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SOUTH ISLAND TERTIARY CARE CPOE PRACTICE CHANGE SUPPORT PLAN FOR CLINICAL TRANSFORMATION TEAM

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South Island Tertiary Care CPOE Practice Change Support Plan for CTT

Purpose of this tool

This support plan is intended to guide and support clinical leaders, mentors and other support resources through the major **practice changes** that Computerized Provider Order Entry (CPOE) brings for nursing and allied health staff.

- Provide awareness, guidance and support on the key high impact practice changes that will be impacting staff with CPOE implementation.
- Provide guidance and links to associated resources that can be used to support staff in understanding the WHY? and adopting the changes.

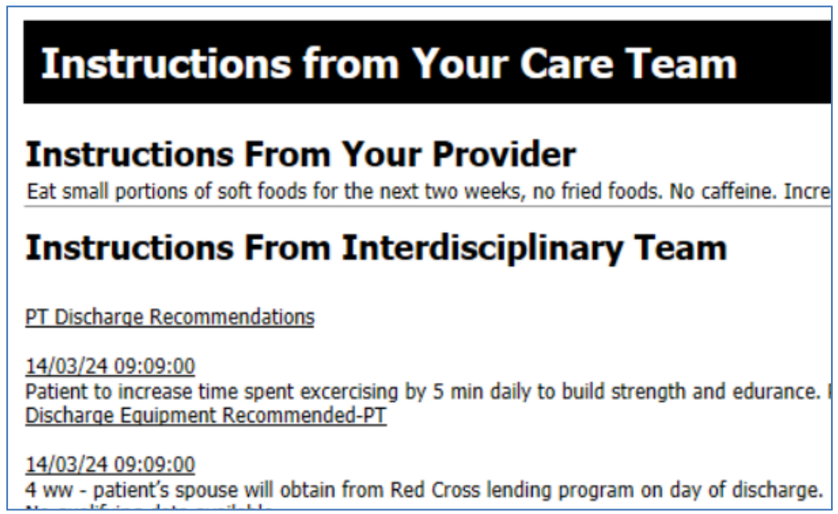
Directions:

1. Review this document to understand and plan how you will use it to prepare for CPOE Implementation
    a. Identify the Key Practice's that apply to the unit/care area and staff you are supporting
    b. Validate and prioritize the Key Practices to address by considering how much of a gap exists between current state practice on your unit and the stated practice standard
2. For each Key Practice selected:
    a. Read "What do I need to Know, AND What do I need to Do"
    b. Review the resources
    c. Print and carry a copy of the Practice Alert and/or Practice Pointer associated with the Key Practice and carry it with you during rounding
3. Track and Report out issues/challenges being met at the unit level via the POD meeting
4. Track the team's Progress of meeting and adopting the stated practice change via survey or chart audits (tools will be provided)
5. Communicate progress and success with the team/staff at regular intervals
6. Connect with your IHealth Practice Consultants for questions, coaching and guidance as needed

CLINICAL DOCUMENTATION: Inpatient Discharge Documentation & Patient Discharge Instructions Practice Change Support Tool for CTT

Included Roles: All clinicians (Nurses & Allied Health)
Nursing and Allied Health students

