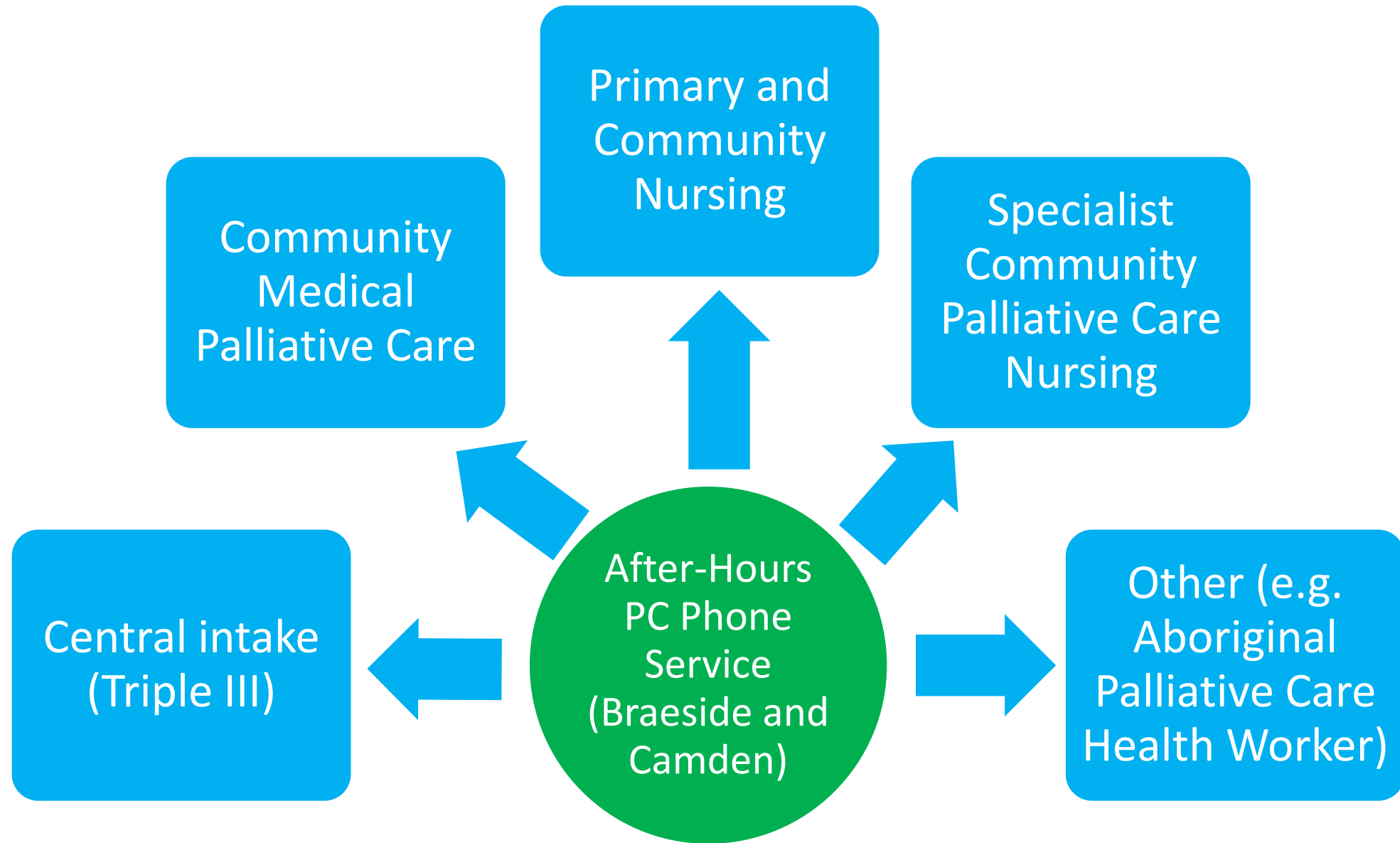


Improving eMR Documentation of Nursing Plan of Care to improve SWSLHD's After-Hours Palliative Care Service




