results





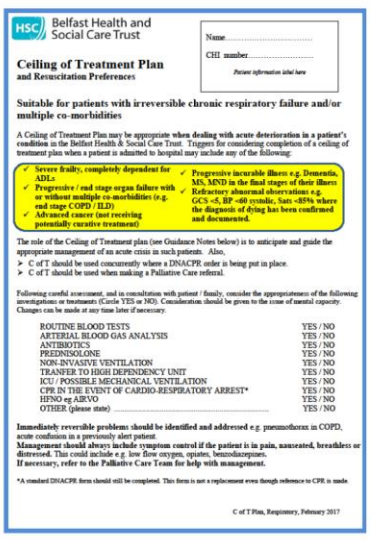


Of the 62 Belfast trust cardiac arrest audit sheets reviewed (over 6 months) 16% were subsequently deemed to be avoidable with appropriate forward planning.

There were 44 referrals to ICU / HDU from the medical specialities in the BCH over a 2 month period. 20% were deemed inappropriate due to frailty / co-morbidity *etc.*

90% of doctors and 73% of nurses state that they have witnessed patients undergoing treatments they consider futile/burdensome

71% of doctors and 77% of nurses state they have been left unsure what active interventions a patient is still considered for



Belfast Health and Social Care Trust

Name.....

CHI number.....

Patient information label here

Ceiling of Treatment Plan
and Resuscitation Preferences

Suitable for patients with irreversible chronic respiratory failure and/or multiple co-morbidities

A Ceiling of Treatment Plan may be appropriate when dealing with acute deterioration in a patient's condition in the Belfast Health & Social Care Trust. Triggers for considering completion of a ceiling of treatment plan when a patient is admitted to hospital may include any of the following:

- ✓ Severe frailty, completely dependent for ADLs
- ✓ Progressive / end stage organ failure with or without multiple co-morbidities (e.g. end stage COPD / ILD)
- ✓ Advanced cancer (not receiving potentially curative treatment)
- ✓ Progressive incurable illness e.g. Dementia, MS, MND in the final stages of their illness
- ✓ Refractory abnormal observations e.g. GCS <8, BP <60 systolic, Sats <85% where the diagnosis of dying has been confirmed and documented.

The role of the Ceiling of Treatment plan (see Guidance Notes below) is to anticipate and guide the appropriate management of an acute crisis in such patients. Also,

- C of T should be used concurrently where a DNACPR order is being put in place.
- C of T should be used when making a Palliative Care referral.

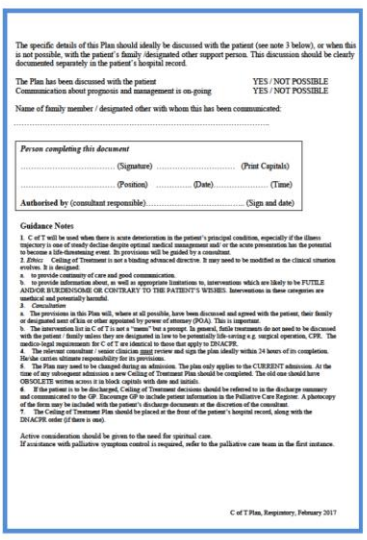
Following careful assessment, and in consultation with patient / family, consider the appropriateness of the following investigations or treatments (Circle YES or NO). Consideration should be given to the issue of mental capacity. Changes can be made at any time later if necessary.

ROUTINE BLOOD TESTS	YES / NO
ARTERIAL BLOOD GAS ANALYSIS	YES / NO
ANTIBIOTICS	YES / NO
PREDNISOLONE	YES / NO
NON-INVASIVE VENTILATION	YES / NO
TRANFER TO HIGH DEPENDENCY UNIT	YES / NO
ICU / POSSIBLE MECHANICAL VENTILATION	YES / NO
CPR IN THE EVENT OF CARDIO-RESPIRATORY ARREST*	YES / NO
HFNO eg AIRVO	YES / NO
OTHER (please state)	YES / NO

Immediately reversible problems should be identified and addressed e.g. pneumothorax in COPD, acute confusion in a previously alert patient.
Management should always include symptom control if the patient is in pain, nauseated, breathless or distressed. This could include e.g. low flow oxygen, opiates, benzodiazepines.
If necessary, refer to the Palliative Care Team for help with management.

*A standard DNACPR form should still be completed. This form is not a replacement even though reference to CPR is made.

