United Lincolnshire Hospitals NHS
NHS Trust

Ward Rounds

Plan from Every Review

A toolkit to support the introduction of a standardised ward round.

innovating for excellence

NHS Midlands and East

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Acknowledgements

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Introduction

Traditionally the ward round is a procession through the hospital, of professionals where most decision making concerning patient care is made. However:

- Have you ever wondered if there is a better way to conduct a ward round?
- Could you improve communication between the multi-disciplinary team regarding the plan to move the patient onto the next step of their journey?
- Have you ever attended a ward round, read the documented plan and been unsure of the detail or who is responsible for completing that plan?
- More importantly have you struggled to identify what actions have been taken and what still needs to be done to implement the plan?
- Do you ever feel frustrated by the lack of routine in reviewing individual patients?

Wouldn't it be better if we could review patients on the ward round using a standardised format which ensured each patient review focused on safety?

How much better would it be if the patient plan was broken down into clear and concise tasks which need to be completed? If these tasks also had a responsible person identified for completing them along with a specific time, wouldn't that improve communication and reduce confusion?

Plan from Every Review will support the team to develop a standardised process to review each patient and set a clear and concise plan of care. Each review will be planned, simple, efficient and generate a Simple, Measurable, Agreed, Relevant and Trackable (SMART) plan to facilitate the patients progression to the next step of their journey towards a safe and timely discharge.

Case Study

The development of the Plan from Every Review Document

Step One - **Recognising the need for change and trying to facilitate it**

An enthusiastic consultant who recognised the need for improving his practice during the ward round had been influenced by the extensive work done by Dr Caldwell**. He was inspired to develop his own safety checklist for each ward round. The checklist detailed all the elements that needed to be reviewed for each patient during the ward round. The consultant laminated his list and taped it to the ward round trolley, however, this did not result in any measurable improvements being made. He had no baseline data set, so it was impossible to capture whether the changes had made an improvement. Secondly, the junior doctors were not trained and supported in how to utilise the checklist effectively, consequently, it soon became 'part of the furniture' and was not referred to. Competing priorities meant that this 'good idea' got lost in translation.

Consultants have many skills, but sometimes with improvement work specialist skills and support are necessary.

To explore this improvement opportunity further the consultant agreed to move forward with the support of the service improvement facilitator.

Step Two - **Understanding the current process**

in order to understand the teams perception of the current system for reviewing patients during the ward round, different professionals were canvased to understand their perception. What did they understand to be the purpose of the ward round?

The answers received highlighted the united vision that the key purpose of the ward round was to set a plan of action to enable the patient to move onto the next step of their journey.

A number of inpatient notes were selected in order to review the detail of each treatment plan documented following a ward round. These plans were often difficult to decipher, had no identified owner, or person responsible for completing the plan and were frequently seen to be duplicated, review after review. There was limited evidence to suggest that every safety critical step was reviewed for each patient, e.g. not all patients had their prophylactic medication for VTE reviewed.

Baseline data collected suggested that only 36% of plans written in the patients' notes were documented as completed.

The Plan from Every Review document is a simple two sided document that provides a standard where by each patient's progress and treatment plan is reviewed. It supports the delivery of a safe and reliable senior review during the ward round.

The Benefits

The benefits realised through utilising the Plan from Every Review document are:

A. It supports **improved patient safety**
- Promotes safe and reliable care
- Every patient will receive the same standard of review
- Every plan set is checked to ensure that each task is completed on time and in full
- Prompts daily review of VTE, DNR and in patient prescriptions

B. It supports **improved communication**
- On call doctors seeing a patient out of hours are able to access the latest review easily and effectively, reducing any delays in treatment.
- Buy in from the multi-disciplinary team (MDT) will result in the standardised document being referred to during planned handovers
- Information given to the patient is documented leading to improved communication between the MDT, patients and their families
- Clear documented evidence of what took place, during the patients review, will assist in addressing concerns and complaints

C. It supports **the reliability of care**
- The standardised document provides a standard for Senior Daily Review
- 'Today's' plans are documented clearly and concisely, detailing a time for each task to be completed along with an identified owner
- Future medical plans and escalation plans are documented

D. It supports **a reduction in LOS**
- The daily checking of the plan will reduce delays and influence a reduction in length of stay
- Discharge criteria are documented promoting weekend discharges
- Predicted dates of discharge are reviewed by a senior clinician daily

E. It supports **the education of junior doctors**
- The standardised format promotes the education of junior doctors to undertake effective and efficient ward rounds
- The clear and concise planning supports junior doctors to prioritise their tasks

Case Study

The development of the Plan from Every Review Document

Step Three - **creating the document**

The information gathered around the current process guided the first steps to redesigning the way ward rounds are documented. The trial was based on one ward, with one Consultant utilising a Plan, Do, Check, Adjust (PDCA) approach

A Failures Mode Effect Analysis or FMEA * highlighted that the absence of an effective treatment plan at the end of the ward round would have the greatest impact on the safety and reliability of the care delivered.