SWSLHD's After-Hours Palliative Care Phone Service

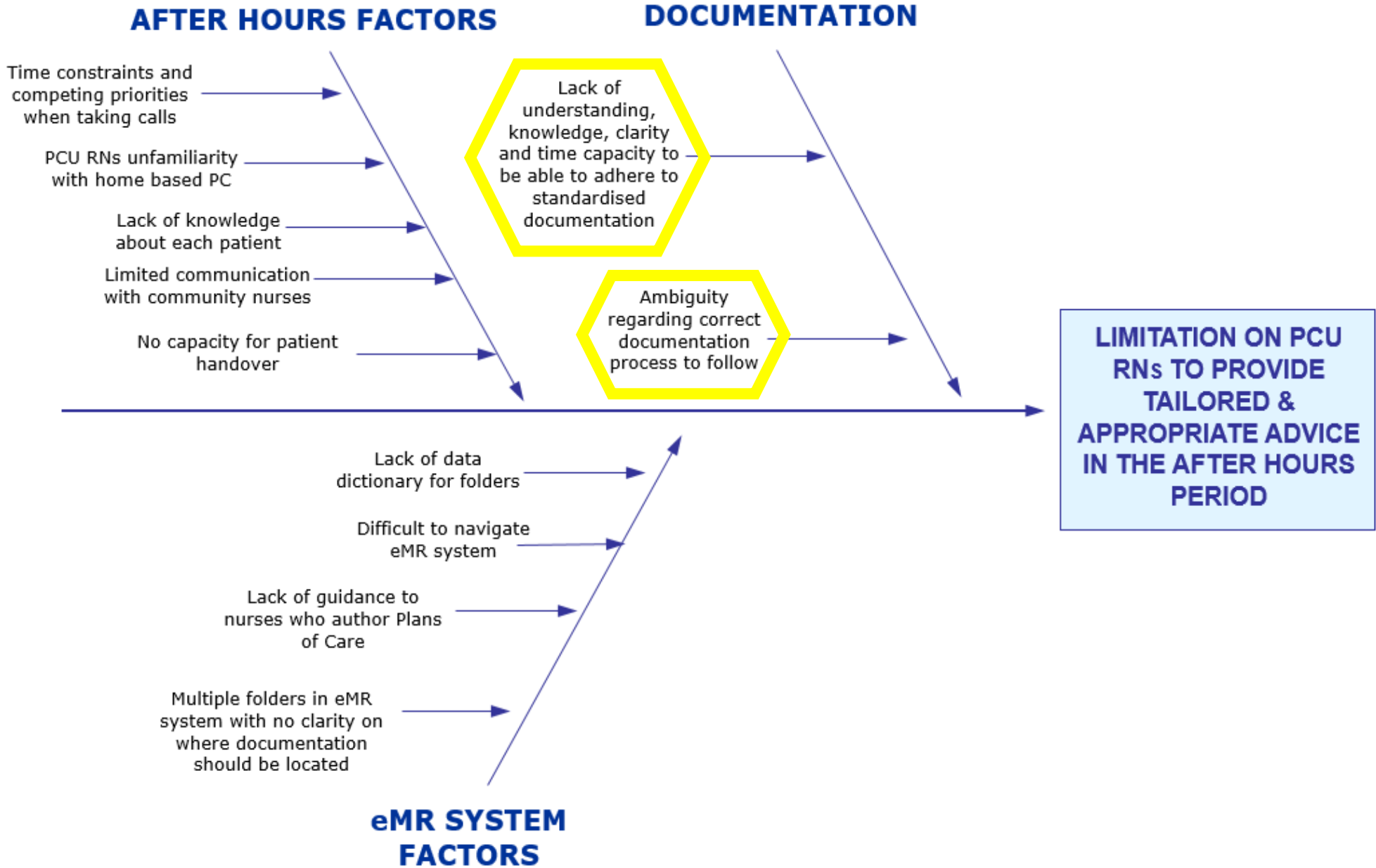


Target State: SMART Goal

Increase the percentage of patients with a suggested plan of care that has:

- 1. been documented in the Nursing Plan of Care folder of eMR**
 - 2. the PROMSNAME elements** 
 - 3. a follow-up management plan**
- from 20% to 40% by July 30 2021.**

