# Critical Care Nursing Discharge Summary

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@riecriticalcare

# Where it all began…

NHS Scotland Flying Start

NHS Lothian Newly Qualified Practitioner Programme

Merge of ITU + HDU

# Background

Patients are often discharged with complex needs

NICE guidance requires a ‘formal structured handover of care’

Poor communication is a key factor in adverse events

Previous research:

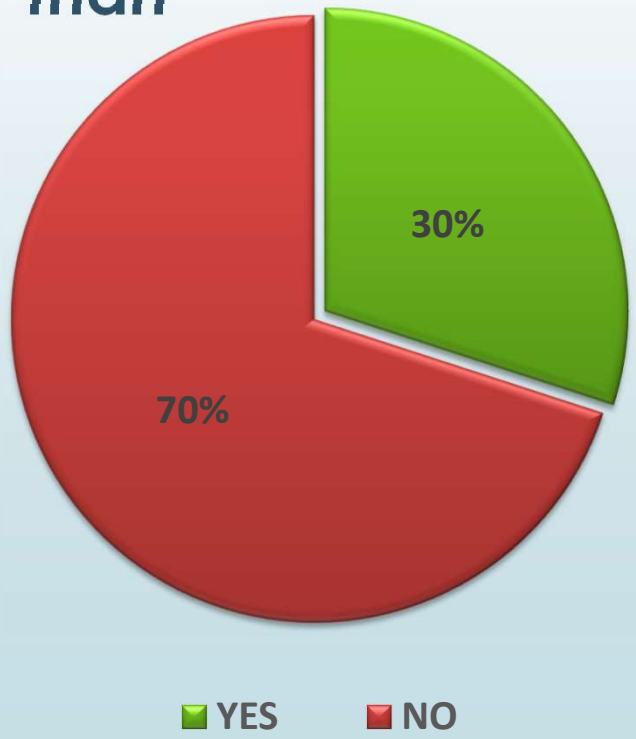
- Committing to standards improves reliability
- Poor documentation leads to breakdown in communication
- Human factors are a contributory factor in preventable harm and adverse events

Studies from other units:

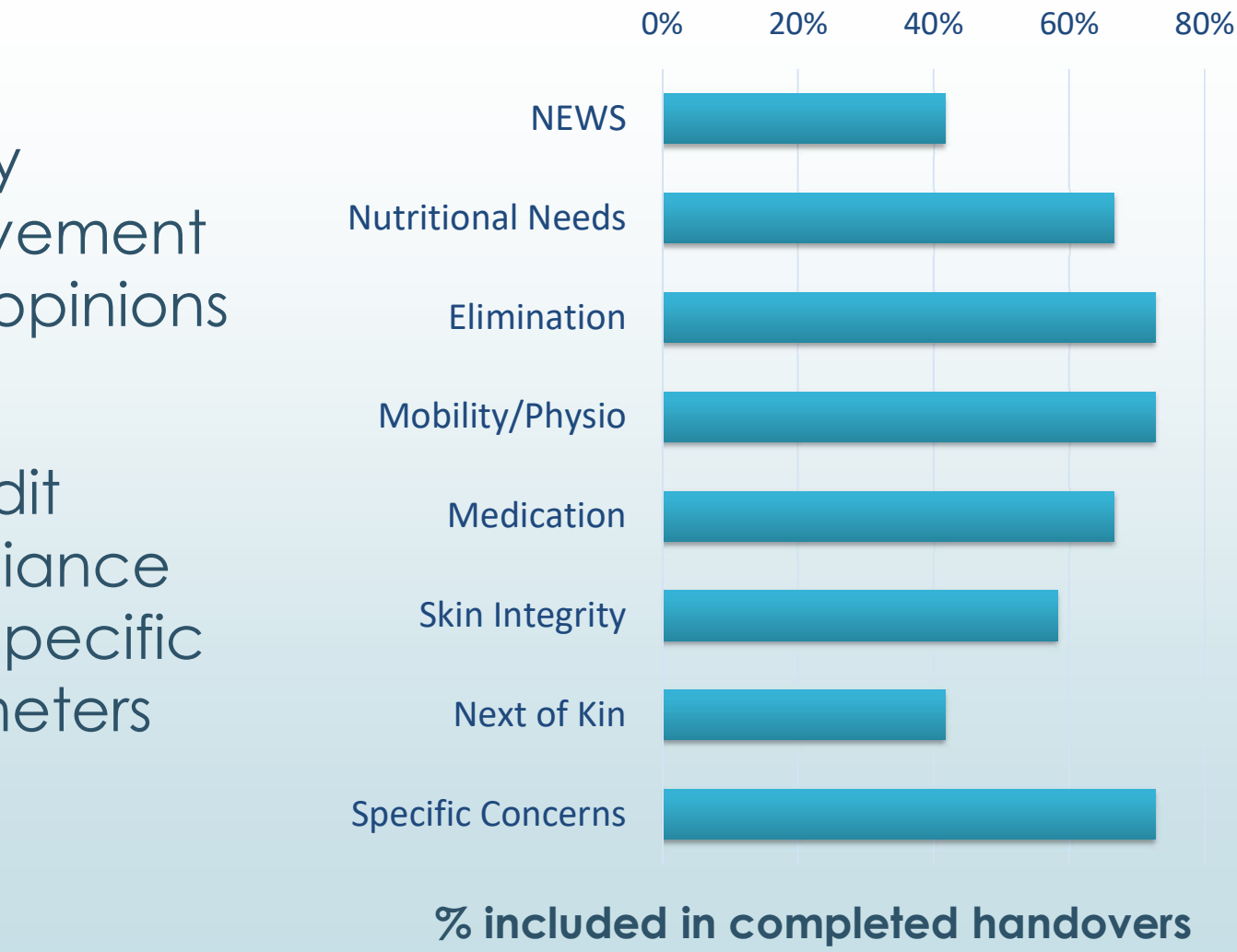
- King's College Hospital - 92% completion rate, 70% of which were of a good standard
- Hillingdon Hospital – 29% documented a verbal nursing handover

# The Process

- Initial 3 week audit measuring compliance with documentation requirements
- **Compliance much lower than expected!**



- Quality improvement team opinions
- Re-audit compliance using specific parameters



# Our TRAK Handover Template

- Creation of a shortcut to auto-fill the template into 'clinical notes'
- Prompts placed on all computers in the unit
- Introduction via unit's daily safety briefing

**Reminder – All patients must have a nursing handover documented on TRAK EPR prior to discharge.**

**Type /ccnd in a progress note to add template**

NEWS on discharge - including reason for score.

Nutritional needs – dietary status, TPN/NG feed etc.

Elimination – document if catheter in-situ and any removal plans (bowel and fluid charts placed in paper notes).

Skin – wound, drains and any pressure areas at risk.

Mobility – has the patient been mobilised with us/physio? How much assistance is required?

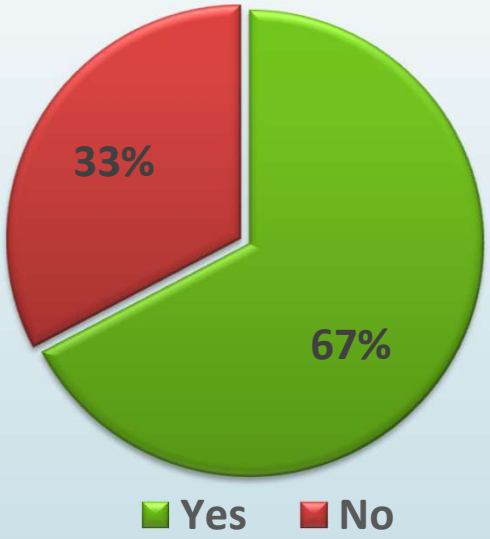
Medication – anything outstanding or currently in progress – PCA, insulin etc. Also note removal time of epidural if relevant.

