Improving governance of clinical advice offered by chemical pathology registrars in Belfast Health and Social Care Trust

Background
Chemical pathology staff at Belfast Health and Social Care Trust provide a 24-hour service, giving clinical advice on a range of biochemical problems. The majority of these calls are answered initially by specialty registrars.

Current state
Hand-written records were kept. Consultant input into clinical cases was sought on an ad-hoc basis, at the trainee’s discretion. The current system has not resulted in any problems, but it was felt by the team that the system could be substantially improved pre-emptively, in an attempt to prevent an adverse event.

Problem statement
A process-mapping exercise was undertaken. A variety of shortcomings were identified and agreed by all team members. These are highlighted in the following fishbone analysis diagram:

Deficiencies in the system were as follows:
1. Record keeping was undertaken by each individual, using a handwritten entry in a notebook or similar. Notes could only be accessed by the individual in possession of them, could easily be misplaced or damaged, and did not facilitate rapid information exchange during handover. No formal record of handover was kept.
2. There was no formal mechanism in place for reviewing the quality of advice given by trainees. Identification of training issues therefore relied largely on self-recognition by trainees.

Goal statement
1. To improve the security of clinical notes kept by chemical pathology trainees, while also ensuring that they are accessible to other members of the team to facilitate continuity of care.
2. To introduce a system in which all clinical advice offered by trainees is reviewed by a consultant chemical pathologist in a timely manner.

Root cause analysis
1. No available record storage system that was sufficiently robust to satisfy the current needs of the team.
2. Consultant advice was available when trainees asked for it, but there was no regular consultant review of all clinical advice offered by trainees.

Determine countermeasures
An options appraisal was performed, and the following were accepted as being likely to improve all identified weaknesses in the system:
1. Develop a secure electronic database, available to view and edit by all members of the chemical pathology team. Trainees would record all clinical advice in this database.
2. In addition to 24/7 availability of a consultant for emergency queries, have protected consultant time each week during which trainees discuss all clinical advice provided that week. Contact could again be made with the referring team if any issues arose. Areas for training development could also be identified during these sessions.

Fishbone analysis of governance systems in place for chemical pathology advice service. Shortcomings in the existing system are shown in red.