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Utilisation of a trauma meeting handover proforma to improve trauma patient pathway

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Abstract

Decision making within orthopaedic centres predominantly occurs at the trauma meeting, where all decisions are made as a part of the multidisciplinary process. This is an essential handover process.

Difficulties occur when teaching and detailed case discussions detract from the actual decision making process, leading to failure in documentation and implementing treatment plans.

An audit was carried out in a busy district general hospital (DGH), assessing the quality of trauma meeting documentation in patient records, and assessing whether the introduction of a proforma document would improve this.

Prospective clinical reviews were performed on all patients discussed in the trauma meeting over a one month period. Following the initial audit cycle a proforma was introduced, and the audit process was repeated at a two month and six month interval.

The quality of the entries were assessed and compared to the Academy of Medical Royal Colleges Standards for the clinical structure and content of patient records, and The Royal College of Surgeons (RCS) of England Guidelines for Clinicians on Medical Records and Notes.

Sixty three patient records during a one month period from 1 August 2014 found that only 16% had any documentation of the trauma meeting, none of which met the standard set at the beginning of the audit. Following the introduction of the proforma, 102 patient records were reviewed from October 2014, showing 70% had documentation of the trauma meeting. This improved further to 84% in February 2015.

The proforma has provided an effective means of documenting and communicating management plans, and in turn also improved the trauma patient pathway to theatre or discharge.

Problem

It is integral to patient care that management plans are clearly documented in patient notes. Vital information can sometimes be missed if the entry is illegible, or if the plan has been documented in a rush. If there is a delay in documentation, recalling the plan may be difficult, causing inaccurate information to be documented, or even worse, failure to document at all.

One of the junior doctor's roles in orthopaedics is to implement the patient management plan following the daily trauma meeting. It can be challenging to remember individual management plans for patients, due to the fast pace of the trauma meeting and number of patients discussed. Furthermore, it is essential that the name of the senior who made the plan is clearly documented in the notes. This ensures the management of a patient can be rediscussed with the appropriate clinician who was responsible for the original management plan. Failure to follow this process has led to confusion, delays in service provision, and has negatively impacted on patient care.

An audit was conducted in the trauma and orthopaedic department of a busy district general hospital (DGH) in greater London, serving a population of over 380 000. The hospital provides a 24 hour, consultant led emergency service.

Prior to this audit being carried out, there was no set way in which junior doctors communicated the decisions and discussions from the trauma meeting into the patient notes.

Background

In orthopaedic departments the majority of management plans and clinical decision making occurs at the daily trauma meeting. Clear recording of the outcome of this meeting serves as a tool to communicate patient management plans to all members of the multidisciplinary team (MDT). Communication is essential in ensuring that interprofessional teams work well together, and deliver safe, efficient, and effective patient centred care.

Prior to the implementation of the proforma it was the junior doctor’s role to ensure these plans were documented and implemented. There was no set standard used to guide what was documented, or how information was presented.

Proformas have been shown to be effective in improving treatment

plan documentation in other clinical settings, such as cancer MDT meetings. They ensure that documentation is clear, in an easily recognisable format, and that plans contain the same set of information for each patient.

The NHS Clinical Advisory Groups Report, September 2010, Regional Networks for Major Trauma, states that effective trauma teams must use quality improvement to evaluate processes and operational infrastructure to ensure good functioning systems, and to drive clinical benefit.[1]

Baseline measurement

The initial audit cycle looked at patients admitted under the trauma team over a one month period. Clinical records were reviewed, and documentation of the trauma meeting was assessed and compared to the Academy of Medical Royal Colleges Standards for the clinical structure and content of patient records,[2] and The Royal College of Surgeons (RCS) of England Guidelines for Clinicians on Medical Records and Notes.[3]

The data set included patient demographics, date of admission, consultant and registrar on call, consultants present in trauma meeting, admitting problem, method of referral, plan and name, designation of person completing the entry, and the date it was completed.

