**Aims**

- Failure to document the review of investigations, management plan and resuscitation status is a common problem on post-take ward rounds (PTWR) and may contribute to poor outcomes for individual patients.\(^1,2\)
- Some authors report an improvement in the recording of information and its subsequent accessibility with a proforma approach.\(^3,4,5\)
- We aimed to audit our unit’s PTWR documentation, and subsequently re-designed our proforma with an aim to improve practice.

**Method**

- Initial audit of all PTWR entries of patients under care of acute medicine team on a single day in November 2012 (n=34).
- Data collected: Documentation of individual investigations, the review of patients’ observations and whether decisions were made regarding escalation of care and resuscitation status.
- New proforma designed and implemented (see below), with an increased emphasis on the review of investigations and the recording of specific clinical decisions.
- Re-audit carried out two months after the introduction of the new proforma, in April 2013, with the same opportunistic sampling approach (n=25).

**Results**

- In the initial audit only 41% of investigations were documented as having been reviewed.
- On re-audit, the proportion of recorded investigations increased to 90%.
- On re-audit, a wide variety of care escalation decisions were recorded and there was improvement in documentation of medication review and venous thromboembolism (VTE) risk review.

**Conclusion**

- We present a simple, effective, change in practice that has resulted in significant improvement in quality and consistency of PTWR documentation, and which has also improved clinical practice.

**References**