

AIM STATEMENT

The aim of this project is to improve communication as to how the renal team operates when caring for patients admitted under renal/general medicine on ward D8 at DGRI. Improvement to be determined by patient feedback score before discharge. Baseline score was 8.73 with an aim of 9.2 to be achieved by 31 March 2023.

Background

Ward D8 at Dumfries and Galloway Royal Infirmary admits patients with general medical, nephrology, cardiology and endocrinology problems. Each speciality is run by specialist consultants and junior staff and operates an individualised schedule for ward rounds and patient reviews. The renal team covers both nephrology and general medical patients. The consultants operate a 1 in 4 rota system where one consultant will cover the ward per week – both in- and out-of-hours.

This system has worked well with good feedback from patients and the ward nurses. Since moving to the new DGRI in December 2017 the team has received one complaint from a patient's family suggesting it would have been better for that particular patient's continuity of care if a single consultant oversaw their care. The team reflected on this and did not feel that they need to change inpatient service design based on one family's feedback.

However, this project was undertaken to look at the patients' understanding of ward operations and improve communication about how the renal team delivers inpatient care.

Developing Change Ideas

An improvement team consisting of myself, a consultant nephrologist and the ward clerkess was made. To understand the current system staff were shadowed including consultants, middle grade doctors, foundation doctors, nurses and ward clerks.

Quality improvement tools such as a stakeholder analysis, process maps and driver diagrams (Figure 1) were constructed to further understand the system, identify areas requiring improvement and begin to develop change ideas.

