

# Improving RACF / Hospital Clinical Handovers

What's missing? Linking patient information to  
patient care.

## Acknowledgements

The Residential Aged Care Facility / Hospital Clinical Handover Project is managed through the Australian Government Department of Health and Ageing and is funded by the Australian Commission on Safety and Quality in Health Care.

Support for this project was received from 20 of the 22 organisations managing the 70 RACFs in the Brisbane North district. We appreciate your support and trust in our ability to undertake this audit on your behalf and believe this report will bring improved understanding, increased knowledge and confidence to change processes toward safer handover for residents transferring to and from acute facilities.

### GPpartners Limited

Suite 2 Centro Lutwyche, 543 Lutwyche Road (PO Box 845)

Lutwyche Qld 4030

Phone 07 3630 7300 | [info@gpartners.com.au](mailto:info@gpartners.com.au) | [www.gpartners.com.au](http://www.gpartners.com.au)

### Project team

Project sponsors	Ms Abbe Anderson, CEO GPpartners Ms Mary Fenn, Assistant Nursing Director (Community Interface) Patient Flow Unit, RBWH	Our thanks to	Mr Brad Long, GPpartners Aged Care IT department Ms Emma Muller, GPpartners, Administration support
GPpartners	Ms Helen Hoare, Aged Care Program Manager Dr Richard Kidd, Board Member, auditor Dr Kylie Norris, auditor Amanda Bushell, Aged Care Project Officer	Advisory Group	Our thanks for the challenging and encouraging debate, guidance and direction for the project. Ms Amanda Bushel Dr Amanda Dines Ms Mary Fenn Dr Richard Kidd Dr Lorna Kratzing Ms Kate Mason Dr Kylie Norris Ms Rhonda Purtill Ms Kath Richter Mr Sam Tapp Ms Kaylene Woollett
Royal Brisbane & Women's Hospital	Ms Karen Kasper, Project Officer Internal Medicine, auditor, project management Ms Lisa Mitchell, Project Officer Internal Medicine, auditor, educator Ms Di Martini, Project Officer Internal Medicine, auditor, educator		

# Contents

<b>Abstract</b> .....	<b>1</b>
Introduction.....	1
Objectives.....	1
Methods.....	1
Results: Admission Information.....	2
Results: Discharge Information .....	3
Conclusion.....	3
<b>Introduction</b> .....	<b>5</b>
Preamble .....	7
Developing Audit Tools .....	8
Formatting .....	9
Methodology.....	9
<b>Audit Process</b> .....	<b>12</b>
Identifying Patients for Audit.....	12
Systems to Identify Patient Information.....	12
Sharing Audit Information.....	12
Factors Affecting Audit Numbers.....	13
<b>Audit Tools</b> .....	<b>14</b>
Audit Form 1: Admission Information from Residential Aged Care.....	14
Section 1: How is information received?.....	14
Section 2: What information is received? .....	15
B: Clinical Information .....	15
C: Usual Functionality .....	16
Section 3: Clinical Outcomes.....	16
Audit Form 2: Discharge Information from Acute Facility .....	18
Section 1: How is discharge information received from the acute facility? .....	18
Section 2: What information is received? .....	19
A: Standard Information .....	19
B: Clinical Information .....	19
<b>Data Collection and Recommendations</b> .....	<b>21</b>
Overview of Collated Information – Admission Information Audits.....	21
Actions Undertaken from Results of Admission Audit 1 .....	26
Residential Aged Care-Acute Care Forum.....	26
Recommendations to be actioned by GPpartners.....	27
Hospital Auditors Feedback .....	29
Further Recommendations ‘Admission Information from Residential Aged Care’ Audits .....	30
Overview of Collated Information: Discharge Information Audits.....	31
GP Auditor Feedback – Review of Discharge Information.....	34
How is the discharge information received from the RBWH .....	34
What information is received? .....	35
Impact on clinical outcomes .....	35
General Comments .....	36
Recommendations from ‘Discharge Information from Acute Facility’ Audits.....	36
<b>Cross Referencing with Audits</b> .....	<b>38</b>
Overview of Collected Information: Cross Audit information Admission Discharge .....	39
<b>Conclusion</b> .....	<b>40</b>



<b>References</b> .....	<b>42</b>
<b>Attachment 1</b> .....	<b>43</b>
Admission Information from Residential Aged Care.....	43
<b>Attachment 2</b> .....	<b>46</b>
Discharge Information from Acute Facility.....	46
<b>Attachment 3</b> .....	<b>49</b>
Guidelines for Admission Information.....	49
<b>Attachment 4</b> .....	<b>52</b>
Guidelines for Discharge Information .....	52
<b>Attachment 5</b> .....	<b>55</b>
Letter of approval RBWH ethics committee .....	55
<b>Attachment 6</b> .....	<b>56</b>
Letter of approval Spiritus ethics committee .....	56
<b>Attachment 7</b> .....	<b>57</b>
Resident consent form .....	57
<b>Attachment 8</b> .....	<b>58</b>
Admission information audits .....	58
<b>Attachment 9</b> .....	<b>76</b>
Discharge information audits.....	76
<b>Attachment 10</b> .....	<b>88</b>
Yellow Envelope flyer .....	88
<b>Attachment 11</b> .....	<b>89</b>
Residential Aged Care Facility Communication Envelope Flyer .....	89
<b>Attachment 12</b> .....	<b>91</b>
Residential Communication Envelope Flow Chart .....	91
<b>Attachment 13</b> .....	<b>92</b>
<b>Attachment 13</b> .....	<b>92</b>
Health Record eXchange Consent Information.....	92
<b>Attachment 14</b> .....	<b>93</b>
HRX Participant Consent Form.....	93



# Abstract

## Introduction

GP partners aged care team, general practitioners (GPs), Residential Aged Care Facilities (RACFs) and the Hospital in the Nursing Home staff of the Royal Brisbane and Women's Hospital (RBWH) were concerned about reports relating to lack of discharge information being received by residential aged care facilities.

Conversely, medical and nursing staff of the hospitals Emergency Department expressed concern at the variation in quality of information received with residents presenting to their department.

## Objectives

The project goal was to deploy a patient care quality improvement initiative targeting the interfaces, hand-over processes and clinical information flow between RACFs, hospitals and their treating GPs.

Specific issues were reported as:

- hospitals report RACF residents have 30% readmission rates
- RACF residents are admitted to hospitals and Emergency Departments (EDs) without necessary clinical information
- RACFs report hospitals return residents without the necessary clinical information at discharge
- visiting GPs report poor information flow is adversely affecting RACF residents health and wellbeing, continuity of care and increasing the risk of medical error.

This project was designed to achieve safer, more effective and more responsive clinical handovers for residential aged care residents as they transfer to and from acute facilities. These patients are recognised as high risk.

## Methods

Two methods for information sharing were identified. One paper based and the other electronic.

An assessment (audit) toolkit was developed utilising the General Practice Advisory Council (GPAC) guidelines. Audits on information received at the Emergency Department from RACFs were performed by two hospital based project officers.

Audits on information received from the hospital by the RACFs were audited by two GPs who currently treat residents in residential aged care.

An initial one month audit was performed as a baseline to gather information on:

- How admission and discharge information is currently received.
- What information is currently received.
- Possible impact on clinical outcomes.

Information obtained from this audit enabled us to target areas of concern and make recommendations.



Some of the interventions following the initial audit included:

- Education on the use of a RACF communication tool – the Yellow Envelope – was provided to hospital staff.
- RACF staff were encouraged to use this tool when transferring residents to the acute facility.
- GP partners commenced discussion, education and consenting of residents in RACFs to the Health Record eXchange (HRX) shared electronic health record system and enabled Hospital In the Nursing Home (HINH) staff access to the system for residents transferring to hospital from residential aged care.

A second audit was performed three months after the initial audit. As this time frame was extremely short, not all planned interventions were completed by the commencement of the second audit.

Information from the two audits was collated and compared and recommendations on continued change are presented in this report.

The toolkit used to undertake these audits has been completed to enable other organisations to perform similar reviews that provide them with the actual clinical data to inform recommendations for improvement.

## **Results: Admission Information**

One hundred and four (104) hospital charts were audited in the first stage and, 91 charts in the second stage.

Although the second audit showed some measurable improvements in the quality of information provided to the hospital by RACFs, there remains concern about the increased risk of accidental harm to residents in hospital when information is not included in their transfer summary.

- Over ninety per cent (91.1%) of residents did not have an End of Life plan or if they did, it was not made available to hospital staff.
- Although information was transferred with the patient there was only evidence that the Yellow Envelope system had been used in 23% of admissions and very little direct input was provided by GPs (25.6% of admissions) on the reason for transfer and recent medical history.
- Current status of the resident with relation to mobility, nutrition, communication needs, behaviours and continence was not available in 35% to 60% of transfer summaries. Medications and allergies were not recorded five to eight per cent of the time.
- Further information was sought from RACFs in 45% to 50% of cases.
- Transfers seemed to be mainly initiated by RACF staff with the majority of transfers occurring between 12 pm (midday) and 6 pm, with the majority of residents remaining in the Emergency Department for three to nine hours.
- Eighty-four per cent (84.4%) of residents were admitted to hospital with an average length of stay around six to ten days.

- Auditors were unsure in 60% to 40% of cases whether improved communication may have prevented these admissions.
- One per cent (1.1%) of transfers were connected to the HRX.

## **Results: Discharge Information**

Sixty-five (65) residential aged care charts were audited in the first stage and, 35 charts in the second stage.


- Over 40% of the time, facilities were not given prior notice of the resident being discharged from hospital. However, 91% of the time discharge information was received with the resident. This was an improvement of over 20% on the first audit.
- Nursing discharge summaries increased from 4.6% to 41.7% between the first and second audits. This could be directly related to a trial being undertaken with an inpatient Hospital in the Nursing Home discharge liaison officer located in the wards.
- Medications available on discharge improved from 32.3% to 72% over the duration of the audits. Again this relates to a project being undertaken between GPpartners, the Queensland Health Safe Medication Practice Unit and the RBWH pharmacy department, yet still almost 30% of residents were discharged without medications or information available.
- GPs' names and contact details matching with discharge information improved by 20%.
- The use of the Yellow Envelope throughout the hospital improved by nine per cent.
- The information most lacking in clinical information upon discharge were follow up arrangements and changes to medications lists (30.6%). It may be a coincidence that 30.6% of residents were also discharged after-hours (i.e. times outside of Monday to Friday 9am – 5pm).
- Almost three per cent (2.8%) had adverse medication events and 2.8% had an adverse clinical event in the first 10 days post discharge.
- Almost twenty-eight per cent of residents (27.8%) were readmitted to hospital within six weeks, 30% of these related to their previous admission.

## **Conclusion**

The audit was successful in enabling identification of the systems currently in use for information collection and sharing. It has helped to identify specific areas of need.

Clearly the clinical information needed by Emergency Departments is not always provided by RACFs' current transfer systems. Conversely follow-up arrangements or ongoing patient management plans are frequently not available for RACFs on discharge from the acute facility.

Standardised forms are available for RACFs but are obviously not in general use. Many facilities have electronic programs that enable health summaries to be printed and these may need content review to ensure all essential information required by the hospital is included.



Further, GPs appear to have little input into the current transfer systems from RACFs to hospital, this should be reviewed.

Discharge programs currently being put into place in the acute facility are showing improvements through the audit but these are unit based and not across the entire facility.

The intense effort to implement electronically produced discharge summaries from the Department of Emergency Medicine is clearly progressing well and combined with the inpatient Hospital in the Nursing Home discharge facilitator is showing 91% of discharge summaries are being received by RACFs within 24 hours of discharge, and mostly with the resident at time of transfer.

There is improved recognition by the hospital that RACF staff need the same information that is provided GPs to enable safe and informed continuity of care. However these process improvements need to be embedded facility-wide.

Using a shared electronic health summary would enhance current transfer processes and enable quicker and more reliable access to patient information for future admissions.

The short time frame of the project did not allow for effective implementation of the HRX system within RACFs. This requires continued implementation, education and follow-up. The HRX would provide structured processes, which have been shown to be beneficial to medical decision making and therefore to patient outcomes. *(Carpenter/Ram – Handover & Discharge Pilot Report, April 2008)*

# Introduction

In 2002 the General Practice Advisory Council (GPAC) held a multi-disciplinary Statewide Discharge Planning Forum with the aim of improving discharge planning across Queensland. The key recommendation from this forum was to provide a framework – a practical agreed set of directions for use by all service providers involved in continuity of care planning in Queensland.

In 2007 the *Continuity of Care Planning Framework for Queensland* came into effect. The framework spells out 'Key Activities in the Continuity of Care Process' and Recommended 'Data Sets' for 'Documentation to Support Continuity of Care Planning'.

This contains areas in relation to:

1. Pre-admission (*Admission Referral*)
2. Pre-admission/Admissions (*Risk Screening Tool*)
3. In Patient (*Care Pathway/Discharge Plan*)
4. Discharge (*Discharge Summary/Referral*)

Key accountabilities have been described for District Managers, GPs, community service providers and patients / families. Resources and systems are discussed clearly outlining the need for a standardised paper based system with recommendations for an information technology platform, integrated with hospital and community (medium term). (*Continuity of Care Planning framework for Queensland – Resource Manual GPA, 2004*)

The guidelines exist and processes to assist to rectify gaps in continuity of care have been developed. However, a 2007 Australian Catholic University survey of RACFs found that 84% of Queensland respondents continue to experience problems with resident's information received back from hospitals and that they have serious concerns about the risk to patients due to unsafe discharge processes. They were also concerned that their duty of care would be compromised by the lack of appropriate information from the hospitals. (*McDonald, T., For Their Sake. Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care? Australian Catholic University National; September 2007*)


In November 2002, a combined workshop was held with representatives from residential aged care facilities (RACFs), the emergency departments of the Queen Elizabeth II Jubilee Hospital, the Mater Private Hospital (adult) and the Princess Alexandra Hospital and Brisbane South Community Health.

The workshop discussed the issues around residents being transferred to Emergency Departments and noted that causal factors for presentation to Emergency Departments included falls requiring x-ray or examination to eliminate fractures, acute illness requiring antibiotics, GP not available or GP request transfer in lieu of attending residents on site and catheter or peg change.

From the workshop a '*Residential Aged Care Facility Clinical Resource Manual*' was developed and a problem solving assessment flow chart designed to reduce transfers to acute facilities.

The workshop also identified issues that included (but were not limited to):

1. Communication between the Emergency Departments and residential aged care was inconsistent and/or inappropriate, and

- 
2. Discharge summaries sent / faxed to GPs from Emergency Departments without discharge information being provided to RACFs.

Communication tools were developed to improve these issues and made available to all RACFs for implementation, including:

- an Aged Care Facility Resident Transfer form (the green form) adapted from a previous form used by the Sunshine Coast Aged Care Regional Forum, Nambour Hospital and Aged Care Queensland
- a Cognitive Impairment Information Form (orange) adapted from Alzheimer's Australia's *First Alert Trial – Cognitive Impairment Information Form SA*,
- an Aged Care Facility Transfer form (yellow) that is completed by the Emergency Department and returned to the RACF.

It seems however, that these forms are not freely used. Some facilities have electronic systems that enable printing of current health summary information, whilst others do not.

However there is no discussion about the role or responsibility of GPs, as health team leaders, in providing transfer information. There is little evidence that RACFs have processes to collect GPs' input or include GP input in transfer documentation and little evidence that GPs are offering this.

The GPAC guidelines state that a key accountability for GPs is “*provision of comprehensive, legible referral information to hospital for all planned admissions, and for referrals to Emergency Department (where relevant)*”.

Most GPs are able to print health summaries from their surgery software and some GPs undertake Comprehensive Medical Assessments of their residents. These forms should include adequate information to provide hospital doctors with sufficient knowledge to aid decision making. This may be paper based but is usually electronic. It appears however, that updated information is not provided to acute facilities upon transfer.

Shared electronic health systems, like the HRX, would improve this.

GPpartners, funded by Department of Health and Ageing through the Australian Commission on Safety and Quality in Healthcare, undertook to develop an audit tool, identify the audit process and undertake an audit to collect evidence based information that can inform recommendations for process change.

The project was aimed at reviewing both a standardised paper based system and to explore the opportunities of an already existing shared electronic health summary known as the Health Record Exchange (HRX) currently deployed on a limited bases by GPpartners and several Brisbane public and private hospitals.

The audit enables organisations to clearly identify areas of concern and target these areas for a more in-depth review. Using the audit tool works well when combined with the *OSSIE 4 Handover\** guidelines on organisational change and the *ISOBAR\** standardised process and content for clinical handover and minimum data set. (*Chien Yee, K & Chao Wong, M, UTAS 2008*).

\* OSSIE – Organisation leadership, Stakeholder engagement, Simple protocol development, Implementation, Evaluation and maintenance.



\*ISOBAR – Identification of patient, Situation and status, Observations, Background and history, Actions and accountability, Responsibility and risk management.

## **Preamble**

### **The Yellow Envelope**

GPpartners in conjunction with Moreton Bay General Practice Network (formerly Redcliffe, Bribie Island & Caboolture Division of General Practice) undertook a program to introduce a 'yellow envelope' system to promote adequate information to be forwarded to acute care facilities in order to enable safe continuity of care and easier decision making on patient care and management.

The C4 size resealable yellow envelope has a distinctive blue design down the right hand side and contains prompts on what information should be included in the envelope by RACF staff to enable good handover of information for acute care staff.

The envelope acts as a visual prompt to alert hospital staff that this person is an aged care resident. The envelope is designed to follow the resident through the hospital system and act as a tool to prompt information to be returned with the resident to the facility.

Checklists on the front and back of the envelope provide prompts to RACF and hospital staff as to what documentation should be included in the envelope. These checklists were developed with an acute hospital emergency department and residential aged care representatives.

Education about the implementing the Yellow Envelope system was provided to the following:

- the acute facility involved in this audit (12 to 18 months prior to the audit being undertaken).
- senior RACF staff
- ambulance and transport services regarding admission and discharge to and from hospital to residential aged care.


Printing and supply of the envelopes was undertaken by GPpartners to assist with continuity of the process.

### **Health Record eXchange**

More than four years ago GPpartners investigated an electronic health record as part of a coordinated care trial (Team Care Health II) funded by the Australian Government Department of Health & Ageing and Queensland Health.

The need for this system arose as paper based methods would not allow timely movement of information between care team members. A shared electronic health summary was trialled for patients with multiple chronic diseases between GPs, Team Care Coordinators, allied health, community service providers and acute care.

Today the Health Record eXchange (HRX) supports coordinated care projects funded by Department of Veterans' Affairs, Queensland Health and Medibank Private Health Insurance by generating and sharing patient electronic health summaries. The HRX enables changes to medication, treatments and ongoing management to be updated at the push of a button when used by GPs with their current medical software such as Medical Director and Practix.



The possibility of how the HRX could work between residential aged care and acute facilities was discussed. It was felt that this electronic process could work well in such a controlled environment, enabling one point of entry for basic details such as name, date of birth, next of kin, current address and current GP details.

The National Reporting and Learning System operated by the National Patient Safety Agency in the United Kingdom reported on areas of concern following a review of errors caused through incorrect patient identification. They identified four classifications, one of which refers to “Mismatches between patients and their medical records, e.g. where a patient’s records or results are filed in another patient’s medical records, or where the wrong medical records are with a patient.” (*Australian Commission on Safety and Quality in HealthCare, ‘Windows into safety and quality in HealthCare 2008’, ACSQHC, Sydney October 2008*)

Loose paper systems lend themselves to these types of errors. An electronic record able to be viewed by various practitioners could reduce the possibility of identification error.

Australian Commission on Safety and Quality in HealthCare also identified that “handover occurs, from one provider or team of providers to another at points of patient transition across settings, between services or levels of care, and due to the need to organise clinical work into manageable shifts.” (*Australian Commission on Safety and Quality in HealthCare, ‘Windows into safety and quality in HealthCare 2008’, ACSQHC, Sydney October 2008*)

Patients transferred to an acute facility will potentially require transfers and be treated by a number of professionals in multiple settings, e.g. the Emergency Department, x-ray, acute ward, discharge unit and back to residential aged care.

A shared electronic health record could assist in providing ease of access to relevant patient information.

Although the electronic health record system can be used by multiple users, they are unable to make changes to the core information but can add relevant information on services provided to the resident, specialist reviews, etc. Less people entering baseline data decreases the risk of inadvertent error.

It was the aim of the project, that following the initial audit, some of the recommendations would be actioned and that these actions should result in some improvement in the second audit.


Despite the tight timeframe, an intense education program to promote the paper based Yellow Envelope at the acute facility was started and negotiations began with GPs and RACFs to register residents to the Health Record exchange.

## **Developing Audit Tools**

To develop the audit forms an advisory group was called together with representation from key areas of the acute facility (including upper management), GPs, Residential Aged Care Facility Managers and GP partners aged care project officers.

Exactly what we wanted to achieve from the audits was discussed and a decision made to identify:

- how information is currently received
- what information is currently received
- possible impact on clinical outcomes.



As GPAC had already done an extensive multi-disciplinary planning framework, agreed to by Queensland Health, it was decided this would be used as the basis for developing the audit forms.

Although many of the questions set out on the GPAC audit are relevant it was agreed that the audits should include more information about factors that influence the admission or discharge process such as time of presentation, admission (or not) to an acute ward from the Emergency Department, length of stay and time of discharge.

The group also decided to capture who was referring the resident to the hospital and whether this influenced the type of information sent with the patient.

It is a common perception that after-hours GPs and nursing agency staff send residents into hospital more often than the usual GP or stable aged care staff due lack of familiarity with the resident and their condition and lack of knowledge about how to find information about the patient's care needs in the facility's information systems.

It is also relevant to identify the acute ward from which the patient has returned, as in large institutions it seems there are a number of different discharge processes in place.

The audits would be based on evidence – information clearly filed or written in patient charts that any health professional providing care would be able to access. Verbal information that may have been given but not include in written information would not be considered as sustainable and reliable information.

Two separate audit sheets were developed – an '*Admission Information from Residential Aged Care*' form and a '*Discharge Information from Acute Facility*' form. Both forms were developed under the three sections previously identified:

- how information is currently received
- what information is currently received
- possible impact on clinical outcomes.

## **Formatting**

The audit forms were set up to be as simple to use as possible. For each question tick boxes were provided to identify evidence of information in charts. An area was also provided for auditors to record further clarification or comments. Guidelines for completing the audit forms were developed to ensure consistency across auditors. All auditors were trained to use the tool and performed a cross audit\* to verify consistency in understanding and answering the questions.

\*Cross audit- each performing the same audit on the same chart and validating findings.

## **Methodology**

For the purposes of the project two separate audits were undertaken. This enabled review of the use of the tool and to make changes to the form or guidelines if it seemed more clarity was required.

There were some minor changes made to the form for the second audit; this helped clarify some of the details for data entry.

## **Timeframe**

Due to the size of the acute facility it was understood that the Emergency Department would receive over 100 residential aged care transfers within a one month period. As the audits would only include transfers from RACFs within the GPpartners area, this was already seen as a limiting factor.

The decision was made not to specify a specific number of audits to be undertaken but to limit the audits to a one month (30 day) period. A second audit would be undertaken three months later.

## **Recruiting auditors**

To improve access and acceptability of the audit within the acute facility, and for the purposes of equity, it was decided that the admission audit would be undertaken by staff of the acute facility. This ensured the auditors were already covered by Queensland Health's code of ethics and that they had the relevant security access needed to obtain patient charts.

Initially it was discussed that a medical officer could undertake the audits but due to workloads it was decided that Registered Nurses with current research experience and access to medical support would undertake the audits. Two nurses based in the Internal Medicine Research Unit were employed under sponsorship of the Assistant Nursing Director (Community Interface) Patient Flow Unit.

To ensure that the audits being undertaken in the RACFs were consistent and to ensure that GPs visiting RACFs were informed, it was decided to recruit two GPs to undertake the discharge audits in the RACFs. Two GPs who currently visit RACFs were recruited to undertake this process.

All resident/patient information was de-identified.

## **Ethics approval**

Once the process was decided, ethics approval was sought from the acute facility and discussion was undertaken with all key residential aged care organisations within the GPpartners area. Only one organisation requested separate ethics approval to be part of the audit. Unfortunately this organisation required consent from all residents participating (not just in their centres) which was contrary to advice from the RBWH ethics committee. Due to this any audits undertaken within this organisation have not been included in the final analysis of the audit.

The acute facility ethics committee decided that patient consent was not required as the audit was not changing patient management but was a retrospective audit on evidence of information.

Letters of support were received by all organisations within the district to participate in the audit process. Residential aged care residents transferred to the acute facility that did not reside within the GPpartners catchment area were excluded from the audit.

Attachment 1 – Admission Information from Residential Aged Care form

Attachment 2 – Discharge Information from Acute Facility form

Attachment 3 – Guidelines for Admission Information form

Attachment 4 – Guidelines for Discharge Information form

Attachment 5 – Letter of approval RBWH ethics committee

Attachment 6 – Letter of approval Spiritus ethics committee (with consent required)



Attachment 7 – Resident consent form

# Audit Process

The audit was designed to be the least invasive as possible to normal staff time, therefore we did not build in reliance on hospital admission staff or residential aged care staff to notify us when a resident was admitted or discharged from hospital. This information was gained from the two acute facility auditors.

## Identifying Patients for Audit

A number of methods were utilised by the acute facility auditors to identify residents transferred to the Emergency Department. This exercise alone identified the difficulties of obtaining information in a disjointed system.

Often the fact that these transfers were from residential aged care was not easily identified as the information systems used within the hospital do not require mandatory identification of the patient as being from a RACF. Therefore hospital staff often rely on the address provided to determine whether the patient is from a RACF, which may or may not include a facility name with the street address. Even so, a facility name does not necessarily identify if the resident is from the independent living units attached or receiving care in a nursing home or hostel section of the facility.

## Systems to Identify Patient Information

1. The Emergency Department uses an electronic system called EDIS (Emergency Department Information System) to register presentations to their department.
2. The acute facility Hospital in the Nursing Home section uses a paper-based list of referred transfers. This was used as a second check list however, not all residential aged care transfers are referred to this program.

A third method of identification was obtained from the electronic Hospital Based Clinical Information System (HBCIS) through the Clinical Coding Department to identify patients admitted to acute facility wards or discharged to RACF during the auditing month.

It is interesting to note that the EDIS and HBCIS systems used internally within the acute facility do not 'speak' to each other. It is also worth noting that access to the EDIS is not necessarily available to clinicians in the acute ward areas, meaning that information entered onto the EDIS system is not necessarily available to the treating clinical admitting team.

## Sharing Audit Information

The acute facility project officers forwarded residents names who were admitted to the GPpartners project officer via password protected emails. A database was set up by GPpartners to collect information about residents admitted to hospital within the audit period.

A geographical list of residents discharged and the facilities to which they were discharged to were generated for the GP auditors. This information was kept on a secure, password protected electronic site at

GP partners and was erased following completion of the audits to ensure patient's identities could not be traced. All audit forms were given a coded number to enable us to match them with data entered.

## Factors Affecting Audit Numbers

There were some unforeseen factors that influenced the number of audits undertaken by both the acute facility auditors and the GP auditors. During the first audit month an industrial dispute within Queensland Health involved medical records staff. This meant access to charts was limited, charts were difficult to place and often the information being sought was not filed. The auditors needed to navigate through the internal system to enable them to perform the audits required.

Externally, a delay in ethics approval for the audits spread the project over two school holiday periods. Both GP auditors had pre-arranged leave and this decreased their amount of audit time. Unfortunately one GP was unwell during the second round of audits and we were unable to obtain a replacement with such short notice.

Still, a reasonable number of audits were undertaken to identify areas of need for further consideration.

Audit number	Admissions	Discharges	Audit ratio, discharge to admission
1	104	65	62.5%
2	91	36	39.5%

The audits were carried out over a defined four week (30 day) period in both cases.

Experience from the first round of audits showed that it was better to delay the commencement of the audits from the actual start of the audit period by approximately two weeks to enable GP auditors to visit facilities in clusters and reduce travel and preparation time. It also enabled auditors to determine whether readmission had occurred following the initial admission.

This also proved relevant for admission audits with auditors waiting one to two weeks from the commencement date to enable better access to completed patient charts following admission and or discharge.



