Improving the Patient Journey within a Minor Injuries Area

Minor Injuries Area
A/E Department
Hairmyres Hospital
East Kilbride

Supported by the Foundation of Nursing Studies Patients First Programme in partnership with the Burdett Trust for Nursing
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Improving the Patient Journey in a Minor Injuries Area

Keywords  Minor Injuries / Improving Patient Journey / Patient Satisfaction/ Quality /Structured Case Records

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Summary of Report
In an effort to enhance the journey of all patients attending the Accident and Emergency (A/E) department within Hairmyres Hospital, a designated area has been developed to allow the flow of minor injuries patients to be seen, treated and discharged by a designated team of health care staff. Included in this team are a group of experienced A/E nurses who have completed a practical and educational developmental pathway of study, Minor Injury Nurse Treatment Service (MINTS), which has ultimately led to them becoming autonomous in their roles and expanding their sphere of practice, to enable them to see, treat and discharge patients from the minor injuries area of the department.

In May 2010 MINTS performance figures from Hairmyres hospital had consistently fallen below NHS Lanarkshire (NHSL) standard (50% of minor injuries patients to be seen by MINTS nurses), and professional relationships were somewhat strained, causing disharmony within and outside the minor injuries area.

This report predominantly discusses the strategy utilised by the minor injuries team as they attempted to improve the patient experience, improve performance figures and enhance team culture within the minor injuries area. In collaboration with the Foundation of Nursing Studies (FoNS), the project team were able to enhance professional relationships, improve performance figures, whilst boosting morale, enthusiasm and drive within the minor injuries area. During this 15 month project, evidence from a patient satisfaction questionnaire clearly demonstrated that the communication methods utilised to inform patients regarding the flow of patients, and up to date approximate waiting times to be seen were ineffective, this led to another strand of work being added to the original project plan, which remains on going at present.

And finally it was noted that documentation of care delivery was in some instances failing to meet professional standards for record keeping as dictated by Nursing and Midwifery Council (NMC) and General Medical Council (GMC). Therefore this report also discusses the development and implementation of structured case records for use by health care professionals working within the minor injuries areas throughout Lanarkshire.
Background
Care delivery to patients attending Accident and Emergency (A/E) departments has significantly changed over recent years, due mainly to the expansion and diversity of nursing roles, the introduction of the European Working Time Directive (2009) and the Modernisation of Medical Careers (2007).

The Unscheduled Care Collaborative (2007) suggested that more efficient and effective care can be delivered to the patients attending the A/E department if it is separated into ‘major’ and ‘minor’ flow groups. They also suggest that designated accommodation and health care professionals should be allocated to deliver care to each of these groups of patients if improvements in care delivery are to be seen.

In response to the need to modernise team working within A/E, NHS Lanarkshire (NHSL) embarked on an innovative nurse led project which was adapted from a service delivery programme described by Crouch et al. (2001). This Minor Injury Nurse Treatment Service (MINTS) programme prepared adequately experience A/E nurses to embark on a practical and educational developmental pathway of study. This would ultimately lead nurses to become autonomous in their roles and expand their sphere of practice to prepare them to see, treat and discharge patients from the minor injuries area of the A/E department.

Throughout NHSL these roles have led to a significant number of nurses (163) expanding their knowledge and skills to enable them to see, treat and discharge minor injured patients efficiently, effectively and most importantly, safely from A/E, GP surgeries and prison service medical centres. This new service has enhanced the patient journey and assisted NHSL to meet the Scottish Government 4 hour A/E performance target which remains in place within the Scottish health agenda. However, different styles of leadership, culture and management within the three A/E departments operating within Lanarkshire has had a major impact on the development of this service and has impacted negatively in some instances on the confidence and competence of nurses working within this sphere of health care.

In June 2010, the project leader took up the newly developed post of team leader for minor injuries within one of these hospitals. On commencing this post she found a team of highly knowledgeable, motivated nurses, enthusiastically wanting to improve patient care and enhance the patient journey. However many of them were lacking in confidence in their own abilities to competently see, treat and discharge patients without the support and guidance of others. It was also observed that nursing leadership within the minor injuries area had been poor over previous years leading to the medical model of health care delivery being nurtured. It was felt that utilising the nursing workforce in this manner not only prevented nurses from developing their knowledge, skills and competence, it also led to a reduction in the numbers of patients being autonomously treated and discharged by MINTS nurses thereby leading to poor performance figures for minor injuries.

In September 2010, the project leader applied to participate in the Patients First Programme in conjunction with the Foundation of Nursing Studies. This project was selected as one of 15 nurse led projects which commenced throughout the UK in November 2010. The following is a report on the strategies utilised by the project team which led to improvements in care delivery within the minor injuries area of a small A/E department.

Initial performance
Following implementation of MINTS in 2006 there was an expectation by NHSL that once the service was embedded, at least 50% of all minor injured patients would be seen, treated and discharged by minor injury nurses. It was envisioned that developing the service in this manner would assist NHSL meet and sustain Scottish governmental 4 hour treatment targets within A/E departments. However as seen below,
by May 2010, Hairmyres Hospital minor injury area was not achieving the expected level of service delivery, while other hospitals within Lanarkshire exceeded the estimated target.