A simple planning template was designed to promote the setting of a clear and concise plan. Each action or task would be clearly explained, have an identified owner and a clear timescale for completion. It would also provide a 'closed loop' in that each task has a documented time of completion or a written reason for non-completion.

The planning template provided the focus for the patients review. The consultant went on to develop a standard proforma around the planning template which would promote the review of key safety critical steps during the ward round. This created a standard by which every patient received the same standard of review.

The first Plan from Every Review document was ready to be trialled on one ward for 30 days. The multi-disciplinary team provided feedback to understand what worked well and what didn't work well. Each 'check' and 'adjust' created a revised document to trial.

The Ward Round and Plan from Every Review

The Plan from Every Review document provides the structure to review each patient. It is used daily during the ward round. The document is completed by the scribe, usually the junior doctor, during the review of each patient's progress and the setting of the treatment plan. The Plan from Every Review document is filed chronologically in the evaluation section of the patient's notes. It is also coloured blue to help it to stand out from the white evaluation sheets as the most recent review of the patients treatment plan and progress.

The Plan from Every Review document has been designed to ensure that every safety critical point in the review is completed, promoting safe and reliable care. It also uses SOAP, an already widely accepted acronym used to conceptualize the process of recording a patient's progress in the medical notes:

S - indicates subjective data obtained from the patient and others close to him;

O - designates objective data obtained by observation, physical examination, diagnostic studies, etc.

A - refers to the assessment of the patient's status through analysis of the problem.

P - designates the plan for patient care.

Case Study

Plan, Do, Check, Adjust (PDCA)

The benefits to utilising PDCA and conducting a small trial on one ward are:

- It involves less time, money and risk.
- The process is a powerful tool for learning; both from ideas that work and those that don't.
- It is safer and less disruptive for patients and staff.
- Because people have been involved in testing and developing ideas there is often less resistance to change.

Using PDCA cycles enables you to test out a change on a small scale because:

- You may not get the results you expect when making changes in a process.
- It is safer and more effective to test out improvements on a small scale.
- Ownership is key to implementing an improvement successfully.
- By involving colleagues in trying something out on a small scale before large scale roll out you will reduce barriers to change.

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Plan From Every Review

Date	
Time	
Senior Doctor	

Name:

Affix Patient Identification Sticker HERE

NHS number:

Previous Plan Checked ☐

Active Problems:

1.		4.	
2.		5.	
3.		6.	

Chart Review

T&T score		Pulse		B.P	
Temp		Sats		Resp. Rate	

If T&T score is greater than 0 please complete observations above

Progress on Active Problems (SOAP by number)

1. Subjective (what the patient tells you)

2. Objective (what you see)

3. Assessment (Impression)

4. Plan

TODAY'S PLAN				
Task list - Task's will be simple, clear and concise to the reader, have an identified owner and time to be completed by today.	Planned completion time	By Whom?	Actual time action completed	Reason for delay in completion
PDD		MFFD	(Y / **N**)	

Future Plans / Discharge Criteria

Escalation / T & T Variation

Information given to patient

Urinary Catheter Removed Yes/No/N/A

IV Cannula Removed Yes/No/ N/A

DNR Reviewed Yes/No /N/A

Prescription Reviewed ☐

VTE Reviewed ☐

H@N Handover required Yes/No

Doctor's Name		Doctor's Signature		GMC No.	

Documenting the Patients Treatment Plan

An example of a completed plan is shown below. This has a clear and concise plan, a predicted date of discharge and the patients medically fit status identified. This is further supported by documentation under the 'Future Plans/ Discharge Criteria section of the Plan from Every Review document.

TODAY'S PLAN				
Task list - Task's will be simple, clear and concise to the reader, have an identified owner and time to be completed by today.	Planned completion time	By Whom?	Actual time action completed	Reason for delay in completion
Request CTB	10:30	Dr	10:15	
Refer to Urology team	14:00	Dr	13:00	
Send MSU	15:00	Nurse	16:00	
Speak to family re: home circumstances	17:00	Nurse		Family didn't visit
PDD 30/9/12	MFFD	(Y / **N**)		

Training and Standards

The consultant/ senior reviewer are key to ensuring that the Plan from Every Review document is utilised effectively. This will require a change in their practice during the ward round.

The four suggested steps to training an individual to utilise the document are:

1. Support the person/ doctor to understand the benefits to the patient through the implementation of Plan from Every Review. Sharing an overview of the benefits realised will support the individual to appreciate the need for change. This is often best achieved through peer discussion.

