Improve legibility of clinical notes on surgical wards

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REASON WHY?

Nurses on the surgical wards take a lot of time having to clarify plans from written medical notes for both Doctors and Nurses which causes delays in patients receiving treatment, possibly resulting in wrong plans being enacted. To reduce the risk of this, it was necessary to improve the current process

SMART AIM

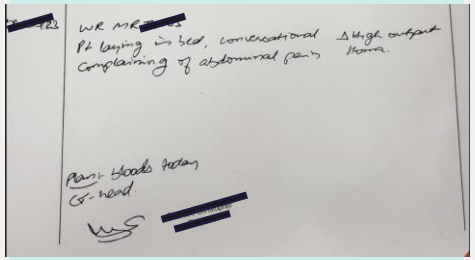
S SPECIFIC | M MEASUREABLE | A ACHIEVABLE | R RELEVANT | T TIME-BOUND

To reduce the incidence of Nurses on Wards 33 and 37 having to clarify plans with Doctors when following written notes by 10% by 25 April 2023.

PLAN

FY1 Doctors reported 2-3 incidences per day of Nurses either bleeping or asking in person to clarify patient plans.
Nurses reported difficulty contacting the right individual. A common theme from both stakeholders was the quality of notation on ward rounds.
Based on our initial audit of 26 sets of notes sampled over one day on wards 33 & 37, 22 sets of notes met our inclusion criteria. Of these an alarming 26.9% could not be read by Nurses, with the same not being able to understand the plan, 38.5% had no GMC number, 38.5% had no name written, 46.2% had no role, and a massive 80.8% had no bleep recorded. We planned to carry out targeted small group teaching for Doctors on good note taking practices underlining the reasons for its importance.

DO



Discussion of correct notation was carried out at departmental teaching covering the common errors detected in audit 1 and the reasons why these could result in poor patient care. Teaching was attended by 7 junior doctors (6 FY1, 1 SHO, 1 registrar), with reference being made to existing departmental posters on how to correctly lay out medical notes

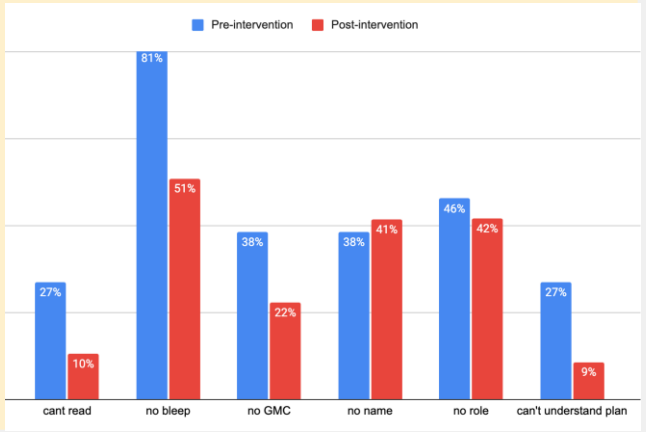
STUDY

Based on our initial audit we found that 26.9% of patient plans were not fully understood by nurses. Following the intervention this was reduced to only 8.5%, an improvement of 18.5%. Similarly Contact details for relevant teams were only missing from 80% of notes in audit 1 which was reduced to 51% in audit 2 following intervention.

From this we can conclude that Doctors without intervention are unlikely to accurately record role in most entries which could lead to confusion when members of MDT or other teams hand over the patient, this was able to be reduced to only 22% following intervention.

We can similarly conclude through improvements across all metrics that Doctors are receptive to suggestions on how to improve practice via teaching; they were more likely to include roles, GMC number and contact details for their teams.

This is an **easy, low-cost** method at improving staff efficiency on the wards and by proxy allowing for more expedient streamlined patient care.



ACT

It is difficult to quantify the effectiveness of this intervention from the sampled dataset, as we were unable to accurately measure improvement against a control sample. Similarly, the short audit window is unable to ascertain change over time.

Next steps to progress this we would like to involve medical as well as surgical teams on a larger scale to allow for control groups.

These could then be sampled over time to determine the appropriate dosing of intervention required to sustain an improvement.

We would recommend:

1. teaching at inductions
2. 4 monthly re-audit cycles with Doctor rotation changes.

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