Table 1. MINTS Figures May 2010

<table>
<thead>
<tr>
<th>Hairmyres Hospital</th>
<th>Wishaw Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total minor injury patients</strong></td>
<td><strong>Total minor injury patients</strong></td>
</tr>
<tr>
<td><strong>No. of pts seen by MINTS nurses</strong></td>
<td><strong>No. of pts seen by MINTS nurses</strong></td>
</tr>
<tr>
<td><strong>% of patients seen by nurses</strong></td>
<td><strong>% of patients seen by nurses</strong></td>
</tr>
<tr>
<td>Week ending</td>
<td></td>
</tr>
<tr>
<td>02/05/2010</td>
<td>762</td>
</tr>
<tr>
<td>09/05/2010</td>
<td>708</td>
</tr>
<tr>
<td>16/05/2010</td>
<td>720</td>
</tr>
<tr>
<td>23/05/2010</td>
<td>792</td>
</tr>
<tr>
<td>30/05/2010</td>
<td>767</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3749</td>
</tr>
<tr>
<td><strong>No. of pts seen by MINTS nurses</strong></td>
<td><strong>No. of pts seen by MINTS nurses</strong></td>
</tr>
<tr>
<td><strong>% of patients seen by nurses</strong></td>
<td><strong>% of patients seen by nurses</strong></td>
</tr>
<tr>
<td>1002</td>
<td>3125</td>
</tr>
<tr>
<td><strong>26.72</strong></td>
<td><strong>68.28</strong></td>
</tr>
</tbody>
</table>

Source: NHS Lanarkshire

Anecdotal evidence suggested the main reason for the discrepancy seen in these figures was due to the different methods of leadership and cultures within each area, and this was personally observed when the team leader joined Hairmyres Hospital in June 2010. It was observed that professional relationships between management, medical staff and the MINTS team on the site had for some time been rather strained. This was due mainly to differences of opinion regarding the service delivery model utilised within the minor injury area. Therefore in the early part of the project, a major part of the work revolved around improving professional relationships and developing a work ethic and culture which was effective and sustainable.

**Aim of the Project**
To improve the patient journey by enhancing the performance of MINTS nursing staff, by developing effective and sustainable professional and team relationships.

**Objectives of the Project**
1. To develop a cohesive minor injury team by improving professional relationships and workplace culture
2. To monitor and improve MINTS performance figures
3. To gather baseline information to understand patient experience, and use this information to implement necessary changes to improve the patient experience and communication methods utilised within the department
4. Audit current documentation practice and implement required changes to ensure compliance with NMC and GMC standards
Methods and Approaches
Throughout the project a number of methods were used to obtain baseline information and evidence on how the service was being delivered and to inform how it could be improved. These included a:

- Values clarification exercise (See Appendix 1)
- Patient experience questionnaire (July 2011) (See Appendix 2)

In addition, evidence gathered from other recent local and national audits, MINTS Documentation Audit NHSL (February 2011), Scottish In-Patient Experience Survey (SPSP 2010), also influenced the work carried out throughout this project.

Details of these methods and their outcomes will be outlined below.

Developing a cohesive minor injuries team
When the project leader joined the minor injuries team at Hairmyres Hospital, it was observed that there were tensions between different members of the team e.g. nurses, doctors, consultants, and management. These tensions generally revolved around the service delivery model being utilised within the department, with each group appearing to have their own separate agenda and little co-ordination or co-operation between parties. These tensions led to stress throughout the department which in turn was affecting the efficiency of care delivery to patients (as evidenced in the MINTS figures previously described). It also contributed to the slow progression and development of some MINTS nurses who came to rely on others to support and direct them in the decision making processes during patients’ journey.

The medical model of care was somewhat entrenched in the culture and it appeared that this was stifling the development of the MINTS nurses as they attempted to develop their confidence and competence in autonomously delivering care to patients. There was also a view that the MINTS was seen by some as an ‘added extra’ to the A/E department, which could be turned on or off dependent on the patient activity or staffing level within the minor injuries area at any given time.

This lack of structure and instability of the MINTS led to:
1. Poor development and insecurity within the nursing team
2. Poor performance figures
3. Lack of confidence from medical personnel in MINTS nurses’ abilities
4. Frustration for the hospital management team and the MINTS project board re lack of development and improvement in performance from MINTS nurses

Drennan (1992, p 3) describes culture as ‘the way things are done around here’. The leader of the project wanted others to question ‘why do we do things this way?’ and ‘could there be an alternative way of delivering care to patients which could benefit patient care and satisfy the needs of the care providers as well as management and the MINTS project board?’

Values clarification exercise
To start to answer these questions, the project team felt it was important to understand the differing values and beliefs of individual staff groups and to determine if there were core values or a common vision which the team could use to develop the service and effectively influence the strategic direction of the department in the future.
Using Warfield and Manley’s (1990) values clarification template, a questionnaire was developed (see Appendix 1) which was distributed via email to 24 members of the management, medical and nursing teams. These 24 members were chosen to represent a cross section of staff involved in delivering or managing care for patients attending this minor Injuries area. It was decided that the use of email to distribute the questionnaire to the wider team would ensure recipients received the questionnaire individually and that it was the easiest way to return the reply without it getting ‘lost’ in post. Copies of the returned questionnaires were held safely on the computer for audit purposes in the future.

A total of 13 individual questionnaires were returned with a further 1 amalgamated questionnaire completed by the 7 consultants within the A/E department, therefore achieving a return rate of 58.33%.