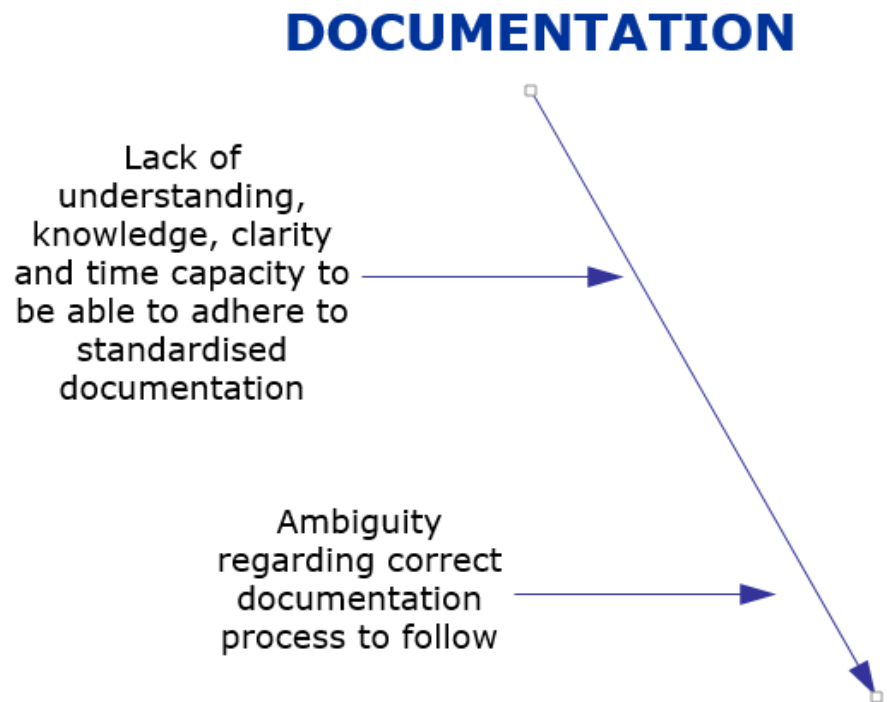
Pain
Respiratory
Orientation & oral
Mobility
Social & sleep
Nausea
Appetite
Medication
Elimination



Key Drivers

Key areas of focus from fishbone:

- Standardisation of documentation requirements for community palliative care patients
- Education for nursing staff



Key Drivers

Community Health Nurses are motivated to improve documentation

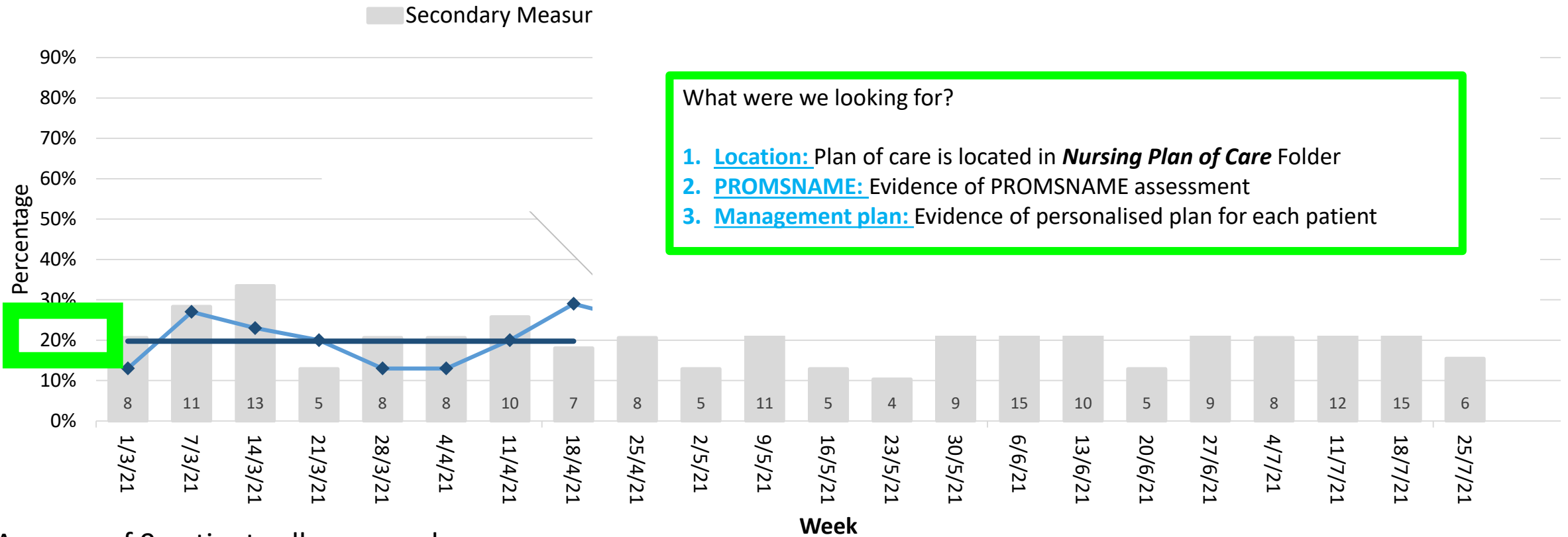
Nurses taking after hours phone calls understand documentation location

