Sunlove NHELP Admission Checklist

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Introduction:

Proper documentation is one of the most important parts of nursing in long term care facilities. A resident's record is the place where all of their important medical information resides. It lets nurses and caregivers know what medications the resident is taking, their dietary restrictions, their diagnoses, and other important medical information. Improper documentation or failure to include pertinent information can lead to poor patient outcomes.

Prior to this project we noticed a lot of errors in staff doing the admission. We embarked on this project to eradicate this issues.

Aim:

To re designed the workflow and educate and trained the staff to be the champions .

Assessment of Problem and Analysis of Its Causes:

Admission assessment comprises of the Initial Assessment [to be completed within 4 hours] and Comprehensive Assessment [to be completed within 72 hours]. Documentation errors were noted with 4 and 72 hours assessments not completely conducted. To address this issue, we form a group to create a proper workflow and checklist before briefing all the staff on the project we were embarking on. We identified and train champions as the primary audit team who will conduct audits on the admission documentation. The main team, also the secondary audit team, will then audit the findings from the primary team. Finally, the findings were shared through zoom with all the staff. We calculated the percentage error based on the accuracy of admission documentation. Staff learned from the mistakes and we could see vast improvement on the percentage of admission documentation. With improved documentation, we saw improvement in the care of the residents as the presenting issues and problems were attended to without being overlooked.

Methodology:

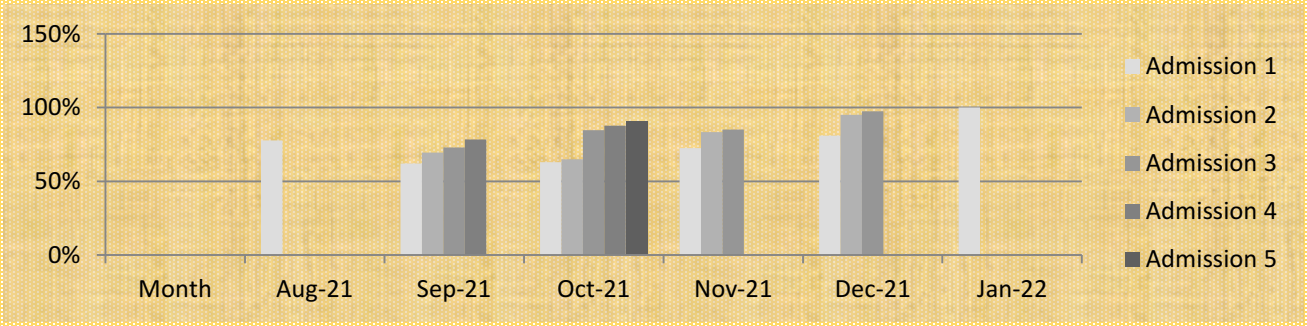
Vital information was updated and no resident medical appointments were missed. This lead to prompt continuation of required care. When assessments were completely updated, we could identify any skin problem, fall risk continence and pain status of the resident, thereby, providing appropriate care as identified by the assessment conducted.

Updated vital signs, bowel charts enable the care nurse to assess the resident's medical status and to highlight to the nursing leaders and doctors for necessary interventions.

Referral to Doctors and Allied Health Professionals lead to comprehensive care of the residents.

Nursing Care Plan and Care Evaluation helped the nurses to plan the care for the residents and evaluate the effectiveness of the care that was rendered by the nurses. We started this project in August 2021 and evaluated the results over 6 months and the results were significantly encouraging. Care staff feedback with the checklist was that it was easier to conduct the admission process without missing out any required admission assessments

Results:



New Admission Audit Result from August 2021- Jan 2022

*Y axis(Percentage for completion of Assessment and Documentation for newly admitted residents)

*X axis (Month which residents admitted in Nursing Home)

3 months after implementation of this New Admission Checklist, the audit team noted that there are still some incomplete assessments and documentation. The findings were shared with all care staff and re-training with regards to required proper assessments and documentations upon admission was conducted. Succeeding results were encouraging with complete assessments and documentations

Conclusion:

To conclude the admission process without missing out any required admission assessments and documentations with the use of the admission checklist was improved. Through multiple training sessions which provided much clarity and guidance on the required work.

Champions were identified across all zones and in all designations to provide one to one practical guidance for staff and this leads to a 100% points in the month of January audit on admission documentation. With successful and encouraging results of complete assessments and documentation on the admission process by Sunlove staff, it was decided to scale this project to our sister nursing home, Surya Home. Our process and strategies of implementation were adopted fully by Surya Home successfully.

Lessons Learnt:

- Training and retraining of staff is very crucial and is highly effective in achieving the desired outcomes.
- Using systematic approach to carry out assessments and evaluations with the use of the checklist, care staff were able to carry out the documentation in a more efficient and timely manner.
- Resident admission is an ongoing process. Hence, the admission checklist and workflow will be utilised by all staff and the audit team will continue to audit the admission documentation.