# Audit Tools

## **Audit Form 1: Admission Information from Residential Aged Care**

### Section 1: How is information received?

The aim of this audit tool was to identify whether there were processes in place for information transfer, whether these processes were used and to determine the most effective way to achieve consistency in transfer information.

This section of the tool investigated how information appeared to have been received at the acute facility. It included options such as the Yellow Envelope, loose paperwork and correspondence from GPs or facilities transported with the patient or sent prior to or following the patients arrival to the Emergency Department.

This section also identified if the family were consulted as a source of information and seeks evidence of a phone call from GPs or RACFs to notify the hospital of the residents' impending arrival.

The questions enabled identification of the types of forms used for transferring patient information, such as the Ambulance form, Comprehensive Medical Assessments or RACF transfer forms. It also included an area to identify if patients were registered with a shared electronic health system.

The time of arrival, who initiated the transfer and whether the event was a re-presentation within a six week period was also included in section 1. Re-presentation rates are a common data set collected by hospitals however, for the purposes of the audit, re-presentation was related to the lack of timely discharge information, follow up arrangements or ongoing management recommendations.

### **Background**


Wong et al (2008) identify seniority/experience of staff, nature/type of communication behaviours, quality/content of information recorded and/or exchanged, discontinuity in patient care, lack of standardised protocols and health professional fatigue as high risk scenarios in clinical handover research.

Mostly the literature refers to internal handover situations but these risks are considered in the context of residential aged care, they can be presumed to become even higher.

Aged care is chronically understaffed by professional health personnel in a stretched work environment. Communication is disjointed with offsite / visiting medical officers, remote Registered Nurse supervision and varying levels of registered and unregistered staff with uncertain levels of understanding of the information needed to enable hospital staff to make appropriate decisions about the patient's care.

Include the removal of a resident from their normal surroundings and health care team and disruption to family in notifying of the need to transfer.

Add to this the current system where often no-one is certain of what facility the ambulance will transfer the resident to.



This all makes a nice recipe for potential disaster and highlights the importance of identifying clear processes for the transfer of required information, or as termed by the General Practice Advisory Council, a minimum data set.

The AMA's *'Safe Handover: Safe Patients Guidelines'* (2006) poses the question of accountability and responsibility – "Poor handover carries significant risks for individual clinicians, their organisations and for their patients."

In residential aged care there is shared accountability and responsibility between the organisation and the GP but how are these roles, responsibilities and accountabilities verified?

## Section 2: What information is received?

Regardless of the format of the information received – via the Yellow Envelope, shared electronic health summary or letter from the RACF – a key consideration was the type and quality of the information provided.

This section of the audit form was broken into three areas.

### **A: Standard Information**

This relates to:

- identification of the patient
- date of birth
- address and contact information
- Relative (next of kin / Enduring Power of Attorney) contact details
- usual GP details
- Advanced Health Directive or End of Life care planning.


This section is seen as vital to the correct identification of the patient and provides correct information for communication with key persons (GP and family). End of Life care planning was seen as a most important component of communication enabling the person's health wishes to be known and asserting their rights as an individual.

ACSQHC (2008) *'Windows into Safety & Quality'* recognised that mismatching between patients and their care is common and can result in incorrect pathology, medications, procedures, medical imaging, admission and record documentation. Procedures should be in place to assist hospital staff in correctly identifying the patient that is transferred to them.

A key principle of the Continuity of Care Planning Framework for Queensland (2007) is "timely, ongoing communication, information transfer and coordination between hospitals and community based services is essential for continuity of care". Without the details audited in this section, communication on discharge would be difficult to achieve.

### **B: Clinical Information**

This relates to the clinical information around the current presentation. It includes the reason for transfer, current or usual observations, current or usual health problems, medications, allergies, nutrition requirements.



This section is the hub of the presentation. Why is the person here? What are the clinical changes, signs/symptoms for presentation? Was a basic and current health summary and management of identified diagnoses included?

The importance of this section was explained by Professor Wendy Chaboyer et al (2008) in saying “information has been described as data put into context. For example, a blood pressure reading may be 100/50, which is simply a piece of data, but if you add the comment that this blood pressure is from a young adult, who is bleeding profusely, then it becomes information.”

It is the whole of the data audited that provides the knowledge to enable the medical staff to make the appropriate care management decisions. Davenport and Prusak (1998) describe knowledge as “the capacity to reason and make sense of information”.

### **C: Usual Functionality**

The includes:

- relevant past history
- mental status
- communication needs
- mobility needs
- continence needs
- behaviours possible management.

This section established safe patient management by identifying the basic care needs of residents and assists communication with the patient.

Risk management tools are being used in hospital settings and are used in residential aged care. The most common of these tools identifies high risk of falls and pressure areas and enables staff to take action to minimise risk of harm to patients.


Communication has been identified as one of the most important elements in the safety and quality agenda. When one in ten people entering hospital experience harm as a result of their care and this harm is not related to the reasons for admission (Wilson et al, 1999), information on patient functionality provides staff with the knowledge to identify safety requirements and reduce the risks of accidental harm.

### **Section 3: Clinical Outcomes**

This section identifies the pathway that care management has taken when the patient presented to the Emergency Department.

It includes the time of presentation and time spent in the Emergency Department. It seeks to ascertain if further information was needed from the GP or RACF to make a better informed decision about the patient's management. It identifies the referral path to Hospital in the Nursing Home or Acute Admission, length of stay and asks whether the admission could have been avoided with improved transfer information. In some cases this last question may be difficult to determine, as it is largely a subjective judgement.

This section identifies if there were any recorded medication or clinical adverse events that may have been caused by a gap in the transfer information.



In the course of a patient's treatment, different teams may care for the same patient over the course of any given day. In particular with the frail elderly, there can be cross over between specialties (e.g. Orthopaedic and medical teams) and an increased multi-disciplinary approach to care. However, if the resident is discharged from the Orthopaedic unit the discharge information may not cover all of the medical information. Knowledge of the pathway assists the team taking over care to obtain further information if required.

Medication management on discharge has long been a concern for residents in residential aged care. Experience has shown that there is confusion with the processes, responsibilities and accountabilities when it comes to ensuring that medication is provided.

There are a number of workforce issues to consider, and it appears that hospital pharmacies fail to accommodate or recognise the needs for un-registered staff (e.g. personal care assistants) to assist with administration of medications, as is required in RACFs. Further, hospital pharmacists do not work after hours and are limited on weekends in most cases. Who then provides the medication for after-hours discharges?

Even within residential aged care organisations and facilities, the processes and responsibilities are not always clear and there are points of legislation that must be considered for all levels of staff to provide safe medication administration for the residents.

Facilities use a number of different methods to overcome the issue of medications on discharge. Without succinct information and written direction, they may revert to the pre-admission medication regime. The potential for mismanagement due to certain medications not being given are quite high, yet frequently the GPs and facilities are faced with making this decision.

In *Phase 3, Final Report on Effectiveness and Cost effectiveness of Dosage Administration Aids* (Stokes et al May 2006) hospital pharmacists agreed that they should facilitate continuity of information on a patient's current drug regimen and continuity of medication supply. However hospital pharmacists themselves were inconsistent in the information they provided to the patient's RACF and community pharmacy. Many hospital pharmacists expressed that they would like the patient's community pharmacy to be informed of any changes while the patient is in hospital but did not enact this themselves. Sometimes this was due to problems identifying the patient's community pharmacy on admission, and partly due to lack of procedures and lack of resources.


Without a known diagnosis or management plan available upon the residents return, the potential for accidental harm or injury to the resident remains high.

What internal section of the hospital would receive a patient without any knowledge of their condition, recent interventions/actions, or plan of management?

Who is accountable for any harm or injury that may result; the GP, facility staff or the hospital? This question is compounded further if the resident has returned to the facility without prior notification.

If the AMA's definition of handover – *the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis* – is the commonly accepted definition, then can responsibility be passed on to the next team?

(Refer [Attachment 1](#) – Admission form,).



Once the questions were decided upon and the advisory group were in agreement that this flow of information would achieve the aims of the audit, guidelines were developed to clarify the questions for the auditors.

(Refer [Attachment 3](#) – Admission guidelines).

## **Audit Form 2: Discharge Information from Acute Facility**

The discharge audit form was based on the same format as the admission form and was broken into the same three sections.

- how information is currently received
- what information is currently received
- possible impact on clinical outcomes.

### **Section 1: How is discharge information received from the acute facility?**

Again this section looked at how information appeared to have been received at the RACF. It included options such as the Yellow Envelope, loose paperwork, letters or faxes sent to the GP or RACF or phone calls made. It identified the timeliness of the receipt of information.

Most GPs and many RACFs operate computerised systems in today's world. Many rely heavily on this system for communication purposes. A large number of GPs visiting RACFs use lap top computers with or without wireless broadband Internet access, or use the RACF computer programs and/or remote access programs. This enables easy and rapid access to patient details as required. The fax machine still has a place but is not seen as the most efficient way of communicating with a GP or RACF, especially where the GP is mobile for most of the day.


GPs and RACFs realise that email is a preferred communication option for them. It provides less invasive access to the GP, enables the GP to view the information or request at a time suitable to them. They can then assess the urgency and reply at a suitable time in writing. This is a safer, quicker and more efficient way to communicate if there are changing patient needs.

Faxes tend to go to one phone number and are gathered up at the end of the day if possible, resulting in delayed access to information and delayed response. Yet this is the system hospitals currently rely on. Phone calls to GPs are also difficult and intrusive when they are in consultation with a patient.

Electronic discharge capability is starting to roll out through the public health system but it is slow.

Encrypted messaging is being introduced across a wide variety of health professionals including hospitals, community pharmacists and specialists. This could also be introduced to RACFs however, a shared electronic health summary is already available and in use in community areas assisting with multi-disciplinary information flow for patients with chronic and complex care needs.

Some acute and private hospital facilities are currently connected to this system. The system alerts the GP if someone has opened the patient's record. The GP can then view any comments or changes made. Core information on this shared record can only be changed by the GP and is updated from their current computer program.



Information systems such as this would reduce the incidence of mismatching between patients and their records with one point of entry for baseline details and one source of accountability for updating records.

The AMA defines the development of information systems that provide comprehensive patient summaries as challenge to good practice in handover. Electronic summaries not only enhance continuity of care but also avoid patient information having to be recollected and re-documented on each presentation and possibly each transfer between units. (Safe Handover-Safe Patients, 2006).

## Section 2: What information is received?

For the discharge summary this section consists of two separate areas:

### **A: Standard Information**

This identifies admission date, discharge date, Unit/Ward, consultant name; contact Medical Officer at the acute facility. This information was seen as vital to enable any ongoing communication and/or clarification that may be required following discharge.

During the research phase of the *Clinical Information Project* undertaken by the South Australian Department of Human Services (2004) it was found that although the hospital is often identified on the discharge summary, only 41% included a phone number, 35% an address and 18% a contact fax number.

In surveying GPs the study found data elements that ranked high in the required stakes included admission date, discharge date, providers name, discharge type (transfer/discharge/deceased), patient ID, date the summary was printed and providers address.

### **B: Clinical Information**

This information was seen as vital to identify the course during the hospital transfer and for the safe continuity of resident care management by the facility and the GP.


These questions are clearly articulated as requirements in the 2007 GPAC guidelines and are seen as the minimum data set to enable appropriate and safe ongoing care of the resident.

Surveys undertaken with South Australian GPs for the National InfoStructure Development Unit (2004) found that GPs placed little value on the clinical synopsis and in-patient treatment but wanted information on discharge medication (and particularly new or altered medication), future hospital outpatient or specialist appointments, referrals to external agencies and any specific ongoing management they were expected to provide.

They saw the summary as a referral for future management rather than a history of past management. GPs rated as essential the description of the principal diagnoses; medication frequency; procedures; adverse reaction and type (drug, food, miscellaneous allergy, miscellaneous contraindication); investigation procedures; dates of future appointments.

## Section 3: Impact on Clinical Outcomes

This section was aimed at identifying influencing factors that may impact on clinical outcomes such as time of discharge, timeliness of receipt of discharge information, adverse medication or clinical events that may



have been caused by delayed or absent discharge information and readmissions to hospital. Readmissions are further broken down into:

- within six weeks following discharge
- apparent link to previous admission
- could the re-admission have been avoided with better and/or more timely discharge information.

The quality and timeliness of current discharge summaries varies enormously from hospital to hospital, State to State, ward to ward and shift to shift. Some sections of the hospital use electronically assisted generation of summaries, some use template driven manually generated summaries, while others use a free text letter style with little structure to the information provided. Some specialists dictate their summaries, which are typed by their administration support personnel. While this may result in good information, the delay in this style of discharge summary can be long. This was also the finding of the South Australian Department of Human Services when undertaking a review for their *Clinical Information Project*, 2004.

This study found that clinical information included in the summary is traditionally determined by the hospital and that this varied from department to department. There is little uniformity in content and often the clinical synopsis is less than concise. Information regarding ongoing management required or proposed is inadequate. This lack of information can in itself be reason for residents representing to the hospital soon after discharge.

(Refer Attachment 2 – Admission form, page 5).

Once the questions for the discharge audit were decided upon, and the advisory group was in agreement that this flow of information would achieve the aims of the audit, guidelines were developed to clarify the questions for the auditors.

(Refer Attachment 4 – Discharge guidelines, page 5).



## Data Collection and Recommendations

A simple excel spreadsheet was developed to capture the audit data. Each audit was given a coded number. Each question was given a number, as was each possible answer or group of answers given a corresponding number.

For example:

Q1.4 – Type of Discharge Summary Received

The question number is 1.4, the answers were coded as follows:

- 1 Medical
- 2 Nursing
- 3 Allied Health
- 4 Medical/Nursing
- 5 Medical/Allied Health
- 6 Nursing/Allied Health
- 7 Medical/Nursing/Allied Health

In Q1.1 a simple yes or no answer is required, therefore the coding was:

1.1 – 1 Yes; 2 No.

The simplicity of using an excel spreadsheet enables clearer data collection and analysis. For example, for the question 'Was the patient discharge without medications discharged after hours?', using the excel spreadsheet enabled easy generation of graphs for presentation purposes.

The audit tools used within this project are general tools, and are not limited to specific software programs, for those who wish to undertake an audit in their facilities.

The following table identifies the outcomes of the audit questions and displays some comments on the results.

Note the information in the following tables is also depicted in graph form as [Attachments 8](#) and [9](#).

## Overview of Collated Information – Admission Information Audits

Question No. How is communication received	Audit Questions	Audit One % available 104 charts audited	Audit Two % available 91 charts audited	Comments This section highlights the lack of process or consistency in providing transfer information
1.1a	Was information received	97%	97%	Further review on individual cases would need to be made to identify why 3% of residents would arrive with no charted evidence of information.
1.1b	Letter from GP	13.6% s	25.6% -	A 12% increase in the numbers of letters sent in by GP. As there has been no formal process to identify this with GPs to date, this result may be due to either an incidental increase, follow up from facility RNs in response to initial audit, or improved auditing.
1.1c	Yellow Envelope	12.6%	23.3%	There was an increase of 10% .This could be a direct response to education sessions undertaken at the Acute Facility and through increase promotion through RACFs.
1.1d	Fax from GP	1.9%	0%	There were no faxes sent by GPs during the second audit. Continue to explore the notation that many GPs are fully electronic and less reliant on faxes. It appears most GPs prefer to communicate via email or electronic means.
1.1e	HRX or electronic information	0%.	1.1%	Considering the short introductory time frame, this is a good response and can only improve with increased awareness and registration of residents to the system.
1.1f	Phone Call from RACF	9.7%	11.1%	An increase of 1.4%. Continue education to RACF regarding policy to call the HINH team prior to transfer. Education to HINH regarding chart entry regarding pre-transfer phone calls from RACF.
1.1g	Information received as loose paperwork	83.5%	38.5%.	There is a decrease of 45%. This could relate to an improved use and knowledge of the yellow envelope system, but would need some further investigation as it does not completely correlate with the 10% improvement in the use of the yellow envelope.
1.1j	Other information detail	37.9%	81.1%	The QAS form was seen as a consistent method of obtaining information on the transferred patient. This is an increase of 43.2% on the original audit and may be a factor of the data entry process to better enable multiple responses.
1.1l	Phone call from GP	2.9%	1.1%	A decrease of 1.8% of evidence existed that the GP had phoned prior to the transfer of the resident. Continue to investigate the current perception of the GP role in acute transfer from RACFs.
1.4	Initiator of Transfer	70.2% regular RACF staff 23.3% regular GP	77.8% regular RACF staff 32.2% regular GP	Need to inform organisations and staff that this information appears to dispel the myth that most transfers are initiated by agency and or after-hours GPs. An increase of 8.9% was initiated by the regular GP and an increase of 5.7% by the after-

Question No.	Audit Questions	Audit One % available	Audit Two % available	Comments
How is communication received		104 charts audited	91 charts audited	This section highlights the lack of process or consistency in providing transfer information
		1% after-hours GP 1% agency staff	6.7% after-hours GP 0% agency staff	hours GP. It would be interesting to investigate further the notation that this audit did extend into the early Christmas school holiday period and may have resulted in an increased use of after-hours GPs to cover the holiday period.
1.5	Was patient re-presented/readmitted to hospital within 6 weeks	36.9%.	26.7%.	There was a decrease of 10% in readmissions. More specific data collection (beyond the scope of this audit) would be required to ascertain reasons for re-admission beyond information sharing.

Section 2: What info is received?	Audit Questions	Audit One % NOT available	Audit Two % NOT available	Recommendations / Explanations.
Standard Information				
2.1	Patient Name	1.9%	3.3%	Further investigation would be required to ascertain reason for this finding. Many facilities have print out summaries from their clinical software and it would seem that the name would be an automatic area completed on this summary. Medication sheets are often used to collect this information.
2.2	Date of Birth	1.9%	4.4%	An increase of 2.5% in lack of DOB identification correlates with Q2.1 and Q2.3
2.3	RACF and Contact Details	1,9%	5.6%.	An increase of 3.7% of details NOT available. This consistent with previous questions.
2.4	Usual/contact GP & contact details	13.6%	10.0%	Lack of current GP information can only increase delay of information being forwarded from hospital in a timely manner and increases risk that information can be sent to the wrong GP.
2.5	Advance Health Directive / End of Life Care Plan	91.3%	91.1%	Continue public, GP and organisational education program toward awareness of the need for this planning to occur.
2.6	Next of Kin/EPOA details	27%	22.2%	A slight decrease may be due to the decrease in audit numbers. Highlights the need for education to RACFs on the importance of hospital doctor's ability to contact NOK for management plans.
2.7	Was next of Kin notified?	35%.	16.7%.	Further review could relate this to the time of transfer, but was not particularly noted on the audit. Many relatives ask not to be contacted over night; however this increases difficulty with communication if the hospital needs to contact them.

Section 2: What info is received?	Audit Questions	Audit One % NOT available	Audit Two % NOT available	Recommendations / Explanations. This section highlights the gaps in basic identification and communication information provision.
Clinical Information				
2.8	Reason for presentation	23.3%	12.2%	An improvement of 12.8%, however this should be a key factor in any transfer information.
2.9	Observations - BP/pulse/temp	50.5%	26.7%	An increase of 26.3% to 70% recent observations available is a marked improvement. Need to review with auditors if this was from RACF form or QAS.
2.10	Usual health problems/past history	28.2%	21.1%	A 12.6% increase identifies a significant improvement to 76.7%.
2.11	Medication List	9.7%	7.8%.	This form was largely relied on for the Name, DOB and Facility address details by the auditors. Often used as a identifier as may contain a photo of the resident.
2.12	Allergies	9.7%.	5.6%	Unrecorded allergies are still a significant risk in transfer despite the low figures displayed.
2.13	Diet/Feeding	42.7%.	33.3%	A significant decrease in information is noted down 19%
2.14	CMA or medical Summary	68.9%	81.1%	This would need further investigation. Not all GPs complete a CMA, but most would complete a medical summary. This would easily be available on a shared electronic health record. RACF and GP process would come into play.
2.15	MMSE/Mental Status	80.6%	42.2%	An improvement of 25.7%. This question was changed for the second audit to identify Mental Status rather than tool specific and could be the reason for improved identification.
2.16	Communication - glasses/hearing aid/language	51.1%	64.4%	A 12.2% decrease in identifying needs, but still highlights that a large proportion of information is either not forwarded with the resident or not filed.
2.17	Mobility	41.7%	35.6%.	A 6.1% decrease in notifying mobility needs relates to a 6.1% increase in risk of falls.
2.18	Contenance	43.7%	36.7%.	A decrease of 13.8% in notification
2.19	Behaviours	47.6%	62.2%.	A decrease of 13.8% in notification shows the same consistency as previous questions.

Section 3: Clinical Outcomes	Audit Questions	Audit One	Audit Two	Recommendations / Explanations. This section highlights the need for further information and the possible delays and effects on clinical decision making.
3.1	Time of presentation to DEM	12am-6am 20.4% 6am-12md 22.3% 12md-6pm 35% 6pm-12mn 22.3%	12am-6am 7.8% 6am-12md 18.9% 12md-6pm 41.4% 6pm-12mn 7.8%	Further review of time of transfer to acute and time of transfer from acute needs to be considered. Does this influence the afterhour's discharges? Does it correspond with times in DEM? Consistently the majority of transfers occurred during daylight hours 6am-6pm. There was a marked decrease in after hours presentations, but still a remarkable evenness in the numbers at these times.
3.2	Time Spent in DEM	0-3 hrs 10.7% 3-6hrs 25.2% 6-9hrs 25.2% 9-12hrs 13.6% 12-15hrs 10.7% 15-18hrs 4.9% 18-21hrs 3.9% >21hrs 1.9%	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% >21hrs 0.0%	70% remained in the DEM for 0-9hrs, with majority again between 3-9hrs. There were no transfers in the department longer than 18 hrs for the second audit. There are several reasons this may occur including initiatives such as the HINH and the Patient Flow Unit aimed to expedite the treatment and discharge of residents from RACFs.

Section 3: Clinical Outcomes	Audit Questions	Audit One % of yes answers	Audit Two % of yes answers	Recommendations / Explanations. This section highlights the need for further information and the possible delays and effects on clinical decision making.
3.3	Was further information sought	59.2%	44.4%	This showed as phone calls to facilities in most instances. Refer Q 3.5. Despite facilities stating they had forwarded all the written information. Further review would be required.
3.4	Was GP Phoned	9.7%	15.6%	Despite the answer to Q3.3 there was a 5.9% in phone calls made to the GP. However Medical officers state that GPs visiting RACFs are very difficult to get in contact with by phone.
3.5	Was RACF phoned	66%	46.7% F.	The RACF is seen as more available for information as they have staff on site 24/24.
3.6	Was there a delay on the decision to admit based on the need to chase info	14.6%	5.6%.	Recommendations would be to follow admissions through the process at the facility for more accurate information in this area.
3.7	Referred to HINH	83.5%	85.6%	This is an excellent result toward improved resident management and RACF/Hospital communication. The audit could be responsible for assisting in identifying residents requiring transfer to the

Section 3: Clinical Outcomes	Audit Questions	Audit One % of yes answers	Audit Two % of yes answers	Recommendations / Explanations. This section highlights the need for further information and the possible delays and effects on clinical decision making.
				service through improved awareness of data collection for RACF.
3.8a	Admitted to Hospital	58.3%	84.4%	An increase of 26% in presentations being admitted. Further investigation into diagnoses would be required to make further comment on the increase in these figures.
3.8b	Length of Stay	1 day 38.3% 2-5 days 15% 6-10days 26.7% 11-15days 8.3% 16-20days 3.3% >20 days 3.3%	1 day 42.1% 2-5 days 14.5% 6-10days 22.4% 11-15days 7.9% 16-20days 1.3% >20 days 5.3%	Again the <24hr turnaround may be attributable to the HINH program, but further investigation into reason for presentation and diagnoses would need to be performed. This was not the intention of this particular audit, but could be included in future audits. .
3.8c	Could admission have been avoidable	7.8% - yes 61.2% - unsure.	0% -yes 40% - unsure.	In cases that were labelled as 'unsure' the auditors felt that there may have been some influence, but that it was difficult to ascertain from the written information.
3.9	Adverse Medication events	0%.	0%	This was audited through clinical incidence forms and is therefore as reliable as the reporting system enables.
3.10	Adverse Clinical events	2.9%.	6.7%	This was audited through clinical incidence forms and is therefore as reliable as the reporting system enables. Case studies would need to be undertaken to ascertain the individual events. This was not in the scope of the project

## **Actions Undertaken from Results of Admission Audit 1**

There were a number of issues identified by this audit.

1. The use of the yellow RACF communication envelope as a tool for sharing information may be used by facilities, but is not widely known or used within the acute facility.
2. Despite the prompts placed on the yellow envelope, there are varying levels of information being sent into the acute facility thus increasing the risk of accidental injury to the resident when in the acute facility.
3. There is little evidence of GP input into the transfer process and access to the GP is limited.
4. Sources for finding core identification information varied.

### **Residential Aged Care-Acute Care Forum**

Preliminary results from this audit were discussed at a Residential Aged Care and Acute Care forum. This already established group meet regularly on a bi-monthly basis and as the name suggests has representation from residential aged care and acute facilities, in particular acute outreach services such as Hospital in the Nursing Home, Palliative Care Outreach, Dementia Care Outreach, chronic heart failure and renal dialysis units. It rarely has representation from the medical unit or the surgical unit, a recommendation that could be made from this audit.

### **Recommendations from the Audit Findings**

1. Continue to recommend and use the yellow envelope system.
  - A number of facilities have contacted GP partners following their education sessions for supplies of the yellow RACF communication envelope.
2. RACFs and hospitals to further inform their employees of the need to improve transfer information through internal education.
  - Identify the increased risk of accidental injury due to lack of appropriate information.
3. RACFs and hospitals to review current transfer information forms internally with a view to ensuring all relevant clinical information is included.
4. Discussion regarding agreement on a recommended universal form to be used for resident transfers to be held at one of the next meetings.
  - To be placed on the agenda for the next Aged Care-Acute Care forum.
5. Conduct review of current processes internally (RACF and hospitals) including GP contact and information.
6. Review the possibilities of a shared electronic health record being implemented across aged and acute care settings.
  - Discussions have been held with a number of organisations.

## Recommendations to be actioned by GPpartners


### 1. Yellow envelope

- Continue to promote this resource to RACFs.
- Use of the yellow RACF communication envelope has been promoted through emails, bulletins and newsletter articles to facilities in the GPpartners catchment area.
- Continue to provide the printed envelopes at no cost to the facilities during this promotion.
  - Envelopes are available and are delivered to organisations on request.
  - Approximately 1,500 envelopes have been distributed over the three months to January 2009.
- Review current attitudes and processes for GPs role in RAC patient transfers.
  - Discussion with GP auditors on current process and understanding between GPs and RACFs.
  - Further information to be sought over an extended period.
- Liaise with hospital marketing toward improved awareness of the yellow envelope in the acute facility.
  - A hospital promotional flyer has been developed by the Acute Facility marketing department.
  - Flyer has been positioned in several allocated display points throughout the campus of the acute facility. (Refer [Attachment 10](#) – RBWH Yellow Envelope promotional flyer).
- Liaise with acute facility departments and deliver education on the Yellow Envelope and its role in sharing of transfer information between RACFs and acute facilities.
  - Education on the Yellow Envelope was delivered to approximately 200 staff in the acute facility following the first RACF-Acute Facility Clinical Handover Audit.
  - Areas involved included – Pharmacy, Physiotherapy, Internal medicine, Discharge Facilitators – Patient Flow Unit, Wards 7AN, 7AS, 8BN,8BS,9BS,9BN, Emergency Department, Receptionists, Nurse Educators forum. (Refer [Attachment 11](#) – Residential Aged Care Facility Communication Envelope Flyer and [Attachment 12](#) – Residential Communication Envelope Flow Chart).

### 2. Shared electronic health summary (HRX)

- Provide information to residential aged care organisations about the HRX and opportunities for residents.
- Discussions have been held with a number of organisations including:
  - The Corporate of Trustees of Order of Sisters of Mercy in Qld.
  - Holy Spirit Home Limited
  - Spiritus
  - Wesley Mission
  - Baptist Care
  - Amarina Investments Pty Ltd

Despite initial interest, no residential aged care organisation wished to commit to implementing the shared electronic health record at the time of year. Each organisation visited agreed with the merits




of the program, but felt that they would prefer to see more commitment from the health department in this arena and were not in a position to or willing to subject staff to any further changes in 2008.

