

CLINICAL GOVERNANCE

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Bulletin

Editorial: Patient experience

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Improving the quality of care and the patient experience of that care is an important aim of the NHS. Over the last few years a lot of attention has been given to ways of involving patients, their carers and the public in shaping their local health service and monitoring the quality of the care delivered.

In this issue we have asked the NHS Modernisation Agency's Clinical Director for Patient Experience in Emergency Care to give an

overview of what has been happening nationally in emergency care; this is followed by a number of practical examples of what has been happening on the ground.

In future issues we would like to address appraisal and lifelong learning, as well as continuing to cover the many other aspects of clinical governance. We look forward to receiving your contributions so that the lessons you have learnt can be shared with colleagues in the NHS.

Patient experience in emergency care – the national picture

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Improving people's experience of emergency care is a priority for government because it is a priority for patients. Accident and emergency (A&E) care, in particular, is one of the biggest 'shop windows' that the NHS has. It is seen – rightly – by both patients and the wider public as a barometer for the state of the whole health-care system.

In September 2003 I was asked to become the first national Clinical Director for Patient Experience in Emergency Care, charged with leading a programme of work focused

on patients' needs and producing tangible improvements in their experience and satisfaction. Other articles in this issue focus on some of the excellent, nurse-led work being done locally across the country. I want to set that work supported through practical steps being taken at a national level.

Background

The first national survey of A&E patients by the Commission for Health Improvement (CHI, now the

In this issue

- 1 Editorial: Patient experience
- 1 Patient experience in emergency care – the national picture
- 3 Improving patients' experience of critical care by acting on narratives
- 4 South Yorkshire paramedic practitioner scheme for older people
- 5 Right care, right time, right place: the role of minor injury units, nurse practitioners and guidelines in providing a patient-centred service
- 7 Emergency access – a project to meet the four-hour target for accident and emergency departments
- 9 The Access Team
- 11 Quality of medical record documentation in urology emergency admissions



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Healthcare Commission), published in July 2003, gives us the baseline¹. Nationally, 85% of respondents rated their overall care in A&E as good, very good or excellent – the lowest rating of the four surveys published in 2003. The second survey is due to be carried out before the end of 2004.

The CHI survey showed a correlation between the length of time patients spent in A&E and their rating of their overall care. At the time of the survey, 78% of patients were in A&E for less than four hours in total; currently that figure is about 95%.

Communications

Rather than simply apply the more general principles of improving patient experience to the particular environment of A&E, the Department of Health's first step was to ask focus groups of patients what they thought needed to improve most. They indicated that the most important need was to reduce waiting time. This was followed by:

- better information
- staff who are polite, friendly and helpful
- a cleaner and more pleasant environment
- better facilities for children.

Then A&E staff – clinical and non-clinical – were asked, again through focus groups, what messages concerning patient experience would be most likely to reach and influence their colleagues. They told us that some key groups of staff (including ancillary workers but also to some extent nurses) were unlikely to receive web-based or email messages. As a result, an information leaflet

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was produced that gave examples of good practice and that highlighted the potential benefits of an improved environment to staff as well as patients. The leaflet was distributed to all English A&E departments in August 2003. The British Association for Accident and Emergency Medicine (BAEM) and the Royal College of Nursing (RCN) were consulted on the content and responded positively.

Our other products have included a multilingual phrasebook for A&E staff, to help them to communicate with patients whose first language is not English. This was developed in consultation with the British Red Cross, the BAEM and RCN and it was distributed to all A&E departments in February 2004. It attracted positive comments from across the world. The Department of Health has also produced a patient information 'toolkit' aimed at NHS communications staff. This offers practical support and guidance on keeping emergency care patients informed. It was endorsed by the Patients Association and published online in May 2004².

Patient Environment Action Team

In 2003 the Department also extended the inspections by the Patient Environment Action Team (PEAT) to A&E. These feed directly into trusts' star ratings. The 2004 results are still being analysed but it is likely they will show that A&E departments are now rated as equal to, or slightly ahead of, other wards and waiting areas in most of the categories that match A&E patients' concerns (listed above).

Patient Experience Fund

In August 2003 all modern matrons in A&E were offered a share of a £2 million Patient Experience Fund. Each matron was entitled to claim £10,000 to spend on the key areas of experience identified by patients. Matrons have used the money pragmatically and imaginatively. Two examples are given below:

- In Southport and Formby, the modern matron looked at her patient survey results and decided to introduce pagers for patients so that they could leave the department while they waited for blood

test results, for instance. This is not only better for the patient, but also helps to ease congestion in the waiting area.

- In North Cumbria, the matrons looked at their PEAT report and organised the provision of air-conditioning units, special chairs for elderly and disabled patients, television and video and an improved, separate paediatric area.

Modern matrons

Underpinning all this work has been a network of enthusiastic and committed modern matrons and other senior nurses, including those who submitted articles included in this issue. Successful national 'summit meetings' in February and June 2004 have helped to build a consensus around what needs to be done and I hope to build on those with more local events in the future.

Conclusion

The results of the next Healthcare Commission A&E patient survey should be available at about the same time as the NHS reaches the four-hour total time target for A&E set out in the NHS Plan³. Whatever the results of the survey, it is inevitable that at least some of the attention now devoted to bringing down total time will, from 2005, begin to switch to wider issues arising from patient experiences. I am confident that we are now in a better position than ever before to build on what has been achieved and turn emergency care in England into a truly world-class service.

