AN ACI RESOURCE FOR IMPROVING THE DOCUMENTATION OF CLINICAL MANAGEMENT PLANS - CONSULTATION DRAFT

Project Overview

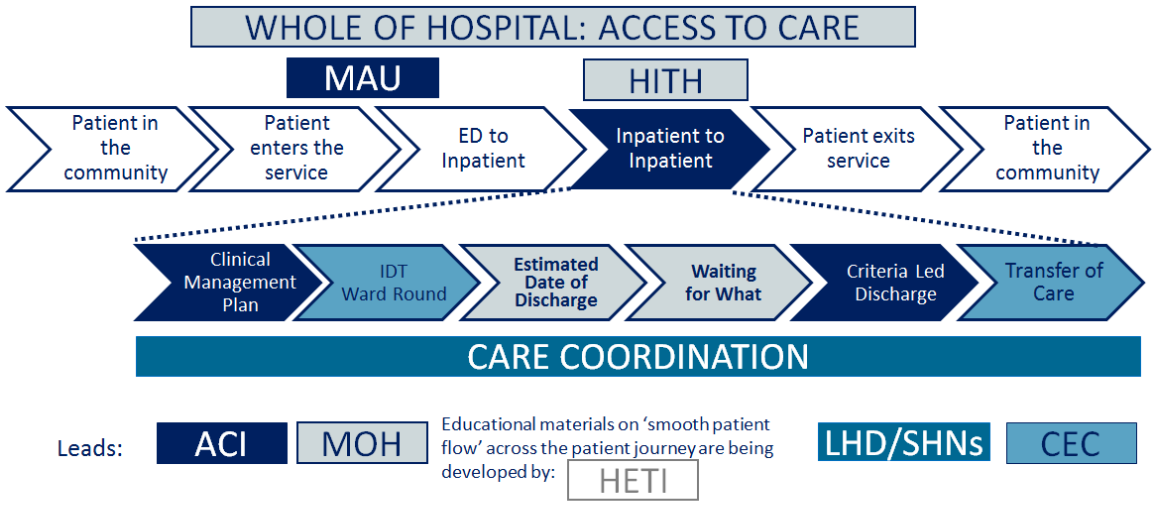
The Acute Care Taskforce (ACT) has been involved in developing solutions for improving the medical patient journey since 2005. This includes work around safe clinical handover, avoidable admissions and the establishment of medical assessment units.

In 2011 the NSW Ministry of Health published a policy directive titled *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals.* Acknowledging that patient involvement contributes to positive health outcomes the policy mandated that hospital teams involve patients/carers in care planning. It highlights five important stages to a coordinated inpatient experience: 1.Pre Admission/Admission; 2.Multidisciplinary team review; 3.Estimated date of discharge (EDD); 4.Referrals and liaison for patient transfer of care and 5.Transfer of care (discharge) out of the hospital.

In 2012 the ACT transitioned to the ACI and in order to build upon this important work the ACI brought together a group of clinicians, consumers and managers. Under the guidance of this group the ACT decided it would focus on improving the medical inpatient journey in 2013. Five important elements to improving the inpatient journey were identified with the system lead noted in brackets (Figure 1):

1. A patient flow systems approach to improving the inpatient experience focused on the EDD and waiting for what functions (NSW Ministry of Health and Health & Education Training Institute)
2. Inpatient clinical management plans (Agency for Clinical Innovation - ACI)
3. Ward rounds (Clinical Excellence Commission - CEC)
4. Criteria led discharge (ACI)
5. Transfer of care / discharge (CEC)

Figure 1 Acute Care Taskforce 2013: a collaborative approach to improving the medical inpatient journey



Key

ACI=NSW Agency for Clinical innovation
CEC=NSW Clinical Excellence Commission
HETI=NSW Health Education and Training Institute
LHD/SHNs=NSW Local Health Districts & Speciality Networks
MOH=NSW Ministry of Health
IDT=Interdisciplinary
HITH=Hospital in the Home
MAU=Medical Assessment Unit

Under the guidance of the ACT Executive two working groups were established: one for clinical management plans (CMP) and another concentrating on criteria led discharge (CLD). Following a comprehensive literature review and in consultation with the statewide ACT the clinician led working groups developed a set of tools to assist staff from Local Health Districts and Specialty Health Networks to:

- Improve documentation of the CMP in their wards and facilities, and/or
- Assess the requirements for implementing CLD.

The solutions are designed to assist teams to make changes to improve the way that care is provided while patients are in hospital. These resources acknowledge that the care provided in hospitals can be complex and that the solutions to improving both the patient and staff experience will require an interdisciplinary effort. These changes include better communication of the clinical management plan, a more streamlined approach to planning for transfer of care (discharge) and a more coordinated inpatient journey.

This resource includes the following components key to implementing CMP:

- An overview chapter outlining the case for change and potential approach to implementation, including
  - Frequently asked questions for documenting the CMP (p20)
  - A set of five questions for measuring the patient experience using Patient Experience Trackers (PETs, p21)
  - A set of five questions for measuring staff experience using PETs (p21)
  - A draft daily interdisciplinary management sheet to be printed on the Progress Note (p23)
  - A draft problem management sheet (p24)
  - A draft weekend handover sheet (p25)
  - An implementation checklist for improving clinical management plans (pp28-29)
- A draft set of orientation/education slides (pp31-45)

A separate resource includes the elements that are fundamental to support the implementation of CLD.

DOCUMENTING IN THE INPATIENT CLINICAL MANAGEMENT PLAN

PRINCIPLES FOR BEST PRACTICE

Know the plan. Share the plan. Action the plan.

Table of Contents

ACKNOWLEDGEMENTS:

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WHAT IS A CLINICAL MANAGEMENT PLAN?

There are many different forms of clinical management plans. They have different names and sometimes slightly different purposes. These include chronic care plans, GP management plan and disease specific management plans (e.g. diabetes management plan).

This work is focused on the inpatient clinical management plan. This is defined as *the plan* that is developed with a patient for their care in hospital and documented in the patient's medical record. This plan should articulate:

1. Patient goals
2. The team's agreed actions including a timeframe for achieving

WHY IS IMPROVING CLINICAL MANAGEMENT PLANS IMPORTANT?

Good communication improves patient safety(1, 2), patient(3) and staff(4) experience and team efficiency.

A hospital admission is a snapshot of care and should be appreciated as such. Throughout the inpatient journey the medical record is a chief communication document across the interdisciplinary team (IDT) for inpatient care. Aside from providing a means of retrieving information about a particular patient, the goals of the clinical management plan are to guide clinical problem-solving and care planning, and to enable this plan to be communicated to other health professionals(5).

Good team communication ensures all team members have a shared mental model and understanding of the current situation and plan for the patient(6).

Audit data of patient medical records indicate that that quality of documentation is varied.

All hospital team members have a responsibility to *Know the plan. Share the plan. Action the plan*.

SIX KEY PRINCIPLES FOR DOCUMENTING CLINICAL MANAGEMENT PLANS

There are six key principles for documenting a clinical management plan:

1. Partner with patients, family and carers
2. Undertake a single interdisciplinary team (IDT) comprehensive assessment to inform the plan
3. Conduct Interdisciplinary team (IDT) documentation
4. Use a structured approach to communication and documentation
5. Confirm, don't repeat: use concise communications that are reviewed regularly

6. Link to Primary Health Care plans

These key principles are outlined in further detail through this document.

THREE STEPS TO DOCUMENTING CLINICAL MANAGEMENT PLANS

Once a patient is admitted to the ward there are three key steps to documenting and updating a clinical management plan:

1. Conduct an interdisciplinary team comprehensive assessment using the BNW methdology, this includes:
    a. A risk assessment
    b. Medication reconciliation
    c. Define the estimated date of discharge (EDD) within 24 hours of admission

    The assessment will be informed by the patient's condition, informal information from the patient and formal information from the existing care plan from the community.

