BLENDING SERVICE WITH TRAINING

Date

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FINAL REPORT – BLENDING SERVICE WITH TRAINING

The changes seen within the medical directorate at Burnley Health Care NHS Trust over the last 12 months have been dramatic. Although complex and wide reaching, word limitation means that this report is able to provide an overview of these changes through the Blending Service With Training project. The aims and investigations outlined along with the procedures undertaken and outcomes of the production of the Generic Assessment Document and various Integrated Care Pathways.

Blending Service With Training – An Overview of the Initiative

9.1.1 As part of the Government Modernization plan, the Northwest Deanery was allocated monies to fund a range of projects where demonstrable improvements in the management of patient care could link with innovations in medical education.

1.1.i The Deanery wished to use the initiative to encourage the development of best-practice and multi professional working. The work undertaken should be high profile within Trusts and go a long way to addressing quality and educational issues highlighted in Government publications such as the recent NHS plan, A First Class Service and A Health Service for all the talents.

1.1.ii Other stipulations from the Deanery were that the project should be innovative and be centered around departments with an enthusiasm for change. The approach should be partnership oriented involving all health care professional and where possible will include the patient perspective.

2. Project Title

Emergency Medical Admissions – Developing Evidence Based Care.

3. Project Outline

3.1 Malcolm Littley, the Clinical Director of the Medical Directorate at Burnley Health Care NHS Trust outlined the project in the initial bid to the North West deanery
"To examine the present pathway of patients admitted through the Accident and Emergency department to acute medical beds in the hospital and to develop further a range of ideas which will benefit patients, junior medical staff (service and training) and potentially the Trust, through improved patient management against the guidelines implicit in care pathways.

3.1.i The project will focus on current practice for a short period to gather audit data which is required for the latter evaluation of the project.
The focus will also include development of the necessary care pathways and planning of the implementation of a major change in practice and culture.
The latter part of the project will also involve implementation with close involvement of the appointee in the clinical process, gathering new evaluation and audit data, collected as a by product of the new process.

3.1.ii This Trust does not yet have 'paperless patient records' and this project is seen as an essential step in bridging the gap between the present position and future technological advances." (Littley 2000)

4. Scope and Aims of the Project

4.1 The aim of the project is to examine, develop and introduce improvement to current practice within the Medical Directorate with a view to providing excellence in evidence based multidisciplinary working.

4.2 Specific Objectives

4.2.i Particular objectives are that the admission process be streamlined through the design and introduction of a unified patient record which will include a structured clerking proforma. This multidisciplinary assessment document (named the Generic Assessment Document or GAD) breaks down interdisciplinary barriers, enhances and standardizes the of quality of admission information through its structure and reduces time consuming duplication.

4.2.ii Integrated Care Pathways will build upon this, supported by and giving support to National service Frameworks and Health Improvement Programmes.

5. Setting the Project in Context / Background

5.1 With 17 wards, acute and rehabilitation, 17 consultants and over 300 staff, the medical directorate at Burnley General Hospital is comparatively large. Between 25 and 40 patients per day, with some seasonal variation, are admitted as acute medical emergencies; approximately 70% of which come via the Accident & Emergency department to the Medical Admissions Centre. Emergency referrals from General Practitioners are admitted via the Medical Assessment Unit.

5.1.i Analysis of figures for March 2001 indicates an average of 28 admissions per day as acute medical emergencies which translates to a total of 9,324 patients per year.

5.1.ii Following admission to either the Medical Assessment Unit or Medical Admissions Centre, the patient will be transferred to a follow up medical ward.

5.1.iii The current admission process involves patient assessment by the Accident and Emergency nurse, the Accident and Emergency SHO, the Medical SHO and the Medical Admissions Center nurse. Accident and Emergency records are separate from the medical clerking records, which in turn are separate from the nursing records. Consequently time consuming duplication and difficulty with interdisciplinary communication occurs. This also has consequences for allied health professionals such as physiotherapists or dieticians; when questioned similar difficulties were experienced in that no consistent place for their written communication existed which leads to either one group of staff receiving written reports or the need for duplications.

5.1.iv Through streamlining and disentangling the admission process patient care can be enhanced. Time consuming duplication will be removed which will release carers to care. A structured clerking proforma will guide information gathering and improve its overall standard.

5.2 Coordination of multidisciplinary care by promoting interdisciplinary communication is of vital importance to patient safety and effectiveness of care, particularly when a patients is admitted and then transferred through a variety of wards.

5.2.i A system of record keeping which reflects the complete episode of the patients admission, investigations and ongoing multidisciplinary management can fulfill both of theses aims and lead to holistic, patient centered care.

9 National Policies Driving Improvement

6.1 The UKCC (1993) recognizes the advantages of 'shared records' and advocates that each practitioner's contribution to such records should be seen as of equal importance and reflect the collaborative and cooperative working within the health care team.

6.1.i Likewise, the Audit Commission (1995) describe the characteristics of the perfect health record as multidisciplinary and integrated, and that it should have a semi-structure format, be legible and incorporate evidence based clinical guidelines.

6.1.ii At present, variations in practice by medical practitioners has had knock on effects for a whole range of other professionals, from admission and discharge of the patients to the range of interventions undertaken by those disciplines. It also means that public money may be spent on ineffective practice. According to Kopp (2000), practice variations occur for two main reasons. Firstly, there is no agreed best practice, so practitioners must choose what they believe to be the most appropriate treatment and secondly, that best practice has been agreed, but not all practitioners are aware of it.

