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**Literature search results**

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**Search details**

Joint MDT assessment documentation for stroke. Does it improve communication and the discharge process?

**Resources searched**

NHS Evidence; National Library for Health; TRIP Database; Cochrane Library; CINAHL; EMBASE; MEDLINE; Google Scholar

**Database search terms**: multi-disciplinary team**”; multidisciplinary team**”; PATIENT CARE TEAM; interdisciplinary team**”; inter-disciplinary team**”; MDT; “patient care team”; MULTIDISCIPLINARY CARE TEAM; stroke; exp STROKE; “transient ischaemic attack”; “transient ischemic attack”; TIA; exp ISCHEMIC ATTACK, TRANSIENT; CEREBRAL ISCHEMIA, TRANSIENT; “cerebrovascular accident”; assessment”; PROCESS ASSESSMENT (HEALTH CARE); OUTCOME AND PROCESS ASSESSMENT (HEALTH CARE); OUTCOME ASSESSMENT (HEALTH CARE); GERIATRIC ASSESSMENT; NEEDS ASSESSMENT; RISK ASSESSMENT; exp NURSING ASSESSMENT; documentation; DOCUMENTATION; records; MEDICAL RECORDS; notes; multidisciplinary; multi-disciplinary; interdisciplinary; inter-disciplinary; communication; COMMUNICATION; COMMUNICATION BARRIERS; INTERDISCIPLINARY COMMUNICATION; exp INTERPROFESSIONAL RELATIONS; HOSPITAL DISCHARGE

**Google search string**: (MDT or multi-disciplinary OR multidisciplinary OR “patient care team” OR interdisciplinary OR inter-disciplinary) (stroke OR TIA OR "cerebrovascular accident" OR "transient ischaemic attack") assessments (documentation OR records) (“interprofessional communication” OR “inter-professional communication” OR “interdisciplinary communication” OR “inter-disciplinary communication” OR “discharge process”)

**Summary**

There is quite a bit of research on interdisciplinary communication within multidisciplinary teams, less on documentation and a definite paucity with regard to stroke care. I have extended the search to include assessment documentation within other disciplines, as you
may find it applicable even though it has not been tested within a stroke unit. I have assumed you are looking at improving communication between health professionals rather than patients, but if you’re interested in the latter, please let me know and I’ll extend the search further.

Guidelines

SIGN
Management of patients with stroke: Rehabilitation, prevention and management of complications, and discharge planning 2010

- However, the provision of consistent information is regarded as a very important task for all members of the multidisciplinary team.
- Successful implementation and audit of guideline recommendations requires good communication between staff and multidisciplinary team working.

Evidence-based reviews

National Institute for Health Research Service Delivery and Organisation programme
Synthesis and conceptual analysis of the SDO Programme’s research on continuity of care 2009

Professionals in the main stroke study referred to the important role of documentation in co-ordinating care and, in this light, the stroke care pathway was seen as a positive thing in the acute setting.

Department of Health
Discharge from hospital: pathway, process and practice 2003

They work to a single care plan and to one set of documentation and support the ward-based care co-ordinator and the wider multidisciplinary team in caring for the patient.

Published research

1. An audit of the adequacy of acute wound care documentation of surgical inpatients.

Author(s): Gartlan J, Smith A, Clennett S, Walshe D, Tomlinson-Smith A, Boas L, Robinson A

Citation: Journal of Clinical Nursing, 01 August 2010, vol./is. 19/15-16(2207-2214), 09621067

Publication Date: 01 August 2010

Abstract: Aims and objectives. This study examined the degree to which acute wound care documentation by doctors and nurses meets the standards set in the Australian Wound Management Association guidelines, focusing on clinical history with regard to the wound, wound characteristics, evidence of a management plan and factors such as wound pain. Background. Wound care documentation is an important component of ‘best practice’ wound management. Evidence suggests that wound documentation by hospital staff is often ad hoc and incomplete. Design. Survey. Method. An audit of acute wound care documentation of inpatients admitted to a surgical ward was conducted in 2006 using the progress notes of 49 acute inpatients in a regional Australian hospital. The audit focused on wound documentation on admission and during dressing changes. Results. The findings demonstrated that, whereas doctors and nurses documented different aspects of the wound on admission, three quarters of patients had no documentation of wound margins and over half had no documentation of wound dimensions, exudate and wound bed. Whereas 122 dressing changes were documented by nurses and 103 by doctors, only 75 (60%) were reviewed by both medical and nursing staff. Doctors and nurses tended to
document different aspects of dressing changes; however, in more than half the cases, there was no documentation about wound bed, margins, exudate and state of surrounding skin, whereas wound dimensions and skin sensation were recorded in less than 5%.

Conclusion. Wound care documentation by doctors and nurses does not meet the Australian standard. The findings suggest there is ineffective communication about wound care in the multidisciplinary setting of the hospital. Relevance to clinical practice. The article concludes that hospitals need to engage medical and nursing staff in collaborative processes to identify the issues that underpin poor wound documentation and to implement interventions to ensure best practice is achieved.

Source: CINAHL

Full Text:
Available in fulltext at Ovid

2. Discharge documentation of patients discharged to subacute facilities: a three-year quality improvement process across an integrated health care system

Author(s): Gandara E., Ungar J., Lee J., Chan-Macrae M., O'Malley T., Schnipper J.L.

Citation: Joint Commission journal on quality and patient safety / Joint Commission Resources, June 2010, vol./is. 36/6(243-251), 1553-7250 (Jun 2010)

Publication Date: June 2010

Abstract: BACKGROUND: Effective communication among physicians during hospital discharge is critical to patient care. Partners Healthcare (Boston) has been engaged in a multi-year process to measure and improve the quality of documentation of all patients discharged from its five acute care hospitals to subacute facilities. METHODS: Partners first engaged stakeholders to develop a consensus set of 12 required data elements for all discharges to subacute facilities. A measurement process was established and later refined. Quality improvement interventions were then initiated to address measured deficiencies and included education of physicians and nurses, improvements in information technology, creation of or improvements in discharge documentation templates, training of hospitalists to serve as role models, feedback to physicians and their service chiefs regarding reviewed cases, and case manager review of documentation before discharge. To measure improvement in quality as a result of these efforts, rates of simultaneous inclusion of all 12 applicable data elements ("defect-free rate") were analyzed over time. RESULTS: Some 3,101 discharge documentation packets of patients discharged to subacute facilities from January 1, 2006, through September 2008 were retrospectively studied. During the 11 monitored quarters, the defect-free rate increased from 65% to 96% (p < .001 for trend). The largest improvements were seen in documentation of preadmission medication lists, allergies, follow-up, and warfarin information. CONCLUSIONS: Institution of rigorous measurement, feedback, and multidisciplinary, multimodal quality improvement processes improved the inclusion of data elements in discharge documentation required for safe hospital discharge across a large integrated health care system.

Source: EMBASE

3. Multidisciplinary recording and continuity of care for stroke patients with eating difficulties

Author(s): Carlsson E., Ehnfors M., Ehrenberg A.

Citation: Journal of interprofessional care, May 2010, vol./is. 24/3(298-310), 1469-9567 (May 2010)

Publication Date: May 2010

Abstract: Eating difficulties after stroke are common and can, in addition to being a risk for serious medical complications, impair functional capability, social life and self-image. Stroke unit care entails systematic multidisciplinary teamwork and continuity of care. The purpose of this study was to describe (i) multidisciplinary stroke care as represented in patient records for patients with eating difficulties, and (ii) the written information that was transferred from hospital to elderly care. Data from 59 patient records were analysed with descriptive statistics and by categorization of phrases. Signs of multidisciplinary
collaboration to manage eating problems were scarce in the records. While two notes from physiotherapists were found, nurses contributed with 78% of all notes (n = 358). Screening of swallowing and body weight was documented for most patients, whereas data on nutritional status and eating were largely lacking. The majority of notes represented patients’ handling of food in the mouth, swallowing and lack of energy. Care plans were unstructured and few contained steps for managing eating. Discharge summaries held poor information on care related to eating difficulties. The language of all professionals was mostly unspecific. However, notes from speech-language therapists were comprehensive and entailed information on follow-up and patient participation.

Source: EMBASE

4. Stroke rehabilitation: The quality journey

Author(s): Worsowicz G.

Citation: Topics in Stroke Rehabilitation, January 2010, vol./is. 17/4(305-307), 1074-9357 (01 Jan 2010)

Publication Date: January 2010

Source: EMBASE

5. An evidence-based practice approach to improving nursing care of acute stroke in an Australian Emergency Department.

Author(s): Considine J, McGillivray B

Citation: Journal of Clinical Nursing, January 2010, vol./is. 19/1-2(138-44), 0962-1067;1365-2702 (2010 Jan)

Publication Date: January 2010

Abstract: AIMS: The aim of this study was to improve the emergency nursing care of acute stroke by enhancing the use of evidence regarding prevention of early complications. BACKGROUND: Preventing complications in the first 24-48 hours decreases stroke-related mortality. Many patients spend considerable part of the first 24 hours following stroke in the Emergency Department therefore emergency nurses play a key role in patient outcomes following stroke. DESIGN: A pre-test/post-test design was used and the study intervention was a guideline for Emergency Department nursing management of acute stroke. METHODS: The following outcomes were measured before and after guideline implementation: triage category, waiting time, Emergency Department length of stay, time to specialist assessment, assessment and monitoring of vital signs, temperature and blood glucose and venous-thromboembolism and pressure injury risk assessment and interventions. RESULTS: There was significant improvement in triage decisions (21.4% increase in triage category 2, p = 0.009; 15.6% decrease in triage category 4, p = 0.048). Frequency of assessments of respiratory rate (p = 0.009), heart rate (p = 0.022), blood pressure (p = 0.032) and oxygen saturation (p = 0.001) increased. In terms of risk management, documentation of pressure area interventions increased by 28.8% (p = 0.006), documentation of nil orally status increased by 13.8% (ns), swallow assessment prior to oral intake increased by 41.3% (p = 0.003), speech pathology assessment in Emergency Department increased by 6.1% (ns) and there was 93.5 minute decrease in time to speech pathology assessment for admitted patients (ns). RELEVANCE TO CLINICAL PRACTICE: An evidence-based guideline can improve emergency nursing care of acute stroke and optimise patient outcomes following stroke. As the continuum of stroke care begins in the Emergency Department, detailed recommendations for evidence-based emergency nursing care should be included in all multidisciplinary guidelines for the management of acute stroke.