This shows the pressures of a much regulated industry that have undergone a lot of enforced change over the last 18 month period with changes to their funding system, increased spot accreditation visits, severe and enforced changes through the elderly abuse regulations and the complaints investigation scheme.

As a whole they agree with the principles of the shared electronic health record system and were not adverse to residents consenting to the HRX through their GPs. They also indicated that they would be pleased to revisit the discussions in the new year.

- Target residential aged care patients of GPs already connected to the HRX for resident consent and uploading to the program.
  - GPs already connected to the HRX who have a significant number of residents were sourced from the GPpartners database. These GPs and their practice managers were approached regarding the consent of residents from RACFs onto the HRX system.
  - Four GPs were targeted. One of these GPs runs a residential aged care practice focus and has over 500 residents on their system. Using this practice has enabled us to work toward a reasonable sample size within the district. In one facility in particular this GP practice has over 98% of the residents.
- Promote HRX to GPs currently visiting RACFs.
  - Where targeted GPs have a monopoly of residents, we have approached the other visiting GPs to consider connecting to the HRX and enabling their residents to be part of this system.
  - The aim here is to enable some consistency within the aged care facility to work toward including the HRX as part of their transfer program. This is yet to be achieved. Again this relates to a time factor. The facilities are keen to be able to implement a possible electronic information sharing system.
- Consent residents in residential aged care to the HRX.
  - As this project has been undertaken with the aim of not increasing the current workloads of any hospital or RACF personnel, the project team has taken on the role of consenting of residents. This has proven a very time consuming and difficult role with the variation in ability of residents to consent and the difficulties in arranging appointment times with working support families. Due to the nature of the elderly, each consent could take the project officers up to 1hr to obtain from the residents.

In view of this, a decision was made to write to all the first contacts, or next of kin, of the residents to inform them of the HRX and to seek permission to register the resident to the system. This enabled the families to assist with decision making and did not require us to be present for the discussion with the family member unless requested. The project team are available to attend family discussion if required, and to provide any further information.



Two methods were trialled. One required an initial phone call to the family to explain the concept and to forward consent forms and information brochures by mail as a follow up, Again a very time consuming process. The second was a reverse of this process and found us forwarding letters to residents with the information brochure and consent forms as the first point of contact and then following this up with a phone call if required.

(Refer [Attachment 13](#) – Health Record eXchange Consent Information and [Attachment 14](#) – Participant Consent Form).

To date a total of 150 residents have been contacted regarding consent to register on the HRX.

- 91 residents have currently consented.
- 91 residents are currently registered and of these 50 have been uploaded onto the system.

GPpartners would like to continue to register residents with the aim that this could be done through the nursing staff as part of their admission process in the future. GPs are encouraged to register any new residents to RACFs to the HRX.

- Discuss the connection of relevant areas of the acute facility to HRX.
  - The HRX has already been introduced to the Acute Care Facility, but in a limited application.
  - Discussion on further roll out has been undertaken through the GPpartners IT team and the hospital- community Collaborative. A decision was made to connect the Hospital in the Nursing Home team to this system as a first priority. When it is considered that 83.5% of transfers to the Emergency Department from RACFs are referred to this team, it makes practical sense to ensure they have access to the current medical summary from the visiting GPs.
- Provide education and connection for acute facility staff to the HRX.
  - Education and connection has been arranged for the full HINH team under the supervision of the project sponsor at RBWH
  - This team is now able to access and view relevant resident information.
  - The Hospital in the Nursing Home team is working on a Hospital in the Nursing Home discharge form that can be used with the HRX to ensure uniform information to the GP and others who may be given access to this system. This is working toward a future aim of RAC staff having access to this shared electronic health system.

## **Hospital Auditors Feedback**

### Lessons learnt and recommendations

- Audits need to be conducted with adequate resources to be successful in gaining access to charts.
- Finding charts is a large part of the chart audit due to misfiled or missing charts and as yet unfilled information.
- Communication with the Emergency Department has to be a priority to gain their support.
- Real time study to reflect the actual use of the yellow envelopes would be beneficial.

- Measurement of the use of yellow envelopes would be a useful indicator to reflect communication between organisations and effectiveness of the tool.
- A longer time for implementation to witness a practice change is required – in particular with relation to general education and the electronic health summary.

#### Communication and Dissemination

Evidence from this project on the deficits of communication between RACF and hospital and the impact this has on patient care, bed days, readmission, morbidity and mortality are important for all clinicians to be aware of. Sustainable options for imparting evidence to clinicians have been attempted, for example doctor orientations, in services, feedback to consultants, nurse education programs and education of case managers.

#### Recommendations and conclusions

- Measurement of the use of yellow envelopes and the shared electronic health summary would be a useful indicator to reflect communication between organisations and tool effectiveness. (Case Managers could audit the use of the tools?).
- Engage the Emergency Department.

#### **Further Recommendations ‘Admission Information from Residential Aged Care’ Audits**

##### Recommendation 1

Review the current communication process for transfer between RACF staff and GPs and the areas of responsibility.

##### Recommendation 2

Review the current forms used by RACFs/GPs for transfer to acute facility – electronic / paper based – against the minimum data set.

##### Recommendation 3

Review the possibility of electronic transfer or access to information across the RACF and acute facility.

## Overview of Collated Information: Discharge Information Audits

Section 1: How is discharge info received?	Audit Questions	Audit One 65 audits % available	Audit Two 36 audits % available	Comments This section highlights the lack of process or consistency in providing transfer information
1.1	Phone call was made prior to discharge to facility	53.8%	58.3%	There is consistency in the notation of phone calls made, but this is an area requiring improvement. It may be recorded on the EDIS system but not charted.
1.2	Discharge information sent with patient	67.7%	91.7%	This marked improvement may directly relate to a current trial project with a dedicated Hospital In the Nursing Home staff member allocated to inpatient wards to improve early discharge rates and promote improved discharge communication. The DEM has introduced a discharge summary process that commences from presentation and has had a Medical Officer driving this program. A marked improvement in the number of summaries has occurred.
1.3	If No- was summary sent to RACF at a later date?	24.6%	0%	Again this question relates to 1.2 and shows a marked improvement.
1.4	Type of Discharge Summary received.	Medical <b>67.7%</b> Nursing <b>4.6%</b> Allied Health <b>3.1%</b>	Medical <b>94.4%</b> Nursing <b>41.7%</b> Allied Health <b>11.1%</b>	It is interesting that with the implementation of the Electronic Discharge Summary being rolled out through QH, that it is limited to a Medical Summary at this stage and not seen as a multi-disciplinary tool.
1.5	Medications and list available.	32.3%	72%	Again a marked improvement. This may relate to a second project being undertaken between GPpartners, QH – Safe Medication Practice Unit, & RBWH. Still nearly 30% are discharged without medications or information available.
1.6	Does GP name on information received match current GP?	56.9%	77.8%	This improvement could be due to the HINH department receiving an administration officer role. This person reviews the information placed into the Emergency Department information system (EDIS) and ensures the RACF box is ticked and changes RACF and GP details as necessary through HINH staff follow up.
1.7	Was the yellow envelope used as a tool to return information?	13.8%	22.2%	Slight improvement. The Patient Discharge Unit keeps a stock of envelopes in the ward and endeavours to ensure discharge information is available, however this does not reflect the flow of information through the acute wards.

Section 2: What info is received?	Audit Questions	Outcomes % of NO answers	Outcomes % of NO answers	Comments This section highlights the gaps in information provision for continued communication, risk analysis and clinical management
Standard Information				
2.1	Admission Date	4.2%	77.8%	Despite the fact this is seen as a mandatory requirement for electronic discharges, it does not seem to appear on current discharge summaries.
2.2	Unit/Ward	6.2%	0%	Noted.
2.3	Discharge Date	18.5%	16.7%	Not apparent on several non-formatted discharge summaries
2.4	Contact Dr at RBWH	16.9%	2.8%	An improvement over the initial audit. This could relate to the formatted discharge summary.
2.5	Consultant Name	20.0%	0%	Noted.
Clinical Information				
2.6	Diagnosis	9.2%	0%	Noted.
2.7	Medications	36.9%	30.6%	Medication not available on discharge. These may relate to after-hours discharges and need to be further reviewed.
2.8	Procedures	7.7%	2.8%	A 5% improvement over the first audit.
2.9	Recommendations for GP	27.7%	2.8%	A marked improvement. Again this relates to the formatted DEM discharge summary and the HINH discharge nurse.
2.10	Course in Hospital	7.7%	2.8%	A corresponding 5% improvement.
2.11	Follow-up arrangements	53.8%	30.6%	Despite over 20% improvement it is still close to 1/3 or transfers have no follow up arrangements clarified.
2.12	Investigations	7.7%	8.3%	A decrease from the initial audit. Perhaps the fact that no investigations were undertaken needs noting to make this clear.
2.13	Information is accurate & legible	9.2%	0%	Legible and appropriate.
2.14	Information provided is relevant & succinct.	9.2%	0%	Relevant and succinct.

Section 3: Impact on clinical outcomes	Audit Questions	Outcomes % of yes answers	Outcomes % of yes answers	Comments. This section highlights workforce issues and outcomes related to lack of or delay in receiving information to enable continuity of care management.
3.1	When was patient discharged?	Within Hours 44.6% After Hours 49.2% Friday PM 3.1% Public Holiday 0.0%	Within Hours 61.1% After Hours 30.6% Friday PM 8.3% Public Holiday 0.0%	After hours related to pre 7am and post 5pm weekday and any time on weekends.
3.2	How long did it take to receive information post discharge?	<=24hrs 76.9% <=48hrs 0.0% <=72hrs 0.0% >72hrs 12.3%	<=24hrs 94.4% <=48hrs 0.0% <=72hrs 2.8% >72hrs 2.8%	Only 2.8% took longer than 72hrs to receive information. However even 2.8% receiving within 72hrs increases the risk of accidental harm to the resident.
3.3	Adverse medication events (in the first 10 days)	1.5%	2.8%	It is not clear from the audit if this directly relates to the 2.8% where information was not received within 24hrs. Further review would be required.
3.4	Adverse clinical events (in the first 10 days)	23.1%	2.8%	It is not clear from the audit if this directly relates to the 2.8% where information was not received within 24hrs. Further review would be required
3.5a	Readmission to hospital within 6 weeks?	35.4%	27.8%	This is consistent with current hospital re-admission rates.
3.5b	Was there an apparent link to the previous admission?	52.2%	30%	This rate is consistent with findings related to readmission rates for elderly with chronic and complex disease in a study at Toowoomba hospital. Hegney D et al(2006)
3..5c	If yes- was it avoidable with improved information?	26.1% 4.3% unsure	0% 66.7% unsure	This was unclear in 66% of cases. However there was no readmission that could clearly be linked to a lack of information during the second audit

## **GP Auditor Feedback – Review of Discharge Information**

### **How is the discharge information received from the RBWH**

There was a reasonable amount of phone contact between hospital and RACF, more so from the ward than from the Emergency Department DEM.

In the progress notes some RACFs phoned the hospital to access information on patient progress and possible date of discharge, frequently ringing the Hospital in the Nursing Home service rather than the ward. The Hospital in the Nursing Home was highly regarded by many RACF staff for improving communication generally between the hospital and RACFs.

Discharge information was frequently sent with the patient at the time. Some summaries were sent later with updated information.

Medical discharge information was the most common form of communication. Nursing information was commonly sent if a patient had been admitted to a ward, especially prolonged admissions. Some nursing information was sent from DEM as entries from Hospital in the Nursing Home, especially relating to specific nursing duties such as wound or catheter care, and if Hospital in the Nursing Home had arranged follow up in the RACF.

Allied health discharge summaries were not frequently received and surprisingly even from wards where there would have been an obvious allied health input such as orthopaedics or rehabilitation admissions.

Medication lists were more frequently sent when patients were admitted to a ward. DEM medication lists were only provided when there was an addition to medications such as antibiotics. This would often come in the form of a signing sheet.

I feel from the RACF perspective this is all that is required and saves the DEM typing out the usual patient medication list which was unaltered.

GP names were variable. A number of audits had no GP name listed. Some had an incorrect name which may have been that the patient was transferred to a different RACF for higher care or interim care needs than from where they were admitted from.

This shows the importance of the RACF receiving all the discharge information. It is still important for the hospital to send all discharge information directly to the GP that they know of. Several RACFs would fax all discharge information they received from the hospital to the patients current GP which is an excellent practice.

It was difficult to ascertain if the yellow envelope was used. As audits were commonly done six weeks after discharge the yellow envelopes were rarely visualised by the auditors in the files. A number of RACFs were not using the yellow envelopes at all, or if they were could not guarantee that they were used for every hospital transfer. Nursing staff could not accurately recall if the yellow envelopes were being returned after such a lag time for each specific patient.

## **What information is received?**

### Standard Information

This information was usually present if any discharge information was sent. The discharge date was commonly omitted from the front page of computerised discharge summaries from the wards. These discharge summaries seem to be constantly added to over the course of admission and printed at the time of discharge.

There was one instance of a significant change in condition at the later stage of a patient's admission and this had not been added to the discharge summary (including relevant medication additions) which led to confusion at the RACF when the patient returned.


### Clinical Information

There were several different formats of medical discharge summaries and from a GP perspective the following are a few comments:

- DEM – usually a one paged typed document. Diagnosis and course in hospital and a summary of relevant investigations and recommendations included. Often no medication lists but a comment on any medication changes made in DEM such as the addition of antibiotics.
- Medical Ward – a typed document with space for all the audit questions included. On occasion some sections were not completed, e.g. allergies or recommendations for GP. This format is very comprehensive but sometimes can result in a large document (the longest 13 pages). The length was usually related to the inclusion of all the results in original form (not summarised). This format has the best medication list showing changes and reasons.
- Rehabilitation Ward – a one page typed summary added to the discharge summary from the original ward.
- Orthopaedics – a two page formatted, hand written discharge summary that is relevant and succinct.
- Urology – a one page typed formatted summary which is relevant and succinct. Some space limitations for medication lists and changes.
- Psychiatry – Formatted, hand written.
- Nursing summaries – a one page formatted document that was hand written and carbon copied.
- Allied health summaries – varied from hand written documents to extensive typed reports.

### **Impact on clinical outcomes**

- There were a number of patients discharged after hours and on weekends. In DEM this could be explained by patients going into DEM during the day and so they had not been treated and transported within a timeframe to be returned during the day as well.
- The hospital needs to be aware the difficulty for RACF staff on weekends and after hours in accessing new medications and having documentation to administer these changes if the GP is



not immediately available. There certainly was evidence that this was being done from the hospital with supplying short courses of medications and sending medication signing sheets.

- The majority of information was received within 24 hours. According to RACF progress notes there were a few instances where information was not received with the patient so the RACF had to contact the hospital directly for information to be faxed. Occasionally there was an updated discharge summary sent to the RACF at a later date but rarely beyond 72 hours.
- Adverse medication events appeared rarely, usually related to insufficient information received about medication changes or the RACFs inability to access new medications quickly.
- Adverse Clinical Events occasionally.
- Readmissions to hospital were common. Sometimes this was difficult to determine if there was an apparent link with the previous admission or not. On the whole the RACF population naturally have multiple complex chronic health problems which may be difficult to deal with in the RACF during acute exacerbations. The most obvious “unavoidable” readmission were cases of falls resulting in injuries – the first admission may exclude various injuries but later symptoms and signs of other injuries may become obvious and require further investigation or treatment. This seemed to occur especially in dementia patients who were unable to give an accurate history at initial presentation.

## **General Comments**

There were some difficulties collecting information for this audit at various RACFs. As there was a delay between the date of patient discharge and when the audits were completed the information was based on letters received in the patient file, nursing progress notes and nursing recollection of events.

Perhaps there may have been more information received on the day of discharge compared to what the auditors saw on the date of auditing.

Some RACFs are using hybrid paper and computerised files. The auditors were given access to the computerised progress notes but as there were different systems in some RACFs sometimes these were difficult to negotiate.


## **Recommendations from ‘Discharge Information from Acute Facility’ Audits**

### Recommendation 1

Identify and establish a consistent process for use of the yellow envelope across the service lines in the acute facility.

### Recommendation 2

Review the current nursing discharge form for compliance with the GPAC Guidelines toward improved information sharing.



Recommendation 3

Incorporate specific education strategies into ward processes, e.g. inclusion in staff induction processes; use of nurse educators and ward receptionist forums; circulate / educate about support resources (e.g. website, flyers etc).

Recommendation 4

Review the current yellow envelope tick box format and identify any changes prior to next print.

Recommendation 5

Increase acute facility clinician access to the HRX.



## Cross Referencing with Audits

Some questions on the admission and discharge audits enable for cross referencing. This helps give some balance to the information and improves validation.

For instance if a percentage of admission forms do not identify the correct GP, then there is a possible flow on that a percentage of discharges may have the incorrect GP information. How can we build in a process that ensures this information is checked and data entered into the system to ensure changes required are made?

Data relating to length of stay (LOS) may help identify possible reasons for adverse events. RACFs have often made statements about residents returning to facilities with pressure areas. Could this be related to the LOS in the DEM where usual pressure relief activity may not be in place?

LOS in DEM also could be related back to discharges after hours. If we know that a percentage of residents are transferred during after-hours or even transferred between 12 midday and 6 pm, then if the average length of stay is nine hours, they will be returning to facilities after-hours.

What communication processes can be put in place to assist this? If resident does not require admission and we all know that best practice is about the right treatment, in the right place, then returning to the facility could be the most appropriate choice. However, this may not be true if staffing is insufficient to manage a return in the early hours of the morning.

How can a facility cater for this in advance? Or what agreement can be reached between the RACFs, the acute facility and the transport departments with regard to returning a resident at reasonable hours of the day?

## Overview of Collected Information: Cross Audit information Admission Discharge

	Audit Questions	Admission Audit % available		Audit Questions	Discharge Audit % available	Comments.
1.6	Usual GP & contact details	77.8%	2.4	Does GP name on information received match current GP.	87.8%	In this case we see that the correct GP has been noted in 10% more cases than the information received.
1.5	Was patient re-presented/readmitted to hospital within 6 weeks	26.7%	3.5a	Re-presentation / readmission to hospital within 6 weeks	27.8%	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.
3.1	Time of presentation to DEM	12am-6am 7.8% 6am-12md 18.9% 12md-6pm 41.4% 6pm-12mn 7.8%				After hours for the purposes of these audits was considered before 7am and after 5pm on weekdays and anytime on weekends.
3.2	Time spent in DEM	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% >21hrs 0.0%	3.1	When was patient discharged?	Within Hours 61.1% After Hours 30.6% Friday PM 8.3% Public Holiday 0.0%	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.

## Conclusion

It seems that the development of accepted minimum data sets is just one step toward the implementation of discharge summaries from acute facilities. The South Australian Department of Human Services (2004) felt that improving the business processes at the hospital and at the recipient's workplace was more important.

The possible implementation of a national electronic discharge summary would go a long way in rectifying some of the gaps in information that are currently visual from the audit undertaken.

The current processes being put into place have shown improvement over the period of the audit. The implementation of an inpatient Hospital in the Nursing Home role has made a marked impact in promoting earlier discharge back to the RACF and improved discharge information.

The implementation of the electronically produced discharge summary in the Department of Emergency Medicine has also made recent impact. How more efficient this would be when able to forward the information directly by electronic means.

Electronic databases that can easily upload current health summary information would certainly decrease the risks of information mismatch with the resident/patient, decrease administrative workloads, improve accessibility and ease of finding information in a clear, concise and formatted way.


A shared electronic health summary that contains all the relevant information would help decrease the risk of accidental injury to residents both in hospital and in the RACF through the provision of structured information. This process would enable real time information sharing to occur. However, the process of consenting residents to a shared electronic health summary has proven challenging and slow.

Mainly this has been due to the already pressured time with financial and legislation changes for the residential aged care organisations. Should they embrace this type of technology, the consent process could occur as part of their usual admission process and delays would not occur. Difficulties arise in that the facility needs to learn another system that does not connect entirely with their current software. However, this is certainly easily overcome with training.

GPpartners will continue to work with visiting GPs to connect residents to the system to enable staff at the Emergency Departments to have easy access to resident health information.

The yellow RACF communication envelope is seen as a worthwhile process to continue when using a paper based system. Comment from the hospital auditors on the successes of this audit include:

- Communication/feedback with GPpartners, Hospital in the Nursing Home and hospital wards has provided further understanding of RACF processes.
- Re-introduction of the usefulness of the yellow envelope as a communication tool had a favourable response from clinicians.
- Excellent marketing campaign undertaken to raise awareness of the yellow RACF communication envelope.



The results of the audit have been extremely helpful in identifying areas that need to be addressed by the RACFs, GPs and acute facility.

Doing an audit of both the information received from RACFs and information received from the acute facility has been a grounding experience for representatives from the RACFs.

Most surveys and reports have been done based on discharge information. This audit has enabled staff from both sides to be more aware of the increased risk of injury to patients (that are already at high risk due to their age, frailty, and degree of chronic illness) from the lack of appropriate information.

The project has been useful in that several ongoing recommendations will be put into action. The hospital is already actioning further process review and developing strategies to improve education on the discharge process to RACFs.

The hospital sponsor for this project has included planning for another audit to be undertaken approximately six months after the review and education strategies have been put into place to ensure further evaluation of the changes made.

The forum of RACF representatives has discussed the need to utilise the results of the audit for staff education, specifically in relation to improving the clinical information that is forwarded with residents to decrease the risks of accidental injury and to be clearer about the reason for transfer. Discussion around the End of Life Planning was promoted when shown the low level of information that was available on transfer.

Further discussion needs to occur with the visiting GPs in relation to their responsibility in the provision of clinical information through current Comprehensive Medical Assessments or health summaries and their role in the transfer process.

## References

- Carpenter, I., Bridgelal Ram, M., *Handover & Discharge Record Content Structure Standards for Hospital Practice: Pilot Report*, April 2008
- GPAC (General practice Advisory Council Qld), *Continuity of Care Planning framework for Queensland – Resource Manual*; April 2004
- McDonald, T., *For Their Sake. Can we improve the quality and safety of resident transfers from acute hospitals to residential aged care?* Australian Catholic University National; September 2007
- QEII Hospital Health Service District & Brisbane South Community Health Service. *Residential Aged Care Facility – Clinical Resource Manual*. November 2006
- Australian Commission on Safety and Quality in HealthCare, *Windows into safety and quality in HealthCare*. ACSQHC Sydney; October 2008
- Chien Yee, K. Chao Wong, M., “A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover”. UTAS; April 2008.
- Australian Commission on Safety and Quality in HealthCare.
- Australian Medical Association, *Guidance on Clinical handover for Clinicians and Managers*; 2006
- Chaboyer, W.; “Information sharing, knowledge transfer and patient safety”, British Association of Critical Care Nurses, *Nursing in Critical Care*; 2008
- Davenport and Prusak; *Working Knowledge*. Cambridge Harvard Business School Press; 1998
- Stokes; Lentile, C; & Roberts, M.; *Phase 3, Final Report on Effectiveness and Cost effectiveness of Dosage Administration Aids*; May 2006
- South Australian Department of Human Services; *Clinical Information Project: Phase 1 Report – Part C. Stream 3: National Hospital Discharge Summary*; April 2004
- Hegney, D; Buikstra, E; Fallon, T; *Nurse Discharge Planning in the Emergency Department: A Toowoomba, Australia Study*. *Journal of Clinical Nursing*; 2006



# Attachment 1

## **Admission Information from Residential Aged Care**

# Admission Information from Residential Aged Care

Study Number:	Patient DEM Arrival Date & Time:	
Auditor:	Date of Admission:	Time taken to complete Audit:

## 1. How admission information is received from Residential Aged Care facilities?

<b>1.1 Mark all appropriate</b>	<input type="checkbox"/> No information received	<input type="checkbox"/> Letter from GP
	<input type="checkbox"/> Yellow Envelope	<input type="checkbox"/> Fax from GP
	<input type="checkbox"/> Health Record eXchange (HRX) or electronic information	<input type="checkbox"/> Phone call from RACF
	<input type="checkbox"/> Loose paperwork <input type="checkbox"/> RACF Transfer form <input type="checkbox"/> Medical Summary <input type="checkbox"/> QAS <input type="checkbox"/> CMA	<input type="checkbox"/> Phone call from GP
	<input type="checkbox"/> Other (i.e. Family) _____	
<b>1.2 Time the information was received?</b>	<input type="checkbox"/> At time of arrival <input type="checkbox"/> Other – add date & time _____	
<b>1.3 Information is legible?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not relevant	
<b>1.4 Who initiated transfer?</b>	<input type="checkbox"/> GP <input type="checkbox"/> AH/GP <input type="checkbox"/> RACF staff <input type="checkbox"/> RN <input type="checkbox"/> EEN <input type="checkbox"/> Agency staff <input type="checkbox"/> Other	
<b>1.5 Was patient re-presented / readmitted to hospital?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <= 3 months	
Notes:		

## 2. What information is received?

<b>Standard information</b>			
2.1 Pt. Name	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.5 Formal Directive (such as copy of Advanced Health Directive / End of life care plan / Family wishes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.2 Date of birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.6 Next of Kin / EPOA with contact details	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.3 RACF and contact details <i>If given, RACF name:</i> _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.7 Was next of kin notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.4 Usual/contact GP and contact details	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Clinical information</b>		<b>Usual Functionality</b>	
2.8 Reason for presentation	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.14 CMA or medical summary	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.9 Observations – BP / pulse / temp	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.15 Mental Status	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.10 Usual health problems / past history	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.16 Communication – glasses / hearing aid / language	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.11 Medication list	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.17 Mobility	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.12 Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.18 Continence	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.13 Diet / feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.19 Behaviours	<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes:

### 3. Clinical outcomes

3.1 Time of presentation to DEM		3.2 Time spent in DEM	
3.3 Was further information sought?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known		
3.4 Was GP phoned?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsuccessful <input type="checkbox"/> Not possible <input type="checkbox"/> Not known <input type="checkbox"/> Not documented	Comments	
3.5 Was RACF phoned?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsuccessful <input type="checkbox"/> Not possible <input type="checkbox"/> Not known <input type="checkbox"/> Not documented	Comments	
3.6 Was there a delay on the decision to admit based on the need to chase information?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment	
3.7 Referred to HINH?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.8 Admitted to hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.8.1 Length of stay?			
3.8.2 Could admission have been avoidable (if necessary information had been available)??	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Comment		
3.9 Adverse medication events?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3.10 Adverse clinical events?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Notes:



## Attachment 2

### **Discharge Information from Acute Facility**

	Date Started:	
Auditor:	Date Completed:	Time to complete audit:          hrs

### 1. How is discharge information received from Acute Facility?

1.1 Phone call was made prior to discharge to..?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.2 Discharge information sent with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.3 If No-was summary sent to RACF at a later date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.4 Type of discharge summary received.	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Allied health
1.5 Medications available at time of discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.6 Does GP name on information received match the current GP?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1.7 Was the yellow envelope used as a tool to return information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Notes:	

### 2. What information is received?

<b>Standard information:</b>			
2.1 Admission date	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.2 Unit/Ward Please Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.3 Discharge date	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.4 Contact Dr at RBWH and contact details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.5 Consultant name	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Clinical information:</b>			
2.6 Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.7 Medication list – changes and reasons	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.8 Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.9 Recommendations for GP	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.10 Course in hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No	2.11 Follow up arrangements	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.12 Investigations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.13 Information is accurate and legible?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.14 Information provided is relevant and succinct?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Notes:			





# Attachment 3

## **Guidelines for Admission Information**

# Clinical Handover Audit



## Guidelines: Completing the Hospital Audit Tool

### How admission information is received from RACFs

- Examine patient file to identify information that has come with patient to Department of Emergency Medicine (DEM).
  - loose paperwork sent with the patient
  - yellow envelope or faxes from GP
  - do notes refer to phone calls initiated from RACF/GP?
  - record how much information is in yellow envelope
- Did DEM receive information when patient arrived?  
Check emergency department info system (EDIS).
- Information is legible?  
Indicate yes or no.
- Who initiated transfer?  
May be indicated in admission notes or information received from RACF. Time of presentation may help determine this. What is documented, i.e. RACF staff, GP.
- Was patient readmitted to hospital or had a presentation to DEM?  
Indicate yes or no.
- From hospital database determine if this is a readmission within 6 weeks.  
Check hospital based clinical information system (HBCIS), EDIS or chart.
- Notes  
Make general comments about how the information is received. For example, is it disorganised or describe what has been received (GP letter, RACF paperwork without identification).