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- 2 NHS. *Providing Patients with Better Information in Emergency Departments – Toolkit*. London: Department of Health, 2004. Available at www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4081347&chk=fid/Sif
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Improving patients' experience of critical care by acting on narratives

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- The 'discovery interview' is a technique which gives insight into patients' thinking and feedback on their care.
- Patients' narratives generate ideas and motivation for local changes in service delivery.
- Improvements meet the personal needs of patients and their carers and are often simple to achieve.
- Ethical approval is required to interview patients if non-clinical information is being sought.
- Interviewers must be trained to allow spontaneity in the narratives.

Robert Burns' phrase 'To see ourselves as others see us' neatly encapsulates the thinking behind the way in which some critical care units have been using patients' insights in the ongoing quest to improve health services. While the more personal needs of patients are often obscured by the imperative to manage underlying pathology, an awareness of them can improve patients' experiences of care.

The discovery interview

Clinical staff have been using 'discovery interviews'¹ to understand better what it is like to be a person going through the health-care system. After giving consent, patients and carers are interviewed and encouraged to give a narrative guided by the chronological sequence of their experiences. Most of these interviews have been carried out in patients' and carers' own homes, although this is optional. The interviews are taped and transcribed; the anonymity of the interviewees is preserved. The transcript is then shared with the clinical teams who had direct contact with the patient. The aim is to identify the underlying needs of patients and carers and to meet those needs by making improvements to the service.

The narratives are not simple 'stories' – their detail and emotional content often surprises listeners. One of the most notable results is a clearer insight into a patient's thinking. This

is because the narrative is presented to staff directly, without any intervening analysis, which makes the whole sequence of events more relevant to them than any clinical paper. This direct relation to the local context has helped staff to manage patients in more thoughtful ways. While the improvements that are generated may be non-clinical, small in scope or lack transferability to other locations, they do show the ability of clinical staff to respond to patients' needs.

Some examples

For example, waking from sedation can be a disturbing experience. One patient's narrative showed a clear need for orientation in time, so clocks were placed where they could be seen more readily.

In another unit, a patient was disturbed because she could not understand why the nurses treating her seemed so short in stature. The reason, and the solution, was immediately obvious to the clinical staff: the beds had been elevated so much as to make the patient think that the nurses were short. The staff realised this immediately and ensured less bed elevation, so that the correct impression of height was given.

While the problem of nocturnal noise on critical care units has been noted in the literature, it required one patient's experience for another unit to pay attention to preventing excessive noise and to provide patients with earplugs at night.

Patients' experiences outside the critical care area have also been fed back to the relevant staff. One patient's narrative highlighted aspects of privacy for young adults after their stay in critical care and is being used to improve services for adolescents across the whole of that hospital.

In another hospital, relatives were concerned about the lack of availability of ward staff during visiting hours. This was raised with the hospital's modern matrons' group, which is taking action.

As well as drawing attention to areas that need to be improved, the narratives generated by discovery interviews provide positive feedback on good clinical care. During one admission, a carer expressed a wish to stay with the patient while invasive procedures were being performed, such as central venous line insertion. Later, during the interview, he said that being with the patient at that time had meant a great deal to him.

Conclusion

The discovery interview is a technique which allows patients and carers to feed back their experiences to clinical staff. Not only are ideas for improvement generated, but also staff are motivated to make changes as a result of the narratives. However, the processes around the interview are not simple:

- interviewing has to be performed with the approval of the ethics committee, because it involves questioning beyond that required in a clinical encounter;
- arrangements must be in place to cope with a patient who becomes distressed during the interview;
- interviewers should be trained to allow as much spontaneity in the narrative as possible.

For further information look at the website of the Critical Care Programme² and that of the Coronary Heart Disease Programme³, which contains more examples of the discovery interview work, with supporting documentation and presentations.

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- 2 www.modern.nhs.uk/criticalcare
- 3 www.modern.nhs.uk/scripts/default.asp?site_id=23&id=4668

South Yorkshire paramedic practitioner scheme for older people

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- The paramedic practitioner scheme for older people can be successfully used to treat older people with minor acute conditions – such as minor injuries (wounds, burns, musculoskeletal injury, head injury) and minor illness (falls, blackouts, epistaxis) – in the community, with initial assessment within the patient's home or care home.
- The development of such a scheme requires a collaborative approach between the ambulance service, the hospital departments, the primary care trust and social services.
- Regular monitoring through audit is necessary to ensure that problems are identified and solutions found.
- The paramedic practitioner scheme for older people could be developed to include emergency admission avoidance work.

Background

An increasing number of older people require unscheduled care and many of these emergencies will be due to minor injuries or falls. The usual response from the ambulance service of transporting such patients to a busy accident and emergency (A&E) department may not be the best way of managing these individuals.

The paramedic practitioner scheme for older people was developed to address some of the acute, unscheduled health-care needs of the elderly population within Sheffield, in recognition of the fact that older people in the city trying to access acute health-care services were disadvantaged. This was mainly because:

- following minor acute events, they often have to call 999 for assistance to transport them to the local A&E department;
- once in the department, their health-care needs may not be adequately addressed, as they may go beyond those of the acute physical

problem that brought them to the department (e.g. social problems);

- the time spent within the department (being assessed and treated) and being transported home is often excessive.

Older patients can feel very disorientated by these experiences, and this may limit the ability of A&E staff to return them into their own environment.