Source: MEDLINE

Full Text:
Available in fulltext at Ovid

6. Documentation and communication of psychooncological findings in an interdisciplinary breast cancer center.
Breast Care, 01 October 2009, vol./is. 4/5(294-298), 16613791

Abstract: Background: Psychooncological interventions are an integral component of the treatment of breast cancer patients in certified breast cancer centers. Effective multidisciplinary care requires excellent communication among the team members, including written communication. The study explores how written communication can be implemented in a multidisciplinary team treating cancer patients. Patients and Methods: A computerized form to enter psychooncological findings into a software designed for the documentation of the diagnostics and therapy of patients with breast cancer was developed. Results: The psychooncological module includes the sections phase of therapy, mood disturbances, difficulties in handling the disease/treatment, psychosocial burdens, psychosocial resources and treatment recommendations as well as notes about a psychological diagnosis (International Classification of Diseases (ICD)-10) where appropriate. 555 psychooncological findings were documented in the newly designed module. 28% of the patients were diagnosed with a mental disorder. 45% received at least one intervention. Conclusions: The psychooncological module facilitates the combination of oncological and psychooncological documentation. It can give structured psychooncological information to the physicians. However, the development of the module has to be continued.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

7. Understanding nursing on an acute stroke unit: Perceptions of space, time and interprofessional practice

Author(s): Seneviratne C.C., Mather C.M., Then K.L.

Citation: Journal of Advanced Nursing, September 2009, vol./is. 65/9(1872-1881), 0309-2402;1365-2648 (September 2009)

Abstract: Title. Understanding nursing on an acute stroke unit: perceptions of space, time and interprofessional practice. Aim. This paper is a report of a study conducted to uncover nurses’ perceptions of the contexts of caring for acute stroke survivors. Background. Nurses coordinate and organize care and continue the rehabilitative role of physiotherapists, occupational therapists and social workers during evenings and at weekends. Healthcare professionals view the nursing role as essential, but are uncertain about its nature. Method. Ethnographic fieldwork was carried out in 2006 on a stroke unit in Canada. Interviews with nine healthcare professionals, including nurses, complemented observations of 20 healthcare professionals during patient care, team meetings and daily interactions. Analysis methods included ethnographic coding of field notes and interview transcripts. Findings. Three local domains frame how nurses understand challenges in organizing stroke care: 1) space, 2) time and 3) interprofessional practice. Structural factors force nurses to work in exceptionally close quarters. Time constraints compel them to find novel ways of providing care. Moreover, sharing of information with other members of the team enhances relationships and improves ‘interprofessional collaboration’. The nurses believed that an interprofessional atmosphere is fundamental for collaborative stroke practice, despite working in a multiprofessional environment. Conclusion. Understanding how care providers conceive of and respond to space, time and interprofessionalism has the potential to improve acute stroke care. Future research focusing on nurses and other professionals as members of interprofessional teams could help inform stroke care to enhance poststroke outcomes. 2009 Blackwell Publishing Ltd.

Source: EMBASE

Full Text:
Available in fulltext at Ovid

Available in fulltext at EBSCO Host
8. **Using all or none compliance with multiple processes prompted by clinical pathways to measure the quality of hospital inpatient care**

**Author(s):** Taylor S., Mcgrath A.

**Citation:** Quality and Safety in Health Care, August 2009, vol./is. 18/4(e1), 1475-3898 (August 2009)

**Publication Date:** August 2009

**Abstract:** Brief Outline of Context: Stroke inpatients in a rural base hospital in Victoria, Australia between 1999 and 2007. Brief Outline of Problem: Process indicators are sensitive measures of quality of patient care. Some patients do not receive all processes of care that would benefit them. An all or none measurement of compliance with all key process indicators provides greater precision in measuring quality of care. Assessment of Problem and Analysis of Its Causes: Checklists and reminders for process indicators were incorporated into clinical pathways for stroke patients. Could improvements be sustained? What proportion of patients received all the key processes of care? Strategy for Change: A multidisciplinary clinical team adapted best practice evidence for stroke for local conditions. Processes of care were provided to clinicians as clinical pathways incorporating checklists and reminders, integrated into the patients' medical record and completed by clinicians as they provide care. Results were regularly fed back to all clinical staff. Measurement of Improvement: The proportion of patients with stroke who received individual and all key processes of care before and after the introduction of the pathway. Effects of Changes: Lessons Learnt: Key success factors were: Each process of care was provided as checklists and reminders incorporated into the patient medical record and completed by clinical staff providing care. Clinical pathways were multidisciplinary, developed improving communication and team work and provided ownership. Funding was provided for the program's coordination. Medical staff were involved early in pathway development and before implementation. There was an established clinical risk management culture. Clinical and executive champions steered the pathway program through hospital clinical and administrative systems. Message for Others: Clinical pathways incorporating checklists and reminders improve and sustain quality of patient care. The all or none measurement approach provides added precision in measuring improvement.

**Source:** EMBASE

**Full Text:** Available in fulltext at Highwire Press

9. **Effects of introducing an allied health assessment pro forma on the management of acute stroke patients.**

**Author(s):** Scurrah A, Sheppard L, Buttner P

**Citation:** Disability & Rehabilitation, 15 July 2009, vol./is. 31/15(1293-1299), 09638288

**Publication Date:** 15 July 2009

**Abstract:** Purpose. There is a small body of evidence that supports the use of care pathways and assessment pro formas for the management of acute stroke patients, however, such tools applied specifically to the allied health disciplines are not in widespread use. This study sought to evaluate the effects of introducing an assessment pro forma on the allied health management of acute stroke patients. Methods. The allied health management of 40 consecutive stroke patients admitted after the introduction of the assessment pro forma was compared with that of a historical control group of the same size. The quality of allied health management was assessed by a variety of measures including the quality of documentation, the inclusion of specific recommended assessment components, the use of standardised assessment tools or outcome measures and the use of specific recommended interventions. These outcomes were used to calculate a total score for each of the allied health disciplines and the combined area of upper limb management, which were then used for analysis. Results. At baseline, there was no statistically significant difference between the control and intervention groups. After the intervention, total allied health scores increased for all disciplines and for the upper limb management section. These increases were statistically significant for all disciplines (p < 0.001, respectively) except speech therapy (p = 0.139). Conclusion. This small study
demonstrated that the use of an assessment pro forma specifically for the allied health disciplines may improve the management of acute stroke patients in terms of quality of documentation, and the use of specific assessment and treatment processes of care.

Source: CINAHL


Author(s): Meyers PM, Schumacher HC, Higashida RT, Derdeyn CP, Nesbit GM, Sacks D, Wechsler LR, Bederson JB, Lavine SD, Rasmussen P

Citation: Stroke, May 2009, vol./is. 40/5(e366-79), 0039-2499;1524-4628 (2009 May)

Publication Date: May 2009

Abstract: BACKGROUND AND PURPOSE: The goal of this article is to provide consensus recommendations for reporting standards, terminology, and written definitions when reporting on the radiological evaluation and endovascular treatment of intracranial, cerebral aneurysms. These criteria can be used to design clinical trials, to provide uniformity of definitions for appropriate selection and stratification of patients, and to allow analysis and meta-analysis of reported data. METHODS: This article was written under the auspices of the Joint Writing Group of the Technology Assessment Committee, Society of Neuroradiology, Society of Interventional Radiology; Joint Section on Cerebrovascular Neurosurgery of the American Association of Neurological Surgeons and Congress of Neurological Surgeons; and Section of Stroke and Interventional Neurology of the American Academy of Neurology. A computerized search of the National Library of Medicine database of literature (PubMed) from January 1991 to December 2007 was conducted with the goal to identify published endovascular cerebrovascular intervention data about the assessment and endovascular treatment of cerebral aneurysms useful as benchmarks for quality assessment. We sought to identify those risk adjustment variables that affect the likelihood of success and complications. This article offers the rationale for different clinical and technical considerations that may be important during the design of clinical trials for endovascular treatment of cerebral aneurysms. Included in this guidance article are suggestions for uniform reporting standards for such trials. These definitions and standards are primarily intended for research purposes; however, they should also be helpful in clinical practice and applicable to all publications. CONCLUSIONS: The evaluation and treatment of brain aneurysms often involve multiple medical specialties. Recent reviews by the American Heart Association have surveyed the medical literature to develop guidelines for the clinical management of ruptured and unruptured cerebral aneurysms. Despite efforts to synthesize existing knowledge on cerebral aneurysm evaluation and treatment, significant inconsistencies remain in nomenclature and definition for research and reporting purposes. These operational definitions were selected by consensus of a multidisciplinary writing group to provide consistency for reporting on imaging in clinical trials and observational studies involving cerebral aneurysms. These definitions should help different groups to publish results that are directly comparable.

