Improving Residential Aged Care/Hospital Clinical Handovers: What's missing? Linking patient information to patient care.

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A Clinical Handover audit project funded by DOHA through the Australian Commission on Safety & Quality in HealthCare.
Outline for today’s presentation

- Introduction to the Clinical Audit Tool (CAT)
- Role Play / Discussion tables - Case Scenario
  1. A table of health professionals to discuss information required when transferring a resident to hospital
  2. A table of health professionals to discuss information required when discharging a resident to a RACF
  3. Undertaking an audit based on the information discussed.
- Feedback from Auditors, process – findings – outcomes.
- Conclusion – outcomes, recommendations, lessons learned.
Why undertake an audit?

- Identify systems in use
- Clearly identify clinical information received
- Identify gaps that may influence decision making
- Identify safety and care issues that arise from these gaps
- Inform change
Systems

- Paper based
  - Yellow envelope
  - Hand written
  - Printed material

- Electronic
  - Shared electronic health records
  - Medical objects – encrypted messaging
Accountability/responsibility

- Resident/family
- Residential Aged Care Staff
- General Practitioner
- Transport staff
- Hospital Medical staff –
  - Allied Health
  - Nursing
- (Duty of Care)
Steps to undertaking an Audit

- Identify key stakeholders
- Seek organisational support – ethics approval
- Agree on the audit templates and guidelines
- Decide on timeframes and scope
- Recruit auditors
- Implement the audit
- Evaluate findings
- Identify gaps and areas for further in-depth investigation
- Make recommendations
Data Collation

• Use simple tools to evaluate your audit.
• No need for special programs an excel spreadsheet will provide you with all you need.
• Keep information anonymous – code audit sheets to ensure this is the case.
• Present information in ways that people can easily see areas of improvement or areas of need. (Graphs / tables)
Graphs

- Section 2 Clinical Information -
  2.9 Recent observations

- % Response Sep08
- % Response Dec08

<table>
<thead>
<tr>
<th></th>
<th>% Yes</th>
<th>% No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sep08</td>
<td>70.0%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Dec08</td>
<td>50.5%</td>
<td>25.7%</td>
</tr>
</tbody>
</table>
### Tables

<table>
<thead>
<tr>
<th>Audit Questions</th>
<th>Admission Audit % available</th>
<th>Audit Questions</th>
<th>Discharge Audit % available</th>
<th>Comments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6 Usual GP &amp; contact details</td>
<td>77.8%</td>
<td>2.4 Does GP name on information received match current GP.</td>
<td>87.8%</td>
<td>In this case we see that the correct GP has been noted in 10% more cases than the information received.</td>
</tr>
<tr>
<td>1.5 Was patient re-presented/readmitted to hospital within 6 weeks</td>
<td>26.7%</td>
<td>3.5a Re-presentation / readmission to hospital within 6 weeks</td>
<td>27.8%</td>
<td>This shows fairly consistent data and the small variation could be due to an admission during the audit period who has not been discharged in time to be included in the discharge information.</td>
</tr>
<tr>
<td>3.1 Time of presentation to DEM</td>
<td>12am-6am 7.8% 6am-12md 18.9% 12md-6pm 41.4% 6pm-12mn 7.8%</td>
<td>3.1 When was patient discharged?</td>
<td></td>
<td>After hours for the purposes of these audits was considered before 7am and after 5pm on weekdays and anytime on weekends.</td>
</tr>
<tr>
<td>3.2 Time spent in DEM</td>
<td>0-3 hrs 10.0% 3-6hrs 27.8% 6-9hrs 32.2% 9-12hrs 5.6% 12-15hrs 5.6% 15-18hrs 4.4% 18-21hrs 0.0% &gt;21hrs 0.0%</td>
<td>3.1 When was patient discharged?</td>
<td>Within Hours 61.1% After Hours 30.6% Friday PM 8.3% Public 0.0%</td>
<td>There may be some correlation between the time of presentation and the LOS in the department to the time of discharge. However, 30.6% are discharged after hours and this includes weekends. Further discussion needs to be undertaken on the specific workforce issues, and patient safety issues for after hours discharges. If all relative information, ongoing management and medications are in order, after hours discharges may be seen as less of an issue than is currently the case.</td>
</tr>
</tbody>
</table>
Recommendations

- Recommendations should come from the respective organisations, and may include suggestions from the Advisory group.
- They can be made regarding the need for more in-depth investigation, or
- Made toward an improvement on the current process undertaken.
- They should be written and agreed.
- Don’t end the process until some change management has been agreed on by the organisations involved.
- You want outcomes – not just information.
Outcomes

- Measuring outcomes is the most important part of the audit process.
- The Audit provides the data.
- The process of evaluation and recommendation provides the impetus for change.
- Measuring outcomes gives credence to the audits.
- This is how the audit fits into any quality cycle used by different organisations.
Lessons

- Adequate time & resources
- Acknowledge limitations of an audit
- Understanding the physical journey of pt & chart (ED & Receptionists)
- Communication with all areas involved
- Real time study to reflect the actual use of yellow envelopes
- Ongoing measurement of the use of yellow envelopes would be a useful indicator to reflect communication between organisations and effectiveness of tool
Conclusion