2. Demonstrating the planning section by preparing an example plan to talk through will help establish the fact that the planning section is the key to moving the patient into the next step of their journey. The checking of these plans will ensure that the patient does not experience any delays in their treatment

3. Encourage the individual to use it whilst reviewing patients during the ward round. A consultant colleague may attend an active ward round to check their progress and support where necessary.

4. Utilise the simple audit post implementation. This will provide evidence which can be used to feedback and help to bridge any gaps to the standard

A set of standards have been developed to support the completion of the Plan from Every Review document to ensure that it is utilised effectively at all times. These standards are documented in the form of Standard Operating Procedures or SOPs

- SOPs document in detail the logical steps required to complete a specific process Each step is explained simply and is supported by key points which ensure the step is completed safely.

See Appendix 1 (SUITE of SOP's)
These SOPs will support the safe implementation of the Plan from Every Review document.

Case Study

Supporting Consultants

A flexible approach to supporting consultants to implement Plan from Every Review is essential. Some consultants will need lots of support, others will not.

For example, Plan from Every Review may require a consultant to amend the way they review their patients during their ward round and support for this change of practice may be needed.

Some consultants will see this as 'just a form' and state 'how difficult is it to complete a form?' Other consultants will be more open to receiving full guidance on the key elements of the document which will promote the patient receiving the RIGHT treatment at the RIGHT time. The key is for each consultant to understand how this will benefit their patients.

Post implementation follow up, supported by the audit tool, will provide the opportunity to check progress and identify any gaps to the standard. It is essential to offer this follow up support to Consultants as it is key to ensuring successful implementation.

Roles and Responsibilities of the team in utilising the Plan from Every Review document

The suggested minimum number of people required to conduct a safe and reliable ward round are:

a. The senior reviewer i.e. the Consultant or Registrar
b. A junior doctor (who will act as the scribe)
c. The nurse responsible for the patients care

The role and responsibility of the **consultant or registrar** is to:

1. Lead the review of the patient using the standard format dictated by the Plan from Every Review document
2. Always check that the last documented plan has been completed on time and in full, and that any gaps are addressed accordingly, before moving on to today's review
3. Be clear and concise, in their decision making, regarding the tasks to be completed today. Each task will have an identified owner and a time to be completed by.
4. Ensure that the junior doctor scribing has interpreted the plans correctly and documented them accurately
5. Document when a task assigned to them, in 'Today's Plan' is completed, or the reason for any delay.
6. Utilise the Plan from Every Review document as a teaching aid for foundation year doctors
7. Support the team to sustain the effective utilisation of the Plan from Every Review document using the monthly audit data which will monitor compliance.

The role and responsibility of the **junior doctor** is to:

1. Prepare the notes by placing The Plan from Every Review document chronologically within the patients notes, ensuring that any space on the previous evaluation sheet is scored through. A new evaluation sheet is then inserted after the Plan from Every Review document to ensure that the notes are 'ready to go' for the next person.
2. Act as the scribe, utilising every learning opportunity and asking for clarification where necessary.
3. Ensure that the detail of the patient's review and treatment plan is accurately captured on the Plan from Every Review document.
4. Document when a task assigned to them, in 'Today's Plan' is completed, or the reason for any delay.
5. Complete a simple audit, on a monthly basis, to monitor compliance with the agreed standards.
6. Share the audit results with their consultant.

NOTE: The rotation of foundation doctors within the workplace provides challenges regarding regular training in the agreed way of working. The consultant or registrar leading the ward round is well placed to guide and mentor the foundation doctors in reviewing patients during the ward round.

Laminated pocket cards have been designed to act as a reminder to junior doctors of their role and responsibility during the ward round. See appendix.2

The role and responsibility of the **nurse** is to:

1. Attend the ward round and act as the patients advocate.
2. Document when a task assigned to them, in 'Today's Plan' is completed, or the reason for any delay.
3. Utilise the Plan from Every Review document to support nurse handovers.

The role and responsibility of the **ward clerk** is to:

1. Hold the ward specific Plan from Every Review document electronically.
2. Print off enough copies of the Plan from Every review document, on blue paper, every Friday, ready for the next weeks ward rounds .e.g. a 28 bedded ward with a daily ward round Mon- Fri = 140 copies required.
3. Store the Plan from Every Review documents in an agreed, easily accessible area which is clearly labelled.

Audit

How are the standards in completing the Plan from Every Review document maintained?

Each consultant will need to build in a 'check' on their performance to ensure that the standards are adhered to and maintained. A simple, well designed audit tool, see example 1, will monitor the teams compliance in their review of the key safety critical steps identified within the Plan from Every Review document.

Who will be responsible for completing the audit?

Audit work is part of the foundation year teaching programme so they are well placed to complete it. It is simple and focuses on the key safety critical steps addressed in the Plan from Every Review document. Following implementation of the document it is recommended that the audit be completed monthly

This audit form is supported by an SOP (see appendix 3).

