Clinical Handover
Engaging the team improves care

A Multidisciplinary Risk Assessment and Care Planning tool

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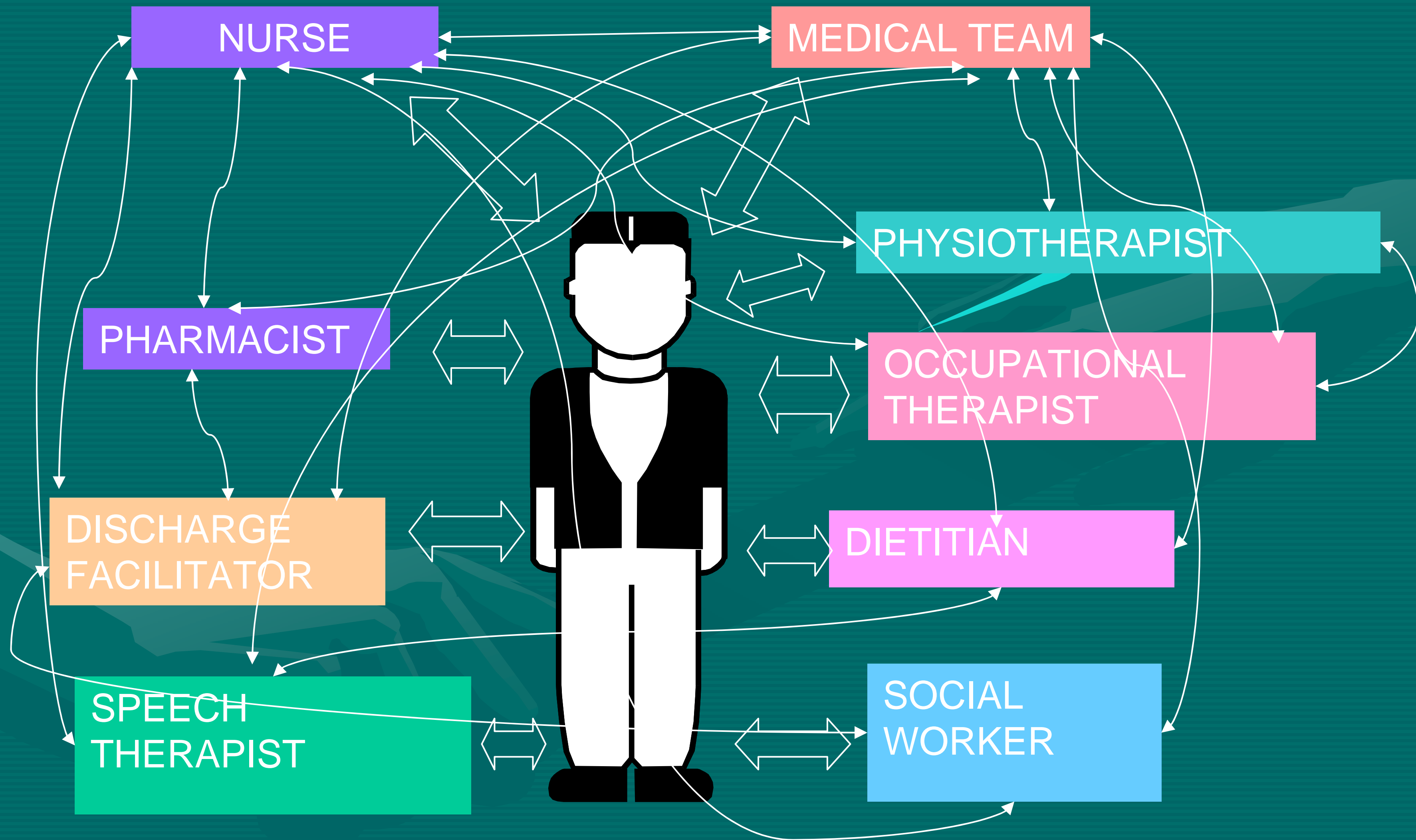
Background

- Communication and teamwork are key to safe efficient patient care
- Medical Inpatients commonly have complex needs and require the efforts of a range of healthcare professionals
- A Multidisciplinary model of care has been implemented in Internal Medicine
  - Unit based teams
  - Structured daily meetings
  - Shared early discharge planning

Challenges

- Multiple documents
- Varying documentation practices
- Frequent staff changes
- Various levels of staff
- Frequent patient bed moves
- Compliance with current documentation
- Duplication of information gathered

Communication Challenge and Medical Patients.........



Aim

- To improve interdisciplinary communication
  - through development and implementation of a standardised multidisciplinary patient risk assessment and care record for acute general medical inpatients.

The beginning……

- 2005 working group of IMMOC committee

- Progressed with project funding in 2006
  - Need recognised for shared concise individualised assessments and plans of care.
    - Screen for major inpatient admission risks
    - Multidisciplinary, action generating, facilitation of ongoing assessment and avoidance of duplication
    - Availability of document at point of care (at bedside).

The journey continues….

