



# Patient Impact Project:

A combined clerking proforma for  
Improving patient assessments and flow  
(IPAF) in hospital

Dr Sam Abraham

Student No: 1812488

BCUHB

# PIP Purpose:

Implement a comprehensive approach to enhance Patient assessments on admission to hospital via Emergency Department to medical and surgical wards to improve patient care and flow through hospital ED

- By developing a combined assessment document for patients when being admitted to hospital via Emergency Department to medical and surgical specialties

## **Key Drivers**

- Crisis facing NHS due to 'winter pressure'
- Increasing ED waiting times and Delayed transfer of Care

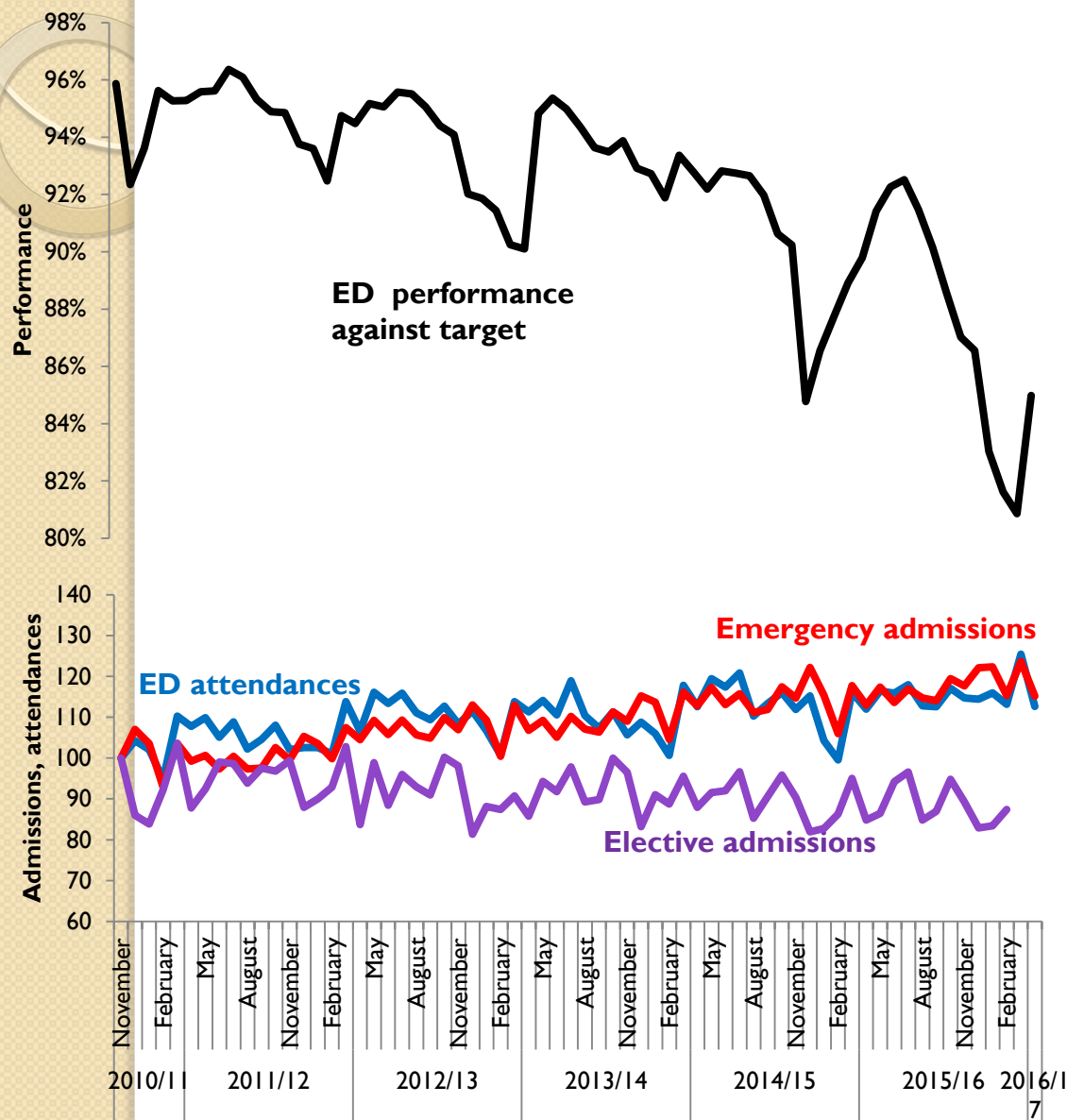
# NHS bed-blocking rises 42% in a year, new figures



## Performance against four-hour A&E standard has continued to decline



### *Improvement*



In winter 2015/16, performance against the national four-hour standard fell sharply and was missed for nearly 20% of patients.

