Clinical Handover

Clinical Audit Toolkit

A member of the Australian General Practice Network

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Clinical Handover
ACSQHC

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'.

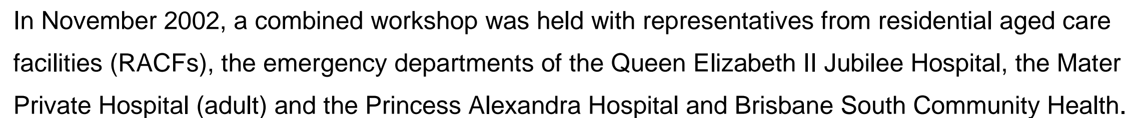
This contains areas in relation to:

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.

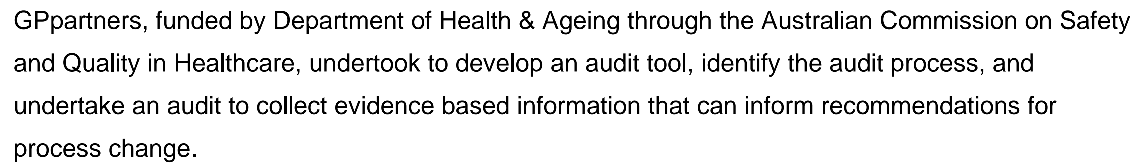
It seems however, that these forms are not widely used. Some facilities have electronic systems that enable printing of current health summary information, whilst others do not.

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.

Steps to perform a clinical audit

1. Identify need and rationale for audit

- Is there a perceived problem with transfer communication in your local area?
- How can you find this information?
  - Literature reviews
  - Local news stories
  - Local forums with appropriate health care workers, family members, residents.
  - Complaints systems
  - Adverse Events Review
  - Surveys
  - Verbal reports and anecdotal evidence

If you decide there are some problems with transfer communication in the clinical handover process, then performing a clinical audit will give you the actual information on what is happening in your local area.

2. Systems identification

Transfer of residents from RACFs to acute facilities is not new and many individual attempts have been made to improve this process.

- Are there some specific organisational processes in place at either the acute facility or RACFs?
- Is there a previously agreed system or systems that are already meant to be in place?

Questions on the audit are aimed to identify:

1. How information is currently received?
2. What information is currently received?
3. Possible impact on clinical outcomes.

3. Identify key stakeholders – who to involve and how?

It is important to identify who needs to be involved in the planning, implementation and review of an audit of transfer information used in the clinical handover process

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- Initially, discuss the need for an audit with the key workers from the main organisations involved –staff of RACFs who have responsibility for organsing transfers to the acute facility and those that receive the resident at the acute facility.
- Include the GPs and Medical Officers.
- Review the discussion with those responsible for the discharge of residents from the acute facility and those responsible for receiving the resident back to the facility. In both discussions you can identify the needs of the aged care facility and the acute facility and review this against current best practice guidelines.

This group could form the basis for an advisory group to guide and oversee the project.

4. Seek organisational support and ethics approval

An outline of the findings from background research and discussions and why you believe an audit needs to be undertaken should be prepared in writing and an avenue for presenting this to organisational management teams needs to be ascertained.

This may be through a Regional Director or nursing meeting in some RACFS, and/or through attendance at an executive meeting at an acute facility. You will need management agreement in order to undertake the audit.

The fact that this audit was a two way review holds it in good stead as it identifies the good points and deficits on both sides of the transfer process, giving a balanced account of the processes used.

Organisational managers may ask that an application is submitted to their respective ethics committees to ensure that the process meets ethical approval. Many organisations will accept the on-line National Ethics Approval Form (NEAF) (https://www.neaf.gov.au/Default.aspx). However, as the audits do not alter treatments, and should be de-identified, a full application may not need to be completed.

It is best to outline the process and security measures decided upon in a letter to the Chair of the Ethics Committees, if a full application is required.

Although organisational managers may request an application to the ethics committees, this would be undertaken following discussions and decisions made through the Advisory Group.

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In the GPpartners project, the project manager ensure all organisations were aware of the project and sought a letter of agreement to participate from the CEO or Nursing Directors.

Advisory Group

Once you have agreement from the management of the key organisations, there is a need to call together a Steering or Advisory Group.

This group would benefit from having some members from the original discussion group, but needs to include representation from key areas of the acute facility (including upper management), GPs, Residential Aged Care Facility Managers, project officers and the project manager.

