Interprofessional Learning Unit 2

Group Number: 71

Audit title: An audit of the handover utilised in Medicine for Older People Rehabilitation Stroke (MORPS).

Confidentiality has been respected throughout this work and no names of people or places have been included.

This report is entirely our own work.

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Word Count: 3218  (excluding executive’s summary, contents and appendices)
An audit of the handover utilised in Medicine for Older People Rehabilitation Stroke (MORPS).

The individuals in the group who compiled the audit, are students studying:
- BSc and MSc in Social Work
- Mpharm Hons Pharmacy
- BN in Adult Nursing
- BSc in Audiology
- BSc Hons in Therapeutic Radiography
- Diploma/Advanced Diploma in Adult Nursing
- Advanced Diploma in Children’s nursing
- Bachelor of Medicine

Executive Summary-

Audit Aims and objectives:

1. The audit aims to carry out an audit to identify the knowledge, understanding and attitudes of nurses towards the Reason-Story-Vital Signs-Plan (RSVP).
2. Evaluate staff understanding of RSVP
3. Assess if nurses were aware of the RSVP system, if they used the system and how they rated it

Standards:
This audit used the following standard:
- Reason
- Story State
- Vital Signs
- Plan

Ethical Considerations:
Throughout this audit the following guidelines were strictly followed:
- Audit Commission Act 1998
- Audit Commission, 2011
- Data Protection Act 1998

Ethical issues that were addressed include confidentiality, anonymity, objectivity, competency and integrity.

Data Collection:
The group audited 7 wards within the MOPRS department to observe nursing handovers.
Observational table was devised using the RSVP system (appendix A) to see which stages were being included or omitted in the handover.
A few short closed questions were also prepared to assess if nurses were aware of the RSVP system, if they used the system and how they rated it.
The number of patient cases that were observed during the handover totalled to 140.

Results:
- 100% of patients’ names were mentioned
- Patient’s age was only mentioned in 27% of cases with ward 7 mentioning it on all patients.
- The reason for patient admission was handed over in only 54% of cases
- The patient’s ward/Bed no. was mentioned 40% of the time overall
- 51% of patients’ past medical history was mentioned
- 59% of immediately preceding events were handed over
- 13% of patients had allergies mentioned
- 31% of patients’ social history was declared
- 44% of patient’s vitals were mentioned in regard to abnormalities.
- 44% of patients’ observation regimes were mentioned
- 64% of patients with current investigations were declared
- 37% of care plans were mentioned
- 9% of patients had a social worker arranged.
- 58% of wards had a visible RSVP poster.
- 67% of wards were aware of RSVP and understood what it is.
- 33% of wards actually used the RSVP system

**Discussion:**
Patient’s age, reason and bed number were not always mentioned. On wards with long-term patients, staff were familiar with the case notes therefore only updated their knowledge since their last shift. Nurses taking on care for a new patient however, should be fully informed. None of the wards audited consistently mentioned allergies or social history. A vast majority of the wards did not mention vital signs, leaving numerous aspects to presumption.

There was a correlation between the wards without posters and those lacking awareness of RSVP. It was also found these wards did also not fully implement the RSVP system. The clear majority of wards do not implement the RSVP system for various reasons for example wards with long term patients are more likely to not utilise the system as staff gain and retain knowledge of individuals’ needs and medical status.

The average rating given between wards was 4, which generally showed a low consensus of opinion towards the RSVP system.

**Recommendations:**
- Create larger posters explaining the RSVP model in all areas used for handovers
- Ensuring all staff have in depth training on the RSVP model
- Scrutinise and make changes to the method and the content of the RSVP training
- Re-audit in twelve months following implementation of the above recommendations to observe any improvements.
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1. Introduction

Handovers play a vital role in providing patients with holistic care. The term refers to the handing over of relevant patient information between healthcare professionals. RSVP (Reason-Story-Vital Signs-Plan) is a system to ensure accurate communication between healthcare staff to prevent deterioration in hospital patients (Featherstone, Chalmers & Smith, 2008, p. 860). Without a standard in place, information can be lost, missed or overlooked. The potential for handovers to vary in quality and content opens healthcare to a large room for error. RSVP is a standard newly proven to be effective and efficient in keeping information passing consistent.