Who will act on the audit results?

The team will act on the results led by their consultant. The audit results will inform the team where the gaps to the standard are in completing the Plan from Every Review document. The team can utilize the results to drive their improved performance. Areas where the team is not meeting the agreed standards can be highlighted and acted upon. Areas where the team are meeting the standards can be celebrated! Different forums can be used to share the audit results, for example, team meetings. You may choose to share your findings more widely through local audit group meetings or hospital management meetings.

Case Study

Audit

During the trial a simple audit was completed at key stages to audit against the key performance indicator of the number of plans documented as completed on time and in full.

The audit process enabled the clinical teams to test to see if the adjustments to the document impacted positively on the key performance indicator. We soon saw our baseline of 36% increase to 68% of plans documented as completed on time and in full in the patients' medical notes.

Other significant improvements highlighted by the audit were:

1. 100% of medical reviews clearly state the patients current active problems
2. 90% of in-patients have a predicted date of discharge
3. 96% of in-patients medically fit status is documented
4. 98% of in-patients have future/ discharge plans documented
5. 98% of patients receive a review of their VTE prophylaxis treatment daily
6. 96% of patients have their prescription reviewed daily
7. 95% had their DNR reviewed daily

After 7 PDCA cycles the document was ready to on another ward. The consultant sought out an enthusiastic colleague who was willing to work to further develop the document.

5 PDCA cycles later the current generic Plan from Every Review document was finalised. The benefits of using this documented were shared more widely within the trust through different forums. It received executive level approval for trust wide rollout.

Plan from Every Review - Sustainability Audit

		Patient 1		Patient 2		Percentage compliance against the standard	Comments
		1	2	1	2		
1	Has the PfER document been inserted chronologically in the patients notes? y/n					0%	
2	Has a patient sticker been applied or the name and NHS number been documented in full? y/n					0%	
3	Is there evidence that the previous plan has been checked? **(Are all of the previous days tasks documented as actioned or a reason for delay identified?) y/n**					0%	
4	Have the active problems been documented? **y/n**					0%	
5	Has the Track and Trigger score been documented where necessary? y/n					0%	
6	Has the progress on the active problems been documented using SOAP? y/n					0%	
7	In 'todays plan' are the tasks simple and concise? (i.e. could you carry out the task without seeking further clarification?) y/n					0%	
8	Does every task have a time to be completed by? y/n					0%	
9	Does every task have an owner identified? y/n					0%	
10	Has a PDD been documented? y/n					0%	
11	Has the patients medically fit status been documented? y/n					0%	
12	Have the future plans/ discharge criteria been documented? y/n					0%	
13	Has the escalation/ T&T variation been completed? y/n					0%	
14	Has the information given to the patient been documented? y/n					0%	
15	Has the need to remove any urinary catheter been addressed? y/n					0%	
16	DNR ticked? y/n					0%	
17	VTE review ticked? y/n					0%	
18	Has the need to remove a cannula been addressed? y/n						
19	Prescription ticked? y/n					0%	
20	H at N been circled? y/n					0%	
21	Has the scribe signed, printed and documented their GMC number? y/n					0%	

In Summary:

Ward rounds are pivotal to the patient receiving the RIGHT treatment at the RIGHT time with the RIGHT length of stay for their condition. A ward round which is standardised, safe and reliable will facilitate the patients journey towards a safe and timely discharge.

The Plan from Every Review document supports a standardised ward round by :

1. Providing a standard which ensures that every patient receives a safe and reliable review of their treatment plan.
2. Improving communication between the multi-disciplinary team through the setting of clear and concise plans
3. Promoting a reduction in length of stay by reducing delays to treatment through the simple checking that plans are completed on time and in full.
4. Promotes improved multi-disciplinary team communication

For further information please contact:

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Case Study

Added benefits

The enthusiastic consultant had the opportunity to develop a vital skill set of service improvement skills. His knowledge base regarding the tools and techniques required to implement a change had grown and he had the opportunity to test many of these concepts. He had become an advocate for change and was key to inspiring his colleagues in following his lead to introduce these new standards within their own specialities.

