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Use of a proforma to improve documentation of the post-take ward round and encourage initiation of the comprehensive geriatric assessment in the care of the older people's service

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Abstract

Aims/Background The post-take ward round is often the first time that a senior clinician reviews a patient on the acute medical take. Despite this, there is no official guidance regarding structure or documentation of the post-take ward round. The aim of this quality improve project was to develop a ward round proforma specifically tailored to the care of the older people's service to improve quality of documentation and to encourage initiation of the comprehensive geriatric assessment.

Methods An initial audit was carried out assessing the documentation of key information and the initiation of the comprehensive geriatric assessment during the post-take ward round. A proforma was subsequently designed and implemented with the aims of improving the quality of documentation and increasing the number of patients for whom the comprehensive geriatric assessment was started. A repeat audit was conducted to assess the effectiveness of the proforma.

Results The results demonstrated an improvement in documentation of all key information criteria and an increase in the initiation of the comprehensive geriatric assessment.

Conclusions Use of a specifically tailored post-take ward round proforma improves the quality and consistency of documentation and encourages the initiation of the comprehensive geriatric assessment.

Key words: Geriatrics; Proforma; Ward round

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Introduction

The post-take ward round is often the first time that a senior clinician reviews a patient on the acute medical take. New information and results are reviewed, on the basis of which important clinical decisions will be made that will influence the course of the patient's admission. Therefore, high quality documentation of clinical findings and management decisions is required to promote a high standard of patient care and to allow plans to be correctly implemented.

This is especially true in the care of the older people's service where patients are more likely to have multiple comorbidities and complex social histories. Furthermore, conversations surrounding treatment escalation and resuscitation status are more likely to take place within this patient population and must be carefully documented. Such information must be easily accessible and understood by all members of the multidisciplinary team. This documentation also forms a medicolegal record of a doctor–patient interaction, so must be an accurate and complete reflection of the ward round.

Despite the above there is currently no guidance from any Royal college or governing body regarding post-take ward round documentation. The Royal College of Physicians only offers guidance on generic ward round documentation in 'Ward Rounds in Medicine: Principles for best practice' (Kirthi et al, 2012).

The post-take ward round is fast paced and there is significant pressure on junior doctors to document accurately, especially when all members of the medical team are interacting with the patient for the first time.

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Previous studies have shown that a ward round proforma can improve quality of documentation (Patel et al, 2015). However, such studies have been limited in their scope with regards to specialty and content of documentation. Furthermore, while there is evidence for the benefits of a ward round proforma in a surgical post-take ward round (Al-Mahrouqi et al, 2013; Duxbury et al, 2013), there is limited evidence with regards to the medical post-take ward round. There is also currently no evidence for how proforma use can encourage initiation of specialist assessments such as the comprehensive geriatric assessment.

The comprehensive geriatric assessment is often defined as the 'gold standard' in the care and assessment of the older person (Parker et al, 2018) and has a wide evidence base for improving mortality and morbidity (Ellis et al, 2017). However, although the benefits are well known, no national guidelines exist for its use and therefore not all patients undergo a comprehensive geriatric assessment. Therefore, a way of encouraging the initiation of the comprehensive geriatric assessment is clearly required.

This article presents the results of a quality improvement project with the aim of standardising the post-take ward round process to improve the quality and content of documentation and to encourage initiation of the comprehensive geriatric assessment. Post-take ward round documentation was audited before and after the implementation of a post-take ward round proforma specifically designed for the care of the older people's service.

Methods

This quality improvement project was carried out in a large teaching hospital with a catchment population of approximately 240 000. The acute medical admissions service is separated into a general medicine service and care of the older people's service. This project focuses on the post-take ward round process for the care of the older people's service. All acute admissions are seen by a designated post-take consultant within 24 hours and also discussed at a daily triage meeting. The designated post-take consultant for the care of the older people's service often changes on a daily basis. Furthermore, there was no standardised method of conducting the post-take ward round, so this would highly depend on the designated consultant for the day.

Before carrying out an initial audit, a group of consultants within the care of the older people's service agreed on key information (Table 1) that should be documented during the post-take ward round. The Royal College of Physicians' guidance with regards to generic ward round documentation was used as a basis for this, with the inclusion of additional information that was felt to be important during a first-time consultant review.