6.1.iii The second part of the Blending Service With Training project involved the development of and introduction of Integrated Care Pathways. These are multidisciplinary guidelines, which set out appropriate care and treatment whilst facilitating best practice. They form a working part of the patient record and promote ease of audit through their design.

6.1.iv Clinical Governance, according to the Government white paper the New NHS; Modern-Dependable (1997), is a new system in NHS Trusts and Primary Care to ensure that clinical standards are met and that processes are in place to ensure continuous improvement. Matthewman responded in the medical directorates clinical governance action plan for 2000/2001. He hopes that care pathways and clinical protocols will address quality issues in care delivery systems and that care will be patient centered and evidence based.

6.1.v The Government White Paper 'Saving Lives' published in July 1999, has the overall aim of improving the health of the population as a whole and also of

the worst off in society. It published targets to achieve by 2010, the first of which is to reduce the death rate in under 75 year olds by at least 40% from coronary heart disease and stroke. In mental illness, death rates from suicide are to be reduced by at least 20%. This Blending Service With Training project will tackle two of these targets through its development of care pathways for acute myocardial infarction, stroke and overdose.

6.1.vi The Government White Paper of 1998 " The New NHS – Modern Dependable" set the agenda for modernization in the NHS and expected health authorities to respond by developing a local Health Programme (HimP). Coronary Heart Disease is widely acknowledged as East Lancashire's 'biggest killer' – with premature death rates a third higher than the national average. The Blending Service With Training project addresses many of East Lancashire's cardiology targets. For example that Trusts will formulate "an agreement on of clinical protocols", will "develop smoking cessation programmes…. building on Nicotine Replacement Therapy Schemes" and will review progress towards 'lipid lowering drugs' (East Lancs Health Authority 2000). The Care Pathway for myocardial infarction includes all of these targets. In addition East Lanc's Health Authority stipulates that a Steering Group with Trusts, Primary Care Groups, Local Authority and patient groups produce a strategy through a number of task orientated sub-groups. The Blending Service With Training project is represented at, and provides a report of progress, at each of the Trust Steering Group meetings.

7. Description of the Procedure

9.1 Achievements to Date

9 Manual audit trail for the current emergency admission process from the Accident & Emergency department to the Medical Admissions Centre.
10

9.1 Comparative audit of admitting times pre and post introduction of the Generic Assessment Document.

9.2 Established and led multidisciplinary groups for Generic Assessment Document development.

9.3 Literature searches and networked to create a resource library of Integrated Care Pathways.

9.4 Established and led a variety of multidisciplinary working groups for the development of specific Integrated Care Pathways.

9.5 Multidisciplinary training sessions in the use of the Generic Assessment Document – over 120 attendees.

9.6 Preparation of medical outlier wards to receive medical patients accompanied by the Generic Assessment Document.

9.7 Launch of the Generic Assessment Document.

9.8 Circulation of updated Cardiac guidelines in preparation for the launch of the the Integrated Care Pathway for Myocardial Infarction.

9.9 Multidisciplinary training sessions for Integrated Care Pathways.

9.10 Launch of the Integrated Care Pathway for Myocardial Infarction in the Accident & Emergency Department and the Medical Directorate.

9.11 Continued development of further Integrated Care Pathways in Stroke, Asthma, Overdose and Rheumatology.

9.12 Creation and lead the 'Trust Wide Support Group for Integrated Care Pathways.

7.2 The Generic Assessment Document
Information Gathering
Audit Trail

7.2.i Although anecdotal evidence of current practice was evident, factual information needed to be established. An audit trail was therefore devised which tracked patients admitted from the Accident & Emergency department through to the medical admissions center.

7.2.ii Specific areas to be analyzed were:

9 Patient admission information such as name, address and next of kin
10 Appropriateness of investigations and accuracy in their recording
11 Patient admission, examination referral and transfer times
12 Signature legibility and use of stamps
13 Allergy checking
14 Supporting documentation such as charts for temperature, pulse and respiratory rate
15 A list of common conditions as diagnosed.

9.1.1 Audit of Admitting Times

9.1.2 The aim of this audit was to establish the average length of time taken to admit a patient as an emergency medical admission. By comparing the traditional record keeping system of separate notes to the new multidisciplinary documentation a quantitative result as an increase or saving could be demonstrated, which of course translates to resource implications of the introduction.

9.1.3 Junior doctors usually change specialties every six months. For this study two senior house officers (one acting as a control) were chosen; these were continuing their medical directorate placement during both time periods and would continue with on call take. Nurses in the medical assessment unit were also chosen because information gathering is from scratch here as the patient is admitted here directly from the GP.

7.4. One to One Meetings

7.4.i Meetings were arranged with heads of departments such as pathology and radiology, as well as service managers such as social work and dietician

and ward managers within the medical directorate. The aims of these meetings were to introduce the Blending Service With Training project to the managers, to introduce the project co-coordinator to the manages and also to gain an insight into the service difficulties associated with the various departments an the medical directorate.

7.5 Multidisciplinary Group Development

7.5.i Ward and departmental representation was sought to establish a multidisciplinary working group. Four meetings were arranged at monthly intervals with attendance averaging around 17. The aim of this group was to consult on changing practice with the focus on the development of a unified, structured clerking proforma. Drafting and redrafting took place through verbal and written feedback.