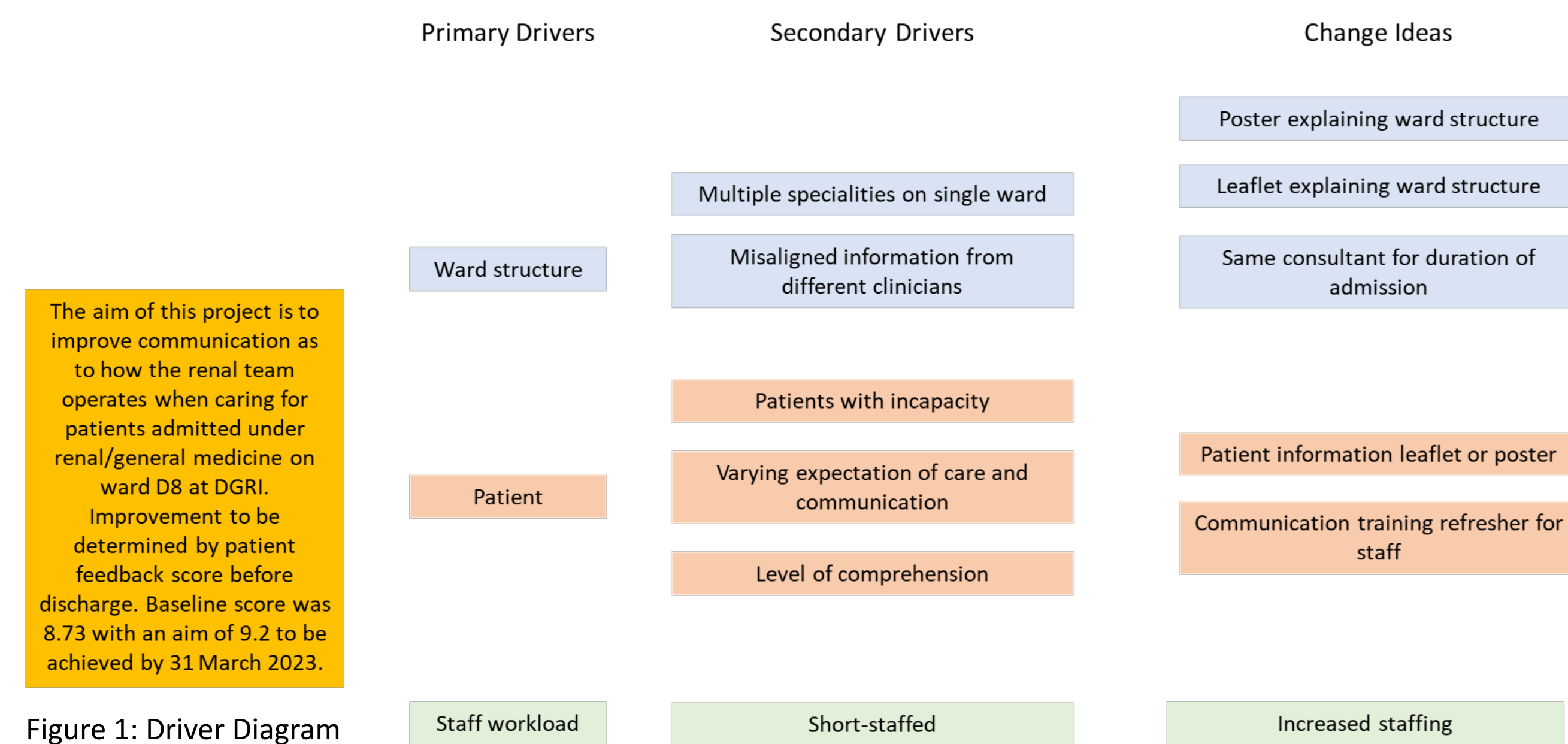


Figure 1: Driver Diagram

Patient Information Leaflet

From the driver diagram several ideas were generated for consideration. These were discussed with the improvement team, wider staff and patients. It was agreed that a patient information leaflet would be the most beneficial. A forcefield analysis was conducted and showed a net positive change, thus we went ahead with the idea (Figure 2).

Before generating the document, several patient profiles were produced to ensure the needs of our diverse patient base were considered and catered for. These considerations included literacy, patient frustrations and goals (Figure 3).