### What information is received?

- Standard information.  
Is information present for all listed categories? Use all information received from RACF/GP.
- RACF contact details and RACF name.  
Indicate yes or no and clarify if this information is correct.
- Is there a formal directive.  
Look for documentation. If yes comment required, e.g. note in chart.
- Are contact details written for NOK and or EPOA  
Indicate yes or no.
- Is there documentation that next of kin was notified of admission or presentation  
Indicate yes or no.
- Clinical Information  
Is info present for all clinical categories? Use all information received from the RACF/GP. Was the information received?
- Observations note  
What observations if present from RACF and or usual pre-morbid vitals.
- Medical history - i.e. pre-morbid (anything documented prior to admission), co-morbidities  
Indicate yes or no
- Medication list  
Indicate yes or no.

- Record discrepancies with allergies  
Indicate yes or no.
- Usual diet or nutrition  
Indicate yes or no.
- Medical summary or Comprehensive Medical Assessment (usual functional status)  
Indicate yes or no.
- MMSE score or usual cognitive status  
Indicate yes or no.
- Communication needs  
Indicate yes or no.
- Mobility  
Indicate yes or no.
- Continence status  
Indicate yes or no.
- Behavioural issues  
Indicate yes or no.
- Notes  
Auditor may make comments about how easy or difficult the information was to be interpreted from what was received, what was helpful and unhelpful.
- GP phoned.  
Indicate yes or no.
- RACF phoned.  
Indicate yes or no.
- Was there a delay in decision?  
Examine medical and nursing progress notes to identify any need to collect further information to make clinical decisions.
- Referral to Hospital in the Nursing Home.  
Was HINH contacted according to progress notes or is there entry in notes from HINH staff? Is the patient listed on HINH database in DEM?
- Admitted to hospital.  
Indicate yes/no.
- Length of stay.  
Calculate number of days between admission and discharge dates.
- Could admission have been avoidable?
  - Examine initial RBWH medical and nursing progress notes.
  - Identify indication where a lack of information or uncertainty has led to DEM staff admitting patient rather than treating in DEM and discharging to RACF.
  - Comment if obvious reasons, write note on how you came to this decision.
- Adverse medication events.  
Indicate yes/no if there have been incidents of incorrect medication administration or allergic/sensitivity reaction which could have been avoided if comprehensive medication and allergy chart was provided to DEM or medical staff at time of presentation.  
Check for this in medical and/or nursing progress notes. Check PRIME (Clinical Incident Management System) data for incident and type.
- Adverse clinical events.  
Indicate yes/no if there are entries recorded in medical and/or nursing notes that indicate an adverse clinical event has occurred as a result of inadequate information provided about patient from RACF.  
Check PRIME data for incident and type.

### Clinical Outcomes

- Time of presentation to DEM.  
Identify from DEM database (EDIS).
- Time spent in DEM  
Identify from DEM database (EDIS).
- Was further information sought?
  - GP / RACF comments
  - examine medical and nursing progress notes to identify attempts to contact RACF or GP during DEM stay or admission process; have attempts been successful
  - under comments, what information specifically have DEM staff wanted to clarify
  - admission process, types of information sought
- Notes  
The auditor may wish to make further comments they feel relevant in relation to what information was received from RACF and its impact on patient's subsequent course in hospital.



# Attachment 4

## **Guidelines for Discharge Information**

# Clinical Handover Audit



## Guidelines: Completing the RACF Audit Tool

The Clinical Handover Audit is conducted on all residents of Residential Aged Care Facilities that are admitted to or discharged from the Royal Brisbane & Women's Hospital over the designated study period.

### How is discharge information received from RBWH

- Phone call was made prior to discharge to facility.  
Review patient progress notes for indication of phone call or, discuss with nursing staff if notation could be facility diary. Indicate yes or no.
- Discharge information sent with patient.  
Review discharge information file identified as being sent with patient. Indicate yes or no.
- If no, was summary sent to RACF at a later date.  
Read nursing progress notes to identify if discharge summary has been referred to and at what time. Examine discharge summary and note completion date. Interview nursing staff to recall exact date discharge summary was received.

### Type of discharge summary received

- Medical – review discharge information in file identified as being sent for the patient.  
Indicate yes or no if a medical discharge summary is present.
- Nursing – review discharge information in file identified as being sent for the patient.  
Indicate yes or no if a nursing handover form is present.
- Allied Health – review discharge information in file identified as being sent for the patient.  
Indicate yes or no if allied health summaries are present.

### Medications and list available at discharge

- Review initial documentation to identify a medication list. Review medication chart and signing sheet.  
Were medications available and provided on return to facility. Indicate yes or no.
- Does GP name on information received match the current GP?  
Indicate yes or no
- Identify usual GP through medical notes. Confirm with nursing staff.  
Indicate yes or no

### Yellow envelope

Examine patient file to identify a yellow envelope. If not present, interview nursing staff as to whether they recall it being present when patient returned.

### Notes

Comment on any difficulties encountered determining this information or if it was unknown; clarify source of identification.

### Was the following standard information documented on the discharge summary:

- Admission date.  
Indicate yes or no.
- Unit / Ward.  
Indicate yes or no.

- Discharge date.  
Indicate yes or no.
- Contact Doctor at RBWH and contact details.  
Indicate yes or no.
- Consultant name .  
Indicate yes or no.

**Was the following clinical Information documented on the discharge summary:**

- Diagnosis.  
Indicate yes or no.
- Medication list, changes and reasons.  
Is there a discharge medication summary? Does it indicate if changes were made and instruction about why changes were made?
- Procedures.  
Indicate yes or no. This may not be relevant as procedures may not have been necessary, taking diagnosis into account (e.g. admission for pneumonia). Indicate if procedures were not relevant to admission.
- Recommendations for.  
Indicate yes or no.
- Course in hospital.  
Indicate yes or no.
- Follow up arrangements.  
Indicate yes or no.
- Investigations.  
Indicate yes or no.
- Information is accurate and legible  
Examine all discharge information received. Are there obvious discrepancies between the information received and information known on patient file? Is the information easy to read?
- Information provided is relevant and succinct  
Does documentation summarise relevant information about admission, outcomes and plan for future care in a concise summary that is easy to understand?
- Notes  
Does the summary provide clear indication of reason for admission, course in hospital, outcomes and future recommendations? If information is not present, have you been provided with a contact to access the information?

**Time of discharge**

Examine nursing progress notes to determine date and time patient returned to RACF.

Identify if within 7am to 6pm (in hours); identify other hours as after-hours; clarify if Friday pm, weekends or public holiday.

**Length of time to receive post discharge**

Refer to information collected previously to determine time between patient arrival at RACF and time discharge information was received.

**Adverse medication events**

Examine nursing notes, interview nursing staff and phone GP to determine if there were any medication incidents associated with administration of medications post hospital discharge.

Incidents include incorrect administration of medication according to new discharge medication list or unnecessary delay providing new medication as it was not provided at time of discharge.

**Adverse clinical events**

Examine nursing progress notes, interview nursing staff and phone GP to determine if there were any clinical incidents that could be explained by lack of timely and appropriate information at time of discharge.

**Readmission to hospital < 6 weeks**

Phone RACF nursing staff at 6 weeks from original discharge date to determine if patient has been readmitted to hospital within this period.

Indicate yes or no if any apparent link to previous admission. Could this have been avoidable? Indicate if avoidable, unavoidable, unsure.

**Additional Comments**

The auditor can make general observations about how discharge information provided from acute facility has impacted on patient's clinical course since return RACF.

The auditor may quote RACF nursing staff and/or GP with observations made in relation to information provided post discharge and its impact on patient's subsequent clinical course.

However most importance is taken from written information.

## Attachment 5

### Letter of approval RBWH ethics committee

<b>2008/087</b>	<b>Ms Helen Hoare</b> <i>GP partners RBWH sponsor Ms Mary Fenn CNC Patient Flow Unit</i>	<b>A Residential Aged Care Organisations or Facilities/Hospitals Clinical Handover Project</b>
<p>At its August 11 2008 meeting the HREC reviewed this study taking into account additional information provided following initial review in July. It was felt to be a project reviewing the adequacy of information provided between community and hospital facilities, as judged by currently accepted standards.</p> <p>As such the Committee recommended approval of this study as a <u>QA/audit</u> of discharge letters. For this reason specific consent of individuals is not required but all organisations must give overall consent for the study to be conducted.</p>		

# Attachment 6

## Letter of approval Spiritus ethics committee

Ms. Helen Hoare,  
Aged Care Project Coordinator,  
GPpartners,  
PO Box 845,  
LUTWYCHE Q 4030

19.08

Dear Helen,

**Re: Application for Ethical approval for Project:  
Residential Aged Care Facilities/Hospitals Clinical  
Hand over Project**

Firstly, I offer sincere apologies for this later than intended response to the above application, and thank you for attending the Meeting to present for the Project.

The Committee was most interested in the Project and believes it would produce useful information and hopefully outcomes.

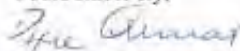
The concern of the Committee was that the approval sought cannot be given unless consent is obtained from all participants, if the findings are to be published. The consent forms as presented are excellent, and it is realized that there is a time constraint. However, the Committee is obliged to notify you of the necessity for such forms to be completed.

Under the circumstances, it remains with GPpartners to decide if the publishing of the papers is to proceed, and if so, consent forms will be a requirement.

Perhaps you could advise me by telephone, of the decision of GPpartners. My home phone is 3836 5852.

I await your call.

Yours sincerely,



Pixie Annat (MBA)  
Chairman  
Human Research Ethics Committee



# Attachment 7

## Resident consent form

### Participant Consent Form Resident of Aged Care Facility

**Title of study: "Residential Aged Care Facility/Hospital Clinical Handover"**

**Investigators:**

1. Helen Hoare Aged Care Project Coordinator, GPpartners Ltd, Australian Division of General Practice, Brisbane
2. Dr Richard Kidd, General Practitioner, GPpartners,
3. Dr Kylie Norris, General Practitioner, GPpartners,
4. Mary Fenn, Assistant Nursing Director, Patient Flow Unit, Queensland Health, RBWH.

I, \_\_\_\_\_ *(please print full name)*, agree to take part in the study 'RACF/Hospital Clinical Handover'. I therefore agree that the following statements are true:

1. I have read the 'Participant information sheet for residents of aged care facilities' and I understand the purpose of this project.
2. I freely consent to my involvement in the study.
3. I have had any questions answered to my satisfaction
4. I understand that if I have any additional questions I can contact the research team
5. I understand that the medical information provided about me on my admission and discharge between the nursing home and the hospital will be examined against an audit tool to see if effective communication is taking place.
6. I understand that absolute confidentiality will be upheld and my privacy will be maintained at all times throughout the study and that I will not be identifiable in any reports about this study
7. I understand that I am free to withdraw from this project at any time without comment or penalty
8. I am aware that I may request further information about this study at any time after its completion by contacting one of the researchers
9. I understand that I may not directly benefit from participating in this research, but that it may help to improve outcomes for future people entering nursing homes
10. I am aware that I will not be paid or receive any form of remuneration for my involvement in this study
11. I wish/do not wish (circle one) to receive findings at the conclusion of this study
12. I understand I can contact the CEO GPpartners on Ph 36307 300 or email: [abbe.anderson@gppartners.com.au](mailto:abbe.anderson@gppartners.com.au) if I have concerns about the ethical conduct of the project

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Enduring Power of Attorney Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_


Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researchers' signatures:

  
Helen Hoare

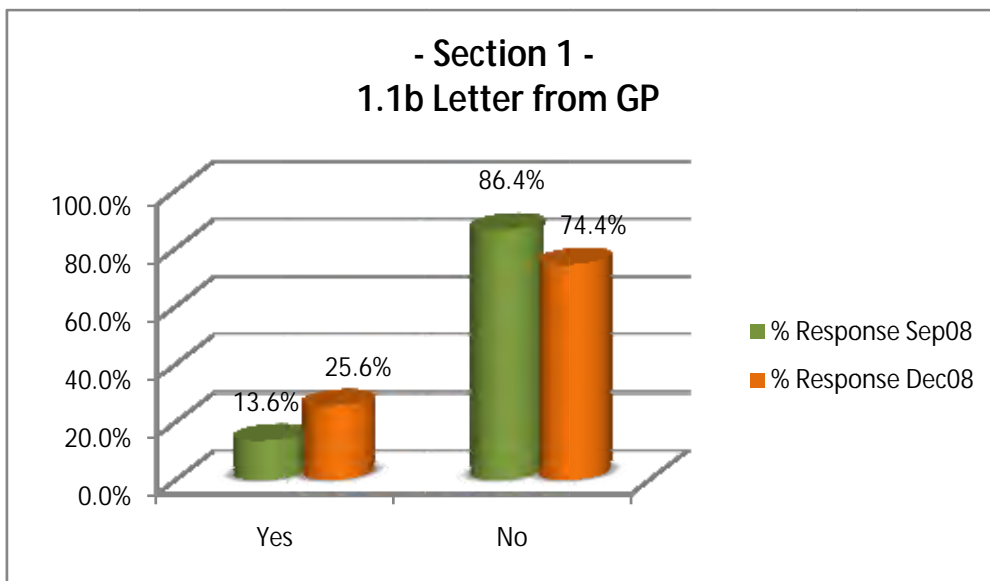
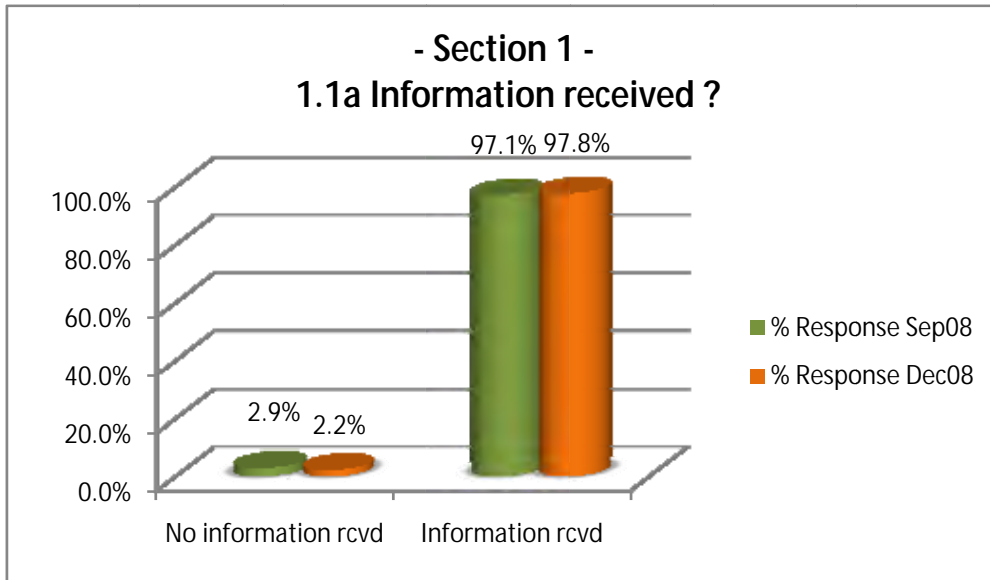
  
Dr Richard Kidd

  
Dr Kylie Norris

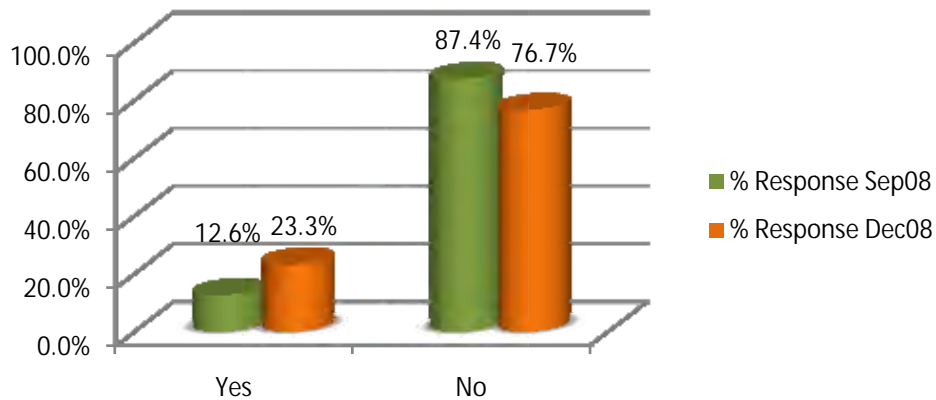
  
Mary Fenn

# Attachment 8

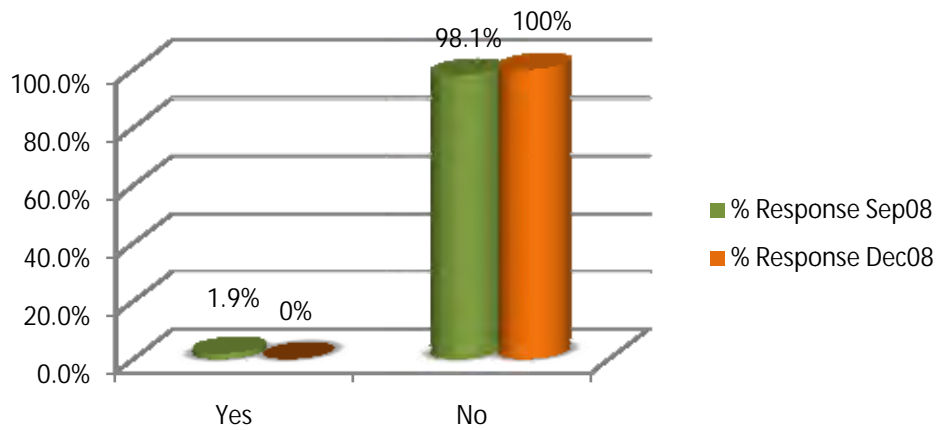
## Admission information audits



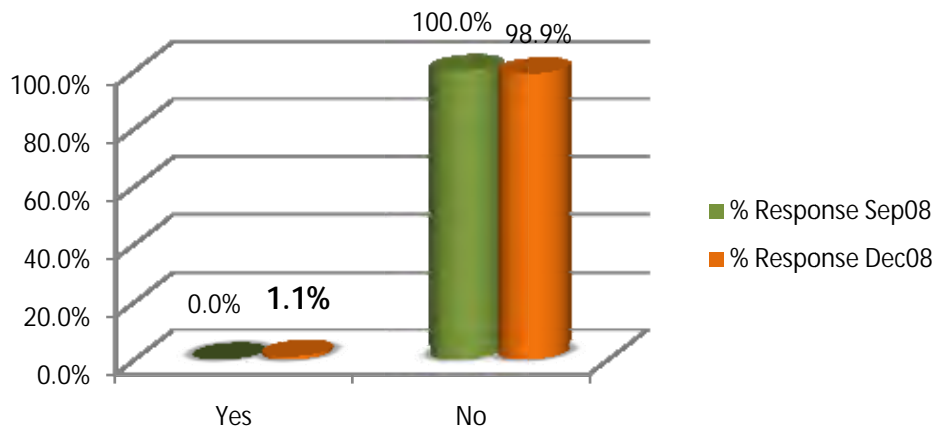
**- Section 1 -  
1.1c Yellow envelope**



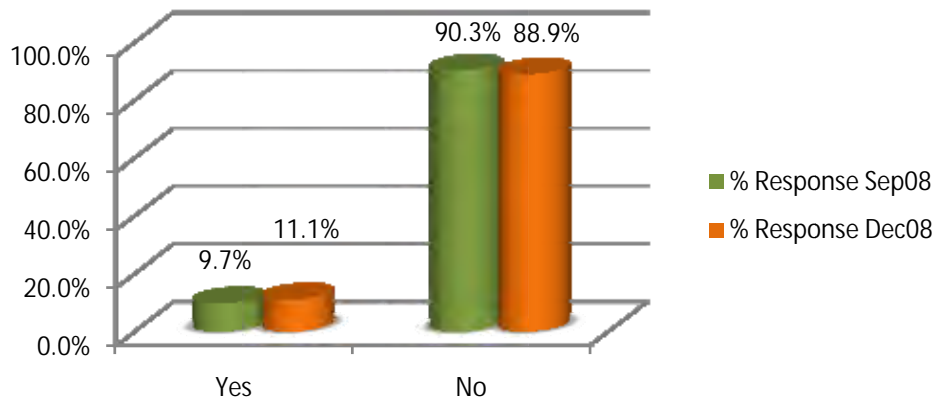
**- Section 1 -  
1.1d Fax from GP**



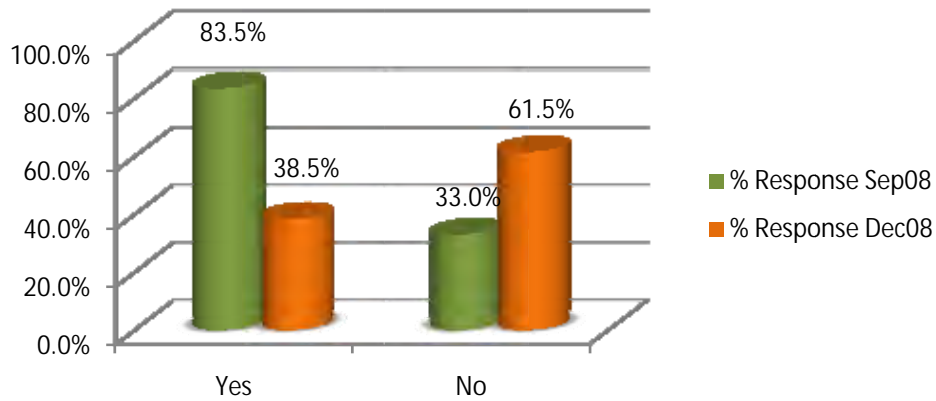
**- Section 1 -  
1.1e Health Record Exchange (EHR)**



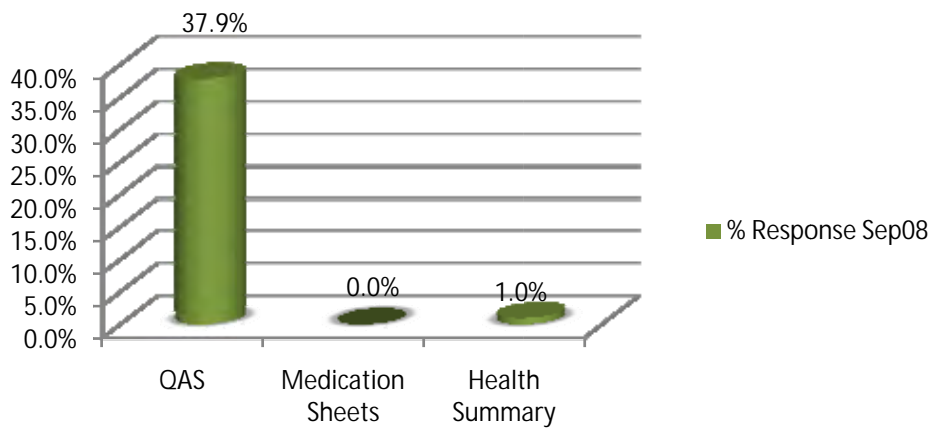
**- Section 1 -  
1.1f Phone Call from RACF**



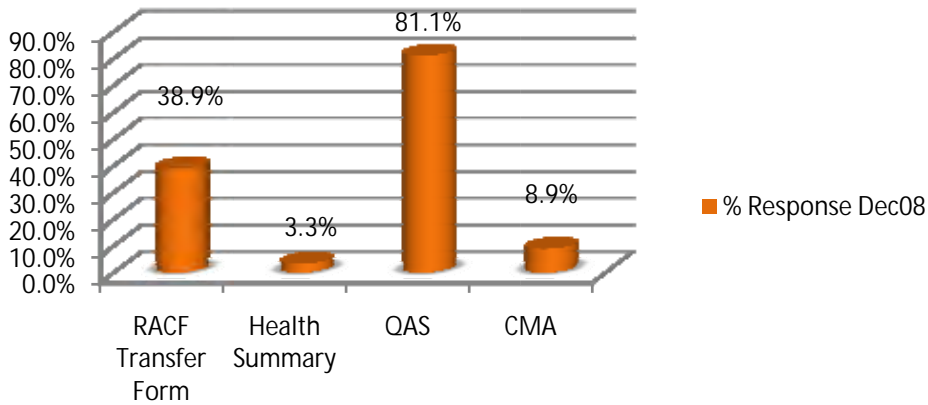
**- Section 1 -  
1.1g Loose paperwork**



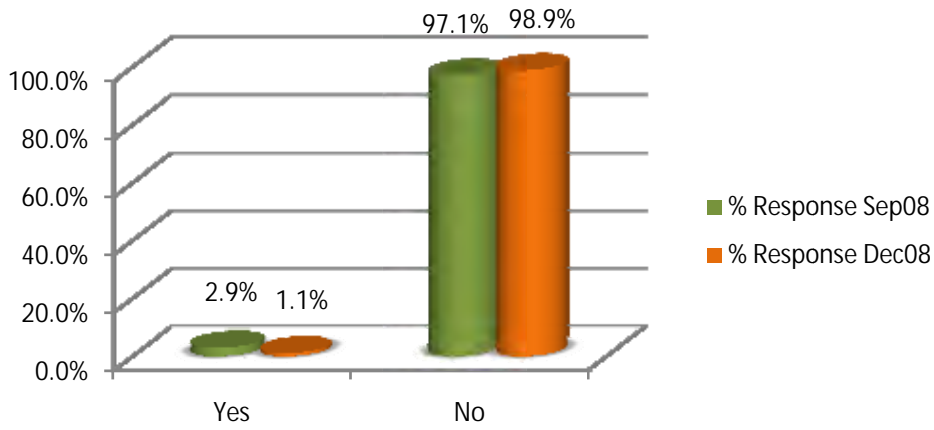
**- Section 1 -  
1.1j Other informant detail**



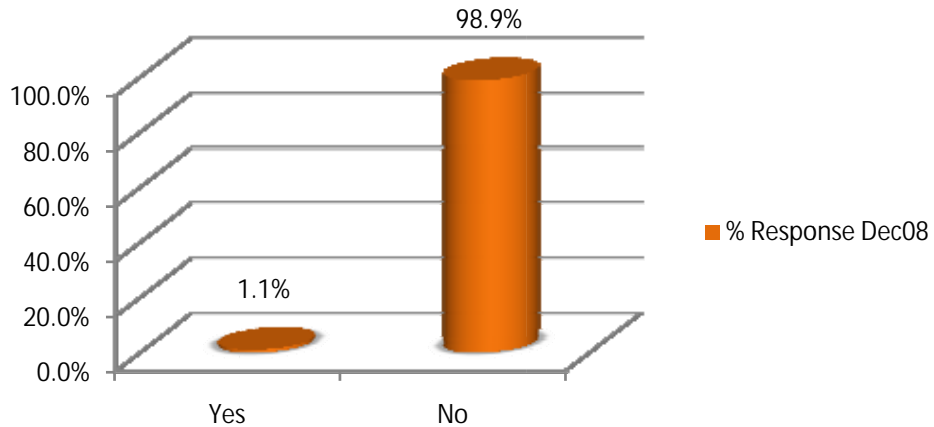
**- Section 1 -  
1.1h Other informant detail**