Post-take ward round documentation from Monday and Saturday of every week for 1 month was audited by three of the authors to assess how much key information was being documented. This was done to ensure that a variety of consultants' and juniors' documentation was being sampled as well as identifying any potential differences between

Table 1. Key information to be documented during the post-take ward round

Name of consultant
Junior doctor sign off
Contact bleep number
Latest observations
Recent imaging
Latest blood test results
Venous thromboprophylaxis
Indwelling lines
Working diagnosis
Escalation plan/resuscitation status

Table 2. Comprehensive geriatric assessment
Rockwood clinical frailty score
Falls history
Hearing
Nutritional status
Bone protection
Continence
Dementia/delirium
Mood review
Medication review

weekday and weekend documentation. For a piece of key information to be deemed correctly documented at least two out of the three auditors had to agree that to be the case. Whether a comprehensive geriatric assessment was initiated was also audited – this had to be clearly documented with at least three domains of the comprehensive geriatric assessment (Table 2) assessed.

In the initial audit, post-take ward round documentation from 78 patients was reviewed and the results were presented at a weekly clinical governance meeting. It was concluded that a ward round proforma may be effective in improving the amount of key information being documented. Furthermore, it could also be used to encourage the initiation of the comprehensive geriatric assessment to ensure that the process was started as early as possible during the patient's admission and therefore improve standards of care.

The hospital uses an electronic documentation system with built-in functionality for designing a documentation template. The proforma was designed with input from the entire multidisciplinary team within the care of the older people's department, with the view to being as comprehensive as possible but still straightforward to fill out. The proforma was designed to prompt the user for required information to fill in gaps to ensure that key information was not missed. The system automatically inputs date and time of documentation, so these were not included as key information. However, a drawback of this electronic documentation system is that it requires the individual documenting to search for the specific proforma. This relies on the individual being aware that the proforma exists, which may not always be the case.

Before formal introduction of the proforma, a training session was held for clinical staff within the department to ensure that clinicians understood the proforma. It was also an opportunity for them to provide feedback and make improvements. After this session a final version of the proforma was agreed upon (Figure 1) and formally introduced. The proforma was used for 1 month and the audit reviewing the documentation of key information repeated. The number of patients who had a comprehensive geriatric assessment initiated was also audited.

Results

The same methods were used for the repeat audit, with post-take ward round documentation of all acute admissions within the care of the older people's service on each Monday and Saturday of 1 month reviewed. In total, documentation for 46 patients was reviewed.

The results of both audits are compared in Table 3. Before the introduction of the proforma there were some clear deficiencies in the documentation of certain key information. For example, a clear escalation plan or resuscitation status for the patient was only documented in 42.3% of cases whereas after the introduction of the proforma this increased to 84.8%.

In general, there were significant improvements in almost all key information criteria. Notable improvements include documentation of 'working diagnosis' (70.5% to 91.3%), latest blood test results (62.8% to 80.4%) and venous thromboprophylaxis (5.1% to 47.8%). Only one criterion saw a decrease – junior doctor sign off reduced from 93.6% to 93.5%,

Care of the Older People Consultant Post-Take Ward Round

Name of consultant:

Presenting complaint:

Background:

ROCKWOOD CLINICAL FRAILTY SCORE:

Living situation – own home/sheltered living/ care home/nursing home

Package of care?

Next of kin –

History:

On examination:

Respiratory rate –

Oxygen saturations –

Blood pressure –

Heart rate –

Temperature –

National Early Warning Score –

Investigations:

Recent imaging –

Bloods –

Electrocardiogram –

Urine –

Comprehensive Geriatric Assessment:

Falls –

Vision –

Hearing –

Nutrition –

Bone protection –

Continence –

Dementia and delirium –

Mood –

Medication review

Comprehensive geriatric assessment bloods done? (vitamin B_{12}/folate/vitamin D/thyroid function tests) –

Patient safety:

Allergies –

Venous thromboprophylaxis prescribed?

Lines –

Urinary catheter –

Oxygen prescribed?

Pressure care (Waterlow score) –

Working diagnosis:

Ceiling of care:

Plan:

<name + bleep>

Figure 1. Care of the older people's service post-take ward round proforma.

which is a negligible difference. Comprehensive geriatric assessment initiation increased from 26.9% to 50% – a clear improvement.