Source: MEDLINE

Full Text: Available in fulltext at Highwire Press

Available in fulltext at Ovid

11. Standardization of change-of-shift report

Author(s): Athwal P., Fields W., Wagnell E.

Citation: Journal of Nursing Care Quality, April 2009, vol./is. 24/2(143-147), 1057-3631 (April/June 2009)

Publication Date: April 2009

Abstract: This article describes a clinical nurse-led initiative that changed the traditional group shift report in the conference room to a combination of a written report with a nurse-to-nurse verbal exchange at the patient's bedside. The new process resulted in less time spent in shift report, financial savings from reduced overtime, and a decrease in the number of patient falls and call lights during change of shift. Copyright 2009 Wolters
12. The effect of a standardized form in guiding communication between peers during the hand-off of patients in a hospital setting

**Author(s):** Phillips A.

**Citation:** Studies in health technology and informatics, 2009, vol./is. 146/(885), 0926-9630 (2009)

**Publication Date:** 2009

**Abstract:** The Joint Commission, whose mission is to continuously improve the safety and quality of care provided to the public through health care organizations establishes annual National Patient Safety Goals as part of their accreditation process of hospitals in the United States. One of the stated goals for 2009 is to improve the effectiveness of communication among caregivers. Hospitals, in meeting this goal, have used various methods, including the development of hand-off standards and improvements to supporting information systems.

**Source:** EMBASE

**Full Text:**
Available in fulltext at [EBSCO Host](https://www.ebscohost.com)


**Author(s):** Demiris G, Washington K, Oliver DP, Wittenberg-Lyles E

**Citation:** Journal of Interprofessional Care, 01 December 2008, vol./is. 22/6(621-629), 13561820

**Publication Date:** 01 December 2008

**Abstract:** The aim of this study was to explore the information flow of hospice interdisciplinary meetings focusing on information access, exchange and documentation. The study participants were members of four hospice interdisciplinary teams in the Midwestern United States. Team members included a diverse range of professionals including physicians, nurses, social workers, bereavement counselors, and others. A total of 81 patient care discussions were videotaped and transcribed. A content analysis revealed several themes that needed to be addressed to improve the overall information flow, such as access to and recording of information, documentation of services, obtaining information from absent team members, data redundancy and updating of recorded information. On average, 5% of all utterances when discussing a patient case were focused on soliciting information from the member who had access to the patient chart. In 12.3% of all discussions, members referred to an absent member who could have provided additional information. In 8.6% of all discussions the same facts were repeated three times or more. Based on the findings we propose guidelines that can address potential informational gaps and enhance team communication in hospice.

**Source:** CINAHL

**Full Text:**
Available in fulltext at [EBSCO Host](https://www.ebscohost.com)


**Author(s):** Censullo J, Chiu D

**Citation:** Critical Pathways in Cardiology: A Journal of Evidence-Based Medicine, September 2008, vol./is. 7/3(178-84), 1535-2811;1535-2811 (2008 Sep)

**Publication Date:** September 2008

**Abstract:** BACKGROUND AND PURPOSE: Recent advances in stroke treatment created a need for a consensus statement by industry experts detailing elements of quality stroke
In 2005, the brain attack coalition published recommendations outlining elements constituting the highest level of stroke care, the comprehensive stroke center. Unlike primary level stroke care, comprehensive center recommendations have not resulted in creation of a corresponding national certification process largely owing to difficulties in establishing quality metrics. The authors proposed 13 comprehensive quality measures and assessed them at a tertiary referral, teaching hospital in Houston, Texas. METHODS: Proposed metrics were derived from the 2005 brain attack coalition’s comprehensive center guidelines. Outcomes measures included morbidity and mortality rates for stroke, cerebral aneurysm, carotid endarterectomy, and stent patients. Process measures included timeliness of brain imaging interpretation, timeliness and consideration of antiplatelet treatment regimes for carotid stent patients, and documentation of National Institutes of Health Stroke Score. Metrics were defined by international classification of disease codes with accompanying inclusion and exclusion criteria. RESULTS: Internal quality was benchmarked against Primary Stroke Center, research literature, and University Health Consortium rates. Baseline data revealed significant opportunities for improvement in the categories of imaging interpretation timeliness and National Institutes of Health Stroke Score documentation. All other measures fell within expected ranges. CONCLUSIONS: Assessment of quality outcomes is the basis for disease-specific certification. Institutions that claim comprehensive capabilities must demonstrate high standards of performance on uniform validated quality metrics. The authors demonstrate the feasibility of operationalizing the metrics outlined in Brain Attack Coalition’s comprehensive stroke center recommendations.

Source: MEDLINE

15. Deficits in discharge documentation in patients transferred to rehabilitation facilities on anticoagulation: results of a systemwide evaluation

Author(s): Gandara E., Moniz T.T., Ungar J., Lee J., Chan-Macrae M., O’Malley T., Schnipper J.L.

Citation: Joint Commission journal on quality and patient safety / Joint Commission Resources, August 2008, vol./is. 34/8(460-463), 1553-7250 (Aug 2008)

Publication Date: August 2008

Abstract: BACKGROUND: Anticoagulation is a commonly prescribed and effective therapy for several medical conditions but requires detailed communication among clinicians to avoid adverse patient outcomes following hospital discharge. METHODS: Discharge documentation packets of a sample of patients discharged from all five acute care hospitals of the Partners Healthcare System to 30 subacute facilities in Boston and prescribed anticoagulation for treatment or prophylaxis of thromboembolic disease were evaluated. Required data elements included information on anticoagulation indication, duration, dosing, monitoring, and follow-up. Discharge documentation packets were randomly selected for reviewers at acute sites, whereas reviewers at subacute sites selected which packets to review. RESULTS: Of 757 patients prescribed anticoagulation at discharge from March 2005 through June 2007, duration of therapy (for unfractionated or low-molecular-weight heparin [UFH/LMWH]) and recent dosing and monitoring information (for warfarin) were the areas with the biggest deficits. Of the patients prescribed UFH/LMWH or warfarin, 45.4% and 16.4%, respectively, had all the required information in the discharge summary. Patients discharged from community hospitals were more likely to be discharged with all the information needed for the use of warfarin (Odds Ratio [OR], 2.56; 95% confidence interval [CI], 1.20-5.46) or UFH/LMWH (OR, 2.97; 95% CI, 1.98-4.44) than patients discharged from academic medical centers. DISCUSSION: Important information to safely prescribe anticoagulation after discharge was often missing from the discharge summaries of patients transferred from acute hospitals to subacute facilities. Future research should focus on developing, implementing, and evaluating quality improvement interventions to address this gap.

Source: EMBASE

16. Nursing documentation for communicating and evaluating care

Author(s): Tornvall E., Wilhelmsson S.

Citation: Journal of Clinical Nursing, August 2008, vol./is. 17/16(2116-2124), 0962-
Aims. To investigate the utility of electronic nursing documentation by exploring to what extent and for what purpose general practitioners use nursing documentation and to what extent and in which cases care unit managers use nursing documentation for quality development of care. Background. As health care includes multidisciplinary activities, communication about the care given is essential. To assure delivery of good and safe care, quality development is necessary. The main tool available for communication and quality development is the patient record. In many studies, nursing documentation has been found to be inadequate for this purpose. Design. This study had a cross-sectional descriptive design. Methods. Data were collected by postal questionnaires, one to the general practitioners (n = 544) and one to care unit managers (n = 82) in primary health care. Data were analysed by descriptive statistical and qualitative content analysis. Results. The general practitioners usually used the nursing record as the foremost source of information for treatment follow-up. The results, however, point out weaknesses and shortcomings in the nursing records, such as difficulties in finding important information because of a huge amount of routine notes. The care unit managers generally (74%) used the record for statistical purposes, while only half of them used it to evaluate care. Conclusion. Nursing records need more clarity and need to be more prominent regarding specific nursing information to fulfil their purpose of transferring information and to constitute a base for quality development of care. Relevance to clinical practice. The results of this study can provide a part of a basis upon which a multi-professional patient record could be developed and which could also function as an alarm to managers at different levels to prioritise the development of nursing documentation. 2008 The Authors.

Source: EMBASE

Full Text:
Available in fulltext at Ovid
Available in fulltext at EBSCO Host
Available in print at Pilgrim Hospital Staff Library

17. Communicating stroke survivors' health and further needs for support in care-planning meetings

Author(s): Hedberg B., Johanson M., Cederborg A.-C.