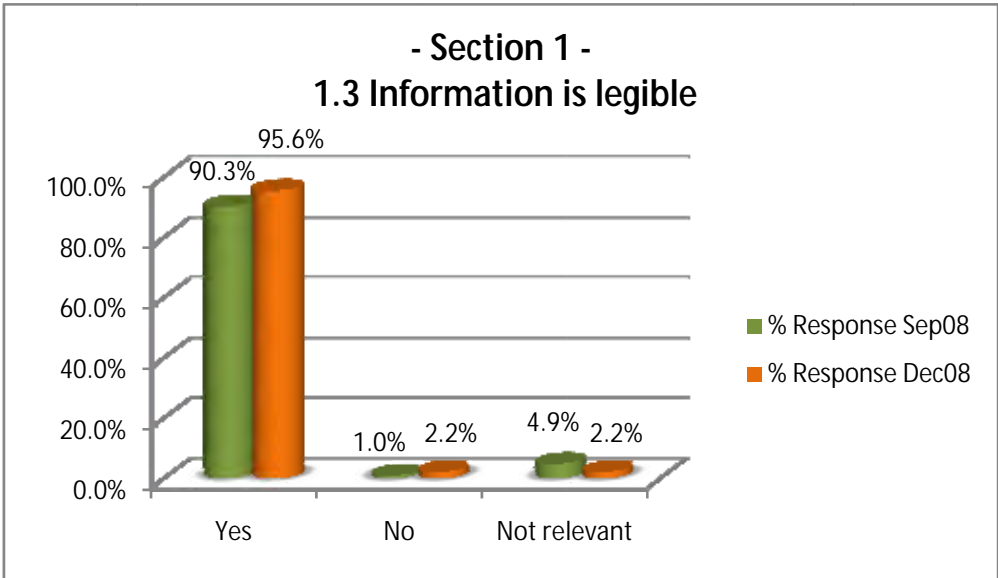
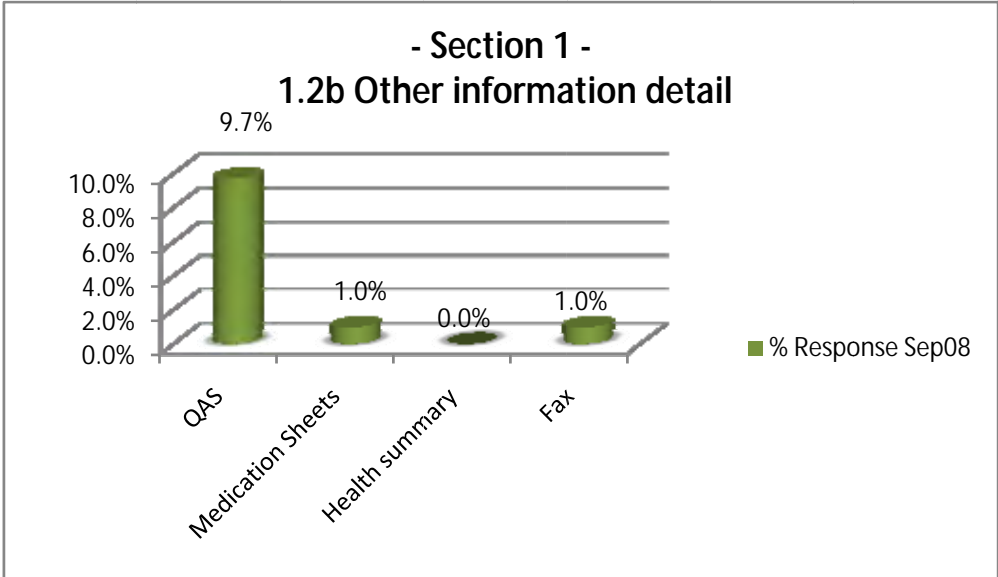
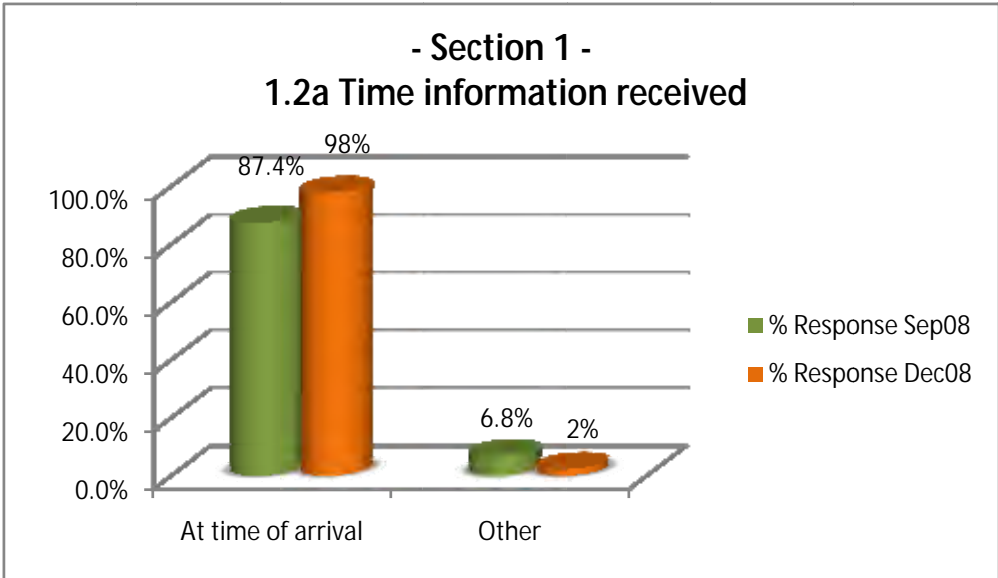


**- Section 1 -  
1.1i Phone Call from GP**

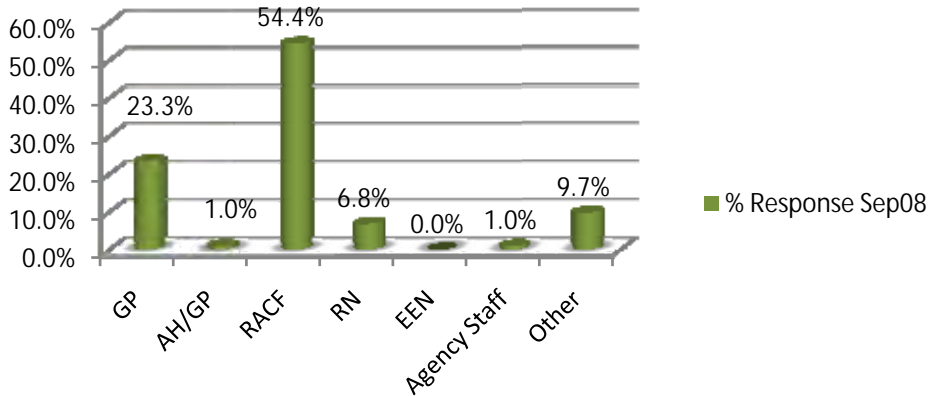


**- Section 1 -  
1.1m Other Informants / Family**

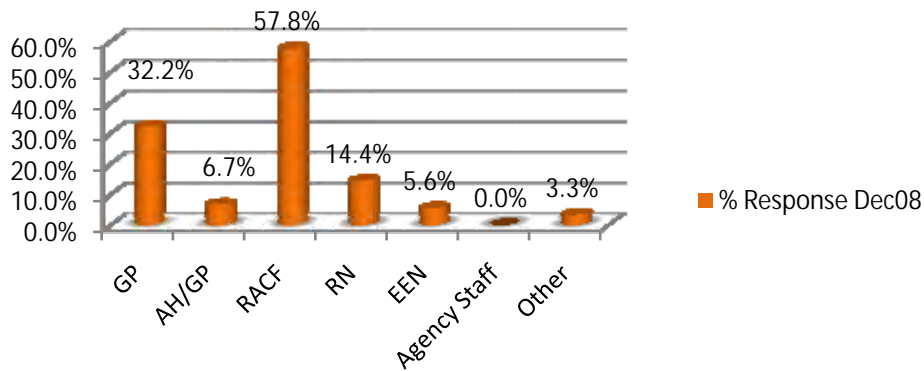




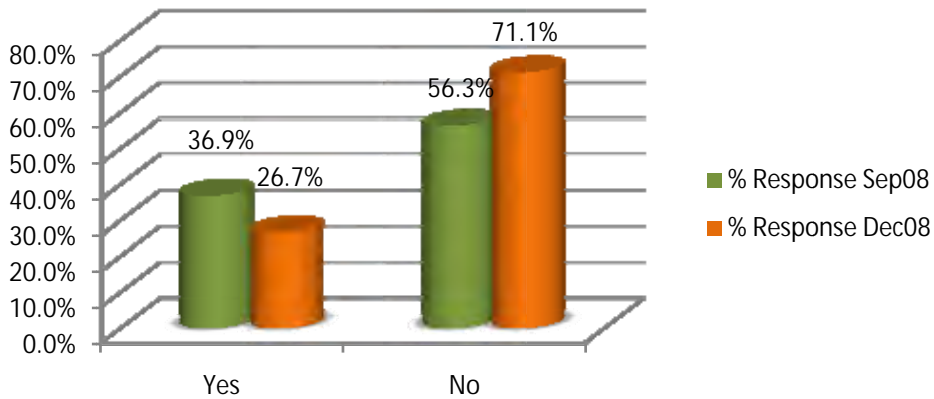
**- Section 1 -  
1.4 Initiator of Transfer**



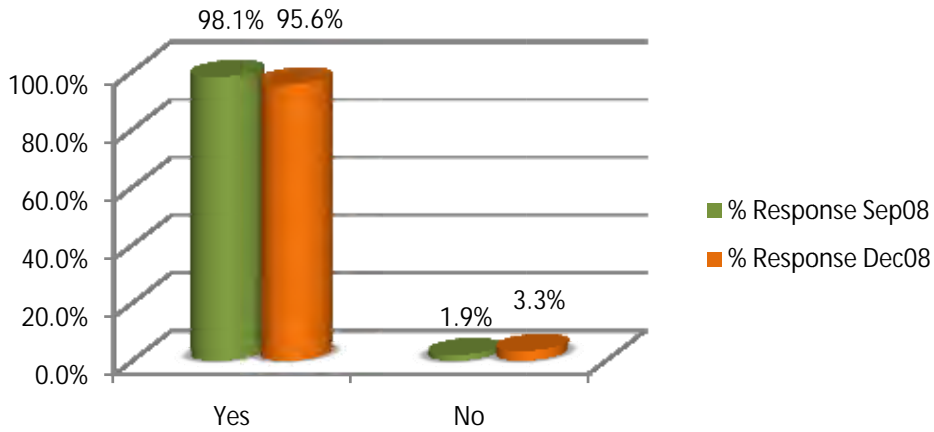
**- Section 1 -  
1.4 Initiator of Transfer across the respondent-  
population**



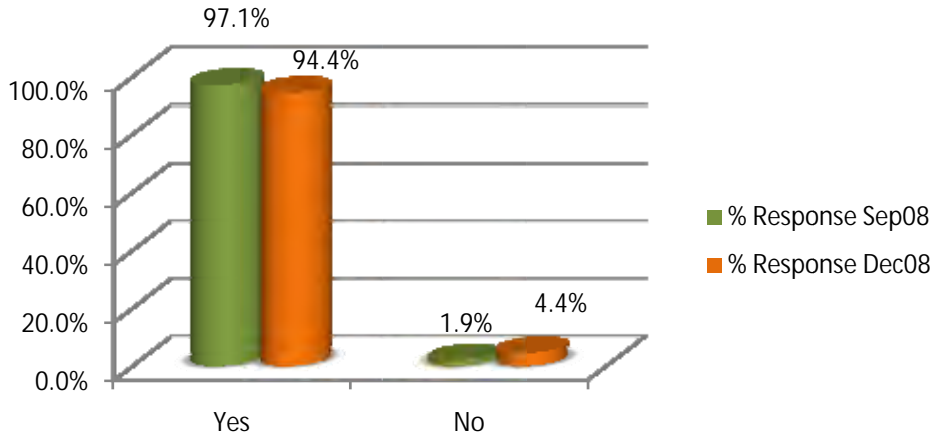
**- Section 1 -  
1.5 Re-presentation to hospital in <= 6 weeks**



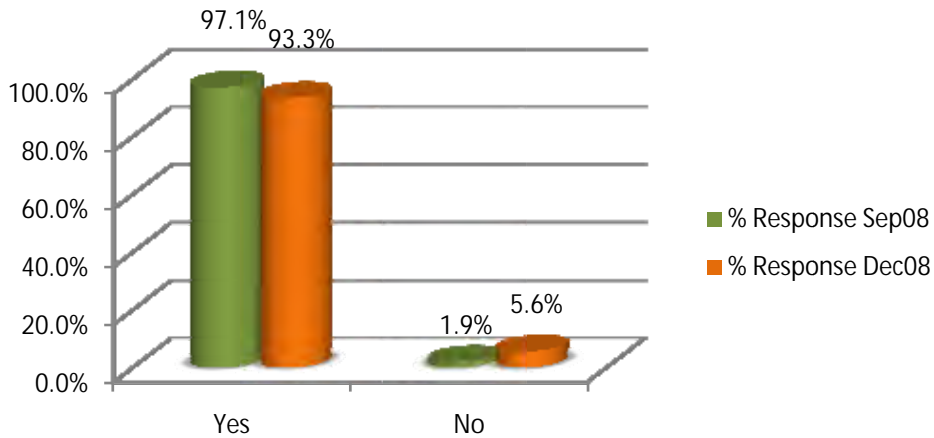
**- Section 2 Standard information -  
2.1 Patient Name**



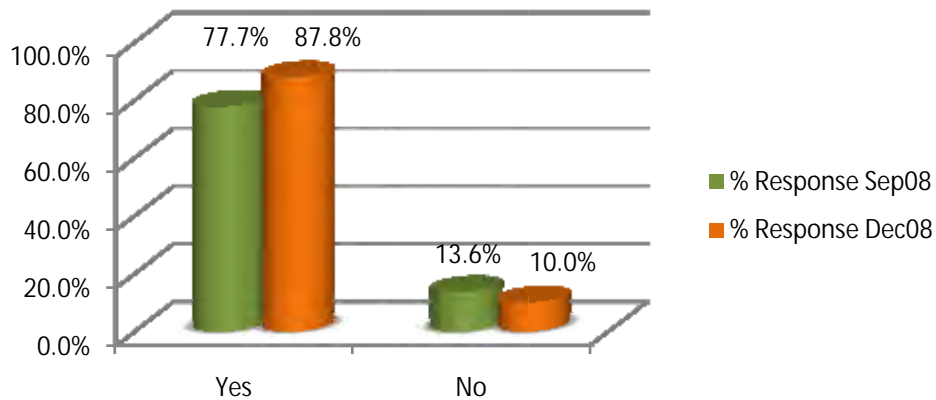
**- Section 2 Standard information -  
2.2 Date of Birth**



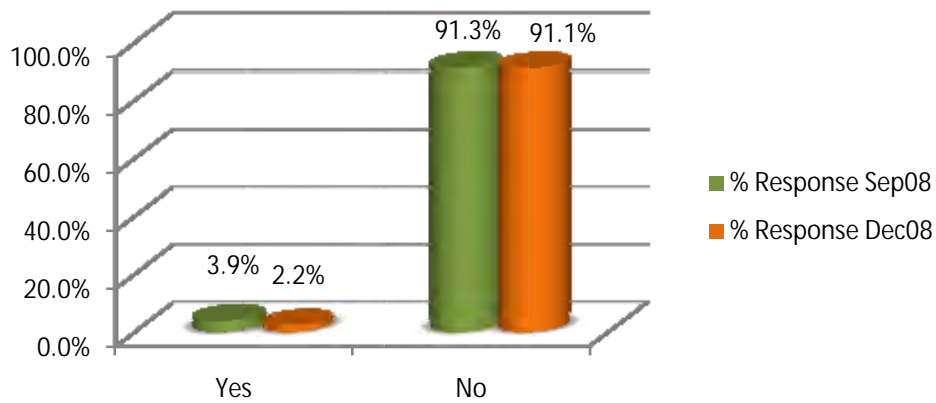
**- Section 2 Standard information -  
2.3 RACF and contact details**



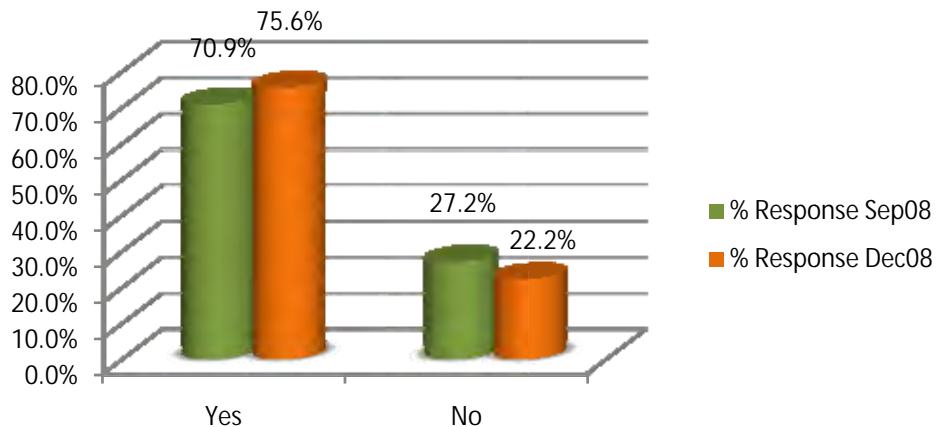
**- Section 2 Standard information -  
2.4 Usual GP and contact details**



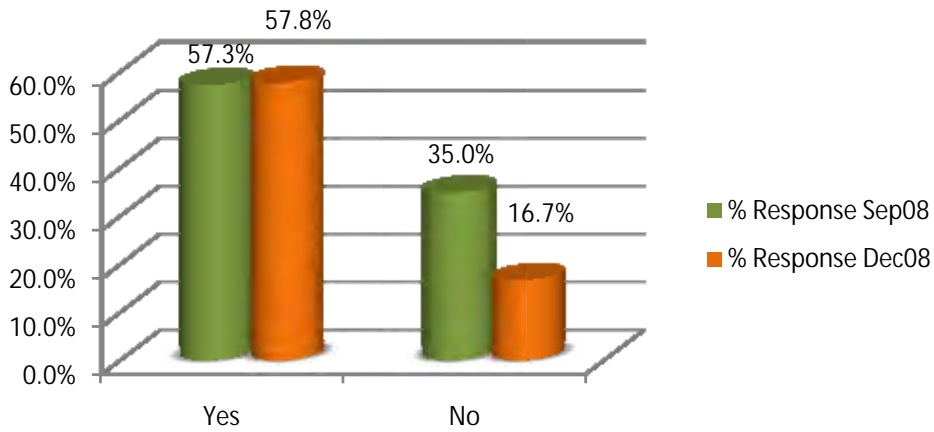
**- Section 2 Standard information -  
2.5 Advance Health Directive / End-of-Life Care Plan**



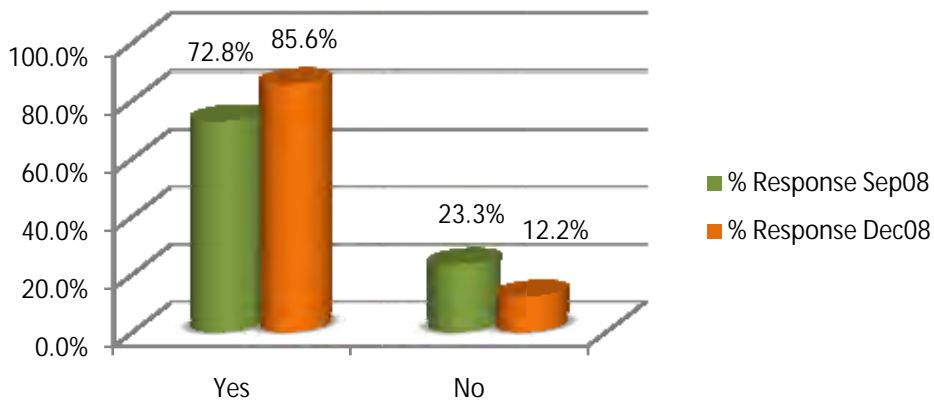
**- Section 2 Standard information -  
2.6 Next-of-Kin / EPOA with contact details**



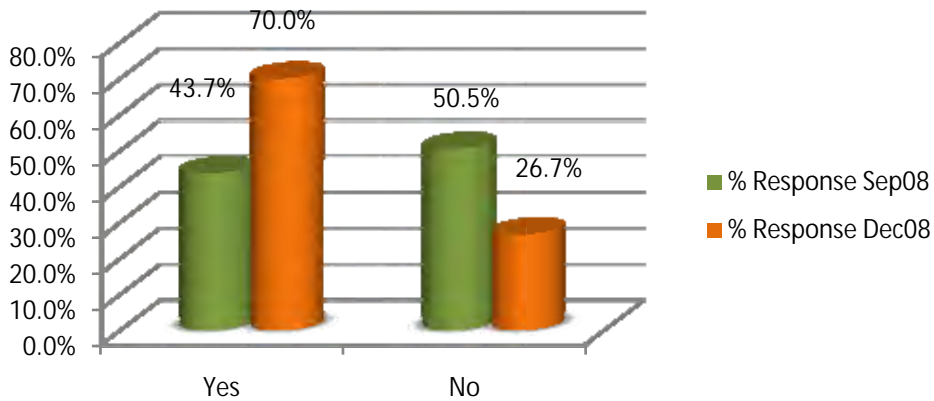
**- Section 2 Standard information -  
2.7 Next-of-Kin notified**



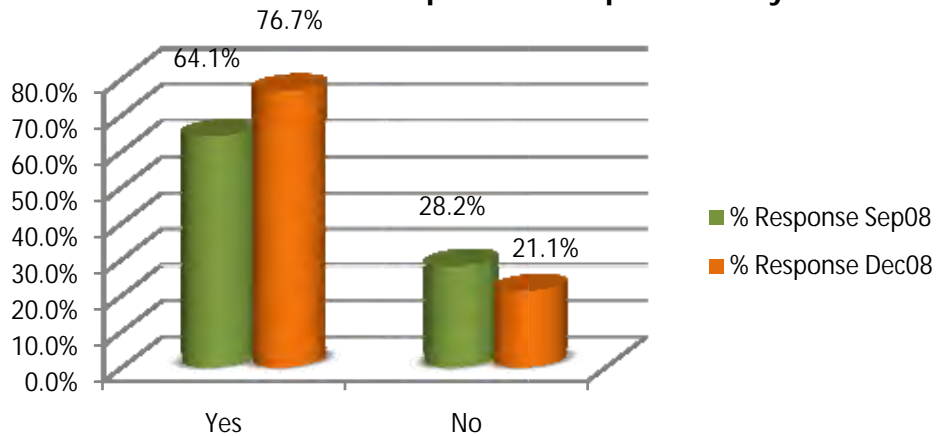
**- Section 2 Clinical Information -  
2.8 Reason for presentation**



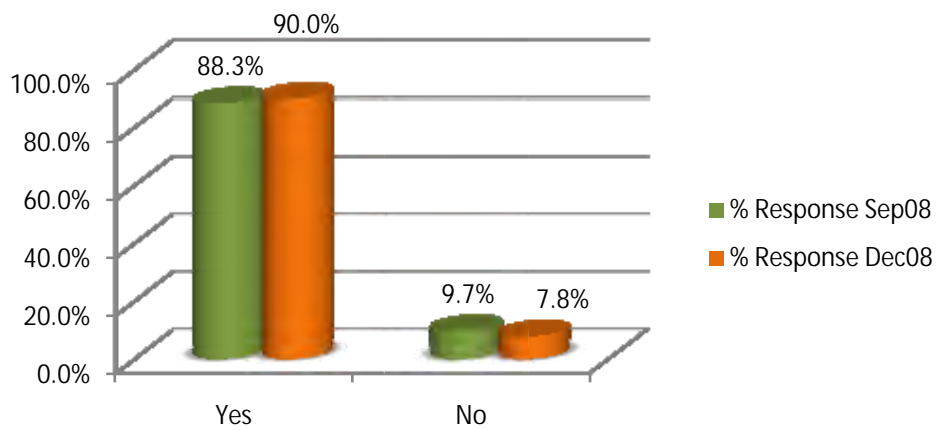
**- Section 2 Clinical Information -  
2.9 Recent observations**



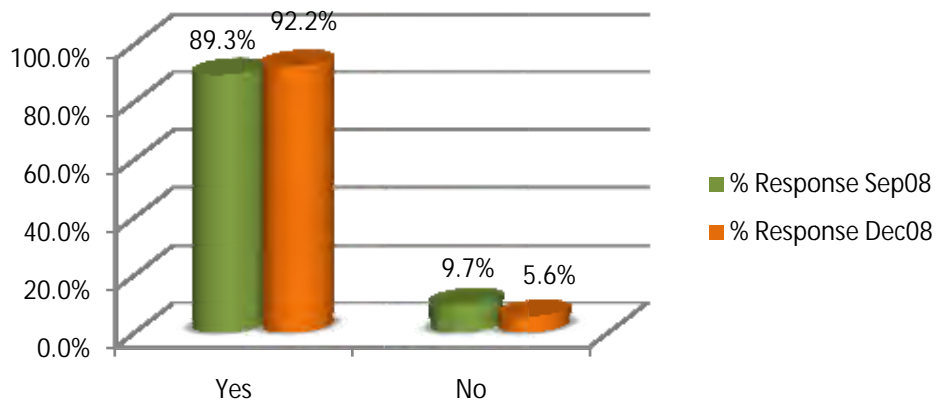
- Section 2 Clinical Information -  
2.10 Usual health problems / past history



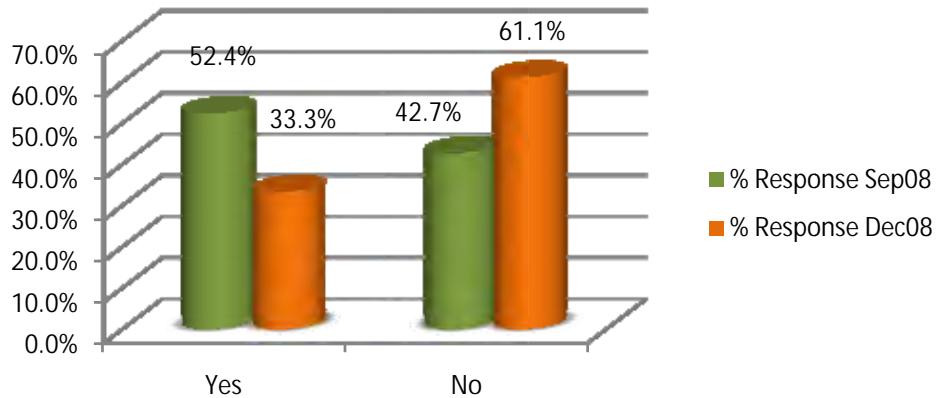
- Section 2 Clinical Information -  
2.11 Medication List



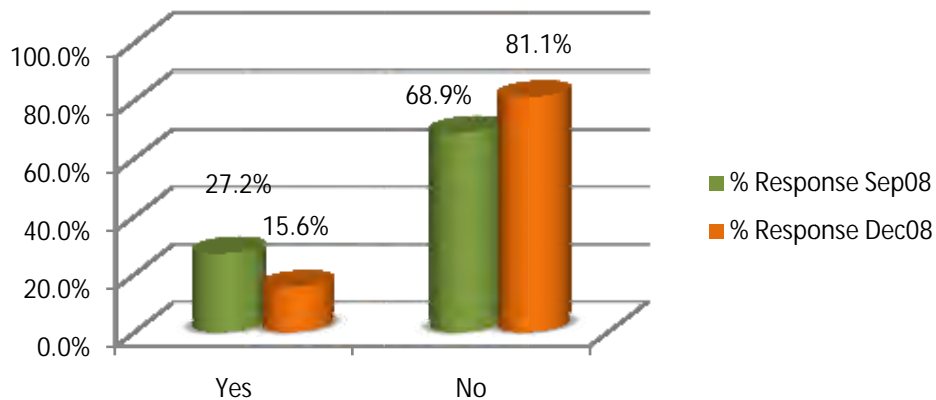
- Section 2 Clinical Information-  
2.12 Allergies