    Document the assessment in the Progress Note
    Enter the EDD in the Patient Flow Portal

2. Work with the entire team, including the patient, to develop an initial clinical management plan based on the comprehensive assessment, this includes assigning responsible person(s) for
    a. initiating investigations,
    b. commencing treatment
    c. arranging referrals

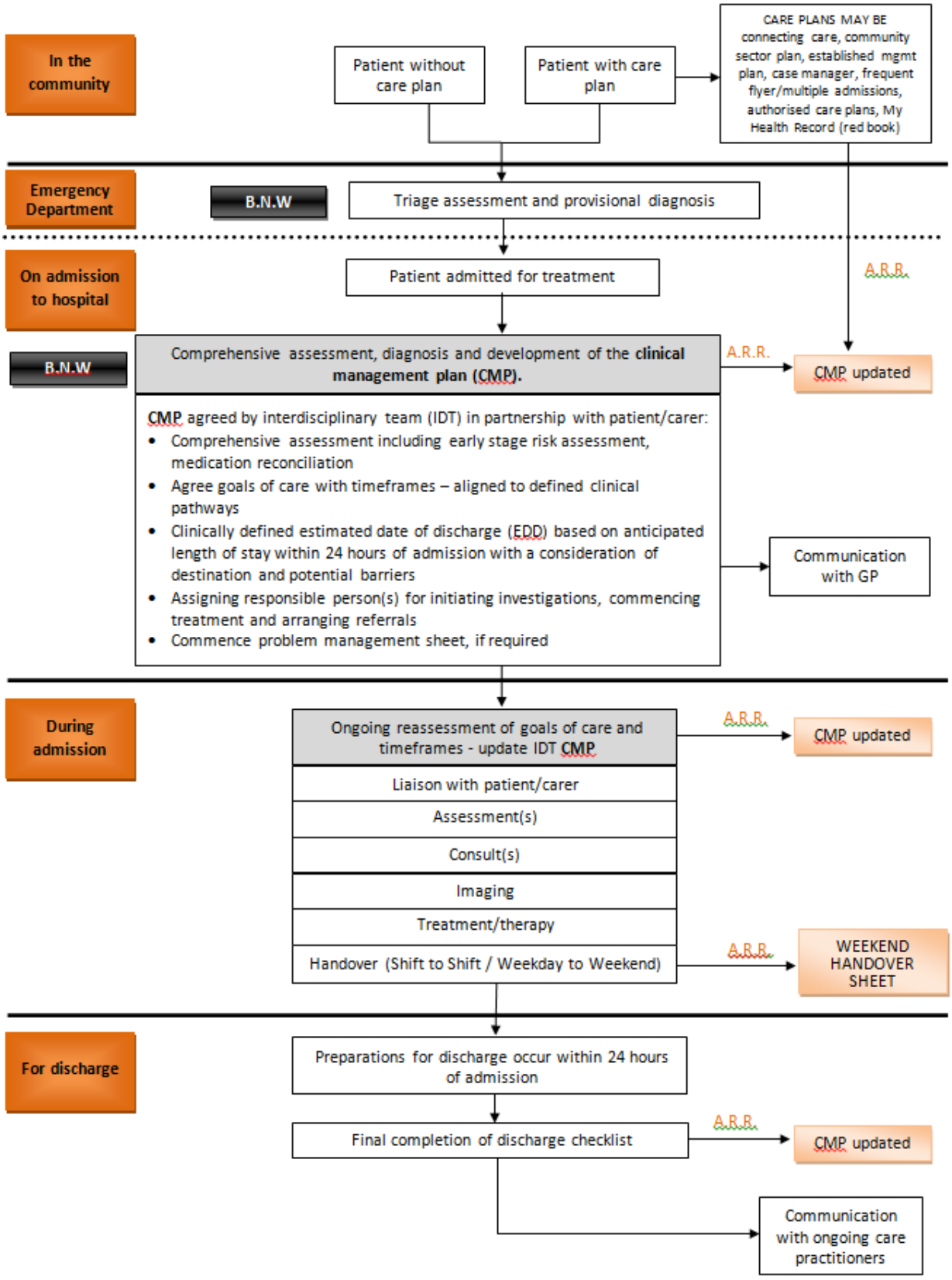
    Document the
    - clinical management plan using the overprint template for the Progress Note
    - the goals for the day and the plan on the patient bedside journey boards

3. Update the clinical management plan each day as new information comes to hand using the Acknowledge, Review, Refine (ARR) methodology.

    Document:
    - the clinical management plan each day using the overprint template for the Progress Note
    - in the problem management sheet if a patient is being managed for several conditions
    - the clinical management plan in the weekend handover template if the weekend team has no face to face handover

Figure 2 outlines the process for documenting the clinical management plan through the patient journey.

Figure 2 Documenting the clinical management plan throughout the patient journey



METHODOLOGIES

A comprehensive assessment is the foundation for building an appropriate inpatient clinical management plan. As such this comprehensive assessment should only be conducted once. A patient should not have to repeat their history for every health professional encounter.

Two methodologies are recommended to ensure that a comprehensive assessment is only conducted once. The Before, Now, Why (BNW) methodology and the Acknowledge, Review, Refine (ARR) methodology.

Before, Now Why Methodology

A comprehensive assessment should seek to understand if there is a difference between a patient's function from before the hospital admission. The Before (B), Now (N), Why (W) methodology has an appreciation for the physical, cognitive and social function of the patient (**Figure 3**). The development of a clinical management plan will follow the comprehensive assessment. This management plan should be developed for this admission (now) in partnership with the patient, their family and/or carers with an understanding for why this variation has occurred.

Figure 3 The BNW methodology for Comprehensive Assessments

<table>
<tr><td colspan="2">A comprehensive assessment of the physical, cognitive and social function of the patient might include:</td></tr>
<tr><td>BEFORE</td><td>• Pre morbid data - to include all functional domains.
• Consider access to other data – e.g.
o informal information from patient/carer(s),
o formal documentation: over 75 assessment, chronic care plans, mental health care plan, as relevant</td></tr>
<tr><td>NOW</td><td>• Current function
• Problem list as documented in the Problem Management Sheet</td></tr>
<tr><td>WHY</td><td>• Diagnosis and differential diagnosis.</td></tr>
<tr><td colspan="2">Following the comprehensive assessment an clinical management plan should developed in partnership with patients, their family and/or carers. This should include the:
• Establishment of goals of care with timeframes in line with defined evidence-based clinical pathways.
• A clinically defined estimated date of discharge (EDD) based on a patient's anticipated length of stay within 24 hours of admission with a consideration of the discharge destination and potential barriers to discharge.
• Assignment of a responsible person(s) for initiating investigations, commencing treatment and arranging referrals to necessary disciplines.
• creation problem management sheet.</td></tr>
</table>

Acknowledge, Review, Refine Methodology

Developing a management plan may involve many people. Implementing the ARR methodology will minimise the problems that may arise from such care (**Figure 4**). This methodology includes acknowledging the work of your colleagues, only adding new data to the record and not repeating comprehensive assessments. Documentation should have a structured approach and both methodologies will link to ISBAR (Figure 4):

- **I**ntroduction
- **S**ituation
- **B**ackground
- **A**ssessment
- **R**ecommendation

Figure 4 Principles of documenting in an clinical management plan according to ARR

ACKNOWLEDGE	• who was present at the review e.g. Patient (+/- carer) seen with +/- other clinicians present
	• whether known previously to patient e.g. Patient previously known, last reviewed 6 days ago e.g. Patient new to me.
	• review of existing data: new of data since last review (include date) or file review e.g. File reviewed since last entry e.g. File reviewed to date
	• other clinicians contribution e.g. Seen by physiotherapist <insert date, time>, e.g. Noted nursing staff challenge with blood pressure e.g. Thank you to JMO for management of <insert incident>
	• unplanned reviews , major events, incidents e.g. MET call, code black <date, time> e.g. Unplanned medical review <date, time>
REVIEW	*Document what new data is available to inform the development of the management plan. This could include new data at a daily review or a shift review.*
	• Add new data - relevant to clinician e.g. Nursing: unstable blood pressure e.g. Allied Health: unstable gait, difficulty walking e.g. Medical: Fever
	• Current function
	• management challenges e.g. confusion, unstable BSLs, unclear discharge destination

	• Response to treatment plan • Investigations: pending, completed, results available • Treatment options
REFINE ***(PLAN)***	*Document the current management plan with goals of care. Refine the plan that has existed with the new information to hand.* • What to do, who to do it and by when • Commence weekend clinical handover, if appropriate • Update the estimated date of discharge (EDD) • Commence planning transfer of care e.g. transfer between clinicans, wards or to community.
In the event of an unexpected change in clinical condition: STOP AND REASSESS. Consider a repeat of the BNW process to understand and document this unexpected change. e.g. in the event of confusion, loss of consciousness, recurrent falls.	

PATIENT JOURNEY BOARDS

There are two main types of patient journey boards:

1. Bedside patient journey boards that document an individual patient's daily goals of care
2. Team patient journey boards that document the patients on the ward

These two tools can assist the team to share information that is documented in the clinical management plan.

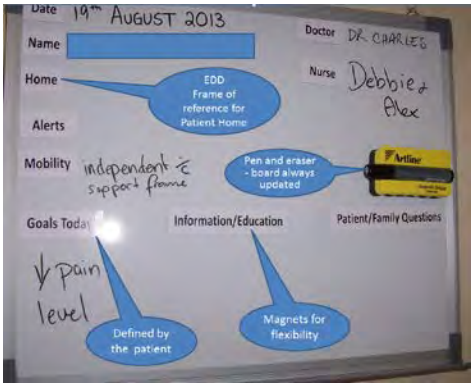
Why use a bedside journey board?

A bedside journey board is usually a small white board that is beside the patient's bed and in view of the patient. They allow staff and patients to see 'at a glance' the patient's:

- Doctor
- Bedside nurse
- Goal for the day
- Plan of care
- Estimated date of discharge

It also provides a space for patients/families to ask questions. They can be powerful enablers to involving the patient in setting their own goals and providing a transparency to the clinical management plan.