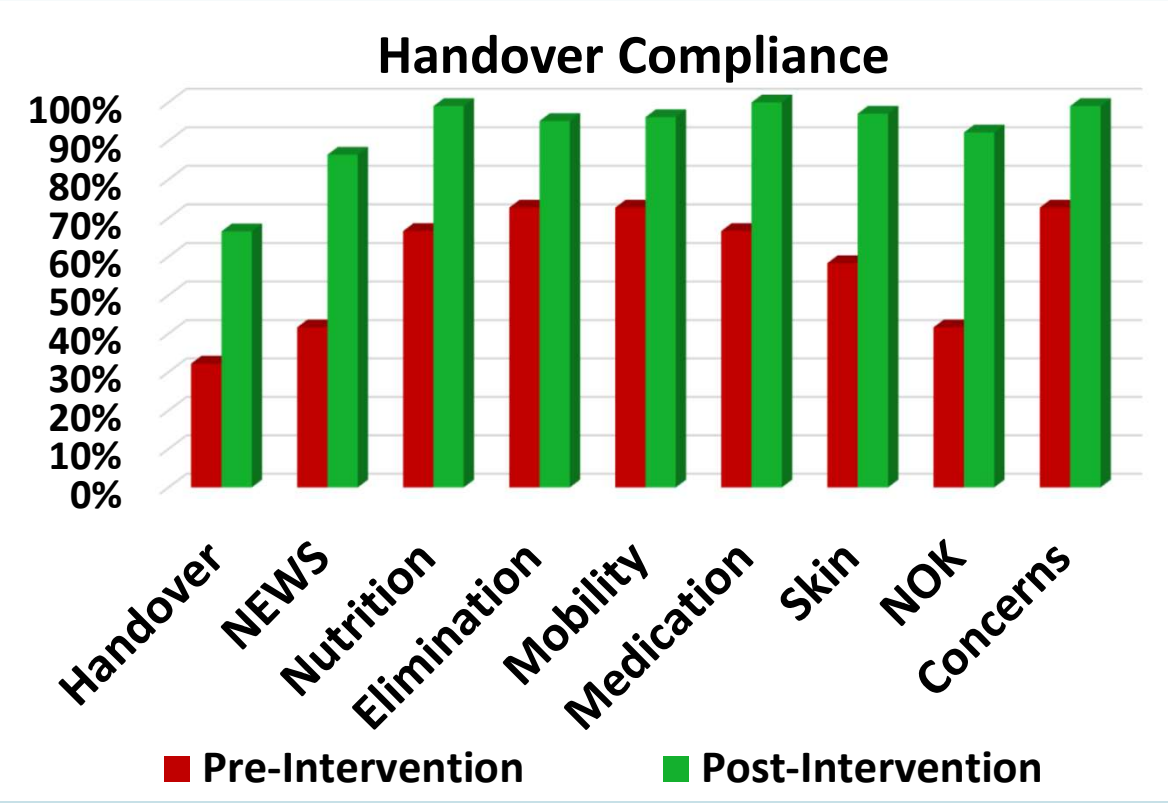
Next of Kin – document if they are aware of transfer and any information such as passwords.

Any general concerns eg pain, ceiling of care, recently had bad news or any specific needs.