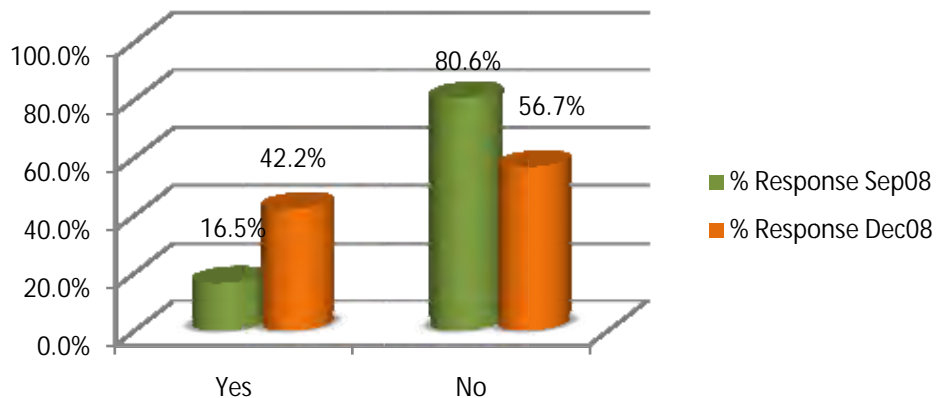
### - Section 2 Clinical Information - 2.13 Diet / Feeding



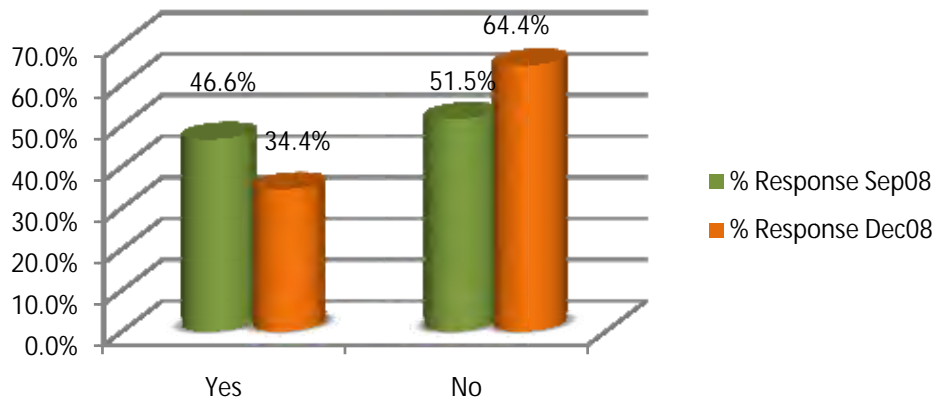
### - Section 2 Usual Functionality - 2.14 CMA or Medical Summary



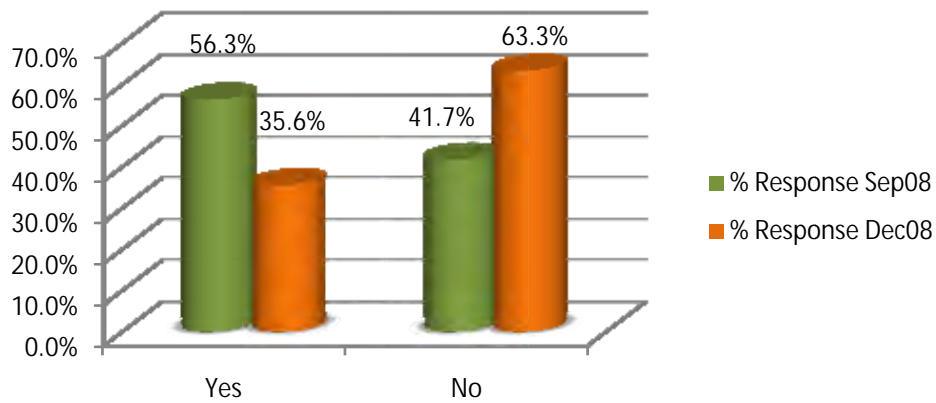
### - Section 2 Usual Functionality - 2.15 MMSE / Mental Status



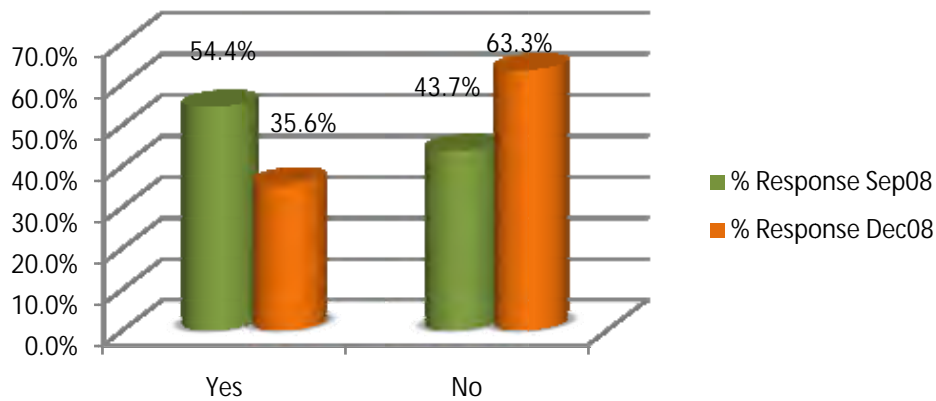
**- Section 2 Usual Functionality -  
2.16 Communication Needs (eg glasses)**



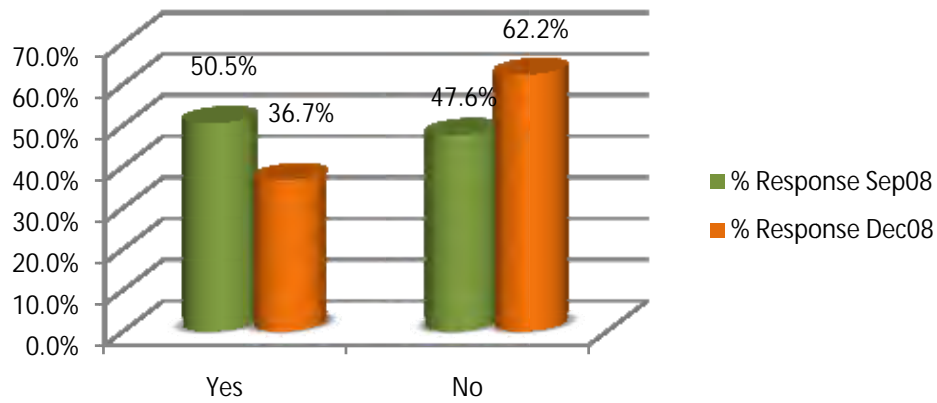
**- Section 2 Usual Functionality -  
2.17 Mobility**



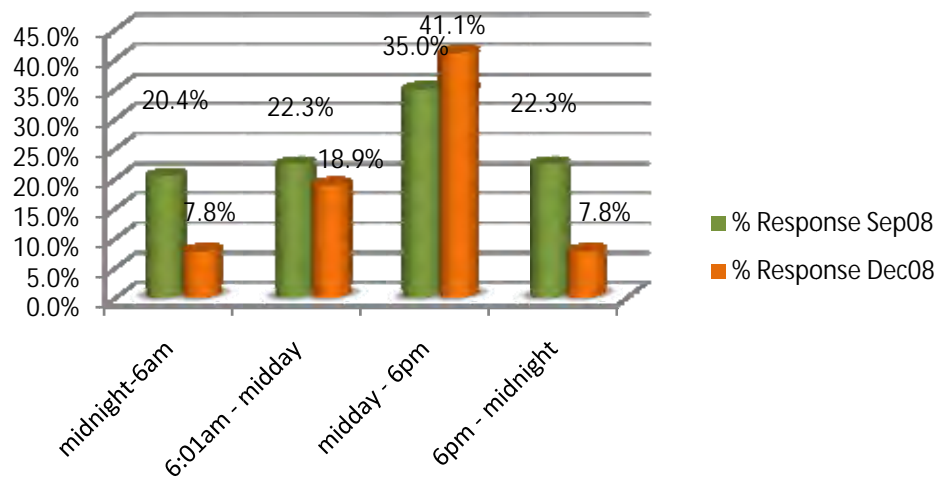
**- Section 2 Usual Functionality -  
2.18 Continence**



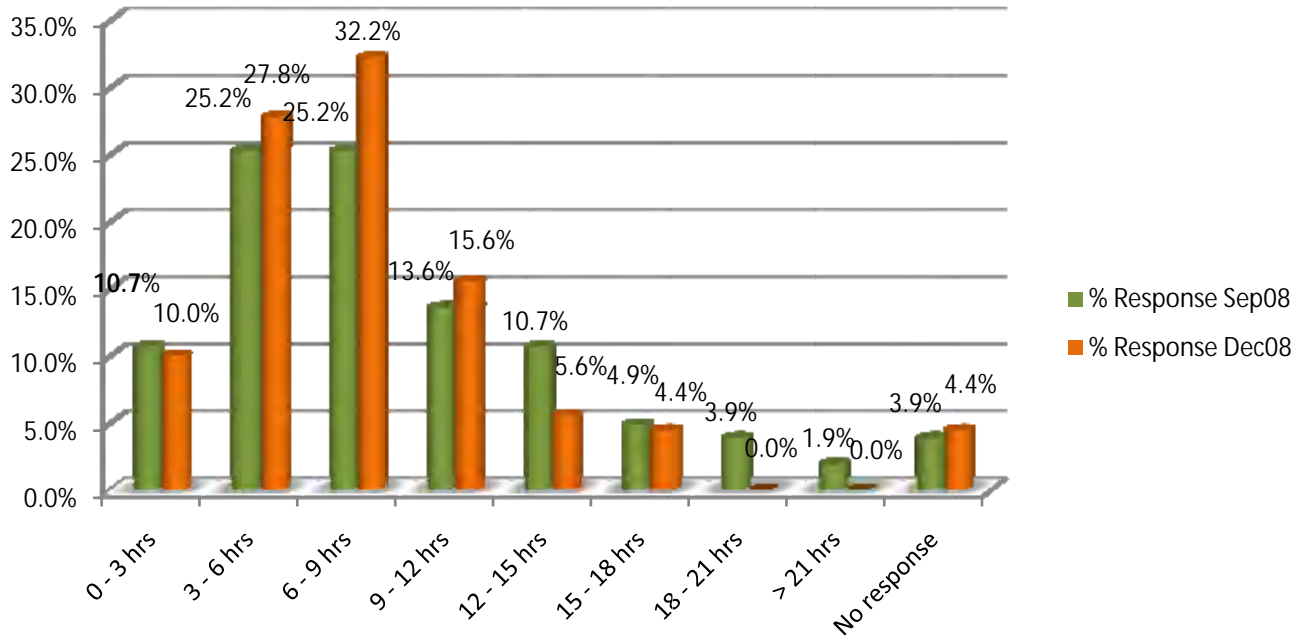
### - Section 2 Usual Functionality - 2.19 Behaviours



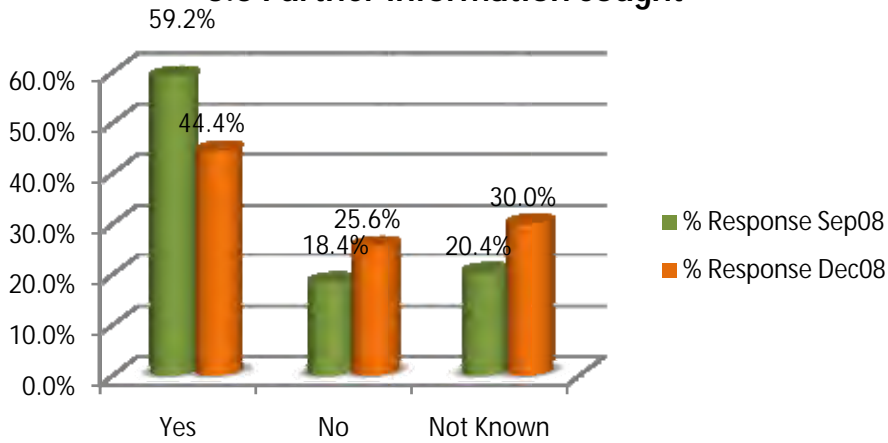
### - Section 3 Clinical Outcomes - 3.1 Time of Presentation



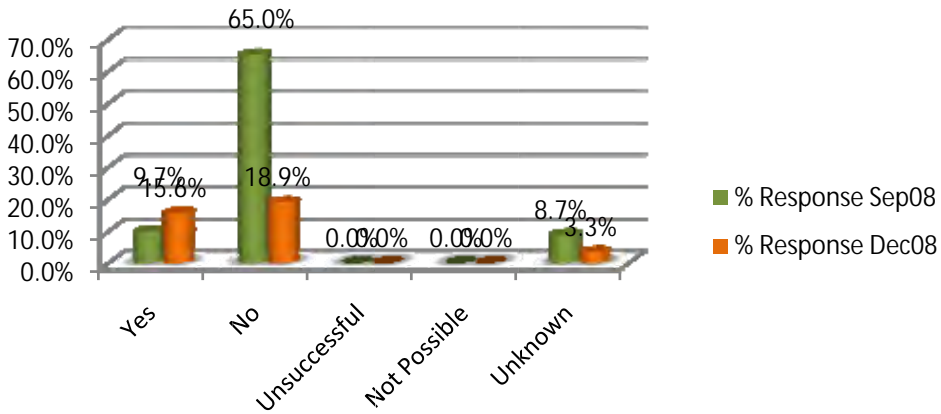
**- Section 3 Clinical Outcomes -  
3.2 Time in DEM**



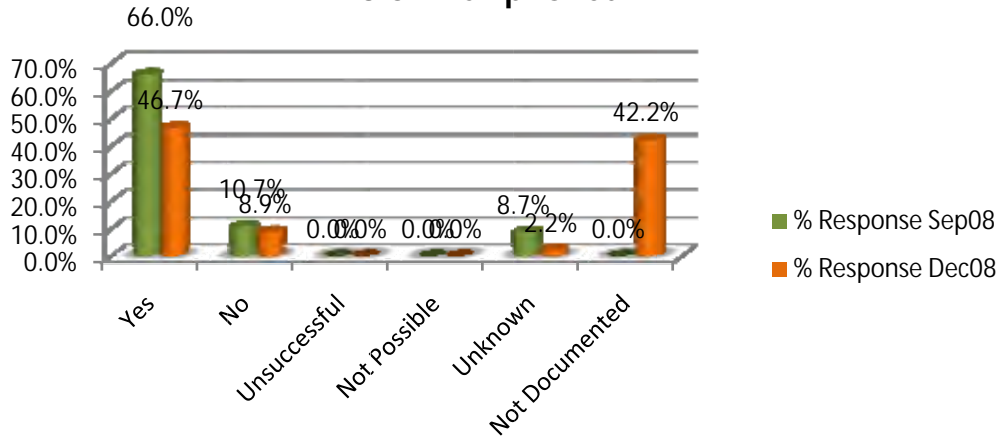
**- Section 3 Clinical Outcomes -  
3.3 Further information sought**



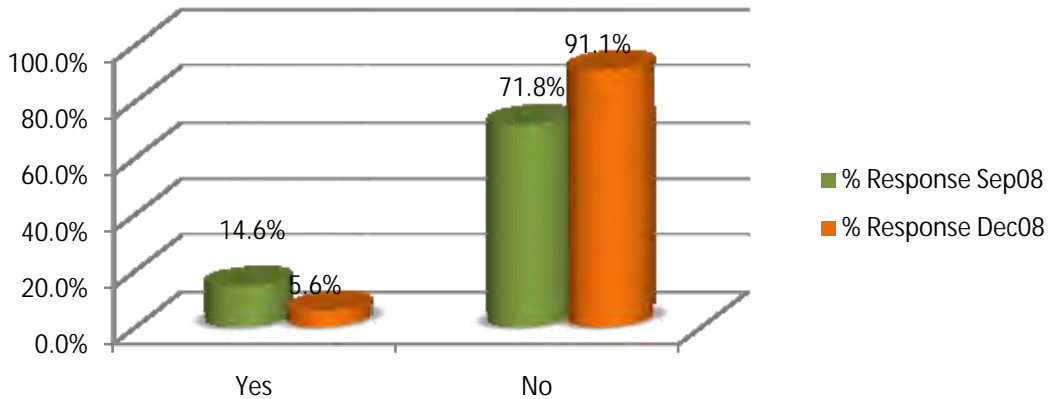
**- Section 3 Clinical Outcomes -  
3.4 GP phoned**



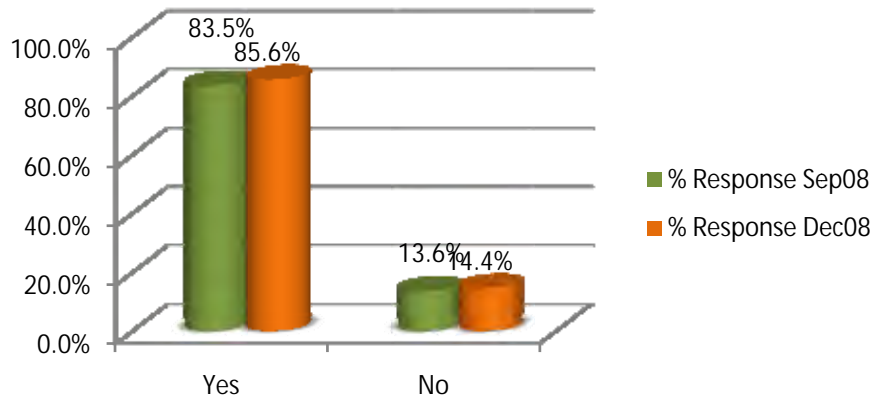
**- Section 3 Clinical Outcomes -  
3.5 RACF phoned**



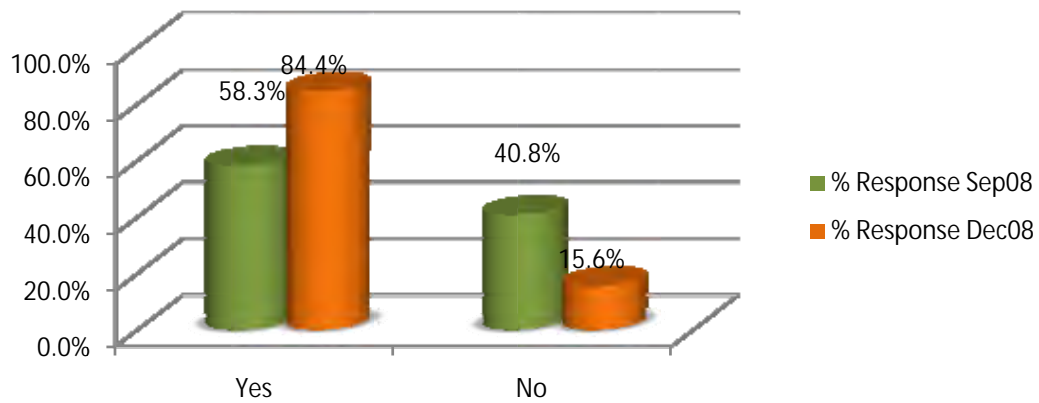
**- Section 3 Clinical Outcomes -  
3.6 Delay in admission due to lack of information**



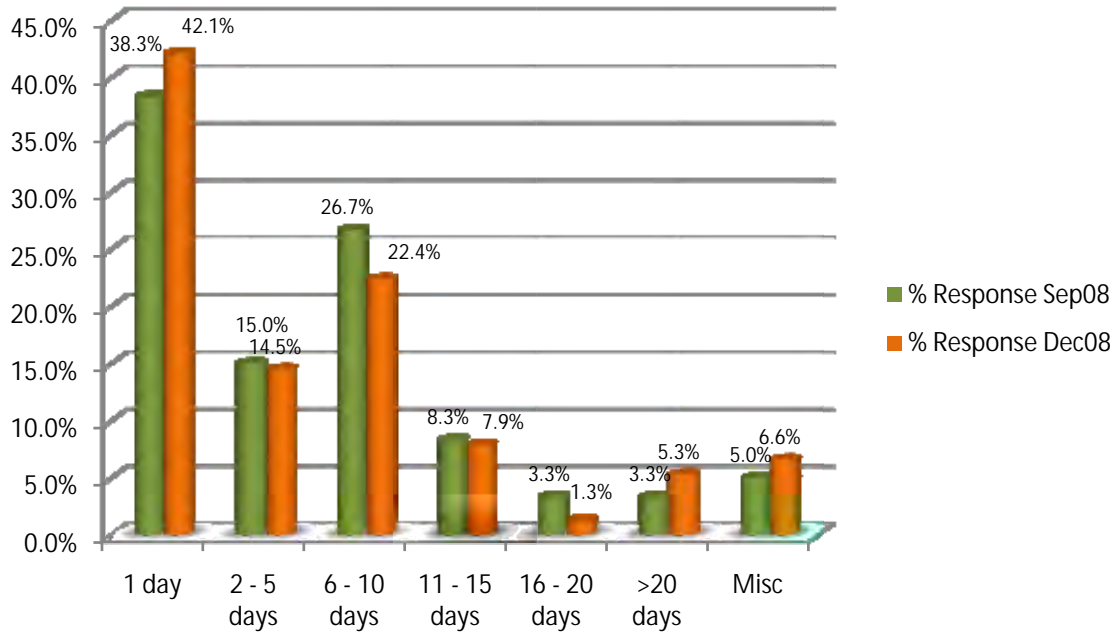
**- Section 3 Clinical Outcomes -  
3.7 Refer to HINH**



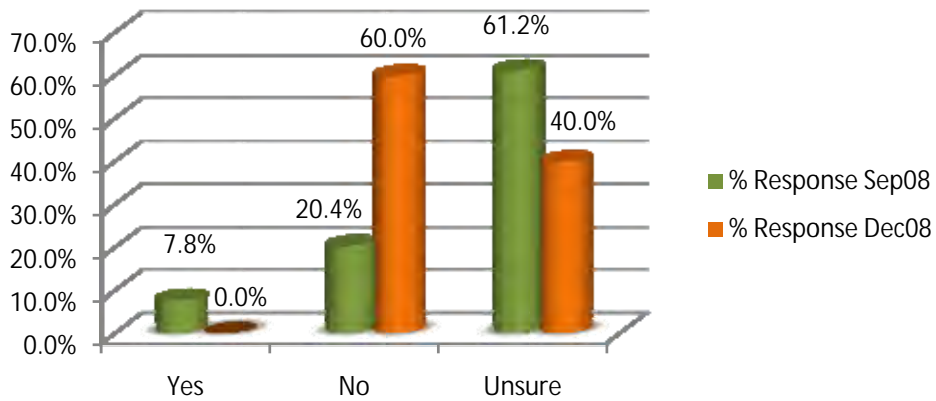
**- Section 3 Clinical Outcomes -  
3.8a Admitted to Hospital**



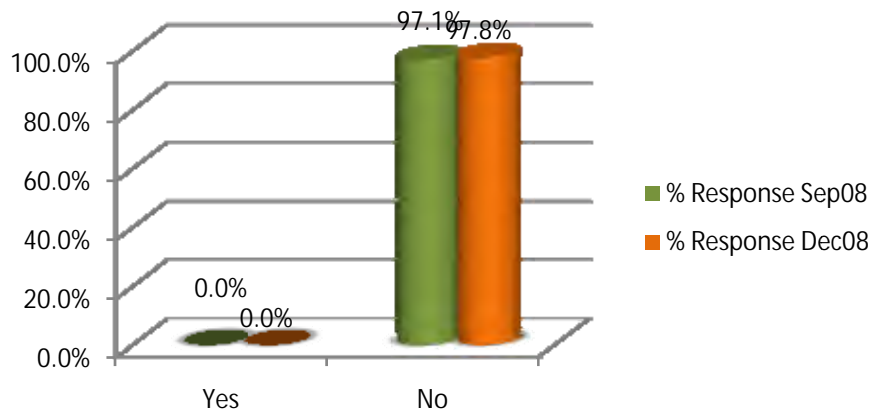
**- Section 3 Clinical Outcomes -  
3.8b Length of Stay**



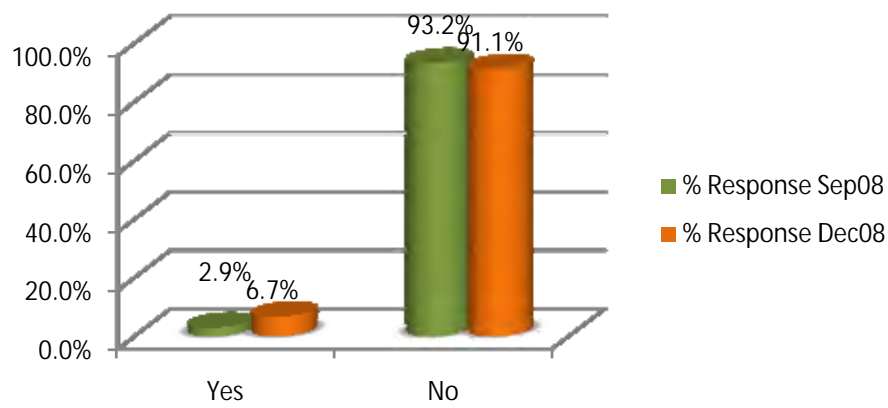
**- Section 3 Clinical Outcomes -  
3.8c Possibly Avoidable Admission**



### - Section 3 Clinical Outcomes - 3.9 Adverse Medication Events

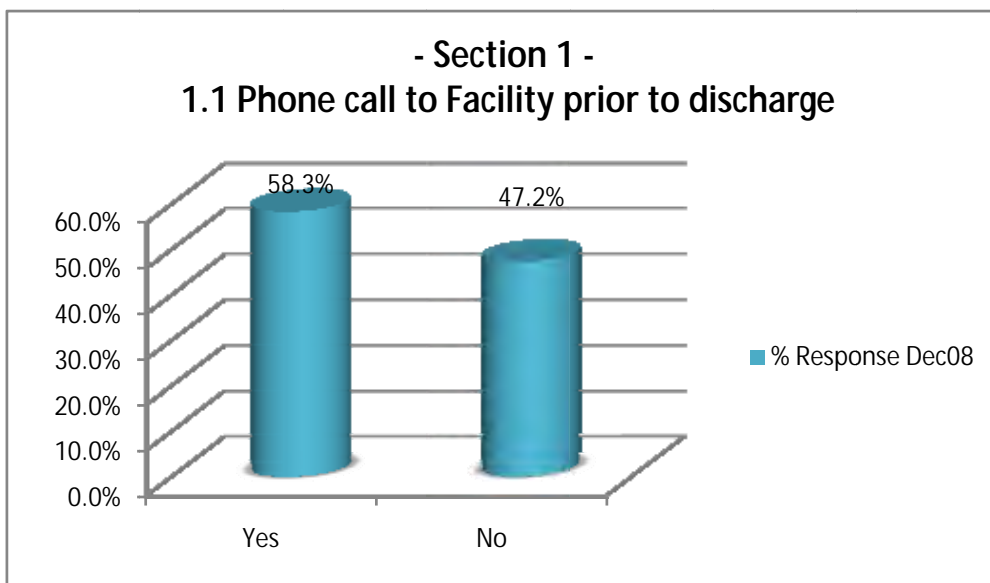
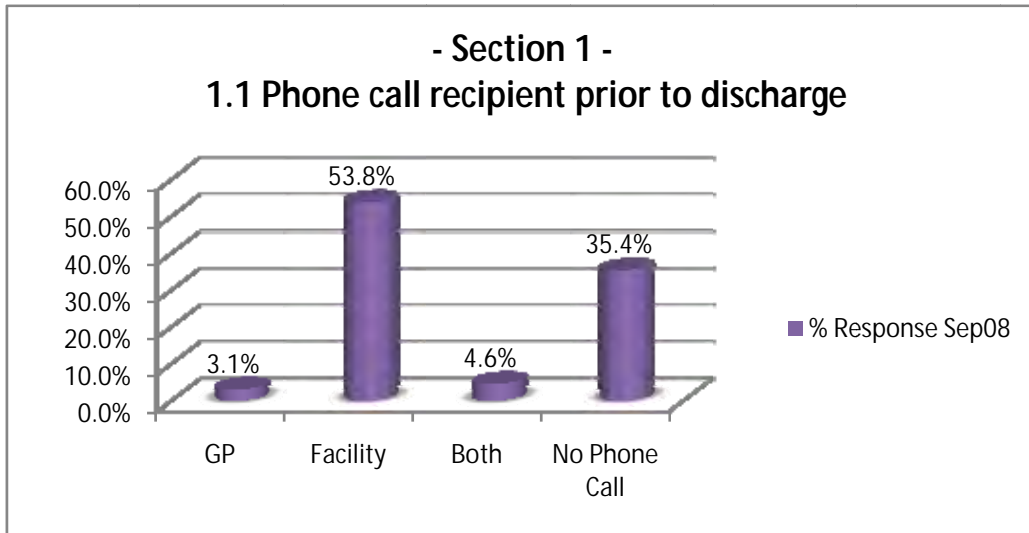