The paramedic practitioner scheme was set up through collaboration between the South Yorkshire Ambulance Service, the A&E Department and the Department of Care of the Elderly at the Northern General Hospital, the Community Social Services Team and the South Yorkshire Workforce Confederation. Within the scheme, paramedics have been trained to provide an acute service in the community for older people with minor acute problems.

Review of one year of A&E attendances from the hospital database identified older patients attending A&E who would be eligible for assessment within the community by the paramedic practitioner. It was estimated that around 6000 patients per year attending the department would be eligible for assessment within their place of residence. At the time of setting up the scheme, it was anticipated that between 25% and 50% of patients eligible to receive this service would be assessed and treated within the home, thus avoiding the need to move these patients to the A&E department.

Objectives

The objectives of the scheme were:

- to provide a community-based clinical assessment for patients aged over 60 years with minor injuries and falls;
- to improve the experience of older people with minor injuries and falls;

- to reduce the numbers of older people attending A&E;
- to improve the waiting and total times for older people who do require an A&E attendance.

Training

Seven paramedic practitioners within Sheffield have been trained to assess the following:

- minor injury, including head injury, to emergency nurse practitioner level, excluding interpretation of radiographs but including the indications for a radiograph and requesting one;
- mental function (abbreviated mental test score);
- the older patient who has had a fall.

In addition, they were trained to treat minor injuries, again to emergency nurse practitioner level. This includes the treatment of minor wounds, wound infections, soft-tissue injuries and the requesting of radiographs where appropriate. Finally, they were also trained to assess older patients' requirements for social care.

The service

The service is available between 08.00 and 20.00 each day and is activated by a 999 call. The following criteria determine whether a paramedic practitioner responds:

- the patient is over 60 years of age;
- the patient is within Sheffield, as defined by certain post codes;
- the call does not fit into 'category A';
- the patient has a problem that is likely to fall within the criteria for practitioner care (this is ascertained through the ambulance service priority coding system).

In addition, other ambulance crews are able to activate a practitioner response.

Evaluation

Evaluation of paramedic practitioner clinical competency has been undertaken using an objective structured clinical examination (OSCE). This has shown them to be equivalent in their level of knowledge and skill to an experienced emergency nurse practitioner.

Regular audit of the scheme by emergency medicine specialists ensures adverse events are detected early and dealt with.

The service is undergoing formal evaluation through a randomised controlled trial, which started in September 2003 and which was due to be concluded by the end of October 2004. This compared patient satisfaction, clinical outcome and the cost-effectiveness of the new service with standard practice (i.e. transferring patients directly to the A&E department).

An evaluation of the first nine months of the service showed that the practitioners saw 1160 older patients (equivalent to 4.5 patient contacts per shift) and that 53% of

these patients did not require referral to A&E.

The 53% of the patients who were not transferred to A&E comprised the following three groups:

- 22% were left at home with no further treatment needed;
- 23% had a community referral to their GP or district nurse, or were reviewed by the paramedic practitioner;
- a further 8% were referred to the community integrated care scheme, which includes social services.

Only two significant problems were detected, and no patient suffered an adverse outcome.

Conclusions

The scheme has shown that it is possible to run a service that provides a viable alternative to the traditional 999 response. The paramedic practitioners already had the skills needed for an emergency response (driving, knowledge of areas, handling com-

munications, working as sole operator in the community and critical skills in evaluating patients quickly). By adding to these skills we have been able to provide a service to a vulnerable group who it was thought would experience maximum benefit. There has been a great deal of praise for the scheme from both patients and the agencies that receive referrals from the paramedic practitioners.

There have been two problem areas. First, the ambulance prioritisation system (the computerised Advanced Medical Priority Despatch System) and strict response times required of the ambulance service make alternative response systems difficult to activate. Second, there have been problems with the rapid and accurate identification of suitable patients for the practitioners to assess and treat.

Discussions are currently underway with local primary care trusts to continue and even expand the scheme as part of the emergency admissions avoidance work in Sheffield, alongside the introduction of emergency care practitioners.

Right care, right time, right place: the role of minor injury units, nurse practitioners and guidelines in providing a patient-centred service

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- A minor injury unit can offer a high standard of care as well as safe maintenance of a patient's condition until transfer to a specific team within a district general hospital (if necessary).
- Policies and procedures, the setting of realistic goals and objectives, the use of performance indicators, risk management and the successful management of the change process are needed to offer a high standard of care to local people.
- Working with all relevant stakeholders within a health economy is crucial to the development of minor injury services.
- A positive organisational culture can help create an environment in which staff feel supported to

improve and maintain efficient high-quality health-care. It also assists the primary care trust in the recruitment and retention of experienced and talented staff.

- A high level of patient involvement is necessary in the development of services, in order to achieve a very low level of dissatisfaction from patients and the health community.
- Support from the emergency department can be provided via telemedicine.

Background

During the late 1980s many minor injury units (MIUs) were lost, owing to centralisation of services. In recent

years, however, there have been moves to increase their number, as they are now considered to be of significant public benefit.

Minor injury units differ widely in terms of facilities, staffing and the range of unscheduled treatments they can safely carry out. They do not have the full facilities and support services of emergency departments (EDs).

In the last five years the NHS Plan¹, the Department of Health's 10-year emergency care modernisation programme², the recommendations made by the British Association for Accident and Emergency Medicine (BAEM)³, the Emergency Services Collaborative⁴ and, in particular, the need to reduce ED waiting times

have all had a major impact on the services provided within MIUs.

