Blending Service with Training

Manchester Children's Hospital Project

"Improving the Management of Specialist Training"

During 2000-2001 Dr Mark Bradbury and Dr Maureen Cleary, assisted by Jo Cumming, Chartered Occupational Psychologist worked with the SHO trainees.

The aims and objectives of the project "Improving the Management of Specialist Training" were:

1. To design and deliver a teaching package
2. Promote deeper understanding of clinical problems in a necessary routine activity as demonstrated by:
   - A logical approach to differential diagnosis
   - Developing a flexible teaching plan
   - Predicting problems that may arise in the course of an illness
   - Developing clarity in imparting information to colleagues
3. Improve the quality of information held in medical case records
4. Improve the quality of patient care particularly routine hours

As the project progressed it soon became clear that there was a need to integrate it with an ongoing project on 'Improving medical handovers'. The fundamental underpinning of both the projects was a need to improve not only 'what' information the SHOs passed to others but also 'how' they carried out the communication, whether face-to-face or in writing. Two of the main learning points at an early stage were that

"Just because you have told someone they may still not know what you know!!"

"The only important thing is the message the receiver ends up with."

This was a revelation to some SHOs and helped them to appreciate why we were doing the project.

To inform the SHOs of good practice, we used a case notes audit (see Appendix). In one exercise they were asked to divide the questions between admittance, ongoing history and discharge. The people who attended the session used the audit to inform their own case notes. On another occasion we brought sets of notes for discharged patients to the session. They audited these informally, using the questionnaire and were surprised to find facts missing, notes not up-to-date, data missing, illegible notes etc. The consultants took this opportunity also talk about the clinical content but unfortunately there were not many SHOs at the session

There was quite good attendance at sessions in 2000 but as we moved into 2001, attendance dropped. There were several reasons for this. Work that would be assessed in exams was given a higher priority. It became apparent that there was no clear system for SHOs and Registrars to cover for each other when one was on a training activity. On several occasions activities were on offer to both groups at the same time. It became obvious that there was no mechanism for getting the SHOs to attend sessions, regardless of the importance of the topic. A decision was then taken by the clinicians to adopt a different strategy. The training package would be designed for delivery during the induction of the next intake of SHOs in August 2001

Several radical steps taken by the consultants to increase the likelihood that all the SHOs would be present, and stay, at the sessions on Change and Learning, 'Improving Case Notes' and 'Improving Medical Handovers'.

- In case there was a sudden emergency, the Crash team was told where they were then the SHOs were asked to turn off their 'bleeps'
- They were given a clear message that they were expected to attend, even if they had been on-call overnight
- They spent half the day on the wards and the rest of the day on various induction activities

They were already saturated with information, after many 15 minute 'death by lecture' sessions. Having the whole group present meant that they could participate in a range of experiential activities and not just be told what to write in case notes. One of the most enlightening activities was based on the game of 'Consequences' or what is sometimes called Chinese Whispers. This time, instead of whispers, the SHOs were given a sheet of paper with a medical term at the top. They had to copy this, fold the paper over and pass on their writing for the next person to copy. This was a salutary lesson in the need to write legibly and check that they were copying accurately.

There were two activities developed where Best Practice was presented rather than giving the SHOs the opportunity to explore the issues themselves. These were:

- The case notes audit questionnaire mentioned above
- 'Best Practice in handovers' which demonstrated the strong link between the information in handovers and case notes and who had responsibility for ensuring the right information was recorded on the case notes at the right time. This included a 'prompt card' (see below) that highlighted the clinical information that needed to be communicated and recorded in the case notes.

As can be seen from the contents of the 'Case Notes Session' - see Appendix, other aspects of the process can be covered, according to the judgement of the consultant trainer and the time available. The manual *"That's not what I meant"* gives guidance on which activities are essential and which are optional.

Ward.....Written communication - medical handover				
Date Time	Patient name	Age	Active problem	
Things to be aware of/potential problems				
Plan/things to do: Signature:			Who?	When?

Prompt card to improve the quality of recorded information

To maintain the momentum of learning, each SHO has been asked to gather information from the speciality unit to which they have been assigned. They are to find out what are the recurring issues that appear in the case notes and how these should be represented so they contain essential information that is clear to others, especially a locum or an SHO covering the unit on-call. As the SHOs share this information it increases the active learning across the group about clinical problems.

