

Clinical Handover

Clinical Audit Toolkit



Acknowledgements

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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.

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Introduction

Continuity of information is vital for the safety of our patients and clinical handover is one of the most important issues to be considered when ensuring continuity of patient care.

GPpartners' 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 the reports relating to the lack of discharge information being received by residential aged care facilities.

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

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 widely 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)"*.

Systems such as a shared electronic health records could be the answer to these questions.

Undertaking a clinical audit enables knowledge that can identify issues local to the area and assist in making recommendations that can achieve safer, more effective and more responsive clinical handovers for residential aged care residents as they transfer to and from acute facilities.



GPpartners, funded by Department of Health & 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 audit enables organisations to clearly identify areas of concern and target these areas for a more in-depth review. The toolkit used to undertake these audits is presented in this workbook to enable other organisations to perform similar reviews that provide them with actual clinical data to inform recommendations for improvement.

What we did

A **Clinical Audit Toolkit** (CAT) was developed for the purpose of this project. Audits on information received at the Emergency Department from Residential Aged Care Facilities were performed by two Hospital based project officers. Audits on information received from the Hospital by the RACFs were performed by two General Practitioners who currently visit residents in Residential Aged Care.

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

- 1: How admission and discharge information is currently received
2. What information is currently received?
3. Possible impact on clinical outcomes.

Information collated from this audit enabled us to target areas of concern. A second audit was performed three months after the initial audit. This time frame was extremely short so not all planned interventions were completed by the commencement of the second audit.

The results of the two audits were collated and compared and recommendations on continued change have been made.

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

Why did we choose the auditors in the way that we did

To improve the 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 that the auditors were already covered by the Health Department's code of ethics and had the relevant security access to the areas needed to obtain the patients' 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 the 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.

For example:

1. Action planning toward improved clinical handover.

The following is a plan to implement some recommendations from the audit within the Acute Facility.

Proposed implementation plan to improve clinical handover practices within the medical and surgical service lines	
<p>Preamble</p> <p>In the time that elapsed between the first and second Clinical Handover Audits notable improvement was demonstrated in:</p> <ol style="list-style-type: none">1. the percentage of occasions discharge information was sent with the patient (from 67.7% in the first audit to 91.7% in the second audit). This marked improvement may be directly related to the positioning of a HINH clinical nurse allocated to inpatient wards to improve early discharge rates and promote improved transition to home for residents.2. the discharge of patients with medications and medication lists (from 32.3% in the first audit to 72% in the second audit). Again a notable improvement which may relate to a second project being undertaken between GPpartners, QH – safe Medication Practice unit and the RBWH.3. the use of the yellow envelope used as a tool to return information (from 13.8% in the first audit to 22.2% in the second audit). This was a difficult indicator to measure the reasons of which are explained in the final report of the Project. However, despite the short time frames there was a short, punchy awareness raising and education campaign conducted across key service lines within RBWH between the first and second audit. <p>The above improvements require ongoing organisational commitment to sustain these changes for the long term.</p> <p>Target group</p> <p>RBWH staff in the Medical and Surgical service lines caring for patients from Residential Aged Care Facilities (RACF)</p> <p>Time frames</p> <p>1st March 2009 to 31st May 2009</p> <p>Funding</p> <p>Available for Clinical Nurse/s for a total of 45 days</p> <p>Objectives</p> <p>To establish/embed communication strategies that improve the transfer of discharge information from medical and surgical service lines to RACFs at the time of resident discharge by:</p> <ol style="list-style-type: none">1. Identifying and establishing a consistent process for use of the Yellow Envelope across the service lines2. Incorporating 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) <p>Strategies</p> <p>It is recommended that an RN/clinical nurse is recruited (part-time and temporary) in both the medical and surgical service line to work closely with the project team (RACFi, IMRU and PFU) to drive a sustainable change within those service lines.</p> <p>It is recommended that the Clinical Nurse from the inpatient arm of HINH (RACFi) undertake a lead role to work with the Clinical Nurses to identify and embed strategies that will meet the needs of hospital and RACF health care environments.</p> <p>Performance indicators</p> <ul style="list-style-type: none">• Increasing the use of the Yellow Envelope• Increasing the number of nursing discharge summaries received by RACF <p>Increase the number of medication lists received <i>by</i> RACFs</p>	



Recommendations could be delivered as part of the final report to the organisations where further review may be required.