Mendip Primary Care Trust (PCT) is in a rural area and has an MIU located in each of the three community hospitals. Full emergency care is provided by three district general hospitals at some distance and patients have to travel an average of 20 miles to the nearest one. The MIUs in Mendip deal with an average of 23,000 category C patients (i.e. ambulance-borne patients who do not require full resuscitation facilities and who can be managed within an MIU) each year and provide a GP/nurse-led fracture clinic to approximately 6000 patients each year.

The PCT is committed to delivering quality services to the local community. This vision – alongside the requirement to achieve government targets, the commitment, passion and drive of staff within the trust, and the needs and views of the people of Mendip (gathered from patient surveys) – led to the decision to implement the BAEM recommendations. These provide a framework for the trust to examine risks to services and patient care within the MIU setting and to develop strategies for reducing or eliminating those risks.

BAEM principles and the Mendip response

A series of principles has been set out by the BAEM concerning the operation of MIUs³, and these have been met by Mendip PCT in the following ways.

Ambulance transfer

Minor injury units may receive patients brought in by ambulance with local agreement and within strict criteria, but should not receive those who require 'blue light' transfer, who may have need of full resuscitation facilities. An ambulance protocol has been developed in conjunction with the local ambulance service, the MIUs, the PCT clinical governance team and the EDs. Regular meetings were held between MIU and ambulance staff to highlight concerns or developments in practice or service delivery. The PCT has been involved in training emergency paramedic practitioner students. There has been audit tracking of patients brought in by ambulance to ensure appropriate and safe patient transfer to either an

MIU or the district general hospital, measured against patient outcomes.

Staffing

Mendip PCT is committed to ensuring that there is a nurse practitioner on duty for each shift. At present, there are 17 staff either undertaking or who have completed a BSc in autonomous practice. Those nurses who do not wish to study at degree level are able to undertake core modules in minor injury, minor ailment and paediatric care. All staff must complete a skills competency framework.

The BAEM recommends that MIU staff should rotate to an ED at agreed intervals. This has proved difficult to achieve. Although it does happen, it is on an ad hoc basis rather than at agreed intervals, mainly due to staffing constraints and vacancies. There is, however, a nurse practitioner network and an Emergency Services Collaborative, which involves representatives from four PCTs and the relevant district general hospital meeting regularly to develop practice and services for the local health community in a partnership approach. As the Collaborative comes to an end, it is hoped to continue with this group in some form.

Links to the ED

Minor injury units should have close links with their nearest ED and clear protocols in place specifying which patients can be treated in the unit and which patients require transfer to an ED. In Mendip, telemedicine links allow MIU staff to send images (e.g. radiographs) to the ED consultant or to operate a three-way consultation with the ED, MIU and patient to discuss treatment, transfer or follow-up.

Critical care

There must be immediate recognition and safe transfer of seriously ill patients, adequate staff training, and equipment to treat potential complications of routine care. All MIUs have standardised resuscitation equipment and all staff undertake mandatory annual advanced life support and paediatric life support training.

Care protocols

Clear, specific protocols outlining the treatment of patients in MIUs before transfer to a district general hospital

are held in each department and are reviewed with staff and the clinical governance team as appropriate.

Nurse practitioner protocols have been designed with the MIUs in Mendip and the surrounding PCTs and EDs, to ensure all emergency nurse practitioners are working to the same standards. Nurse practitioners also have direct referral rights to specific teams within the district general hospital.

Nurses who request and interpret radiographs work according to the main X-ray department's protocols. Each nurse, as part of professional development and to ensure best practice, audits the radiograph requests and interpretations against the radiologists' reports. In addition, the clinical governance team carries out regular audits of all nurse-requested radiographs.

Drugs for all types of treatment are administered under directions that are regularly updated via a trust-wide multi-professional group.

Documentation

Documentation within Mendip is partly computerised and is currently under review. The MIU staff and the clinical governance team have designed the MIU record of care to ensure full clinical records are kept for both adults and children. Copies are forwarded with all transferred patients, or to the GP and health visitor, as appropriate. All documentation is regularly audited and each MIU is involved in peer review of this documentation to ensure best practice is developed. Other local PCTs have adopted the MIU-specific documentation developed by nurses in Mendip.

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- 3 British Association of Accident and Emergency Medicine Clinical Service Committee. *Minor Injury Units*. London: BAEM, 2000. Available at www.baem.org.uk/miu.htm
- 4 Emergency Services Collaborative. See www.modern.nhs.uk/scripts/default.asp?site_id=35

Emergency access – a project to meet the four-hour target for accident and emergency departments

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- We wished to achieve the target set out in the NHS Plan to have a maximum visit duration of four hours for patients attending an accident and emergency (A&E) department but a review showed that our systems and practices did not have the capability to do so.
- An analysis of performance revealed the principal reasons for delays, and an action plan was drawn up.
- There were four key elements of the plan: an emergency clinical decision unit (ECDU) was introduced; emergency medical admissions from GPs were no longer routed via A&E but were instead directed to an emergency medical assessment unit (EMAU); emergency acute medical clinics were established for the follow-up of patients; and the general processes of accident and emergency care were improved.
- Improvements in access and the quality of emergency care can be achieved only if all elements of secondary care work closely together and include primary care, to generate local solutions.

Origins and objectives of the project

Our key objective was to achieve the target set out in the NHS Plan¹ to have a maximum visit duration of four hours for patients attending an accident and emergency (A&E) department, by implementing a robust system that could produce and reproduce a 100% performance. On 23 January 2004, the Department of Health announced a package of incentives aimed at encouraging this target to be met.