C of T Plan, Respiratory, February 2017



The specific details of this Plan should ideally be discussed with the patient (see note 3 below), or when this is not possible, with the patient's family /designated other support person. This discussion should be clearly documented separately in the patient's hospital record.

The Plan has been discussed with the patient — YES / NOT POSSIBLE
Communication about prognosis and management is on-going — YES / NOT POSSIBLE

Name of family member / designated other with whom this has been communicated:

Person completing this document

.....(Signature) .....(Print Capitals)

.....(Position) .....(Date).....(Time)

Authorised by (consultant responsible).....(Sign and date)

Guidance Notes

1. C of T will be used when there is acute deterioration in the patient's principal condition, especially if the illness trajectory is one of steady decline despite optimal medical management and/ or the acute presentation has the potential to become a life-threatening event. Its provisions will be guided by a consultant.
2. *Ethics* Ceiling of Treatment is not a binding advanced directive. It may need to be modified as the clinical situation evolves. It is designed
   a. to provide continuity of care and good communication.
   b. to provide information about, as well as appropriate limitations to, interventions which are likely to be FUTILE AND/OR BURDENSOME OR CONTRARY TO THE PATIENT'S WISHES. Interventions in these categories are unethical and potentially harmful.
3. Consultation
   a. The provisions in this Plan will, where at all possible, have been discussed and agreed with the patient, their family or designated next of kin or other appointed by power of attorney (POA). This is important.
   b. The intervention list in C of T is not a "menu" but a prompt. In general, futile treatments do not need to be discussed with the patient / family unless they are designated in law to be potentially life-saving e.g. surgical operation, CPR. The medico-legal requirements for C of T are identical to those that apply to DNACPR.
4. The relevant consultant / senior clinician must review and sign the plan ideally within 24 hours of its completion. He/she carries ultimate responsibility for its provisions.
5. The Plan may need to be changed during an admission. The plan only applies to this CURRENT admission. At the time of any subsequent admission a new Ceiling of Treatment Plan should be completed. The old one should have OBSOLETE written across it in block capitals with date and initials.
6. If the patient is to be discharged, Ceiling of Treatment decisions should be referred to in the discharge summary and communicated to the GP. Encourage GP to include patient information in the Palliative Care Register. A photocopy of the form may be included with the patient's discharge documents at the discretion of the consultant.
7. The Ceiling of Treatment Plan should be placed at the front of the patient's hospital record, along with the DNACPR order (if there is one).

Active consideration should be given to the need for spiritual care.
If assistance with palliative symptom control is required, refer to the palliative care team in the first instance.

C of T Plan, Respiratory, February 2017

Discussion

With the acknowledgment that as many as 10% of current acute hospital inpatients could die during their index admission and almost 30% could die within one year, the concept of 'hospital anticipatory care planning', or 'ceiling of treatments' have become increasingly topical in recent years. The Resuscitation Council (UK) have worked with a number of organisations to create and promote their 'ReSPECT' campaign and we can expect this to develop further in the next number of years.

All these pieces of work share our same core principles; the importance of good open communication with our patients, encouraging patients to be involved in decision making around their future care in the event of deterioration, and the avoidance of interventions or investigations that are futile, burdensome, or contrary to the patient's wishes.

Our work to date demonstrates a lack of forward planning for this cohort of patients. Medical emergency teams are performing futile and burdensome investigations / interventions, often as no one anticipated the deterioration or what impact this could have on the patient, their families and staff. With local education and the introduction of a pre-emptive ceiling of treatment form targeted at this cohort, we are already seeing improvement in communication, documentation, and patient involvement in their future care.

Further data collection will continue to measure the impact on ICU/HDU referrals, the number of cardiac arrest calls deemed inappropriate, and we will perform a further staff questionnaire post implementation. Work is already underway with other specialities to create similar ceiling of treatment templates which are more appropriate to their patient cohort.

Acknowledgements:

All the staff in wards 8 North and 8 South in the BCH.

Professor Robin Taylor. Research Consultant, Primary Palliative Care Research Group, Centre for Population Health Sciences, Faculty of Medicine, University of Edinburgh and NHS Lanarkshire.