This group will help to ratify that the questions of the audit will enable the data required to be captured and result in evidence based recommendations for improvement.

This group can assist in the development of the implementation process and ensure there is a broader communication about the audit being undertaken across participating organisations.

Enabling organisations to have input into these stages ensures implementation of the audit is much smoother and is a more widely accepted process.

This group should decide, or agree upon:

- what you want to achieve from these audits
- how information is currently received (systems review)
- what information is currently received (sufficient to enable decision making)
- possible impact on clinical outcomes (reduces the risk of accidental harm)
- Use of audit tool, i.e. agreement to use or adapt the audit form included in this kit
- Audit guidelines (supplement to the audit tool to provide guidance to auditors). Decide whether to use or adapt the guidelines included in this kit.
- the processes for implementing the audit at the local level.

The group does not need to be involved during implementation of the audit but should be called together again at the end of the audit to

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review results and assist with recommendations and feedback from the collated information.

5. Using the audit templates

Two separate clinical audit forms were developed:

- Admission Information from Residential Aged Care
- Discharge Information from Acute Facility.

Both forms were developed based on the three sections previously identified:

1. How information is currently received?
2. What information is currently received?
3. 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.

Questions used in the template reflect the Minimum Data Set as established by the GPAC guidelines and 'other' influencing factors.

- See Attachment 1 – Admission Information from Residential Aged Care
- See Attachment 2 – Discharge Information from Acute Facility.

Developing clinical audit guidelines

The audits are based on evidence – information that is clearly filed or written in the patient's charts that any health professional providing care to the person would be able to access. Any verbal information that may be given, which is not entered into the person's written information, should not be considered as reliable information. However, the auditors may decide to mention this information in the comments section of the audit for further clarification.

Notes

A specific set of guidelines about the questions is available for both of the forms to ensure that any person undertaking the audit would be consistent in performing the task.

Each auditor needs to be trained to use the tool and performing a cross audit* assists to verify consistency in understanding and answering the questions.

- See Attachment 3 – Guideline
- See Attachment 4 – Discharge Information from Acute Facility.

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

6. Timeframe and scope of audit

The timeframe depends on the scope of your project and the locality within which the audit is being undertaken.

Due to the size of the area in which the initial audit was undertaken (70 RACFs, 220 visiting GPs, and a major acute tertiary/teaching hospital), we understood that the emergency department would receive over 100 RACF 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. A decision was made not to specify the number of audits to be undertaken but to limit the audits to a one month (30 day) period. A second audit was undertaken three months later. However this short period was due to the project time frame.

A further limitation was made by identifying Wards that would be included in the audit process. This meant that we could better inform these staff about the audit and audit process and helped to target education and feedback on the results of the audits undertaken.

For the purposes of this audit we targeted areas most likely to receive residents from RACFs – the Department of Emergency Medicine, Hospital in the Nursing Home, medical, surgical and orthopaedic wards.

In smaller centers it may be necessary to undertake the audits over a two month period dependent on the number of expected presentations and or discharges over a given period for that locality.

As simple as it may seem to be able to gather information on the number of presentations from your local hospital, our experience is that gathering information on residents from RACFs is very difficult, unless you have a specialist team already involved who gather their own specific information. The Health Information Management Team or

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Clinical Coders are often the main source of data collection around the types of admissions or presentations to the hospital.

An audit is only part of the process. It is using the knowledge gained from the audit that is most important. For our project two separate audits were undertaken. The time frame for undertaking a second audit is dependent upon the recommendations to be put into effect following the initial audit, and the plan for their implementation.

Change management processes are not expedient in any health setting. Time is needed to embed any change into the usual education sessions and practice. This may well take a full six months or even longer.

The second audit needs to be carried out over the same conditions as the first. The timing of performing the second audit however, depends on the implementation plan for the recommendations being put into practice.

In normal circumstances, a second audit should be undertaken 6-12 months after the first audit and after the implementation of some of the recommendations. In an ideal world a third audit 6-12 months after the second audit would give information on sustainability.

- Audit One – Base line data informing evidence based recommendations.
- Audit Two – 6-12 months post implementation of chosen recommendations.
- Audit Three - 6-12 months following the second audit to test sustainability.

7. Recruiting Auditors

To improve the access and acceptability of the audit within the Acute Facility and for the purposes of equity, it is advised that the Admission audit should be undertaken by staff of the Acute Facility.