For the Salford Hospitals NHS Trust, baseline data collected from previous 'sitreps' (situation reports) were analysed with the help of information analysts at the Emergency Services Collaborative (these reports are weekly submissions on

performance data to the Strategic Health Authority). This review showed that our systems and practices did not have the capability to meet the March 2004 94% target within the A&E incentive scheme; it also indicated significant risk of not meeting the existing 90% benchmark.

A multidisciplinary multi-agency project team was set up to look at performance and to identify measures for improvement. The group included representatives from the local primary care trust (PCT) as well as the staff of the Salford Royal Hospitals NHS Trust.

Our analysis of performance showed that delays arose principally for the following reasons:

- there were no medical beds available to which to move patients from A&E;
- surgical staff were not immediately available to attend A&E to see referred patients;
- there were no beds available for medical patients arriving in A&E after referral by a GP.

As a consequence of these delays, some A&E patients with minor complaints were in turn more delayed as a result of the overstretching of the resources in A&E.

Our project was started in order for us to improve the patient experience and to achieve the targets by following a specific action plan.

The action plan

The following strategies were employed in order to reach the target for waiting times and to improve the quality of care for patients presenting at A&E:

- An emergency clinical decision unit was introduced. This is a 15-bed/10-seat assessment area, which takes GPs' directly referred surgical patients and A&E observation patients. It has an average length of stay of 6 hours and a maximum length of stay of 24 hours. Access is under the clinical leadership of A&E.

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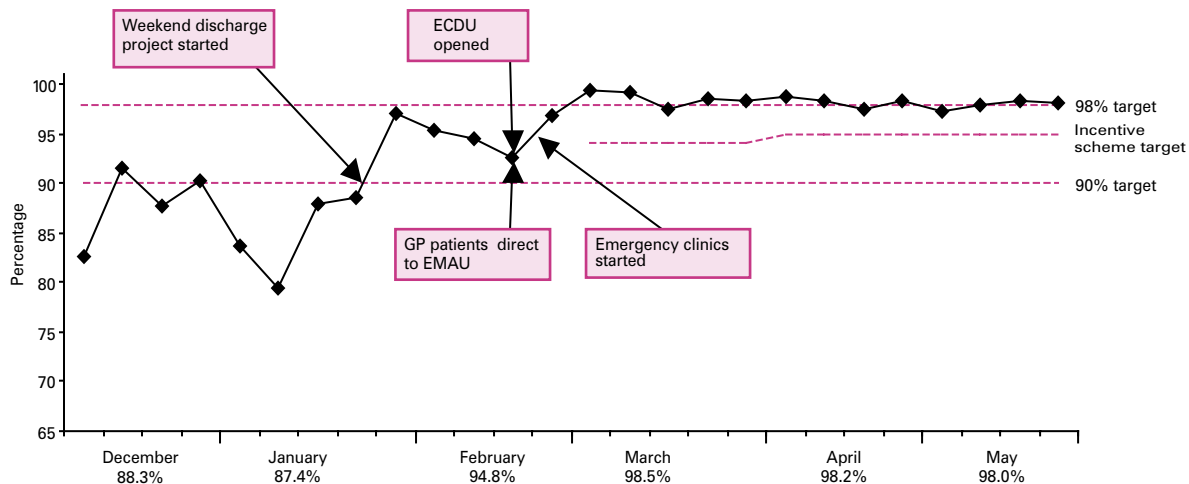


Figure 1. Percentage of patients admitted to the accident and emergency department who were treated within the four-year target set out in the NHS Plan. Also indicated are the 90% and 98% targets and the target set by the Department of Health's incentive scheme. ECDU, emergency clinical decision unit; EMAU, emergency medical assessment unit.

- Emergency medical admissions from GPs were no longer routed via A&E but were instead directed to an emergency medical assessment unit (EMAU). The EMAU now has a seated waiting area for GP referrals and an assessment bed and trolley. Patients are seen here before a decision is made on whether or not to admit.
- Emergency acute medical clinics were established, three times a week (sufficient to see 18 patients). EMAU consultants now have these clinics to which to refer patients for follow-up, rather than having to admit them to an inpatient bed. In addition, for medical emergency patients, a weekend discharge project was introduced, where suitable patients were reviewed and appropriate discharge facilitated on Saturdays and Sundays.
- The processes of A&E have been improved. For example, modifications have been made to triage, and plans have been made to put into A&E a GP out-of-hours service and a walk-in facility with extended pharmacy services.

Project management

Estimates were made of the improvements in performance expected from each point of the action plan. The analysis and the action plan were taken to the Trust's Operations Board and to a joint forum with the PCT-Patient Access Group to get agreement and support.

Implementation and monitoring of the plan were carried out through

weekly multidisciplinary meetings using a traffic light scoring system, which was also used for submission to the Strategic Health Authority (SHA) to report our progress against the benchmarks set out in the incentive scheme. There has been excellent teamwork from the nursing, medical, managerial and clerical staff in making these changes work in a short period of time.

The system has also been tested during a period of high bed pressure, when there were sudden large increases in demand for medical beds in Salford. Our service coped well

with this, and was also able to provide support for a number of patients diverted from other trusts.

Outcomes

Alternatives to admission have been created with the introduction of emergency clinics and targeted diagnostics.