Definitions of sub-folder categories in the EMR

Community Health Nurses understand new documentation requirements

Baseline

% of patients with a suggested plan of care documented in the Nursing Plan of Care folder and containing the PROMSNAME elements with a follow up management plan



Average of 9 patient calls per week

Baseline average of **correct documentation was 20%** for these patients

Interventions

Key Drivers

Community Health Nurses are motivated to improve documentation

Nurses taking after hours phone calls understand documentation location

X
Definitions of sub-folder categories in the EMR

Community Health Nurses understand new documentation requirements

SWSLHD Community Nursing eMR Documentation Location Guideline

To **locate** documentation in the eMR: Patient List → Select Client → Clinical Notes → Palliative Care → Required Sub Folder.

NURSING ACTIVITY	PALLIATIVE CARE FOLDER Sub Folder Locations
Palliative Care Triage Phone Call	Telephone Consult Sub Folder
First Home Visit	Initial Assessment Sub Folder
Ongoing Home Visits	Nursing Plan of Care Sub Folder ** Where PCU staff documents documented here**
Case Review	Multidisciplinary Team Case Conference Sub Folder
Ongoing Clinical Telephone Calls. When clinical discussion occurs and or clinical advice is provided	Palliative Care Telephone Consult Sub Folder ** Where PCU enter document A.H 13# Phone calls**
Ongoing Non Clinical Phone Calls and Information	Palliative Care Nursing Consults, Education Sub Folder
NURSING ACTIVITY & DISCUSSIONS	ADVANCE CARE PLANNING FOLDER Sub Folder Locations
Preferred place for End of Life Care G.P Phone and Home Visit availability B.H & A.H Verification of Death arrangements Knowledge re burial or cremation G.P ability to provide MCCD & Cremation Forms Funeral arrangements	Record of Advance Care Planning Sub Folder
Completed Advance Care Directive Completed NSW Ambulance Authorised Palliative Care Plan	Advance Care Directive Sub Folder NSW Ambulance Authorised P.C Sub Folder