Dr Shea McNeill was funded as part of the Royal College of Physicians Chief Registrar programme

References

1. End of life care for adults. NICE Guideline 2011
2. Clark D et al. (2014). Imminence of death among hospital inpatients: Prevalent cohort study. Palliative Medicine, 28(6), 474-479
3. The Parliamentary Ombudsman's Report 2015: Dying without Dignity
4. Hospital rapid response team and patients with life-limiting illness: A multicentre retrospective cohort study. Sulisto et al., Palliative Medicine 2015; 29(4): 302–309

Papilloedema pathway: a chief registrar project encouraging 4 specialties to see eye to eye

A. Puttanna, M. Yan. Sandwell and South West Birmingham NHS Trust

Background

Birmingham and Midlands Eye Centre is one of the largest centres in Europe and receives patients across the Midlands. (1) As a result of this, the medical take receives a number of referrals for patients noted to have papilloedema for further investigation. The standard process is for the patient to be referred to the medical unit for review, imaging and further neurology input. Difficulty arose with out of hours referrals, delays in investigation and junior doctor changeover resulting in lack of knowledge of the process.

Aim

As chief registrar, the aim of this quality improvement project was to liaise with the acute medical unit, neurology, ophthalmology and radiology to create a simple pathway that could be followed by the medical team to reduce delays and clarify management plans in order to improve the patient experience, clinical care and optimise discharges.

Method

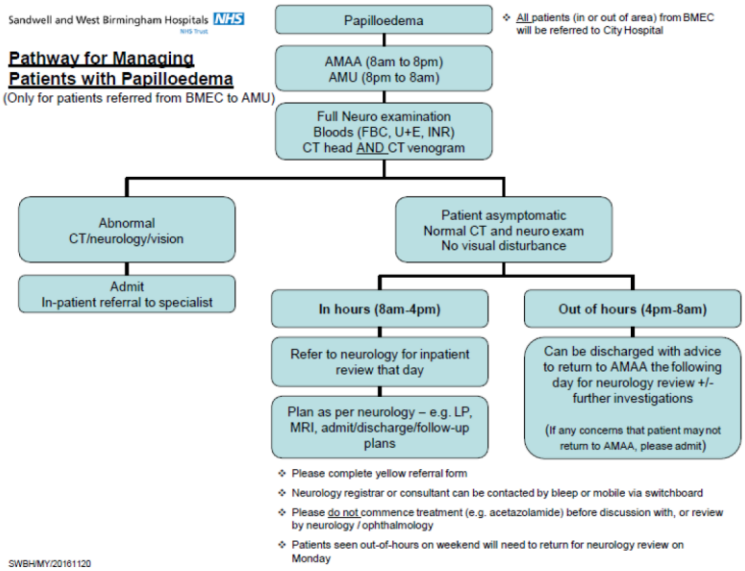
A 'papilloedema pathway' was designed and implemented at the trust with utilisation of the acute nurse prescribers in the ambulatory care area (AMAA) to admit, cannulate and obtain blood samples; medical team to prioritise such patients and organise computed tomography imaging of the head; and neurology input. Stipulations were placed as to when out of hours discharges were appropriate without neurology review and return the following day. Uptake and waiting times following implementation of the pathway was assessed.

Results

Over a 2 month initial trial of the project 11 patients were reviewed utilising the pathway.

Patient	CT head/CT venogram	Discharged that day	LP	Diagnosis
1	Yes	Yes	No	Hypertensive retinopathy
2	Yes	Yes	Yes	IIH
3	Yes	No	Yes	IIH + otitis
4	Yes	Yes	Yes	IIH
5	Yes	Yes	No	pseudopapilloedema
6	Yes	No	No	pseudopapilloedema
7	Yes	No	Yes	IIH with CN 6 palsy
8	Yes	No	No	SOL
9	Yes	Yes	Yes	IIH
10	Yes	Yes	Yes	IIH
11	Yes	No	Yes	IIH

IIH – Idiopathic Intracranial Hypertension
LP – Lumbar Puncture
SOL – Space Occupying Lesion



Discussion

Papilloedema is a potentially life-threatening condition that can result from a number of underlying conditions, though idiopathic intracranial hypertension (IIH) is becoming commoner due to the increasing incidence of obesity. (2)

Assessment of the patient requires true interdisciplinary interaction and input. Due to the nature of assessment, the patient journey during their inpatient stay can result in unnecessary delays and frustration. By creating this simple to use pathway for all patients referred with papilloedema, we allowed for simplification of the process as well as reduced inpatient time. The pathway also allowed for all clinicians to manage patients appropriately regardless of their grade or time of day.

This project is cost and time saving:
Out of 11 patients, 4 avoided lumbar puncture.