This continued a five-year trend: between March 2011 and March 2016 performance against the standard fell 14 percentage points.

Attendances and admissions both increased over the same period.

In recent years, summer performance has dropped below the 95% threshold. With hospitals now already at capacity going into the winter, this may explain the increasingly deep winter troughs in performance.

# The story of Mrs Jones

- 75 yr old lady . Admitted with fall Wednesday .
- She had a fall at home and been on floor since Monday night
- Friend came to visit on Wednesday morning
- Paramedics had brought her to A&E @ 14.12 hrs
- **Seen in A&E -16.45 hrs. (ED wait:2hrs 33mts)**
- History reviewed: Atrial fibrillation Warfarin. H/o type II diabetes mellitus, hypercholesterolemia, hypertension and chronic leg oedema.
- Afebrile. No systemic symptoms. BP was slightly low at 90/71 mmHg.
- Plan: Immediate Fluid resuscitation . Further 1 litre of normal saline to be given at 4 hourly intervals. Routine bloods done.
- After Initial assessment and treatment –**referred to medics at 17:15 hrs for hospital admission as patient not well enough to go home.**

# Medical review

- Waiting to be seen !!!
- Seen by on call medical doctor at **1.20 am !!**  
( ~ 8 hrs after initial referral from ED)
- BP stable – Patient conscious chatting – I am Okay.
- CK > 63000- indicating muscle damage (Rhabdomyolysis)
- Nursing staff –report patient was on warfarin which was withheld as initial INR 4.8, but patient took warfarin at night.
- Catheterised. Repeat INR. Continue IV fluids

# Consultant Post take

- Reviewed at 10.15 am the next day
- Alert and co-operative. BP stable. c/o mild pain abdomen. Good Urine out put- 1.2 litres
- Past medical history –rechecked –previous history of Abdominal cyst –refused surgery. INR -8.1.
- Abdomen distended –diffuse tenderness.
- Per rectal exam –normal, no bleeding. Vitamin K given to correct INR plus reassess for bleeding. Advice to continue fluid resuscitation.
- Abdominal –X-ray to be arranged and asked for surgical review after X-rays.
- Repeat bloods for U&E, CK, INR after 2hrs