The project team were disappointed that only 1 amalgamated questionnaire was received from the consultant body within the department as it was hoped that each individual would use this opportunity to express their own views and opinions regarding service delivery within the department. However it was recognised that the consultants were a cohesive body within the department, and that their co-operation was integral to improve relationships.

Collation of the values and beliefs responses was carried out by the project team and Figure 1 shows the common themes that emerged:
The most common theme gained from this exercise was that robust leadership and management from the nurse consultant, team leader, senior charge nurse, and operational management were seen as key to the future success of the MINTS project within the Hairmyres A/E department.

The values clarification exercise gave the project team a better understanding of the issues which concerned different staff groups, and allowed the project to focus on some of these issues in an attempt to improve relationships between differing staff groups.

The themes arising from the exercise were sent to each individual member of the team who were originally asked to complete the questionnaire and copies of the themes were made available for all members of nursing and medical team to access. It was hoped that this would allow all staff groups to recognise their own and others concerns and views on the delivery of the service, and so make everyone feel included in the decisions and change management over coming months.

From the values clarification exercise, the project team recognised the issues that would form their focus over the next 12 months; however the fragility of the relationships within the department made it difficult to develop a formal action plan and therefore the team worked hard at building professional relationships
by utilising a transformational style of leadership. The themes which emerged were utilised to drive the actions below.

- **MINTS Staffing** - It was decided that on each shift a senior MINTS nurse would be allocated to the minor injuries area to support a more junior member of the team. The aim of this was to provide support for the junior members, encouraging them to increase their confidence and competence within the area and progress their portfolio of evidence required for the project board. Since the start of this project with the support of the senior MINTS nurses, three further members of the nursing team have progressed to Level 4 (autonomous practitioner), and a further four members of the nursing team have commenced their MINTS training. This has given the team a great psychological boost with staff now appearing to feel more confident and competent working within the minor injury area.

- **Consultant Support** - The effect of ensuring that a senior MINTS nurse was specifically allocated to the minor injuries area on a regular basis appears to have given confidence to the consultants re the constancy of service delivery within the area. MINTS staff now work in collaboration with medical staff, with each staff group supporting and assisting the other, leading to a much more professional and conducive atmosphere. There is now a more balanced level of medical input into the minor injuries area, allowing a higher level of medical staff input into the major area of the department which is often under enormous pressure due to increased activity and bed shortages within the hospital.

- **A/E Nursing Establishment** - As stated above, the activity within the major area of the department is often at critical level, and on a regular basis it is necessary to redeploy one of the MINTS nurses to support the main department to ensure patient safety and security. Since the start of the project, the nursing establishment within the A/E department has been slightly increased on a temporary basis and this has had a positive effect on the department as a whole; however the ‘pulling’ of MINTS nurses continues in times of increased activity. Utilising staff in this manner causes them to become frustrated and unsettled and has a detrimental impact on the MINTS performance within the minor injuries area, and this has been demonstrated when the weekly MINTS figures are produced and the level of service provision from MINTS nurses subside from previous weeks. The project team, along with the senior charge nurse and management, will continue to work to establish alternative strategies to manage very busy times, in an attempt to prevent disruption of the service offered by the MINTS nurses.

- **Leadership** - Partnership and collaboration between the MINTS team leader and the senior charge nurse within the A/E department have been utilised to drive the changes within the minor injuries area. However at times, it would appear that the positivity seen within the minor injuries area of the department has not extended to the major area, with staff verbalising and displaying signs of increased stress and emotion on a regular basis. This is generally due to increased activity in the department, bed shortages within the hospital, and staffing levels which many staff feel are inadequate to give safe, efficient and effective care to those patients attending the department. This has been highlighted in many ways to senior management within the organisation e.g. through datix recording, stress audits, personal letters of concern.

**Improving MINTS performance figures**

Below is the minor injuries report for NHS Lanarkshire for December 2011. Although a new computer system was implemented within NHSL in 2011 causing changes in the extraction of figures from the system resulting in differences in total minor injury patient numbers, it can be seen in table 2, the performance figures for MINTS nurses seeing patients at Hairmyres Hospital has significantly increased from the previous table presenting figures for May 2010, and there now appears to be a more consistent level of compliance between hospitals.
Table 2. MINTS Figures December 2011

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<thead>
<tr>
<th></th>
<th>Hairmyres Hospital</th>
<th></th>
<th>Wishaw Hospital</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Total minor injury patients</td>
<td>No. of pts seen by MINTS nurses</td>
<td>% of patients seen by nurses</td>
<td>Total minor injury patients</td>
</tr>
<tr>
<td>Week ending</td>
<td></td>
<td></td>
<td>Week ending</td>
<td></td>
</tr>
<tr>
<td>04/12/2011</td>
<td>307</td>
<td>207</td>
<td>04/12/2011</td>
<td>286</td>
</tr>
<tr>
<td>18/12/2011</td>
<td>310</td>
<td>194</td>
<td>18/12/2011</td>
<td>277</td>
</tr>
<tr>
<td>25/12/2011</td>
<td>233</td>
<td>183</td>
<td>25/12/2011</td>
<td>243</td>
</tr>
<tr>
<td>01/01/2012</td>
<td>236</td>
<td>181</td>
<td>01/01/2012</td>
<td>273</td>
</tr>
<tr>
<td>Total</td>
<td>1350</td>
<td>952</td>
<td>Total</td>
<td>1374</td>
</tr>
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</table>

Source: NHS Lanarkshire

It is unclear if the changes described previously were fully responsible for the improvement in the figures shown here; however the project leader feels that they contributed to the improvement in performance, and the professional relationships between members of the A/E team which has made the department a pleasant and exciting place to work.