7.6 The Generic Assessment Document – Preparation & Launch

7.6.i The concept of a shared record with equality in access posed difficulties for many from a cultural point of view. Information giving and requests for individual feedback was therefore considered essential in order to gain ownership on such a huge scale.

7.6.ii Current documentation was collected and analyzed. The framework for the combined, structured admission document was designed and distributed to each consultant, sister and departmental manager who were asked for their teams contribution to the various drafts. Multidisciplinary meetings were held with minutes circulated. Presentations were given at the medical directorates consultant, junior doctor and sister's meetings. Posters were sent to wards and departments on a monthly, then fortnightly, then weekly basis informing of the imminent launch of the Generic Assessment Document. In addition training sessions were held at various times of the day and evening to teach all staff in its use.

7.6.iii A trial period of six months was planned. Patient numbers were projected for that time period and subsequent amounts of the document were printed. These were distributed to wards which are points of entry to the Medical Directorate and all former documentation was removed.

7.7 Care Pathway Development

7.7.i The second part of the project involved the development of integrated care pathways

7.7.ii Information Gathering
Using traditional library resources and the internet, information was gathered about practice elsewhere. Networks with other hospitals and with

organizations such as the National Pathways Association were also established to shared information and practice. From this a resource library was created and a Trust Wide Support Group for Integrated Care Pathways was established.

7.7.iii Trust Wide Support Group for Integrated Care Pathways
The primary aim when considering this group's development was to share information with other Trust staff who may be considering Integrated Care Pathways in their own fields, to prevent staff 're-inventing the wheel'. In addition the work undertaken within the medical directorate, as part of the Blending service with Training Project, could be promoted as being the forerunner of future development within the Trust. In this way a corporate image would be created which would encourage greater uptake staff would be familiar with the format of the pathways where ever they may work.

9.1 Multidisciplinary Group Development

7.8.i A decision regarding the choice of, and order of Integrated Care Pathway development was made. This was based upon the result of the audit trail showing that chest pain and angina, stroke and overdose were the most frequently reported diagnosis for acute medical admissions. Supporting this were national targets which required local attention such as the National Service Frameworks for Coronary Heart Disease (2000), mental health (2000) and elderly (2001). It was therefore agreed that Integrated Care Pathways for acute myocardial infarction, stroke, and overdose would be addressed during the project timescale.

7.8.ii A working party was established for each of these conditions. The groups were multidisciplinary and included representation from nurses, including specialist nurses, from physiotherapists, occupational therapists, speech and language therapists, social workers, pharmacy, consultants and specialist registrars.

7.8.iii Integrated Care Pathways and the Accident & Emergency department
The Accident and Emergency dept recognizes the important contribution that they play to medically ill patients. They were keen to improve the service that they provided and so, although not part of the medical directorate, agreed that integrated care pathways would commence in the Accident and Emergency department.

9.1 The Integrated Care Pathway for Myocardial Infarction
The National Service Framework for coronary Heart Disease (2000) provided the stimulus to examine the current evidence basis behind Burnley's Cardiac Guidelines and service provision. Particular attention was

drawn to the care and treatment of a patient experiencing acute myocardial infarction.

7.9.i A multidisciplinary working group was established, meetings held monthly and through consultation and feedback the care pathway for acute myocardial infarction was developed. Again a series of posters were sent to wards and departments in preparation for the launch of the MI Pathway. A training programme was planned with over 100 attendees and the care pathway for acute myocardial infarction was launched on the 2nd April 2001. On going support to staff id provided as planned in the Blending Service With Training bid by the Practice Development Advisor, along with the Cardiology Nurse Practitioner. Formal review and evaluation of the pathway is to take place after use with 50 patients.

7.10 <u>The Integrated Care Pathway for Stroke</u>
Multidisciplinary working was again established and Burnleys current service and documentation was examined along with other service provided locally and nationally. Consultation was sought from the Royal College of Physicians (2000) and the Scottish Intercollegiate Guidelines Network (1997) recommendations. Through regular meetings and a half day workshop, the Integrated care pathway for stroke was developed. Education and training sessions are to be planned prior to launch in June.

9.1 <u>The integrated Care Pathway for Asthma</u>
An initial meeting with the Respiratory Nurse Specialist was held and an outline of asthma care devised. This was drawn up into a pathway using British Thoracic Society (1997) guidelines for the initial assessment. Meetings were then held with the respiratory consultants and specialist registrar and changes made to the pathway drafts. This now needs to be rolled out to the Accident & Emergency department and ward nurses prior to a final draft being produced and then launched.

9.2 The Integrated Care Pathway for Overdose
Overdose was one of the conditions most frequently reported on the Medical Admissions Centre. For this reason staff were keen to develop a care pathway for this condition. An initial meeting was held with the ward sister and aspects of care discussed. A draft wad produced following this meeting which was added to by the psychiatric nurse team who assess a patient following overdose. A letter was sent to the consultant psychiatrists inviting input from a member of their team. Input will again also be welcomed from the Accident and Emergency department and the medical wards.

Burnley Health Care NHS
NHS Trust

A&E TO M.A.C.
AUDIT REPORT

Siobhan Knight

Introduction

As part of the Government Modernization Plan and subsequent Blending Service With Training project, an audit trail was undertaken to examine the present pathway of patients admitted through the Accident and Emergency Department to acute medical beds in Burnley General Hospital.

Methodology

50 Accident and Emergency (A&E) cards and subsequent ward-based records, both medical and nursing, were analysed. Particular attention was paid to areas of duplication.