6 were discharged that day, avoiding inpatient bed stay. Of those that were kept inpatient only one had an uncomplicated admission with IIH and could have been discharged.

Cost of 1 bed day = £400 (3)
Projected savings of just under £15,000/year on bed stays alone.

Detailed cost analysis including lumbar puncture, staffing and unnecessary investigation would result in further savings. Assessment of clinician and patient satisfaction is planned.

Acknowledgements: The authors would like to thank Dr. David Nicholl and Dr. Arul Sivaguru (consultant neurologists), Dr. Sarah Yusuf (consultant radiologist) and Mr. Tim Matthews (consultant ophthalmologist) for their input in this pathway.

References

1 http://www.nhs.uk/services/clinics/overview/defaultview.aspx?id=1812 accessed 14/03/17
2 Mollan SP, et al. A practical approach to, diagnosis, assessment and management of idiopathic intracranial hypertension Pract Neurol 2014;0:1–11.
3 https://data.gov.uk/data-request/nhs-hospital-stay accessed 14/03/17

Royal College of Physicians | Future Hospital

Gloucestershire Hospitals NHS
NHS Foundation Trust

Our Inner Chief: The Inner Workings of a Chief Registrar

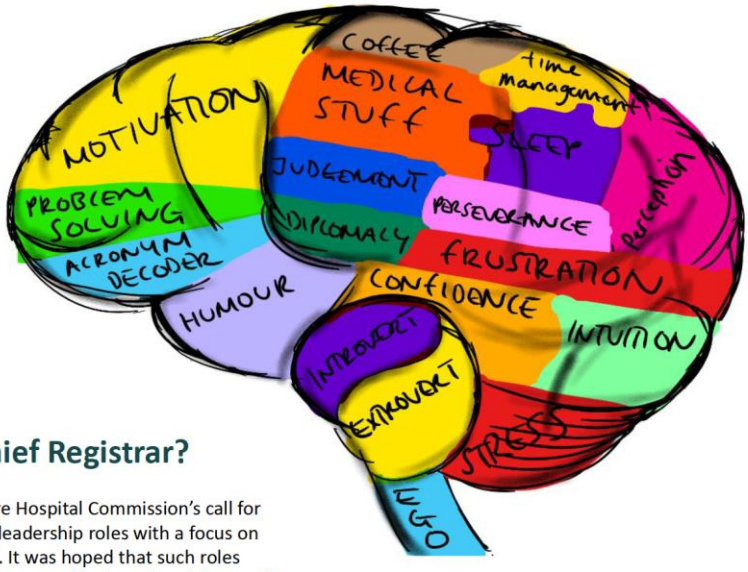
Zoe Jones and Emily Bowen. Gloucestershire Hospitals NHS Trust

Introduction

The Chief Registrar role has been, without question, one of the steepest learning curves of our career so far. Not just understanding 'management speak', but learning how to write a business case, chair a meeting, or prise money out of the finance department....! But what exactly does it take to be a 'chief registrar', and what makes us tick?

The Bigger Picture

The role has allowed us to gain an insight into the inner workings of our organisation, and a better understanding of the local health economy. With this comes a more strategic way of thinking and enhanced problem solving skills



What Exactly is a Chief Registrar?

The role originated from the Future Hospital Commission's call for the establishment of 'new, senior leadership roles with a focus on delivering high quality, safe care'1. It was hoped that such roles would begin to bridge the divide between 'the board and the ward', giving junior doctors a voice and driving forward improvements in service delivery and training.

The role is aimed at senior registrars, and is split between clinical work (around 60%) and leadership and management.

What Have we Learned?

A Whole New Language

Much like medicine, management has its own language, and a whole host of new acronyms. Learning to 'talk management' was difficult at first, but being able to 'translate' business speak into a clinical context and vice versa has been invaluable.

The Art of Juggling

Juggling the demands of the 'day job' with the 'other stuff' can be difficult and stressful at times, but developing effective time management and prioritisation skills should stand us in good stead for our future career, wherever that may take us....

Myers Briggs in Practice

The role has given us an insight into our strengths and weaknesses, giving us improved self awareness and a deeper understanding of how we work in teams, communicate with colleagues, manage difficult situations and respond to stress.

Conclusion

Being a consultant is as much about leadership and management as the clinical work – leading a service or setting up a new one, writing a business case, managing difficult colleagues and much more besides

The Chief Registrar programme has taught us a huge amount, and we feel we've gained experiences that, whether or not we go into leadership roles in the future, will help us to be better doctors and ultimately provide an improved service for our patients.