Figure 5 Bedside patient journey board



Source: Patient Flow Project Manager, Bega Valley Health Service

Why use a team whiteboard?

The team patient journey boards are usually large whiteboards that allow the entire team to see 'at a glance' the plan for the patient (**Figure 6**). When combined with the rapid round – a quick interdisciplinary team meeting where all the patients on the ward are discussed – they are a very powerful tool for sharing information across the entire team. They are a flexible tool to meet the needs of individual teams and the following is a list that has been used on various boards:

- Where the patient is
- What is planned next for the patient
- Which consultant team is looking after the patient
- What allied health involvement is required for the patient
- What else the patient requires before discharge
- When the patient is due to go home (the Estimated Date of Discharge)
- Whether the discharge medication has been requested/ received
- Whether transport is required / has been booked to take the patient home

Figure 6 Team patient journey board

Note: the patient name has been cropped out of this image
Source: Manger Clinical Redesign, Northern Beaches and Hornsby Ku-ring-gai Health Services

Figure 7 Communication in the patient record according to the structured ISBAR aligned to the A.R.R.

<table>
<tr><th colspan="2">ISBAR</th><th colspan="2">ARR</th></tr>
<tr><td rowspan="2">Introduction</td><td>Introduce yourself and your role in the patient's care</td><td rowspan="5">Acknowledge</td><td rowspan="5">• who was present at the review
• whether known previously to patient
• review of existing data: new of data since last review (include date) or file review
• other clinicians contribution
• unplanned reviews , major events, incidents</td></tr>
<tr><td>Document your role in the unit/team</td></tr>
<tr><td rowspan="2">Situation</td><td>Specify patient name, diagnosis and current condition according to the principles of:
• Before (is this usual for the patient or a new symptom)
• Now (active problem list)
• Why (diagnosis)</td></tr>
<tr><td>Explain what has happened to trigger the documentation</td></tr>
<tr><td rowspan="2">Background</td><td>State admission date, patient's diagnosis +/- differential diagnosis, and pertinent medical history</td></tr>
<tr><td>Acknowledge what has been done so far</td></tr>
<tr><td rowspan="2">Assessment</td><td>Give a summary of the patient's condition or situation according to the principles of BNW</td><td rowspan="2">Review</td><td rowspan="2">• add new data - relevant to clinician
• current function
• management challenges</td></tr>
<tr><td>Note clearly the trend in patient observations</td></tr>
</table>

	Explain what you think the problem is		• response to treatment plan • Investigations: pending, completed, results available • treatment options
	Expand upon your statement with specific signs and symptoms		
Recommendation	Explain what you would like to see done	**R**efine	• Document/refine management plan. • update the EDD • What to do, who to do it and by when • Commence weekend clinical handover, if appropriate • Commence planning transfer of care
	State any new treatments or changes ordered		

SIX KEY PRINCIPLES IN FURTHER DETAIL

1. PARTNER WITH PATIENTS, FAMILY AND CARERS

The management plan should be developed and agreed by the multidisciplinary team in partnership with the patient, their family and/or carer according to the principles of Before, Now, Why (BNW).

Patients and their families report feeling safe when continuity of care is demonstrated by the health care team(7); this involves personal communication between inpatient and outpatient providers(8). Patients will feel physical frustrations when waiting for information or a diagnosis(7).

Patients report that they want to be empowered to participate in shared decision making(9) ; part of this involves being included as a partner in their own care or the care of their families**(7)**.

In order to partner well with patients, their families and/or carers a clinician will need a good understanding of the patient. Using the BNW methodology or Before, Now, Why will develop this understanding.

Key tip:

- Use bedside patient journey boards to document the patient goals and plan for the day – see 'bedside patient journey boards'

2. UNDERTAKE A SINGLE COMPREHENSIVE ASSESSMENT TO INFORM THE PLAN

The IDT should work together to ensure that a single comprehensive assessment of the patient is undertaken. This assessment will lead to the development of the clinical management plan

The plan should be updated throughout the inpatient journey. This assessment should consider the physical, cognitive and social function of the patient according to the Before, Now and Why (BNW) methodology.

Key tip:

- Use the Before, Now and Why (BNW) methodology to conduct the comprehensive assessment

3. USE A STRUCTURED APPROACH TO COMMUNICATION

Evidence from observational studies suggests that explicit communication facilitates behaviours associated with good patient outcomes(10). Taking this even further with a more structured approach evidence suggests that safety checklists empower all members of the team to participate in ensuring that key components of the review are not overlooked by the team(11).

A template for documenting the care of a patient improves documentation of co-morbidities and complications and as a result reduces patient specific predicted mortality(12), enhancing patient care(13). A pre-populated structured template has also been found to reduce use of unapproved abbreviations(14).

The ISBAR acronym provides a simple but effective way of prioritising information when communicating about a patient and their situation.

Key tips:

- Use the daily clinical management plan template as an overprint on the Progress Note to document the interdisciplinary ward round
- Use the 'rapid round' at the team whiteboard to share information verbally and document this in the Progress Note – see 'patient journey boards'

4. INTERDISCPLINARY DOCUMENTATION

Entries by different professional groups should be integrated in the progress / clinical notes in the patient record and documented according to the Acknowledge, Review, Refine (ARR) methodology. Clinical management plan entries by different professional groups must be integrated; there should not be separate sections for each professional group(15).

Additionally, the team should ensure that verbal communications are documented to improve patient care(5).

Key tips:

- Use the daily clinical management plan template as an overprint on the Progress Note to document the interdisciplinary ward round
- Use the weekend handover sheet to share the clinical management plan with the weekend team

5. CONCISE COMMUNICATIONS REVIEWED REGULARLY

Writing more is not the solution; simply writing with greater efficiency will cut down on time spent in documentation (16).

The management plan should be regularly reviewed and documented in a concise manner to ensure the entire health care team are aware of decision making. This is particularly important for transfer of care to overnight and weekend teams.

Patients should not have to continually repeat their story in order to receive appropriate care. A comprehensive assessment should only be conducted once.

Key tips:

- Use coloured stickers for different professional groups when documenting in the Progress Note to highlight documentation

- Use the Acknowledge, Review, Refine (ARR) methodology to ensure that documentation is concise and not repeated

6. LINK TO PRIMARY HEALTH CARE PLANS

The clinical management plan should be directly linked to any existing plan from the primary health care team. This will certainly provide the inpatient team with a rich source of information. It may be a plan that has been developed by the GP and is held in the My Health Record (or red book).

Upon transfer of care (discharge) advice should be provided directly to the primary health care team to provide guidance on updating the primary health care plan.

ALWAYS / NEVER EVENTS

Each of the principles and the methodologies outlined in this resource are designed to improve the medical inpatient journey. As such teams can link this approach to a set of always and never events(17)

'Always events' are those things that should happen for every patient, for every admission, and 'Never events' are those things that should not be a part of a patient journey at any time)*. Many always and never events will apply to all patients but this resource acknowledges that some local variation will exist and therefore encourages local teams to build a relevant always and never event listing. The following list is provided as a guide for local teams.

ALWAYS EVENTS

- Always involve a patient and their families in the care planning process
- Always clearly document a patient's goals of care within 24 hours of admission; this includes a clinician defined estimated date of discharge (EDD)
- Always address patient/family concerns
- Each admitted patient is always seen by an admitting consultant within 24 hours of admission
- Discuss with GP and community health providers within 48 hours of admission.
- Always meet the individuals family member/guardian within 48 hours of admission
- Conduct a medication reconciliation (medication review)
- Make referrals for allied health early and promptly
- Seek consensus from involved clinicians with regards to a patient's transfer of care
- The patient's goals of care are always reviewed during ward rounds, and updated if necessary
- Always consider the need for a patient's post-discharge follow up

NEVER EVENTS

- Never ignore an unexpected change in clinical condition
- Never repeat the comprehensive assessment when the information can be obtained from the patient notes
- A patient is never discharged who says that they are unsafe to return home
- Never order a review or referral without assigning a responsible person
- Never create a management plan without a documented diagnosis/differential diagnosis
- A patient is never discharged until they are medically stable
- The patient's discharge from hospital is never a surprise (to ward staff, support services, the patient's general practitioner, or the patient and their family)*
- Discharge a patient without family member and/or carer being contacted
- Discharge a patient without their discharge summary
- Discharge a patient without family/carer/nursing home involvement
- Never discharge a patient without immediate access to their required medication(s)

Figure 8 Documenting the care plan for Joan, a 78 year old hostel resident who presents to the hospital with a fractured humerus following a fall.