Citation: Journal of Clinical Nursing, June 2008, vol./is. 17/11(1481-1491), 0962-1067:1365-2702 (June 2008)

Publication Date: June 2008

Abstract: Aims and objectives. This study will illustrate how stroke survivors, their relatives and different professionals communicated in care-planning meetings when planning care for patients after their discharge from hospital. We wanted to know what topics participants were talking about, to what extent they were involved in the discussion and how the communication was organized. Background. Communication in health care is sometimes problematic because of the participants' asymmetrical positions when negotiating how to understand the patients' future care. Methods. A qualitative and a quantitative design were adopted with a sample of 14 authentic audio-recorded care-planning meetings. The transcribed meetings were, together with observational notes, analysed from a data-driven approach. Findings. Five topics emerged. The professionals tended to dominate the discourse space even if their involvement varied depending on the topic talked about. The most noteworthy finding was the patients' need of communicative alliances with other participants when negotiating their needs and desires of further care. When making decisions two approaches emerged. The 'aim-driven' approach was characterized by alliances between those participants who seemed to share a common goal for the patient's further care. When the participants used the 'open-minded' approach they merged information and discussed different solutions leading to a goal step by step. Conclusions. The importance of strengthening stroke survivors' participation in care-planning meetings is highlighted. Professionals have to increase their knowledge about how to involve the patients as well as their awareness of how to avoid power struggles between various professionals, patients and relatives. Relevance to clinical practice. This study shows the
necessity for professionals to involve relatives when negotiating these patients' need of further care and to learn more about how to advocate stroke survivors. 2008 Blackwell Publishing Ltd.

**Source:** EMBASE

**Full Text:**
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18. ISBAR--model for better communication between health personnel. Inefficient communication contributes to the majority of injuries in health care. [Swedish] SBAR--modell för bättre kommunikation mellan vårdpersonel. Ineffektiv kommunikation bidrar till majoriteten av skador i vården.

**Author(s):** Wallin CJ, Thor J

**Citation:** Lakartidningen, June 2008, vol./is. 105/26-27(1922-5), 0023-7205;0023-7205 (2008 Jun 25-Jul 1)

**Publication Date:** June 2008

**Source:** MEDLINE

19. Enhancing multiple disciplinary teamwork.

**Author(s):** Weaver TE

**Citation:** Nursing Outlook, May 2008, vol./is. 56/3(108-114.e2), 0029-6554;1528-3968 (2008 May-Jun)

**Publication Date:** May 2008

**Abstract:** Multiple disciplinary research provides an opportunity to bring together investigators across disciplines to provide new views and develop innovative approaches to important questions. Through this shared experience, novel paradigms are formed, original frameworks are developed, and new language is generated. Integral to the successful construction of effective cross-disciplinary teams is the recognition of antecedent factors that affect the development of the team such as intrapersonal, social, physical environmental, organizational, and institutional influences. Team functioning is enhanced with well-developed behavioral, affective, interpersonal, and intellectual processes. Outcomes of effective multiple disciplinary research teams include novel ideas, integrative models, new training programs, institutional change, and innovative policies that can also influence the degree to which antecedents and processes contribute to team performance. Ongoing evaluation of team functioning and achievement of designated outcomes ensures the continued development of the multiple disciplinary team and confirmation of this approach as important to the advancement of science.

**Source:** MEDLINE

20. Interdisciplinary collaboration and the electronic medical record.

**Author(s):** Green SD, Thomas JD

**Citation:** Pediatric Nursing, 01 May 2008, vol./is. 34/3(225-228), 00979805

**Publication Date:** 01 May 2008

**Abstract:** Purpose: To examine interdisciplinary collaboration via electronic medical records (EMRs) with a focus on physicians' perception of nursing documentation. Design: Quality improvement project using a survey instrument. Location: Tertiary care pediatric hospital. Participants: Thirty-seven physicians. Outcome Measure: Physicians perceptions of nursing documentation after EMR implementation Key Findings: Physicians desire nursing documentation with greater clarity and additional information. Physicians indicate checklists alone for patient assessment and intervention data are insufficient for effective nurse/physician collaboration. Narrative nursing summaries are invaluable references that guide medical treatment decisions. Physicians see detailed assessments and well-
described interventions of nurses’ as critical to their ability to effectively practice medicine. Key Conclusions: Health care technology is called to develop EMRs that enable nurses to document detailed patient data in a swift and straightforward manner. Joint collaboration between nurses, physicians, and technology specialists is recommended to develop effective EMR systems.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

21. Comparison of patients’ assessments of the quality of stroke care with audit findings

Author(s): Howell E., Graham C., Hoffman A., Lowe D., McKeivitt C., Reeves R., Rudd A.G.

Citation: Quality and Safety in Health Care, December 2007, vol./is. 16/6(450-455), 1475-3898 (Dec 2007)

Publication Date: December 2007

Abstract: Objective: To determine the extent of correlation between stroke patients’ experiences of hospital care with the quality of services assessed in a national audit. Methods: Patients’ assessments of their care derived from survey data were linked to data obtained in the National Sentinel Stroke Audit 2004 for 670 patients in 51 English NHS trusts. A measure of patients’ experience of hospital stroke care was derived by summing responses to 31 survey items and grouping these into three broad concept domains: quality of care; information; and relationships with staff. Audit data were extracted from hospital admissions data and management information to assess the organisation of services, and obtained retrospectively from patient records to evaluate the delivery of care. Patient survey responses were compared with audit measures of organisation of care and compliance with clinical process standards. Results: Patient experience scores were positively correlated with clinicians’ assessment of the organisational quality of stroke care, but were largely unrelated to clinical process standards. Responses to individual questions regarding communication about diagnosis revealed a discrepancy between clinicians’ and patients' reports. Conclusions: Better organised stroke care is associated with more positive patient experiences. Examining areas of disparity between patients' and clinicians' reports is important for understanding the complex nature of healthcare and for identifying areas for quality improvement. Future evaluations of the quality of stroke services should include a validated patient experience survey in addition to audit of clinical records.

Source: EMBASE

Full Text:
Available in fulltext at Highwire Press


Author(s): Prvu Bettger JA, Stineman MG

Citation: Archives of Physical Medicine & Rehabilitation, November 2007, vol./is. 88/11(1526-34), 0003-9993;1532-821X (2007 Nov)

Publication Date: November 2007

Abstract: OBJECTIVES: To summarize the efficacy of postacute rehabilitation and to outline future research strategies for increasing knowledge of its effectiveness. DATA SOURCES: English-language systematic reviews that examined multidisciplinary therapy-based rehabilitation services for adults, published in the last 25 years and available through Cochrane, Medline, or CINAHL databases. We excluded multidisciplinary biopsychosocial rehabilitation programs and mental health services. STUDY SELECTION: Using the search term rehabilitation, 167 records were identified in the Cochrane database, 1163 meta-analyses and reviews were identified in Medline, and 226 in CINAHL. The Medline and CINAHL search was further refined with 3 additional search terms: therapy, multidisciplinary, and interdisciplinary. In summary, we used 12 reviews to summarize the
efficacy of multidisciplinary, therapy-based postacute rehabilitation; the 12 covered only 5 populations. DATA EXTRACTION: Two reviewers extracted information about study populations, sample sizes, study designs, the settings and timing of rehabilitation, interventions, and findings. DATA SYNTHESIS: Based on systematic reviews, the evidence for efficacy of postacute rehabilitation services across the continuum was strongest for stroke. There was also strong evidence supporting multidisciplinary inpatient rehabilitation for patients with rheumatoid arthritis, moderate to severe acquired brain injury, including traumatic etiologies, and for older adults. Heterogeneity limited our ability to conclude a benefit or a lack of a benefit for rehabilitation in other postacute settings for the other conditions in which systematic reviews had been completed. The efficacy of multidisciplinary rehabilitation services has not been systematically reviewed for many of the diagnostic conditions treated in rehabilitation. We did not complete a summary of findings from individual studies. CONCLUSIONS: Given the limitations and paucity of systematic reviews, information from carefully designed nonrandomized studies could be used to complement randomized controlled trials in the study of the effectiveness of postacute rehabilitation. Consequently, a stronger evidence base would become available with which to inform policy decisions, guide the use of services, and improve patient access and outcomes.

Source: MEDLINE

23. True collaboration: interdisciplinary rounds in nonteaching hospitals--it can be done!

Author(s): Falise J.P.
Citation: AACN advanced critical care, October 2007, vol./is. 18/4(346-351), 1559-7768 (2007 Oct-Dec)
Publication Date: October 2007
Source: EMBASE
Full Text: Available in fulltext at Ovid


Author(s): Maloney C.G., Wolfe D., Gesteland P.H., Hales J.W., Nkoy F.L.
Citation: AMIA ... Annual Symposium proceedings / AMIA Symposium. AMIA Symposium, 2007(493-497), 1559-4076 (2007)
Publication Date: 2007
Abstract: Hospital bed demands sometimes exceed capacity, leading to delays in patient admissions, transfers and cancellations of surgical procedures. Effective strategies must be in place for an efficient use of existing beds. Establishing such strategies at academic hospitals poses serious challenges. We developed and implemented a web-based software application called "Patient Tracker" to manage the discharge process, minimize delays in admission and reduce surgical procedure cancellations. We also tested the effectiveness of the software on the work flow by comparing outcomes between the pre-implementation control group (2002-2003) and the post-implementation experimental group (2003-2006). Following the implementation of the software, the number of cancelled surgical procedures decreased (120 vs. 12, p<0.01). During the same period, the average number of inpatient admissions increased (5725 vs. 6120), and the median emergency department LOS decreased (247 vs. 232, p<0.01).
Source: EMBASE

25. Documentation of acute stroke - The stroke emergency study of Essen [German] Dokumentation beim akuten schlaganfall: Die Essener blaulichtstudie

Author(s): Maschke M., Busch E., Nitsch C., Dommes P., Weimar C., Berlit P., Rogozinski A., Gerhard H., Tenfelde V., Diener H.C.
Citation: Nervenheilkunde, 2007, vol./is. 26/4(285-290), 0722-1541 (2007)
Abstract: The creation of acute Stroke Units in Germany during the last years has led to a marked improvement in care of patients with acute strokes. Stroke registries have been established in several German federal states to document the quality of stroke care. In Essen, a new documentation system was initiated in 2003 within the town district of Essen (Stroke Emergency Study of Essen). The data set comprises a minimum of items gathering the most relevant information about the (pre-)hospital phase and functional outcome after acute stroke. The data obtained so far can serve to control patient management. This article presents the documentation system and results of the first two years after its implementation. 2007 Schattauer GmbH.

