



Service Priorities and Programmes Electronic Presentations

Convention ID: 453

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Using of "Interdisciplinary conference record" to promote the team communication in setting an integrated care plan to patient

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Keywords:

interdisciplinary conference record

Team communication

Integrated care plan

Introduction

The health care need in older person is complex than general adult, especially in those with multi-disease and comorbidities.

Therefore, a multidisciplinary team approach for identifying the individual's need and the early care planning are essential for targeting in problem-solving and quality care planning to those, most challenging client population. As a result to promote the early discharge, shorten the length of hospital stay and avoid the unnecessary readmission. In the Medical & Geriatrics unit of Shatin Hospital, a multidisciplinary with Clinician led team has been used for a long time in assessing patient and has a discussion of the issues, review symptoms and plan the ongoing management of each patient in a weekly basis.

However, the disciplines have performed the assessments separately and repeatedly as a result of generating the multiple care plans or pathways to patient, instead of formulating an effective integrated one.

So a workgroup was formed with the representative from the multidisciplinary to review our existing case conference's practice; an integrated care plan was then formulated to consolidate individual needs and goal setting and promote the clear documentation in the conference.

Objectives

- 1) Allows each discipline to document their assessment finding in the integrated form for minimizing the duplication of assessments.
- 2) Consolidate individual needs and goal setting by an integrated care plan
- 3) Facilitate the documentation and communication in the case conference.

Methodology

A workgroup from multidisciplinary, including Doctor, Nurse, Physiotherapist and Occupational Therapist was formed in June 2017 to review the existing practice of the

multidisciplinary team approach in assessment and care planning.
Revised the existing "Team conference record" in July 2017, to a record with showing the assessments and care plans of each disciplines and allow spaces for generating an integrated, person-center care planning to fulfil individual's need.
Piloted the revised record in two of the Medical & Geriatrics wards in Aug 2017 with conducting a briefing session beforehand.

The preliminary evaluation was obtained in Oct 2017 by the retrospective documentation audit

The logistic and the form was revised again base on the finding and recommendations of the evaluation in Jan 2018.

Plan for fully implementation in all Medical & Geriatrics wards in 1Q 2018.

And evaluate the project again in 3Q 2018.

Result

In the preliminary evaluation, we have identified some technical issues in logistic, such as, duplication of signature requirement and the "must filled" column design in the form which is not feasible in the individualized care planning of the patient.

Therefore, the logistic and the form have been reviewed by workgroup's member again.

The fully implementation plan will be rolled out as scheduled after completion of staff training.

In conclusion, we hope this form can serve as an integrated assessment & care plan and weekly case conference record, which facilitate the good formulation of individualized care plan with a specific goal setting to fulfill patient actual needs. As a result of promoting the early discharge, shorten the length of hospital stay and avoid the unnecessary readmission of our patients.