# 1 Month Post-Implementation

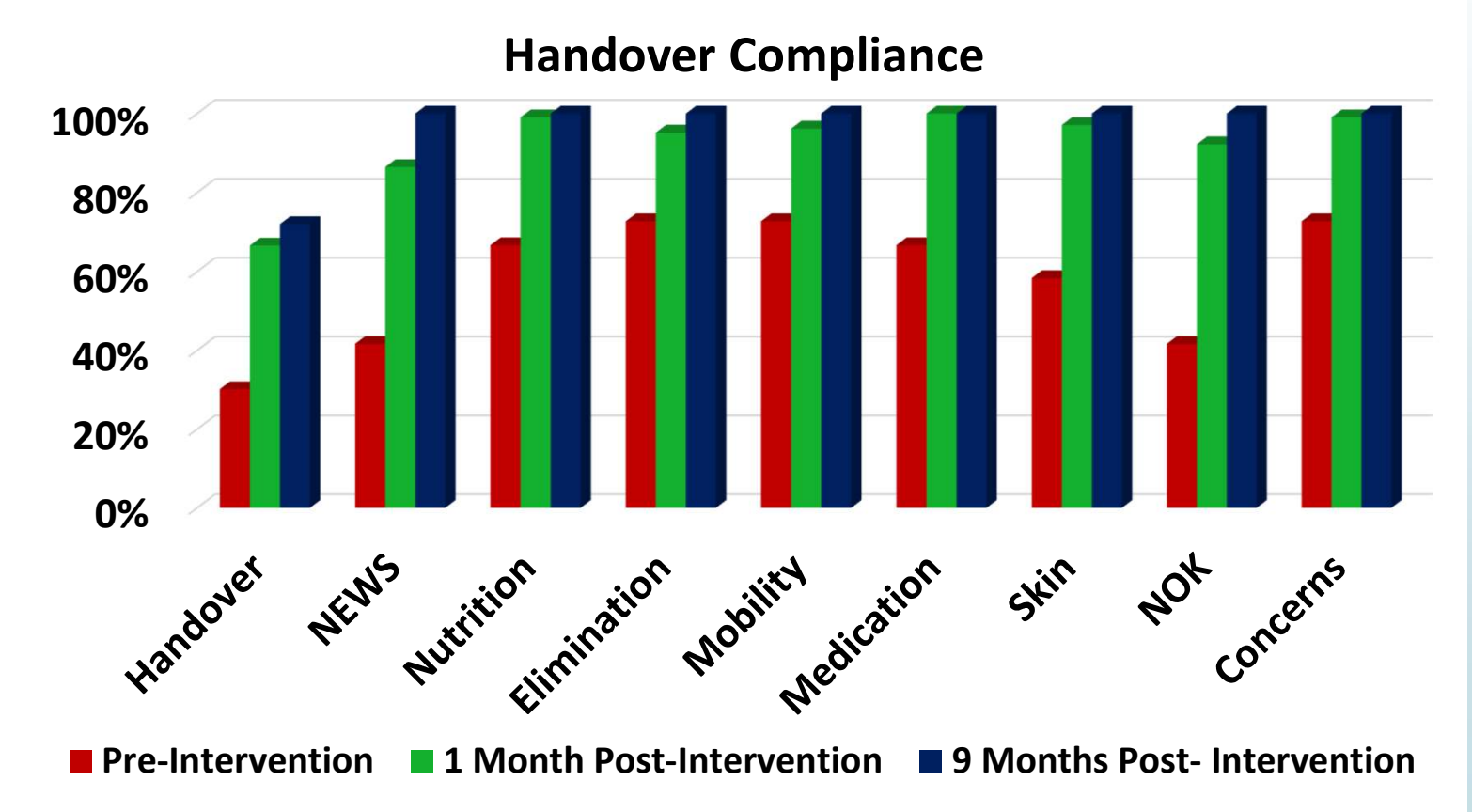
- 104 patient records audited over 3 week period