Process	Inappropriate process	Appropriate process
Comprehensive assessment	• Joan is required to repeat same information repeatedly to multiple clinicians conducting clinician specific comprehensive assessments	• Responsible clinician conducts comprehensive assessment once. • Family, GP and hostel contacted regarding background information regarding Joan's function and care preferences. • All clinicians acknowledge comprehensive assessment and add information as relevant. **REPETITION AVOIDED.**
Establishment of goals of care	• Joan told what the goals of care are, no consultation on developing these goals • Lack of understanding for Joan's physical, cognitive and social function prior to hospital admission	• Goals of care developed in partnership with Joan (+family/ carer) • Use of **B**efore**, N**ow**, W**hy (**BNW**) methodology to develop an understanding of Joan's baseline physical, cognitive and social function and care expectations. • Informed by Primary Health Care management plans and informal information from Joan/family/carer. • Link to evidence based clinical pathways for certain patients.
Discharge planning	• No consideration regarding goals to achieve for safe discharge. • Estimated date of discharge (EDD) according to admission diagnosis. No communication of plans (or EDD) to Joan/family/facility.	• Planning for discharge commences on admission with an understanding of Joan's current function and the function required for safe discharge home. • Open discussion with Joan, Joan's family and facility to allow for planning.
Investigation(s), treatment(s), referral(s)	• Request forms for investigations completed	• Required investigations discussed with patient and relevant others. Request forms completed. Responsible person assigned to follow up on each request
Management of problems	• Issues relating to patient care documented in various places (e.g. end of bed, medical record) • Issues not shared in the inter-disciplinary team	• Problem Management Sheet commenced. • Visible and easily accessed in medical record.
Documenting	• Record of actions held in various places and not shared across the inter-disciplinary team.	• Medical record is the location of clinical management plan. • **A**cknowledge, **R**eview, **R**efine (ARR) methodology produces a shared and streamlined approach to managing Joan's care.
Management plan	• Joan (+family/carer) told what the management plan is, no consultation on developing this plan.	• Management plan developed in partnership with patient/family/carer after diagnosis/differential diagnosis
Coordinated care	• Patients results available and discharge planned. Patient not aware of either until day of discharge.	• Joan, Joan's family and facility updated regarding progress . Discharge plans agreed upon.
Day of discharge	• Discharge summary unavailable, faxed the next day to hostel.	• Discharge summary provided to patient and facility. • Verbal transfer of care. • Follow up appointments discussed, as required.

RELEVANT HETI TRAINING MODULES

- Clinical documentation
- Clinical handover- ISBAR

These modules can be completed at: http://nswhealth.moodle.com.au/

RELEVANT NSW HEALTH DOCUMENTATION

Useful Forms (currently in development)

- Progress Notes/Clinical Notes with overprint for daily management plan
- Problem Sheet
- Weekend Clinical Plan

NSW Health Policy Documents

- PD2012_069 Health Care Records – Documentation and Management(15)
- PD2011_015 Care Coordination(18)

APPENDIX 1: CMP FREQUENTLY ASKED QUESTIONS

What is a Clinical Management Plan?

For the purposes of this work a clinical management plan is defined as *the plan* that is developed with a patient for their care in hospital and documented in the patient's medical record.

All team members have a responsibility to *Know the plan. Share the plan. Action the plan.*

What is best practice for documenting a Clinical Management Plan in hospital?

Six key principles inform best practice for documenting the clinical management plan:

1. *Partner with patients, family and carers to develop the plan.*
2. *Undertake a single interdisciplinary team (IDT) comprehensive assessment to inform the plan.* The plan should be updated throughout the inpatient journey. This assessment should consider the physical, cognitive and social function of the patient according to the **B**efore, **N**ow and **W**hy (BNW) methodology.
3. *Support IDT documentation.*
4. Use a structured approach to communication and documentation (e.g. ISBAR).
5. *Confirm, don't repeat: use concise communications that are reviewed regularly.* The Acknowledge, Review and Refine (ARR) methodology asks staff to **A**cknowledge their team's contribution to the plan, **R**eview new data and **R**efine the plan with the patient's existing status.
6. *Link to Primary Health Care plans.* This is particularly important to inform the patient's status pre-hospital (BNW methodology).

What do we mean by interdisciplinary team?

An *Interdisciplinary team* integrates separate disciplines into a single consultation. This is where the patient-history taking, assessment, diagnosis, intervention and management goals are conducted by the team, together with the patient, at the one time[1].

A multidisciplinary team utilises the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective[1].

What are the potential benefits of improving the documentation of Clinical Management Plans?

- **Improve patient experience:** develop patient centred care approach where patients are involved in the decisions about their care[2,3]; improve care coordination.
- **Enhance patient safety:** structured standardised documentation improves information[4,5] and medication compliance[6].
- **Improve staff satisfaction:** improved communication between the IDT; more engaged staff which leads to better patient outcomes[7,8].
- **Reduce unnecessary length of stay:** structured standardised documentation reduces length of stay[6].

What resources are available to assist our team to improve documenting the Clinical Management Plans?

- **A daily clinical management plan template:** this can be used as an overprint on the progress note to document the clinical management plan and conduct a safety checklist on the ward round each day.
- **A weekend handover sheet:** this can facilitate improved handover communication between weekend and weekday staff. It highlights the current issues, special instructions, weekend contacts, end of life care plans that exist and provides a space for acknowledging handover.
- **A problem management sheet:** this can be stored at the beginning of the medical record to highlight the key problems that are being managed. This is particularly useful for complex medical patients.
- **A set of orientation/education slides**
- **A comprehensive guide to documenting the clinical management plan:** this highlights the key methodologies to guide teams to improve the developing and documenting clinical management plans.

These resources are designed for a paper based medical record and can be easily adapted as the NSW moves to an electronic system.

Where can I find more information on Clinical Management Plans?

The full set of resources are available at: www.aci.health.nsw.gov.au/cmp.

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APPENDIX 2: PATIENT AND STAFF EXPERIENCE QUESTIONS

The Patient Experience Tracker (PET) is a small electronic hand held device that can be used to collect patient and/or staff feedback at the point of care (Figure 9). The device can have up to 5 customised questions with multiple choice answers. Patients and staff can respond to each question by the press of a button. It is fast and effective way to collect patient feedback and measure patient and staff experience. The de-identified data from the devices is collated every day and the reports are sent back via email to nominated staff overnight. The reports are presented in graphical form which is easy to interpret and provides information to act on in 'Real Time'. A weekly and monthly summary report is also available.

Figure 9: ACI Patient Experience Tracker

The CMP working group has devised a set of patient (Table 1) and staff (Table 2) experience questions to be used to measure improvements to documenting the clinical management plan.

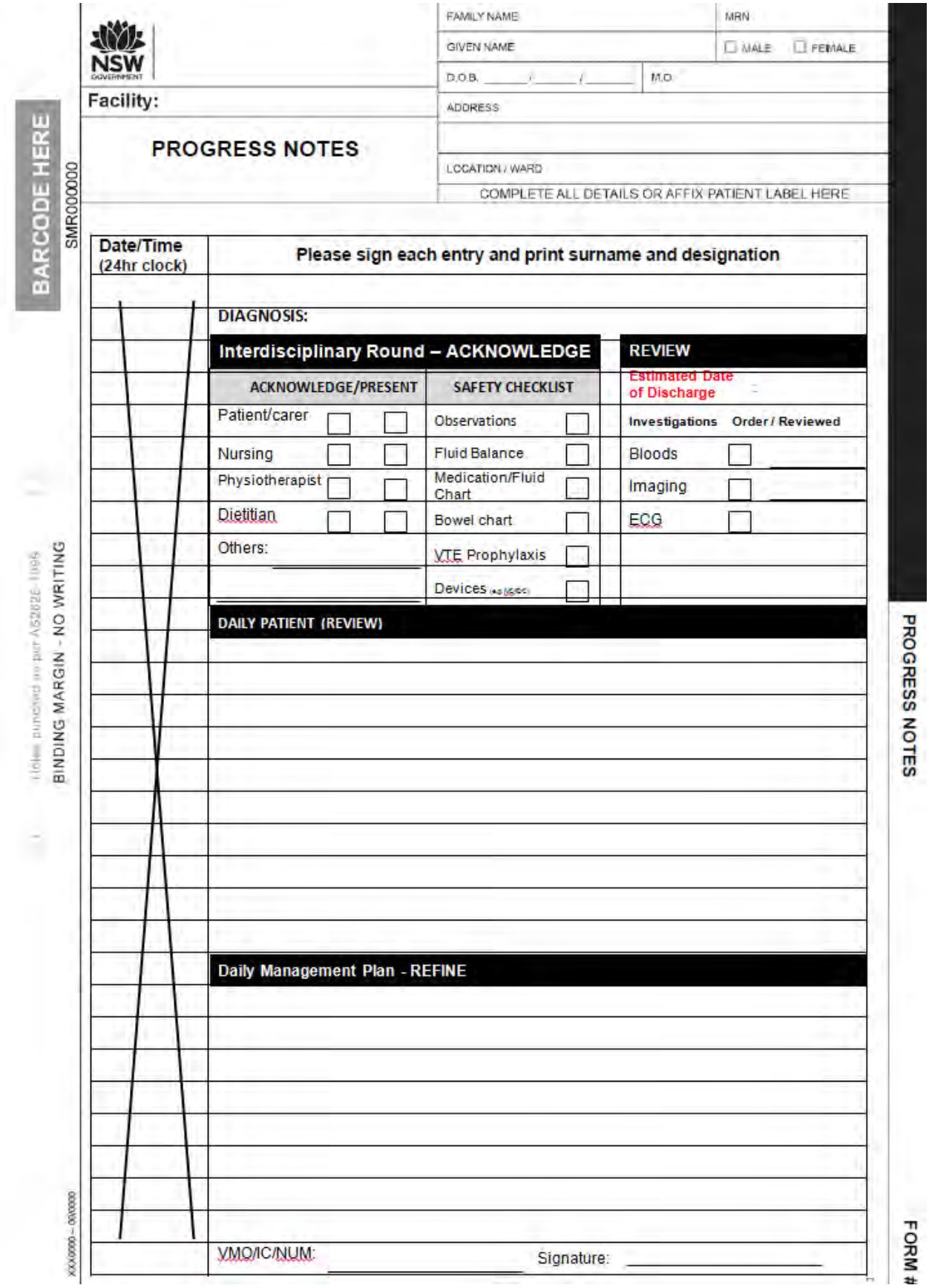
Table 1 Clinical Management Plan Patient Experience Questions