Tempted?

Recruitment for the 2017 / 18 cohort is underway.....

For further information visit: www.rcplondon.ac.uk/FHP

Or contact futurehospital@rcplondon.ac.uk

References:

1 Royal College of Physicians. Future Hospital Commission. *Future Hospital: Caring for Medical Patients. London, RCP, 2013*

Improving Ward Round Standards with the use of a Structured Pro-forma

McNeill S, Kumar D, O'Neill M, King C, McBride F, Butler C

Background

The Royal College of Physicians and the Academy of Medical Royal colleges have provided guidelines regarding the structure and content of medical record keeping.

Lack of document standardisation can compromise the quality of medical record keeping, promote significant variation, and have a negative impact on handover and continuity of care.

Busy clinical staff, working in highly pressurised environments, are more likely to overlook important issues, or make errors and omissions that can impact on a patient's experience, their safety or their clinical outcome.

Aims

The aim of this Quality Improvement project was to determine whether introducing a standardised ward round pro-forma would result in improved documentation standards.

It was also designed to promote the daily consideration of a number of selected areas including; Thromboprophylaxis, Oxygen prescription, Fluid status, Antibiotic review, Estimated date of discharge (EDD), Ceiling of treatment consideration, DNACPR status, National early warning scoring (NEWS), along with a number of other selected measures. These are highlighted in the results section.

Methods

A baseline audit was performed on a busy respiratory ward in the mater Infirmorum Hospital, Belfast for three consecutive weeks prior to pro-forma implementation.

Individual case notes were examined and data was collected using a standardised collection sheet.

Standards of basic documentation, along with documentary evidence of a number of predefined areas were evaluated. These are clearly listed in the results section.

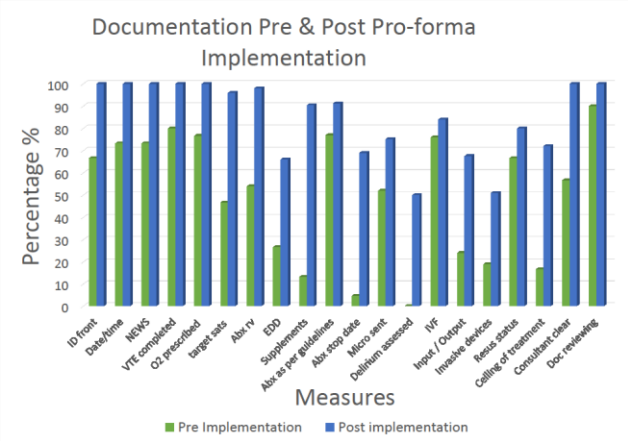
Educational sessions were provided to both consultant and junior medical staff on week three (date of implementation) and again on week six. Following implementation of the standardised pro-forma, the same data measures were collected weekly for a further five weeks.

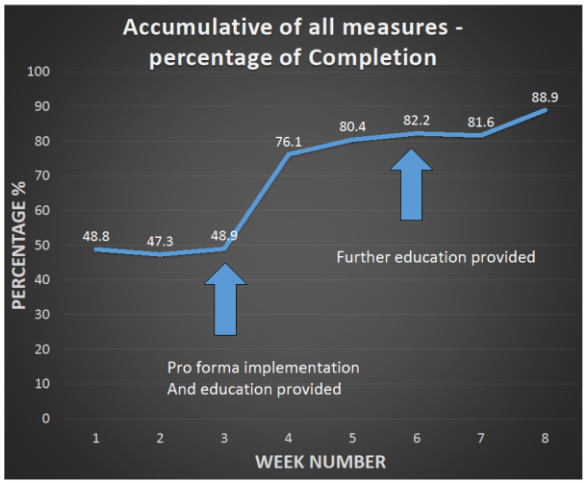
Results

Compliance with the pro-forma has risen from 70% to 85%.

When all measures are collated, there is an overall improvement in the standards of documentation and the consideration of the aforementioned selected areas from 49% to 89%.

Specific areas such as clear patient & doctor identification, date & time, thromboprophylaxis, NEWS assessment and oxygen prescription are now persistently 100%.





Discussion

The quality of medical record keeping can vary widely and often can be considered substandard. This often becomes particularly evident during times of litigation.