For example:

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.



Reporting

A report of the collated findings should be made available to all participating organizations upon completion of the audit project.

Key Factors to undertake a clinical audit

1. Identify Need and Rationale for Audit
2. Systems Identification
3. Identify Key Stakeholders – Who to involve and how?
4. Seek organisational support and ethics approval
 - Appoint an Advisory Group
5. Using the Audit Templates
6. Timeframe and scope of audit
7. Recruiting Auditors
8. Implementing the Audit
9. Evaluating Findings
10. Identifying Gaps for making recommendations

Conclusion

Using the Clinical Audit toolkit has resulted in significant outcomes and improvements to the handover process and communication between Residential Aged Care and the Acute Facility. Simply undertaking this audit provoked the awareness of a range of health personnel to the need for improvements to provide safer continuity of patient care.



References

- RACF-Hospital Clinical Handover Report: What's missing? Linking patient information to patient care
- GPAC Guidelines
<http://www.gpac.net.au/downloads/Continuity%20of%20Care%20Planning%20Framework%20for%20Queensland.pdf>
- RACF Clinical Resource Manual
- AMA Safe Handover : Safe patients
- ACSQHC a Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover prepared by The eHealth Services Research Group, University of Tasmania. 2008, Wong,M; Yee,K; Turner.P; authors.

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?

1.1 Mark all appropriate	<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) _____	
1.2 Time the information was received?	<input type="checkbox"/> At time of arrival <input type="checkbox"/> Other – add date & time _____	
1.3 Information is legible?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not relevant	
1.4 Who initiated transfer?	<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	
1.5 Was patient re-presented / readmitted to hospital?	<input type="checkbox"/> No <input type="checkbox"/> Yes <= 3 months	
Notes:		

2. What information is received?

Standard information			
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		
Clinical information		Usual Functionality	
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?

Standard information:			
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		
Clinical information:			
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:			



3. Impact on clinical outcomes

3.1 When was patient discharged?	<input type="checkbox"/> Within hours <input type="checkbox"/> After hours <input type="checkbox"/> Friday pm <input type="checkbox"/> Weekend <input type="checkbox"/> Public holiday <input type="checkbox"/> Weekends
3.2 How long did it take to receive information post discharge?	<input type="checkbox"/> Within 24 hours <input type="checkbox"/> Within 48 hours <input type="checkbox"/> Within 72 hours <input type="checkbox"/> > 72hours
3.3 Adverse medication events (in first 10 days)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.4 Adverse clinical events (in first 10 days)	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.5a Readmission to hospital within 6 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.5 b Apparent link to previous admission	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.5c If Yes – Could it have been avoidable	<input type="checkbox"/> Avoidable <input type="checkbox"/> Unavoidable <input type="checkbox"/> Unsure

Notes:

Additional Comments:



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.

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.
- 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.



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 – Coding formula

NAME	QUESTION	CODING
CODE	Study Number	1-100
Auditor	Auditor	1-Karen Kasper
		2- Lisa Mitchell
		3 - Both
		4 - DM
DEM Arrival Date	Patient DEM Arrival Date	01/11/08 - 31/12/08
Dem Arrival Time	Patient DEM Time	Time
Date of Admiss.	Date of Admission	01/11/08 - 31/12/08
Time Audit	Time take to complete audit	Time
1.1a	No information received	1-Yes
		2-No
1.1b	Letter from GP	1-Yes
		2-No
1.1c	Yellow Envelope	1-Yes
		2-No
1.1d	Fax from GP	1-Yes
		2-No
1.1e	HRX or electronic information	1-Yes
		2-No
1.1f	Phone Call from RACF	1-Yes
		2-No
1.1g	Loose Paperwork	1-Yes
		2-No
1.1h	RACF Transfer Form	1-Yes
		2-No
1.1i	Medical Summary	1-Yes
		2-No
1.1j	QAS	1-Yes
		2-No
1.1k	CMA	1-Yes
		2-No
1.1l	Phone Call from GP	1-Yes
		2-No
1.1m	Other	1-Yes
		2-No
1.2a	Time Information was received	1-At time of Arrival
		2-Other
1.2b	Other Detail	1-QAS
		2-Med Sheets
		3-Health Summary
		4-Fax
1.3	Information is legible	1-Yes
		2-No
		3-Not relevant

