

Cardiology a ward rounds: rationale of using a checklist

Editor – I read with great interest Herring *et al*'s professional issues paper (*Clin Med* Feb 2011 pp 20–2) on ward rounds and using a checklist to improve quality and safety. In the modern NHS, there is often significant pressure on consultant staff to consolidate several clinical duties during their clinical sessions. As our population is aging and people are living longer than ever before, the majority of patients in medical wards are now elderly with multiple medical issues and also social issues. This obviously creates complexity in ward rounds.

From our experience, cardiology ward rounds can be divided into many facets. A few examples are as follows: a) consultant-led ward round; b) specialist registrar (SpR)-led ward round; c) senior house officer-led ward round; d) consultant/SpR led board ward round; e) post-take ward rounds led by consultants; f) foundation year 1-led ward round (should not happen ideally).

Cardiology is predominantly a procedure driven specialty. Checklists will be very relevant in various cardiac patients who get admitted for various cardiac procedures ranging from ablation to percutaneous coronary intervention. This checklist could include vascular complications, follow-up planning details and also be individualised for each cardiovascular procedures. Checklists already exist for cardiac procedures in various NHS hospitals and they are embedded in procedural pathways. They become relevant in ward rounds as patients requiring overnight stay for their procedures will be reviewed by ward-based teams at some stage. For example, post-pacemaker implantation patients should have a chest X-ray the next day and a checklist-based system will facilitate the ward team to make sure this is reviewed before discharge. Overall, this reduces complications, clinical/nursing errors and facilitates early discharge of patients. It also provides one pathway communication between several teams involved in a patient's care.

PANKAJ GARG

*Specialist registrar in cardiology
Cardiology and Cardiothoracic Department
Northern General Hospital, Sheffield*

In response

It was rewarding to read Garg's vision for using checklists on a cardiology ward round. We would encourage medical specialties to practise using the ward round checklists and adapt them in accordance to their personal practice and specialty needs. Our experience has shown us that checklists are potentially useful in complex processes in which errors are common, or have serious effects, or both. It is important to make the purpose of the checklist obvious, stick to important points that tend to get missed, and keep the font large! The process of error checking should not slow the pace of work and should be embraced by every member of the ward round team.

ROSELLE HERRING

*Specialist registrar in diabetes and endocrinology
Worthing Hospital
Western Sussex NHS Trust*

What reductions in dependency cost result from treatment in an inpatient neurological rehabilitation unit for people with stroke?

Editor – We read with keen interest, the very timely study of O'Connor *et al* (*Clin Med* Feb 2011 pp 40–3). It was reassuring to note the significant reduction in dependency, dependency costs and improvement in functional ability as measured using the median Barthel index in stroke patients who have undergone goal-oriented multidisciplinary inpatient neurological rehabilitation. This is pertinent in the current financial climate where commissioning of healthcare is about to be radically transformed from primary care trusts to GP consortia with no robust evidence, including pilot study, to back such a monumental change within the NHS.

Although the study did not mention the formal follow-up of the cohort of stroke patients in a dedicated outpatient clinic and community therapy team after inpatient rehabilitation, we wonder if the team has any data regarding further improvement in physical ability or further reduction in dependency and dependency costs subsequent to follow-up in a dedicated

outpatient clinic in conjunction with outpatient or community therapy input.

It is possible that any additional data to support further gains after inpatient rehabilitation, either by a dedicated community team led by rehabilitation medicine physicians or by general practitioners with an interest in stroke or neurological disability, would in no small measure help drive home the message of the beneficial impact of both inpatient and outpatient input in stroke patients by all and sundry, including commissioners. The potential savings on scanty resources and the improvement of the quality of life of stroke patients cannot be overemphasised.

NOSA AKPOREHWE

*Consultant physician
Department of Rehabilitation Medicine
Woodend Hospital
Aberdeen*

KERSTIN AKPOREHWE

*GP
The Glen Medical Centre
Hebburn, Tyne and Wear*

RAJIB PURKAYASTHA

*Consultant physician
Department of Rehabilitation Medicine
Woodend Hospital
Aberdeen*

In response

Editor – We would like to thank Akporehwe *et al* for their interest in our study. Recently, we had the opportunity to investigate the reduction in dependency and care costs associated with a newly established goal-oriented multidisciplinary community stroke rehabilitation team. This team comprises consultant physicians in rehabilitation medicine, occupational and physical therapists, speech and language therapists, dietitians, and psychologists.