### - Section 3 Clinical Outcomes - 3.10 Adverse Clinical Events

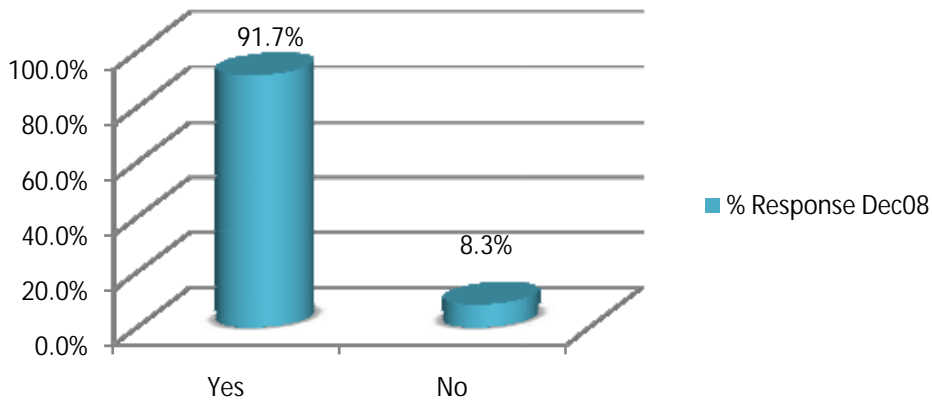


# Attachment 9

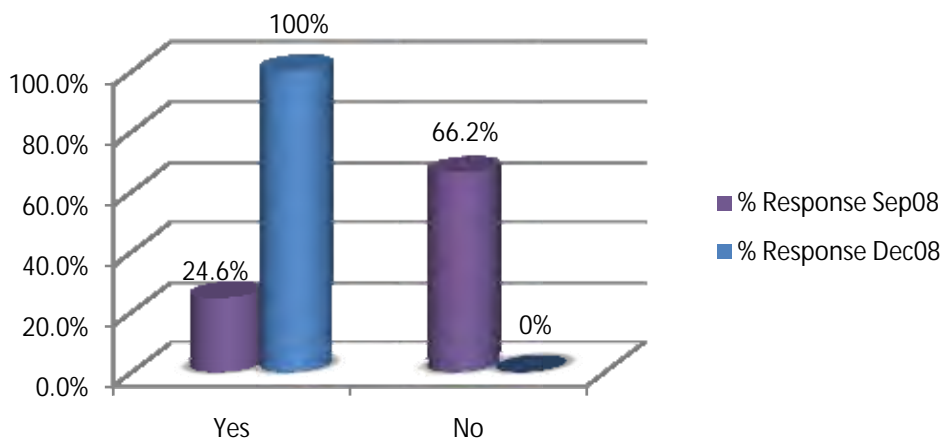
## Discharge information audits



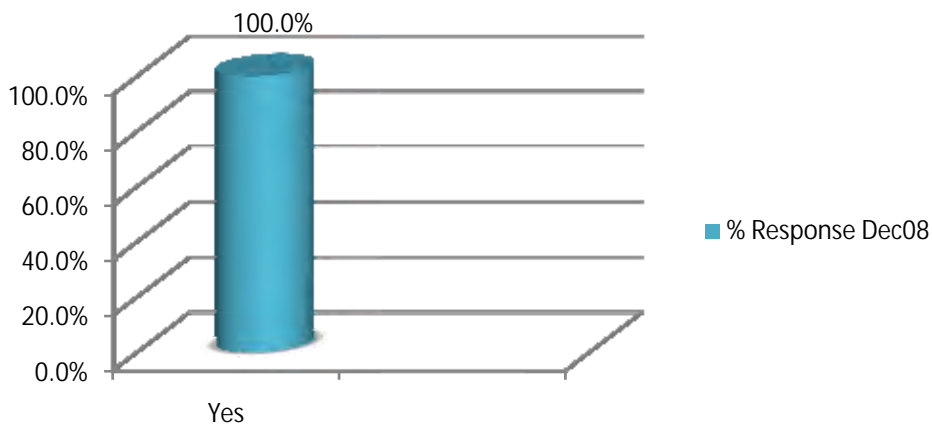
**- Section 1 -**  
**1.2 Summary Information sent with patient**



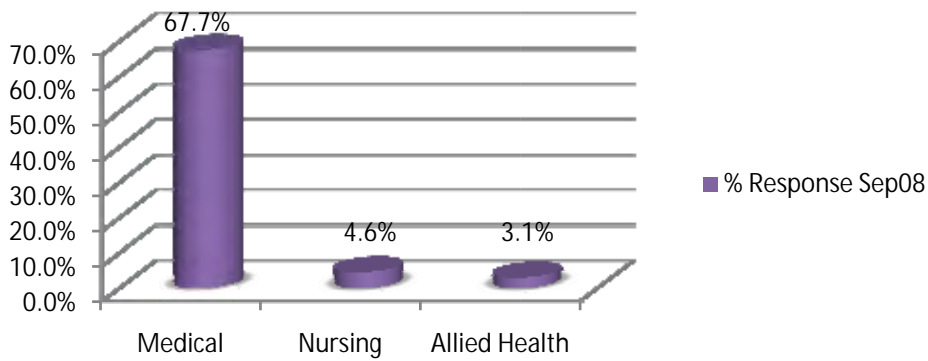
**- Section 1 -**  
**1.3 ~ Summary Information sent to facility at a later date**



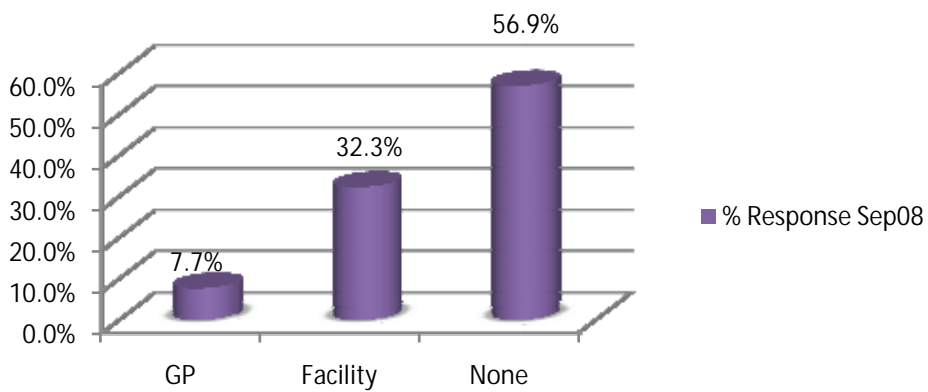
**- Section 1 -**  
**1.3 Summary Information received at a later date**



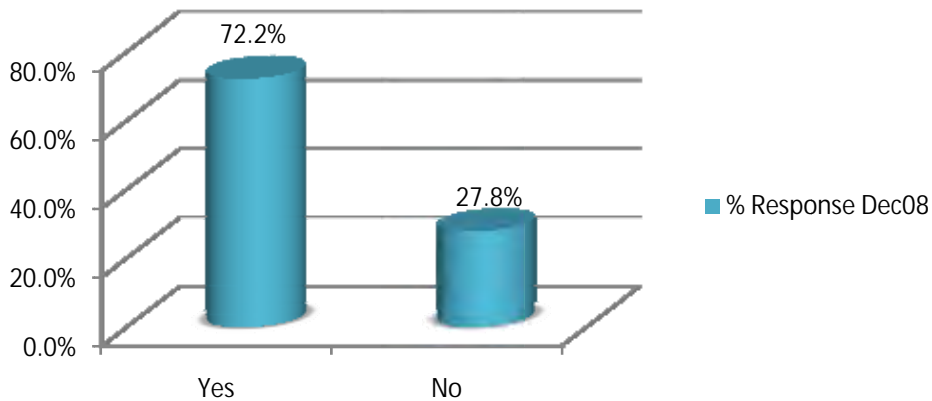
**- Section 1 -**  
**1.4 ~ Primary Summary Information sent with patient**

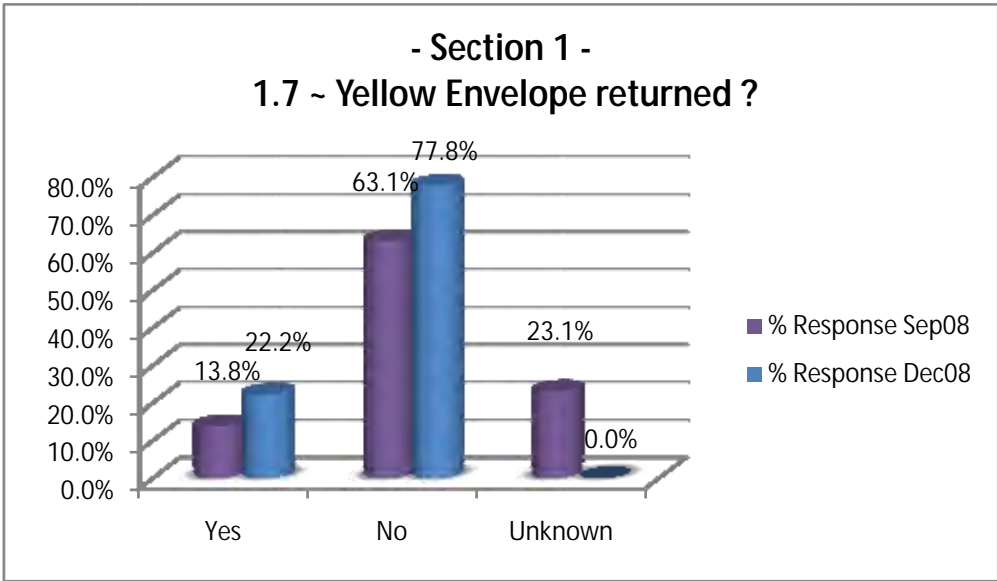
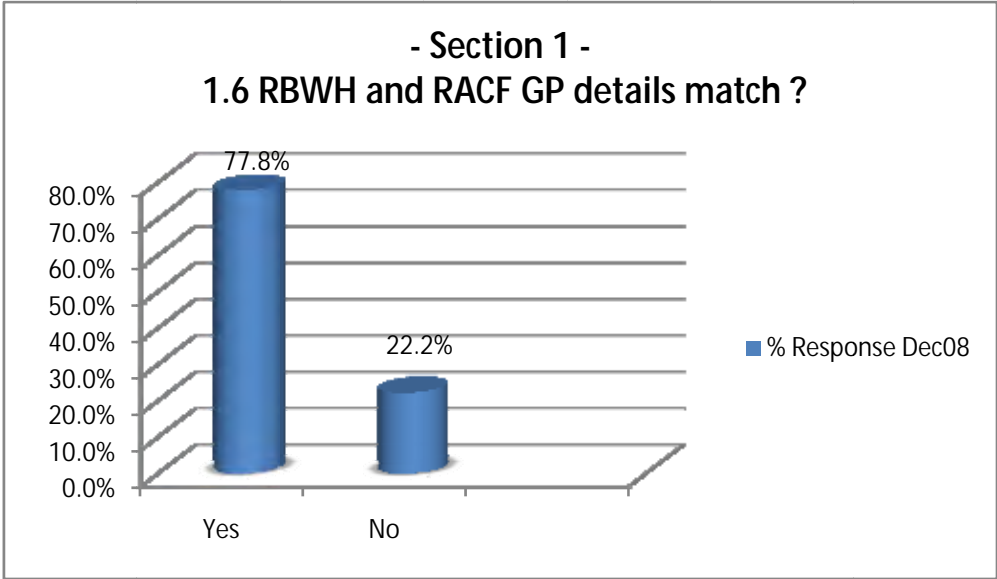
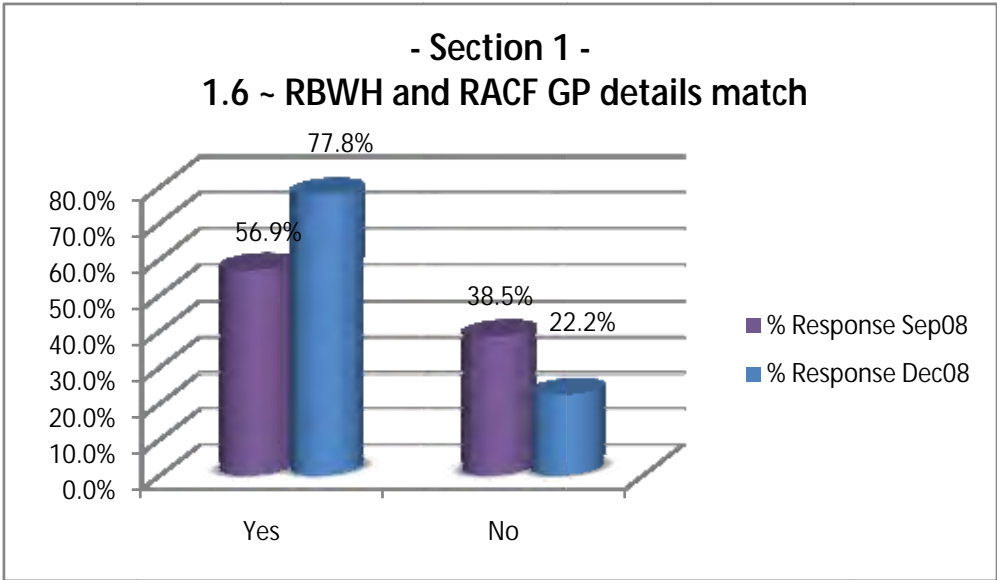


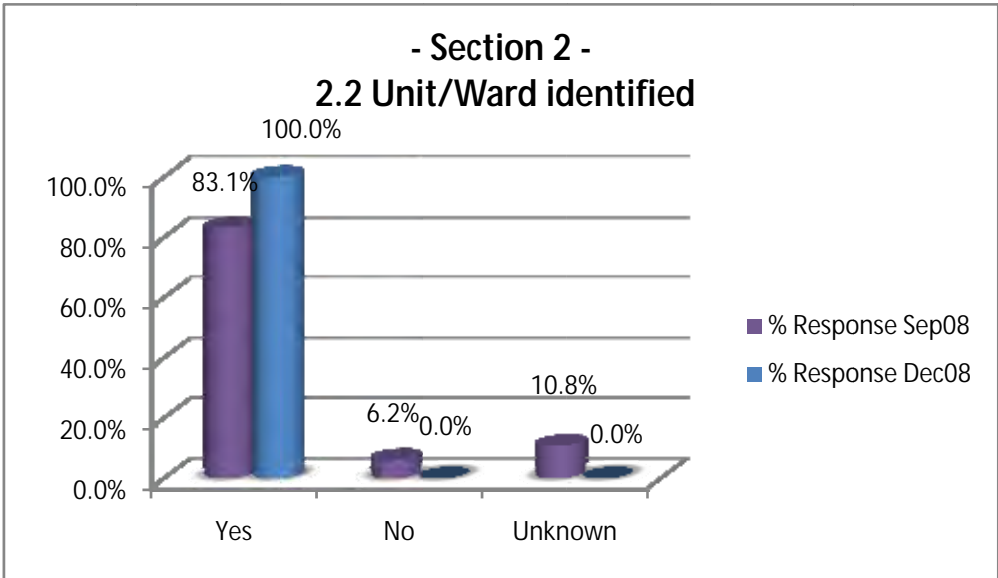
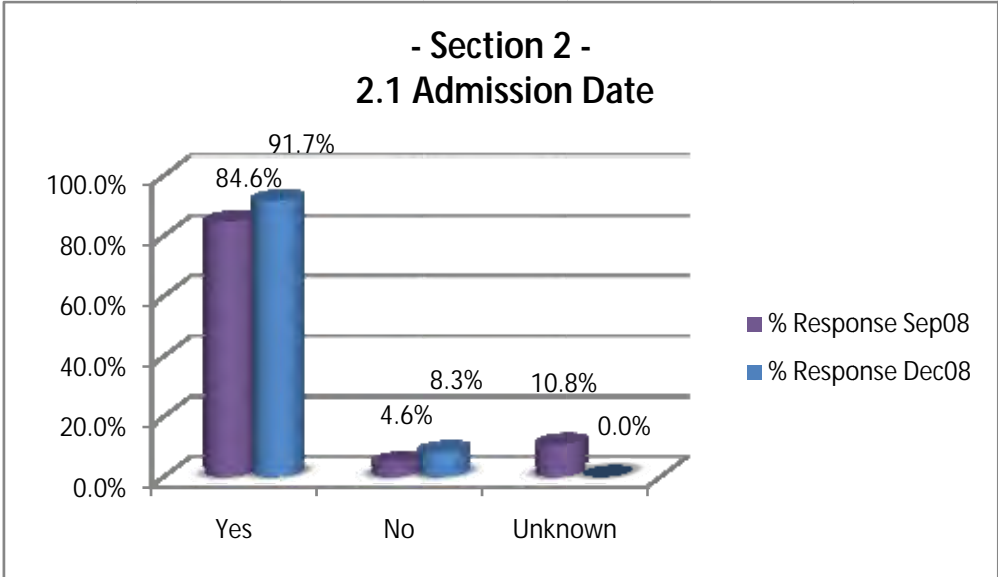
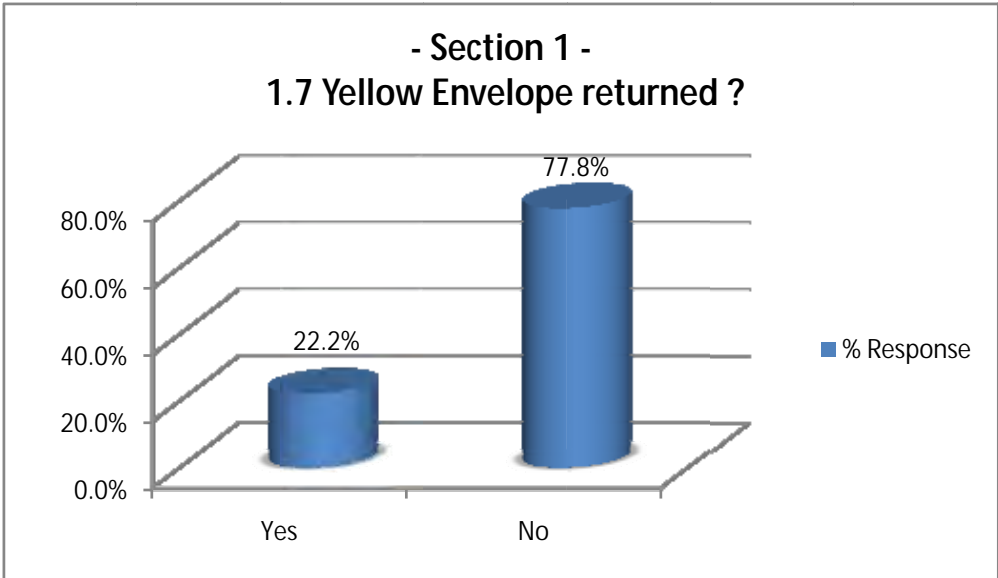
**- Section 1 -**  
**1.5 ~ Medications & List at time of discharge**



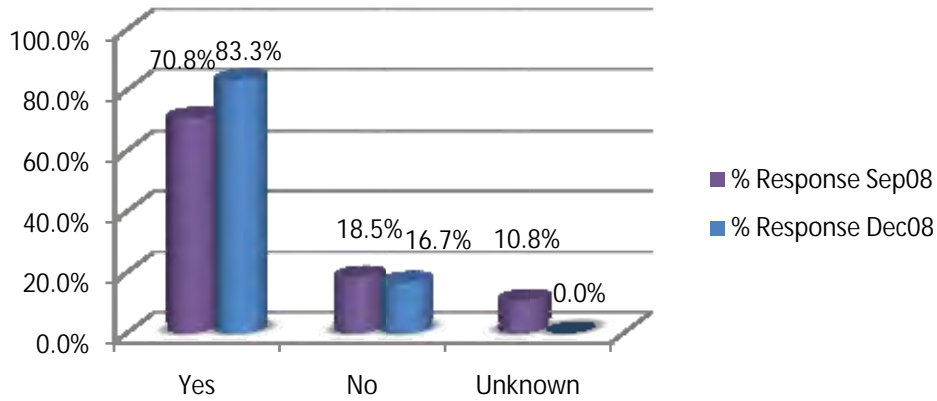
**- Section 1 -**  
**1.5 Medications & List at time of discharge**



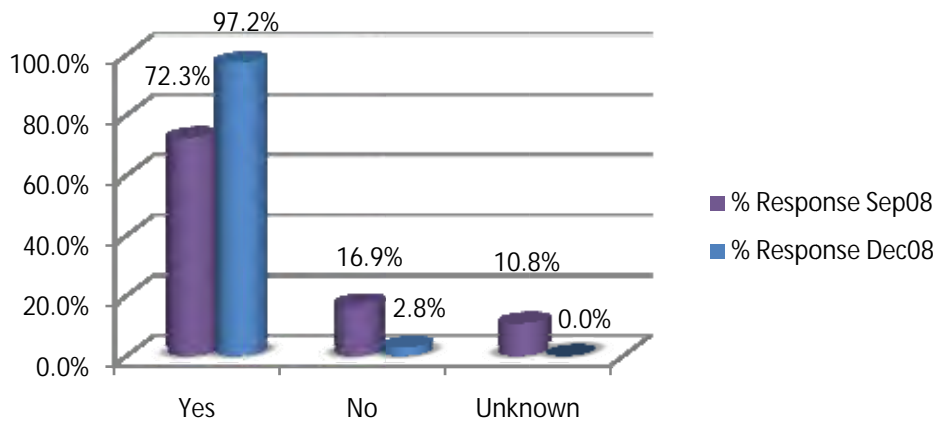




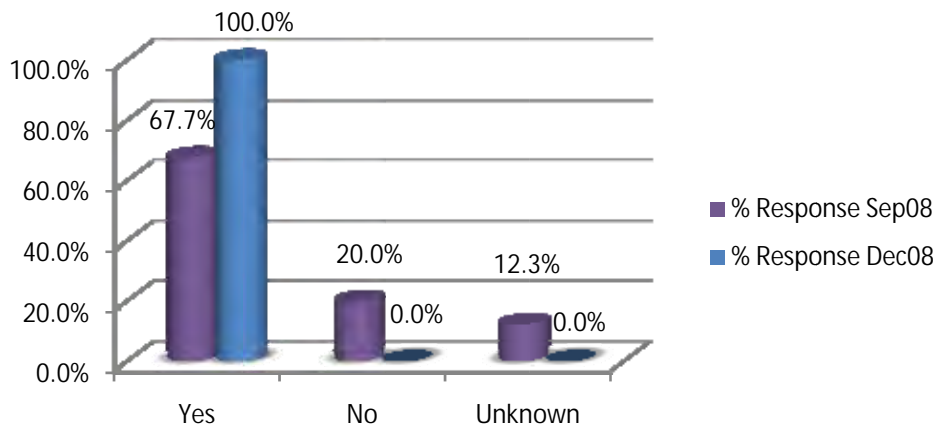
### - Section 2 - 2.3 Discharge Date



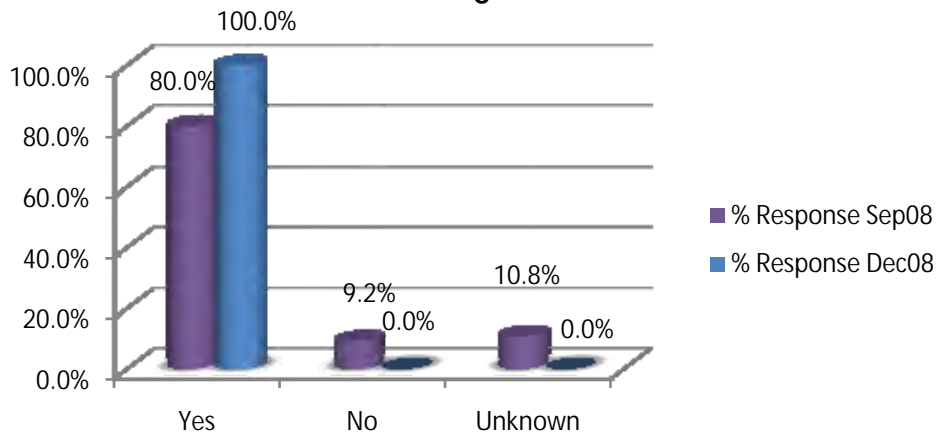
### - Section 2 - 2.4 Contact Dr at RBWH



