Guidelines for Audit Tools

Guidelines for Admission

How is admission information received from Residential Aged Care Facilities (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.

Guidelines for Discharge Information

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 the hospital?

- 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.

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.