This will ensure the auditors are already covered by the Health Department's code of ethics and have the relevant security access to the areas needed to obtain the patients' charts. They will most likely understand the internal systems and charting processes.

A medical officer (registrar) could complete the audits as part of their training program, or Registered Nurses with current research experience and access to Medical support could undertake the audits. Often in an acute system the auditors will need to work under the sponsorship of a senior management representative.

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In the residential aged care setting the audits could be undertaken by Registered Nursing staff, or by visiting General Practitioners. We chose to use General Practitioners for two reasons.

One relates to the current workforce shortage of Registered Nurses in residential aged care. The other relates to neutrality. Nurse auditors would need access to medical advice when required to make clinical decisions about adverse clinical or medication events, and re-admissions to hospital.

8. Implementing the Audit

The auditors at the acute facility need to ensure good communication about the project being undertaken to all the relevant internal departments. This includes nurses, Medical Officers and administration staff of the Emergency Department, and as in our case the Medical, Orthopedic and Surgical Units of the hospital.

They also needed to inform the Administration Manager and the Health Records Information Manager that they will be would be seeking charts of residents admitted to hospital from the Residential Aged Care Facilities.

Ensuring the managers of each section were well informed made their job in finding the charts and receiving information on admissions much easier and there was less skepticism of the project when it was understood that both admission information and discharge information was being reviewed.

The project manager from GPpartners ensured that all organisations were aware of the project and sought a letter of agreement to participate from the CEO or Nursing Directors of the organisations. The letter of agreement to participate was then used to inform the different facility managers that permission had been given for the auditors to enter their facility and to view the needed information.

A flyer was also developed to inform managers of the project and to enable them to share this information with their staff. Photos of the GP auditors were included on the flyer and the GPs were given photographic Identification cards.

The GPs were restricted from auditing their own patients, and were not allocated to centers where they have a number of residents as their clients.

Experience taught us that it is best to start the actual auditing process approximately two –three weeks after the official audit start date. This

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allowed time for loose documents to be filed in the charts, and made it easier to locate the charts particularly if the resident had already been discharged.

From the RACF perspective, it enabled the GPs to do group visits, reducing travel time and enabling more audits to be completed.

We also found that this helped us when reviewing the 6 week follow up on readmission rates.

9. Evaluating Findings

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 clear data collection and analysis. For example, for the question 'Was the patient discharged without medications discharged after hours?' To answer this question is easy as each coded resident numbers' information is available along the same line allowing you to physically review connections such as this that may occur.

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. Information can easily be correlated into numbers or percentages making it simple to add the figures into a table format.

Notes

Using the excel spreadsheet enabled easy generation of graphs for presentation purposes.

- See Attachment 5 – Coding formula
- See Attachment 6 – Sample spreadsheet
- See Attachment 7 – Sample table format
- See Attachment 8 – Sample graphs

10. Identifying gaps and making recommendations

Having hard data helps people recognise the need for change. Being able to present that data in a clear and succinct format (tables and graphs) assists people to visualize the areas that clearly need to be addressed.

The results need to be presented to the Advisory Group made up of key personnel from the different areas – Hospital Management, Residential Aged Care Management, General Practitioners, and project officers. The Advisory Group can assist in identifying recommendations for their prospective organisations based on the gaps identified.

Recommendations should be based on how these gaps could be:

- addressed toward improving clinical handover; and/or
- further reviewed if more in-depth information is required

The recommendations should then be written down as part of the report to the key organisations.

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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

Preamble

In the time that elapsed between the first and second Clinical Handover Audits notable improvement was demonstrated in:

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.

The above improvements require ongoing organisational commitment to sustain these changes for the long term.

Target group

RBWH staff in the Medical and Surgical service lines caring for patients from Residential Aged Care Facilities (RACF)

Time frames

1st March 2009 to 31st May 2009

Funding

Available for Clinical Nurse/s for a total of 45 days

Objectives

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:

1. Identifying and establishing a consistent process for use of the Yellow Envelope across the service lines
2. 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)

Strategies

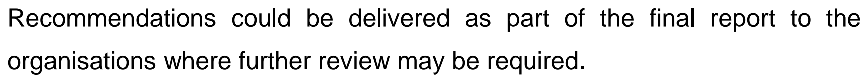
It is recommended that an RN/clinical nurse is recruited (part-time and temporary) in both the medical and surgical service line to work closely with the project team (RACFi, IMRU and PFU) to drive a sustainable change within those service lines.

