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QUALITY IMPROVEMENT PROJECT TO IMPROVE ACUTE MEDICAL UNIT'S WARD ROUND ENTRIES AS PER GENERIC MEDICAL RECORD KEEPING STANDARDS SET BY ROYAL COLLEGE OF PHYSICIANS AT A DISTRICT GENERAL HOSPITAL

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Abstract:
Background and reason for the project: *It was brought to attention by the ward matron of the Hospital's AMU that a lot of junior doctors and physician associates were not making ward round entries as per the standards, causing patient safety issues. For instance, not putting patient's full name and ID on all the pages of notes or not documenting the time entry etc. According to RCP approved 'Generic Medical Record Keeping Standards'; every page in the medical record keeping should include patient's name, identification number and location in the hospital. Every entry in the medical records should be dated, timed and signed by the person making the entry along with their name and designation. Every entry in medical record keeping should identify the most senior healthcare professional present [who is responsible for decision making] at the time entry is made. In addition to that, the consultant responsible for patient's care should also be mentioned with each entry.*
This project will looked at if these guidelines are being followed in our AMU ward rounds.

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INTRODUCTION:

Medication errors occur at any point of the medication management process involving prescribing, transcribing, dispensing, administering and monitoring, [1] have been reported to account for approximately one-quarter of all healthcare errors.3 Medication errors are a major cause of death and harm globally [2]. According to the World Health Organisation [WHO], medication errors cost an estimated US$42 billion annually worldwide, which is 0.7% of the total global health expenditure. Systematic reviews examining interventions aimed at reducing errors have largely focused on specialty settings, such as patients situated in adult and paediatric intensive care units, emergency departments, and neonatal intensive care and paediatric units.6–10 Previous relevant systematic reviews relating to testing interventions for reducing medication errors in general hospital settings have focused on administration errors only, [3] have involved adult and paediatric settings or have tested interventions in specialty and general hospital settings with no differentiation in results [4]. This project aims to compare the effectiveness of different interventions in improving the documentation during ward rounds and in turn reducing prescribing, dispensing and administration medication errors in acute medical settings. Information obtained from this review can inform clinicians and policymakers about the types of interventions that have been shown to be effective, which can guide the development of comprehensive guidelines for clinical practice and policy directives.

Project aims:

The goal of this project is to improve documentation of ward rounds as per RCP guidelines and to investigate ways of making improvements where needed that will overall improve patient safety.

Project objectives [SMART – Specific, Measurable, Achievable, Realistic and Timely]:

This project looked into around 50 ward round entries per cycle. Data was collected on yes/no basis if the various parameters of Generic Medical Record Keeping Standards are being adhered to. After the data set is collected, it was analysed, and appropriate interventions/actions made/proposed as needed to improve ward round entries as mentioned above. The aim is to at least do 2-3 PDSA cycle.

Sample Type: Retrospective Data Collection

First cycle – 49 samples, data collected against 11 standards
Overall compliance – 55%

Fist Intervention: Discussed the data and RCP standards on induction to new doctors – explained RCP guidelines and AMU sheets and the current compliance and the repercussions of poor adherence

2nd audit - data set collected and analyzed – 50 samples
Overall compliance improved – 68%

2nd cycle intervention – 2 interventions tested together – first an email reminder sent to all junior doctors and then 3 weeks later modified sheets introduced [discussed using Pt Name and ID stickers-not possible due to wastage and small machine not available for smaller no. stickers]

3rd data set collected- [noted that right after email the outcome was very favorable and as the days passed the compliance decreased, the sheets introduced prompts to help improve compliance] – overall compliance rate improved to 85% -Noted that very often, new staff including locums join AMU hence the 3rd intervention tested as below

3rd intervention – posters [for newcomers/locums/new students] and email to all the juniors with a promise of prize

4th data set collected [around 71 samples] and then – posters helped the newcomers – found that overall documentation of newcomers improved compared to previous data, the 4th sample size was the largest i.e., 71 samples collected – Overall compliance improved to 88%

Final Conclusions and Comparisons:

- First Cycle Overall Compliance: 55%
- Second Cycle Overall Compliance: 68% [after 1st Intervention in AMU Induction]
- Third Cycle Overall Compliance: 85% [after 2nd Intervention of Email reminder and new sheet]
- Fourth Cycle Overall Compliance: 88% [after 3rd Intervention of poster and promise of reward]

Best improvement noticed with email reminder followed by verbal emphasis during Induction meeting.

Predictions and aims of the projects were to achieve improvement in compliance to 100%

Final suggestions and Future Plan:

- To keep the posters and the new sheets.

- To send monthly email reminders to all the junior staff.
- When new juniors join for their AMU rotation, to mention the significance of RCP generic record keeping standards in the induction Session
- To audit and re-design the Friday ward round sheets
- Future Audit to achieve 100% compliance

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