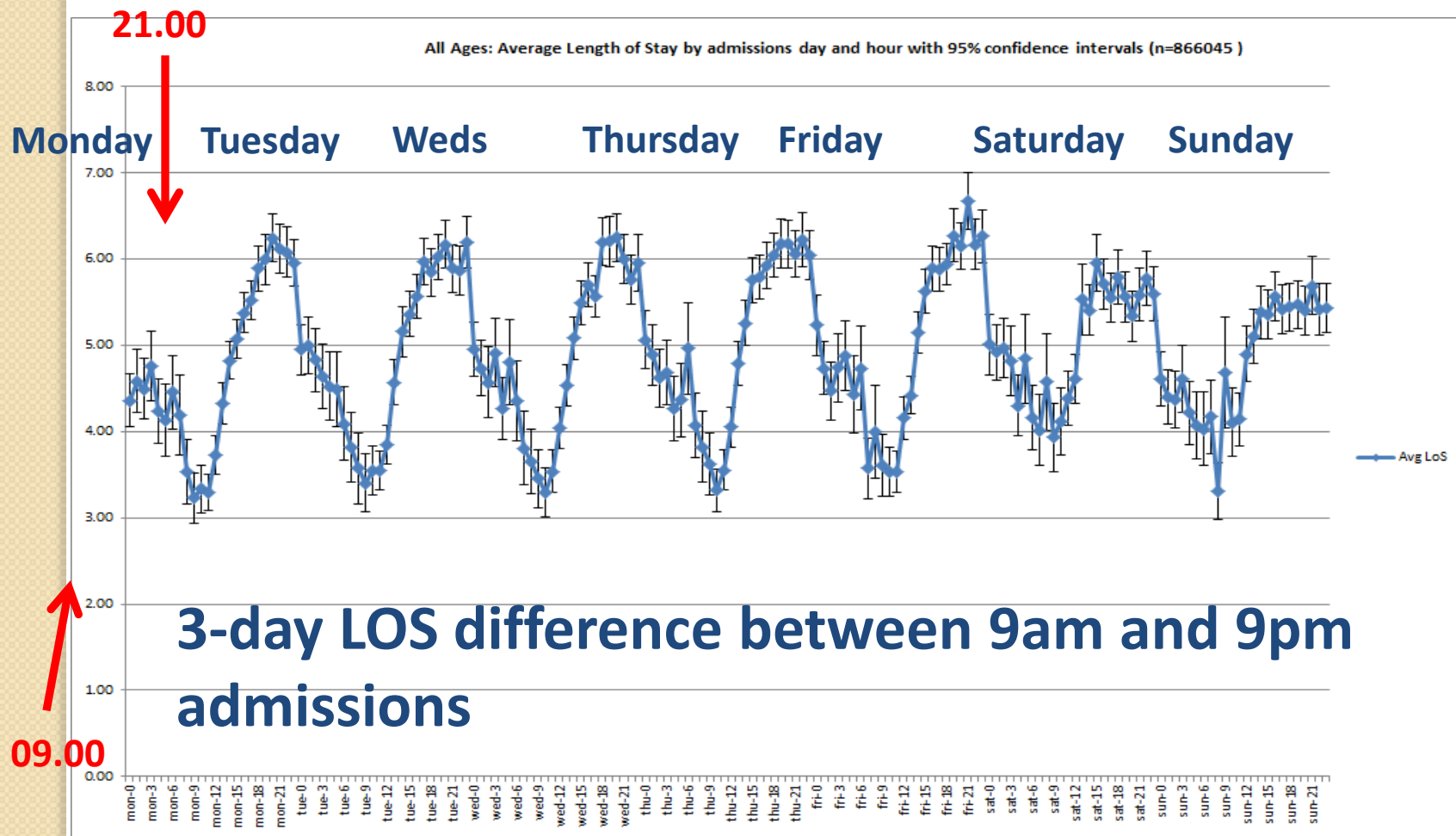
# Progress

- Unwell at 18.05 pm. Low BP -90/60
- On call doctors called.
- Fluid resuscitation .BP improves initially -124/70
- Collapses with un-recordable BP at 18.45 pm – Diffuse abdominal distension
- Seen by surgeons 9pm-? Perforation
- Discussion with Consultant surgeon and myself – High risk of mortality - too high surgical risk.
- Decision made to manage conservatively with palliative consideration. DNACPR. Moved to medical ward.
- Patient dies later next day at around 2pm

# Several difficult questions?

- Is it a system failure?
- Is it just a result of increased pressure on admissions via ED?
- What could we have done better?
- Could the patient have had an earlier specialist review?
- Was the death preventable?
- Mortality for acutely ill patients is higher for those admitted at nights and at weekends, when less experienced doctors are on site.

( Royal College of Physicians 2012 :Hospitals on the Edge.  
<http://www.rcplondon.ac.uk/press-releases/patients-deserve-better-out-hours-care-says-rcp-president->)



**Why?**

Late admissions less likely to have a consultant review; more likely to 'board'; more likely to have a care plan from junior doctor; more likely to be admitted from a crowded A&E

(Hospitals on the Edge report from Royal college of physicians ( RCP. 2012).

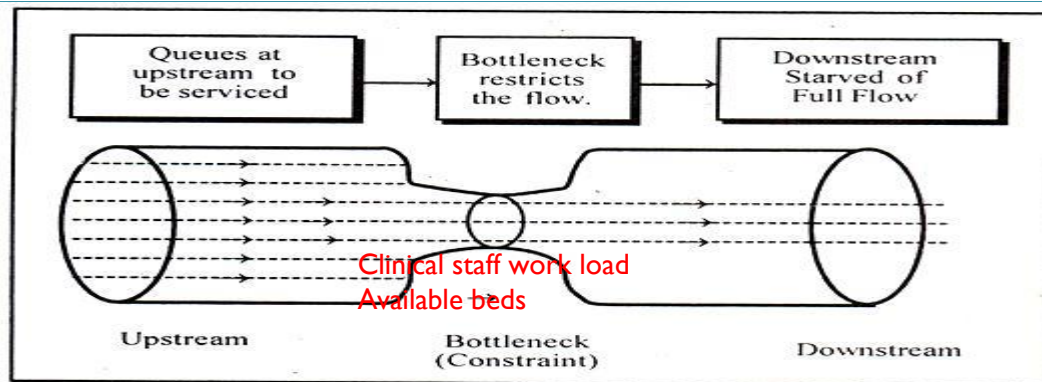
<http://www.rcplondon.ac.uk/press-releases/patients-deserve-better-out-hours-care-says-rcp-president->)

# • Can we influence Capacity and Flow ???

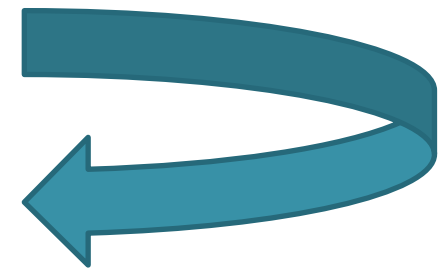
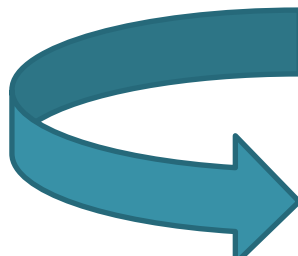
Capacity is not just about numbers of beds, but about how effectively those beds are used, and when they become available for patients requiring them. ( *Clifford Mann* )

Where is the bottle neck?