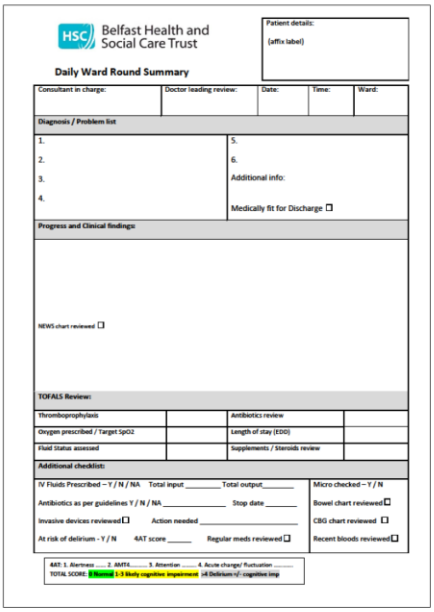
Clinical staff work in high pressure environments and this can contribute to medical errors and the overlooking of key issues. Junior doctors can also be provided with little guidance as to what is expected from them as part of a daily ward review.

The impact of delayed escalation / de-escalation of antibiotics, omitting thromboprophylaxis, checking microbiology results, assessing need of indwelling devices etc, cannot be underestimated as a cause of significant morbidity, mortality, and as a loss of NHS bed days.

Our work to date highlights the benefits of using a standardised ward round document to address some of these key areas. Further work will continue to assess the impact on length of stay in a number of selected champion wards.

References

- Ward rounds in medicine Principles for best practice; A joint publication of the Royal college of Physicians and Royal college of Nursing October 2012.
- Acute care toolkit 2: High-quality acute care; www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-2-high-quality-acute-care
- James A. O'Hare; Anatomy of the ward round; European Journal of Internal medicine 19 (2008) 309-313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Patient details: (affix label)

Daily Ward Round Summary

Consultant in charge: | Doctor leading review: | Date: | Time: | Ward:

Diagnosis / Problem list

1. 2. 3. 4. 5. 6.

Additional info:

Medically fit for Discharge ☐

Progress and Clinical findings:

NEWS chart reviewed ☐

TOFALS Review:

Thromboprophylaxis		Antibiotics review	
Oxygen prescribed / Target SpO2		Length of stay (EDD)	
Fluid Status assessed		Supplements / Steroids review	

Additional checklist:

IV Fluids Prescribed – Y / N / NA Total input _____ Total output _____ Micro checked – Y / N

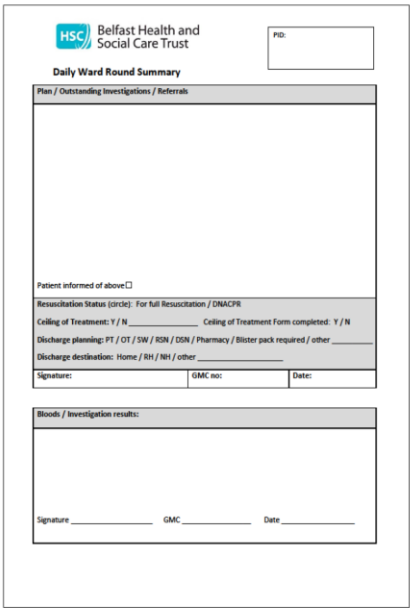
Antibiotics as per guidelines Y / N / NA _____ Stop date _____ Bowel chart reviewed ☐

Invasive devices reviewed ☐ Action needed _____ CBG chart reviewed ☐

At risk of delirium - Y / N 4AT score _____ Regular meds reviewed ☐ Recent bloods reviewed ☐

4AT: 1. Alertness _____ 2. AMT4 _____ 3. Attention _____ 4. Acute change/ fluctuation _____

TOTAL SCORE: 0 Normal; 1-3 likely cognitive impairment; >4 Delirium +/- cognitive imp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PID:

Daily Ward Round Summary

Plan / Outstanding Investigations / Referrals

Patient informed of above ☐

Resuscitation Status (circle): For full Resuscitation / DNACPR

Ceiling of Treatment: Y / N _____ Ceiling of Treatment Form completed: Y / N

Discharge planning: PT / OT / SW / RSN / DSN / Pharmacy / Blister pack required / other _____

Discharge destination: Home / RH / NH / other _____

Signature: | GMC no: | Date:

Bloods / Investigation results:

Signature _____ GMC _____ Date _____

Developing a triage system in a new acute medical assessment unit

Dr Leanne Griffin, Jack Cantelo, Dr Robin Ghosal
Hywel Dda University Health Board

Introduction

Recently, the Front of House in Prince Philip Hospital has undergone significant change. The A&E department has been changed to a Minor Injuries Unit, and the emergency medical patients that present via 999 ambulances are admitted directly under the acute medical take to the acute medical assessment unit (AMAU). This new configuration is a different way of working for the clinicians, nursing staff and allied health professionals within the hospital, all of whom agreed on the acute need for a safe method of triage. A collaborative approach with medical registrars, consultants and nursing staff was therefore sought in the design and implementation of a new triage system.