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.

Performance indicators

- Increasing the use of the Yellow Envelope
- Increasing the number of nursing discharge summaries received by RACF

Increase the number of medication lists received *by RA*CFs



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

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

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

2. What information is received?

Standard information			
2.1 Pt. Name	☐ Yes ☐ No	2.5 Formal Directive (such as copy of Advanced Health Directive / End of life care plan / Family wishes)	☐ Yes ☐ No
2.2 Date of birth	☐ Yes ☐ No	2.6 Next of Kin / EPOA with contact details	☐ Yes ☐ No
2.3 RACF and contact details *If given, RACF name:* ___________________________	☐ Yes ☐ No	2.7 Was next of kin notified?	☐ Yes ☐ No
2.4 Usual/contact GP and contact details	☐ Yes ☐ No		
Clinical information		***Usual Functionality***	

2.8 Reason for presentation	☐ Yes ☐ No	2.14 CMA or medical summary	☐ Yes ☐ No
2.9 Observations – BP / pulse / temp	☐ Yes ☐ No	2.15 Mental Status	☐ Yes ☐ No
2.10 Usual health problems / past history	☐ Yes ☐ No	2.16 Communication – glasses / hearing aid / language	☐ Yes ☐ No
2.11 Medication list	☐ Yes ☐ No	2.17 Mobility	☐ Yes ☐ No
2.12 Allergies	☐ Yes ☐ No	2.18 Continence	☐ Yes ☐ No
2.13 Diet / feeding	☐ Yes ☐ No	2.19 Behaviours	☐ Yes ☐ No
Notes:			

3. Clinical outcomes

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

3.9 Adverse medication events?	☐ Yes ☐ No
3.10 Adverse clinical events?	☐ Yes ☐ No
Notes:	

Attachment 2 – Discharge Information from Acute Facility

Auditor:	Date Started: 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..?	☐ Yes ☐ No
1.2 Discharge information sent with patient?	☐ Yes ☐ No
1.3 If No-was summary sent to RACF at a later date?	☐ Yes ☐ No
1.4 Type of discharge summary received.	☐ Medical ☐ Nursing ☐ Allied health
1.5 Medications available at time of discharge?	☐ Yes ☐ No
1.6 Does GP name on information received match the current GP?	☐ Yes ☐ No
1.7 Was the yellow envelope used as a tool to return information?	☐ Yes ☐ No
Notes:	

2. What information is received?

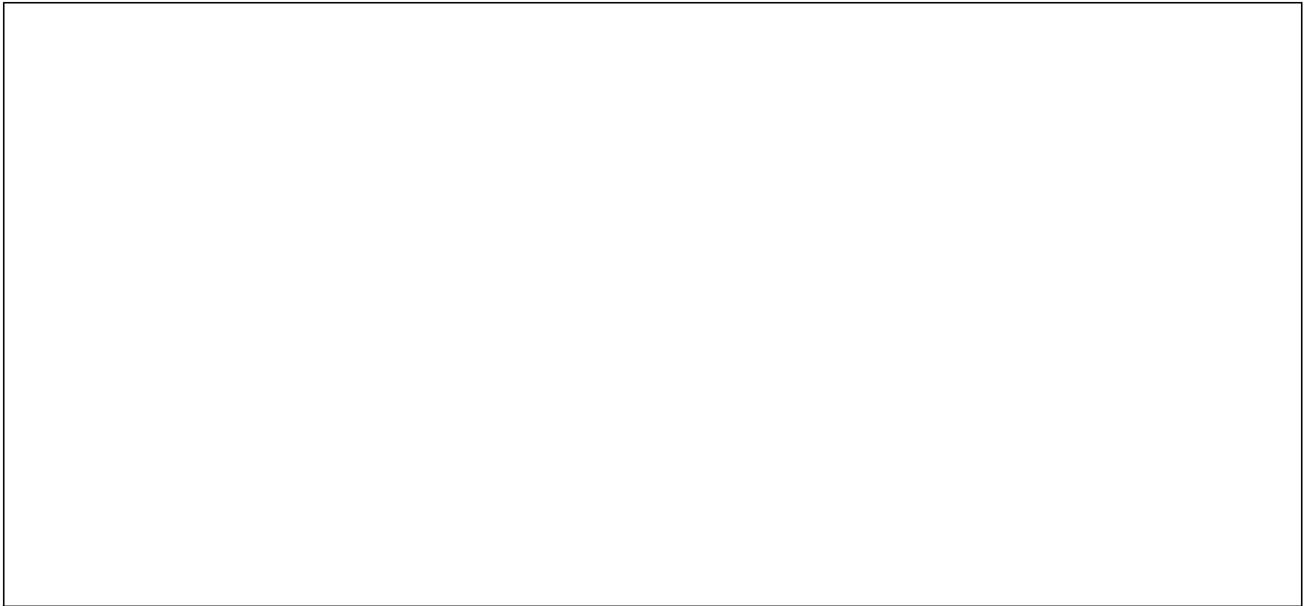
Standard information:			
2.1 Admission date	☐ Yes ☐ No	2.2 Unit/Ward Please Specify:	☐ Yes ☐ No
2.3 Discharge date	☐ Yes ☐ No	2.4 Contact Dr at RBWH and contact details:	☐ Yes ☐ No
2.5 Consultant name	☐ Yes ☐ No		
Clinical information:			
2.6 Diagnosis	☐ Yes ☐ No	2.7 Medication list – changes and reasons	☐ Yes ☐ No
2.8 Procedures	☐ Yes ☐ No	2.9 Recommendations for GP	☐ Yes ☐ No

