Research Papers

Does a Post-take Ward Round Proforma Lead to Sustainable Improvements in Quality of Documentation for Patients Admitted to the Medical Assessment Unit?

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Abstract

This study assessed the quality of post-take ward round (PTWR) documentation, specifically looking at twelve criteria, in the medical assessment unit (MAU) prior to, 3-months and 2-years after introducing a PTWR proforma. 216 case records were analysed; 40 prior to, 40 three-months and 146 two-years after introducing the PTWR proforma. There was a significant improvement in eight criteria three-months after introducing the PTWR proforma. These improvements were sustained two-years later and significant improvements made in a further 3 criteria (1 at $p < 0.05$ and 2 at $p < 0.01$).

Keywords

Ward round (WR), post-take ward round (PTWR), medical admissions unit (MAU), documentation.

Introduction

Accurate documentation in case notes is an essential aspect of patient care.[1] This has become increasingly important as a result of greater shift working among NHS doctors in order to comply with the European Working time Directive.[2] Furthermore, a patient's in-hospital stay may involve several geographical moves, resulting in changes of the team(s) of doctors responsible for their care during their admission.[1] Good quality clinical records will improve the quality of handover between clinical teams.

The Royal College of Physicians recommends a consultant physician review of each newly admitted patient within 24 hours of admission.[2] This review usually occurs as part of a Post-Take Ward Round (PTWR), which represents an important step in the patient's initial management. It provides the opportunity to review initial management and results of investigations, formulate a differential diagnosis and create a detailed management plan. Accurate documentation of this is crucial, but is often delegated to a junior member of the team.

In Southampton the acute medical 'take' is split into two periods. The 'day take' between 9am and 5pm is supervised by one of the two Acute Medicine Consultants, who undertake a post take ward round at the end of this period. After 5pm the take is supervised (usually from home) by one of a number of consultants accredited in G(I)M, who undertake a ward round at 8am the following morning. Documentation on the evening PTWR is usually undertaken by the Foundation Year 1 doctor (F1) or Senior House Officer who has reviewed the patients earlier in the day. Two teams of junior doctors join the morning PTWR: those who have been on-call from 5pm-10pm the previous evening and those who have done the night shift; documentation responsibilities are usually shared depending on which doctor saw the patient at the time of admission.

Aims

- To assess quality of documentation before and after the introduction of a post-take ward round proforma.
- To determine whether improvements could be sustained over a 3 year period.
- To compare quality of documentation on morning and evening ward rounds to determine factors which may influence this.

Method

Audit Cycle 1

Review of Practice: Notes of 40 consecutive patients admitted to the Medical Admissions Unit (MAU) of Southampton University Hospitals NHS Trust were examined. A series of standards were agreed by the acute medical team **(see Table 1)**. The record of the post take ward round, documented in these notes was compared to these standards.

Implementation of change: Following the initial review of practice, a new proforma was introduced. This comprised a 5 page 'fold-out' booklet. The 'clerking' is written on the front and internal pages, in which the initial impression and management of the patient prior to consultant review is documented. The final page comprises a full sheet for documentation of post take ward round findings **(Figure 1)**.

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Criterion	Standard	Exceptions / Notes
Date of ward round documented	100%	
Time of ward round documented	100%	
Name of Consultant	100%	
ECG findings documented	80%	Assumes that ECG is not required in approximately 20% of admissions
CXR Findings documented	80%	Assumes CXR not required in approximately 20% of admissions. If result not available at time of ward round – should be documented 'not available'
Diagnosis / Differential	100%	
Management Plan	100%	
Estimated LOS documented	100%	
Proposed localisation area documented	100%	
Entry Signed	100%	

Table 1. Audit Standards for Post Take Ward Round

Re-assessment of practice: Three months after introduction of the new proforma, notes of a further 40 consecutive patients, admitted to the MAU, were examined, using the same criteria.

Differences in findings were compared using two-tailed statistical analysis (Microsoft Excel software).

Audit Cycle 2

Following the initial audit further changes in practice were undertaken. A teaching session on the importance of accurate documentation in patients' notes was introduced into the Acute Medicine teaching programme for Foundation Year doctors, and regular re-enforcement of this was undertaken for doctors attached to the MAU. The same criteria were used two years later to analyse the notes of a random selection of 146 patients admitted over a 4 week period. The notes were divided into two groups: those who had been seen as part of the morning PTWR by one of the general medical consultants ('Gen Med') and those who had been seen on the evening PTWR, by one of the Acute medical consultants ('Acute Med'). Results for the whole group were compared to the original and re-audit figures and comparisons made between the two groups using the statistical package described above.