Patients who were admitted with neck of femur fractures were excluded, as these patients already had a proforma in place and were under the care of the orthogeriatricians.

Sixty three sets of patient records were reviewed from August 2014. Sixteen percent (n=11) had documentation of the trauma meeting, which varied in quality. Eleven percent (n=7) had documented the senior member of the team who had made the management plan. No clinical records had the name of the admitting consultant, the registrar on call, or the admitting problem.

See supplementary file: ds6500.pptx - “Patient trauma pathway”

Design

Introducing a proforma that could be completed during the trauma meeting and then later filed in the patients' notes seemed the simplest way of overcoming the need to recall each individual patient discussion, and ensured a template was used so that all patients would have the same information recorded.

The proforma was designed to be used as a general tool for all patients admitted under the trauma team. It recorded the mode of referral, name of the admitting consultant, registrar on call, and date of admission. It also recorded the admitting problem, the management plan, and which consultants were present in the trauma meeting. If it was decided that the patient needed an operation, details of the date, procedure, and operating list from which it was to be carried out were also documented.

It was decided that a single A4 sheet of paper would be most suitable, with the majority of the information available with options to select from, for example consultant names, in order for them to be completed quickly.

After the proforma was introduced, the audit was repeated two months later, and again four months after that.

The proforma was printed on pink sheets so they would stand out in the clinical records.

Strategy

PDSA cycle 1: The proforma was designed with the help of senior members of the orthopaedic team, to ensure all information was included without making the proforma overcomplicated.

PDSA cycle 2: Following the initial audit the proforma was introduced to the orthopaedic senior house officers and house officers. They fed back that despite making documenting plans easier and more accurate, it was still a rush to complete the proforma during the trauma meeting while the patient in question was being discussed.

PDSA cycle 3: The proforma was adapted to include more "circle only" options, to eliminate as much writing as possible. The improved proforma received positive feedback. It was implemented, and two further audit cycles were subsequently carried out.

PDSA cycle 4: Following the results of the initial two cycles, a meeting was carried out with the junior doctors to ask for feedback about the use of a proforma.

Results

Following the introduction of the proforma, a prospective re-audit was conducted. One hundred and two patient records were reviewed from October 2014, showing 70% (n=71) had documentation of the trauma meeting, compared to 16% in August. The majority (68%) of this documentation was of high quality, and met the standards set out by the RCS and Academy of Medical Royal Colleges.

This audit was repeated again in February 2015 and showed a further increase to 84% (n=47) documentation of the trauma meeting (figure 2). Again, the majority (67%) of these met the standard set out at the beginning of the audit. Information missed out consisted of the consultant on call, registrar on call, planned operation date, and date of procedure.

See supplementary file: ds6501.pptx - “Results graph”

Lessons and limitations

Introduction of the proforma has led to a vast improvement in documentation of patient management plans, and led to better communication between junior and senior members of the

orthopaedic team.

By completing these forms at the time of discussion and planning, it has allowed the junior doctors to foresee planning issues and deal with them then and there, thus avoiding delays in decision making.

So far this project has been a success, improving the quality of trauma meeting management plan documentation. The junior doctors working for the trauma team felt that although there had been an increase in workload during the trauma meeting, overall the running of the trauma service had been improved. They reported time previously spent rediscussing patients was now used to facilitate earlier discharges, prompt requesting of investigations, and in general had led to better utilisation of junior doctors' time.

Further assessment is needed to ensure the proforma continues to be a helpful tool, and avoids becoming more paperwork to complete.

Conclusion

The proforma has provided an effective means of documenting and communicating management plans. Multiple audit cycles have been conducted, which have had reproducible results with minimal training, with demonstrable benefits in multidisciplinary communication and patient safety.

References

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Declaration of interests

Nothing to declare

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Ethical approval

No ethical approval was needed as this work was deemed an improvement study and not a study on human subjects, and local policy meant that ethical approval was not required.