This partnership of care delivery style between medical and nursing staff was praised recently in a diagnostic team visit report by the Emergency Access Support Team from the Scottish Government (August 2011). They stated that ‘the discharge of a substantial number of flow group 1 (non admitted minors) patients within the hour ... is a credit to the ED [Emergency Department] and represents good quality access for these patients’. They go on to praise the protected environment in which minor patients are seen, however they were critical of the ‘standing down’ of the minors service when pressures within the major area became critical to patient safety, which in turn leads to an increased wait for first assessment of minor injury patients.

The whole ethos of the MINTS is the delivery of autonomous, individualised care; however this does rely on the support and advice of others within the team. Effective teamwork and collaboration between medical, nursing and managerial staff should provide a partnership to build on the success already achieved within the MINTS.

Improving patient experience and communication
Waiting times and the physical environment patients wait in, and are treated in, have a major impact on their overall A/E experience (Design Council, 2011). In a recent report by the Design Council (2011) they noted that when patients arrive in A/E departments they ‘do not expect to wait’, however when they do have to wait, these waits are often uncomfortable, boring, or stressful.
For the majority of patients or carers arriving in A/E, the stressors which affect them most include waiting times, staff attitudes, lack of up to date information on waiting times and lack of understanding of the process path for them and/or others within the waiting area (Design Council, 2011).

When the project started in December 2010, it was decided that it was important for the project team to look at and understand the whole patient journey to determine where improvements could be made to reduce patients stress, waiting times, improve practice or to enhance the overall patient experience. Over recent years there has been much quantitative evidence gathered within NHSL on care delivery within emergency services e.g. weekly performance figures, 4 hour target figures, time to first assessment figures; however many would suggest that the real test of performance within the NHS will be found in obtaining the views and experience of the service users. Using patients’ views and reflections on their experience within health care is a very powerful tool in attempting to improve service delivery (Larsson, 2007; Lyttle and Ryan, 2010; Coulter et al., 2009). Avis (1997) suggests that patient experience surveys can monitor and drive quality improvements within health care, and the Picker Institute (www.pickereurope.org) suggest that obtaining patient views on clinical care should be an integral part of the care process.

The project team looked at numerous forms of feedback which could have been utilised to obtain patient views, but some were rejected for the following reasons:

- Telephone interviews: It was thought this would cause imposition to patients following discharge
- Patient diaries: There were concerns that these would not be completed and returned by patients
- Mystery shopper: The project team were unsure about the ethics of using this approach within this health care environment

It was therefore decided to focus on developing a patient experience questionnaire which would ask specific questions about the patient’s experience within the minor injuries area of Hairmyres Hospital. Asking patients for their views in this manner gave patients the opportunity to express their views and concerns regarding their journey through the A/E department. The project team were aware that this method does have its limitations as the pre-determined questions could be seen as focusing on measures of satisfaction rather than truly understanding the patient experience.

The questionnaire was developed (see Appendix 2) using questions from the NHS Institute for Innovation and Improvement (2009) experience based design approach; advice from the Picker Institute website and incorporating some questions which had been utilised in previous patient satisfaction surveys carried out by NHSL and NHS Scotland.

The questionnaire was administered to randomly selected patients or their relative by a Clinical Support Worker (CSW) over a two day period. Patients were assured of the anonymity of the questionnaire and assured that any responses given would be utilised to improve the patient experience within the minor injuries area. All clinical care was complete before an approach was made to any patient, and the patients were taken out of the clinical area for completion of the questionnaire. Informed verbal consent was obtained from all patients or relatives.

To create objective data collection, the CSW was not in clinical uniform when helping patients to complete the questionnaire, nor was he employed within the minor injuries area. Having one person administer the questionnaire ensured continuity in the approach utilised when engaging with patients, it also ensured consistency with the documentation of patients’ replies and stories. This person also assisted in the analysis of the results, and this was very helpful as he could vividly recall the conversations had with individual patients or relatives.
Whilst the questionnaire was being administered, patients and relatives appeared to be happy to be asked about their experience within the department, and were very constructive in their views and opinions as to how this service could be improved. Comments, suggestions and patients stories are included in the main body of this report.

Findings from patient experience questionnaire

In total, 48 questionnaires were completed (19 females, 29 males) with only one person refusing; this was due mainly to child care issues. The age range of patients was from 8 months to 84 years.

The total length of time patients were in the department from registration to discharge varied from 22 minutes to 4 hours 30 minutes, with an overall average time of 74.54 minutes.

Arrival and check in

When asked about arrival and check in at reception there was a mixed reaction from the patients. The majority of patients who expressed their feelings described their first impressions of the department as being safe, welcoming, listened to and comfortable. Some of the comments on the questionnaires regarding arrival and check in included statements such as:

‘Quick, efficient, smooth process’
‘Friendly’
‘Always the same, nice’

However there were a number of patients who used words such as ‘frustrated’, ‘anxious’, ‘bored’ and most concerning ‘ignored’ when describing how they felt at check in; unfortunately there was no patient story which explained the reason why this individual felt this way. The Design Council (2011) report suggests that a ‘negative first impression’ reduces satisfaction levels of patients and carers throughout their whole A/E journey, whereas a ‘positive first impression’ will shift a patient’s zone of tolerance towards satisfaction or delight with service delivery.