2.10 Course in hospital	☐ Yes ☐ No	2.11 Follow up arrangements	☐ Yes ☐ No
2.12 Investigations	☐ Yes ☐ No		
2.13 Information is accurate and legible?	☐ Yes ☐ No		
2.14 Information provided is relevant and succinct?	☐ Yes ☐ No		
Notes:			

3. Impact on clinical outcomes

3.1 When was patient discharged?	☐ Within hours ☐ After hours ☐ Friday pm ☐ Weekend ☐ Public holiday ☐ Weekends
3.2 How long did it take to receive information post discharge?	☐ Within 24 hours ☐ Within 48 hours ☐ Within 72 hours ☐ > 72hours
3.3 Adverse medication events (in first 10 days)	☐ Yes ☐ No
3.4 Adverse clinical events (in first 10 days)	☐ Yes ☐ No
3.5a Readmission to hospital within 6 weeks 3.5 b Apparent link to previous admission 3.5c **If Yes –** Could it have been avoidable	☐ Yes ☐ No ☐ Yes ☐ No ☐ Avoidable ☐ Unavoidable ☐ 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 indicted 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 premorbid vitals.
- Medical history - i.e. premorbid (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.

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.

- 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.

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 from 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.

Clinical Handover Audit

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
		1-Karen Kasper
		2- Lisa Mitchell
		3 - Both
Auditor	Auditor	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 compelte audit	Time
		1-Yes
1.1a	No information received	2-No
		1-Yes
1.1b	Letter from GP	2-No
		1-Yes
1.1c	Yellow Envelope	2-No
		1-Yes
1.1d	Fax from GP	2-No
		1-Yes
1.1e	HRX or electronic information	2-No
		1-Yes
1.1f	Phone Call from RACF	2-No
		1-Yes
1.1g	Loose Paperwork	2-No
		1-Yes
1.1h	RACF Transfer Form	2-No
		1-Yes
1.1i	Medical Summary	2-No
		1-Yes
1.1j	QAS	2-No
		1-Yes
1.1k	CMA	2-No
		1-Yes
1.1l	Phone Call from GP	2-No
		1-Yes
1.1m	Other	2-No
		1-At time of Arrival
1.2a	Time Information was received	2-Other
		1-QAS
		2-Med Sheets
		3-Health Summary
1.2b	Other Detail	4-Fax
		1-Yes
		2-No
1.3	Information is legible	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	Continence	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