Source: EMBASE

26. Multi-disciplinary team (MDT) management in an outpatient cancer setting.

Author(s): Baxter K

Citation: Nursing Monograph, 01 January 2007, vol./is. /(26-35), 13286137

Abstract: The introduction of a new position funded by the Cancer Institute New South Wales (NSW) for a Cancer Nurse Care Coordinator (CCC) for chemotherapy gave this local Sydney based Haematology - Oncology team the opportunity to explore an appropriate assessment tool for patients and their carers. It provided a means of preventing crisis within the unit with a view to providing documentation and flow of patient treatment along with contact from the Multidisciplinary Team (MDT). MDT members from cancer services were invited to help create an appropriate screening tool to suit the outpatient chemotherapy department's needs. The tool selected was adapted with permission from the Peter MacCallum Centre, Melbourne. Use of their validated supportive screening tool was adapted to encompass the values and demographics within out-patient cancer services of St.Vincent's Hospital, Sydney. A trial commenced for a 6 month period from June 2006 - Dec 2006. The tool was given to every patient who was commenced on outpatient intravenous chemotherapy treatment for initial or recurrent disease. It was given on initial consultation with the CCC, who, following the review made appropriate referrals to key allied health professionals as required by the patient's individual needs. The tool highlighted the increasing demand for referrals to the allied health team and the need for enhanced communication within the MDT, particularly in relation to specific tumour groups. Duplication of workload decreased and communication across MDT members improved, along with the recognition of the need for improved documentation within the department. The tool highlighted patients who were at higher risk of hospital admission and in need of service input before they reached crisis point.

Source: CINAHL

Full Text: 
Available in fulltext at EBSCO Host

27. Documentation of medication management by graduate nurses in patient progress notes: a way forward for patient safety.

Author(s): Aitken R, Manias E, Dunning T

Citation: Collegian, 01 October 2006, vol./is. 13/4(5-11), 13227696

Abstract: Nursing documentation provides evidence of nurses' management, the patient response, and evaluation of care. The aim of the study was to examine how graduate nurses document their medication management in the progress notes. A prospective clinical audit of patient medication charts and the progress notes made by 12 graduate nurses was undertaken. Graduate nurses were also individually interviewed and asked clarifying questions about their medication management. Documentation was examined based on four areas: assessment, planning care, administration of medications, and evaluating outcomes of medications. Recorded information about assessment focused on cues of a biomedical rather than a psychosocial nature. Planning care involved non-specific documentation of discharge planning needs, and little information about
communication with doctors, pharmacists, nurses, patients and next of kin. Administration of medications included details about the names of medications given to patients, but no information about medication education provided to patients during this time. Evaluation of outcomes of medication administration was poorly documented. Graduate nurses tended to focus on assessing medications before their administration without considering how the patient responded to treatment. Recommendations are proposed for improving the quality of graduate nurses' progress notes. These recommendations include implementing and evaluating protocols that link nurses' decision-making to documentation processes. Adopting a supportive multidisciplinary approach to quality improvement and providing education that emphasises written documentation of verbal communication are also recommended.

Source: CINAHL

28. Improving team meetings to support discharge planning
Author(s): Tarling M., Jauffur H.
Citation: Nursing times, June 2006, vol./is. 102/26(32-35), 0954-7762 (2006 Jun 27-Jul 3)
Publication Date: June 2006
Abstract: Following the establishment of a discharge working group, several concerns were raised about the management of multidisciplinary team (MDT) discharge meetings throughout the trust. A project was established to observe MDT meetings, identify good practice and produce practice guidance to improve standards and achieve consistency throughout the organisation.

Source: EMBASE

Full Text:
Available in fulltext at Ovid
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

29. Innovation and teamwork: introducing multidisciplinary team ward rounds.
Author(s): Moroney N, Knowles C
Citation: Nursing Management - UK, 01 April 2006, vol./is. 13/1(28-31), 13545760
Publication Date: 01 April 2006
Abstract: Implementing ward rounds involving all members of multidisciplinary teams as well as patients can improve teamwork and therefore patient care, say Natalie Moroney and Charles Knowles.

Source: CINAHL

Full Text:
Available in fulltext at Ovid; Note: not incl 2003-04 to 2005-09
Available in fulltext at EBSCO Host
Available in print at Pilgrim Hospital Staff Library

30. Quantitative evaluation of regular morning meetings aimed at improving work practices associated with effective interdisciplinary communication
Author(s): Aston J., Shi E., Bullot H., Galway R., Crisp J.
Citation: International journal of nursing practice, April 2006, vol./is. 12/2(57-63), 1322-7114 (Apr 2006)
Publication Date: April 2006
Abstract: In 2000, an interdisciplinary surgical morning meeting (SMM) was introduced into the infants' and toddlers' ward of a major paediatric hospital to help overcome a number of communication and work process problems among the health professionals providing care to children/families. The objective of this study was to evaluate the impact of the SMM on a range of work practices. Comparative design including pre- and postintervention data collection was used. Data were collected on 100 patient records. Twenty children, from each of the five diagnostic-related groups most commonly admitted to the ward, were included. Demographic, medical review, documentation, critical incidents and complaint variables were obtained from three sources: the hospital clinical information system, the children's medical records and the hospital reporting systems for complaints and critical incidents. Children in the postintervention group were significantly more likely to be reviewed regularly by medical staff, to be reviewed in the morning, to have plans for discharge documented regularly throughout their admission and to have admission summary sheets completed at the time of discharge. The findings of the quantitative evaluation add some weight to the arguments for the purposely structured introduction of interdisciplinary teams into acute-care environments.

Source: EMBASE

Full Text: Available in fulltext at EBSCO Host

31. Up the the job? Auditing to assess the adequacy of an established ICP

Author(s): Johnston C.

Citation: Journal of Integrated Care Pathways, April 2006, vol./is. 10/1(13-16), 1473-2297 (Apr 2006)

Publication Date: April 2006

Abstract: An integrated care pathway (ICP) for stroke patients is in use on a Stroke Rehabilitation Unit. As part of a project to develop and extend its use, its current use was explored by talking to members of the multidisciplinary team and observing practice. Concerns were raised that nurses' documentation was not always adequate or accurate. An audit comparing written information with nurses' spoken communication at shift change was performed, which showed a low rate of inconsistent documentation, and served to highlight areas where the ICP structure did not lend itself to easy documentation. The audit was a simple and useful way of providing reassurance about the quality of documentation and for highlighting areas where further development was needed. The Royal Society of Medicine Press 2006.

Source: EMBASE

32. Research to practice: nursing stroke assessment guidelines link to clinical performance indicators

Author(s): Lindsay M.P., Kelloway L., McConnell H.

Citation: Axone (Dartmouth, N.S.), June 2005, vol./is. 26/4(22-27), 0834-7824 (Jun 2005)

Publication Date: June 2005

Abstract: Stroke is the fourth leading cause of death in Canada and, each year, approximately 50,000 Canadians will suffer a stroke with a range of severities from mild, short duration symptoms to significant long-term disability or death. Of these 50,000 patients, at least 20,000 are hospitalized. Earlier this year, a core set of evidence-based performance indicators were identified by a national consensus panel that may be used to determine the quality of care provided to stroke patients in hospital during the acute phase of illness. Nurses play a critical role in stroke care across the continuum and recently published stroke assessment guidelines for nurses clearly describe key approaches to assessment and/or screening of stroke survivors. Many of the nursing assessments and/or screening actions recommended in the guidelines have direct or indirect associations with the recent performance indicators. This article describes where those relationships exist and the role nurses may play in determining overall performance for acute stroke patient care delivery during the hospitalization phase of the stroke continuum of care.
Guideline recommendations for management of patients admitted with acute stroke: Implications of a local audit

Author(s): Gommans J., Sye D., MacDonald A.

Citation: New Zealand Medical Journal, May 2005, vol./is. 118/1214, 1175-8716 (06 May 2005)

Publication Date: May 2005

Abstract: Aim: To assess the feasibility of implementing the New Zealand guideline for management of stroke by auditing the gap between recommended care and that provided in Hawke’s Bay Hospital (HBH). Methods: Fifty randomly selected records of patients discharged with acute stroke between 1 June and 30 November 2003 were retrospectively reviewed using an audit tool developed from the guideline. Results: Eight patients (16%) with non stroke syndromes were incorrectly diagnosed or coded as stroke on the basis of computed tomography (CT) scan reports. Brain imaging compliance was 100%; 86% within first 48 hours. Aspirin use or documented contraindications occurred in 62% patients within 48 hours, although the delay after imaging averaged 12.55 hours. At discharge, aspirin compliance was 100% in the surviving 42 patients. Twenty-nine (69%) patients were discharged on antihypertensive therapy, but two patients were readmitted with hypotension. Compliance with recommended multidisciplinary assessments within 48 hours included swallowing (88%), mobility (88%), communication (78%), and self care ability (60%). Patients not admitted directly to the stroke unit (19, 38%) were less likely to receive recommended interventions. Compliance with recommended predischarge assessments included suitability of accommodation (100%) and home supports (92%), but only 19% received documented advice about driving. Conclusions: Management of inpatients with acute stroke in HBH is close to most of the guideline recommendations. The identified deficiencies in patient care are potentially easily rectifiable and full implementation of the guidelines is feasible. NZMA.