The new triage system

AMAU is not subject to the same national targets as emergency departments such as the '4 hour wait', however early experience suggests that patients are prioritised according to time of arrival, rather than greatest need. The baseline data (Fig. 1) demonstrates the wait time for doctor review per patient on one day before the implementation of the triage system. We looked at 23 patients who presented to the AMAU, and calculated the time to medical review. We used our new triage system to retrospectively triage these patients, which is represented by the coloured bars. The variation in assessment times may be explained by differences in experience within the nursing and medical teams, as well as varying pressure on and within the department.

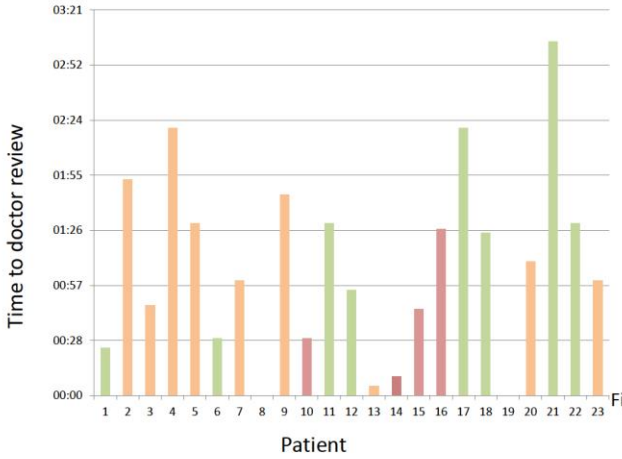


Fig. 1

RED	ORANGE	GREEN
NEWS ≥ 7 (Less than Alert on AVPU, Stroke)	NEWS 5-6 (Chest pain, DKA, sepsis)	NEWS ≤ 4

Our aim is to ensure 100% of patients who present to AMAU are prioritised based on clinical need.
As far as we are aware, there is no validated triage tool for acute medical units.
Our new triage system would use a triage proforma to standardise the method of clinical prioritisation within the department, and would empower nurses to categorise patients into one of three categories (red, orange or green) based on their presenting symptoms and early warning scores[1].
Patients categorised as 'red' should be seen immediately, orange should be seen within an hour, and green, within four hours. The triage system is currently being implemented within the AMAU, however the use has been infrequent so far (Fig. 2).

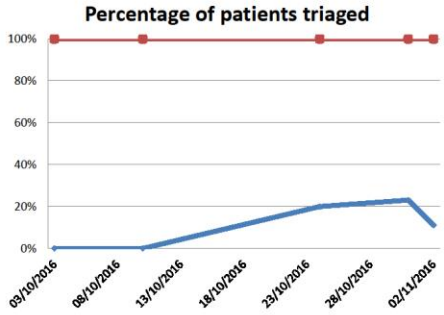


Fig. 2

Next Steps

Despite collaboration with the medical teams and nursing staff, embedding the new system in to the working culture has been a challenge. There may be a number of possible explanations for this, including lack of confidence amongst nursing staff, or a perception that this may add to an already high workload. We plan to work with the nursing staff to arrange triage training, and gather feedback from medical and nursing teams regarding efficiency and ease of use in order to prompt further PDSA cycles, and ultimately develop a robust, safe and reliable method of triage.

References
1. Royal College of Physicians (2012) National Early Warning Score (NEWS), Standardising the assessment of acute-illness severity in the NHS

Acute Medicine and Acute Oncology Interface

Chief Registrar as a 'change agent'

Mridula Rajwani [1], Emma Doyle [2], Kay McCallum [3], Jordan Bowen [4], Sudhir Singh [5], James Price [5], Daniel Lasserson[6]

1 Chief Registrar, Ambulatory Care; 2 Core Medical Trainee Year 2; 3 Acute Oncology Nurse Specialist; 4 Ambulatory Care Consultant, Consultant Geriatrician; 5 Consultant Acute General Medicine and Geratology; 6 Senior Interface Physician, Ambulatory Care

Background

The Future Hospitals Programme brings timely and effective specialist care to patients both in hospital and the community - a critical component is Ambulatory Care. There is a significant interface between acute ambulatory care and acute oncology including patients with new cancer diagnoses presenting with rapid development of symptoms.