Patients in ED  
& GP referrals  
for admission



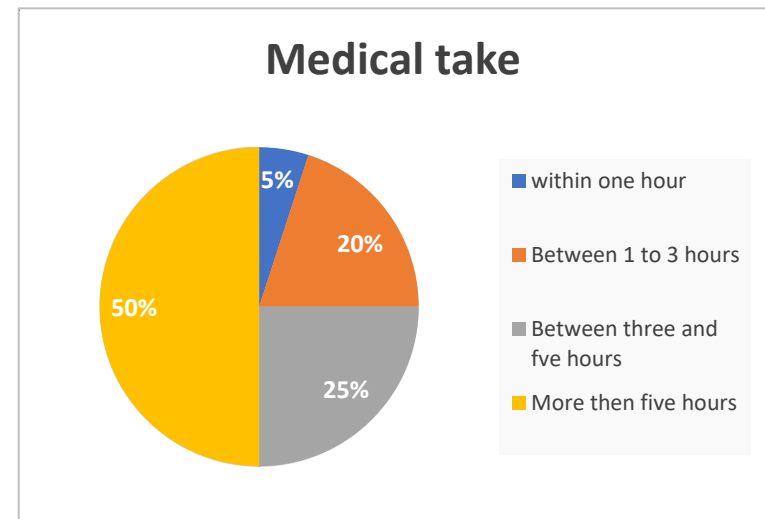
Awaiting POC  
Possible discharge Home  
Discharge to assess  
Step down beds



# Customer Impact:



- Some patients wait in A&E for up to 12 hrs or more to see ED clinician & then have to wait again for several hours to see a specialty doctor.
- Our recent study has shown that average wait after specialist referral is 7hours
- After referral 50% of patients wait 5hrs or more before being seen by Medical junior doctors



# Customer Impact Project:

**Purpose :** To create a combined assessment document for patients when being admitted to hospital via Emergency Department to medical and surgical specialties

**Intended Impact:** Improve patient experience by reducing length of time to first consultant review and improve comprehensive patient assessments on ward rounds. Thus helping overall patient care and flow.

# Deliverables:

- Initial communication and meeting to and agree on the need for improvement.
- Brainstorming session and discussion about what is important in patient journey through hospital.
- Establishment of an interest group with key stakeholders. ( hospital director, clinical director, therapy leads, hospital medical director specialty leads and other interested colleagues)
- Virtual e-mail consultations with consultant colleagues and using Action learning

# Progress of Deliverables:

- We did - 4 half day discussion sessions on what is important in patient journey in ED and why we should improve delayed transfer of care between specialties.
- Showed evidence that 50% of patients are already adequately clerked by ED and this could save time to consultant review if using a Combined Clerking Proforma
- Identify and agree with colleagues what key elements of patient care that doctors need to look at during formal ward rounds !! – This was done through virtual e-mail consultation.
- Regular meeting group of interested peers to drive change. Ongoing virtual e-mail consultations.

# Deliverables -The process

- Met with ED leads and clinicians at 3 sites in BCUHB
- 3 different systems in use.
- Changing concepts. Using all the influencing styles we learned.
- Discuss with Junior doctors with regard to what is acceptable in the clerking document using junior doctor forum
- Further brain storming sessions with a facilitative, accommodating, negotiating and collaborative approach

## Virtual e-mail consultations

- Consultation with Stakeholder groups  
prophylaxis group
  - 1000lives improvement Sepsis
  - Antibiotic audit group
- Improve proforma using PDSA cycle.



