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Implementing an interprofessional patient record

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ABSTRACT – This paper describes the implementation of an interprofessional patient record (IPPR) at Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). The IPPR was a two-year project, commencing in May 2008, aimed at creating a single IPPR to which all staff contribute. Prior to the IPPR, records were profession specific with nursing, medical and therapy staff keeping separate ones. This paper describes the process for the project including the stakeholder engagement plan, the development of IPPR standards, the education and training programme and the key measures used to assess implementation. The staff survey and clinical audit data suggest that the IPPR was successfully implemented with many of the perceived benefits realised. The keys to success of this major change project were: time spent engaging clinical staff, board level support, the appointment of a dedicated project team and the involvement and support of many staff involved in patient records throughout STHFT.

KEY WORDS: communication, interprofessional, record keeping, standards

Background

Record keeping is an integral part of clinical practice. High quality patient records are used to support safe, effective patient care and good communication within care teams and with the patient.[1,2] Well kept patient records ensure all members of the healthcare team know what has happened to the patient and have the necessary information to plan ongoing care.

By contrast, poorly maintained patient records carry significant risks to patient safety as they can lead to poor communication, repetition of investigations and delays to patient care.[3] Between July 2008 and June 2009 almost 700,000 patient safety incidents occurring in acute trusts were reported to the National Patient Safety Agency (NPSA). Seven per cent of these related to patient documentation, including incidents such as missing notes, incorrect patient details, misfiled information and missing consent forms.[4]

Local context

Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) is a large acute teaching hospital that incorporates five different hospitals on two main sites. STHFT employs around 14,000 staff and treats over one million patients per year.[5] Due to its size, complexity and historically different practices of clinical departments, documentation and record keeping throughout STHFT had become varied and inconsistent with many healthcare professionals keeping independent patient records. This would often mean that several narratives would be created for a patient during their hospital stay with nurses, doctors and allied health professionals, such as physiotherapists, occupational therapists and dieticians, all keeping separate records for patients. This way of working had, in some cases, led to serious risks to patient care, as none of the separate records contained sufficient information to support the most safe and effective patient care. This system of record keeping often led to lots of unnecessary repetition in the patient records which, in turn, reduced the amount of direct hands-on care that clinical staff could provide.[6]

Several key opinion leaders on patient records at STHFT, who were members of the Patient Record Committee, produced a proposal to the trust board that the implementation of an interprofessional patient record (IPPR) would support best patient care.[6–9] The proposal suggested that an IPPR would improve communication among healthcare professionals and with patients, would lead to a reduction in the amount of time spent writing records and would help support accurate clinical coding. Approval was given for the project and some funding was made available for a small project team to begin implementing the IPPR over a two-year period from May 2008.

Establishing the IPPR standards

A project manager was appointed to lead the IPPR and a consultant in geriatric medicine was appointed, with dedicated time, as the executive lead. A clinical educator, clinical audit lead and administrative support were also assigned. A project group was established to help drive the work; the members of this group are detailed in Box 1.

This project team was responsible for the week-to-week running of the IPPR and the project manager and executive lead reported monthly progress to a project board, chaired by the medical director.

From the outset it was crucial that staff throughout STHFT had the opportunity to input into the structure and content of the IPPR. As the IPPR represented a major change to working practice, it was vital that stakeholders were engaged as this would help ensure that changes would be both successful and sustainable.[10] Between May 2008 and March 2009 a major communication programme was undertaken to inform staff about

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IPPR and involve them in the decision-making process. This involved:

- eight one-hour open meetings to discuss the project – these were attended by over 250 STHFT staff from various professions and disciplines
- four poster sessions in the staff canteens
- presentations at two STHFT sharing good practice events
- attendance at either an operational or executive meeting in 26 clinical directorates
- attendance at other ad hoc meetings and one-to-one sessions with key opinion leaders
- articles in the STHFT LINK magazine and communication bulletins.

At all these sessions, feedback was gathered that helped establish the key objectives and changes to practice that IPPR would deliver.

