GP Admissions to the Acute Medical Unit at Royal Hampshire County Hospital: Reflections on our Team-Based Quality Improvement Fellowship

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The project
- **Why did we do it?** To improve the experience of GP referrals attending the AMU at RHCH, aiming for senior decision-making no more than 4 hours from time of arrival (mimicking the A&E 4 hour target)
- **Why present it?** To learn from our reflections and bear them in mind for future projects
- **What was happening?** GP referrals were perceived to be waiting longer than their A&E counterparts for a decision to admit, discharge or ambulate
- **How did we gather evidence?** 2 weeks of data collection on time of arrival, time to initial clerking, blood test results, chest x-ray completion and consultant review followed by run chart analysis
- **What did we find?** Delay to decision-making came down to time of post-take ward round, particularly following change of hands to the on-call general medicine consultant from 4pm

Challenges faced

1. **Deciding on our project**
   - Our initial aim was too ambitious for our skills set and timeframe, so we had to redefine it to something more realistic and achievable
   - **Tip:** Small changes can make big differences – take time to decide on an objective and don’t be afraid to change the scope of your project

2. **Working as a team**
   - Our team was formed opportunistically based on timing rather than on skills contributed or experience
   - **Tip:** Know your members and recognise whether the group is actually a team or not, and be aware of how group dynamics will change

3. **Engaging stakeholders**
   - Because the scope of our project changed, one stakeholder lost interest and consequently we lost support for what we wanted to achieve
   - **Tip:** Identify and invite stakeholders to be involved in the process, and use your data to support your argument for change

4. **Testing commitment**
   - Some team members lost confidence in the project when the objective had to be modified
   - **Tip:** Recognise the importance of testing commitment – even the most motivated individuals can’t achieve QI alone

5. **Describing existing processes**
   - We thought we had a clear idea of where the problems lay in our unit, until we process mapped it and identified several missing areas
   - **Tip:** Process mapping helps to identify major activities in a process and what steps are embedded in each activity

6. **Establishing a baseline**
   - We were fortunate in that we had an IT system available which easily provided high quality, representative data
   - **Tip:** Choose your data points carefully so that the objective of your project can be translated into specific aspects of care to be measured

7. **Delivering change**
   - Although we weren’t able to progress beyond the baseline data collection phase, we know that QI is an ongoing process that can be continued by sharing what we’ve discovered so far
   - **Tip:** Communicate and share what you’ve learnt with stakeholders and interested parties

8. **Time management**
   - Halfway through our project many team members changed jobs, and were no longer working in the same environment as our project. Consequently, individuals’ priorities changed
   - **Tip:** Think ahead about future competing roles and responsibilities

Final thoughts

We have found the team-based QI Fellowship a privilege to be a part of, and have learnt an incredible amount about what it means to deliver high standards of quality improvement in our clinical environment

We plan to go back to our stakeholders with what we’ve learnt, and hope they will carry on the project with the data we have provided them