Staff, patients and relatives all provide evidence of an improved service. Satisfaction surveys from the EMAU, ECDU and the A&E department confirm this. Following the changes, no patient has been

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Length: 500–800 words plus a maximum of five references in Vancouver (numerical) style.

Illustrations: where appropriate, use tables, charts, summary boxes etc. to present information, and to break up the text.

Web links: where possible, provide web and/or email addresses for further information – e.g. Department of Health reports or circulars, publications, societies, etc.

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'bedded down' in the A&E department; these sorts of measures are essential to our continuing success. Formal review of the changes made, and the effect they have had, is still under way. Initial findings are very promising. Our improved system and processes have proved capable of routinely producing performances of 100%, and we have achieved the first milestone in performance required by the incentive scheme of an average of over 94% for the month of March 2004 (actual performance was 98.5%) (Figure 1). In the first two months of the service changes, no complaints were received; indeed, members of staff received letters of appreciation.

Sustaining performance

The main consideration now is sustaining the performance. There are three key issues:

- establishing recurrent funding
- progressing the action plan
- finding permanent accommodation for new services.

Action is being taken to address each of these key issues. In addition, further and more complete evaluation of the changes is being carried out. Data gathered after the changes are being evaluated using the NHS Modernisation Agency's methodology that was employed to analyse the baseline data. In addition, data indicating reductions in admissions from both the ECDU and emergency clinics are being collated and validated. This will be particularly helpful in achieving support for recurrent funding.

These approaches have helped to meet the target in the NHS Plan and have improved the quality of care provided.

Care has been taken to raise awareness of the project, and the work has been reported to various meetings and boards, including:

- the Patient Access Group (a joint PCT, Trust, ambulance trust and social services meeting);
- an A&E incentive scheme meeting;
- the Emergency Access Performance Group (which has representatives from across the trust);
- the Greater Manchester Emergency Services Collaborative leads;
- the Trust's Operations Board;
- the Trust Board.

Reference

- 1 NHS. *The NHS Plan. A Plan for Investment. A Plan for Reform*. London: Stationery Office, 2000. Available at www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

The Access Team

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- **The Access Team based in the Royal Devon and Exeter Hospital is an umbrella service that is tackling the problems of avoidable admissions and delayed discharge.**
- **The team works across boundaries to promote a patient-centred service that can reduce waste, delay and duplication and act as a single point of access and referral.**
- **Of the 972 patients referred to the team so far, 747 (77%) avoided admission.**

The North and East Devon health and social care community has been part of an international initiative to improve the quality of health and social care. This involves a patient-centred approach to avoiding unnecessary emergency admissions and reducing delays to discharge. The local initiative is jointly funded by organisations across the community.

The community is one of only four UK sites involved with the Pursuing Perfection programme¹ and has been

acting as a pilot to 'raise the bar' and move towards standards of care never attained before, while putting the patient at the centre of change.

The Access Team

The chief executives of all five participating organisations – one acute trust, three primary care trusts (PCTs) and social services – have signed up to the joint approach to manage avoidable admissions and delays to discharge across the whole community. The PCTs have agreed to 'own' their patients within the secondary care system.

The Access Team was the realisation of some of this work, and for the organisations represents one method that can be used to reduce the rising number of emergency admissions. The benefits are seen in the adoption of a patient-centred approach and the reaching of national targets. The team is based in the acute hospital and is an umbrella service. The

clinical members of the team are listed below; the manager is accountable to all five organisations through the Pursuing Perfection board and the team has a full support structure. The board is chaired by a PCT chief executive and has director-level representation from each organisation, which allows for rapid decision making.

The concept behind the team has been to work across both organisational and professional boundaries. The aim is to promote a patient-centred service that reduces waste, delay and duplication, and acts as a single point of access and referral for staff across all the organisations.

Avoidable admissions service

Two full-time occupational therapists (OTs) and two social service community care workers (CCWs) work with the staff of the emergency department and emergency medical unit to facilitate discharge, either

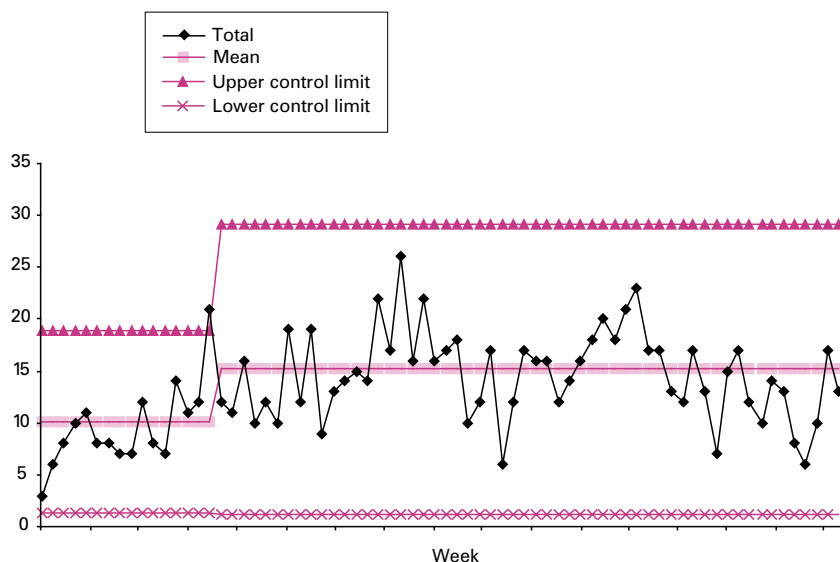


Figure 1. Numbers of referrals each week to the Access Team's avoidable admissions service, from 10 March 2003 to 24 July 2004.

home or to an appropriate primary care setting, for those patients who do not require admission to secondary care. Thus, following the necessary clinical interventions and with the support of a referral coordinator, they assess patients for either packages of care at home or, together with the PCT discharge nurses, transfer to a community hospital or intermediate care bed.