Clinical Handover funding 2007

Risk screening tool

- Social and demographic information
- Screen for major risks during admission
- Summary of findings
- Communication

Care Plan

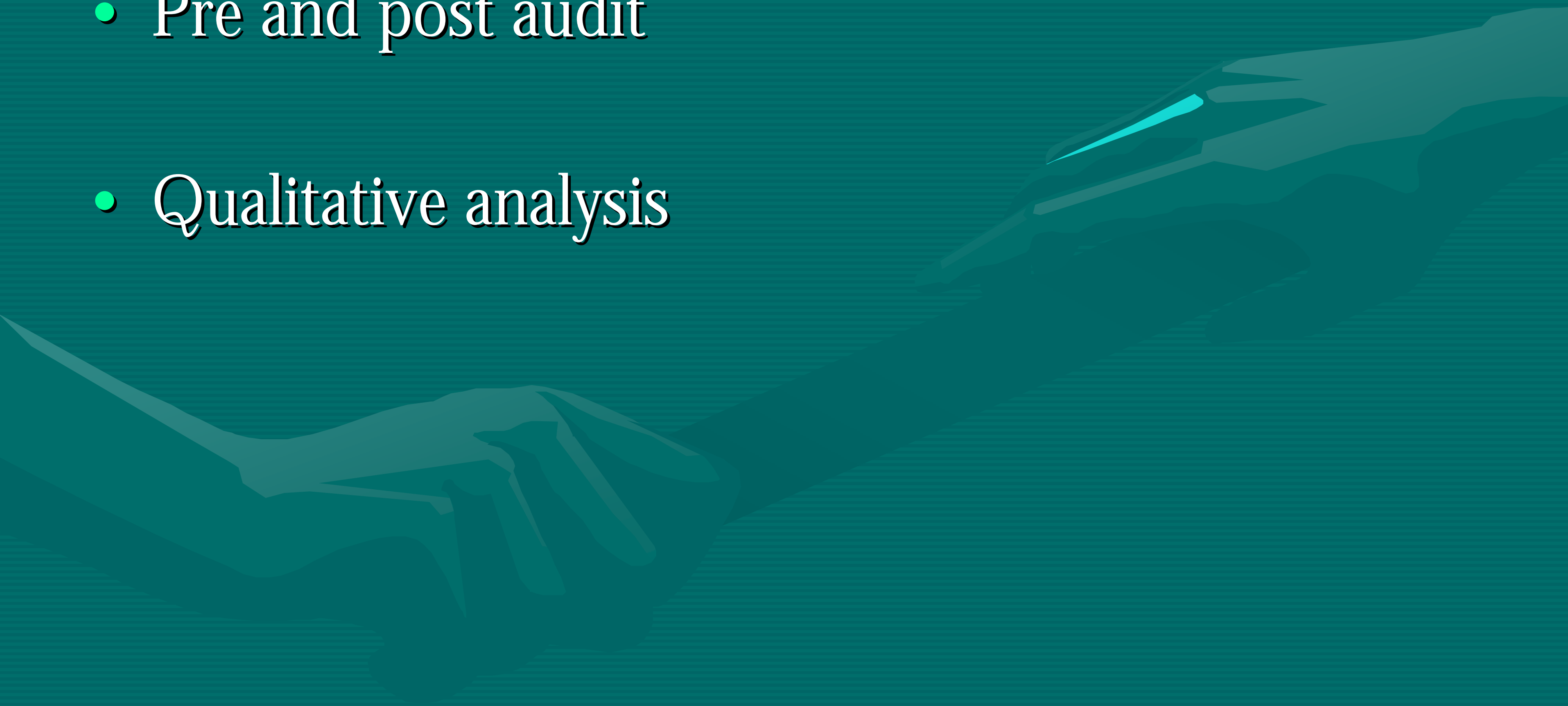
- Daily
- Tick box with some room for free text
- Sign for meeting indicator/target for each domain.
- Communication of changes to care/daily orders

Implementation

- Awareness raising
- Information Flyers
- In-service/education sessions
- Audit and feedback – to and from
- One on one detailing
- Identification of clinical champions

Evaluation

- Pre and post audit
- Qualitative analysis



Audit Results

Risk domain/tool	% documentation in pre-implementation audit (n=40)	% documentation in post-implementation audit (n=41)
Previous function (ADL)	61	88
Cognition	10	78
Discharge risks	80	95
Skin Integrity	91	93
Malnutrition Screen	3	83
Falls Risk	31	100

Audit – Screening Tool

Domain	% risk assessments completed (n=41)
Delirium	85
Medication risks	95
Venous Thromboembolism	78
Infection Control	66
Dysphagia	66
Depression	49
Body Mass Index	22

Audit – Care Plan

Discipline	% documentation in changes to care/daily orders (per patient n=34)
Nursing	71%
Medical Officer (Consultant, Registrar, RMO)	47%
Allied Health	24%

Qualitative

- Interviews with staff
- One on one
- Range of comments
- Results to inform rollout education

Key outcomes

- Shared document that supports education and best practice.
    - Screen for major inpatient admission risks
    - Multidisciplinary, action generating, facilitation of ongoing assessment and avoidance of duplication
    - Availability of document at point of care (at bedside).

Where to?

- Rollout trial to all medical units/wards
- Re-evaluate in 4 to 6 months
- Continue to links with other projects
  - Falls
  - Delirium
  - VTE
- Explore links with other processes being developed.
- Trial Nursing Handover