We collected data on dependency using the Northwick Park Dependency Score (NPDS)¹ in a cohort of stroke survivors participating in the rehabilitation programme (45 males, 26 females; median age 71 years, interquartile range (IQR) 39–96 years). The median length of the rehabilitation programme was nine weeks (IQR 8–13 weeks).

Table 1. Dependency and care costs on admission and discharge.

Outcome	Admission median (IQR)	Discharge median (IQR)	Z-score p-value
NPDS	7 (2–14)	1 (0–5)	–6.842 <0.001
Cost of care (£ per week)	234 (168–564)	102 (18–168)	–6.851 <0.001

NPDS = Northwick Park Dependency Score.

The interim analyses are presented in Table 1 and demonstrate both substantial improvements in independence, and reductions in care costs. We would strongly encourage other rehabilitation teams to collect and collate data for commissioners to demonstrate the effectiveness of multidisciplinary rehabilitation programmes.

RORY O'CONNOR

Senior lecturer and honorary consultant physician
in rehabilitation medicine
Academic Department of Rehabilitation Medicine

CLARISSA MARTYN-HEMPHILL

Year 5 medical student

CATRIONA MCNICOL

Year 5 medical student

RORY MORRISON

Year 5 medical student

University of Leeds

Reference

- 1 Turner-Stokes L, Tonge P, Nyein K *et al.* The Northwick Park Dependency Score (NPDS): a measure of nursing dependency in rehabilitation. *Clin Rehabil* 1998;12:304–18.

Diagnosis and management of urinary infections in older people

Congratulations to Drs Woodford and George for a well researched article on urinary infections in older people (*Clin Med* Feb 2011 pp 80–3), a common diagnosis encountered during most medical takes. As their article states, urine samples may be hard to obtain in older patients due to incontinence or cognitive impairment, but misdiagnosis of urinary tract infections may result in inappropriate exposure to antibiotics and delay in establishing the correct diagnosis, and urine culture 'if possible' is advised in the appropriate clinical context.

It would have been of interest to review any evidence base, techniques or recommendations for obtaining the urine culture in this commonly encountered subset of patients. Much is written in the paediatric literature about collection of urine by collection bags, supra-pubic aspiration, or 'in-out' catheterisation in young children who are not able to provide a sample easily, and it would be useful to know if these techniques may also have benefit in the adult population.

GUY HAGAN

Specialist registrar in respiratory/general medicine
West Midlands

Clinical and scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

The need for dedicated dermatology beds

Increasing pressure on inpatient beds has no doubt contributed to the ongoing reduction in designated dermatology beds within acute hospital trusts. Studies in Scotland¹ and Manchester² have highlighted an 82% and 57% reduction respectively in dedicated dermatology beds in recent years. This loss of acute beds for the treatment of patients with severe skin disease has led to a shift away from patient admission towards management in the community with expensive immunosuppressant therapies associated with potentially serious side effects.

We report a study from a designated 12-bedded dermatology ward at Amersham General Hospital in Buckinghamshire, which investigated the impact of admission on the Dermatology Life Quality Index (DLQI)³ of patients with skin disease.

In total, 107 patients were admitted to the ward over a six-month period. Fifty-four per cent (58/107) were female and 46% (49/107) male. The average age was 53.8 years (range 16–94 years). The mean length of stay was 13.9 days (range 2–57 days). Fifty-two per cent of admissions to the ward were planned (eg photoinvestigations, eczema clearance and education) and 48% were emergency admissions (eg acute flares of eczema, psoriasis or cellulitis). The average DLQI score at time of admission was 12 (range 0–30). Three months post-discharge, the average DLQI was 6.5 with an individual average 5.8 point reduction in DLQI score (paired t test, p=0.0001).