Overall Aim – to improve the impact of CMC records on the outcomes of patients who use THH ED or inpatient department

For patients attending ED but not admitted:

CMC records are in all/ XX% ED attenders notes

Relevant community services are aware of ED attendance by CMC record holder, and reasons for attendance

For patients admitted to THH

- Patients have relevant TEP +/- DNACPR
- Where appropriate ACPs are further developed and recorded in CMC and /or discharge summary
- Patients are discharged in timely manner
- Relevant information is shared with community services

Primary Drivers

AIM:
CMC BATON IS RECEIVED
Teams are aware of existing CMC records and use the detail to plan care

AIM:
CMC BATON IS PASSED ON
Teams use Advance Care Plan and record updates either on CMC or Discharge summary

CMC RECORD CATEGORY
Full active treatment +/- CPR = FULL
Treatment rev in acute = HOSPITAL
Treatment / symptom home only= HOME

Process

Mon – fri daily actions- review ED attendances in previous 24hrs AND
Use triage process – letter to community
Review patients admitted who are HOME category
Review patients admitted who are HOSPITAL category who are still inpt at day 5
Complete activity / outcome database

- Patient attends ED – all
- ED admin staff print CMC on purple paper and place with notes
- ED clinical staff review CMC and use it to plan care

- Patient attends ED and is admitted
- Pall care team review cases and divides them into
  - FULL
    - No further action
  - HOSPITAL
    - Plan day 5 review – prompting team to reassess situation and facilitate discharge
  - HOME
    - Pall care team review patient and liase with team inc purple prompt sheet

- Patient attends ED – not admitted
- Pall care team reviews and triages ED notes, then liases with community services, inc action to be undertaken

Actions

- Record activity:
  - number of attendances
  - number of attendances where CMC records printed
- Offer teaching session / awareness raising sessions to ED staff re CMC
- Review poster created by IC, leaflet RBH – use at THH?

- Record activity –
  - no. of FULL, no. HOSPITAL, no. HOME
  - no of pts HOME who were seen
  - no. of purple prompt sheets placed in notes
  - no. of HOSPITAL category patients still in hospital at Day 5
  - no. of HOSPITAL category patients still in hospital at day 5 who were seen
- Record outcome –
  - HOME
    - No. patients discharged
    - No, where PPD changed to THH
    - No. CMC record updated
  - HOSPITAL 5 day review
    - No. flagged to ward team
    - No. flagged to IDT
    - No. on pall care caseload
    - No. CMC record updated

- Record activity:
  - Letters sent – no. Y/ N /NA

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