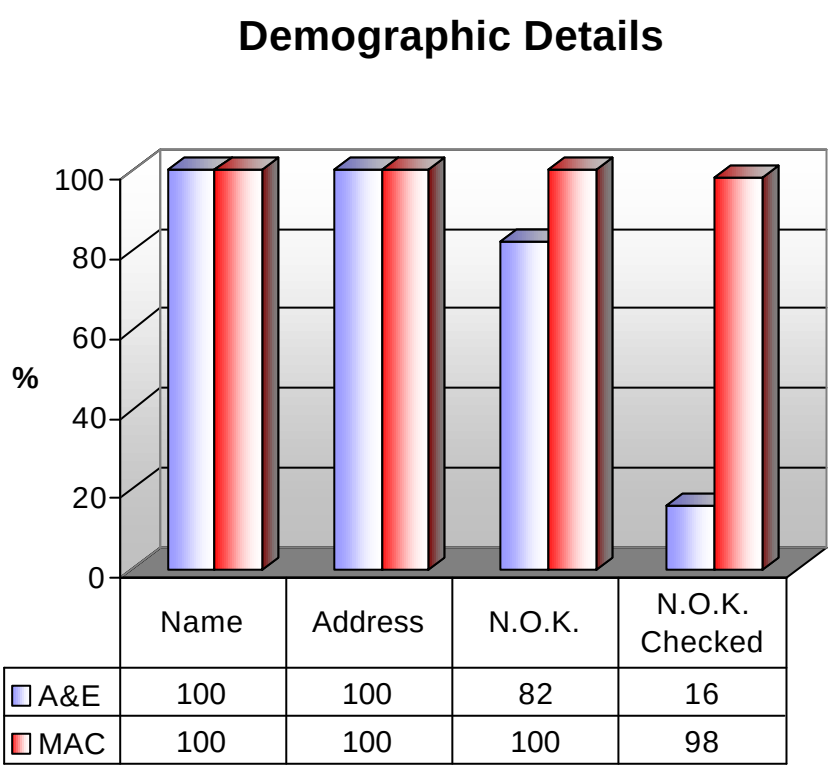
Specific Areas Analysed

- Patient admission information such as name, address and next of kin
- Patient admission, examination, referral and transfer times
- Signature legibility and use of stamps
- Allergy checking
- Supporting documentation such as charts for temperature, pulse and respiration rate
- A list of common conditions as diagnosed

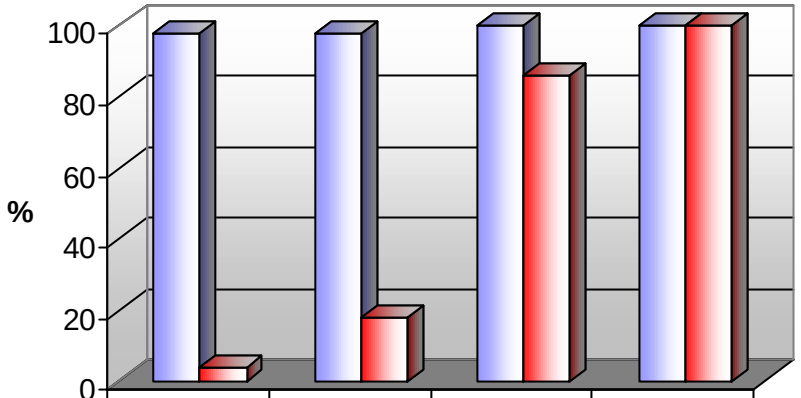
Feedback was communicated to all service users at a meeting and backed up in written form.

Results were analysed and charted as follows.

DUPLICATIONS

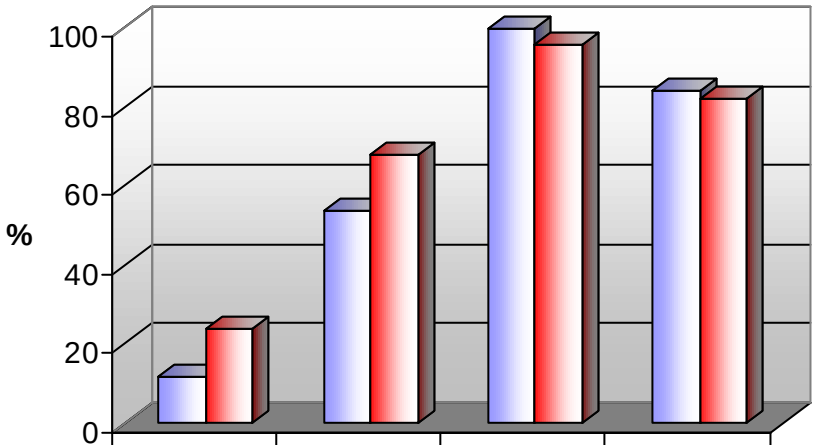


Presenting / Social History



	A&E	A&E DR	MED SHO	MAC NURSE
Presenting History	98	98	100	100
Social History	4	18	86	100

Drug History / Previous Medical History (PMH)