Source: EMBASE

Improving patient and carer communication, multidisciplinary team working and goal-setting in stroke rehabilitation.

Author(s): Monaghan J, Channell K, McDowell D, Sharma AK

Citation: Clinical Rehabilitation, March 2005, vol./is. 19/2(194-9), 0269-2155;0269-2155 (2005 Mar)

Publication Date: March 2005

Abstract: OBJECTIVE: To determine the extent to which three forms of multidisciplinary team (MDT) care in stroke rehabilitation meet the standards set by the United Kingdom National Service Framework (NSF). DESIGN: Consecutive assessment of the three forms of care was completed. SUBJECTS: The study included three groups of 25 stroke inpatients on the stroke rehabilitation ward. INTERVENTION: (1) A standard weekly MDT meeting using a standard form for documentation; (2) a standard MDT meeting using a newly devised form; and (3) a novel MDT ward round using the new form, and attended by doctors. RESULTS: MDT ward rounds result in significantly better consideration of patients’ needs (median 7 per patient compared with 0 and 5 in phases one and two), enhanced SMART (specific, measurable, achievable, realistic and time framed) goal-setting (median 3 per patient compared to 1 in phases one and two); greater patient involvement (12 patients compared to 0 and 4 in phases one and two); and improved team working (measured using the team climate inventory) than do MDT meetings. CONCLUSIONS: In the present study, standard weekly MDT meetings did not meet the standards set for MDT care by the NSF. The use of a MDT ward round allows these standards to be achieved.

Source: MEDLINE
35. Quality of stroke prevention in general practice: Relationship with practice organization

Author(s): de Koning J.S., Klazinga N., Koudstaal P.J., Prins A., Borsboom G.J.J.M., Mackenbach J.P.

Citation: International Journal for Quality in Health Care, February 2005, vol./is. 17/1(59-65), 1353-4505 (Feb 2005)

Publication Date: February 2005

Abstract: Objective. To investigate the relationship between elements of practice organization related to stroke prevention in general practice, and suboptimal preventive care preceding the occurrence of stroke. Design. This study was conducted among 69 Dutch general practitioners in the Rotterdam region. Information on the implementation of elements of practice organization related to stroke prevention was collected by postal questionnaire. Data on the process of patient care were collected by means of chart review and interviews with general practitioners. Cases of stroke (n = 186) were retrospectively audited by an expert panel with guideline-based review criteria. Using logistic regression analysis we investigated the relationship between the probability of suboptimal care delivery and the presence of specific elements of practice organization related to stroke prevention (tailored information systems, formal delegation of preventive tasks, standardization of care). Results. For some elements of practice organization significant relationships with the quality of stroke prevention were found. Suboptimal care was less common among general practitioners with a higher level of noting high risk patients in the patient records (odds ratio 0.30; 95% CI 0.13-0.69, P = 0.01), delegating follow-up visits to support staff (odds ratio 0.42; 95% CI 0.22-0.82, P = 0.01) and compliance with the hypertension guideline (odds ratio 0.57; 95% CI 0.41-0.78, P = <0.001). Except for practice type (general practitioners in health centres less often provided suboptimal care, P = 0.02), no significant relationships with general practitioner and practice characteristics were found. Conclusion. This study shows that general practitioners with a higher level of integrated organizational structures for stroke prevention (record keeping, formal delegation of preventive tasks, guideline compliance) are less likely to deliver suboptimal care. International Society for Quality in Health Care and Oxford University Press 2005; all rights reserved.

Source: EMBASE

36. Comparing processes of stroke care in high- and low-mortality hospitals in the West Midlands, UK

Author(s): Mohammed M.A., Mant J., Bentham L., Raftery J.

Citation: International Journal for Quality in Health Care, February 2005, vol./is. 17/1(31-36), 1353-4505 (Feb 2005)

Publication Date: February 2005

Abstract: Objective. There are wide variations in hospital-specific mortality for stroke. The aim of this study was to investigate whether there were differences in quality of care when a group of hospitals with high standardized mortality ratios (SMRs) in nationally published league tables were compared with a group with low SMRs. Design. Retrospective case note review of a random sample of patients from hospitals with high and low mortality according to published league tables. Setting. Eight hospitals in the West Midlands, UK. Participants. 702 patients admitted to hospital with acute stroke during the year 2000-2001. Main outcome measures. Process measures derived from the Intercollegiate Stroke Audit Package. Results. Crude 30 day mortality was 25% (99/402) in 'top' ranking hospitals and 38% (113/300) in 'bottom' ranking hospitals (P < 0.001). Bottom hospitals performed significantly (P < 0.001) less well on four out of seven indicators of process of care relating
to the patients’ first 24 hours in hospital - assessment of eye movements and visual fields, screening for swallowing disorders and sensory testing. However, analysis at the individual hospital level showed that this was largely due to poor performance in one hospital with high mortality. If this outlier was omitted, there was little relationship between process of care and SMR. No significant differences were found in care provided after 24 hours. Nevertheless even in 'top' ranking hospitals only 47% of stroke patients had at least 50% of their hospital stay in a stroke/rehabilitation unit and only 40% were on aspirin within 48 hours. Conclusions. Our results show that there is scope for improving the quality of stroke care irrespective of where a hospital ranks in terms of mortality. The lack of association between SMR and quality of care as assessed by process measures casts some doubt over the value of ranking hospitals in terms of stroke SMR. International Society for Quality in Health Care and Oxford University Press 2005; all rights reserved.

Source: EMBASE

Full Text: Available in fulltext at Highwire Press

37. Practice on an acute stroke unit after implementation of a decision-making algorithm for dietary management of dysphagia.

Author(s): Runions S, Rodrigue N, White C

Citation: Journal of Neuroscience Nursing, August 2004, vol./is. 36/4(200-7), 0888-0395;0888-0395 (2004 Aug)

Publication Date: August 2004

Abstract: Dysphagia is a common disability seen in stroke survivors that has been associated with high morbidity and mortality. Research has indicated that implementing clinical guidelines and algorithms improves dysphagia management and patient outcomes. A decision-making algorithm designed to enhance the assessment and dietary treatment of swallowing difficulties in the acute stroke patient was implemented on a dedicated neuroscience unit in January 2002. Following implementation, the medical records of 30 acute stroke patients consecutively admitted to the unit between February and May 2002 were reviewed for stroke and dysphagia characteristics, dysphagia-related complications, discharge dispositions, interdisciplinary baseline assessments, and nursing evaluations throughout the hospitalization. Of those patients admitted with stroke, 56.7% were dysphagic. As compared with the nondysphagic patients, the dysphagic patients had three times' longer inpatient stay, an increased incidence of complications, higher morbidity, and increased need for inpatient rehabilitation services and institutionalized care following discharge. Twenty percent of patients did not receive a formal evaluation of swallowing function within the first 48 hours of admission. In 10% of the patients, diets were changed following the formal evaluation of swallowing to change an unsafe, prescribed diet. More than 70% of patients showed clinical improvement in swallowing function during their hospitalization. Nurses tended to document assessments of general neurological factors (e.g., level of consciousness) related to swallowing function more frequently than factors felt to be more specific to swallowing (e.g., choking) and nutrition (e.g., tolerates diet). The results support the important role of the neuroscience nurse in the early and ongoing assessment of swallowing function and in providing directions to further improve the quality of care delivered to stroke patients with various degrees of swallowing dysfunction.

Source: MEDLINE

38. Continuity of care with written information and dedicated nurses: a literature review. Part 1 [Italian] La continuita dell’assistenza basata su informazioni scritte e infermieri dedicati: revisione della letteratura. Prima parte

Author(s): Colle F., Palese A., Brusaferro S.

Citation: Assistenza infermieristica e ricerca : AIR, July 2004, vol./is. 23/3(179-185), 1592-5986 (2004 Jul-Sep)

Publication Date: July 2004

Abstract: Continuity of care is one of the major challenges of contemporary care. The aim of this review is to evaluate the efficacy of written information and dedicated discharge
nurses on continuity of care. A literature search was done on Medline (1966-March 2004) and Cinhal (1984-2004) with the following key words: "Community Health Nursing e Discharge Planning/Nursing Records/Continuity of Patient Care", "discharge liaison nurse", "liaison nurse", "transfer nurse" and "discharge coordinator (co-ordinator)" and "case manager nurse", a search by author was also performed. Editorials, letters and comments were excluded. Overall, 35 articles were identified. There are no evidences that written information improves the continuity of care and no agreement exists on the information to be registered: a diary of the patient hospital stay or detailed prescriptions of future interventions. A discharge professional seems to be effective on costs reduction, patients' satisfaction and according to some authors, also on the continuity of care. New and more extensive research is needed to shed a light on this pivotal aspect of care.