Table 3. Number and percentage of patients for which key information was documented

	Before proforma	After proforma
Name of consultant	71/78 (91.0%)	46/46 (100%)
Junior doctor sign off	73/78 (93.6%)	43/46 (93.5%)
Contact bleep number	55/78 (70.5%)	39/46 (84.8%)
Latest observations	54/78 (69.2%)	36/46 (78.3%)
Recent imaging	54/78 (69.2%)	35/46 (76.1%)
Latest blood test results	49/78 (62.8%)	37/46 (80.4%)
Venous thromboprophylaxis	4/78 (5.1%)	22/46 (47.8%)
Indwelling lines	0/78 (0%)	15/46 (32.6%)
Working diagnosis	55/78 (70.5%)	42/46 (91.3%)
Escalation plan/resuscitation status	33/78 (42.3%)	39/46 (84.8%)
Comprehensive geriatric assessment initiated	21/78 (26.9%)	23/46 (50%)

The general consensus among all members of the auditing team was that key information was much more accessible on the new proforma. It was clear where something had or had not been documented as gaps would be left on the proforma if the latter was the case. Also, having the comprehensive geriatric assessment as a section to fill out on the proforma encouraged its initiation and documentation.

Feedback was sought from members of the medical team that had been using the proforma. All of those who had used the proforma felt that it was simple to use and fill out and that the prompts meant that important information was never accidentally left out.

Discussion

This quality improvement project demonstrates that use of a post-take ward round proforma can improve the quality of documentation. A further benefit is that the proforma allows partial 'automation' of the post-take ward round, prompting for important information such as latest observations, so that more focus and time can be spent on examination and clinical decision making. This is especially important for patients within the care of the older people's service who are typically complex. While it is difficult to conduct a full comprehensive geriatric assessment on the first encounter with the patient for multiple reasons, including lack of information or inability to assess during an acute illness, encouraging the initiation of the comprehensive geriatric assessment as early as possible has clear benefits for ongoing care.

Furthermore, in an acute medical setting where junior doctors rotate frequently and services often rely on temporary staff, a proforma can help provide consistency and guide those with less experience of the specialty or department.

Drawbacks of the proforma mainly relate to the initial learning curve associated with a new method of documentation. As with any implementation of a change of practice, initial difficulties are to be expected, but as time went on the use of the proforma improved. Indeed, the main reason why certain key information was not documented after the implementation of the proforma was because the proforma was not actually used. This could be mitigated by providing further teaching sessions or department-wide notification to encourage ongoing use of the proforma.

These results reflect those of other studies in both a daily ward round and post-take ward round setting. These studies were mostly focused on a general medical or surgical ward round whereas this quality improvement project was directed towards the care of the older people's service. Proforma use in general has been successfully implemented throughout the healthcare setting, including patient handover (Mughal et al, 2019) and radiological reporting (Patel et al, 2018).

However, there are some limitations to this study. This project focused on the quality of documentation but not clinical outcome. While the proforma promoted initiation of the comprehensive geriatric assessment, improvement in quality of clinical care or assessment was not measured. On the other hand, certain aspects of documentation also rely heavily on the junior doctor documenting – there were occasions where it was clear that the entire clinical assessment was not documented. The next step of the study would be to look at clinical outcome and length of stay while also assessing long-term sustainability of proforma use. A further re-audit was planned but the hospital has changed how acute admissions are managed as a result of the COVID-19 pandemic. Any re-audit conducted during the pandemic would also likely not be truly representative of 'normal' times because of the overall decrease in acute admissions seen nationally and the demographic of admissions being skewed by the pandemic.

Despite these shortcomings there were clear improvements made that promote improved clinical care and the consistency obtained is highly valuable to the entire multidisciplinary team.

Conclusions

The use of a post-take ward round proforma improves the quality and consistency of documentation and can be tailored to a specialty such as care of the older people to promote

Key points

- The post-take ward round is often the first time a senior clinician will review a patient on the acute medical take. Despite this there is no official guidance on structure or documentation.
- The comprehensive geriatric assessment has often been described as the 'gold standard' in the care and assessment and older person, but there is no official guidance on its initiation in the acute care setting.
- A ward round proforma can improve the quality of documentation and encourage the initiation of the comprehensive geriatric assessment during the post-take ward round.

higher quality clinical assessment. The authors encourage the creation of proformas that are specialty specific as this promotes initiation of clinical assessment or investigations that are vital or necessary for that specialty. Those working in a setting where electronic documentation is used would also benefit from the flexibility. For example, during the COVID-19 pandemic, specific changes were made to the proforma to ensure documentation of important information to aid in clinical assessment during this time period.

While this quality improvement project highlights the logistical benefits of a proforma, further research is required into how proforma use affects clinical outcome and length of stay.

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Conflicts of interest

The authors declare no conflicts of interest.

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