

# HOSPICE HEALTH CARE RECORD REDESIGN MULTI-DISCIPLINARY TEAM INVOLVEMENT

## BACKGROUND

Kilbryde Hospice identified an opportunity to review the current paper In Patient documentation and assessment tools. The Hospice awaits a national digital platform.

Using the Plan, Do, Study, Act Cycle (PDSA) (Patient Safety Learning, 2020) to steer the working group to allow a strong and robust process of improvement to take place with clear, measurable and positive outcomes.

The aim was to make all the documentation more user friendly, streamline documentation and incorporate goal setting and “What Matters To Me”

## METHOD

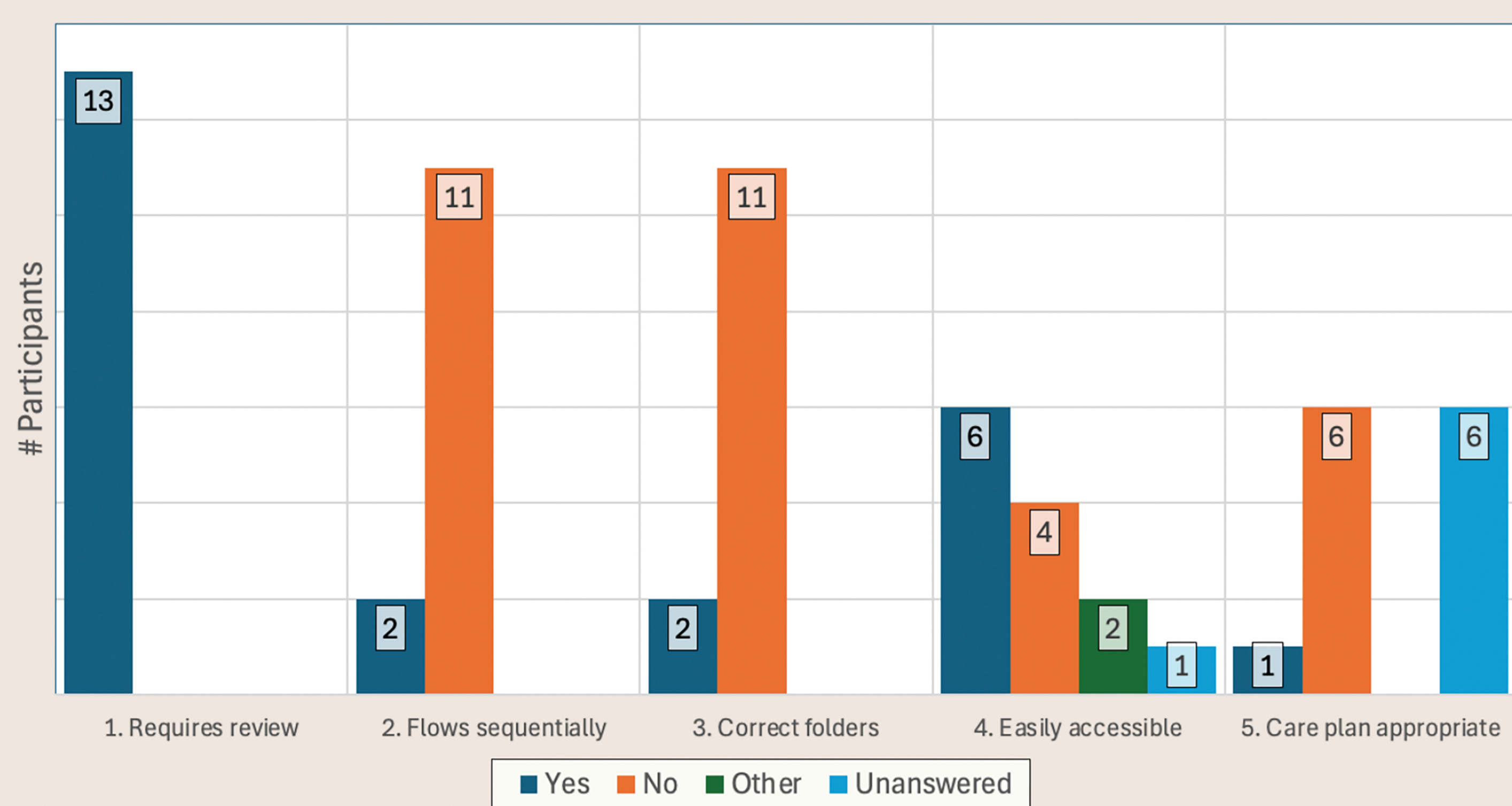
Before commencing the review, a staff survey was designed to gather information regarding the current quality of documentation. This would subsequently be compared to a survey conducted post review.

Questions asked included:

- “do you agree the ward documentation required review”
- “do you feel that the current documentation flows sequentially?”
- “do you think the current documentation is contained within the correct folders?”
- “do you feel the documents are easily accessible?!”
- “do you think that the current care plan identifies the needs of our patients and is used appropriately?”