Source: EMBASE

39. A content analysis of forms, guidelines, and other materials documenting end-of-life care in intensive care units.

Author(s): Clarke EB, Luce JM, Curtis JR, Danis M, Levy M, Nelson J, Solomon MZ

Citation: Journal of Critical Care, 01 June 2004, vol./is. 19/2(108-117), 08839441

Publication Date: 01 June 2004

Abstract: OBJECTIVE: The purpose of this study was to determine the extent to which data entry forms, guidelines, and other materials used for documentation in intensive care units (ICUs) attend to 6 key end-of-life care (EOLC) domains: 1) patient and family-centered decision making, 2) communication, 3) continuity of care, 4) emotional and practical support, 5) symptom management and comfort care, and 6) spiritual support. A second purpose was to determine how these materials might be modified to include more EOLC content and used to trigger clinical behaviors that might improve the quality of EOLC. PARTICIPANTS: Fifteen adult ICUs-8 medical, 2 surgical, and 4 mixed ICUs from the United States, and 1 mixed ICU in Canada, all affiliated with the Critical Care End-of-Life Peer Workgroup METHODS: Physician-nurse teams in each ICU received detailed checklists to facilitate and standardize collection of requested documentation materials. Content analysis was performed on the collected documents, aimed at characterizing the types of materials in use and the extent to which EOLC content was incorporated. MEASUREMENTS AND MAIN RESULTS: The domain of symptom management and comfort care was integrated most consistently on forms and other materials across the 15 ICUs, particularly pain assessment and management. The 5 other EOLC domains of patient and family centered decision-making, communication, emotional and practical support, continuity of care, and spiritual support were not well-represented on documentation. None of the 15 ICUs supplied a comprehensive EOLC policy or EOLC critical pathway that outlined an overall, interdisciplinary, sequenced approach for the care of dying patients and their families. Nursing materials included more cues for attending to EOLC domains and were more consistently preprinted and computerized than materials used by physicians. Computerized forms concerning EOLC were uncommon. Across the 15 ICUs, there were opportunities to make EOLC-related materials more capable of triggering and documenting specific EOLC clinical behaviors. CONCLUSIONS: Inclusion of EOLC items on ICU formatted data entry forms and other materials capable of triggering and documenting clinician behaviors is limited, particularly for physicians. Standardized scales, protocols, and guidelines exist for many of the EOLC domains and should be evaluated for possible use in ICUs. Whether such materials can improve EOLC has yet to be determined. Copyright © 2004 by Elsevier Science (USA).

Source: CINAHL

40. Toward a taxonomy of rehabilitation interventions: Using an inductive approach to examine the "black box" of rehabilitation.

Author(s): Dejong G, Horn SD, Gassaway JA, Slavin MD, Dijkers MP

Citation: Archives of Physical Medicine & Rehabilitation, April 2004, vol./is. 85/4(678-86), 0003-9993;0003-9993 (2004 Apr)

Publication Date: April 2004

Abstract: A barrier in outcomes and effectiveness research is the ability to characterize
the interventions under review. This has been the case especially in rehabilitation in which interventions are commonly multidisciplinary, customized to the patient, and lack standardization in definition and measurement. This commentary describes how investigators and clinicians, working together, in a major multisite stroke rehabilitation outcome study were able to define and characterize diverse stroke rehabilitation interventions in a comprehensive, yet parsimonious, fashion and thus capture what actually transpires in a hospital-based stroke rehabilitation program. We consider the implications of the study's classification system for a more comprehensive taxonomy of rehabilitation interventions and the potential utility of such a taxonomy in operationalizing practice standards, medical record keeping, and rehabilitation research.

Source: MEDLINE

41. Multidisciplinary patient records in a palliative care setting.

Author(s): Simpson M

Citation: Nursing Times, 21 January 2003, vol./is. 99/3(33-34), 09547762

Publication Date: 21 January 2003

Abstract: Multidisciplinary team working is essential to the delivery of specialist palliative care. Recent government initiatives have focused on improving the quality of patient care through a collaborative approach. The palliative care directorate of the Thames Gateway NHS Trust developed a patient record system that could be utilised by all health care professionals. An audit was carried out and showed that the new documentation, which provides only one set of records, improves the clarity of information, enhances communication, avoids duplication and helps to maintain the continuity of the patient's journey.

Source: CINAHL

Full Text:
Available in print at Grantham Hospital Staff Library
Available in print at Lincoln County Hospital Professional Library
Available in print at Louth County Hospital Medical Library
Available in print at Pilgrim Hospital Staff Library

42. Can staff attitudes to team working in stroke care be improved?

Author(s): Gibbon B., Watkins C., Barer D., Waters K., Davies S., Lightbody L., Leathley M.

Citation: Journal of advanced nursing, October 2002, vol./is. 40/1(105-111), 0309-2402 (Oct 2002)

Publication Date: October 2002

Abstract: Teamwork is regarded as the cornerstone of rehabilitation. It is recognized that the skills of a multiprofessional team are required to provide the care and interventions necessary to maximize the patient's potential to recover from his/her stroke. LITERATURE REVIEW: Critical evaluation of team working is lacking in the literature. Indeed, there is no consensus on a precise definition of teamwork or on the best way of implementing it, beyond a general exhortation to members to work to the same therapeutic plan in a cohesive manner. The literature has highlighted many problems in team working, including petty jealousies, ignorance and a perceived loss of autonomy and threat to professional status. AIM: To determine if the use of team co-ordinated approaches to stroke care and rehabilitation would improve staff attitudes to team working. METHOD: A pre-post design was adopted using 'The Team Climate Inventory' to explore attitudes to team working before and after introducing the interventions. Local Research Ethics Committee approval was obtained. RESULTS: Improvements in attitudes towards team working suggest that the introduction of team co-ordinated approaches (integrated care pathways and team notes) did not result in greater team working. LIMITATIONS: The introduction of an integrated care pathway and team notes is based on an assumption that they would enhance team working. CONCLUSIONS: The results suggest that the introduction of team co-ordinated approaches (team notes and care pathways) do not
improve attitudes to team working, teams appear to take a long time to establish cohesion and develop shared values.

Source: EMBASE

Full Text:
Available in fulltext at Ovid
Available in fulltext at EBSCO Host
Available in print at Grantham Hospital Staff Library
Available in print at Pilgrim Hospital Staff Library

43. Clinical information systems for primary care: More than just an electronic medical record

Author(s): Hesse K.A., Siebens H.

Citation: Topics in Stroke Rehabilitation, September 2002, vol./is. 9/3(39-59), 1074-9357 (Sep 2002)

Publication Date: September 2002

Abstract: Massachusetts General Hospital Senior Health has integrated a computer-based clinical information system into all aspects of its patient care. This technology includes a longitudinal medical record but has broader functionality that encourages communication, education, and quality improvement activities. Care of geriatric patients is often challenging because of the complex nature of their clinical presentations. The case presented here, a patient at risk for stroke, illustrates how a clinical information system can facilitate quality care. The benefits, as well as difficulties, experienced as the system was integrated into the program's clinical practice are also described.

Source: EMBASE

44. Successful interdisciplinary documentation through nursing interventions classification.

Author(s): Smith K, Smith V

Citation: Seminars for Nurse Managers, 01 June 2002, vol./is. 10/2(100-104), 10663851

Publication Date: 01 June 2002

Abstract: Automated documentation systems enable health care professionals to develop dynamic, interdisciplinary care plans. Use of a standardized nomenclature provides a common framework and language for the communication of the plan, and also can support data collection to determine best clinical practices. A comprehensive patient care record will link the interdisciplinary care plan to clinical charting and the documentation of outcomes. This article reviews efforts to improve interdisciplinary communication by computerizing the documentation system, using the Nursing Interventions Classification (NIC). Copyright © 2002 by Elsevier Science (USA).

Source: CINAHL


Author(s): Sulch D, Evans A, Melbourn A, Kalra L

Citation: Age & Ageing, May 2002, vol./is. 31/3(175-9), 0002-0729;0002-0729 (2002 May)

Publication Date: May 2002

Abstract: OBJECTIVE: to evaluate whether integrated care pathways improve the processes of care in stroke rehabilitation. DESIGN: comparison of processes of care data collected in a randomized controlled trial. PARTICIPANTS: acute stroke patients undergoing rehabilitation randomized to receive integrated care pathways management (n=76) or conventional multidisciplinary care (n=76). MEASUREMENTS: proportion of patients meeting recommended standards for processes of care using a validated stroke audit tool. RESULTS: integrated care pathways methodology was associated with higher
frequency of stroke specific assessments, notably testing for inattention (84% versus 60%; 
P=0.015) and nutritional assessment (74% versus 22%, P<0.001). Documentation of 
provision of certain information to patients/carers (89% versus 70%; P=0.024) and early 
discharge notification to general practitioners (80% versus 45%; P<0.001) were also more 
common in this group. There were no significant differences in the processes of 
interdisciplinary co-ordination and patient management between the integrated care 
pathways group and the control group. CONCLUSION: integrated care pathways may 
improve assessment and communication, even in specialist stroke settings.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at Ovid
Available in print at Pilgrim Hospital Staff Library

46. Development of an integrated care pathway for the management of hemiplegic shoulder pain

Author(s): Jackson D., Turner-Stokes L., Khattoo N., Stern H., Knight L., O’Connell A.
Citation: Disability and Rehabilitation, May 2002, vol./is. 24/7(390-398), 0963-8288 (10 May 2002)
Publication Date: May 2002

Abstract: Purpose: To improve clinical management of patients with hemiplegic shoulder pain through development of an evidence-based multidisciplinary integrated care pathway (ICP), and to use this to audit quality of care against predefined standards. Methods: The ICP was developed by a team of medical, paramedical and nursing staff. The evidence base was established through a systematic literature review supplemented by clinical consensus to ensure best practice where scientific evidence was lacking. Following development, performance was assessed against standards in a cohort of stroke patients with hemiplegia (n=32) consecutively admitted to a regional unit providing in-patient rehabilitation for young patients with complex disabilities. Results: Performance showed improvements in assessment and documentation of pain and in initial care, including analgesia and application of positioning/handling protocols. However, review and response to continuing or changing symptoms were poorly documented. Changes to the ICP were introduced to improve this. Conclusions: Principal benefits have been to raise awareness of shoulder pain, to educate staff and prompt management in line with recommended best practice, but strong leadership is essential to ensure continuity in clinical practice. Future research is needed to establish whether improved quality of care offsets the substantial investment of staff time in ICP development.