When developing the standards and principles for the IPPR it was important to ensure that national standards were recognised and that anything that was produced was consistent with the guidance provided nationally for clinical staff. As part of this the IPPR project lead made contact with the Royal College of Physicians regarding their record keeping standards and members of the project group also attended a workshop held by the Nursing and Midwifery Council about the record keeping guidance they provide.[1,11] In addition to this a thorough literature search was conducted so that other professional guidance on record keeping was taken into account when establishing the IPPR.[12–14]

Following the consultation process and the commitment to establishing an IPPR that would be consistent with national standards the project group developed 10 key objectives that the IPPR would deliver (Box 2).

Box 1. Membership of the interprofessional patient record (IPPR) project group.

- IPPR project manager
- IPPR project executive lead
- IPPR clinical educator
- IPPR clinical audit coordinator
- IPPR administrator
- Clinical director for professional services
- Nurse director for critical care
- Lead nurse for surgical services
- Head of learning and development
- Chair of nursing records group
- Practice development advisor
- Clinical risk manager
- Medical records manager
- Clinical informatics advisor
- Staff governor
- Patient governor

Implementing the IPPR

Once the IPPR objectives had been established an implementation plan was developed to roll out the new patient record at STHFT. Due to the size of the organisation and with 26 different clinical directorates in which to implement the IPPR it was agreed that a phased implementation would be the best approach. This would allow time for adequate staff training in each clinical area in how to use the IPPR and would also allow for any problems to be addressed and corrected before moving on to the next area.

Surgical services were the first area to introduce the IPPR in April 2009, chosen as a manageable unit and because the lead nurse was on the project group. Before going live with the new system of record keeping, training was essential for clinical and administration staff. The main changes for clinical staff were the introduction of the patient problem sheet, signature sheet and collaborative narrative. For administrative staff the order of notes was changed so it was essential that they were trained in how to file the IPPR correctly.

Drop-in training sessions were proposed as the best way to capture staff, as the demands of clinical work made it difficult for staff to commit to set days and times for training. For the sessions, sample IPPR patient records were produced for staff to look through and understand the new system. In addition a leaflet was created detailing the changes to practice and laminated sheets indicating the correct filing order were also given out to all those who attended training. In surgery, around 20 one-hour drop-in training sessions were made available and ward managers, service managers and consultant medical staff were asked to ensure that their staff attended one of the sessions prior to the IPPR being launched. The training sessions were an opportunity for staff to understand the changes

Box 2. The 10 key interprofessional patient record objectives.

1 All patient records will contain an inter-professional problem sheet that will be used for all episodes of care.
2 All patient records will contain one set of patient identification details recorded and this will be at the front of the record behind the patient problem sheet.
3 All staff involved in the care of the patient will add their details to a multidisciplinary staff signature sheet.
4 All patients will undergo a standardised and consistent nursing and medical assessment wherever they are admitted at STHFT.
5 All staff involved in the care of the patient will contribute to one continuous clinical record.
6 All clinical information relating to an episode of care will be stored in chronological order.
7 The patient record will not contain undue repetition.
8 At discharge, the patient record folder will be reviewed, retaining the relevant clinical information for future admissions with all other information archived.
9 The main patient record folder will be the primary record for use by all disciplines and no separate individual professional record will be kept unless there is a clear case of need.
10 The patient record folder will be standardised and consistent.

they had to make to record keeping, understand the potential benefits of the IPPR and ask any questions of the project team. Following all these training sessions surgery implemented the IPPR at the end of April 2009.

This approach to introducing the IPPR had worked well in surgery so the project team then developed a 12-month rolling programme of implementation throughout the remaining clinical directorates. The drop-in training sessions were repeated elsewhere and were supported with attendance at any existing protected teaching for staff of all professional groups. Over the rollout period, progress was monitored and the forward programme evolved at weekly team meetings. There was also the opportunity to agree on focused interventions as indicated by the active feedback which was encouraged.