Results

Results are shown in **Table 2**. Significant improvements in almost all categories of documentation were noted during the initial audit cycle. However, very few criteria met the desired 100% standard either before or after introduction of the new paperwork. Documentation of Differential Diagnosis did not significantly improve, although management plan was reasonably well documented prior to introduction of the proforma. Most dramatic improvements were noted in the documentation of ECG and Chest X-ray findings, as well

CRITERIA	COMPLIANCE							
	Baseline							
	(n=40) (%)	3 Months (n=40; %)	P-value	2 Years Total	P-value (n=146; %)	Gen Med (n=91; %)	Ac Med (n=55; %)	P-value
Cons Name	45	67.5	0.042	97.26	0.001	95.60	100.00	0.114
Date	45	67.5	0.042	93.84	0.001	91.21	98.18	0.089
Time	45	67.5	0.042	72.60	0.001	70.33	76.36	0.429
ECG	5	20	0.042	42.47	0.001	36.26	52.73	0.051
CXR	12.5	40	0.005	61.64	0.001	61.54	61.82	0.976
DDX	65	67.5	0.82	94.52	0.001	91.21	100.00	0.024
Plan	85	92.5	0.289	97.26	0.002	95.60	100.00	0.114
ESTAY	7.5	45	0.001	51.37	0.001	38.46	72.73	0.001
PROLOCA	12.5	45	0.001	24.66	0.101	13.19	43.64	0.001
Name	65	100	0.001	90.41	0.001	89.01	92.73	0.459
Bleep	35	40	0.646	83.56	0.001	80.22	89.09	0.162
Sign	95	100	0.153	86.30	0.133	89.01	81.82	0.222

Table 2. Percentage Documentation of PTWR details before and after the introduction of a PTWR proforma.

Key: Con WR = consultant ward round; Cons Name = consultant's name; DDX = differential diagnosis; ESTAY = estimated length of stay; PROLOCA = proposed ward of localisation

Post-Take Consultant Ward Round

Consultant: **Date:** **Time:**

Review of History Examination

ECG Findings:

CXR Findings:

Urinalysis:

Results Of Relevant Investigations:

Mews Score:

Provisional Diagnosis / Differential / Problem List

1 .....

2 ....

3 ....

4 ....

Plan:

1 ....

2 ....

3 ....

4 ....

5 ....

Expected length of stay: <24hrs 24-48hrs <1 week >1 week

Proposed Localisational: Home; AMU; Resp; GI / Renal; Endocrine, E/C; Stroke; CCU;

Any Other .....

Suitable for Community Rapid Response Service? Yes / No

Signed .....Name . . . . . Bleep (not on-call bleep).....

Figure 1. Post Take Ward Round Proforma

as the names of those carrying out the rounds, dates and times. It was not possible to determine whether results of these were available at the time of the ward round in all cases from review of the notes.

On re-audit there had been further improvements, particularly in the documentation of accurate differential diagnosis. Documentation of length of stay (LOS) and proposed speciality area for localisation on transfer from the MAU remained disappointing, although these were significantly better following the evening 'acute medicine' consultant ward rounds.

Discussion

The consultant PTWR represents an important milestone in a patient's care following emergency admission to hospital. Introduction of a proforma appeared to result in significant improvements in the quality of many aspects of documentation at the time of the PTWR. These improvements were sustained, and in many cases increased, following re-enforcement over the next 2 years. When implementing changes to improve compliance with any method of practice, multiple active strategies are better than passive dissemination of guidelines alone.[3]

Patients' admission documents are clearly identifiable in their notes, and the position of the PTWR record on the reverse of this document makes it easy to find. Personal experience of the authors and discussions with colleagues indicate that this is regularly used as a point of reference for clinicians when reviewing patients later in their hospital stay or on subsequent admissions. This may have contributed to the improvements in practice over the two years following introduction of the proforma - appreciation of the value of the documentation by junior medical staff in the ongoing care of their patients may make them more likely to ensure adequate completion.

Documentation of Chest X-ray and ECG findings as part of the PTWR ensures that interpretation of these can clearly be attributable to the consultant undertaking the round. Chest X-ray and ECG findings were very poorly documented before changes of the paperwork with results only being found in 12% and 5% of PTWR notes respectively. Although these figures improved to 40% and 20% respectively after changing the paperwork, with a further improvement to 62% and 42% on re-audit this remains disappointing. In many cases the results may have been documented elsewhere in the patient's clerking record; however failure to document this in the PTWR note could be taken to imply that the consultant did not see these if medico-legally challenged. It is possible that the results of CXR were unavailable in many cases; the investigation is sometimes delayed for several hours after a patient arrives in hospital. It was not possible to confirm this from reading the notes; we now encourage junior doctors to document 'not available' in the appropriate box if a test result is not available at the time of consultant review.

With regards to the differential level of documentation on acute and general medicine consultant led PTWRs, except for the signature of the junior doctor, the proportion of documentation was better on all criteria on acute medicine consultant led PTWRs. However, the differences were statistically significant for only three criteria: differential diagnoses ($p < 0.05$), estimated length of stay and proposed localisation ward ($p < 0.01$).

Conclusion

This study has shown the influence of audit in improving practice. We believe these changes are more likely to be sustained and further improved by continuing increased awareness of the importance of adequate completion of the of PTWR proforma. It is crucial that the importance of accurate and complete documentation of ward round notes is adequately taught at an early stage, and re-enforced throughout junior doctor training.

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