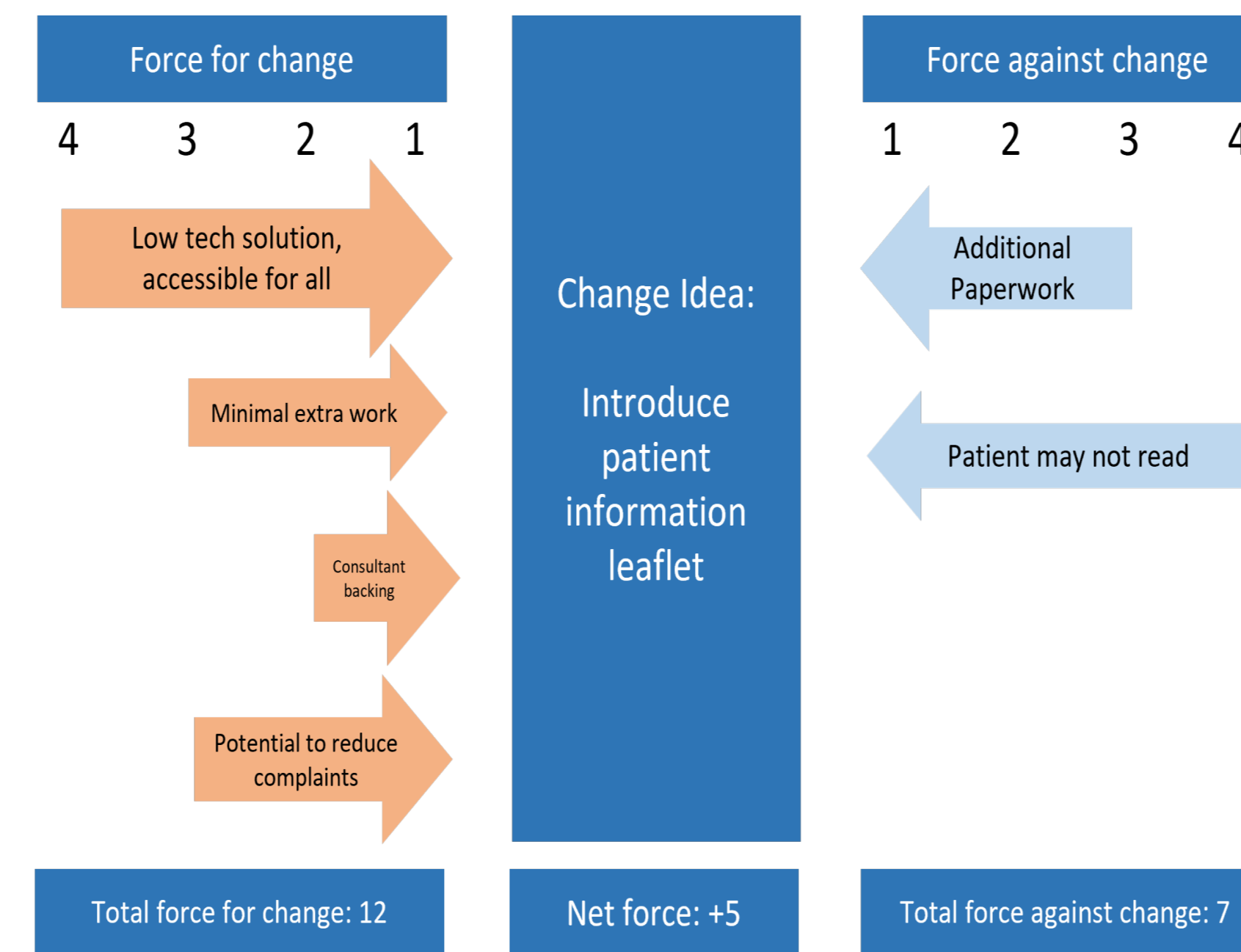


Figure 2: Forcefield analysis

Name	Patient x	Age
Occupation	Retired	Education High School
Routines	At home enjoys gardening and completing	
Goals/Needs	Wants daily updates on their care	
Motivations	Wants to update family members and	
Frustrations	Not sure which days a doctor will update them	
		Low Fair High
Tech Literacy	x	
Devices Owned	x	
Medical Knowledge		x
Numerical Knowledge		x

Figure 3: Patient profile example

An initial draft of the document was produced by the improvement team. Throughout the process we were following the plan-do-study-act methodology when creating the information leaflet (QR Code). This is highlighted in the flow diagram. The leaflet was reviewed by a consultant, several patients and the patient information coordinator at the hospital. This iterative change ensured the document was accurate and suitable for all patients before dissemination (Figure 4).