1.1 The aim of the project is to identify how and when RSVP is used by nurses working in MOPRS wards in a large general hospital in the South of England. This project would also reveal the rate of compliance to handover care guidelines. Handovers in the MOPRS wards have been audited in the past, resulting in the development of the RSVP system. This audit will be carried out by an Interprofessional Learning Unit (IPLU) group.

1.2. The objectives are to carry out an audit to identify the knowledge, understanding and attitudes of nurses towards the RSVP standard and the extent of its implementation.

1.3. In 2009, the Clinical Audit Advisory Group provided a new definition of Clinical Audit reporting and that “Clinical Audit is the assessment of the process using evidence based criteria, with the intention to stimulate and support national and local quality improvement interventions and through re-auditing to assess the impact of such intervention”. This definition is supported by the common learning handbook (common learning handbook, 2011) which suggests that an audit is the monitoring of clinical practice against standards aiming to improve the quality of patient care as a result of the outcome. Handovers are used to pass information on about patient care (Calleja, Aitken & Cooke, 2010, p. 14) and provide “an opportunity for nurses to update each other on progress and ongoing issues for patients” (Wilson, Ho & Walsh, 2007, p. 87). Messam and Pettifer (2009, p. 190) found that if there is neither informal agreement nor formal guidance as to what information should be included or excluded, the content of the handover varied between those delivering it. Handovers often appeared unstructured and unfocused.

Manias and Street (2000), cited by Pothier, Monteiro, Mooktiar and Shaw (2005, p. 1090) commented that “any failures in a handover may result in serious consequences for patients and for this reason the handover process must be subject to the same scrutiny as any other nursing or medical process involved in patient care”. Audit is one way in which handovers can be assessed.
Deficits in the quality, quantity and appropriate information have often been identified as a major issue with clinical handovers (Calleja, Aitken & Cooke, 2010, p. 14), which is one reason why the RSVP system is being implemented. Currently the RSVP standard for handover has been introduced and used on a couple of wards but is yet to reach the majority.

It is hoped that the RSVP system will improve communication between staff “to create a picture that efficiently and reliably conveys their concerns so that they get the help that they need without delay” (Featherstone, Chalmers &and Smith, 2008, p. 860).

2. Standards:
An audit looks at the care patients are receiving and gives clinicians reliable, valid information that helps them review their performance and identify areas where they can make improvement. This audit was based on the standards of the RSVP system (Featherstone, 2008).

2.1. Figure 1 shows explains the RSVP system:

**Figure 1**

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<th>R</th>
<th>Reason-</th>
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<tbody>
<tr>
<td>1.</td>
<td>State the identity of caller</td>
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<td>2.</td>
<td>Check that you are speaking to the correct person</td>
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<tr>
<td>3.</td>
<td>State patient’s name and location</td>
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<tr>
<td>4.</td>
<td>State the reason for the call</td>
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<td></td>
<td>I am …..(Nurse A)</td>
</tr>
<tr>
<td></td>
<td>Is that ……..(Doctor B?)</td>
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</tbody>
</table>

<table>
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<tr>
<th>S</th>
<th>Story State:</th>
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<tbody>
<tr>
<td>1.</td>
<td>Background information about the patient</td>
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<td>2.</td>
<td>Reason for admission</td>
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<td>3.</td>
<td>Relevant past medical history</td>
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<tr>
<td>4.</td>
<td>The patient's resuscitation status</td>
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<th>V</th>
<th>Vital Signs</th>
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<td>Vital signs are:</td>
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<td>Temperature</td>
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<td>Pulse rate and rhythm</td>
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<td>Blood pressure <em><strong><strong>/</strong></strong></em></td>
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<td>Breathing rate</td>
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<td>Conscious level, mental state</td>
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<td>Capillary refill time</td>
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<td>Sweating?</td>
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<td>SaO₂, FiO₂</td>
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<td>Urine output</td>
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<td>Early warning score</td>
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<tr>
<th>P</th>
<th>Plan</th>
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<tr>
<td>A.</td>
<td>My plan is…..</td>
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<tr>
<td>or</td>
<td></td>
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<tr>
<td>B.</td>
<td>What is your plan?</td>
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<tr>
<td></td>
<td>Say what is required from the receiver of the call</td>
</tr>
</tbody>
</table>
2.2. The basic methods of audit including:

