Effect of european working time directive on a stroke unit


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Legibility of doctors’ handwriting is as good (or bad) as everyone else’s

Doctors have a reputation for illegible handwriting. Is such notoriety deserved?

Methods

With approval of the Kansas University Human Subjects Committee, we recruited 10 right-handed men and 10 right-handed women with seven different occupations (accountant, attorney, automobile technician, builder, engineer, doctor and scientist). Participants wrote in cursive “The quick brown fox jumps over the lazy dog” in <17 s.

The number of malformed individual letters was judged by an investigator, blinded to participant characteristics. Four blinded investigators independently rated the global legibility of the writing samples using a four-point scale: poor, fair, good and excellent. Investigators independently rated the global legibility, not different from that of administrators.

This lack of difference in handwriting legibility does not excuse doctors from responsibility for clarity and accuracy in their written communication. As handwriting legibility correlates with prescription error rates and misinterpretation of orders, doctors should strive to have “better” handwriting than everyone else or embrace the computerisation of medical records and orders.

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References


Effect of European working time directive on a stroke ward

The European working time directive (EWTD) was introduced into National Health Service hospitals for doctors in training in August 2004. Mounting evidence had shown that fatigue in doctors contributes to adverse events in patients. However, the implementation of potential quality improvements requires an understanding of whole healthcare systems. Before the introduction of the EWTD, our stroke ward had a resident senior house officer who provided weekend care, ensuring that all patients were medically reviewed on a daily basis. This is required, as patients with acute stroke are at high risk of many complications.

We assessed junior doctors’ weekday attendance on the stroke ward after the introduction of the EWTD.

During the study period, 82 patients (43 women and 39 men) of mean (SD) age 72.8 (15.6) years were admitted to the ward. Programme Foundation 1 doctors or senior house officers did not attend the ward on 33 weekdays (52%), over the study period of 64 days. No specialist registrar was present on the ward for 27 weekdays (42%). On 18 weekdays (28%), no junior doctor attended the ward.

This study shows an alarming change in junior doctor practice in one ward in a district general hospital after the introduction of the EWTD. The drop of 28% in weekday attendance raises important service and training issues.

This is particularly true of stroke care, as stroke outcomes in the UK and Ireland already appear to be less favourable than those in North America and northwestern Europe. Even before the introduction of the EWTD, it was recognised that there was insufficient evidence to estimate the effect of any intervention to limit the working hours of doctors.

Surgeons and anaesthetists have documented a decrease in training capacity in terms of procedure counts after the introduction of the EWTD. Recent changes in the UK postgraduate system combined with the EWTD may have halved the total number of hours of postgraduate “training.” Our study implies that follow-up of medical patients or continuity of care, which is recognised as an important service quality of junior doctors and as an integral part of training, may be

| Table 1 Participant characteristics and handwriting scores |
|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Attorney | Builder | Scientist | Engineer | Doctor | Accountant | AutoTech | p Value |
| Sex (M/F) | 10/10 | 10/10 | 10/10 | 10/10 | 10/10 | 10/10 | 10/10 | 10/10 |
| Age* (years) | 41 (10) | 34 (7) | 36 (10) | 29 (6) | 36 (10) | 35 (12) | 31 (5) | 29 (9) |
| Education* (years) | 20 (2) | 13 (1) | 22 (2) | 17 (1) | 22 (2) | 17 (1) | 14 (2) | 0.313 |
| Poorly formed letters* | 11.3 (5.0) | 9.4 (6.2) | 8.8 (3.2) | 8.6 (7.9) | 8.5 (5.2) | 7.0 (6.7) | 5.8 (3.9) | 0.705 |
| Median score (1–4) | 2.0 (1.2–2.8) | 2.0 (1.6–3.0) | 2.1 (1.2–3.0) | 2.3 (1.0–3.2) | 2.4 (1.6–3.0) | 2.6 (1.0–3.0) | 2.6 (1.2–3.2) | 0.076 |
| Illegible (<2.0) | 40% | 40% | 40% | 25% | 25% | 25% | 30% | 0.619 |
| Median score (1–4) | 2.0 | 2.0 | 2.1 | 1.8† | 1.9† | 2.3† | 3.9† | <0.001 |
| Male | 2.0 | 2.0 | 2.1 | 1.8† | 1.9† | 2.3† | 3.9† | <0.001 |
| Female | 2.2 | 2.2 | 2.1 | 2.9 | 3.7 | 2.9 | 2.9 | <0.001 |
| Pairwise p value | 0.439 | 0.114 | 0.424 | 0.003 | 0.020 | 0.038 | 0.020 | <0.001 |

AutoTech, automobile technician; M/F, male/female. *Data are presented as mean (standard deviation). †Pairwise comparison, p < 0.04.
suboptimal in some hospitals under the EWTD.