# Key Challenges in Creating the Proforma

Recognition and treatment of  
**Sepsis**

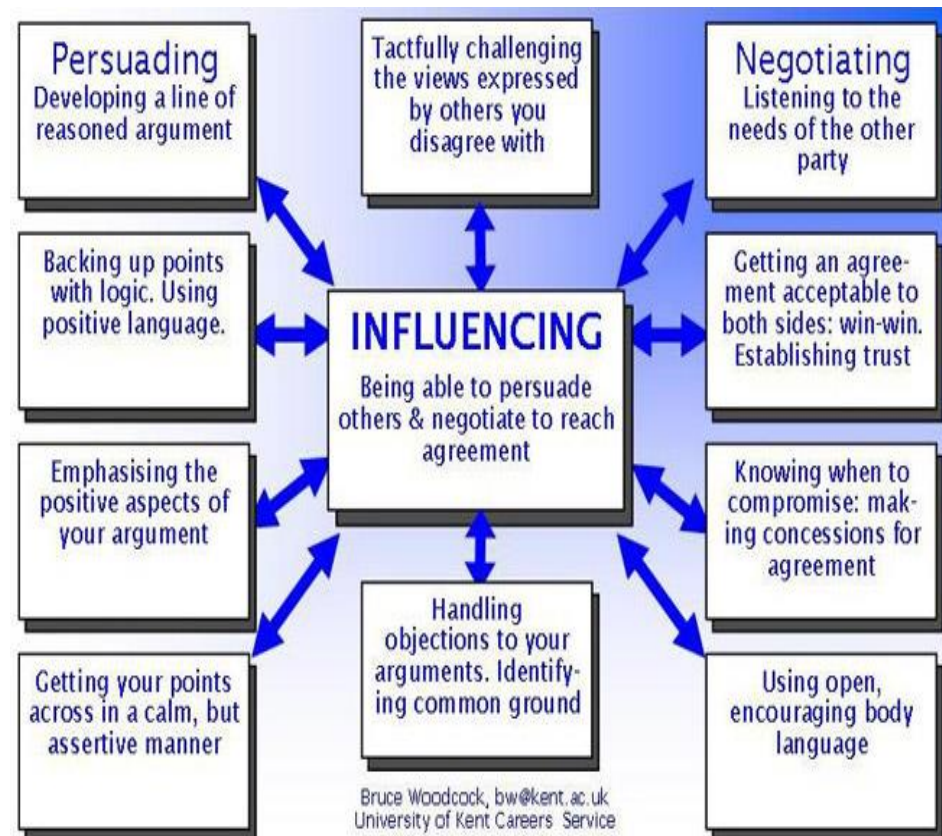


Risks due to Antibiotics -  
**Hospital Acquired infections**

- **Making this complex system to work while providing High Quality Care is not easy !**

DVT PROPHYLAXIS - document reasons for not giving

Dementia and Delirium Care.



# Key considerations in Creating the Proforma

EDD & MFD

DANCPR/Treatment  
Escalation plan

Therapy and Social Input/Available  
care package

Delayed Discharges

# Outcome

- Able to reach agreement with colleagues with regard to final proforma-July 2019
- And a 24 hour review
- All 3 site ED clinical leads have agreed to trail the new proforma- Aug 2019
- Proforma Trial run being started at Wrexham Maelor Hospital site.

# Outcome

- Link to Combined Clerking Proforma
- Project : [bcu combined clerking doc 08.08.19 -final.pdf](#)
- FAQ's : [FAQs for Combined Clerking booklet 2019 - SA.docx](#)

# Success Criteria:

Key measurements would be:

- a. Average time for ED patients waiting for specialist review.
- b. Time to average first Consultant review:
- c. Number of patients seen between 9 to 7 pm

And audit 24 hr Review sheet monitoring

# My reflections on Leadership challenges with Project

- Motivating, collaborative and Engaging style
- Several challenges on the way that tested negotiating skills and organisational ability.

Key learning from Leadership academy (John Storey and Richard Holti. (2013, June). *Towards a New Model of Leadership for the NHS.*)

- Provide and justify a clear sense of purpose and contribution
- Motivate teams and individuals to work effectively
- Focus on improving system performance.

# Action Plan:

- Under take further PDSA cycle
- Make amendments and share results
- Roll out proforma at other sites
- Repeat PDSA process with regard to the Proforma in few months time.
- Annual review to keep the proforma updated.
- Once established look at involving other specialties like Trauma and Orthopaedics.

# Thank you for listening

## Special thanks to

- My colleagues and Clinical leads in ED at BCUHB Dr Robin Roop, Rob Perry & Tom O Driscoll
- Hospital site Medical directors, Clinical leads In Medicine and Surgery at BCUHB
- Hazel and Joanna from Care pathway group
- Dave Hill from Public Health Wales, Dr Chris Subbe and Dr Indrajit Chatterjee & Cameron Abbott –Consultants
- Ishaq Khan, Katie Bishop, Emma Edmunds, Catherine Speare, and Mustafa Abdimalik from Junior doctor forum for their valuable contributions!
- And to the MLP team and colleagues, for making this possible.