eMR Location Guide July 13th 2021 Stanford Project

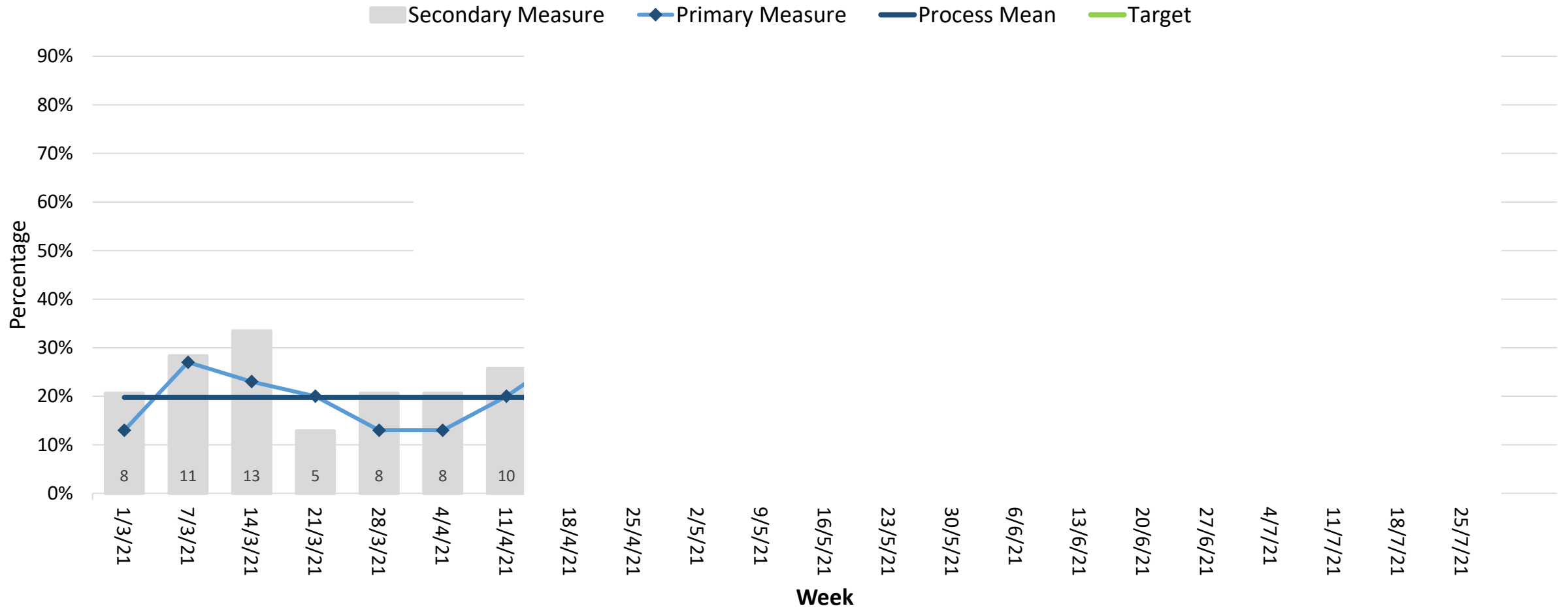
SWSLHD P&CH Palliative Care Nursing Documentation Guideline

To **enter** documentation into the eMR: Choose client → Ad Hoc → Palliative Care → choose appropriate P.C form to enter documentation in.

NURSING ACTIVITY	Palliative Care Form	N.B
Palliative Care Triage Phone Call	Palliative Care Telephone Consult Form	Refer to Triage Phone Call Guide
First Home Visit (CHN only)	Palliative Care Initial Assessment Form	This template Includes a Nursing Plan of Care section for all noted symptoms
Ongoing Home Visits CHN & PEACH R.N	Palliative Care Nursing Plan of Care	Include utilisation of all PROMSNAMES elements Include a plan of care for all noted symptoms. Include next planned contact date
Case Review	Palliative Care Multidisciplinary Team Case Conference Review Form	Use as a template for multidisciplinary team case conference review
Clinical Telephone Calls where clinical discussion and advice occurs/provided	Palliative Care Telephone Consult Form	Triple I staff document 1300# clinical calls here. In Service Type choose Other and enter Triple I PCU staff document 1300# After Hours calls here. In Service Type choose Other as Palliative Care
Non Clinical Phone Calls and Information	Palliative Care Nursing Consults, Education Form	Use as a template for non clinical telephone consults and education related visit
Preferred place for End of Life Care G.P Phone & Home Visit availability B.H & A.H Verification of Death arrangements Funeral, burial &/or cremation discussions G.P ability to provide MCCD/Cremation Forms	Record of Advance Care Planning Form	N.B When completed Directives/Plans are uploaded to the eMR AN Advance Care PLAN Alert is actioned Completed Advance Care Directive forms are sent to Triple I for uploading & must be accompanied by the form titled: "Request for Advance Care Planning Documents for Scanning Cover Sheet" Found on the SWSLHD intranet Completed P.C Ambulance Plans are sent to Triple I for uploading

Results

% of patients with a suggested plan of care documented in the Nursing Plan of Care folder and containing the PROMSNAME elements with a follow up management plan



Additional Results



SWSLHD Community Nursing eMR Documentation Location Guideline

To **locate** documentation in the eMR: Patient List → Select Client → Clinical Notes → Palliative Care → Required Sub Folder.