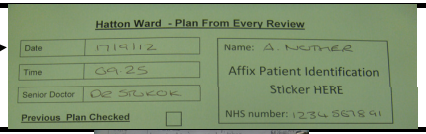
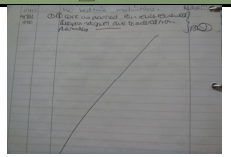
There have been many lessons learnt along the way

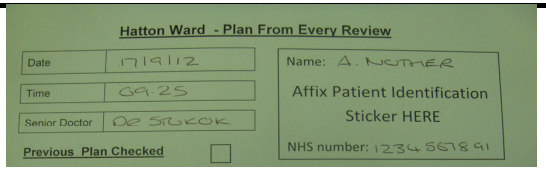
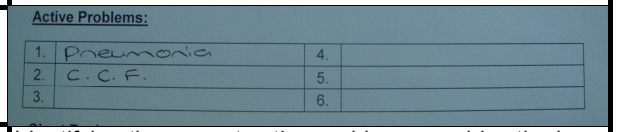
1. Change is never easy.
2. PDCA is the most effective way to test out new ideas.
3. An enthusiastic consultant lead is key to success.
4. A clear structured and robust method for testing and implementing a change in practice is vital to ensure the outcomes.
5. Keeping the Plan from Every Review document simple promoted compliance.
6. Simple audits will monitor compliance to the agreed standards and provide consultant leads with a clear picture of where any gaps to the standard lie.

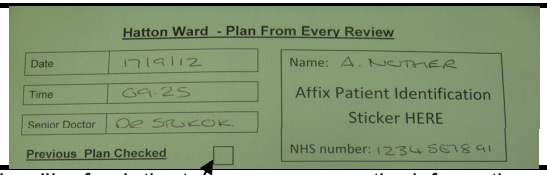
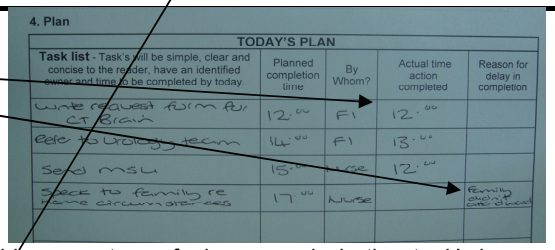
What local staff said about their experience of the Plan from Every Review document

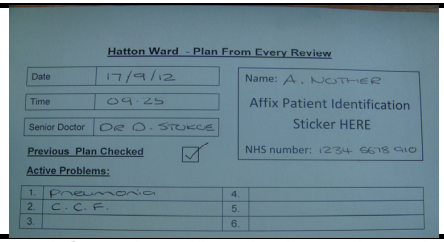
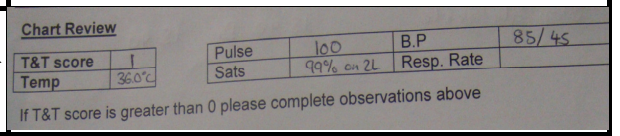
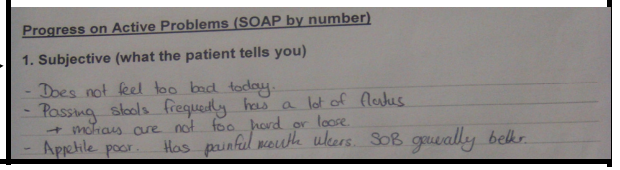
'The Plan from Every Review document means that the plan for each patient*** is clearly documented. It speeds up nursing handovers and it especially helpful for bank staff as it provides a clear and concise summary of the last medical review'
Ward Manager

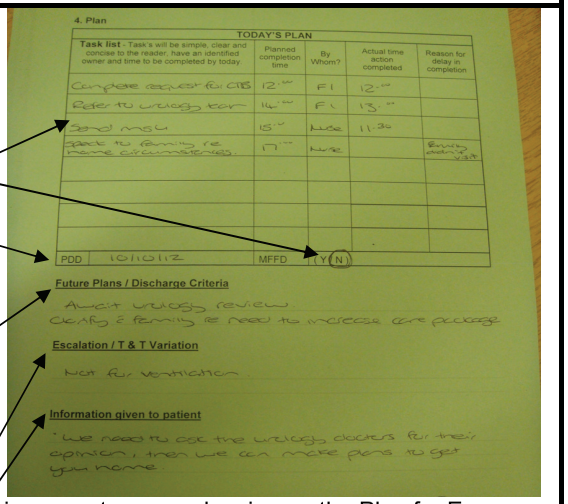
The structure acts as an aid memoire to getting everything done. Patient safety is at the heart of this document. It also highlights any delays in treatment for the patient. these in turn can be addressed in a timely manner. In my absence I am reassured that the junior doctors will follow the same standard as they review each patient. I can also use it as an educational tool as it demonstrates, to me, the way a junior doctor is thinking.
Consultant