Most of the comments given (n=11), regarding arrival and check in were positive, however some patients suggested the reception staff were ‘less than helpful’ at times, and this is an issue which needs to be addressed to improve and give the ‘positive first impression’ suggested within the Design Council report.

Flow group

Patients were asked if they were aware or had been informed via any communication method that the A/E department was separated into two distinct clinical treatment areas i.e. major area and minor injuries area. Of the 48 patients included in the study, 37 (77%) were unaware of the streaming of minor and major flow groups within the A/E department (see Figure 1).

Figure 1. Awareness of flow groups

Were you aware that A/E patients were separated into minor and major flow groups?

- Yes
- No

37
11
The Unscheduled Care Collaborative (2007) suggest that separating minor and major flow groups within the emergency care environment increases the efficiency of the major flow group while at the same time improves the waiting time for the minor injured patient.

There were many concerns and suggestions from the patients who completed the questionnaire regarding the lack of information/communication regarding the patient journey within the A/E department. Some patients thought there was a need for posters or video screen information to be installed which would give easy to understand information about the streaming of patients into flow groups. One patient thought this information would avoid unnecessary approaches to the reception staff and also prevent frustration and anger within the waiting area when ‘patients arriving in the department after you were called to treatment area before you’. This quote would suggest that some patients and relatives are unaware that patients attending A/E are seen in order of clinical priority as opposed to time of arrival and perhaps further communication of this within the waiting room is required.

In an effort to address the above concerns an NHSL A/E communications group has recently been set up with representatives from all three A/E departments to proactively look at and improve the communication strategies utilised within all hospitals. To date, in collaboration with the communication team it has been agreed that the most efficient and cost effective method of communicating with patients in the waiting room will be through the use of the plasma screen televisions. Short video presentations will be filmed using site specific staff to welcome patients to the department and explain how the flow of patients operates within the unit; it will also give information on how staff determine which flow group specific injuries or illnesses are assessed into, and how initial assessment of patients is carried out by nursing staff.

**Waiting time information**
When patients were asked if they were aware of the approximate waiting time to be seen in the minor injuries area, there was mixed reactions. 14(29%) respondents said they were aware of the waiting time, with most suggesting it was the ‘rolling screen’ which advised them of this; 34 (71%) respondents said they were unaware of the waiting time (see Figure 2).

![Figure 2. Awareness of waiting times](image)

Further feedback from patients suggested that the rolling screen advising patients of the approximate waiting time was consistently sitting at four hours and there was no distinction to advise patients as to the difference between the major or minor flow groups waiting time. One respondent stated she saw the waiting time at four hours, therefore advised her relative to go home and she would contact them nearer...
her discharge time, only to be seen, treated and discharged within the hour, hardly time for her relative to get home before they had to return. She suggested that if the appropriate waiting time for specific flow groups were highlighted this would prevent confusion for relatives and friends.

Another respondent reported, she had asked the receptionist if the approximate waiting time was correct, only to be advised ‘the sign is probably wrong’. This highlights the fact that staff are aware incorrect information is often displayed on the sign, giving rise to the question: how often is this sign altered to ensure correct and up to date information is being given to patients and relatives, and is the information explicit enough to inform patients which flow group of patients it is aimed at?

Through the communications group it has been decided to adapt the plasma screen televisions to present a rolling screen display of up to date waiting times for different areas of the department which can easily be changed by A/E staff from a dedicated computer terminal. Utilising the initial assessment nurse to regularly update the current waiting times for minor and major areas of the department should ensure that relevant information is reaching patients waiting for treatment in the department, and hopefully relieving stress or anxiety re waiting time.

**Time to first assessment**

27(56%) patients advised us they were first seen by a health care professional within 30 minutes of registration, 16(33%) within one hour of arrival and 5(10%) waited over one hour before being seen, no patient waited over than two hours before being first assessed (see Figure 3).

**Figure 3. Time to first assessment**

It is concerning that 21(44%) out of 48 patients waited over 30 minutes to first assessment by a health care professional. This is an issue the department and NHSL have been working hard to improve with the implementation of a dedicated initial assessment nurse who attempts to see each individual patient attending the department within 30 minutes of arrival, and makes a clinical decision as to whether they need immediate attention and categorise each patient utilising a modified triage system. This is a highly demanding role for the nurse, especially at times of increased activity within the unit. It is by utilising skills and knowledge, the initial assessment nurse needs to prioritise the more severely ill or unwell patients before assessing minor injured patients. Therefore patients seen in the minor injuries area are often first assessed by the minor injury staff.

**Help and advice from health care professional**

46(96%) of the 48 patients surveyed stated that they were happy with the care and treatment from their care provider. Both patients who suggested they were not happy with care provided stated the reason for this was that they came to A/E expecting an x-ray and this had not been given.
Health care providers within the minor injuries area of the department are given extensive training and education on patient safety and clinical policy states that clinical need drives the necessity for further investigation, and it is imperative that patients are fully involved and informed of decisions made by care providers.

**Feeling forgotten**

5(10%) of the 48 patients within this survey thought they had been forgotten about at some stage during their time in the minor injuries area. Upon review, all 5 patients had been seen, treated and discharged from the minor injury area in under 2 hours 10 minutes, with 2 of these patients being discharged in 47 and 58 minutes respectively.