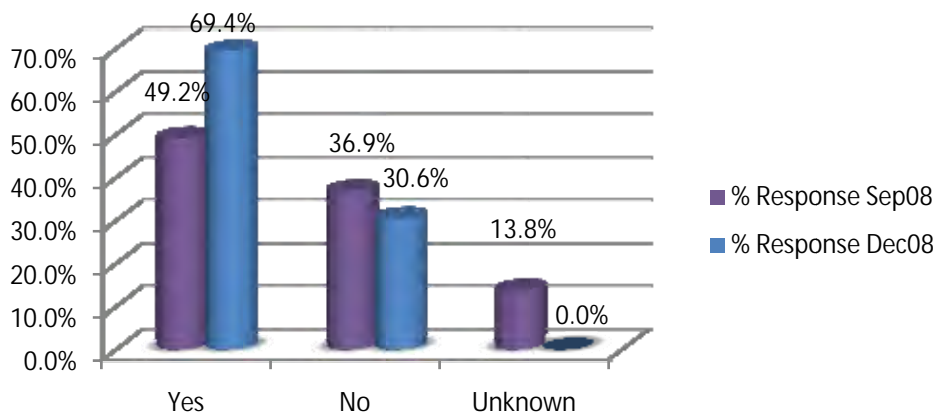
### - Section 2 - 2.5 Consultant Name



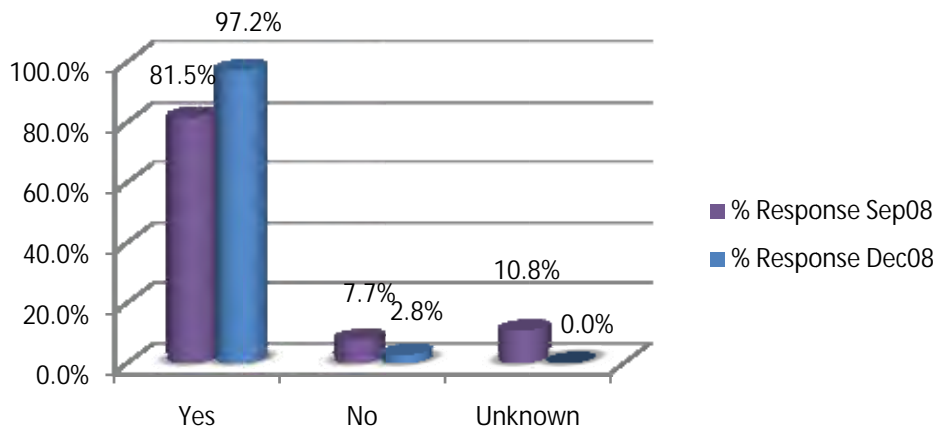
### - Section 2 - 2.6 Diagnosis

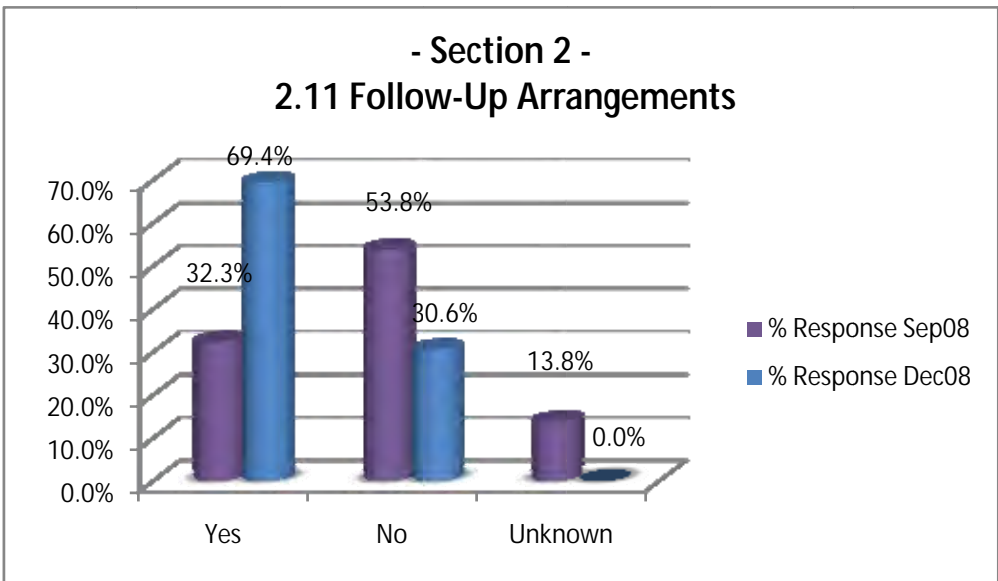
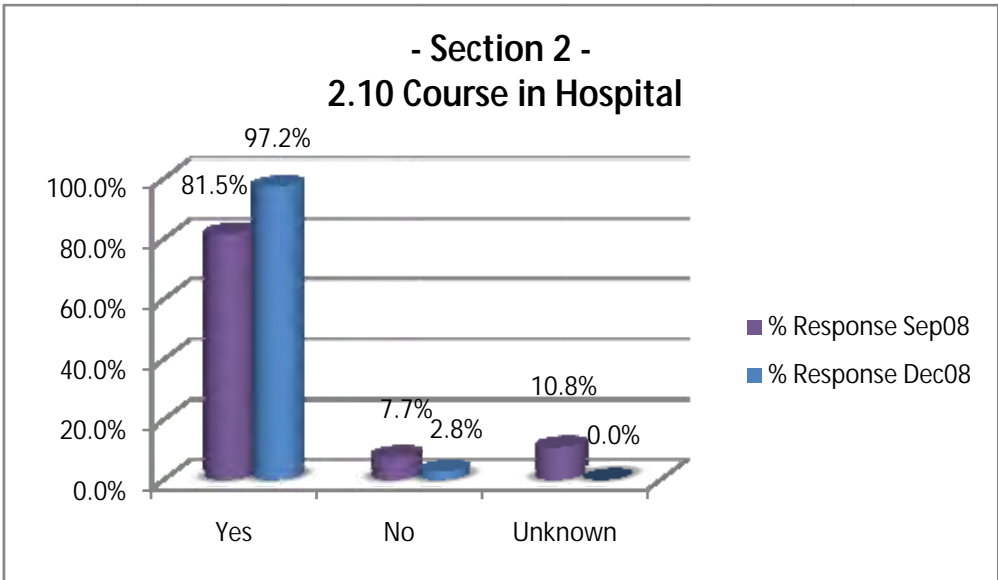
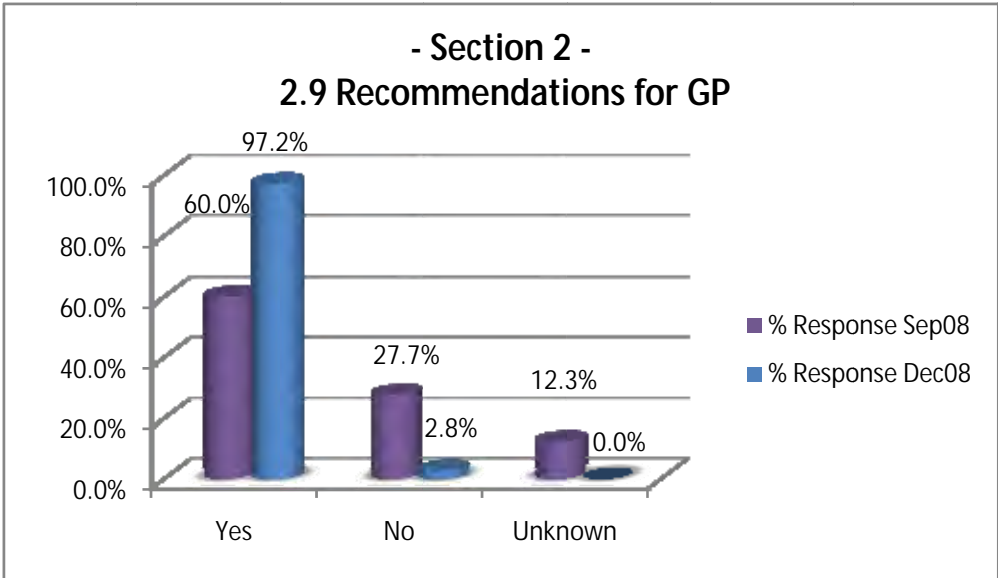


### - Section 2 - 2.7 Medication List

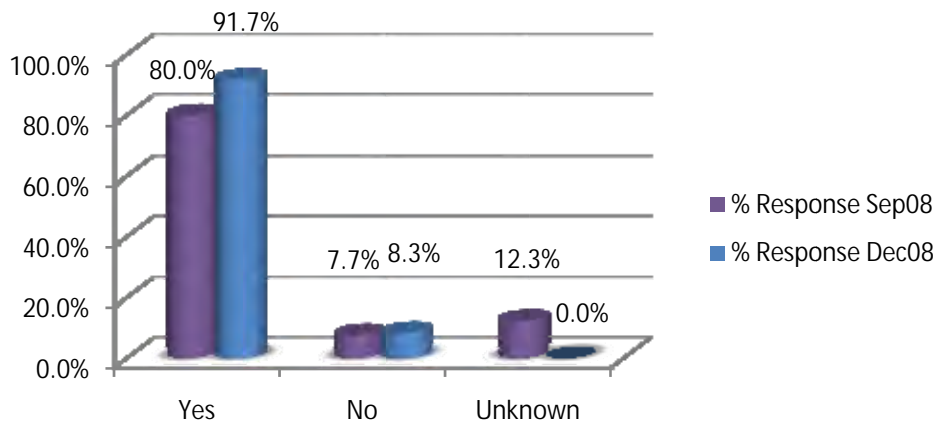


### - Section 2 - 2.8 Procedures

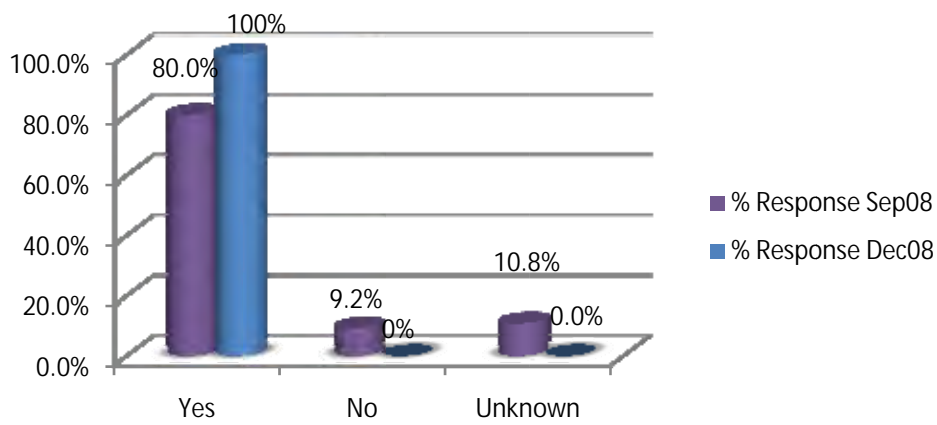




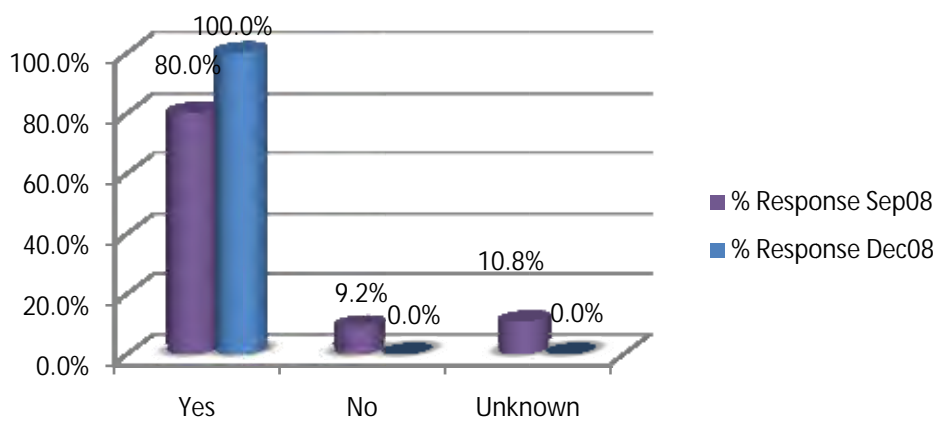
### - Section 2 - 2.12 Investigations



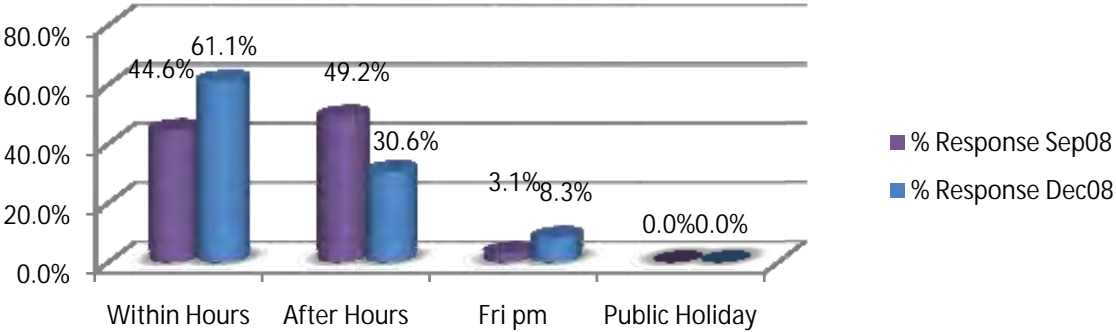
### - Section 2 - 2.13 Information Accurate & Legible



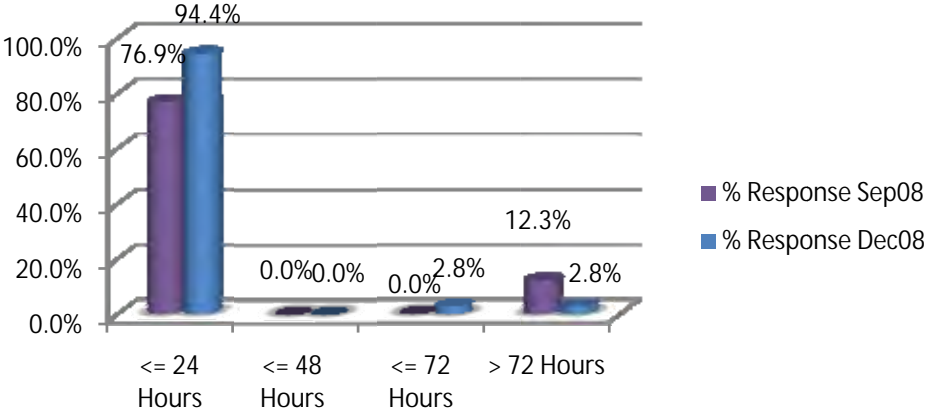
### - Section 2 - 2.14 Information Relevant & Succinct



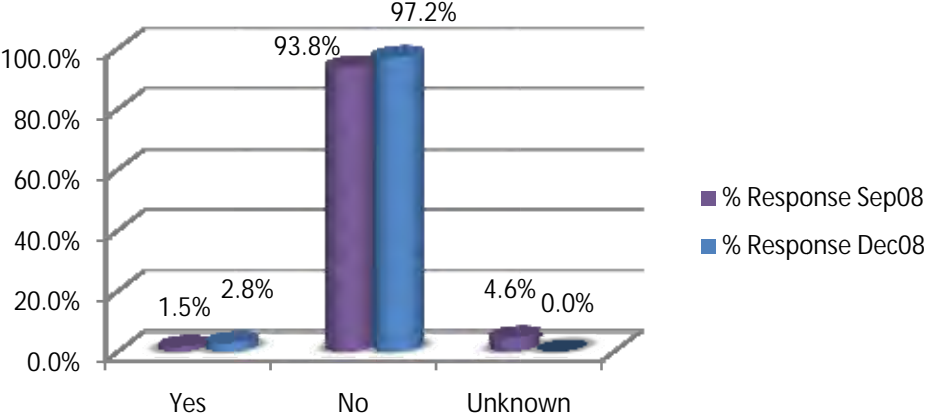
**- Section 3 -  
3.1 Time of Discharge**



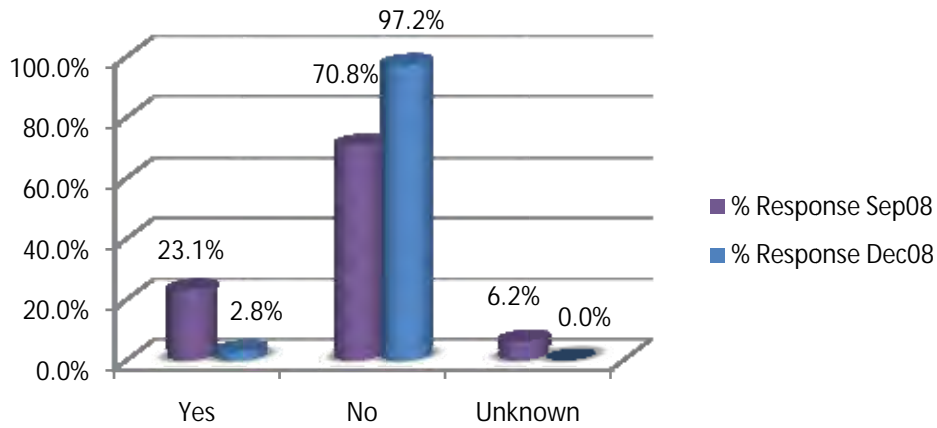
**- Section 3 -  
3.2 Time to receipt of information**



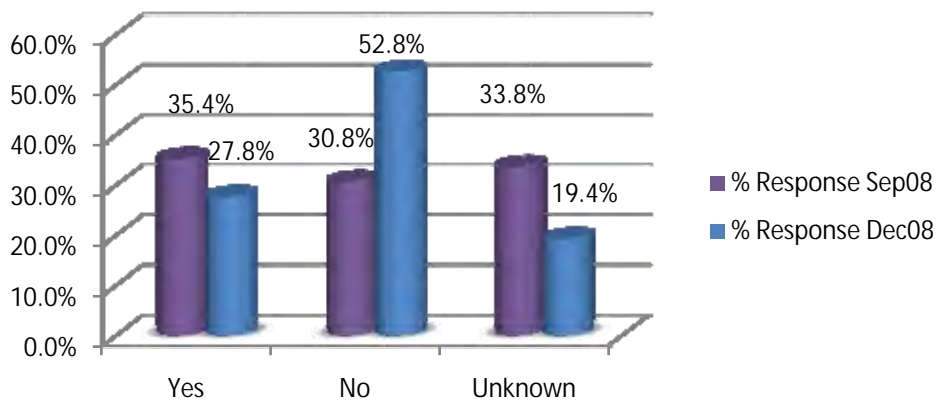
**- Section 3 -  
3.3 Adverse Medication Event**



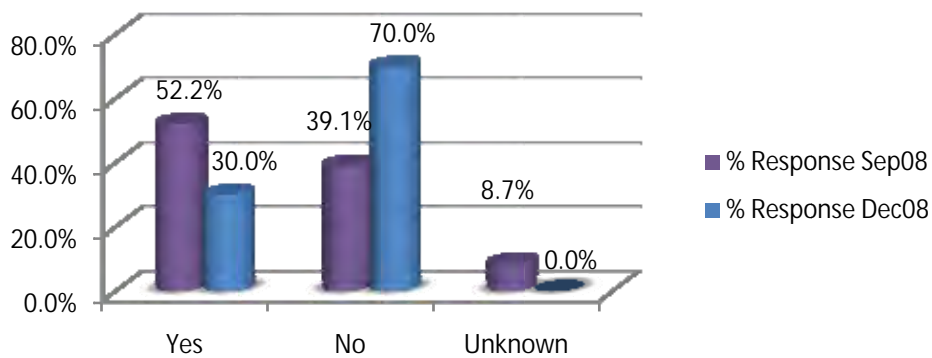
**- Section 3 -  
3.4 Adverse Clinical Events**



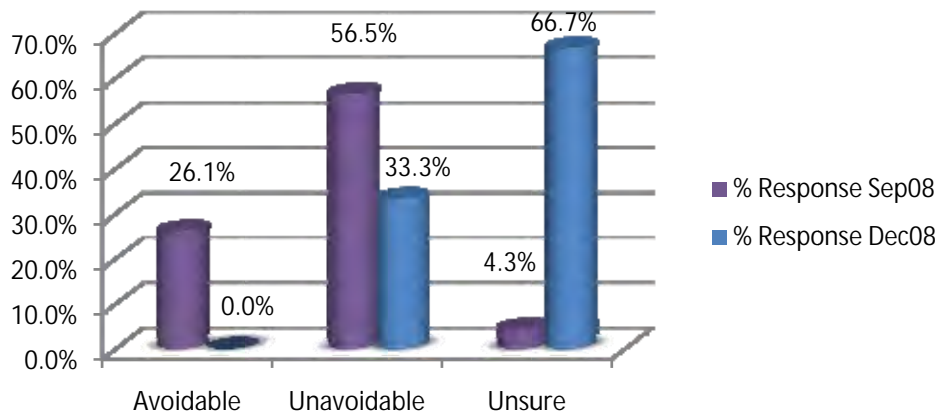
**- Section 3 -  
3.5a Readmission <= 6 weeks**



**- Section 3 -  
3.5b For <=6 week readmissions, link to previous admission?**



- Section 3 -  
3.5b For <=6 week readmissions, was it avoidable?



# Attachment 10

## Yellow Envelope flyer



# RACF Communication Envelope

(the 'yellow envelope')



The **yellow envelope** is a communication tool to assist staff of **Residential Aged Care Facilities (RACFs)** and hospitals to provide relevant information about patients transferred to and from hospital and RACFs.

The envelope remains in the patients's chart throughout their hospital stay. The contents is updated by hospital staff upon discharge and sent back to the patient's usual care providers (the RACF and GP).

**FRONT**

Printed on the **front** of the yellow envelope are the patients RACF, GP details and a checklist of **information required by RACF staff from the hospital** upon discharge and back to the facility.



**BACK**

Printed on the **back** of the yellow envelope is a checklist of **information hospitals may need** when patient arrives at DEM or is admitted to a ward.

**GPpartners**   
Advancing Primary Care

# Attachment 11

## Residential Aged Care Facility Communication Envelope Flyer



### Residential Aged Care Facility Communication Envelope

(aka 'the yellow envelope')

The yellow envelope is a communication tool that assists staff of residential aged care facilities (RACFs) and hospitals to provide relevant medical information about patients transferred to and from hospital from RACFs.

#### How it works

The envelope design and size is a visual prompt to alert hospital staff that the patient is a resident of a RACF and that all the relevant information can be found in the envelope upon admission to D&M or to the ward.

The envelope remains in the patient's chart throughout their hospital stay and its contents are updated by hospital staff upon discharge.

The idea of the envelope is not to change discharge process but to act as a tool to collect all discharge information from all involved in the patient's hospital care, and for that information to be provided back to the patient's usual care providers (the RACF and GP) in a timely way.

#### Why a communication tool?

The lack of clear and relevant information about a patient's health and care status contributes to confusion, inadequate or inappropriate care, longer hospital stays and re-admissions.

A survey of Emergency Department and general ward staff found they were dissatisfied with the quality of patient information provided by RACFs. They found:

- a lack of consistency and relevant information
- unclear definition as to current presentation
- unclear information about patient's care needs
- unknown cognitive, speech or mobility status.

- missing GP contact details
- confusion about medication sent with the patient

A survey of staff at RACFs found that information received back from hospital was inadequate, including:

- unclear discharge diagnosis
- no discharge information
- no information about medication changes.

This lack of communication caused confusion, particularly around issues relating to medication changes, and in some instances resulted in readmission.

The yellow envelope tool is designed to help prevent this.

#### Implementation

The yellow envelope is currently being introduced across the northern Brisbane area in both public and private hospitals and has potential to be rolled out state-wide.

The envelope was introduced in the Redcliffe / Caboolture area in June 2006. Evaluation has shown an improvement in the quality of information transferred from RACFs to hospitals however, hospitals have been slower to utilise the system fully.

#### The design

The C4 size yellow/gold envelope has checklists printed on both sides and a distinctive blue/green pattern on the front.

Printed on the back of the envelope is a checklist of information hospitals may need when the patient arrives at DEM or is admitted to a ward.

RACF staff are responsible for preparing this information and the envelope when a patient is transferred to hospital.

Printed on the front of the envelope are the patient's RACF and GP details and a checklist of information required by RACF staff from the hospital upon discharge back to the facility.

Prompts are also included for hospital staff (e.g. 'GP contacted', 'Family contacted', facility advised of patient return) to assist RACF staff once the patient arrives back at the facility.

### Evaluation

RACF staff monitor the returns from hospital and provide feedback to hospitals when the system fails or is incomplete (either directly to the ward or via the adverse events process/complaints system of hospital).

GPpartners is currently providing introductions and training to all who would be exposed to the yellow envelope, including:

- RACF nursing staff
- ambulance crews
- hospital nursing and medical staff
- hospital pharmacy and allied health staff
- hospital wardpersons and transport staff.

The trial of the yellow envelope will continue until June 2007.

### Contact

Helen Hoare

Aged Care Project Coordinator

helen.hoare@gppartners.com.au

Phone 07 3630 7314

Fax 07 36307 814

This person is a resident of an aged care facility.

Patient name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_  
Postcode: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Facility: \_\_\_\_\_

Request to complete this section on discharge:

Discharge necessary to aged care facility  
 Yes  
 No

Medication for \_\_\_\_\_  
 Yes  
 No

Discharge medication ready and available  
 Yes  
 No

Facility advised  
 Yes  
 No

Read receipt of informed  
 Yes  
 No

Please return this checklist with patient.

GPpartners logo and other logos are visible at the bottom.

Communication tool - checklist envelope

This RACF Communication envelope, which accompanies the resident of aged care patients, should include the following to all:

Name and hospital suite for \_\_\_\_\_  
 Transfer letter including:  
- ICD10 for primary diagnosis  
- ICD10 for secondary diagnosis  
- patient's telephone number for RACF or aged care facility  
- patient's telephone number for contact on and off site.

Addressed to the patient  
 Yes  
 No

Ensuring receipt of patient  
 Yes  
 No

Days of patient's discharge planned  
 Yes  
 No

Medication sent with patient  
 Yes  
 No

Facility returns to emergency health department upon admission  
 Yes  
 No

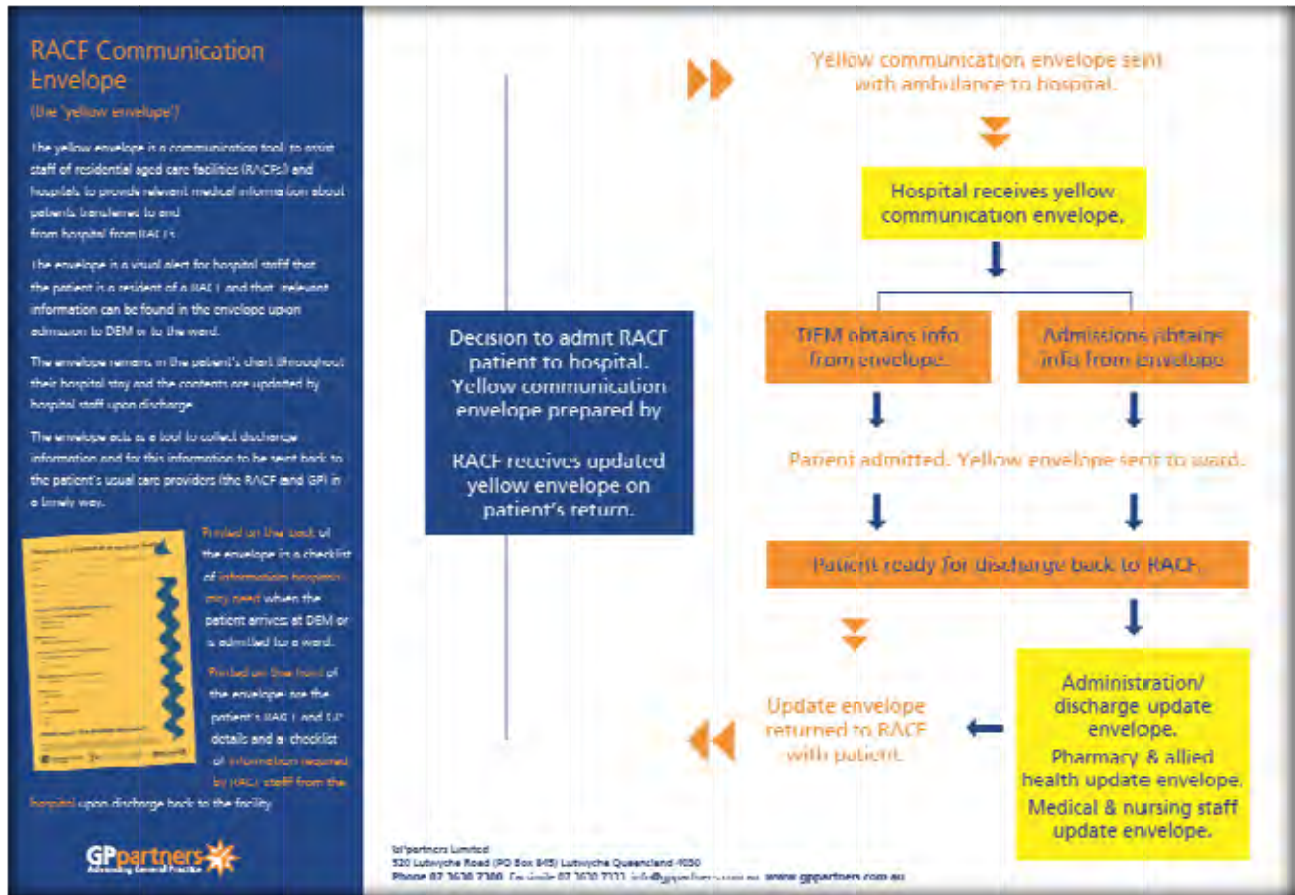
Facility advised of return  
 Yes  
 No

This envelope must contain any other patient information, e.g. return letter to patient.

GPpartners logo and other logos are visible at the bottom.

# Attachment 12

## Residential Communication Envelope Flow Chart



# Attachment 13

## Health Record eXchange Consent Information



GPpartners Limited | [www.gpartners.com.au](http://www.gpartners.com.au)  
Free call 1800 250 502

# Attachment 14

## HRX Participant Consent Form

### Participant Consent Form

1. I have been provided with a copy of the “**GPpartners Participant Pamphlet**”.
2. I acknowledge that I have read and understand the “**GPpartners Participant Pamphlet**”.
3. I agree to participate in selected programs nominated below as described in the **GPpartners Participant Pamphlet**.
4. I have been given adequate time to ask any questions I might have about the GPpartners Programs and how they may affect me. I have received satisfactory answers to any questions that I have asked.
5. I understand that GPpartners will collect, store and provide access to my health information with and between health providers involved in my care.
6. I understand that my decision to participate in the selected GPpartners programs is voluntary and that I am free to withdraw at any time without prejudice.
7. The privacy of the information, including sensitive health information, I provide will be safeguarded and only disclosed where I have consented to the disclosure in accordance with the provisions of this consent form or as required by law.

Program:	<input checked="" type="checkbox"/>	Health Record eXchange (HRX)
----------	-------------------------------------	------------------------------

**Participant’s name:** Mr/Mrs/Ms/Miss ..... Date of birth .....

Address:.....

Signature: ..... Date: .....

**Witness:** ..... Date: ..... Signature: .....

If the participant cannot sign:

**Full Name of Authorised Person:** .....

Signature of Authorised Person:..... Date: .....

Address:.....

Relationship to Participant:.....

*Please attach supporting documentation/evidence of reason participant is unable to sign and tick box.*

For alternative forms of signature:

**Full Name of Witness:** .....

Signature of Witness:..... Date: .....

Reason participant is unable to sign: .....