



CLINICAL MANAGEMENT PLANS

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PRINCIPLES / GOALS

- The medical record as the chief communication document
- Establish a system / process to improve documentation within the medical record and hence communication
- Good communication improves safety, satisfaction and efficiency
- The idea that an admission is a snapshot of care and must be appreciated as such
- "The more we know the less we need"



WHAT TO DO

- Comprehensive assessment on admission
- Not a common pathway – individualised care plan
- BNW – Before, Now (active problem list), Why (diagnosis)
- Importance of documenting diagnosis and diff diagnosis
- Clear management plan – investigations, treatment, planned discussions, directions re review criteria
- Regular review of plan – results, what has worked and hasn't, what has been discussed and is yet to be discussed
- Summaries and suggestions for teams overnight and at weekends e.g. delirium, deteriorating or dying patient
- Acknowledge, Review, Refine



CHALLENGES /SOLUTIONS

- Takes more time initially, new way of documenting especially on surgical wards
- Transparency – can be a challenge
- Importance of a format / guidelines– uniformity to improve familiarity e.g. EDS
- All units using the same approach
- Supported by senior clinicians expected part of ward round



OUTCOMES

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| PATIENT | <ul style="list-style-type: none">▪ less repetition of data▪ clear communication from staff re plan▪ SAFETY |
| STAFF | <ul style="list-style-type: none">▪ avoids unnecessary testing▪ improves communication and time management▪ avoids duplication▪ improved job satisfaction |
| FACILITY | <ul style="list-style-type: none">▪ patient and staff satisfaction▪ SAFETY▪ costs |
| EXTERNAL HEALTH PROVIDERS | <ul style="list-style-type: none">▪ involved▪ improved data available for EDS |