The lack of progress along the A/E journey can cause anxiety and concern for some patients or relatives and this in turn can develop into frustrations and anger which could be directed at A/E staff, therefore it is imperative that patients and carers are informed and kept up to date of progress throughout their time within the department. In an effort to address this issue the communications group is considering utilising some of the Design Council (2011) suggestions re use of ‘slices’ of relevant information in specific areas of the department which highlights what should expected at that stage in their A/E journey e.g. waiting area, treatment area or x-ray, and what to do if they feel their journey has stalled at this stage.

**Having confidence in treatment**

48(100%) patients included within this study stated they were confident in the care and treatment delivered to them by the nurse or the doctor during their visit to the minor injuries area. Avis (1997) suggests that patients are often reluctant to criticise care delivery from health care professionals out of gratitude or fear that this may jeopardise further treatment, however it was interesting to note that patients were not so reluctant to criticise other non clinical staff, and this is evidenced by the comments given by patients within this study.

Porter–O’Grady (2003) suggests that health care should be viewed from ‘*The balcony as opposed to the street*’ to allow staff to view the service with more vision. Conducting this patient experience questionnaire has allowed a better picture of patients’ views and expectations to be obtained, and changes of the communication processes within the minor injuries area are planned as a result of the findings.

**Conclusions from the questionnaire**

The responses to the questionnaire identified that the patient information and communication processes within the waiting area are inefficient and misleading for the patients and carers arriving and waiting to be seen. There is no information within the waiting area to advise patients that the there is a ‘streaming process’ separating minor and major patients within the A/E department. Nor is there information regarding patient flow and initial assessment.

Most of the negative comments regarding the waiting room were in respect of the waiting time ‘rolling screen’, with 26(54%) of the 48 patients making comments on the inefficiency of the screen. Many patients felt that the information on the rolling screen could be more effective e.g. giving separate waiting times for minor and major patients, however this would only be effective if patients were made aware of which flow group they were waiting in.

Suggestions that other forms of communication could be used to convey information included use of posters, leaflets and utilising the health promotion rolling video screen to inform patients of how flow groups and streaming were determined are now being planned.
In general it would appear that patients were happy with the care and treatment delivered from the health care professionals, however communication with patients regarding waiting times and progress through the minor injuries area received negative comments and this will be addressed via the communication group.

**Recommendations of the communications group**
- Use of the plasma screen TV to inform patients of waiting times and the A/E journey
- Posters explaining the streaming process to minor and major areas of the A/E department
- Up to date and relevant information to be displayed on the plasma screen TV

**Improving written documentation**

Documentation of care delivered by the health care provider is integral to care provision within the NHS (NMC, 2008; GMC, 1995). It is an essential part of the role of a registered nurse or doctor and omissions of documented observations or care delivery could be seen as a breach of duty and may lead to suggestions that optimum care has not been provided. Southard and Frankel (1989, p 393) suggest that clinical documentation should be ‘a written chronological evidence of care delivery....which depicts quality of care delivery.......and allows this to become a method of communication with other members of the health delivery team treating the patient’.

Evidence gathered from a previous internal audit of A/E records (NHSL, 2010) showed that on a regular basis certain aspects of care delivery were not being documented onto some A/E cards, e.g.
- 12/20 practitioners failed to record negative findings in their clinical examination section
- 4/20 documents had illegible handwriting
- 4/20 utilised inappropriate abbreviations within written document
- 2/5 failed to document patient allergies or tetanus status

The project team recognised that the development of a set of structured case sheets for nurses and doctors on which to document their clinical examination, findings and treatment, which was set out in chronological order, and provided written prompts for staff to follow, could potentially prevent vital information being omitted from written documentation of care, enhance the provision of safe and effective care to patients, and ultimately protect the public.

The potential benefits of developing structured case sheets to be utilised within a minor injuries area include:-
- Reduction in time spent on documentation
- Establishes a standard of care required of practitioners
- More robust method of documenting care delivery
- Improved communication with other health care providers
- Easier to audit / research practice delivery
- Reduction in waiting times for patients
- Gives confidence to the organisation (NHSL) and professional bodies (e.g. NMC, GMC, RCN, BMA) that full and accurate information regarding care delivery is being documented

However one drawback of utilising case sheets structured in this format, could be that documentation becomes a ‘tick box’ exercise. To counter this, a small group of staff drawn from across NHSL joined together to work on developing structured case sheets which could improve written documentation of care delivery. The documents were devised using the knowledge and skills of the group participants and systematically documenting the care delivery of specific minor injury conditions e.g. ankle injuries or minor...
wounds. The group included input from the practice development team who provided valuable assistance in formatting the documents.

Pilot versions of the first four structured case records were produced, agreed and implemented within all three hospitals for a period of two months. The project team wanted to pilot these to allow staff the opportunity to familiarise themselves with the new documents and to constructively critique the documents to ensure that the format was easy to use and contained all the relevant information. During this two month period the format for the forms was taken to the documentation audit group within NHSL to ensure they fulfilled NHSL’s criteria for appropriate documentation for use within the A/E department. This was agreed in principle, with the caveat that final versions of all documents would be agreed and signed off by this group once all forms had been piloted and audited for relevance at clinical level.