No.	Question	Select the most appropriate answer
1	I know who to ask if I have questions about my plan of care	Always Mostly Sometimes Rarely Never
2	I receive daily updates about my plan of care	
3	I am involved in the development of my discharge plan	
4	Did the staff appear to work as a team to care for you?	
5	Staff provide information about my healthcare when I need it	

Table 2 Clinical Management Plan Staff Experience Questions

No.	Question	Select the most appropriate answer
1	I use a structured approach to documenting a patient's management plan (e.g. ISBAR/ISOBAR)	Always Mostly Sometimes Rarely Never
2	Our team uses an interdisciplinary approach to developing a patient's management plan in hospital	
3	I involve the patient/family in developing a management plan while they are in hospital	
4	I review and update each patient's plan of care every day while they are in hospital	
5	Our team uses a transfer of care checklist when planning for a patient's discharge	

APPENDIX 3: DAILY INTERDISCIPLINARY REVIEW



NSW GOVERNMENT

Facility:

PROGRESS NOTES

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE

SMR000000

Date/Time (24hr clock)	Please sign each entry and print surname and designation

DIAGNOSIS:

Interdisciplinary Round – ACKNOWLEDGE

ACKNOWLEDGE/PRESENT		SAFETY CHECKLIST	
Patient/carer	☐ ☐	Observations	☐
Nursing	☐ ☐	Fluid Balance	☐
Physiotherapist	☐ ☐	Medication/Fluid Chart	☐
Dietitian	☐ ☐	Bowel chart	☐
Others: _____		VTE Prophylaxis	☐
_____		Devices (as above)	☐

REVIEW

Estimated Date of Discharge -

Investigations	Order / Reviewed
Bloods	☐ _____
Imaging	☐ _____
ECG	☐

DAILY PATIENT (REVIEW)

Daily Management Plan - REFINE

VMO/IC/NUM: _____ Signature: _____

BINDING MARGIN - NO WRITING

PROGRESS NOTES

FORM #

APPENDIX 4: PROBLEM MANAGEMENT SHEET

BARCODE HERE

SMR000000

NSW GOVERNMENT

Facility:

PROBLEM MANAGEMENT SHEET

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE: _____

PRESENTING SYMPTOMS .....

PROVISIONAL DIAGNOSIS .....

Date	Problem/Diagnosis	Special Instructions/Investigation	Outcome	Initial

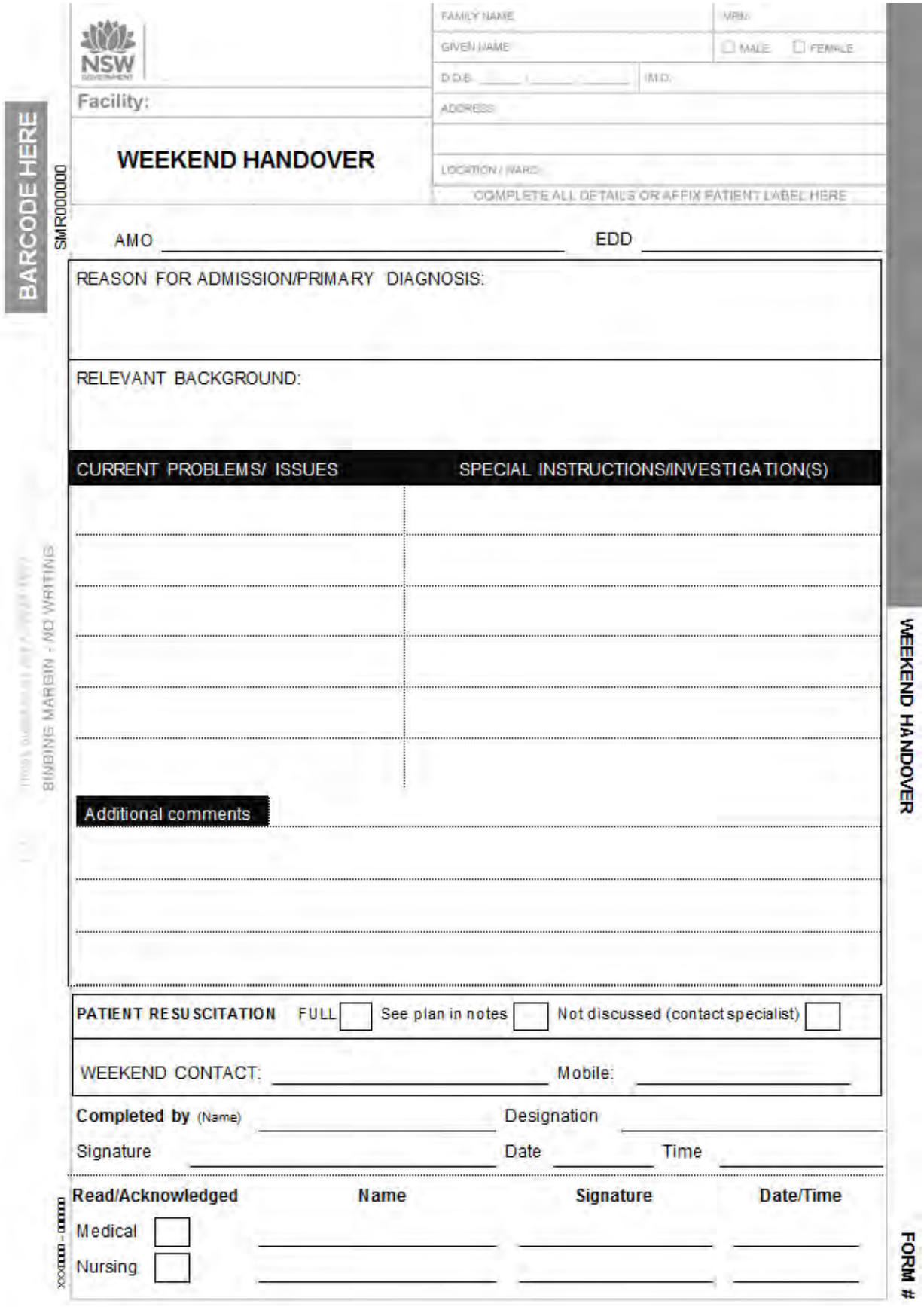
Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

PROBLEM MANAGEMENT SHEET

FORM #

APPENDIX 5: WEEKEND HANDOVER



NSW GOVERNMENT

FAMILY NAME | MRN:

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ___/___/___ | M.O.:

ADDRESS:

Facility:

LOCATION / WARD:

WEEKEND HANDOVER

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BARCODE HERE

SMR000000

AMO _____ EDD _____

REASON FOR ADMISSION/PRIMARY DIAGNOSIS:

RELEVANT BACKGROUND:

CURRENT PROBLEMS/ ISSUES	SPECIAL INSTRUCTIONS/INVESTIGATION(S)

Additional comments

PATIENT RESUSCITATION FULL ☐ See plan in notes ☐ Not discussed (contact specialist) ☐

WEEKEND CONTACT: _____ Mobile: _____

Completed by (Name) _____ Designation _____

Signature _____ Date _____ Time _____

Read/Acknowledged	Name	Signature	Date/Time
Medical ☐			
Nursing ☐			

BIMBING MARGIN - NO WRITING

WEEKEND HANDOVER

FORM #

APPENDIX 6: PD2012_069 Health Care Records

PD2012_069 Health Care Records – Documentation and Management

In particular, it is worth highlighting that the principles outlined in this document align to the NSW Health Policy directive PD2012_069 Health Care Records – Documentation and Management. (http://www0.health.nsw.gov.au/policies/pd/2012/PD2012_069.html) This PD outlines the standards for documentation in health care records which states documentation must comply with the following:

Be clear and accurate.

Legible and in English.

Use approved abbreviations and symbols.

Written in dark ink that is readily reproducible, legible, and difficult to erase and write over for paper based records.

Time of entry (using a 24-hour clock – hhmm).

Date of entry (using ddmmyy or ddmmyyyy).

Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system eg. electronic signature.