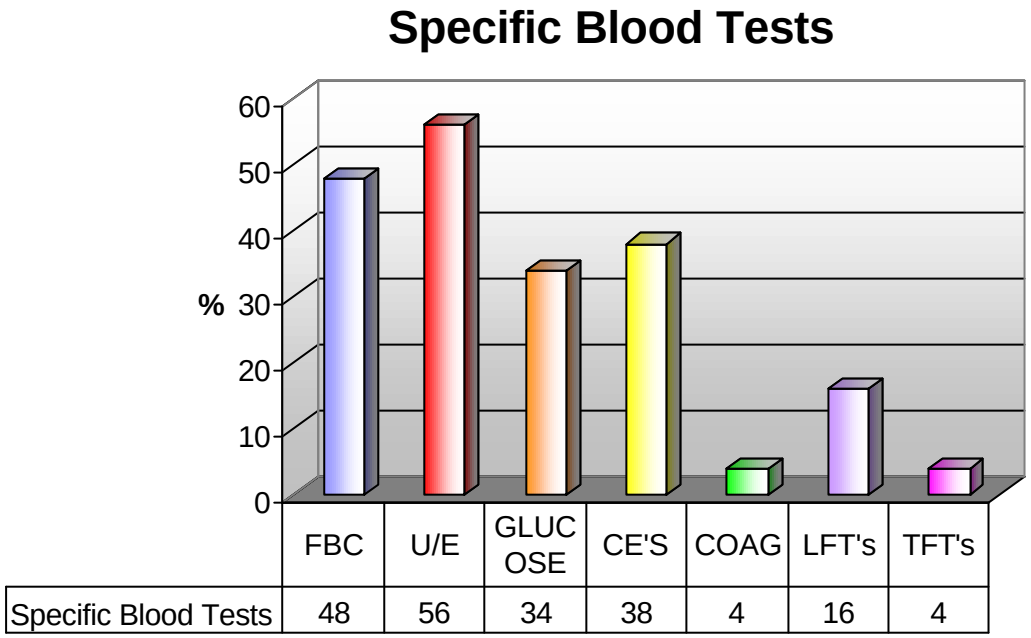


	A&E	A&E DR	MED SHO	MAC NURSE
Drugs	12	54	100	84
PMH	24	68	96	82

INVESTIGATIONS

Blood Tests

Blood tests were performed in A&E on 98% of patients; however in 42% of cases, it was impossible to ascertain the specific tests performed.



Electrocardiograph

- 76% of patients had an ECG

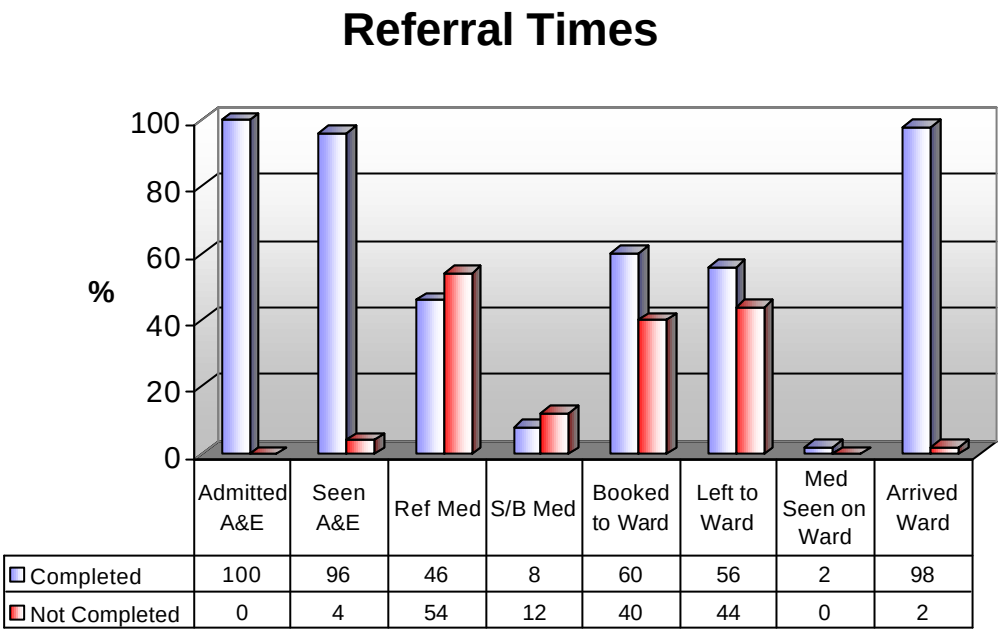
Chest X-Ray

- 74% of patients had a Chest X-Ray

Urinalysis

- A urinalysis was requested for 22% of patients but only 6% had one performed
- Result Documentation
- Investigation results were documented on the A&E Card in 20% of cases.