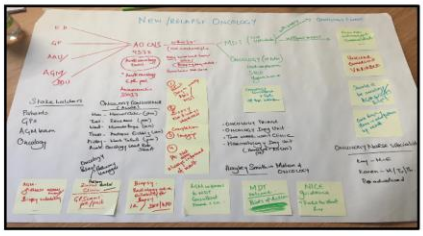
Aim

My aim was to improve the journey for patients with cancer and acute illness by creating an interface between the Acute Oncology Service (AOS) and Acute General Medicine (AGM). I wanted to minimise delays in specialist decisions, reduce hospital admissions and most importantly, improve the patient and carer experience.

How did we identify problems at the acute medicine/oncology interface?

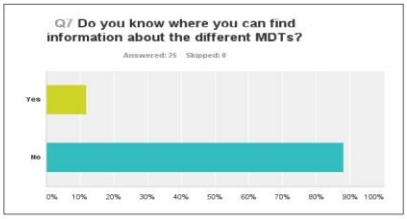
Focus Group Methodology

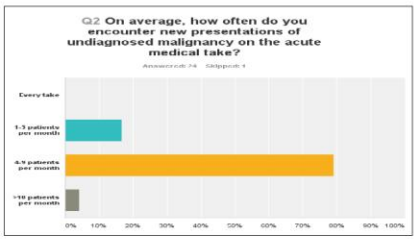
Those involved:
Chief Registrar led
Acute Oncology Nurse Specialist
Acute Oncology Consultants
Ambulatory Care Consultants
Acute Medicine Lead

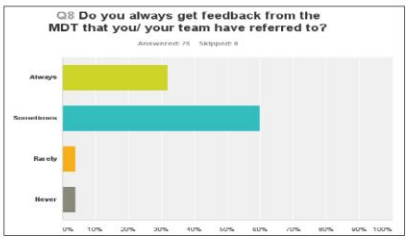


Survey Methodology

Those surveyed:
Acute General Medical Consultants
Registrars
SHOs
Foundation doctors







What did we find ?

1. Lack of a formal referral system
2. Patients staying in hospital awaiting MDT outcomes
3. Lack of awareness among staff regarding pathway for patients diagnosed with a new malignancy (what days MDTs are on, what imaging is needed?).
4. MDT outcomes being sent to referring doctors who may have moved firms/specialty- worry that patient is lost to follow up
5. Patients not always informed of diagnosis prior to acute oncology referral
6. Unclear overall responsibility for the patient journey

Timeline of Activity

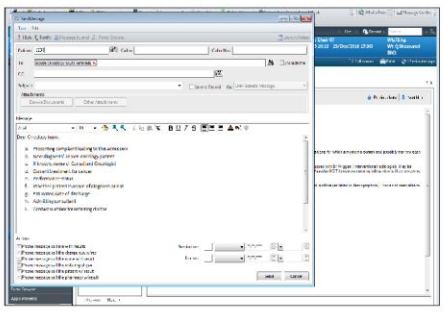
November 2016
Chief Registrar led focus group discussion.

December 2016
1. Chief Registrar attendance at Monthly Acute Oncology Meeting to speak to the department about project.
2. Doctor Survey conducted

January 2017
1. Chief Registrar writes guidance for Acute oncology referrals- sent to AOS/AGM for approval
2. Ambulatory care/ AOS Virtual Ward Round initiation

February 2017
1. Creation of electronic Referral system for AGM- to be extended to other specialties
2. Guidance gets approval
3. Presentation at Clinical Governance Meeting

March 2017
1. Chief Registrar meets with AOS and Lead for Acute Oncology- to get admin support for monitoring of electronic referrals.
2. Starting patient journey mapping process



Reflections & Conclusion

Throughout the course of this project, we overcame issues of separate sites, directorates and silo working with my role as a Chief Registrar spending 'immersion time' in oncology to understand processes of care and specialty perspectives.
The chief registrar is a powerful 'change' agent. We are senior enough to be credible yet junior doctor status ensures that we are seen as non-threatening by other specialties during a period of change. This is a significant strength of the chief registrar programme.