Entries by students involved in the care and treatment of a patient / client must be cosigned by the student's supervising clinician.

Entries by different professional groups are integrated ie. there are not separate sections for each professional group.

Be accurate statements of clinical interactions between the patient / client and their significant others, and the health service relating to assessment; diagnosis; care planning; management / care / treatment/ services provided and response / outcomes; professional advice sought and provided; observation/s taken and results.

Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient / client or to provide ongoing service at any time.

Written in an objective way and not include demeaning or derogatory remarks.

Distinguish between what was observed or performed, what was reported by others as happening and / or professional opinion.

Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.

Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.

Be relevant to that patient / client.

Only include personal information about other people when relevant and necessary for the care and treatment of the patient / client.

Addendum – if an entry omits details any additional details must be documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum.
For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and / or attached to existing forms.

Written in error - all errors are must be appropriately corrected.

No alteration and correction of records is to render information in the records illegible.

An original incorrect entry must remain readable ie. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or 'strikethrough' text in electronic records; document "written in error", followed by the author's printed name, signature, designation and date / time of correction.

For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as "written in error". This provides the viewer with both the erroneous record and the corrected record.

APPENDIX 7: IMPLEMENTATION PLAN FOR IMPROVING CLINICAL MANAGEMENT PLANS

Area	Ref	Task	Owner	Timeframe	Status
Governance	1.1	Identify executive lead			
Governance	1.2	Identify clinical lead (s): minimum both medical and nursing			
Governance	1.3	Identify implementation lead			
Governance	1.4	Define, document and agree roles and responsibilities for the clinical leads			
Governance	1.5	Define, document and agree roles and responsibilities for the implementation officer			
Governance	1.6	Finalise local implementation team • Terms of Reference • Regular meeting dates are established			
Governance	1.7	Risk assessment • Identify and manage local implementation risk and issue resolution process • Involve managers and clinicians (unit specific) • Identify any potential barriers and solutions to patient flow			
Governance	1.8	Define and measure implementation and outcome measures (see data set) • What local outcomes will be measured? • At what points of the implementation will you measure outcomes? • How will you track and report the outcomes?			
Operating Design	2.1	Define local approach for documenting the clinical management plan			
Operating Design	2.2	Determine changes to local operating models, procedures and clinical guidelines e.g. adapting existing protocols			
Operating Design	2.3	Steering Committee sign-off			

Area	Ref	Task	Owner	Timeframe	Status
Awareness/Training	3.1	Communication plan/ Communication strategy to report achievements			
Awareness/Training	3.2	Create awareness of the new approach to documenting the clinical management plan, impact on existing business processes and 'go-live' dates for hospital management			
Awareness/Training	3.3	Schedule orientation and training sessions for identified clinicians			
Data/Evaluation	4.1	Define roles and responsibilities for • IT (e.g. if you use an electronic medical record) • Data and planning team			
Data/Evaluation	4.2	**Possible data set** • Patient and carer experience with patient story gathering • Compliance with clinician defined estimated date of discharge • Mortality data • Ward data (length of stay, traffic) • Readmission rate • Audit of medical records o Utilisation of clinical management plan template o Utilisation of weekend handover o Utilisation of problem management sheet o % of patients with relevant form o % of completed forms o % of patients with weekend handover acknowledged o % of patients with weekend to weekday handover			

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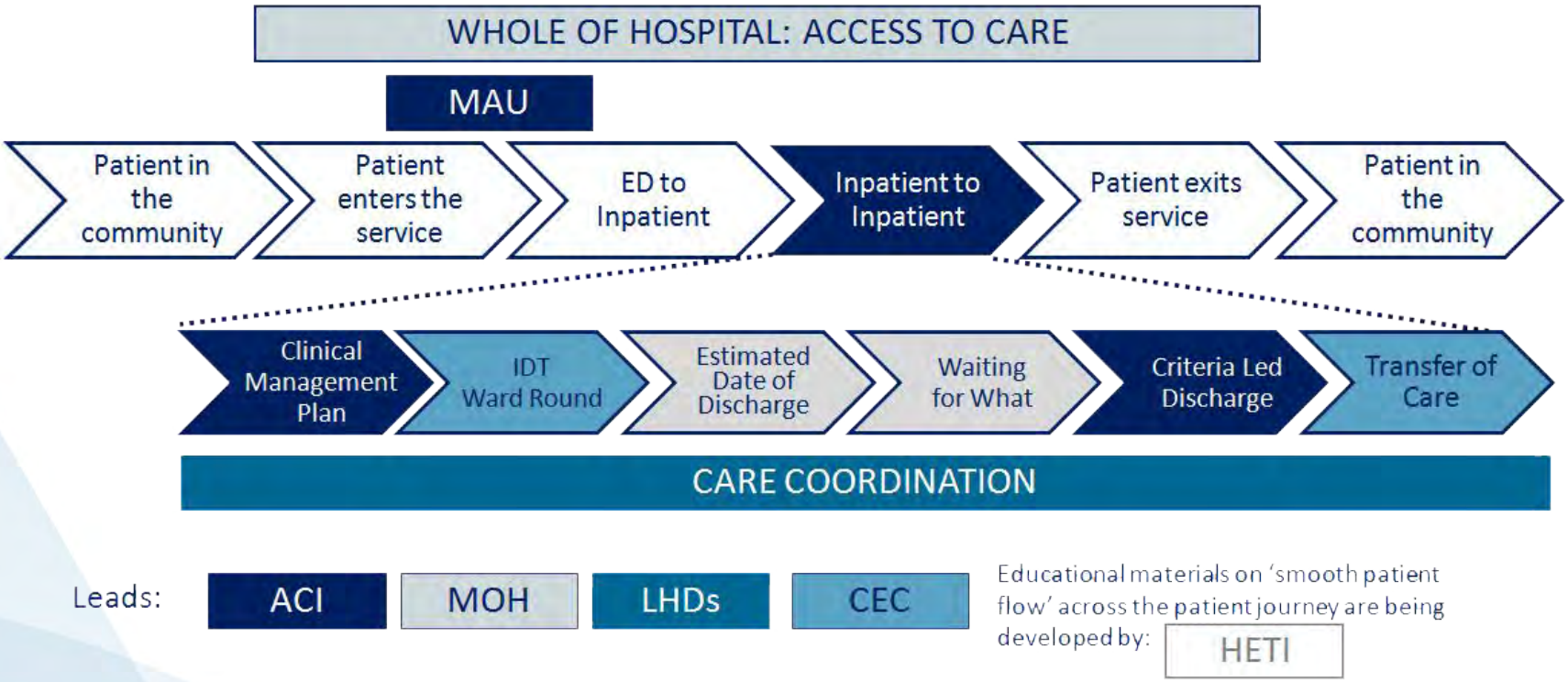
ACI NSW Agency for Clinical Innovation

INSERT LOCAL LOGO

Clinical Management Plan

Know the Plan. Share the Plan. Action the Plan.

The medical inpatient journey



The Clinical Management Plan

…*the plan* that is

- developed with a patient for their care in hospital; and
- documented in the patient's medical record

Improve:

- Communication
- Patient safety
- Patient experience
- Staff experience

Key principles

1. Partner with patients, family and carers to develop the plan.
2. Undertake a single interdisciplinary team (IDT) comprehensive assessment to inform the plan.
3. Support IDT documentation.
4. Use a structured approach to communication and documentation (ISBAR).
5. Confirm, don't repeat: use concise communications that are reviewed regularly.
6. Link to Primary Health Care plans.

Comprehensive Assessment - BNW

- Conduct a comprehensive assessment once

BEFORE	• Pre morbid data to include all functional domains. • Consider access to other data – e.g. o *informal information:* from patient/carer(s) o *formal documentation*: over 75 assessment, chronic care plans, mental health care plan, as relevant
NOW	• Current function • Problem list as documented in the Problem Management Sheet
WHY	• Diagnosis and differential diagnosis

ARR methodology

ACKNOWLEDGE	Document: • who was present at the review • whether known previously to patient • review of existing data • other clinicians contribution • unplanned reviews , major events, incidents
REVIEW	*Document what new data is available to inform the development of the management plan.* • new data relevant to clinician • current function • management challenges • response to treatment plan • investigations: pending, completed, results available. • treatment options
REFINE **(PLAN)**	*Document the management plan, including the goals of care. Refine an existing management plan with new information to hand.* • What to do , who to do it and by when • Commence weekend clinical handover, if appropriate • update the estimated date of discharge (EDD) • Commence planning transfer of care