Source: EMBASE

Full Text:
Available in print at Pilgrim Hospital Staff Library

47. Communication issues for the interdisciplinary community palliative care team.

Author(s): Street A, Blackford J
Citation: Journal of Clinical Nursing, 01 September 2001, vol./is. 10/5(643-650), 09621067
Publication Date: 01 September 2001

Abstract: * This paper discusses the findings of a critical study that examined the communication patterns between nurses and general practitioners (GPs) providing palliative care in Australia.

Source: CINAHL

Full Text:
48. Practice brief. Transfer of patient health information across the continuum (updated)

Author(s): Hughes G.

Citation: Journal of AHIMA / American Health Information Management Association, June 2001, vol./is. 72/6(64S-64Z), 1060-5487 (Jun 2001)

Publication Date: June 2001

Source: EMBASE

49. Improving stroke patients' care: A patient held record is not enough

Author(s): Ayana M., Pound P., Lampe F., Ebrahim S.

Citation: BMC Health Services Research, March 2001, vol./is. 1/(1-6), 1472-6963 (06 Mar 2001)

Publication Date: March 2001

Abstract: Background: Stroke patients' care in hospital tends to be poorly organised, with poor communication and a lack of information being frequent sources of complaint. The purpose of this study was to evaluate whether a patient-held record (PHR) would result in greater patient satisfaction and better care planning for stroke patients. Methods: A time series control (6 months) - intervention (8 months) - control (6 months) was used among London teaching hospital general medical and geriatric medicine inpatient wards. All stroke patients admitted to the wards during the intervention phase received a PHR and were instructed in its use. Demographic, stroke severity, social factors and outcomes were collected from all stroke patients during all phases of the study. Results: Of 252 stroke patients aged 46 to 98 years entered into the study, by six months after admission 118 (46.8%) had died. PHR and control group patients were well matched in terms of socio-demographic characteristics and pre-stroke ability. At six months after admission, 119 (97%) patients responded to the questionnaire. Just over half (56%, 13) of intervention group patients recalled receiving a PHR. Of those patients, 59% reported reading the PHR, 27% had lost their PHR, and two-thirds said they had difficulties encouraging staff to write in the PHR. Half felt that possession of the PHR was more trouble than it was worth. PHR group patients were more satisfied with the recovery they had made (79% vs. 59%, p=0.04), but felt less able to talk to staff about their problems (61% vs. 82%, p=0.02). PHR group patients reported receiving fewer explanations about their condition (18% vs. 33%, p=0.12) and treatment (26% vs. 45%, p=0.07), and were more afraid of asking doctors questions (21% vs. 4%, p=0.01) than controls. PHR group patients were no better prepared for hospital discharge than control group patients, and both groups were ill-informed about services and benefits that might have helped after discharge from hospital. Conclusions: Stroke patients received poor information and explanations regardless of whether they received a PHR. A PHR did not appear to improve patient satisfaction or discharge planning, and may have reduced opportunities for communication and explanation.

Source: EMBASE

50. Cerebrovascular accident clinical pathway

Author(s): Wilkinson G, Parcell M, MacDonald A
Citation: Journal of Quality in Clinical Practice, June 2000, vol./is. 20/2-3(109-12), 1320-5455;1320-5455 (2000 Jun-Sep)

Publication Date: June 2000

Abstract: The cerebrovascular accident (CVA) clinical pathway project was selected to complement the work already underway within the West Moreton Health Services District such as the development of a continuum of care model, revision of work practices to complement the new hospital redevelopment and encouraging team and evidence-based approaches to problem solving. Specific objectives were set for the project along with a detailed evaluation plan. A steering group was convened to run the project and a full time project officer was appointed. At the end of the 12 month period all the objectives were met. Specific achievements included a reduction in the overall average length of stay for those patients who experience CVA, improved clinical outcomes and a more effective use of resources. Quality of care has been improved through the preparation of specialized clinical pathway documentation, education packages, patient surveys, focus groups, independent reviews and benchmarking. Complementing these measures has been a series of process changes and environmental modifications. Furthermore, good working relationships have been established with private sector providers of health care and other external bodies. The development of the CVA clinical pathway at the Ipswich Hospital has meant timely referrals and a streamlined assessment and referral process to get patients into rehabilitation sooner. It has promoted good communication between, and recognition of, the professional roles of various team members and has put the patient back at the centre of the care process.

Source: MEDLINE

Full Text: Available in fulltext at EBSCO Host

51. Discharge and follow-up for people with stroke: What happens and why

Author(s): Tyson S., Turner G.

Citation: Clinical Rehabilitation, 2000, vol./is. 14/4(381-392), 0269-2155 (2000)

Publication Date: 2000

Abstract: Objective: To assess the quality of the process of discharge from hospital and follow-up services for people with stroke. Design: A criterion-based process audit and basic outcome measures, combined with surveys of patients' satisfaction and staff opinion of the service. Setting: All units treating stroke patients in a health care district including an acute and a community NHS trust, and 23 participating GP practices. Subjects: Process audit: documented notes of 98 stroke patients admitted and discharged over a four-month period. Patient satisfaction survey: 93 surviving stroke patients. Staff opinion survey: general practitioners, hospital doctors, therapists and nurses treating stroke patients throughout the district. Results: A poor level of service was found. The main shortcomings were poor communication and liaison and a narrow focus of rehabilitation which concentrated on the assessment and provision of basic home care and activities of daily living (ADL) required to obtain discharge. There was a paucity of provision beyond this most basic level and little follow-up after discharge. Pass rates against agreed criteria were: communication between staff and patients/carers 47%, liaison between staff 44%, assessment of home-based needs 48%, assessment of domestic skills 15.5%. Fifty-one percent of patients were referred for follow-up therapy and of these 72% started follow-up therapy within six weeks of discharge, only 27% had any follow-up assessment of activity levels and well-being. Patients were dissatisfied with the information, support services and therapy they received. The main reasons for the shortcomings were lack of awareness of the services provided, professionals' low expectations of patients' abilities, and limitations of community-based therapy services. Conclusions: Evidence from other publications suggests that these results do not indicate a service that is any worse than other districts, rather it represents the poor deal offered to stroke patients. By comprehensively assessing several aspects of the service together this methodology has been able to reveal these inadequacies and the reasons for them.

Source: EMBASE

Full Text:
The national sentinel audit for stroke: a tool for raising standards of care.


Citation: Journal of the Royal College of Physicians of London, September 1999, vol./is. 33/5(460-4), 0035-8819;0035-8819 (1999 Sep-Oct)

Publication Date: September 1999

Abstract: STUDY OBJECTIVE: To assess the quality of inpatient care and follow-up for stroke in England, Wales and Northern Ireland. DESIGN: Retrospective audit of case notes and service organisation. SETTING: 197 trust (80% of eligible trusts in England, Wales and Northern Ireland). PATIENTS: 6,894 consecutive stroke patients admitted between 1 January 1998 and 31 March 1998 (up to 40 per trust). AUDIT TOOL: The Intercollegiate Stroke Audit. RESULTS: Most patients were admitted to acute hospitals with access to the appropriate acute investigations and treatments. Only 64% of trusts had a physician with responsibility for stroke and only 50% had a stroke team. Involvement of different members of the multidisciplinary team within appropriate time-frames varied from 37% to 61%. Assessment of impairments specific to stroke was inadequate (screening for swallowing disorders in only 55%, cognitive function tests in 23% and visual field examination in 44%). Rehabilitation goals were agreed by the multidisciplinary team in only 55% of eligible cases. 41% of patients were contacted by their GP within 3 days of discharge. The best compliance with standards was achieved for the 18% of patients who spent at least 50% of their time in a stroke unit. CONCLUSIONS: This national audit demonstrates that care is suboptimal in many areas, and that there is wide variation in standards for the management of stroke across the country. This may have implications for clinical governance.

Source: MEDLINE

Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams

D Sheehan, L Robertson... - ... of Interprofessional Care, 2007 - informahealthcare.com... Care 2000; 14(3)237–247. Gair G., Hartery T. Medical dominance in multidisciplinary team work: A case study of discharge decision-making in a geriatric assessment unit... D., Waters K., Davies S., Lightbody L., Leathely M. Can staff attitudes to team working in stroke care be...

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