• You need the data. No changes will take place unless you can show what is actually happening.
• Undertaking this audit has provided us with clear evidence of process breakdown.
• This process of auditing information in and out keeps a neutrality to the audit and prevents a divisive them/us attitude.
• It focuses on the safety of the patient and the duty of care for all health professionals.
• Apart from the new born, these patients are some of the most vulnerable people in our society.
• Good transfer of information enables professionals to apply their knowledge in using this information to provide safe and appropriate health management.
• Let’s keep them safe.
Case study – Clinical Handover

- Mrs MB
- 92 years old
- Lives in a hostel
- Found by nursing staff at 6am lying on her bathroom floor. Unable to tell staff when she fell.
- Unable to weight bear on Right leg.
What you did not know

- GP information would inform you that-
- Mrs MB has a past history of IHD, HT, recurrent TIA’s, NIDDM – diet controlled
- Medications – Plavix, Noten, Coversyl, Diamicron
- Her usual mental state is reasonable MMSE 28/30. Definitely more confused on presentation to hospital so concern of head injury needed to be eliminated.
Discharge

- Mrs MB is discharged back to the hostel after a two week hospital stay following a repair of a # Right Neck of Femur (NOF)
What you may not know

- Medical notes identify-
- During hospitalisation has a repair of # R NOF
- Has regular physiotherapy with ongoing recommendations for mobility
- Post operative complications include a URTI and antibiotics have been commenced.
GP Auditors feedback
GP Auditors feedback

• Process of Audits

• RACF permission

• View documentation from hospital

• RACF nursing comments – written & verbal
Findings

- Medication issues
- Ongoing care
- Value of HINH
- GP Issues
GP Auditors Recommendations:

• **RACF to Hospital:**
  - Standard “ready to go’ documentation
    1. Patient Details
    2. Medical Summary/CMA
    3. Advanced Health Directive
  - Current relevant information
    1. Reason for transfer
    2. Medication list
    3. Current level of functioning
GP Auditors Recommendations:

- Hospital to RACF
  1. Phone Calls – clarification / level of care
  2. Timeliness
  3. Medications
It’s all about the journey!
Clinical Handover
RACF/ GP/ Hospital

"Hospital Perspective"

Karen Kasper, Lisa Mitchell & Diane Martini (Internal Medicine Research Unit)
Hospital Perspective

- Problem – transfer of patient information
- Aim – Identify current practice & improve
- Methods – audit and feedback
- Outcomes – audit tool & yellow envelope
- Lessons – consultation, implementation, time
- Recommendations – scope, measure & feedback
Problem & background

*RACF Pts are frequently admitted to RBWH*

- Appropriate information needs to be shared - RACF, GP & RBWH

*Develop audit tool to review effectiveness of communication*

- Audit tool as a standardise template
Aims - Identify current practice & improve

- Collaborate on a standardise audit tool
- Trialling the audit tool (process and definition)
- Identify deficits – yellow envelope, Nursing Discharge summaries, DNR, Medication
Methods - Audit tool

What do you want to know & why do you want to know it and what can we do?

“Are patients coming in with adequate information required for clinicians to make appropriate clinical decisions?”. 
Methods – audit tool

- **Defining data** (ambulance form, cognition v MMSE, what is a clinical incident?, observations, premorbid or current, understanding each others common language, what is legible, ? Adverse med events Confirmation of GP, can’t make any assumptions, UNDERSTANDING limitations).

- **Consistency of data** – review data, repeatable

- **Process mapping** – understanding physical journey, filing
Methods - Feedback

• *What can we do?* (based on time & resources)

- Yellow envelope

- Audit results (key messages)

- Champions (target information to right people, i.e. receptions)
Yellow envelope

- Checklist
- Communication
- Highlights important information
Outcomes – audit tool & yellow envelope

• Completed two audits

• Communication/feedback

• Yellow envelope reintroduced – *Worthwhile*
  Raised awareness Marketing – spin offs
  – Surgical
  – Gympie hospital
Recommendations

• Case managers/DF/user - audit the use of the yellow envelope

• Standardisation - engage from ED to D/C

• Include in orientation programs for sustainability

• Keep it simple
Keep it Simple!

Savage Chickens
by Doug Savage

\[ \frac{n}{2} \sum_{m=3}^{n/2} \frac{1}{ln m} \ln(n-m) \approx \frac{n}{2ln^2 n} \]

STOP BEING SO DIFFICULT

www.savagechickens.com
Electronic health records

- The future for informed, timely information sharing.
- Current probabilities:
  - Secure encrypted messaging
  - Shared electronic health records
Advantages

• Stores a summary of health information provided by the GP and other related documents to be used by GPs, hospitals and other healthcare providers.
• Quick and easy. No flipping through miles of papers (or five charts) to find previous history.
• Same information accessed by any department. No need to repeat information.
Issues

• Currently a cumbersome consent process. Need organisational faith to ensure a smooth consent process for residents. Ie Part of their entry to the facility.

• Secure digital certificates currently individual or department. Working on a hospital wide certificate managed by IT.
Good clinical handover can reduce the risk of accidental harm. We all need to do our part in assisting a safe journey for our elderly.