Structured Communications: ISBAR

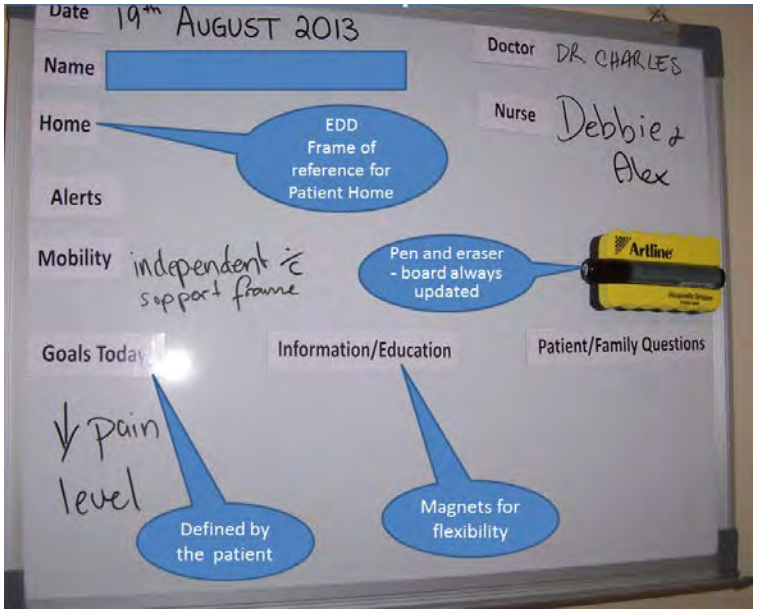
ISOBAR			A.R.R.
I	Introduction	Introduce yourself and your role in the patient's care	Acknowledge
S	Situation	Specify the patient's name, diagnosis and current condition according to the principles of Before, Now, Why (BNW).	
		Explain what has happened to trigger the documentation	
B	Background	State the admission date of the patient, his or her diagnosis +/- differential diagnosis, and pertinent medical history	
		Acknowledge what has been done so far	
A	Assessment	Give a summary of the patient's condition or situation according to the principles of BNW	Review
		Note clearly the trend in patient observations	
		Explain what you think the problem is	
		Expand upon your statement with specific symptoms	
R	Recommendation	Explain what you would like to see done	Refine
		State any new treatments or changes ordered	

Patient Journey Boards

TEAM PATIENT JOURNEY BOARD

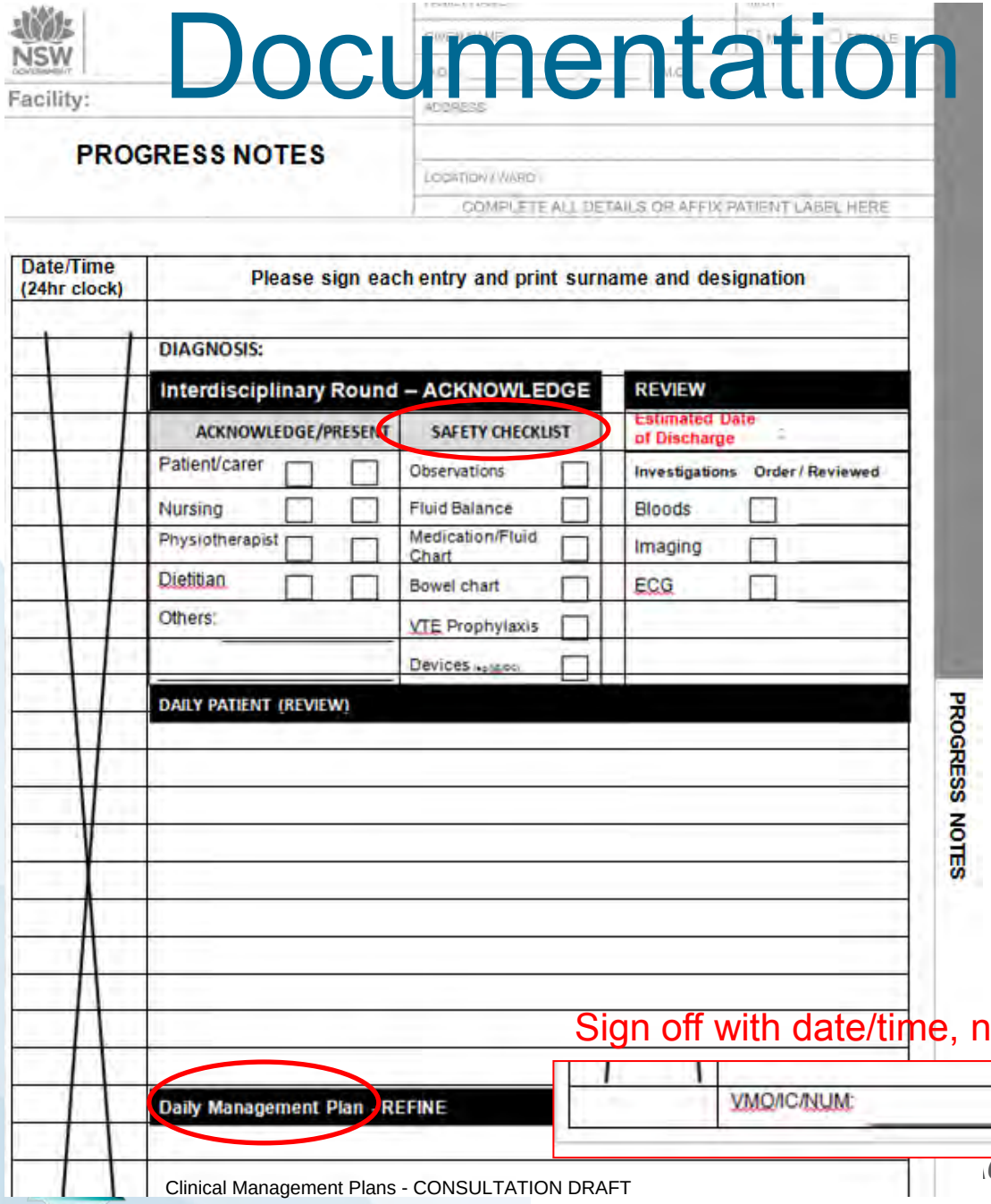
Note: the patient name has been cropped out of this image
Source: Manger Clinical Redesign, Northern Beaches and Hornsby Ku-ring-gai Health Services

BEDSIDE PATIENT JOURNEY BOARD



Source: Patient Flow Project Manager, Bega Valley Health Service

Documentation - Daily

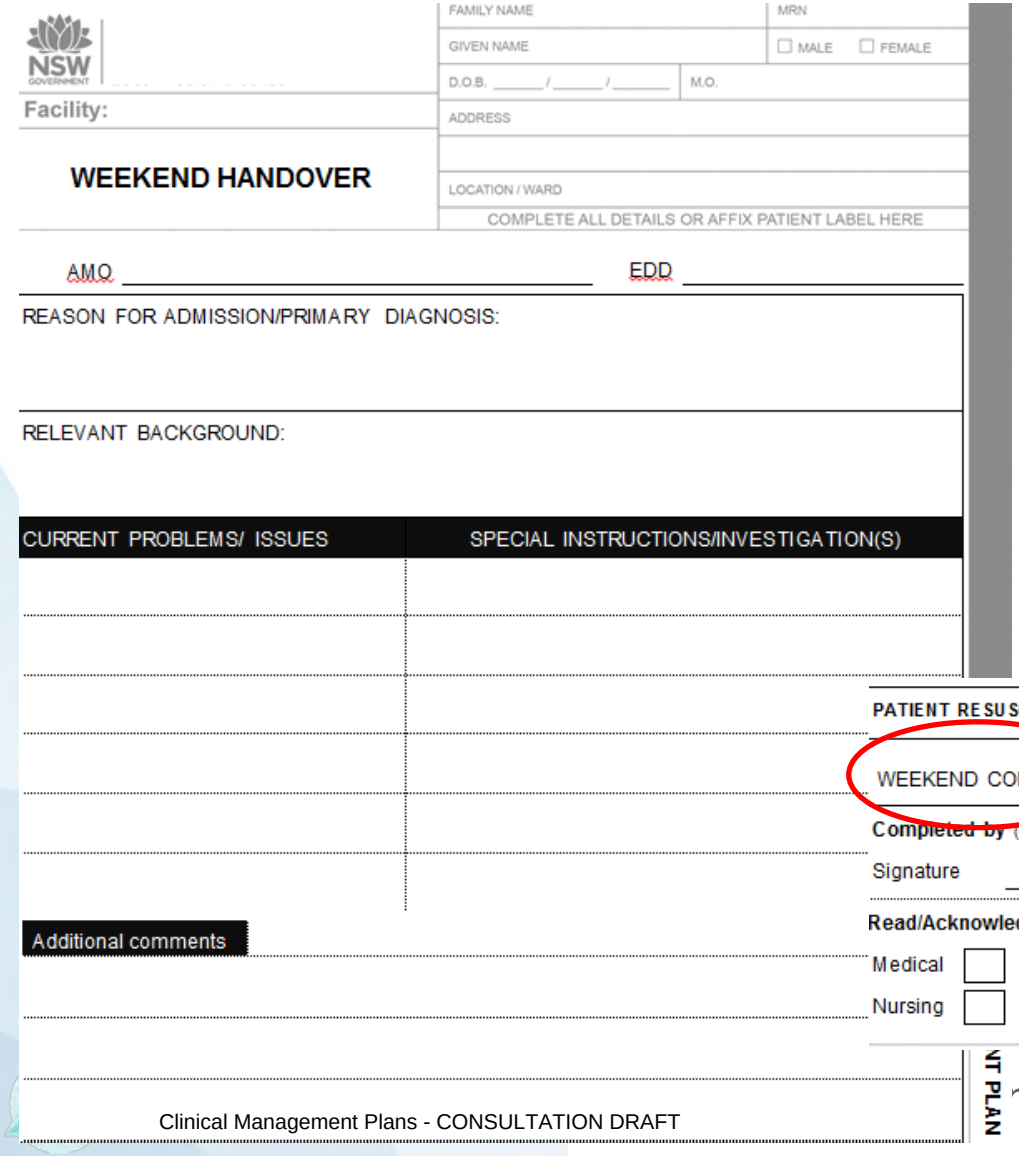


- **A**cknowledge
- **R**eview
- **R**efine
- Overpint onto **Progress Notes** for interdisciplinary documentation