- Stage 1: select topic
- Stage 2: set criteria and standards;
- Stage 3: data collection;
- Stage 4: compare data to standards;
- Stage 5: identify changes;
- Stage 6: implementing changed (an action plan).
- Stage 7: re-audit

The Audit Cycle (National Institute for Health and Clinical Excellence 2002)

Before beginning the audit, permission was obtained from the hospital manager. The audit was conducted over a random one week period; the data collected was part of a “normal” working day. Seven handovers were audited from different shift patterns. The handover was timed from the moment the name of the first patient was introduced, to the last words spoken about last patient. The content of the handover was audited by using a checklist. The data was collaborated in an excel spreadsheet and used to perform the analysis.

3. Ethical considerations:
Audits conducted within the NHS, such as ours are bound by the Audit Commission Act 1998. Such legislation provides a code of conduct that promotes best practice in regard to the standards and techniques of auditing (Audit Commission, 2011). This particular audit was carried out within a hospital setting therefore certain ethical considerations were incorporated. Firstly, is the handling of personal information. The NHS has access to and utilises vast amounts of personal information, all of which is subject to the Data Protection Act 1998, an awareness of this was crucial to the audit of ward handovers. In carrying out the audit, permission to observe the handover was first obtained from the ward staff. All the ward handovers were observed and content recorded onto a tick sheet; this contained no personal information and therefore maintained the confidentiality of patients and adhered to the Data Protection Act.

Two individuals attended each ward to ensure the information gathered was accurate and reliable In addition the individual wards have not been identified and the data collecting sheets have been destroyed to maintain anonymity.

4. Methodology:
The group was assigned with 7 wards to study the nursing handover used in MOPRS, more specifically if and how the RSVP method was used. A collective decision was made by the group to
audit each ward in one handover and to also ensure at least one morning, one lunch time and one evening handover was observed.

As the nursing handover is a particularly busy period on the wards it was decided that the audit should try to be as observational and objective as possible and only include as small number of quick closed questions to receive a subjective viewpoint. From this an observational table was devised using the posters and information on the Reason Story Vital signs Plan system (see appendix B) to see which stages were being included or omitted in the handover and how accurately each of the stages were being followed. The audit tool also included questions to assess if nurses were aware of the RSVP system, if they used the system and how they rated it (see appendix C).

4.1. Pilot study: A pilot study was conducted to assess the audit tool and its validity for auditing the RSVP system of nursing handover without missing out relevant information. This was carried out by two of the group members conducting the first audit using the observational chart and questions and feeding back to the group. As a group there were no problems found with the tool and it continued to be used in the audit.

5. Data Collection:
For data collection the group split into six pairs to carry out an audit on each of the 7 wards, with one pair conducting the audit for 2 wards. One morning and evening handover audit were carried out with the other 5 being conducted at the lunchtime handover. All members of the team had a copy of the audit tool (appendix C), which was filled out during the handover. All the nursing teams were happy to comply with the audit and both the members of the group and the nursing staff were made aware that the results would remain confidential in order to protect the validity of the audit results.

6. Analysis of methodology:
The research data was collated and analysed to allow conclusions to be drawn of the use and understanding of the RSVP system of nursing handover.
The methodology was reliable as it provided mainly an objective assessment therefore allowing the nurses to continue with the handover as usual therefore reducing bias. However the method could be improved by carrying out audits on each ward at the three separate daily nursing handovers. It may also be important to look into other methods of data gathering for this audit as tick sheets, although the best for the observation and time constraints could be considered to be too vague.
7. Results and findings:
The RSVP Handover System is broken down into 4 headings, Reason, Story, Vital signs and Plan. For each of these headings, certain artefacts of information regarding the patient must be given to ensure appropriate handover is performed. For the audit of the usage of RSVP within MOPRS Wards, we designed a check sheet which broadly encompassed the information that should be given during handovers between shifts. Our audit sampled 7 wards in a South East England hospital. A blank copy of the check sheet is included in the appendix C.