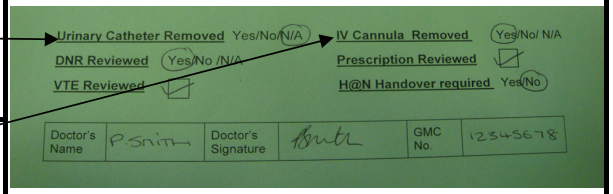
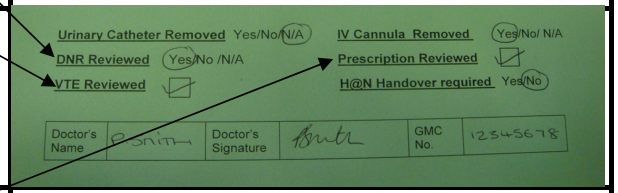
SOP No: 1	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date Sheet:	15th October 2012 1
Time (Mins)	1 min				Frequency	Daily - Monday - Friday, during the ward round
Description of task:	Preparation of multi disciplinary notes prior to patients medical review and preparation of the Plan From Every Review (PFER) sheet					
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**		
Items needed	Plan From Every Review sheet (PfER) Current inpatient notes History sheet		All items needed can be accessed from the multi disciplinary notes trolley trolley The PfER sheet is BLUE so that it is easily identifiable in the patient notes Stock is replenished by the ward clerk			
Who	Junior doctor (Scribe)					
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**		
	Select 1st patients inpatient multi disciplinary notes and turn to the evaluation section					
	Collect PfER sheet and insert patients ID sticker		If patients ID sticker is not available write patients name and NHS number as indicated	This is the minimal legal requirement for identifiable information on a document		
	Populate PfER sheet with the date, time and the name of the senior doctor reviewing the patient		Print doctors name clearly to clarify which grade of doctor has led the patients review			
	Insert PfER sheet after the last history sheet and score through any unnused lines on the previous history sheet		PfER sheet must be filed chronologically in the patients notes	 To prevent the team accidently documenting care delivered in the wrong section		
	Collect new history sheet and insert patient ID sticker		If patients ID sticker is not available write patients name and NHS number as indicated			
	Insert new history sheet after PfER sheet in inpatient notes			To ensure that the medical note are ready for the next member of the MDT to document care delivered		

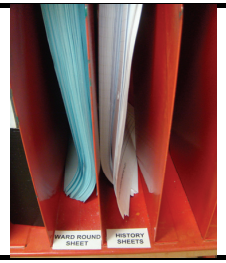
SOP No: 2	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date 15th October 2012 Sheet: 1
Time (Mins)	**3 mins**			**Frequency**	**Daily - Monday - Friday, during the ward round**
Description of task:	**Reviewing a NEW patient**				
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**	
Items needed	Multidisciplinary notes containing a prepared PfER sheet		see SOP No:1		
Who	Senior Reviewer, Junior Doctor (scribe) & Nurse				
	The senior reviewer will greet the new patient and inform them that the team will be looking through their notes before speaking with them shortly			This will put the patient at ease	
	Senior reviewer will read through the patients admission documentation		Senior reviewer may ask the junior doctor for clarifycation around information read	To familiarise themselves with the patients history	
	Senior reviewer will talk out loud to his/her team as he/she asseses the problems that require addressing		This is a learning opportunity for the junior doctors	This helps the junior doctors to understand the thought process of the senior reviewer	
	Senior reviewer will confirm the current active problems		The senior reviewer will state the current active problems clearly so that the identified scribe can document them.An example of an active problem may be pnuemonia and CCF		
	Senior reviewer will check that the scribe has understood and documented these correctly		Verbal clarifycation prevents misunderstandings	Identifying the current active problems provides the base for the whole patient review	

SOP No: 3	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date 15th October 2012 Sheet: 1 of 2
Time (Mins)	**2 mins**			**Frequency**	**Daily - Monday - Friday, during the ward round**
Description of task:	**Reviewing an EXISTING patient**				
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**	
Items needed	Multidisciplinary notes containing a prepared PfER sheet		see SOP No:1		
Who	Senior Reviewer, Junior Doctor (scribe) & Nurse				
Start	The senior reviewer and junior doctor turn back to the previous days PfER sheet		The PfER sheet is blue to ensure it is easily accessible in the multi disciplinary notes	This will refresh the teams memory re the information documented at the last medical review	
	The senior reviewer will ask if the last plan documented has been completed in full.		If 'yes', ensure that that this has been documented in the corresponding column If 'no' the senior reviewer will ask 'why' ? and has the reason the task has not been completed been documented If appropriate the incomplete task will be replanned into todays PfER sheet, clearly and concisely, identifying a time for completion and an owner responsible for completing the task. It is the responsibility of the professional assigned the task to document the time when the task is completed in full Place a tick in 'Previous plan checked ' box' on todays PfER sheet **DO NOT MOVE ON UNTIL YESTERDAYS PLAN HAS BEEN CHECKED AND ADJUSTED IN FULL**	 This prevents confusion around whether task's have been completed Tasks not completed on time and in full will cause a delay in the patients journey to discharge If the Plan, Do, Check, Adjust cycle is broken the planning becomes ineffective	
	The senior reviewer will review the previous PfER sheet's documented active problems		Active problems will be converted to diagnosis as test resullts provide clarifycation of the patients condition Current active problems may not necessarily reflect the reason for admission The scribe **MUT NOT** copy any current problems from the previous PfER sheet prior to todays review commencing	Ensure the patients review is focused on resolving the current active problems presented To prevent resolved problems from being documented Supports the move from problems to diagnosis	