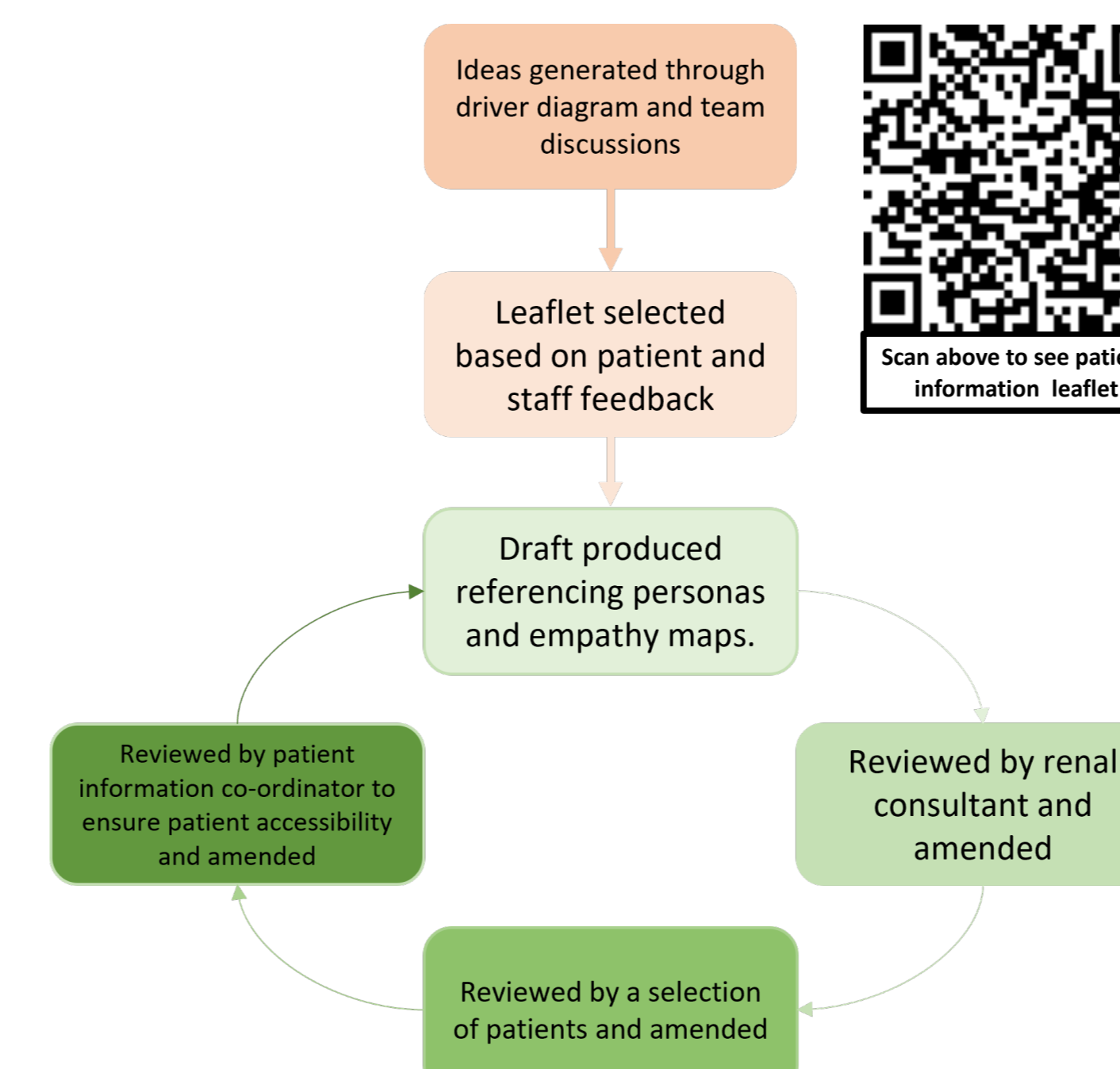


Figure 4: Flow diagram of leaflet design process.

Results

To determine baseline figures patients were asked to complete questionnaires prior to discharge. These were collected over a 6-week period. After the implementation of the leaflet patients were again asked to complete the questionnaire prior to discharge. The success of the project was determined by the measures outlined in figure 5.

Outcome measure	Communication rating (1-10) given by patients prior to discharge
Process measures	Percentage of patients knew their current consultant
	Usefulness of patient information leaflet (1-10)
	Patients' opinion: Would a change of consultant during their admission negatively affect their care (1-10)
Balancing measures	Staff stress level and time pressure