The PDSA cycle is an ideal quality improvement tool that can be used to test improvements by temporarily trialling and changes and accessing its impact.

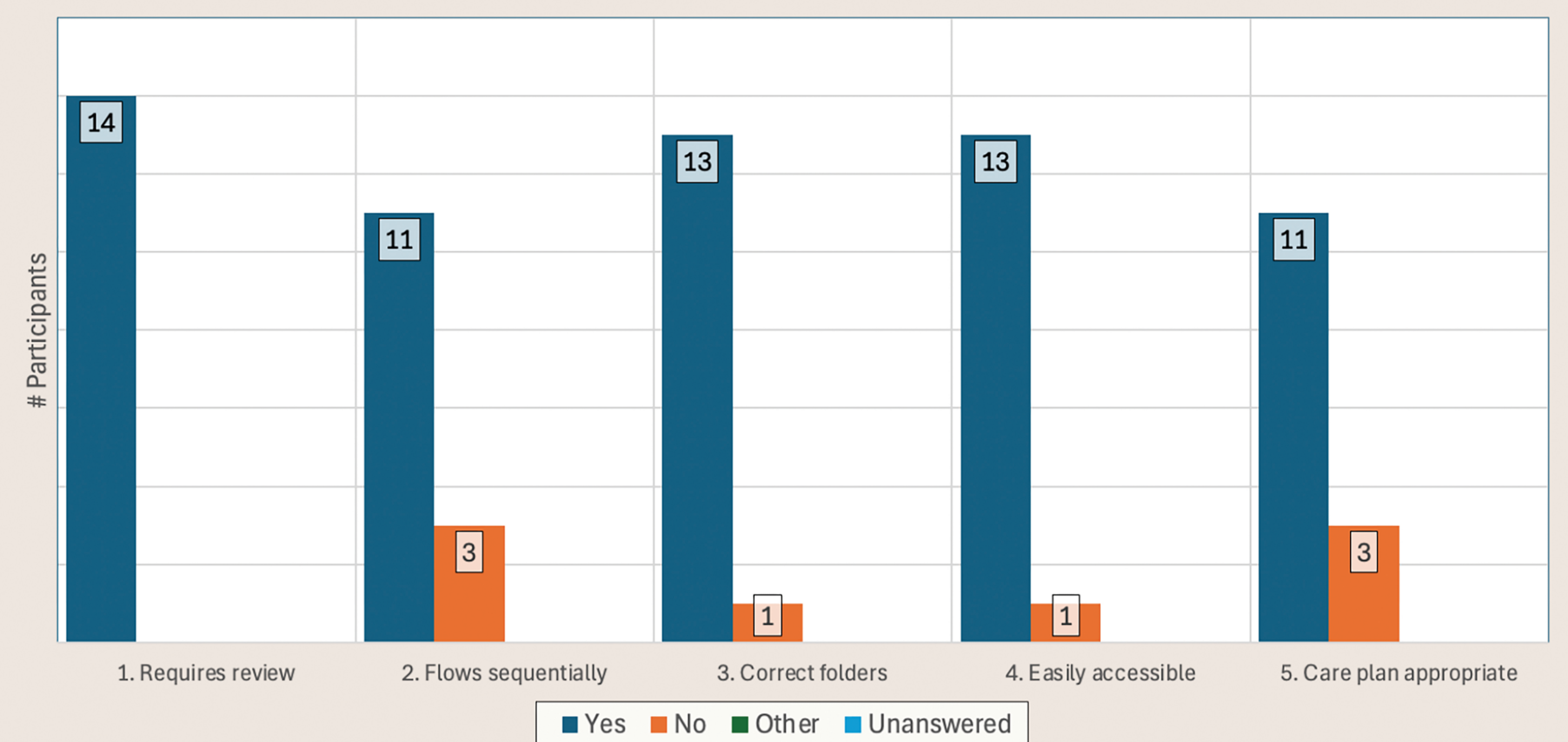
Survey Results (Pre) - Based on 13 Participants



## RESULTS

Through the implementation of the IPU documentation working group, and as demonstrated through the QI cycle, the IPU team feel we have achieved some very positive outcomes. As evidenced by the post survey results, there was significant improvement in all areas studied which the working group are delighted to achieve this.

Survey Results (POST) - Based on 14 Participants



## CONCLUSION

The use of the PDSA Cycle has successfully steered the working group, allowing a strong and robust process of improvement to take place with clear, measurable and positive outcomes demonstrated.

Moving forward, we will focus on sustaining these improvements by encouraging continued openness to change, development and promote ownership of all documentation within the team.

The most successful part for the working group is improved individualised, holistic, safe, effective patient care documented to the very highest standard.

## REFERENCES

Patient Safety Learning (2020) NHS Education for Scotland: Plan Do Study Act (PDSA).

Available at: [NHS Scotland PDSA Methodology](https://www.nhs.uk/healthcareimprovement/pdsa-methodology/)

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