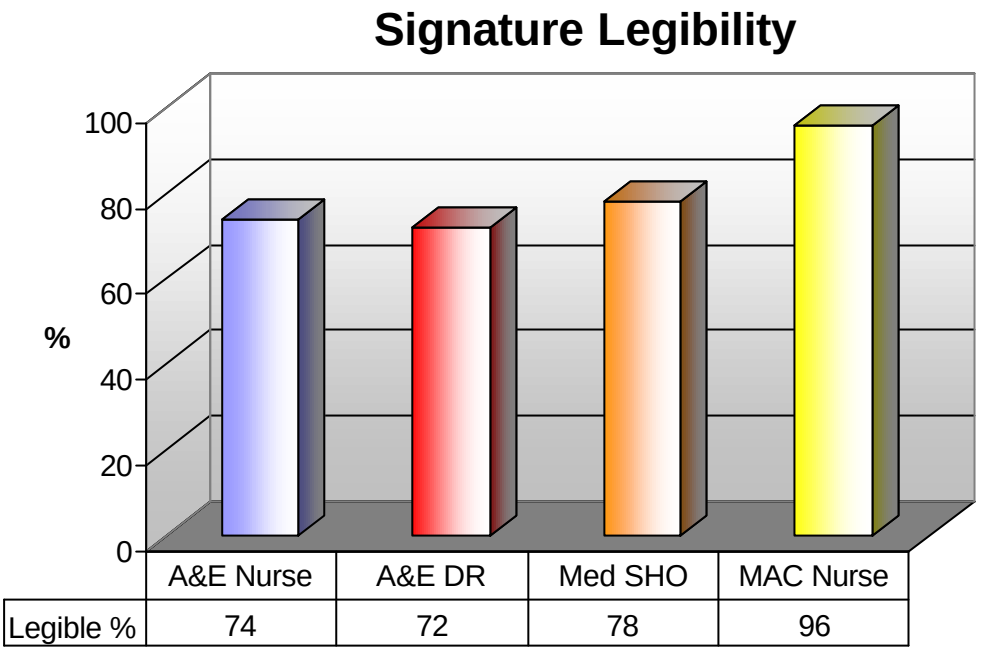
Interim computer print outs were used in 60% of cases.



	Admitted A&E	Seen A&E	Ref Med	S/B Med	Booked to Ward	Left to Ward	Med Seen on Ward	Arrived Ward
Completed	100	96	46	8	60	56	2	98
Not Completed	0	4	54	12	40	44	0	2

Notes:

- It was documented in only 8% of patients, that the medical SHO had seen the patient in A&E; the majority of the time (82%) this had been noted in the medical notes only.

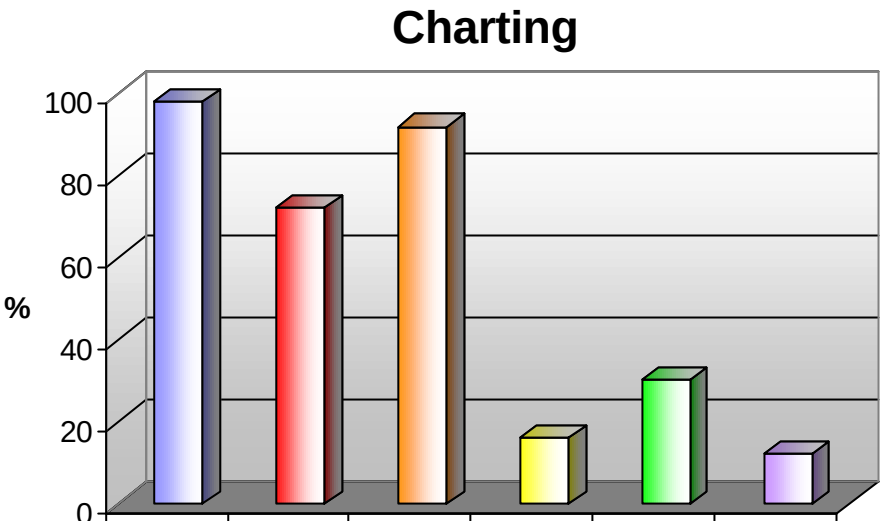


Notes:

- 8% of the signatures classed as legible were stamped. It is anticipated that this percentage will increase in time as stamps are taken up on a more widespread basis.

Allergies

- In A&E, allergy status was documented in only 2% of patients. However, in the Medical Admissions Centre the figure was 100%.



	Care Plans	Medley	TPR	Insulin / Diabetic	Intake / Output	Peak Flow
Assessment %	98	72	92	16	30	12

Notes

The above charts were used in addition to the nurses and doctors records.

Diagnosis – List of Conditions (%)

Chest Pain / Angina	26
Stroke / TIA	22
Chest Infection	10
Overdose	8
Chronic Obstructive Pulmonary Disease	8
Congestive Cardiac Failure	8
Diabetes	4
Collapse (? Cause)	4
Acute confusional state	2
Hypertension	2
Haematemesis	2
#Zygoma (fall)	2
Paroxysmal AF	2
Haematoma lower calf	2

Demographic Details Recorded

		Totals
Name	A&E	50
	MAC	50
Address	A&E	50
	MAC	50
NOK	A&E	41
	MAC	50
NOK Checked	A&E	8
	MAC	49

History & Social Details Recorded

		Totals
Presenting History	A&E	49
	A&E Dr	49
	Med SHO	50
	MAC Nurse	50
Social	A&E	2
	A&E Dr	9
	Med SHO	43

	MAC Nurse	50

Drugs & PMH Details Recorded

		Totals
Drugs	A&E	49
	A&E Dr	49
	Med SHO	50
	MAC Nurse	50
Previous Medical History	A&E	2
	A&E Dr	9
	Med SHO	43
	MAC Nurse	50