Figure 1 shows the weekly activity of the team since its start in March 2003. Some of the variation in referrals reflects the staff changes to the team in its first year and tests of change in referral procedure and staffing practices. From 2005, the team will be based in the emergency

department, which will allow for greater visibility and potentially more referrals for action or advice.

Figure 2 shows the disposal of the first 972 patients referred to the service. Of these, 747 avoided admission. A success rate of 77% represents a potential significant saving for reinvestment by the PCTs. It also lays the foundations for meeting the national agenda for chronic disease management and the changing needs of the ageing population, as laid down in the Older People's National Service Framework². More importantly, it means that these patients received their care in a more appropriate setting, without an unnecessary journey through secondary care.

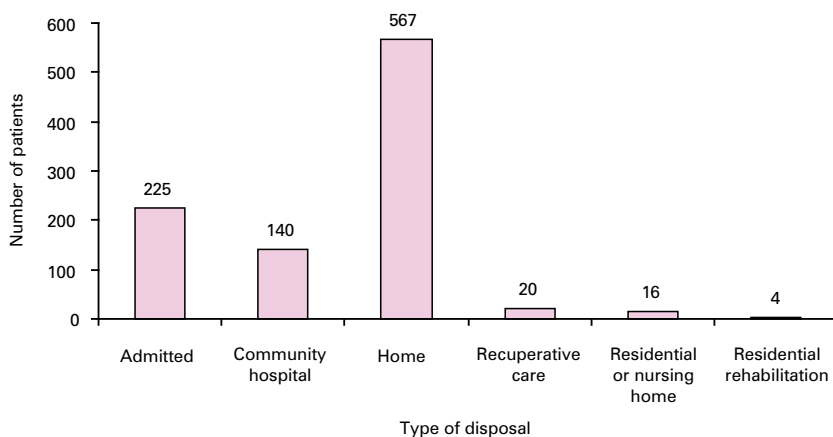


Figure 2. Disposal of the first 972 patients referred to the Access Team's avoidable admissions service.

The team is now looking at how skills can be shared across traditional professional boundaries. For example, the OTs within the service could commission care if they could make use of the relevant information technology (IT), and could enhance their assessment skills with training from the physiotherapy department.

The CCWs have made links with mental health liaison and drug and alcohol teams to ensure that the needs of the more complex patients arriving in emergency care can be met from within the service.

Delays to discharge team

Three PCT discharge nurses work within the acute trust to facilitate the discharge of patients to community hospitals or intermediate care beds. The wards in the hospital can access them through direct referral and the nurses utilise IT services to track those patients from their PCT. Adopting a 'pull' philosophy of care, they aim to deliver the right care in the right place at the right time for the patients.

They have reduced the number of patients waiting within the acute trust for a bed at a community hospital. They have also reduced the number of patients sent to inappropriate community hospitals or intermediate care beds, which could happen when secondary care moved to a 'push' model in times of high demand.

The nurses assess patients' suitability for care in the PCTs and have admitting rights to intermediate care and recuperative beds, as well as strong links to the wards in the community hospitals. As an example, with the appointment of the discharge nurse for East Devon within the hospital, the number of patients waiting for a bed in the community hospitals reduced from an average of seven to an average of two, and there were frequent spells when no patients were waiting. This occurred within the context of similar improvement work, utilising the same principles, across East Devon PCT to increase the flow of patients through its beds.

The combined effect meant that a closure of one of the East Devon community hospital beds for major refurbishment did not result in any noticeable increase in the number of patients waiting for East Devon beds

within the Royal Devon and Exeter Hospital.

Future developments

The avoidable admissions service will work with the PCT falls coordinators and the local ambulance trust to identify patients who have multiple admissions due to falls. Utilising the information systems of both the emergency department and the ambulance service, the aim is

to identify both patients and locations requiring additional input on reducing the risk of falls.

The service is also working with local 'reablement' teams on identifying gaps in services for patients and making recommendations for how they can be addressed.

The delay to discharges team aims to support a more integrated discharge service based around wards with a large proportion of patients who have complex needs. This

includes mapping the work of the social worker, occupational therapist and discharge nurse to avoid duplication and delay, and then exploring how these professionals should work together in the future to provide a seamless, patient-centred discharge service.

References

- 1 See www.modern.nhs.uk/pursuingperfection
- 2 See www.publications.doh.gov.uk/nsf/older-people/index.htm

Quality of medical record documentation in urology emergency admissions

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- Documentation in the medical records of urology emergency admissions is variable.
- Only 15% of urology patients are seen by a doctor more senior than a senior house officer before admission.
- The importance of accurate medical records should be emphasised in junior doctors' specialty induction programme and in educational programmes.
- The provision of protocols (for reference) in the accident and emergency department could help improve urology practice.

Medical records have been in existence for centuries. Their use has enabled us to establish the aetiology of disease, attitudes towards the sick and the evolution of medical practice. The role of medical records in the current climate extends much further. Such documentation facilitates diagnosis and treatment, communicates information to other providers of care, provides information on patient progress, and provides a tool for teaching and the advancement of knowledge. Medical records also serve to justify interventions that have been carried out on patients, and reflect the quality of care provided¹. Importantly, medical records provide

a medico-legal function in risk management².