Sign off with date/time, name, signature

INSERT LOCAL LOGO

Documentation - Weekend



NSW GOVERNMENT

Facility:

WEEKEND HANDOVER

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

AMO _____ EDD _____

REASON FOR ADMISSION/PRIMARY DIAGNOSIS:

RELEVANT BACKGROUND:

CURRENT PROBLEMS/ ISSUES	SPECIAL INSTRUCTIONS/INVESTIGATION(S)

Additional comments

PATIENT RESUSCITATION FULL ☐ See plan in notes ☐ Not discussed (contact specialist) ☐

WEEKEND CONTACT: _____ Mobile: _____

Completed by (Name) _____ Designation _____

Signature _____ Date _____ Time _____

Read/Acknowledged	Name	Signature	Date/Time
Medical ☐			
Nursing ☐			

FORM #

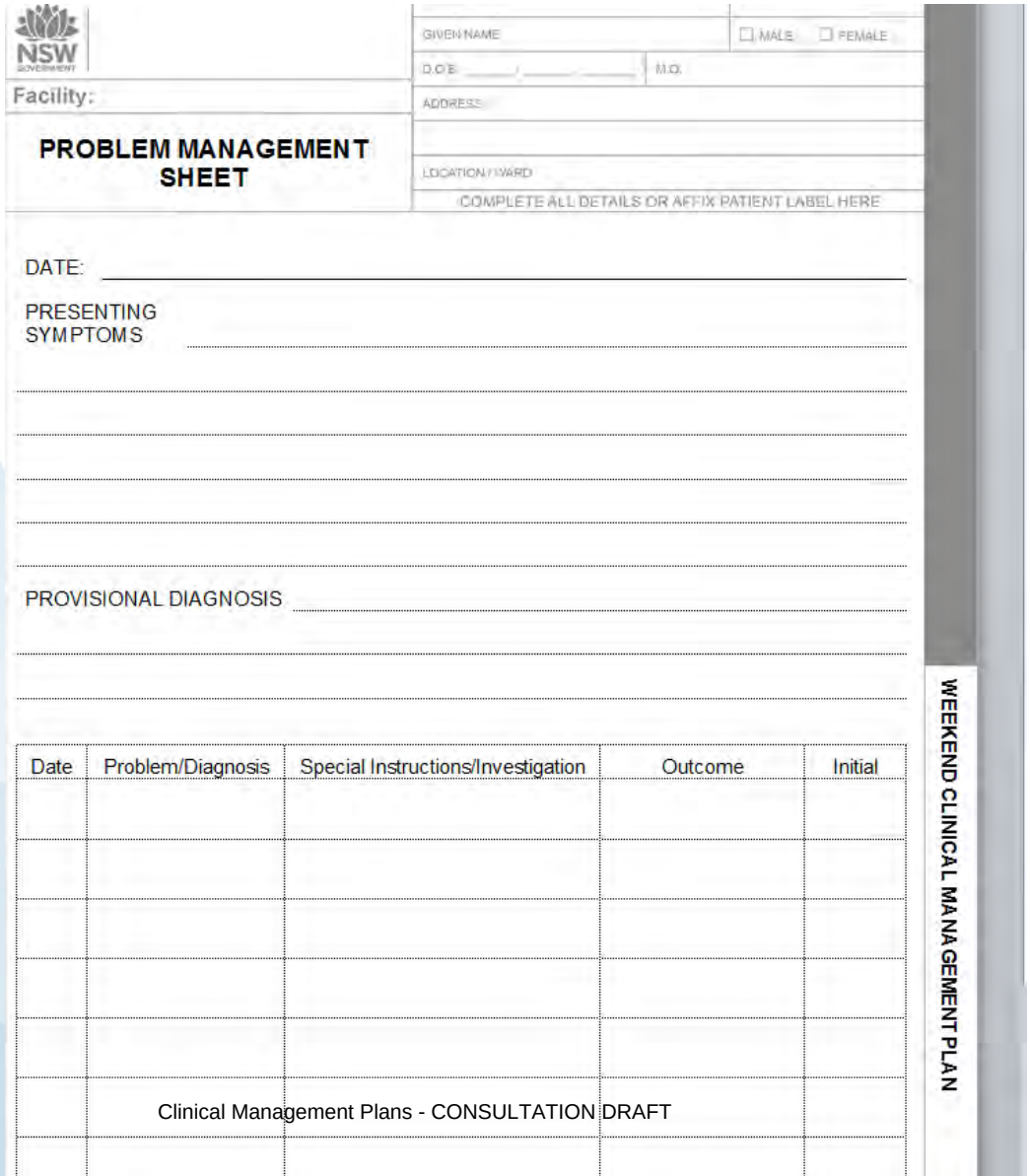
NT PLAN

- Clear, concise
- Document using ISBAR
- **A**cknowledge
- **R**eview
- **R**efine

n. Action the Plan.

INSERT LOCAL LOGO

Documentation - PROBLEM



NSW GOVERNMENT

Facility:

PROBLEM MANAGEMENT SHEET

GIVEN NAME ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DATE: _____

PRESENTING SYMPTOMS .....

PROVISIONAL DIAGNOSIS .....

Date	Problem/Diagnosis	Special Instructions/Investigation	Outcome	Initial

WEEKEND CLINICAL MANAGEMENT PLAN

- At a glance what is being managed by the entire team
- Useful for complex patients

Always / Never events

ALWAYS EVENTS

1. Always involve a patient and their families in the care planning process
2. Always clearly document a patient's goals of care within 24 hours of admission; this includes a clinician defined estimated date of discharge (EDD)
3. Always address patient/family concerns

NEVER EVENTS

1. Never ignore an unexpected change in clinical condition
2. Never repeat the comprehensive assessment when the information can be obtained from the patient notes
3. A patient is never discharged who says that they are unsafe to return home

Joan, a 78 year old hostel resident presented to the hospital with a fractured humerus following a fall.

Process	Inappropriate process	Appropriate process
Comprehensive assessment	• Joan is required to repeat same information repeatedly to multiple clinicians conducting clinician specific comprehensive assessments	• Comprehensive assessment **once**. • Family, GP and hostel contacted for background information • All clinicians acknowledge and add information as relevant
Establishment of goals of care	• Joan told what her goals of care are • Lack of understanding for Joan's function prior to hospital admission	• Goals of care developed in partnership with Joan (+family/carer) • Before, Now, Why (**BNW**) = Joan's current and previous physical, cognitive and social function. • Link to evidence based clinical pathways
Discharge planning	• No consideration of goals for safe discharge. • Estimated date of discharge (EDD) according to diagnosis but no communication of planned date	• Planning for discharge commences on admission with an understanding of Joan's function • Open discussion with Joan (+family/facility) to allow for planning
Investigations, treatment, referrals	• Request forms for investigations completed	• Investigations discussed with patient and relevant others • Request forms completed, responsible person assigned
Management of problems	• Issues relating to patient care documented in various places (end of bed, medical record, clinical software)	• Problem Management Sheet commenced • Information visible and easily able to be accessed
Management plan	• Joan (+family/carer) told what the management plan is, no consultation on developing plan	• Management plan developed in partnership with Joan after diagnosis/differential diagnosis
Documenting the management plan	• Record of actions held in various places and not shared across the inter-disciplinary team.	• Medical record = location of management plan • Acknowledge, Review, Refine (**ARR**) = shared and streamlined approach, • **ISBAR** = structured communications
Coordinated care	• Joan's results available and discharge planned, Joan not aware of either until day of discharge.	• Joan, Joan's family and facility updated regarding progress. • Discharge plans agreed upon.
Day of discharge	• Discharge summary unavailable but faxed the next day to hostel.	• Discharge summary provided to patient and facility. • Verbal transfer of care. • Follow up appointments discussed, as required.

Implementation Team

XX

XX

Kate Lloyd – Manager Acute Care (ACI) on kate.lloyd@aci.health.nsw.gov.au or 9464 4623

Add names and contacts for Local implementation team +/- ACI staff

Acknowledgements

- ACI Acute Care Taskforce
- ACI Clinical Management Plan Working Group
- Bega Hospital (Medical Ward)