Medical Acute Take Handover

Theme | Quality Improvement Project (QIP)

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SaTH Improvement Hub

The Shrewsbury and Telford Hospital NHS Trust

REASON WHY?

Following a local audit, it became clear that areas of the surgical notes presented opportunities for improvement. In particular, variation in the standards of documentation. This resulted in safety concerns as important information could be missed/unclear who to contact. Most notes did not meet the identifying criteria.

SMART AIM

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

Improve documentation by ensuring 100% compliance to all ward entries on general surgical wards at RSH by ensuring name, GMC number and signature annotated by attending clinician by 25 November 2024.

PLAN

The intervention was guided by the NHS standards for clinical record-keeping.
It was decided that it was important to ensure accurate documentation for legal reasons and most importantly patient safety.

During a pre-intervention local audit 60% of notes did not meet the required standards for documentation. This defect rate provided the “reason why” to conduct a QIP to improve compliance.

Following feedback from colleagues, it was agreed that many doctors were not aware of the requirement and therefore, decided to test out a poster to remind all colleagues of the requirement for accurate completion of documentation. Alongside this, additional education would be provided.

We also need to ensure greater awareness within all members of the MDT so that they feel comfortable to challenge the attending clinician when needed.

DO

A poster was put up in the main doctors office in SAU. It was decided that this was the location that would have the most impact. This is because notes are often ‘prepped’ in this office before ward round and also documentation when reviewing unwell patients is often here due to the presence of computers. In addition, even though it did not cover 25 or 37, most doctors would see patients here at some point during the day. In addition, we had weekly teaching during surgery and it was covered in a short segment at one of those sessions.

FAO ALL resident doctors

Recent audit showed that **60%** of notes did not have a gmc number, signature and name.

This has the potential to have **major** legal consequences.

Also impacting **patient care** due to nurses not being aware who to contact if plan unclear

Plan:

Please can we ensure ALL entries (not just ward rounds), have at least your surname, gmc number and signature

Notes are a **legal** document and can be used in court

STUDY

The poster was placed in the doctor’s office for a period of 4 weeks as part of the PDSA cycle. Additionally, education was given to re-emphasise the message over a two-week period.
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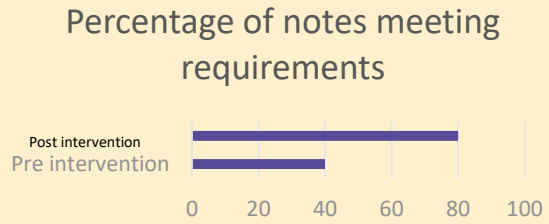
Another local audit of random sets of notes from all general surgical wards was completed at the end of this four week period.

The results are as follows:

Post intervention, 80% of notes had the required identifying markers for the most recent entry. The few that did not comply were only missing one criteria.



Overall, the results demonstrate a positive improvement in several key areas of the documentation in line with legal requirement and NHS guidance for record-keeping. We will continue to improve compliance and aim for 100%.

ACT

It has been agreed to adopt the poster to remind all new doctors who join on a surgical rotation the importance and requirement to maintain accurate documentation.

ACKNOWLEDGEMENTS & REFERENCES | Dr Peter Fitzroy, Dr Joshua Wilcox, Consultant Mr A. Farquharson