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Using a sentinel adverse incident audit on a Medicine for the Elderly ward

Adverse events in healthcare occur more often in older people,1,2 and older people are more vulnerable to the effects of adverse events. Despite this, there are few studies that focus specifically on reducing adverse events in older people.3 Several problems have been noted with systems such as the incident reporting (IR1) system used in the National Health Service—lack of anonymity,4 failure of medical staff to fill in reports,5 bias towards certain types of events (eg, falls) and lack of feedback to ward staff. We therefore introduced an anonymous adverse incident reporting system on our Medicine for the Elderly ward in Ninewells Hospital, Tayside, Scotland to ascertain (a) whether additional events would be detected by this system and (b) to provide a driver for ward-based quality improvement activities.

The audit ran between November 2004 and October 2005. The tool was based on a tool previously developed by one of the authors, the trial for which was conducted in general medical wards in an Australian hospital.6 Before its introduction, an orientation session took place at the weekly ward multidisciplinary meeting. Reports were collated at three-monthly intervals by the middle grade doctor on the ward (MDW) and presented to the multidisciplinary team in aggregate form. These aggregate reports were then used to select a small number of areas on which to focus ward-level quality improvement activities.

In all, 268 patients, all female, mean age 85.2 years, were admitted to the ward during the study period. Table 1 compares the audit results with IR1 reports from the same timeframe and from the previous year. A total of 32 of 72 (44%) of sentinel audit incidents were reported by nursing staff and 37 of 72 (51%) by medical staff, with three reports not attributable. No incidents were reported by allied health professionals. There was no overlap in reports between the sentinel audit and the IR1 system. The adverse incident audit was acceptable to staff, quick to use and generated additional adverse event reports to the IR1. Event categories for both the audit and IR1 were similar to those previously reported.7 The frequency and type of events reported using the IR1 system did not change when the sentinel audit was introduced, confirming that the audit collected new information. The results were easily fed back to the ward team, who initiated new ward-level quality improvement activities as a result. A simple, anonymous adverse incident audit can therefore provide useful additional information to drive quality improvement activities in a Medicine for the Elderly hospital service.

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<table>
<thead>
<tr>
<th>Table 1</th>
<th>Adverse incidents captured by sentinel audit and IR1 reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Sentinel audit 2004–5</td>
</tr>
<tr>
<td>Delay in investigation or diagnosis or treatment</td>
<td>24</td>
</tr>
<tr>
<td>Prescribing error</td>
<td>14</td>
</tr>
<tr>
<td>No discharge summary or notes entry</td>
<td>5</td>
</tr>
<tr>
<td>Inappropriate treatment</td>
<td>4</td>
</tr>
<tr>
<td>Unplanned readmission</td>
<td>4</td>
</tr>
<tr>
<td>Canceled or inadequate discharge</td>
<td>4</td>
</tr>
<tr>
<td>Adverse drug reaction</td>
<td>4</td>
</tr>
<tr>
<td>Unprescribed fluids or warfarin</td>
<td>3</td>
</tr>
<tr>
<td>Over-anticoagulation</td>
<td>2</td>
</tr>
<tr>
<td>Observations not recorded</td>
<td>2</td>
</tr>
<tr>
<td>Patients with slip, trips and falls</td>
<td>0</td>
</tr>
<tr>
<td>Drug administration error</td>
<td>0</td>
</tr>
<tr>
<td>Hospital-acquired infection</td>
<td>0</td>
</tr>
<tr>
<td>Patient mistreatment by staff</td>
<td>0</td>
</tr>
<tr>
<td>Theft or intruder</td>
<td>0</td>
</tr>
<tr>
<td>Violence and aggression</td>
<td>0</td>
</tr>
<tr>
<td>Other injury (staff or patient)</td>
<td>0</td>
</tr>
<tr>
<td>Unsafe staffing levels</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
</tr>
</tbody>
</table>

Bedside tipple?

Alcohol hand-gel is now provided at all patient–staff contact points throughout the National Health Service as part of the Department of Health’s “clean your hands” campaign. This potentially could influence patient care as we found out in our hospital. A 53-year-old patient admitted with alcoholic liver disease and acute renal failure consumed about 350 ml of spirigol from the container at his bedside. Gastric lavage was not considered safe and he was monitored closely over the next two days. He did not manifest any signs of ethanol intoxication and was discharged in due course. Spirigel contains 70% ethanol and small quantities of glycerol, bitrex and triethanolamine. The features of toxicity are entirely due to the ethanol. The estimated fatal dose for this gentleman was about 680 ml. The presence of bitrex and the consistency of this product discourage ingestion. However, the easy availability of this rather rich source of alcohol could prove tempting to patients known to misuse alcohol. It is perhaps prudent to put in place measures to limit access to alcohol-containing products for this type of patients.

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