Mortality data in checklist versus non checklist groups

Abstract G594 Figure 1

Problem Stabilisation of paediatric admissions

High mortality levels within first 24 h of admission.
Often no identifiable cause of death from note keeping.
Lack of documentation of stabilisation procedures.
Clinically unstable children on ward

Assessment of problem and analysis of its causes Liaison with the clinical staff identified lack of full stabilisation of patients prior to ward transfer.

Assessing patient files revealed poor note keeping of stabilisation/lack of early stabilisation interventions.

Intervention Five point checklist designed to standardise early care for all paediatric admissions. Filled out by nurses. The 5 points covered were

- Airway, Breathing and Circulation stable
- Check glucose if not alert
- Take haemoglobin and cross match samples if pale
- Medications written up regularly on drug chart
- First dose of medications given

The checklist informed staff that each of the points must be completed before the child was to be transferred to the paediatric ward and what to do if these were not performed.

Patient demographics, staff details included.

Study design Retrospective analysis of mortality cases over a 3 month period.

End point examined was change in mortality rates within first 24 h of admission in intervention and non intervention populations.

Strategy for change 'Safety checklist' designed and trialled by nursing team in the Emergency Department. This was refined and expanded to cover 5 key clinical points.

Several meetings with nursing staff were undertaken. Nurses designated to complete the checklist for new admissions. Local consultant paediatrician agreed to trial of checklist in notes.

From September 2014 administration staff were able to put the checklist in every child's file prior to Emergency Department clerking.

Results of the study have been discussed with the teams involved and both nurses and clinical officers in the emergency department have agreed to continue working with the checklist.

Further data from the hospital has been requested to monitor for ongoing change.

Measurement of improvement All available mortality files over a three month period July–September 2014 were reviewed. Groups with a checklist and without were compared at different time intervals from admission.

All available notes of paediatric admissions to the hospital during the same period were reviewed to identify the uptake of the checklist prior to it being put in to all medical files.

A 24% reduction in mortality within the first 24 h was observed in the checklist group compared with the non-checklist group.

Effects of changes Initial results reveal that a lower percentage of deaths were in the first 24 h of admission in the checklist versus non checklist group.

Further data is required to allow month on month comparisons now that every child is receiving a checklist in their notes to see if there is a direct effect on total mortality figures.

Objectively fewer numbers of unstable patients seen on the ward.

There were initial difficulties with getting people to fill in the checklist and insert it in to the patient's file. This was much improved by getting the checklist put in the patient notes by the clinical records team before the child was admitted.

Nurses team nominated for a Kenyan award for their using checklist to improve clinical governance measures.

Lessons learnt To liaise early with nursing team regarding additions to improvement project.

To get one group of staff to take responsibility for checklist completion as avoids confusion of roles.

To get records department to include checklist in admission clerking sheets to allow ease of use and continuity of provision of checklist.

Message for others Simple checklist intervention can have a substantial influence on child mortality within the first 24 h of admission and lead to better level of standardisation of care for acutely unwell children.

G595 IMPROVING DISCHARGE SUMMARIES-IMPROVING QUALITY OF CARE

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Context The improvement project was done in a paediatric tertiary hospital; it was led by a junior doctor and administrative staff officer with involvement of a consultant, junior doctors and nurses.

Problem Trust strategy is to achieve zero harm, no waits, no waste and working together. In addition, the National Clinical Data Standards Assurance Program (2010) has mandated that electronic Discharge Summary (DS) should be sent out from medical teams to the appropriate GP within 24 h of the patient being discharged and the patient should be sent home with one copy of DS in their hands. In 2013, 60% of the Renal Ward discharge summaries were being sent out in time.

Assessment of problem and analysis of its causes We interviewed doctors, nurses and pharmacists to get a better understanding of the process that led to DS being posted to GPs. We identified following factors that led to delays: poor communication within the team and lack of ownership of this task. We held a stakeholder meeting for brain storming and shared ideas to improve the existing process. We developed junior doctor rota describing who is responsible for the DS completion and agreed that the patient's nurse was responsible for ensuring that patient did not leave without DS.

Intervention The new process for writing DC comprised of a number of steps. On call junior doctor for the week is in charge of getting information from the senior nurse on who will need the DS on a daily basis; the same person is in charge of completing DS, printing it and giving it to the patient's nurse who was not allowed to discharge patient without a DS. We allocated new place for the storage of GP copies of DS to trigger action from administrative staff to post DS to GPs. We ensured that all team members were aware of the new system by attending handover sessions.

Study design Observational study.

Strategy for change We attended 'away days' for all levels of nurses and junior doctors induction and informed them of the new system. We encouraged all team members to approach project leads if they identify new problems as those were to be our new PDSA cycles. We aimed to have >90% DC summaries

done timely over a 16 week period. The National standard is 95%.

Measurement of improvement We kept a record of every DS completed. For those not completed a mini root cause analysis was done to investigate the cause of the delay. Data analysed weekly and results shared with all staff.

Effects of changes The effects of changes were better quality of patient care as timely DS done (one of six domains of quality) and improved communication between professionals in tertiary care and GPs. We achieved and sustained >90% target (Figure 1).

Lessons learnt This project taught me the importance of a multi-disciplinary approach when planning change. We need a desire and commitment to change and on planning the improvements. It is crucial to see problem through different professionals views as this aids problem analysis. Next time, I would involve a patient or a parent to oversee our work.

Message for others Understanding problem and the process before implementing change is crucial for success. Making sure that all team members are aware of project and evaluating feedback is important for sustainability. This improvement is important for quality of care we provide as it addresses one of six quality care domains. Discuss each failure with the team and perform new PDSA for each problem identified.

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IMPROVING PAEDIATRIC PRESCRIBING

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