Investigations

		Totals
Bloods	How many had done A&E	49
	Not Specified Which	21

	Totals
FBC	29
U/E	28
Glucose	17
CE's	19
Coag	2

LTF's	8
TFT's	2

Blood Results Recorded

A&E Card / Printed

	Totals
A&E Card	10
Printed	30

ECG & CXR

	Totals
ECG	38
CXR	37

Urinalysis

	Totals
Urinalysis Req	11
Not Performed	0
Unsure If	8
Performed	3

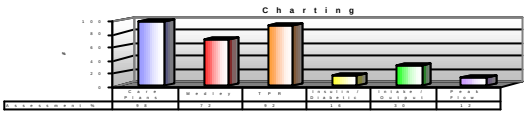
Referral Times	Completed		Not Completed	
	Admitted A&E	50	Admitted A&E	0
	Seen A&E	48	Seen A&E	2
	Ref Med	23	Ref Med	27
	S/B Med A&E Card	4	S/B Med A&E Card	6
	Notes	41	Notes	1
	Booked to Ward	30	Booked to Ward	20
	Left to Ward	28	Left to Ward	22
	Med seen on Ward	1	Med seen on Ward	0
	Arrived Ward	49	Arrived Ward	1

Signatures Legible	
A&E	37
A&E Dr	36
Med SHO	39
MAC Nurse	48
Stamps	4

Allergies Checked	
A&E	1
MAC	50

Charts	
Care Plans	49
Medley	36
TPR	46
Insulin / Diaburin	8
I/O	15
Peak Flow	6

Diagnosis	
Chest Pain / Angina	13
CVA / TIA	11
Chest Infection	5
Overdose	4
CCF	4
COPD	4
Diabetes	2
Collapse ?Cause	2
Acute Confusional State	1
A&E Same as MAC	21



Audit of Admitting Times

Pre and Post Introduction of

Generic Assessment Document

Siobhan Knight

Introduction

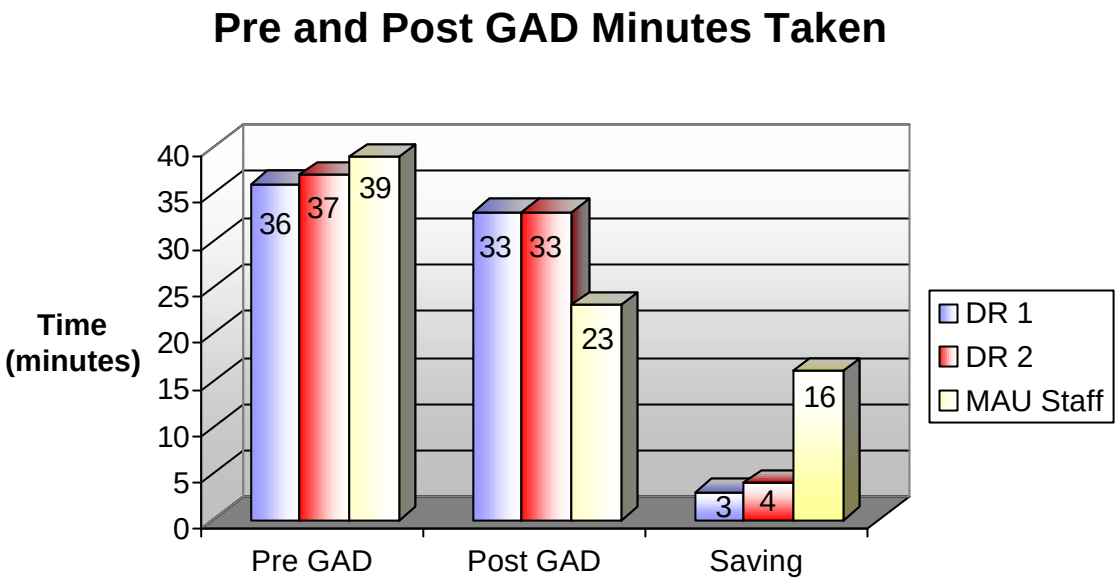
As part of the Blending Service with Training Project, the Medical Directorate at Burnley General Hospital has removed separate nursing and doctor notes and has implemented multidisciplinary patient records. This has been named the Generic Assessment Document (GAD). In order to measure its effect from a time and resource management perspective, an audit was undertaken of time spent admitting a patient using the old system of separate notes compared to the new Generic Assessment Document.

Methodology

Staff were asked to record the time taken to admit acute medical emergency patients on pre-determined days. Two medical SHO's were chosen; one was to act as a control.
In addition, nurses within the Medical Assessment Unit were chosen as they have no prior knowledge of the patient (having been admitted via their GP and not A&E), and so assessment is full and complete. These staff were to remain within the Medical Directorate pre and post implementation of the Generic Assessment Document. Results were analysed and time savings charted.

Time Taken

	Average Time (minutes)		
	Pre GAD	Post GAD	Saving
Dr 1 (Prabash Tatineni)	36	33	3
Dr 2 (Kamal Khan)	37	33	4
MAU Staff (SN J Bannister) (SN N Masih)	39	23	16


Pre and Post GAD Minutes Taken
Time (minutes)
40
35
30
25
20
15
10
5
0
36
37
39
33
33
23
3
4
16
Pre GAD
Post GAD
Saving
DR 1
DR 2
MAU Staff

Nursing Time Saved

Nurses saving = 16 mins per patient

8 patients per day = (MAU)	128 mins saving per day
	640 mins saving per week (5 day week) 10.66 hours saving per week
	554.32 hours per year