Figure 5: Table outlining measures for the project

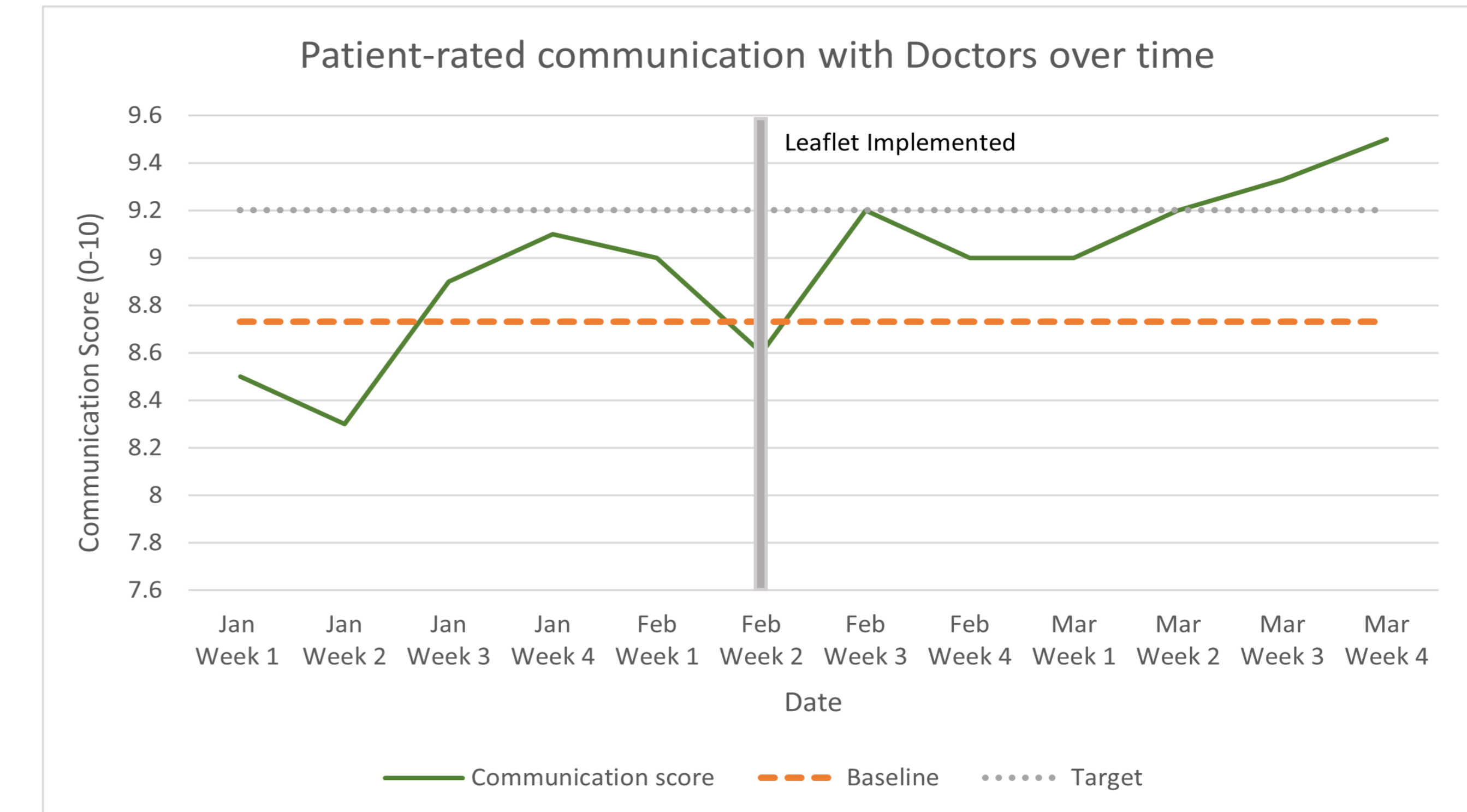


Figure 6: Run chart showing patient communication score over time. Patient information leaflet implemented second week of February.