7.1 For the heading of “Reason” the relevant information that should be given during the handover must include: Patients’ Name, Age, Reason for admission and Ward/Bed No.

The wards sampled contained a varying number of patients however the audit sampled the first 20 of these brought up during a staff handover.

- 100% of patients’ names were mentioned
- Patient’s age was only mentioned in 27% of cases with ward 7 mentioning it on all patients.
- The reason for patient admission was handed over in only 54% of cases
- The patient’s ward/Bed no. was mentioned 40% of the time overall

Ward 7 managed to follow the RSVP system for all patients providing all 4 criteria for the Reason heading. This is considered to be a perfect handover with no information lost between staff.

For the heading of “Story” the relevant information that should be given during the handover must include Relevant past medical history, Immediately Preceding events, Allergies and Social History.
• 51% of patients’ past medical history was mentioned
• 59% of Immediately preceding events were handed over
• Only 13% of patients had allergies mentioned
• 31% of patients social history was declared

For the heading of “Vital Signs” the only criteria required is any changes or abnormalities since last observation.
• 44% of patient’s vitals were mentioned in regard to abnormalities.

For the heading of “Plan” the relevant information that should be given during the handover must include Frequency of Observations, Current Investigations, Is there a care plan in place and is a social worker arranged.

• 44% of patients’ observation regimes were mentioned during the handovers
• 64% of patients with current investigations were declared
• Only 37% of care plans were mentioned in the handovers
• 9% of patients had a social worker arranged.

7.2 In order to assess the awareness and usage of RSVP within the wards during handovers, a few questions were asked and observations made.

- 58% of wards had a visible RSVP poster.
- 67% of wards were aware of RSVP and understood what it is.
- Only 33% of wards actually used the RSVP system.
The graph above shows how the different wards rated the RSVP system, where a rating of 10 was very good and a rating of 1 was very poor. The average rating given between wards was 4, which generally showed a low consensus of opinion towards the RSVP system.

8. Discussion:
From the results obtained from graph 1, all wards showed good practice in mentioning the patient’s name. However the patient’s age, reason for admission and patient’s bed number was not always mentioned. This does not indicate good practice because a patient’s age may determine or indicate necessity for future or additional care. The reason for admission should always be mentioned also, because this is the primary reason in which care is being given to this particular patient. In ward 7, all staff followed good practice when handing over information regarding to elements of reason. All other wards appeared sporadic in mentioning all four elements of this section. Despite the importance of this information, handovers are carried out under time pressures, an important factor to consider. In wards with longer-term patients, the staff are familiar with the case notes therefore it is arguable for nurses to only update their knowledge since their last shift. Nurses taking on care for a new patient however, should be fully informed.

Graph 2 shows that the relevant past medical history was only mentioned in 51% of cases. Although this information should always be included in any handover, if this was a patient’s first admission, then there may not be any relevant past medical history. There was, however, no mention of whether this was a patients first admission. Immediately preceding events should always be mentioned whether there is something pertinent or not as this could help provide vital information when giving care. Despite not every patient having an allergy, it should be confirmed that the patient has no allergies rather than leaving it to presumption. None of the wards audited consistently mentioned allergies, in fact it was largely dismissed with wards 2, 5 and 7 specifically had no mention of allergies at all. Social history should be mentioned or at least sought after because it could help determine any on-going care that may need to be given once discharged.

Similarly, it would be important to confirm that there has been no an abnormality or changes in the vital sign. Leaving numerous aspects to presumption may encourage less vigilance in the nurses ensuring they’ve attained an accurate picture during handover. Of the 20 patients mentioned in ward
2, 18 of these had their vital signs mentioned during the handover, whether there were any abnormalities or not. This demonstrates a very clear, accurate practice, if not quite perfect.

Graph 4 shows the data from the elements of plan section. It reveals that on average under half of the patient’s observations schedule was mentioned. Wards 2 and 7 excelled in their discussion of current investigations as they both mentioned it in 95% of cases. Of the wards that were audited, only 37% of care plans were mentioned during the handovers. This does not indicate good practice because further treatment and on-going care must be discussed in order to provide patient care once they are discharged. It would seem very important, especially when planning a ward change or patient discharge, to involve a social worker in the on-going care plans as they are intrinsic in the planning of continuing older people care.

