Can admission notes be improved by using preprinted assessment sheets?

We were most interested to read Goodyear and Lloyd’s report on the improvement achieved with preprinted assessment sheets in a paediatric setting.1

We performed a similar exercise on our own ward for admissions to the adult wards in the Medicine for the Elderly Unit at Nether Edge Hospital. This was part of a large multidisciplinary project to develop a tool to assess individual patients that would also provide a basis for data collection and audit for each discipline.

An initial all encompassing 14 page form was piloted but rejected after peer review because of its length and lack of free space! After a second trial, a seven sided document was refined to a two sided sheet. This included demographic details, core patient information, and certain standardized assessment scales (abbreviated mental test score), Barthel activities of daily living (ADL) index,1 geriatric depression score,2 Glasgow coma scale score,3 and a modified Winchester disability score4). Clerking guidelines specifying what was to be included in the free text were issued to the admitting doctor.

Our initial tool was too ambitious to be suitable for everyday use and only produced data when artificially supported by extra clerking staff. In the more concise forms, thoughts tested to be the realm of nursing or therapy staff were often omitted (finding consistent with those of other researchers1), and feedback on a daily basis to junior doctors was essential to ensure the gathering of other pertinent patient information. Despite consultation with senior and junior doctors at every stage during the 18 month developmental period, several changes of junior doctors meant changing opinions and necessitated introductory and follow up teaching sessions.

Many lessons can be learnt from our experiences. Clear goals for what the form has to achieve need to be set and it should only include essential information. Consultants should ensure that all information gathered is seen to be used. All interested parties must be represented during its development so that the enthusiasm of users is harnessed. Regular education of new users and follow up of their progress is needed along with recognition of the reluctance of doctors to change. Implementation is time consuming, but by paying attention to organisational issues this process can be shortened.

Importantly, we discovered that in our initial thrust for change the need for an auditable document was insufficient to drive the development of the form and that clinical need was the overriding factor in initiating and maintaining change.

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