G552(P) CHASING OUTSTANDING INVESTIGATIONS FOR PATIENTS DISCHARGED FROM THE PAEDIATRIC UNIT: SYSTEM CHANGE

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Context This project was undertaken in the paediatric department of a district general hospital. We involved medical, nursing and administrative staff.

Problem There were two previous systems for chasing outstanding results for discharged patients. Those for patients seen on the Paediatric Assessment Unit (PAU) were recorded at time of discharge in a folder. Those for discharged inpatients were added to the inpatient job list with allocation to a named individual.

We found these systems resulted in investigations being seen much later than date available with the prospect of adverse impact on patient care.

Assessment of problem and analysis of its causes Random selection and analysis of 50 entries from the old system showed that 31 (62%) of results had been chased/actioned. Only 9 (18%) had documentation indicating results had been seen/actioned within 24 h of availability.

Multi-disciplinary team (MDT) discussion concluded that a major contributory factor was that investigations were being listed in the order of generation without consideration of the potential result availability date. Consequently, if a colleague chased results which were not available within their time (typically one week) on shift, these investigations would not be routinely chased resulting in potential for numerous delayed results.

Our aim was to devise a single efficient system to address all of these problems.

Intervention Following further MDT discussion a jobs book was designed. This comprised of a page-per-day diary. Any patients discharged from PAU with outstanding results were entered on the page of the anticipated result date. Those discharged from the inpatient ward with results expected beyond 48 h would also be entered into the diary. Each entry would include: patient and clinician details (including bleep number); job details; and outcome and documentation. The responsibility of looking at the results expected on each day was that of the team on PAU. If a result was not available when expected, then a note would be added to a revised future date to ensure follow-up.

Study design Observational study to assess effect of intervention.

Strategy for change The MDT was apprised through circulation of emails and presentation at grand-rounds of the proposed new system, rationale, aims and rules of use. Feedback was sought via email and verbally. Proposed changes were agreed with key stakeholders and colleagues before implementation. A review was planned after 6 weeks of use.

Measurement of improvement We analysed a random selection of 50 entries from each system (total 100). The new system was shown to be superior with 46 (92%) of jobs completed (previously 62%), with 32 (64%) of total jobs acted upon within 24 h of results becoming available (previously 18%) (Figure 1).

Effects of changes There has been a significant improvement in the chasing, actioning and documentation of results, including dates and timings which improved patient care and experience.

The team has improved ownership, traceability and accountability of clinicians who have entered and completed tasks. This

Comparison of old & new system

Abstract G552(P) Figure 1

encourages and reinforces a culture of teamwork to meet common goals.

The few results unavailable on the date expected are now routinely entered for chasing on an appropriate future date to ensure completion.

The new system acts as a record for future reference, audit or monitoring.

Lessons learnt Liaising with a wide variety of MDT colleagues of all grades and utilising a variety of appropriate communication methods were essential for successful system change.

Message for others We have proven that a relatively simple change in working can significantly improve patient care and foster good team working.

This system is readily replicable and can be implemented in any department to yield similar results.

G553(P) RESUSCITATING RESUS

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Context This project was based in a busy district general's Paediatric resuscitation bay. Doctors, nurses and the resuscitation team were involved.

Problem The Resuscitation Council states: 'Healthcare organisations have an obligation to provide a high-quality resuscitation service' and 'staff have immediate access to appropriate resuscitation equipment and drugs' with 'A reliable system of equipment checks and replacement in place'. It states that appropriate airway equipment should be immediately available and circulation equipment accessible within minutes.

The current Paediatric resuscitation bay was felt to not fully meet the above criteria. The resus bay was not an intuitive area and had no clear restocking guidelines with trust incident forms being logged for missing equipment during resuscitations.

Assessment of problem and analysis of its causes Two lists of equipment were devised: one of simple airway equipment and one of equipment required to gain IV access and give a dextrose bolus. We timed one SHO trying to find specific equipment in our current resuscitation bay. The results were discussed in departmental meeting to consolidate the opinion of the Paediatric team, the Anaesthetic team, the Resuscitation officers and the Paediatric nurses, an action plan was devised to address the failings noted by staff in the department.