NAME	QUESTION	CODING
		1-GP
		2-AH/GP
		3-RACF Staff
		4-RN
		5-EEN
		6-Agency Staff
		7-Other
		1,5 - GP, EEN
		1,7 - GP, Other
		3,5 - RACF, EEN
		3,4 - RACF, RN
		1,3 - GP, RACF
1.4	Who Initiated Transfer	1,3,4 - GP, RACF, RN
		1-Yes
1.5	Was patient re-presented/readmitted to hospital	2-No
		1-Yes
2.1	Patient Name	2-No
		1-Yes
2.2	Date of Birth	2-No
		1-Yes
2.3a	RACF and Contact Details	2-No
2.3b	RACF and Contact Details List	LIST DETAILS
		1-Yes
2.4	Usual/contact GP & contact details	2-No
		1-Yes
2.5	Formal Directive	2-No
		1-Yes
2.6	Next of Kin/EPOA details	2-No
		1-Yes
2.7	Was next of Kin notified?	2-No
		1-Yes
2.8	Reason for presentation	2-No
		1-Yes
2.9	Observations - BP/pulse/temp	2-No
		1-Yes
2.10	Usual health problems/past history	2-No
		1-Yes
2.11	Medication List	2-No
		1-Yes
2.12	Allergies	2-No
		1-Yes
2.13	Diet/Feeding	2-No
		1-Yes
2.14	CMA or medical Summary	2-No
		1-Yes
2.15	Mental Status	2-No

NAME	QUESTION	CODING
2.16	Communication - glasses/hearing aid/language	1-Yes
		2-No
2.17	Mobility	1-Yes
		2-No
2.18	Contenance	1-Yes
		2-No
2.19	Behaviours	1-Yes
		2-No
3.1	Time of presentation to DEM	Time - 24hrs
3.2	Time Spent in DEM	Time - hours
3.3	Was further information sought	1-Yes
		2-No
		3-Not Known
3.4	Was GP Phoned	1-Yes
		2-No
		3-Unsuccessful
		4-Not Possible
		5-Unknown
		6 - Not Documented
3.5	Was RACF phoned	1-Yes
		2-No
		3-Unsuccessful
		4-Not Possible
		5-Unknown
		6 - Not Documented
3.6	Was there a delay on the decision to admit based on the need to chase information	1-Yes
		2-No
3.7	Referred to HINH	1-Yes
		2-No
3.8	Admitted to Hospital	1-Yes
		2-No
3.8.1	Length of Stay	Enter days as digit (e.g 14)
3.8.2	Could admission have been avoidable	1-Yes
		2-No
3.9	Adverse Medication events	1-Yes
		2-No
3.10	Adverse Clinical events	1-Yes
		2-No