SOP No: 4	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date 15th October 2012 Sheet: 1
Time (Mins)	**4 mins**			**Frequency**	**Daily - Monday - Friday, during the ward round**
Description of task:	**Review of Current Active Problems**				
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**	
Items needed	Multidisciplinary notes containing a prepared PfER sheet		see SOP No:1+ SOP No:2 for a NEW patient or SOP No:3 for an EXISTING patient		
Who	Senior Reviewer, Junior Doctor (scribe) & Nurse				
Start	Senior reviewer ask's the nurse how the patient has been over the last 24 hours		The nurse will hand over her observations and update and act as the patients advocate	The nurses information will assist the senior reviewer to asses the patients progress	
	Junior doctor (scribe) will look at track and trigger chart and document the last score		If the score is greater than 0 the triggering observation will be documented in the appropriate box →		
	Junior doctor (scribe) will locate yesterdays test results in the medical notes and report them to the senior reviewer		Senior reviewer will check that the 'active problems' are still accurate	The test results may influence the active problems documented moving symptoms to diagnosis	
	Senior reviewer will talk to the patient asking him/her how they are feeling today		Questioning will be focused around the identified active problems The scribe will summarise the patients answer and document under 'Progress on Active Problems(SOAP by number), section No:1 → SOAP is an acronymn for Subjective, Objective, Assessment and Plan		

SOP No: 5	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date 15th October 2012 Sheet: 1	
Time (Mins)	**2mins**				**Frequency**	**Daily - Monday - Friday, during the ward round**
Description of task:	**Setting the Plan for the Patient**					
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**		
Items needed	Multidisciplinary notes containing a prepared PfER sheet		see SOP No:1+ SOP No:2 or 3 + SOP No:4			
Who	Senior Reviewer, Junior Doctor & Nurse					
Stages	Senior reviewer will state whether or not the patient is medically fit for discharge		Junior doctor (scribe) will circle Y/N accordingly in the plan	 This supports nurse planning on the Plan for Every Patient board		
	Senior reviewer will state the predicted date of discharge		Junior doctor (scribe) will document the date accordingly in the PDD box in the plan			
	Senior reviewer will set the plan for today, clearly stating when each task will be completed and who will be responsible for completing the task		Junior doctor (scribe) will document this plan using the template. Each task will be simple, clear and concise to the reader, have an identified owner and time to be completed by today			
	Senior reviewer will sum up the patients progress and clarify and future plans or discharge criteria		Junior doctor (scribe) will document the decision under Future Plans/Discharge Criteria			
	The senior reviewer will state any escalation plans or variance from the trust track and trigger policy		The junior doctor will scribe seeking clarification where necessary. If the patient is identified as being medically unstable an escalation plan will be agreed by the team and documented	This will support an out of hours review in an emergency situation		

SOP No: 6	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date 15th October 2012 Sheet: 1
Time (Mins)					Frequency: Daily - Monday - Friday, during the ward round
Description of task:	Chart Review and Completing the Patients Review				
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**	
Items needed	Multidisciplinary notes containing a prepared PfER sheet		see SOP No:1+ SOP No:2 or 3 + SOP No:4 + SOP No:5		
Who	Senior Reviewer, Junior Doctor (scribe) & Nurse				
	The senior reviewer make a decision regarding the continued need for a urinary catheter		Early removal of urinary catheters will reduce the risk to the patient of aquiring a hospital related infection		
	The senior reviewer make a decision regarding the continued need for a cannula		Early removal of cannula's will reduce the risk to the patient of aquiring a hospital related infection		
	Senior reviewer will look at and review the patients DNR form		This form is found at the front of the multi disciplinary notes A tick is placed in the 'DNR Reviewed' box by the scribe when the review is complete	Trust policy dictates that DNR forms are kept uo to date	
	Senior reviewer will look at and review the VTE prophylactic medication prescribed and make any alterations according to trust policy		A tick is placed in the 'VTE Reveiwed' box when the review is complete		
	Senior reviewer will continue to review other prescribed medications and alter any medication as prescribed		The junior doctor may be asked to prescribe a revised medication A tick in the Prescription Reviewed box when the review is complete	Prescribing with senior support promotes safe and accurate prescribing	