BE1 f_x 3.8c

	CODE	Audito	DEM Arrival Da	DEM Arrival Tin	Date of Admis	Time Auc	1.1a	1.1b	1.1c	1.1d	1.1e	1.1f	1.1g	1.1h - R	1.1i - M	1.1j -Q/	1.1k-CN
2	202	4	10/12/2008	8:38	10/12/2008		2	2	2	2	2	1	2	1	2	1	2
3	173	2	16/11/2008	17:40	17/11/2008	20	2	2	2	2	2	2	2	1	2	1	2
4	165	2	4/12/2008	15:59	4/12/2008	15	2	2	2	2	2	1	1	2	2	1	2
5	129	2	11/11/2008	8:52	11/11/2008		2	2	2	2	2	2	2	1	2	1	1
6	187	4	5/12/2008	16:24	6/12/2008	10	2	2	1	2	2	2	2	1	2	1	2
7	133	4	19/11/2008	8:11		20	2	2	1	2	2	2	1	2	2	1	2
8	125	2	11/11/2008	19:50	12/11/2008		2	2	2	2	2	2	2	2	2	1	2
9	162	4	21/11/2008	17:21	21/11/2008	15	2	2	1	2	2	2	2	1	2	1	2
10	130	2	22/11/2008	15:37	22/11/2008	20	2	1	2	2	2	2	1	2	2	1	1
11	132	2	20/11/2008	15:03	20/11/2008	20	2	2	1	2	2	2	2	1	2	1	2
12	126	2	10/11/2008	14:41	10/11/2008		2	2	2	2	2	2	1	2	2	1	2
13	149	2	24/11/2008	16:55	24/11/2008		2	1	2	2	2	2	2	2	2	1	2
14	136	4	15/11/2008	9:38		15	2	2	2	2	2	1	1	1	2	1	2
15	198	4	8/12/2008	13:23		10	2	2	2	2	2	2	1	2	2	1	2
16	211	4	10/11/2008	21:16			2	2	2	2	2	2	1	1	2	2	2
17	194	4	8/12/2008	12:03	8/12/2008	15	2	2	1	2	2	2	2	2	2	1	2
18	190	2	17/11/2008	22:05	18/11/2008		2	1	2	2	2	2	1	2	1	1	2
19	181	4	27/11/2008	14:14	27/11/2008	15	1	2	2	2	2	2	2	2	2	2	2
20	158	4	27/11/2008	2:00	27/11/2008	15	2	1	2	2	2	2	1	1	2	2	1
21	168	2	7/12/2008	10:21	7/12/2008	20	2	2	2	2	2	2	2	2	2	1	2
22	148	4	23/11/2008	14:26	23/11/2008		2	1	2	2	2	2	1	2	2	1	2
23	201	4	30/11/2008	1:25	30/11/2008	15	2	2	2	2	2	2	1	2	2	1	2
24	209	4	23/11/2008	15:26	23/11/2008	15	2	2	2	2	2	2	1	1	2	1	2
25	137	2	10/11/2008	9:41	10/11/2008	15	2	1	2	2	2	2	1	2	2	1	2
26	210	4	22/11/2008	19:35	22/11/2008	20	2	1	2	2	2	2	1	2	2	1	2
27	122	2	12/11/2008	12:06	12/11/2008	15	2	2	2	2	2	2	1	2	2	1	2
28	197	4	19/11/2008	15:02	19/11/2008	15	2	2	1	2	2	1	2	2	2	1	2
29	120	2	11/11/2008	14:15	11/11/2008	15	2	1	2	2	2	2	1	1	2	2	2
30	207	4	3/12/2008	19:27	3/12/2008	15	2	2	2	2	2	2	1	1	2	1	2
31	146	4	20/11/2008	3:51	20/11/2008	15	2	2	1	2	2	2	2	1	2	1	2
32	147	4	23/11/2008	22:17	24/11/2008	15	2	2	2	2	2	2	2	2	2	1	2
33	196	4	27/11/2008	13:13	27/11/2008	15	2	2	1	2	2	1	2	1	2	2	2
34	215	4	21/11/2008	21:56	21/11/2008		2	1	2	2	2	2	1	2	2	1	2
35	127	2	13/11/2008	20:08	14/11/2008	15	2	1	2	2	2	2	1	1	2	1	2
36	183	4	5/12/2008	0:52	5/12/2008		2	1	2	2	2	2	1	2	2	2	2
37	177	4	2/12/2008	20:18	2/12/2008	10	2	2	2	2	2	2	1	2	2	1	2

3.1_ADM / 3.2_ADM / 3.3_ADM / 3.4_ADM / 3.5_ADM / 3.6_ADM / 3.7_ADM / Admission / Admission Dec08 / 3.8a_ADM / 3.