The aim of the present study was to assess the quality of documentation in the medical records of urology patients admitted through the accident and emergency (A&E) department.

Method

The study was set in a busy district general hospital. All urology patients referred by a GP or by the A&E department are seen by the on-call surgical senior house officer (SHO). The patients who have been admitted are referred to the urology team the following morning and are then seen by the urology specialist registrar (SpR) during the 8 a.m. ward round.

For the present study, the grade of the doctor admitting the patient and the number of patients who had senior review were documented. Eight measures were selected for review:

- management plan;
- blood results;
- digital rectal examination;
- urinalysis;
- urine sent to laboratory;
- residual volume;
- imaging results in notes;

- imaging results available on the ward.

We believed these were required to establish a diagnosis and formulate a management plan. For all eight measures, 'yes' was coded if the relevant information was appropriately documented. In addition, we noted whether a working diagnosis and a differential diagnosis had been recorded in the notes. The admitting doctors were not aware of the audit process, to minimise any bias.

Results

Over eight weeks we prospectively reviewed the medical notes of 61 patients. The majority had been referred by the A&E department (85%) and were admitted by the on-call surgical SHO (93%). The remainder were assessed by a pre-registration house officer or specialist registrar.

Only 20% of all urology admissions were subject to senior review (15% seen; 5% discussed). Most patients had a documented diagnosis (95%), a management plan (95%) and the results of blood tests recorded in their notes (85%).

Only 59% of patients had a digital rectal examination and residual volume following catheterisation

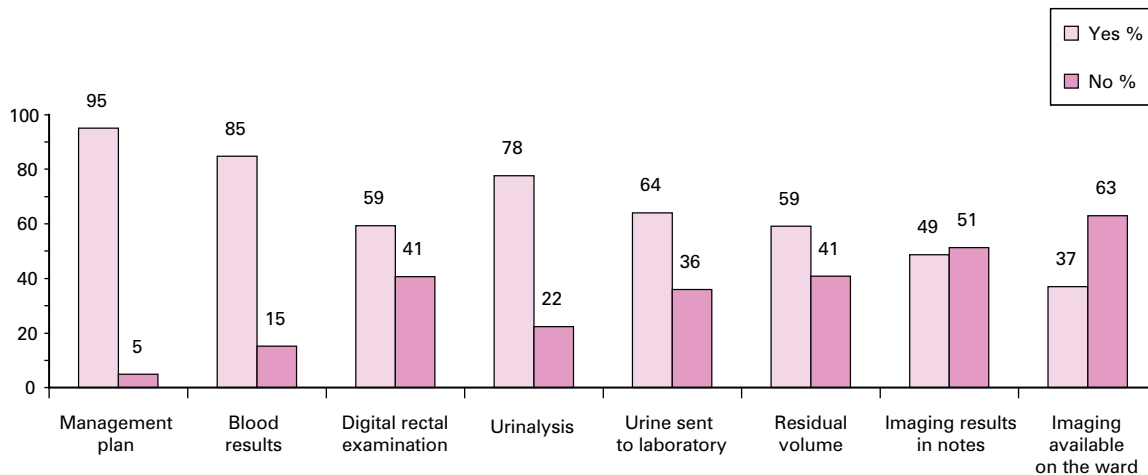


Figure 1. Results on the eight survey items (percentage of case-notes with measure recorded, 'Yes', nor not, 'No').

documented. Urinalysis was recorded for most patients (78%), although only two-thirds of patients had a note that a urine sample had been sent to the microbiology laboratory (64%).

Less than half the patients had evidence of review of their imaging by the admitting doctor (49%), and only 37% of these films were on the ward by the time of the morning urology ward round.

Figure 1 shows the results in graphical form.

Discussion

All eight measures contribute to effective patient care in a urology setting, and we found the status of notes fell below desirable levels. It is not known whether or not the absence of required information in medical records adversely affected the quality of care that patients received. However, poor documentation would have delayed diagnoses and decisions. For example, urine should be sent to the microbiology laboratory before a patient starts taking antibiotics, in cases of urinary sepsis. If this is not done, as we found in one-third of our admissions, the patient's possible sensitivity to antibiotics would not always be known. Similarly, it is crucial to know the residual volume following catheterisation for effective management of a patient with urinary retention. The measures included in the questionnaire were selected for two reasons:

- these were measures that were required for decisions on patient management;

- they are required for best practice with urology patients³.

In addition, poor documentation has medico-legal implications. Many litigation cases take an average of six years to come to trial. If it is not recorded, in legal terms, it did not happen⁴.

In summary, we believe that there is room for improvement in the documentation of urology emergency admissions, which will lead to an improvement in urology practice. Our current solution is education of junior doctors and the provision of protocols for reference in the A&E department and on the hospital intranet. Once these measures have

been put in place, this audit will be repeated and the benefit of these interventions ascertained.

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- 2 Dresselhaus TR, Peabody JW, Lee M, Wang MM, Luck J. Measuring compliance with preventative care guidelines: standardized patients, clinical vignettes, and the medical record. *Journal of General Internal Medicine* 2000;15:782-8
- 3 BAUS guidelines. See www.baus.org.uk
- 4 Frazier HW, Brand DA. Emergency department trauma care: priorities and documentation. *Surgical Clinics of North America* 1980;60:1009

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