SOP No: 7	**Standard Operating Procedure - Daily Senior Review**			Version 1	Date Sheet:	10th July 2012 1
Time (Mins)	10 mins				Frequency	Weekly on a Friday
Description of task:	Replenishing the of stock of Plan from Every Review sheets and History Sheets to the multi disciplinary notes trolley					
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**		
Items needed	Plan from Every Review sheet History sheets History sheets		Electronic copy on ward computer desk top http://intranet/subsites/Take_Note/default.asp			
Who	Ward Clerk					
Stages	Print off 150 history sheets and 150 Plan from Every Review sheets on a Friday afternoon		The link for electronic copies is highlighted above. 28 copies of each document will be used daily.	Ensures the team have a weeks supply ready to go on Monday morning		
	Place printed copies in clearly labelled section on the multi disciplinary notes trolley		Split the printed documents between the ward team notes trolleys 28 copies of each document will be used daily Monday to Friday			

Appendix 2 – Junior doctor pocket prompt cards

Top Tips for completing the **PLAN FROM EVERY REVIEW**

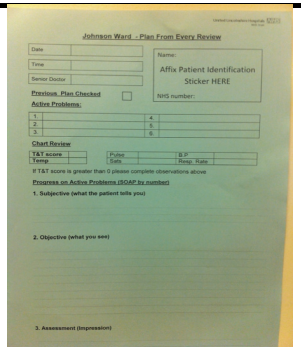
- Prepare the notes - insert Plan from Every Review document chronologically , scoring through any blank spaces on the previous evaluation sheet. Insert a new evaluation sheet after the Plan from Every Review document so that the notes are ready to go for the next person
- Act as the scribe utilising every learning opportunity
- Ensure that the detail of the patients review and treatment plan is accurately captured on the Plan from Every Review document.
- Document when a task assigned to you, in 'Todays Plan' is completed, or the reason for any delay.
- Complete a monthly audit, sharing the results with your consultant

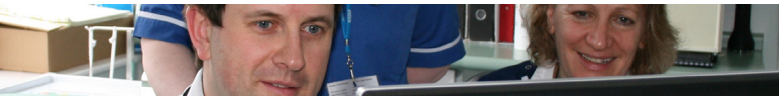
If you are unsure…ASK FOR CLARIFICATION!

An example of a clear and concise plan that has been checked

TODAY'S PLAN				
Task list - Task's will be simple, clear and concise to the reader, have an identified owner and time to be completed by today.	Planned completion time	By Whom?	Actual time action completed	Reason for delay in completion
Request CTB	10:30	Dr	10:15	
Refer to Urology team	14:00	Dr	13:00	
Send MSU	15:00	Nurse	16:00	
Speak to family re: home circumstances	17:00	Nurse		Family didn't visit
PDD 30/9/12		**MFFD**	(Y / **N**)	
Predicted date of discharge		**Medically Fit For Discharge, yes or no**		

ALWAYS CHECK YESTERDAYS PLAN HAS BEEN COMPLETED IN FULL BEFORE MOVING FORWARD WITH TODAYS REVIEW

SOP No: 1	**Standard Operating Procedure**			Version 1	Date 18th Sep 2012
					Sheet: 1
Time (Mins)	**20 minutes**			**Frequency**	**Monthly**
Description of task:	Sustainability audit for Plan from Every Review document				
Stages	**Operational Description**	**Time (mins)**	**Key Points**	**Reasons/Diagrams**	
Items needed	Data collection sheet pencil / rubber 10 current in -patient medical notes Electronic excel data collection template		On ward compluter desk top		
Who	junior doctor				
Prepare	Identify two consequtive historical dates to audit		Do not identify yesterdays date unless todays ward round has been completed allowing the opportunity to check yesterdays plan		
Commence audit	Collect 1st set of in-patient medical notes				
	Turn to the PfER document completed on the first agreed audit date		If the patient was not an in-patient during the identified audit dates, select anothe patients notes	10 sets of notes will generate an effective 'snap shot' o compliance against the standard	
	Work through each question on the audit sheet answering yes or no		Move down the audit sheet under Pateint 1, No 1 for the first PfER document to be audited	Each patient will have 2 PfER documents audited	
	Move to the next PfER document corresponding to the 2nd agreed audit date				
	Work through each question on the audit sheet answering yes or no		Move down the audit sheet under Pateint 1, No 2 for the second PfER document to be audited	Each patient will have 2 PfER documents audited	
	Repeat the above for another 9 sets of notes				
	Input data onto electronic excell data collection sheet		On ward computer desk top	This will provide you with the percentage compliance with each standard audited - these results will be shared with the consultant so a plan can be created to close any gaps to the standard highlighted by the audit	



* For more information on FMEA see:
http://en.wikipedia.org/wiki/Failure_mode_and_effects_analysis

** Dr Caldwell's work
http://www.carebydesign.org/news/ward-round-process-delivering-safer-care
(accessed 12/10/12. Ward Round checklist)

*** Baker M. & Taylor I.(2009) Making Hospitals Work – How to improve patient care while saving everyone's time and hospitals' resources. Lean Enterprise Academy Ltd, Goodrich, UK