Assessing success

Throughout the implementation programme it was crucial that data were collected to assess the success of the project.[15] A simple one-page survey was distributed to approximately 700 staff in nine of the clinical areas that have implemented IPPR. A total of 261 completed surveys were returned by a mixture of nurses, doctors, therapists and administration staff (a response rate of 37%). The key results from the survey were:

- 70% of staff found writing an IPPR easier or no more difficult than the old notes (30% stated writing an IPPR was more difficult than previous systems of record keeping)
- 22% of staff spent less time documenting care in an IPPR than before (56% spent about the same amount of time and 22% spent more time writing notes in the IPPR)
- 27% of staff believed the IPPR had allowed them to spend more time caring for patients (with 55% stating they spent the same time in direct patient care with 18% feeling that the IPPR had taken time away from patient care)
- 100% of staff either always or sometimes read and/or used the information recorded by fellow healthcare professionals in the IPPR
- 55% of staff stated that the IPPR had improved communication within the wider healthcare team (with 38% believing communication had remained the same)
- 38% of staff indicated the IPPR had enabled better communication with patients and 70% of all staff surveyed felt better able to provide accurate information to patients because of the IPPR
- overall, 44% of all those surveyed felt the IPPR had impacted positively on patient care.

Alongside the staff survey data, clinical audit of patient records was also performed to assess the quality of entries in the IPPR. In total, 170 IPPR records were audited and the results are detailed in Table 1.

In summary, the staff survey and clinical audit data results provide evidence to suggest that the IPPR has been a success in most areas for the majority of clinical staff. Despite this there have been a number of challenges that the project team have had to overcome. These include the lack of attendance in training from medical staff, ensuring all staff treat the patient notes as a shared record, poor completion of signature sheets and problems sheets and some incorrect filing.

Table 1. Key results from the interprofessional patient record clinical audit.

Question	Compliance (%)
Is there only one folder for the current care episode (ie no separate nursing/therapy notes)?	96
Is all documentation in the patient record stored in chronological order?	99
Is it clear what was wrong with the patient?	96
Are all entries written in chronological order?	98
Does the record contain entries by all staff from different professions caring for the patient?	99
Are all notes free from undue repetition?	95
Overall, do you feel that the patient record of care allows you to identify what problems the patient had and what care they received?	88

This has been the first concerted effort to support, improve and standardise records practice. Staff on occasion attributed difficulties with the record to the project rather than the pre-existing state of the notes and lack of interest in their maintenance. It has been important to adopt a flexible stance, while not compromising on key principles, to mould the IPPR to suit all settings. The problems have been less than expected and limited to a few areas so the team has been able to offer additional training and support to ensure people understand how to use the IPPR and their roles and responsibilities for maintaining it. Alongside this, clinical areas have continued to audit patient records to identify and rectify any issues with the IPPR.

Conclusion

Before the IPPR project began in May 2008, almost all inpatient areas had separate profession-specific notes. This way of working led to risks to patient safety through poor communication within the interprofessional team as there were often several separate narratives of care for one patient. This led to significant repetition, difficulty in following the progress of a patient journey and a lack of communication between healthcare professionals with resulting inefficiencies, delays and risks to patient care. The IPPR has significantly changed this with the biggest change to practice being that the treating clinician now has a record containing all the necessary clinical information recorded by all staff, essential to support safe and effective patient care. Other benefits from the IPPR are reduced repetition in the patient record (leading to reduced time updating records and an increase in direct care time), a reduction in paperwork in the notes (and associated printing and filing costs), a more manageable record and one that supports interprofessional working, and enables effective communication with patients.

In addition to these benefits staff from all professions now understand better the central role that a well kept record plays in safe and effective patient care. The IPPR has been a major change to working practice at STHFT, such a huge and diverse organisation. The success of the project can be attributed to having senior clinical leadership and board level support, a dedicated project lead and team, a comprehensive stakeholder engagement programme, and the commitment and enthusiasm of the vast majority of clinical and non-clinical staff involved. At STHFT the IPPR has been a vital step in improving the quality and content of patient records and creating a consistent structure that will be crucial in preparation for the electronic patient record.

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