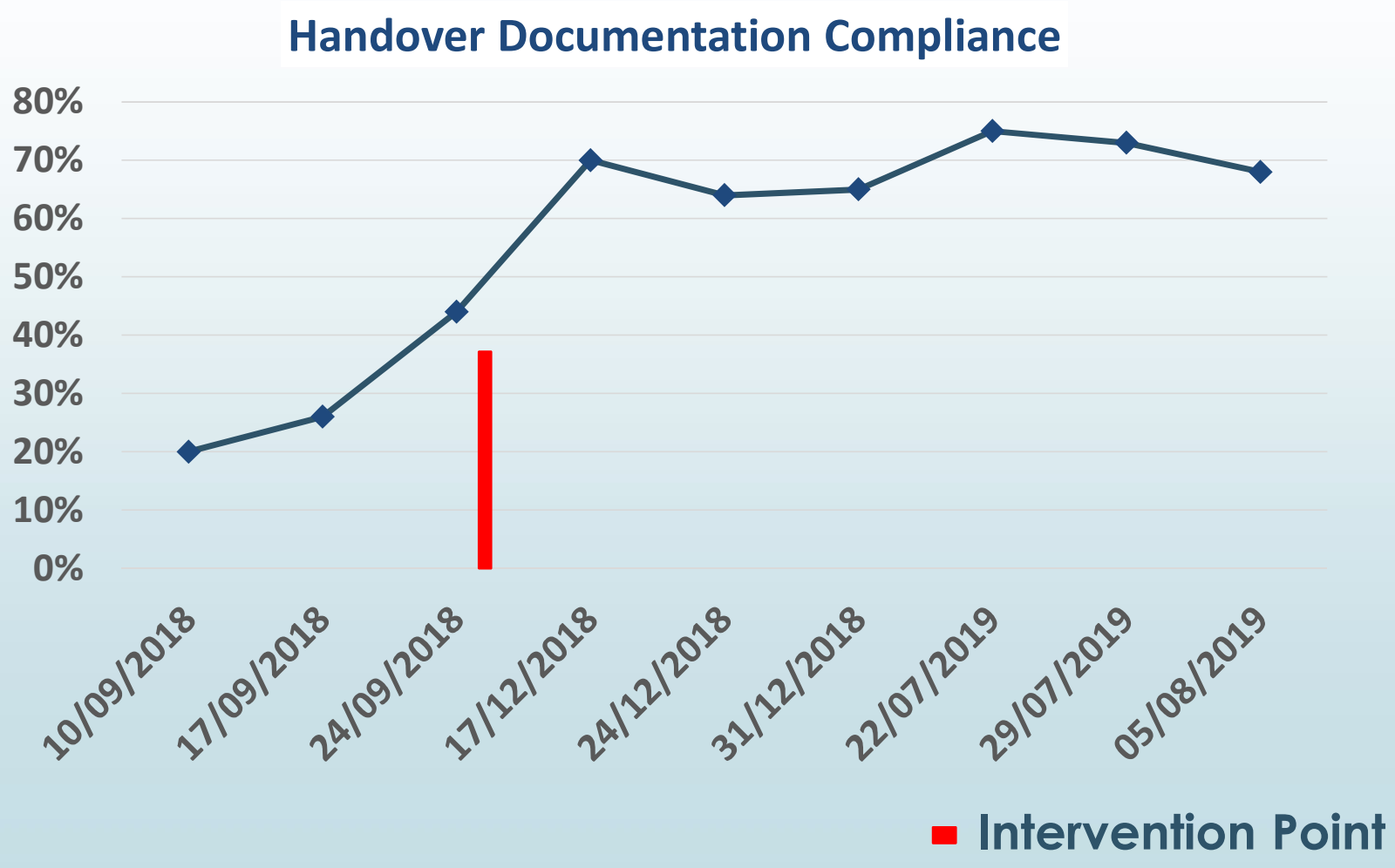



# 9 Months Post-Implementation

- Further 3 week audit period of 54 records



# Overall Results



# Lessons and Limitations

- Effective and simple project to improve communication, continuity and patient safety
- Initial challenges; creation of TRAK template

  - staff familiarity with the program
- Time pressures continue to be a barrier to completion
- Ongoing IT issues with reliability of PCs/laptops
- Change is now imbedded in best practice so should be sustainable as our unit continues to expand

# References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