The period of testing highlighted generally similar issues and suggestions from all three sites and these were implemented into the final document before the completed document was agreed and implemented (see Appendix 3 and 4). During this meeting further pilot versions of documents were produced for other frequently seen conditions and once again a pilot stage of production, was undertaken for these forms. To date there are ten agreed profomas including ankle injury, wounds, bites and stings, and minor burns, shoulder, elbow, wrist, hand, knee, minor head injury. In collaboration with the project team, the document formats will be subject to regular review to ensure they stay relevant and fit for purpose.

**Discussion**

McCormack et al (2004) suggest that by utilising an ‘emancipatory ‘approach to change, the culture and context of care can be transformed and improvements in care delivery can be achieved.

When the project leader joined the team in June 2010, it appeared that the minor injuries area within Hairmyres Hospital, was being driven by a technical approach to practice development e.g. expert authoritative figures (doctors) directed practice which was being determined by outcomes e.g. target driven results (management), with the nursing staff often caught in the middle of a power struggle for supremacy.

By utilising a number of different leadership styles:-democratic/ transformational / transactional the project leader was able to enable changes which have seen improvements not only in the numbers of patients seen by minor injuries nurses, but has also in the culture and work environment. This is evidenced by the team working ethic which is now utilised by both medical and nursing staff, with medical staff infiltrating into the minor injuries area to assist at times of increased activity and nursing staff sharing their knowledge and experience with the more junior members of the medical team to ensure patients receive optimum level of care during their visit.

At the start of the project the team leader had one clear goal, to increase the numbers of patients seen treated and discharged by MINTS nurses. However as the project progressed, with the support and vision of the FoNS team, and an increasing professional respect between medical and nursing staff it became more important that the clinical teams should work as a cohesive interdependent team, as opposed to independent professional groups pulling in separate directions. It is unclear when or if there was a change in leadership style during this process, however since the start of this process, team work between medical and nursing staff has significantly improved, leading to more efficient and effective delivery of care for patients.

**Assumptions**

At the start of this programme the project leader made a number of assumptions:  
- There was a commitment from all parties involved during the project
• There would be full involvement with all stakeholders during the project
• There would be collaboration, inclusion and participation from all stakeholders

Even in the early stages of the project, it became clear that perhaps not everyone was as committed to this process as had been initially envisaged. Full involvement had not been forthcoming from all staff groups, and it was difficult to generate participation and collaboration from these same staff members. Despite this, the main aim was to improve care delivery to the patients attending the department, and to support and encourage all members of the team to deliver optimum care to patients attending the department, and to this end the project team feels this has been achieved.

Maintaining the focus of the project has been difficult, with the potential to become distracted to examine other service improvements ever present. However improved communication and the development of structured case record sheets were natural progressions within the project.

Conclusion
The main challenge for the project leader over the past 18 months has been enabling the development of a cohesive minor injury team. It was imperative that strong leadership skills were utilised to drive and improve the service delivery model utilised within the minor injuries area. Utilising the values clarification exercise with all members of the nursing, medical and management staff allowed individuals to recognise the views and concerns of others, and enabled the development of a vision statement, which captured how the service would be delivered. However this was only achievable with the commitment of a small group of staff who were enthusiastic and committed to improving the patients’ journey and experience.

Improvements are very noticeable, with nursing and medical staff working as a cohesive team of health care professionals. The numbers of patients seen and discharged from the minor injuries area by the MINTS nurses has increased by almost 50% in the last year, and the professional respect between senior nurses and consultants within the department has improved dramatically, and this is evidenced by the collaborative manner in which the structured case records were constructed and implemented.

By utilising the patient experience questionnaire, the project team were able to obtain patient’s views, concerns and complaints regarding communication. Although the Design Council (2011) looked at the effect poor communications had in terms of violence and aggression within A/E, the findings of this small survey reflect the results found by them, therefore it would be prudent to utilise their advice and implement changes relating to up to date waiting times, patient flow diagrams, and explanations as to flow group determination. The work to improve the communication network for patients attending the department continues, and with the drive and commitment of staff from all 3 A/E departments, the project team are confident this will improve in the very near future.

The development of the structured case record sheets has proved to be the most time consuming part of this project to date. They were developed to ensure quality and consistency of documentation, to ensure standards of care are being delivered and accurately document care delivery in a timely and legible manner. It is anticipated that these documents will be useful to all members of the minor injuries team within Lanarkshire and to a wider audience.
## References

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<th>Title / Description</th>
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<td><em>Modernising Medical Careers</em>. Department of Health :London.</td>
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| NHS Lanarkshire | 2011 | MINTS Documentation Audit  
NHS Lanarkshire: Scotland. |
| Nursing and Midwifery Council | 2008 | The Code: Standards of conduct, performance and ethics for nurses and midwives  
NMC: London. |
| Picker Institute | | [www.pickereurope.org](http://www.pickereurope.org) |
| Porter-O’Grady, T. | 2003 | A different age for leadership (Part 1)  
| Scottish Government | 2011 | Scottish Government Directorates for Health and Social Care  
Emergency Access Support Team (EAST)  
Hairmyres Report.  
Diagnostic Visit 22\textsuperscript{nd} Aug 2011. |
NHS Scotland: Edinburgh. |
(Last accessed 22/10/2011.)  
Appendix 1- Values clarification questionnaire
Thanks for agreeing to assist the patients' first Project group as we endeavour to improve the MINTS service delivered within Hairmyres A/E department. We would ask that you critically evaluate all the statements below and complete the statement as extensively as you wish ~ giving full and frank explanation for all constructive comments or criticisms given.