Doctors Time Saved

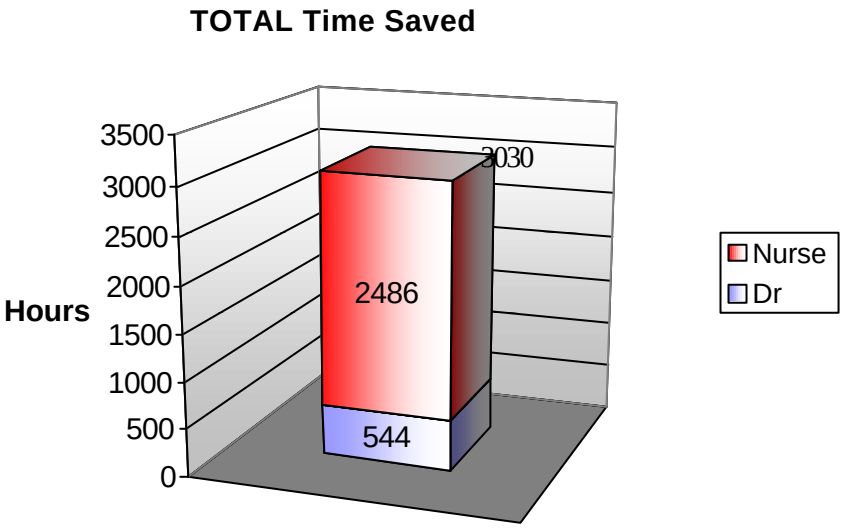
Doctors = 3.5 mins per patient

8 patients per day = (MAU Patients) 20 patients per day = (MAC Patients)	28 Patients x 3.5 mins = 98 minutes per day (Average of March 2001)
MAU open 253 days per year 8 patients / day	= 2,024 patients / year
MAC open 365 days per year 20 patients / day	= 7,300 patients / year

TOTAL patients / year	(2,024 + 7,300) = 9,324 patients / year

TOTAL Time Saved

Doctor Saving	9,324 Patients x 3.5 mins = 32,634 mins (544 hours) per year saved
Nurse Saving	9,324 Patients x 16 mins = 149,184 mins (2,486.4 hours) per year saved
TOTAL SAVING	Total time saved admitting a patient (acute emergency medical admission) = = 544 hours + 2,486 hours **= 3,030 hours per year**



Conclusion

In conclusion, the introduction of the Generic Assessment Document to the Medical Directorate at Burnley Health Care NHS Trust will save 3,030 hours per year in

admitting time alone.

9. Discussion

9.1 Enormity of the Project

Early in the 12 month timescale the enormity of the project became evident. The project in itself was two fold; the development and introduction of a unified record which incorporated a structured clerking proforma, and also the development and introduction of integrated care pathways. The original plan was to develop 'specialist sections for 10-12 common conditions' Littley (2000). It soon became apparent, that these 'sections' were to be multidisciplinary, evidence based integrated care pathways, then the original plan was unrealistic. Therefore the project plan and time scales were altered accordingly.

9.1.i The sheer size of the medical directorate brings its own difficulties. With 17 wards over 3 sites and over 300 staff, the logistics of gaining ownership of any change with so many people poses challenges.

9.2 Medical Outliers

The number of patients requiring medical beds at Burnley Health Care exceeds the number of beds available. Therefore medical patients are transferred to beds outside the directorate, such as orthopaedic, surgical or gynaecology wards. These patients become known as medical outliers. As an example of the extent of the problem, there are on average 30 medical outliers every day, however, on May 1st 2001 there were 80. This has dramatic effect on the Blending Service with Training project. Preparation of each outlier ward was needed to use the new system of unified records. This has caused challenges for them, who are therefore faced with two systems of care documentation, separate nursing and doctor records for their own patients and unified records for the medical patients.

9.3 Culture Changes

Huge culture changes have occurred as a result of the implementation of shared records. For some, these adjustments have proved difficult as doctors and nurses have held separate patient records for many years. Resistance has come in many forms, from outright hostility to indifference and so broad shoulders and many forms of persuasion have had to be employed to overcome these challenges.

9.4 Information Technology Set-backs

Delay in delivery of the computer at the start of the project and multiple printer failures were frustrating challenges. Difficulty accessing internet information for evidence basis and also to delays in speed of communications and forging networks were subsequent events.

10. Conclusions

10.1 Practice has changed on a grand scale at Burnley Health Care as a direct result of the Blending Service with Training project. The admission process has been streamlined through the design and introduction of a unified, structured admission document.

10.1.i From a resource management perspective the introduction of this Generic Assessment Document will save over 3000 hours in admitting time alone. On the quality front, the vast majority of users prefer the new unified records and state that amid other benefits, interdisciplinary communication has improved and decline the return of the old system of separate notes.

10.1.ii The quality agenda is uppermost in the introduction of the integrated care pathways. Best, evidence based practice should reduce unacceptable variations in practice and improve patient care from a clinical risk prospective.

10.1.iii The benefits associated with this Blending Service With Training Project 'Emergency Medical Admissions – Developing Evidence Based Care' have certainly been felt outside the acute medical directorate. The rehabilitation wards of the medical directorate all use the Generic Assessment Document, as does the Elective Medical Ward. Outlier wards also prefer to continue the use of the Generic Assessment Document rather than revert to their separate notes and the mental health and surgical directorates are showing keen interest in these developments, as are medical directorates at two other local hospitals.

10.1.iv The medical directorate has responded by continuing funding for a further nine months in order that further care pathways can be developed and introduced and in order that systematic review and audit can take place of these.

10.1.v In conclusion, the aims of the Northwest Deanery Blending Service With Training have been demonstrated. Best practice, multidisciplinary working, quality and educational issues have been addressed. A multidisciplinary, integrated, semi structured format which improves legibility and incorporates evidence based guidelines – the secret of good record keeping; this has been introduced.

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