**PDSA Cycle 1**

**Aim:** what are you trying to accomplish?

The aim of the QIP is to improve documentation of ceiling of care decisions for patients admitted to the OPMHS unit. This will avoid unnecessary transfers to the general hospital that are not in patient’s best interest and will assist in advanced care planning on the ward. After meeting with the consultant a plan was agreed that by default all patients are for active transfer to the general hospital unless the weekly MDT entries state otherwise. If transfer to the general hospital, is not in best interest that will be recorded in the weekly MDT proforma.

**Plan:** what will your test be?

To go through the electronic notes for all inpatients at the OPMHS unit and see whether appropriate documentation on ceiling of care is recorded. It was agreed to search for various terms which may lead us to the documentation. Notes were searched for "ceiling" "advance" "transfer" "CPR" "DNAR" "DNR" "resus" "hospital", as well as by searching for the hospitals by name. Not only was it recorded if this information was documented but also where it was documented as it was imagined there would be no consistency.

**Prediction:** what do you think will happen as a result of your test?

It was predicted that documentation of ceiling of care would be low and that the number of patients with a clear treatment plan in event of deterioration of be low, however following the intervention it was hoped to show an improvement from the baseline level of recording and consistency.

**Do:** what happened when you carried out your test?

The records were analysed of all 14 patients on the dementia ward. Of the 14 in-patients on the ward, 5 were either new patients or had changes in their ceiling of care or resuscitation status compared with the baseline study. Therefore the other 9 patients would show the same results as previously recorded. It was decided to consolidate the results into one category rather than separately recording DNAR status and ceiling of care. The categories previously suggested in this QIP were used, based off those used in the acute hospital. 0=full active treatment and CPR, 1= DNAR, full active treatment, 2=not for transfer, treatment on ward, 3= not for transfer, palliate.

It was also recorded when the latest change in this status was made by the MDT.

**Study:** how did the results of your test compare with predictions?

Of the 5 changes in status the breakdown was as follows. 2 of the patients were for full active treatment, 1 of these was specified in the MDT notes (this was useful despite not being a requirement as would be the case by default) and the other had “for resuscitation” specified in the MDT notes.

1 patient had been made “not for resuscitation” in the MDT notes and had also been specified in the MDT entry that the patient was still for transfer and active treatment.

2 patients were made “not for resuscitation” and “not for transfer to the general hospitals” but still “for ward level treatment”. On one occasion this was recorded in the MDT notes, on the other unfortunately this was recorded as a separate note by the consultant and not in the MDT notes.

So of the 5 new statuses, 4 fully complied with our suggested changes and 1 partially complied (the conversation had occurred and was recorded but not in the ideal location. It was however easy to find in the notes). This was much better than first predicted.

**Act:** how will you change your previous test in light of what you have learned?

As the results were much better than was first predicted it was decided to continue with the plan to record decisions in the MDT notes. It was felt that the next step was to spread wider knowledge of this and the first step was to discuss the progress of the QIP with the junior doctor colleagues, medical director and director of medical education at the Junior Doctors Forum.

**PDSA Cycle 2**

**Aim:** what are you trying to accomplish?

The aim is to continue propagating change in the recording of ceiling of care decisions for patients on the dementia ward. After the first cycle there is evidence of a change possibly occurring and improved consistency of recording of decisions. The aim is now to ensure that this continues and ideally that compliance improves.

**Plan:** what will your test be?

For the second cycle of the QIP it was decided to review all of the notes of the patients on the ward after another month has elapsed. The data was collected on all of the inpatients with particular interest in both new patients on the ward and also any patients were there has been a change in their CPR or ceiling of care status and whether there had been improved recording of this. There was use of consistent search methods and spreadsheet recording from the last cycle.

**Prediction:** what do you think will happen as a result of your test?

It was hoped that the positive change that was seen in cycle 1 will continue to be evident on the ward after more time has elapsed. It may not have been realistic to expect complete compliance but it was predicted that there would be at least sustained change.

**Do:** what happened when you carried out your test?

Next the records of all 17 patients on the dementia ward were scrutinized. Of the 17 in-patients on the ward, 8 were either new patients or had changes in their ceiling of care or resuscitation status compared with the baseline study. Therefore the other 9 patients would show the same results as previously recorded.

**Study:** how did the results of your test compare with predictions?

Excluding the newest patient (who had not yet been reviewed) 5 of the 7 patients had their CPR status and ceiling of care suitably recorded in the MDT notes. 2 patients did not have their status consistently recorded in the MDT entries but in the alerts and general notes. There was no change in the other 9 patients on the ward, all of whom had been admitted prior to the first cycle of the QIP.

As with the previous cycle there was not complete compliance however on the occasions that the status was not recorded in the MDT notes it was at least recorded in the alerts and general notes.

In cycle 2 this equated to 5 of the 7 patients complying fully while it was 4 of the 5 patients in cycle 1.

**Act:** how will you change your previous test in light of what you have learned?

The analysis has shown positive change in both cycles and of a similar degree though taking into account the small numbers of patients. It seems that at this stage there is some consistency in recording. Any discrepancies we found in the notes were flagged up with the consultant and it was decided to continue with plans to spread information further as detailed later in the QIP.