NURSING ACTIVITY	PALLIATIVE CARE FOLDER Sub Folder Locations
Palliative Care Triage Phone Call	Telephone Consult Sub Folder
First Home Visit	Initial Assessment Sub Folder
Ongoing Home Visits	Nursing Plan of Care Sub Folder ** PEACH home visit by Braeside staff is documented here**
Case Review	Multidisciplinary Team Case Conference Sub Folder
Ongoing Clinical Telephone Calls. When clinical discussion occurs and or clinical advice is provided	Palliative Care Telephone Consult Sub Folder ** Where PCU enter document A.H 1300 Phone calls**
Ongoing Non Clinical Phone Calls and Information	Palliative Care Nursing Progress Comm. Notes Sub Folder
NURSING ACTIVITY & DISCUSSIONS	ADVANCE CARE PLANNING FOLDER Sub Folder Locations
Preferred place for End of Life Care G.P Phone and Home Visit availability B.H & A.H Verification of Death arrangements Knowledge re burial or cremation G.P ability to provide MCCD & Cremation Forms Funeral arrangements	Record of Advance Care Planning Sub Folder
Completed Advance Care Directive Completed NSW Ambulance Authorised Palliative Care Plan	Advance Care Directive Sub Folder NSW Ambulance Authorised P.C Sub Folder

eMR Location Guide July 13th 2021 Stanford Project

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SWSLHD P&CH Palliative Care Nursing Documentation Guideline

To **enter** documentation into the eMR → Choose client → Ad Hoc → Palliative Care → choose appropriate P.C form to enter documentation in.

NURSING ACTIVITY	Palliative Care Form	N.B
Palliative Care Triage Phone Call	Palliative Care Telephone Consult	Refer to Triage Phone Call Guide
First Home Visit (CHN only)	Palliative Care Initial Assessment	This template Includes a Nursing Plan of Care section for all noted symptoms
Ongoing Home Visits CHN & PEACH R.N	Palliative Care Nursing Plan of Care	Include utilisation of all PROMSNAMES elements Include a plan of care for all noted symptoms Include next planned contact date
Case Review	Multidisciplinary Team Case Review	Document all staff present at Case Review
Clinical Telephone Calls where clinical discussion and advice occurs/provided	Palliative Care Telephone Consult	Triple I staff document 1300# clinical calls here. In Service Type choose Other and enter Triple I PCU staff document 1300# After Hours calls here. In Service Type choose After Hours Palliative Care
Non Clinical Phone Calls and Information	Palliative Care Nursing Progress Com	E.g. Carer cancels planned visit
Preferred place for End of Life Care G.P Phone & Home Visit availability B.H & A.H Verification of Death arrangements Funeral, burial &/or cremation discussions G.P ability to provide MCCD/Cremation Forms	Record of Advance Care Planning Form	N.B When completed Directives/Plans are uploaded to the eMR AN Advance Care PLAN Alert is actioned Completed Advance Care Directive forms are sent to Triple I for uploading & must be accompanied by the form titled: "Request for Advance Care Planning Documents for Scanning Cover Sheet" found on the SWSLHD Intranet Completed P.C Ambulance Plans are sent to Triple I for uploading