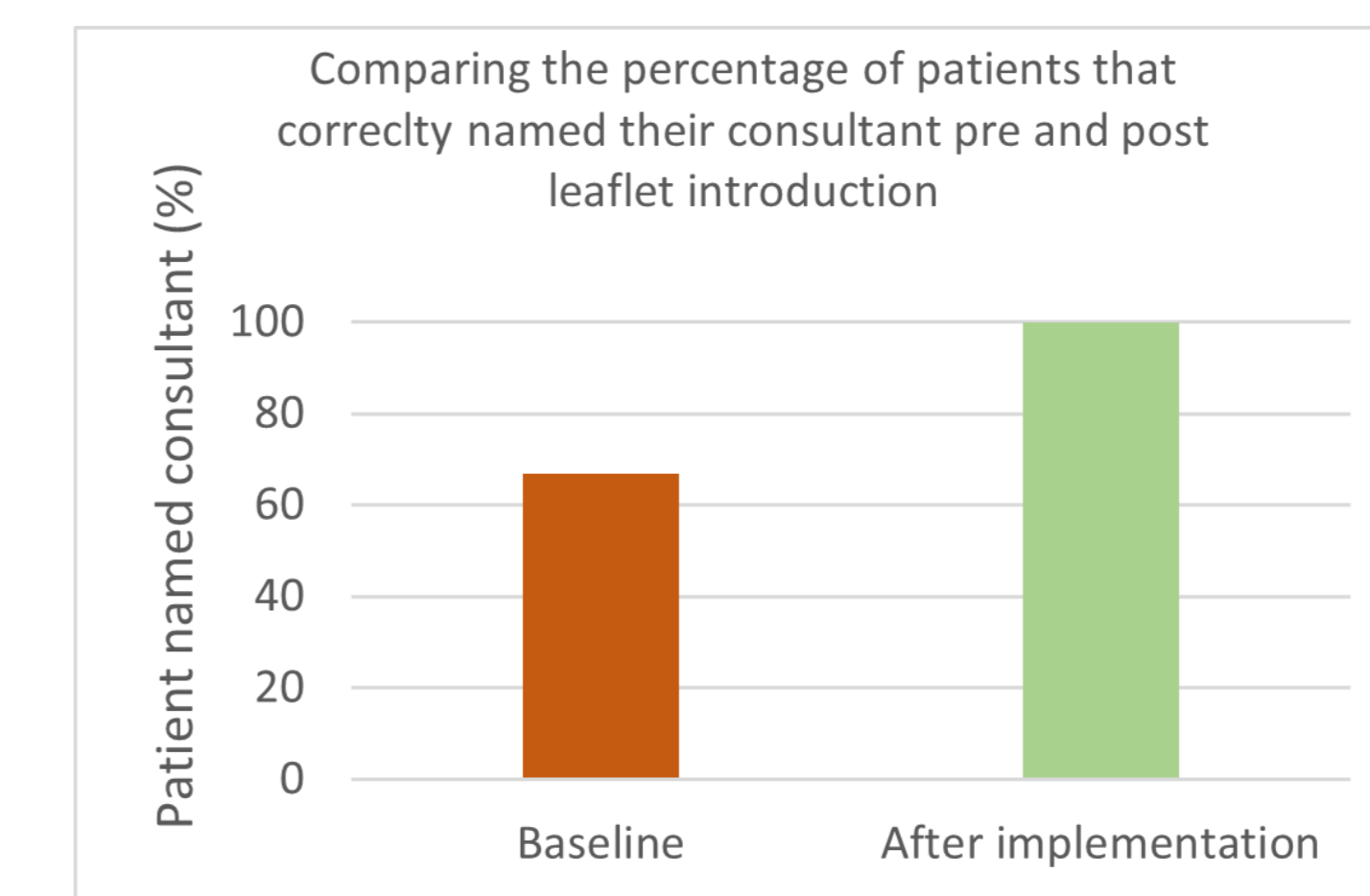


Figure 7: Bar chart comparing percentage of patients that could name their consultant before and after implementation of the patient information leaflet.

The aim of the project was to improve the communication score from 8.73 to 9.2 by 31 March 2023. At the conclusion of the project the communication score rose to 9.5, an increase of 0.77 from baseline, thus achieving the aim of the project (figure 6). Figure 7 highlighted an example of a balancing measure showing improvement in patient awareness of their treating physician.

Implications

- Demonstrated improvement could be made to patient-doctor communication through a visual aid.
- Patients' understanding of ward and renal team's operations may decrease confusion and potential complaints.

Challenges

- Low patient turnover resulted in a limited data pool.
- Staffing issues and patients being moved to different wards hindered accurate data capture.
- The document was ineffective for certain patient groups such as the visually impaired.

Next Steps

- Implement Patient Information Leaflet into ward D8 admission pack.
- Disseminate this project and patient information leaflet to wider hospital teams to consider producing similar documents.
- Consider alternative communication methods for patients with visual impairment.

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