Attachment 6 – Sample spreadsheet

Master Clinical Audit Data Entry Sheet_090220.xlsx - Microsoft Excel

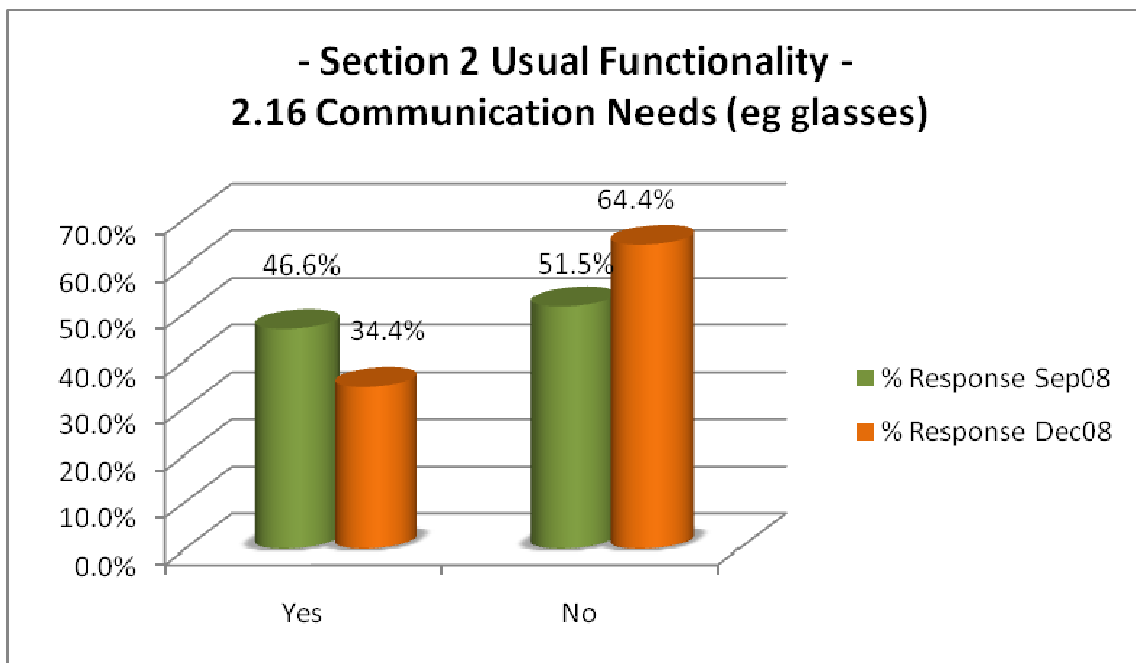
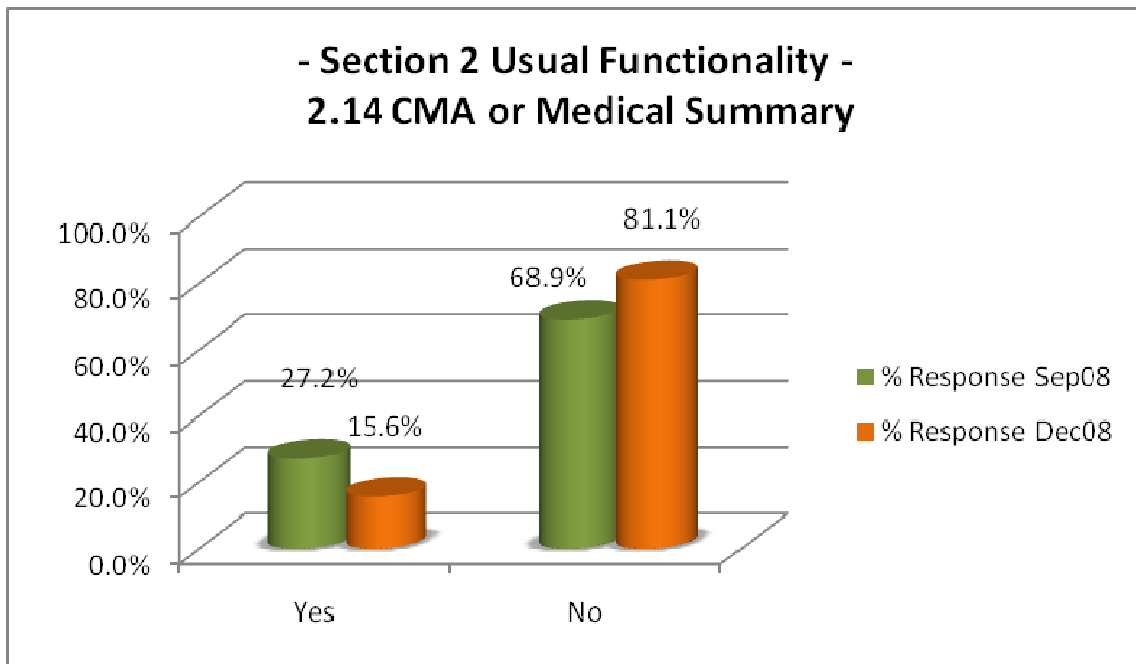
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
	CODE	Auditof	DEM Arrival Da	DEM Arrival Tin	Date of Admis	Time Arr	1.1a	1.1b	1.1c	1.1d	1.1e	1.1f	1.1g	1.1h	1.1i	1.1j	1.1k
202	4	10/12/2008	8:38	10/12/2008	2	2	2	2	2	2	2	2	1	2	1	2	1
173	2	16/11/2008	17:40	17/11/2008	20	2	2	2	2	2	2	2	2	2	2	2	2
165	2	4/12/2008	15:59	4/12/2008	15	2	2	2	2	2	2	2	1	2	2	2	1
179	2	11/11/2008	8:52	11/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	1
187	4	5/12/2008	16:24	6/12/2008	10	2	2	2	2	2	2	2	2	2	2	2	2
133	4	19/11/2008	8:11	19/11/2008	20	2	2	2	2	2	2	2	2	2	2	2	2
125	2	11/11/2008	19:50	12/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
162	4	21/11/2008	17:21	21/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
130	2	22/11/2008	15:37	22/11/2008	20	2	2	2	2	2	2	2	2	2	2	2	1
132	2	20/11/2008	15:03	20/11/2008	20	2	2	2	2	2	2	2	2	2	2	2	2
126	2	10/11/2008	14:41	10/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
149	2	24/11/2008	16:55	24/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
136	4	15/11/2008	9:38	15/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
198	4	8/12/2008	13:23	8/12/2008	10	2	2	2	2	2	2	2	2	2	2	2	2
211	4	10/11/2008	21:16	10/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
194	4	8/12/2008	12:03	8/12/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
190	2	17/11/2008	22:05	18/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
181	4	27/11/2008	14:14	27/11/2008	15	1	2	2	2	2	2	2	2	2	2	2	2
158	4	27/11/2008	2:00	27/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
168	2	7/12/2008	10:21	7/12/2008	20	2	2	2	2	2	2	2	2	2	2	2	2
148	4	23/11/2008	14:26	23/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
201	4	30/11/2008	1:25	30/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
209	4	23/11/2008	15:26	23/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