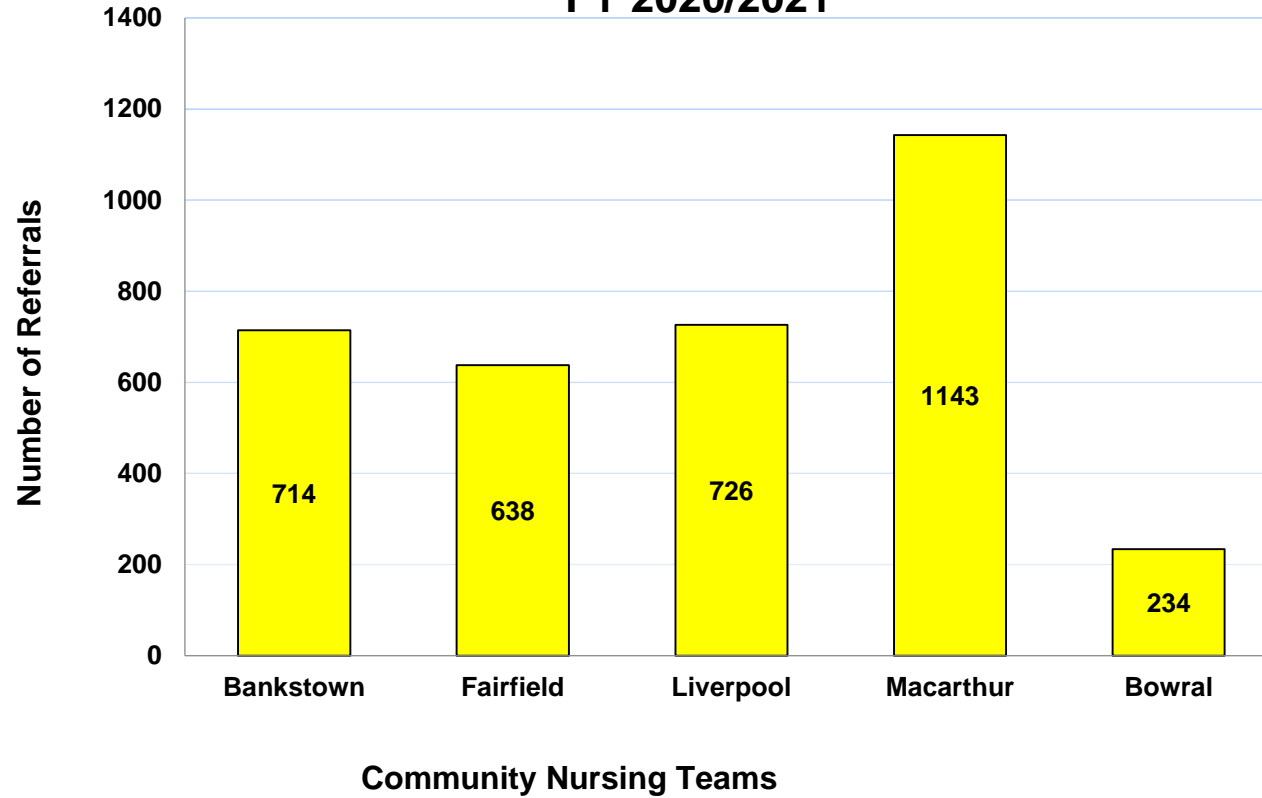
Development of new Guidelines:

1. Community Nursing EMR Documentation Location Guideline
2. Palliative Care and Community Health Nursing Documentation Guideline
3. PCU Nurse After Hours Phone Call Documentation Guideline
4. PEACH RN Documentation Guideline

Improvement for **all** community Palliative Care patients



**Community Palliative Care Nursing Referrals
FY 2020/2021**



Total referrals FY 2020/2021:

3,455

Sustainability

Interventions to sustain	Owner	Sustain method and frequency	Report to
EMR Documentation Guide	Senior palliative care nurse	Senior palliative care nurse will review documentation guide results and share them with nursing team in huddle once a month	Nursing executive
Embedding documentation guide into practice	Senior palliative care nurse	Introduce new staff to documentation guide at orientation and also provide ongoing education	CNE & NUM
“Snapshot” auditing	Senior palliative care nurse	Audit of notes during palliative care primary and community health multidisciplinary case reviews	NUM & nursing executive

Key learning points

- Small changes can result in **BIG** improvements
- Health professionals from across services will get behind QI initiatives if they can see its value and impact
- A better understanding of why previous QI projects have not been successful

Next steps:

- Improving documentation at the transfer of care Reviewing documentation in the acute setting
- Reviewing documentation by specialist palliative care acute settings
- Expanding education/awareness into other departments (e.g. ED)