1. I believe the purpose of the MINTS service is to ~

2. I believe the role of the MINTS Nurse is ~

3. I believe my role in the MINTS service is ~

4. I believe the factors that inhibit the MINTS service are ~

5. I believe the factors that inhibit the MINTS nurse is ~

6. I believe the factors that would improve the MINTS service is ~
Appendix 2- Patient experience questionnaire

Your A/E Visit Today

In an effort to improve the Minor Injury service within NHSL, we’d like to give you the opportunity to tell us about your A/E visit today and give you the opportunity to comment on the care and treatment you received.

1. Arrival and Check-in ~
   A. What was your initial impression of the department on first walking into the waiting area today?
   
   B. Would any of the following words describe how you felt on first arrival at A/E ~
   
   Frightened  Supported  Safe  Comfortable  In Pain
   Angry  Embarrassed  Worried  Frustrated  Welcomed
   Important  Listened to  Ignored
   
   Please add any other words / comments you feel would better explain your first impressions of the department

2. Waiting

   A. Were you aware / informed that patients attending A/E were separated into Minor Injury / Major injury & illness Yes  No
   
   B. Were you aware / informed of the waiting time for Minor Injury patients today?
   Yes  No
   
   C. If yes ~ how was this communicated to you?
   
   D. If no ~ Do you have any suggestions as to how this information could be communicated better to patients in waiting area ~
   
   E. Would any of the following words describe how you felt while waiting in waiting room ~
   
   Frightened  Supported  Safe  Comfortable  In Pain
   Angry  Embarrassed  Worried  Frustrated  Welcomed
   Important  Listened to
   
   Please add any other words / comments you feel would better explain your first impressions of the department

3. Treatment

   A. How long did you wait before you were first seen by a nurse or a doctor?
   0-30 Mins  31-59 Mins  over 1 hr  over 2 hrs
   
   B. During the consultation and treatment ~ did the Nurse / Doctor give you all the help and advice you needed? Yes  No
   
   C. If No ~ please give further details
   
   D. During your time in A/E did you ever feel that the nurse or Doctor had forgotten you? Yes  No
E. Did you feel confident in the treatment and care delivered by the Nurse or Doctor looking after you?

   Yes                      No

F. If No ~ please give further details

4. **Discharge**
   A. Were you given information and discharge advice on your condition?
      ~
      Yes                      No
   B. Did you fully understand this before discharge?
      Yes                      No
   C. Were you happy with the overall care and treatment delivered to you today?
      Yes                      No
      If No ~ in an effort to address patients concerns ~ please explain further

D. Do you have any further comments you would like to make re your visit to A/E today?

Time of Arrival
Time of Departure
Age
Male / Female
Appendix 3 - Example of new documentation proforma

Patient name: Emergency Department
Address: Minor Injury Service:
Date of Birth: Management of Wounds
CHI number: Hospital: Hairmyres □ Monklands □ Wishaw

See by: Employment/School:
Dominant hand: Accompanied by:

Presenting Complaint/History of Presenting Complaint

Date and time of wound:

Relevant Past Medical History/Drug History

Known allergies:

Analgesia:

Before admission: On admission:

- Pain Score:
  - If 4 or more consider intranasal dexamphetamine

On examination

/Site and size of wound:

Type of Wounds:

- Abrasion □ Laceration □ Puncture □ Penetrating
- Incised □ Crush □ Other (specify)

Depth of Wounds:

- Superficial □ Partial Thickness □ Full Thickness □ Skin loss

Right Hand

Right Foot

Left Foot

Left Hand
### Patient name: [Redacted]  
**CHI number:** [Redacted]

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<th>Option 2</th>
<th>Option 3</th>
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<td>Inflammation</td>
<td>Infection (if yes, consider antibiotics)</td>
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<td>Tracking</td>
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**Evaluation of Care/Additional Comments**

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Appendix 4 - Example 2 of new documentation proforma

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<td>See by:</td>
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<td>Dominant hand:</td>
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**Presenting Complaint/History of Presenting Complaint**

**Relevant Past Medical History/Drug History**

**Known allergies:**

**Analgesia:**

Before admission: 

On admission:

Pain Score: 

- If 4 or more consider intra-nasal diamorphine

**Date and Time of injury:**

**Hand/Finger injured:**

☐ Left ☐ Right

**Family/Social History:**

**Examination**

**Left Hand**

**Right Hand**

**Inspection: (Describe)**

Swelling: 

Deformity: 

Bruiising: 

Wound: 

**Anatomical snuff box:**

Ulna co lateral ligament (laxity): 

Nail injury? ☐ Yes ☐ No
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<td>- Styloid</td>
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<td>Thumb</td>
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**Movement:**

**Investigations:**
- Hand x-ray
- Thumb x-ray
- Finger x-ray

**Diagnosis:**
- Soft tissue injury
- Fracture of (specify)
- Other (specify)

**Treatment and Follow-up:**
- Treatment:
- Follow-up:
  - Ortho referral
  - Fracture Clinic
  - Minor Injury Clinic
  - GP

**Tetanus Status:**
- Covered
- Tetanus Immunoglobulin
- Revaxis

**Patient Protection/Health Promotion:**
- Child/Adult Protection Screening
- Alcohol Screening
- Other (specify)
- Vulnerable Adult
- Assault Audit

**Signature:**

**Designation:**

**Discharge Time:**

**Evaluation of Care/Additional Comments**

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