The competence of the SHOs case notes is going to be assessed within six weeks of the induction by their clinical tutor. They will take sets of their case notes to a tutorial as a topic for discussion. Later in the 2001-20002 programme a sample of case notes will be audited.

The resulting new practice / structure planned was:
1. A teaching package to develop written communication skills
2. Active learning about clinical problems
3. Improved notekeeping

Appendix - extract from 'That's not what I meant!' learning package

IMPROVING CASE NOTES

Session 3 – Improving Medical Case Notes

Overview

This session focuses on ensuring the SHOs understand:

- Understand structure and content of case notes at MCH

Aims of the session

- Able to identify strengths and weaknesses in writing case notes
- Able to rectify the weaknesses
- Recognise omissions and errors
- Produce quality case notes
- Know what you still need to learn over the next 12 months

We give a session map of this section on page 4, to help you choose which mix of activities will help you achieve these aims.

Contents

Activity 7 'Meet Anita' - Best practice in writing case notes

Purpose

To give the group the experience of writing case notes, getting feedback and understanding what is Best Practice in writing case notes. They will gain insight to why a case note is acceptable or unacceptable

Session Map

Activity No.	Activity Name	Time in minutes
1*	Introduction	5
2*	Hopes and concerns	5
3*	Consequences	10
4	Real world learning - 'Death of a child' revisited	15-30
5**	Case notes audit	40
6	'Your case' - Putting it all together	35
7**	'Meet Anita' - Best practice in writing case notes	30

You may choose whichever activities suit your preferences. However, to ensure the SHOs get a mix of input and skills development we recommend including the ones marked with an asterix.

A double asterix is where we feel the activity is essential for their learning.

Post-training Case Notes Evaluation Process Name……

Tutor guidelines: Go through one or two sets of case notes, to which the SHO has had a considerable input, and audit them against this list, putting a '✓' or a 'X' in each empty box. Use your best judgement for any items you think may not be relevant.

Items to be audited	Admission	Daily Update	Discharge	Comments
1. Admitted under (consultant noted)				
2. Audited by				
3. Length of Stay (days)				
4. Age				
5. Discharge diagnosis				
6. Source of Admission				
7. Are Drugs on Admission Clear?				
8. Are the Notes Adequate?				
9. Is there a Clear Problem Assessment? (active/inactive)				
10. Is clinical course documented + prospective planning?				
11. Are all entries signed?				
12. Was biochemistry done?				
13. … was it necessary? (results recorded)				
14. Was haematology done?				
15. … was it necessary? (results recorded)				
16. Was bacteriology done?				
17. … was it necessary? (results recorded)				
18. Was radiology done?				
19. … was it necessary? (results recorded)				
20. Were any tests omitted?				
21. Was the treatment appropriate?				
22. Were any drugs used inappropriately?				
23. Was each identified problem dealt with appropriately?				
24. Is it clear what information was given to relatives?				
25. Was GP letter adequate?				
26. Is it clear what the discharge medications were?				

27. Is it clear what information was given to parents/child?				
28. Are follow up plans clear? (safety netting)				
29. Is the head circumference centile recorded?				
30. …weight centile recorded?				
31. …height Centile recorded?				
32. Was development recorded?				
33. Was prescription written properly				
34. Was protocol followed? (if available)				
35. Were results of X-Rays noted?				
36. Was MSU available before discharge?				
37. Was treatment given noted?				
38. Was patient seen by a consultant?				
39. Was discharge discussed with consultant?				
40. Was the parent seen by a consultant?				
41. Was the discharge diagnosis noted?				
42. Was a handout given?				
43. Was OP follow up arranged?				
44. …was it necessary?				
45. Was BP recorded?				

People may have to make decisions on these case notes when on-call but when with no experience of the ward/unit. Bearing this in mind, circle one box for each question….

How easy was it to find the required information?	EASY	OK	DIFFICULT
How easy was it to read (legible)?	EASY	OK	DIFFICULT
To what extent do you judge all relevant information was present?	MOSTLY THERE	SOME	SPARSE
How understandable was the information, even allowing for this being potentially a new discipline for the reader?	CLEAR	MIXED	POOR

Comments

Signed …… (assessor) Date……