Current practice	Future State/ What do I need to know?	What do I need to do?	Resources
There is **considerable** variation between staff members, units and programs in degree and comprehensiveness of discharge documentation. Wide variation in clinician discharge documentation practices produces inconsistency in care and lack of a comprehensive source of truth for patient discharge information. **Practice Standard** Beginning at time of admission, care team members are responsible for ensuring a safe and seamless discharge, based upon patient/client needs which includes documentation of the following: • Interprofessionally informed discharge care planning • Comprehensive and timely documentation of all clinically relevant patient/client discharge information • Follow up information & appointments	**Practice Standard/Expectation** Not only do the current state clinical practice expectations (nurses and allied health) for discharge documentation remain in place i.e.: ○ Informed interprofessional discharge care planning (i.e. Discharge IPOC) ○ Comprehensive and timely documentation of all clinically relevant patient/client discharge information (i.e. Discharge Planning PowerForm, Nursing Discharge Summary, PT Discharge Summary) ○ Follow Up Information ○ Patient Education Handouts ○ instructions provided must be documented on the patient chart but also now includes the creation of a **Patient Discharge Instructions** note that pulls together all pertinent discharge information for the patient in a single and standardized form. A comprehensive source of truth for patients and/or their supportive others for discharge instructions is a requirement for safe and seamless transitions in care, and provides Island Health with a record of what was provided to the patient re: discharge instructions. The **Patient Discharge Instructions** note includes:	**Understand** Each interprofessional team member is responsible for contributing to and documenting patient discharge information in alignment with their professional scope and organizational practice expectations Timely and comprehensive documentation from all team members supports nursing to provide the patient with a reliable source of truth for the patient to safely transition from hospital to home. It is the responsibility of the nurse caring for the patient at time of discharge to review, print and provide the Patient Discharge Instructions to the patient and/or their supportive others prior to the patient leaving the unit	Discharge Practice Pointer Practice Change Alert: Patient Discharge Instructions **Nursing Education Resources**: Preparing Patient Discharge Information WIKI page Patient Discharge Instructions handout WIKI page Discharge Planning & Patient Discharge video Navigating Discharge Workflow Page Clinicians Viewing Discharge Plan in the Discharge Summary Page

• Patient Education Handouts ○ Instructions provided must be documented on the patient chart Interprofessional care team members must communicate and collaborate in shared/patient focused documentation (i.e. care plans) whenever clinically appropriate **Nurses discharge documentation includes:** Paper Discharge section of paper Interprofessional Patient Care Plan (or unit/program specific discharge care plan) provides documentation and review for all team members Electronic The Discharge Workflow Clinician Summary Page is used review and provide quick access to discharge documentation from interprofessional team members. T Electronic documentation includes: • Discharge Planning PowerForm • Follow up information provided to the patient • Patient education & Patient education handouts	• The medical providers' Discharge Medication Reconciliation • Reason for Visit (in patient friendly terms) • Follow Up Information • Education Materials • Discharge Instructions from Interdisciplinary team members i.e. Provider, OT, PT, SLP Physician's/Provider's and Allied Health Clinicians are responsible for ensuring their discipline specific discharge documentation (i.e. Provider's discharge Medication Reconciliation, Follow Up appointments/instructions, and Discharge Summary, PT discharge recommendations from PT Discharge Assessment form) is completed in a timely manner that supports nursing to create a comprehensive Patient Discharge Instructions note at time of discharge.  The most responsible nurse caring for the patient on day of discharge is responsible for: • Documenting "My Reason for Visit" in patient friendly terms	**Review** The information in the future state/what do I need to know column The Practice Change Alert in the resources column. Review the education supports in the resources column. Print and carry a copy with you as you round/support **Support** Support Clinicians with your knowledge of this practice at Clinical POD meetings, change readiness events, unit huddles and in conversation/communication with clinician's on the unit	Documenting Nursing Discharge Summary Documenting Follow Up Appointments **Allied Health Education Resources** Navigating Discharge Workflow Tab (Allied Health) Discharge Planning PowerForm Allied Health Documenting Discharge Barriers: Dietitian Which Form – OT Which Form – PT Which Form – SLP OT Discharge Documentation Video

• Nursing Discharge Summary PowerForm **Allied Health discharge documentation includes:** Paper: Informed interprofessional Care Planning (i.e. discipline specific contributions to care plans) Electronic: • Discipline specific barriers to patient discharge and actions taken (i.e. Discharge Planning Powerform, Barriers and Actions) • Discipline specific (i.e. PT, OT, SLP, SW) discharge documentation (i.e. PT Discharge Summary) ALL interdisciplinary team members (i.e. provider, allied health clinicians and nurses) are each responsible for providing the patient any pertinent discharge instruction information, in a variety of formats (handouts, Prescriptions, and follow up information)	• Documenting any Follow Up Instructions that the provider has requested nursing communicate/provided to the patient • Attaching appropriate Patient Education Handouts to the Patient Discharge Instructions • Reviewing the Patient Discharge Instructions for completeness prior to printing • Printing the Patient Discharge Instructions • Providing the printed Patient Discharge Instructions to the patient, and reviewing them with the patient to ensuring patient understanding of information provided