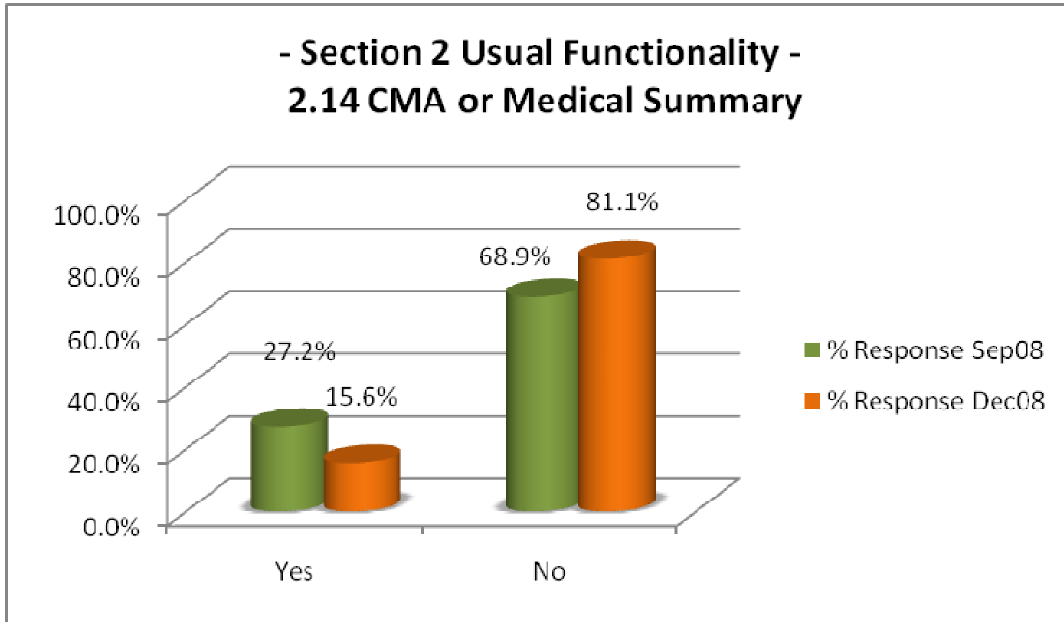
Ready Filter Mode Average: 2.4 Count: 71 Sum: 168 100%

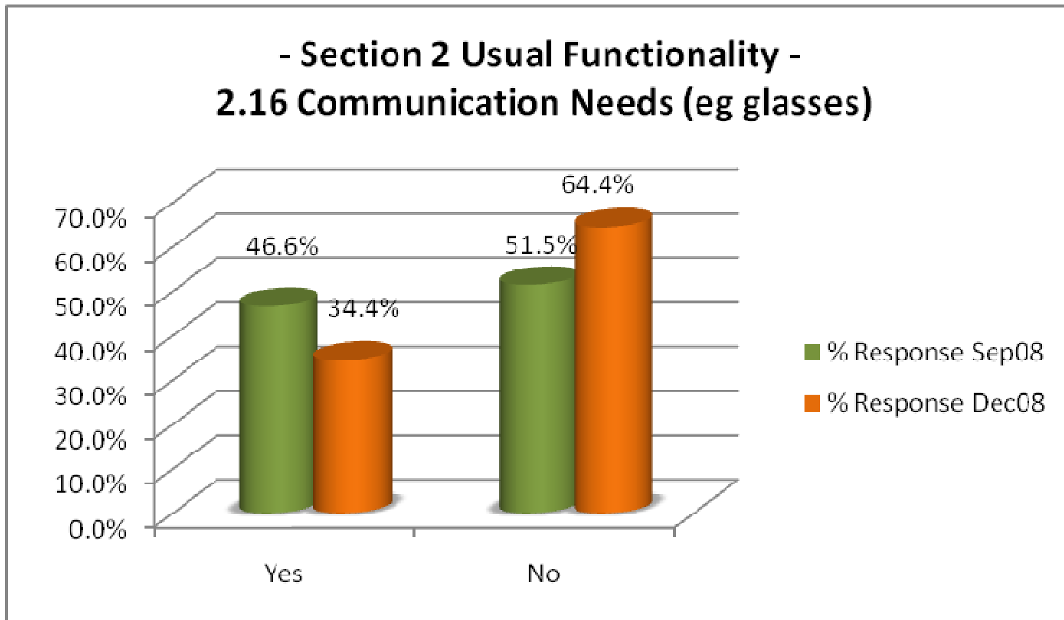
Attachment 7 – Sample table format

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 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.
1.1 l	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-

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





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