137	2	10/11/2008	9:41	10/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
210	4	22/11/2008	19:35	22/11/2008	20	2	2	2	2	2	2	2	2	2	2	2	2
122	2	12/11/2008	12:06	12/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
197	4	19/11/2008	15:02	19/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
120	2	11/11/2008	14:15	11/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
207	4	3/12/2008	19:27	3/12/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
146	4	20/11/2008	3:51	20/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
147	4	23/11/2008	22:17	24/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
196	4	27/11/2008	13:13	27/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
215	4	21/11/2008	21:56	21/11/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
127	2	13/11/2008	20:08	14/11/2008	15	2	2	2	2	2	2	2	2	2	2	2	2
183	4	5/12/2008	0:52	5/12/2008	2	2	2	2	2	2	2	2	2	2	2	2	2
177	4	2/12/2008	20:18	2/12/2008	10	2	2	2	2	2	2	2	2	2	2	2	2
	3.1_ADMIN	3.2_ADMIN	3.3_ADMIN	3.4_ADMIN	3.5_ADMIN	3.6_ADMIN	3.7_ADMIN	3.8_ADMIN	3.9_ADMIN	3.10_ADMIN	3.11_ADMIN	3.12_ADMIN	3.13_ADMIN	3.14_ADMIN	3.15_ADMIN	3.16_ADMIN	3.17_ADMIN
	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission	Admission
	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Average 2.4	Count: 71	Sum: 168														

Attachment 7 – Sample table format

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
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%	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 notion 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 F-INH 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.
1.1i	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	77.5% 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 0.9% was initiated by the regular GP and an increase of 5.7% by the after-

Attachment 8 – Sample graphs: Information to Acute Facility from RACFs



Attachment 9 – Sample graphs: Information to RACFs from Acute Facility