In order to promote the usage of the RSVP system, the information poster describing all the sections should be displayed clearly and easy to follow or understand. Just under half of the wards that were surveyed did not have a visible RSVP poster. It seems interesting that these wards did not fully implement the RSVP system compared to those wards that did have the RSVP information on display.

When asking about staff awareness of the RSVP system, there is a clear correlation between this and the understanding of the systems practice. It appears that more experienced staff were more likely to be aware and understand the system than newer staff that may not have been taught about its existence.

When surveying graph 9, reasons stated for a low rating included that the handover system is not trained to new staff and therefore not standardised, also that the system is impractical for long-term patients as well as time consuming. However wards with acute patients found that the system was effective to provide information about their short-term patients. The RSVP system for providing information over the phone was generally praised as a good structured method for conveying information in a logical and concise way.

The clear majority of wards do not implement the RSVP system for various reasons, when considering the data above, it is important to bear in mind the ward specialities. An acute care ward may find the RSVP standard more relevant as patients are new and fairly quickly transferred, they will not have time to become as familiar with patients as one would on a longer term, rehab ward for example. This is potentially problematic for new staff, or those who may have been away on holidays. During this audit no single ward provided all relevant information that the RSVP system requires for an effective handover.

Another consideration is the time the audit surveys were carried out. Midday shifts will be much harder pressed for time than the morning or evening shifts so information passing may be briefer.
Whilst those carrying out the survey were trainee health care professionals, it is possible they did not all fully understand the terminology used by nurses, leading to possible inaccuracies within the recording. Inconsistencies may have also arisen through the individuals surveying, bringing their own subjective error. The project has limits, due to time constraints and the IPL groups differing knowledge and understanding of medical terminology and abbreviations.

9. Recommendations:
The following recommendations for the use of the RSVP model of nursing handover have been made based on from the findings of the audit. Implementing these recommendations could mean that the RSVP model of handover is effectively carried out on all wards and therefore handovers will be more efficient and less information will be lost. The suggestions follow:

- Ensure every ward has large visible posters explaining the RSVP model in all rooms used for handovers and next to telephones. It may be necessary to have specific posters for both inter-shift and telephone handovers, with specific topics that are relevant to each situation mentioned
- Carry out further training to all nursing staff on the all the wards, ensuring that in particular all junior or new members of staff have in depth training on the RSVP model
- Within the training particular attention needs to be paid to the importance of the ‘S’ in the model which stands for Story. None of the wards were consistent at handing over previous medical history, preceding events, allergies and social background and so the importance of these topics should be covered in the training
- Re-audit in twelve months following implementation of the above recommendations, this will continue the audit cycle and ensure further changes can be made if necessary

10. Conclusion
The need for a structured model of handover has been highlighted and it was therefore important that an audit was undertaken into the use of one particular model for this. From undertaking this audit it has been established that there is varying use of the RSVP model for handover amongst the MOPRS wards in the hospital being evaluated. Surveys found that wards better informed, with RSVP clearly publicised displayed a much more consistent, standardised handover than those wards without. The RSVP standard was widely found useful in regards to phone calls and with new staff or patients but on general handovers, the standard was not well implemented. Using the findings, areas of the model were identified as being inadequately followed, such as ‘Story’. From this, recommendations were made in an attempt to improve the use of this model and therefore ensure less information gets lost during handovers.
Finally, there is an obvious need identified for the standardisation of handovers and the RSVP system is clearly beneficial in ensuring there is detailed information transfer, especially on acute care wards. There is an argument for its lack of diligent use within a long-term care setting but the evidence here has shown, even in these environments, having the RSVP system as a backbone will greatly improve information handover and consequentially, patient care.
Appendix A: REFERENCES


APPENDIX C: Blank example of auditing sheet

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1. Is the RSVP poster clearly visible? Yes/No
2. Are you aware of the RSVP? Yes/No
3. Do you know what RSVP stands for? Yes/No
4. How would you rate the RSVP system? (1 Best-10 Worst) ........

Ward: 
Time: 

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