Shared Care Documentation

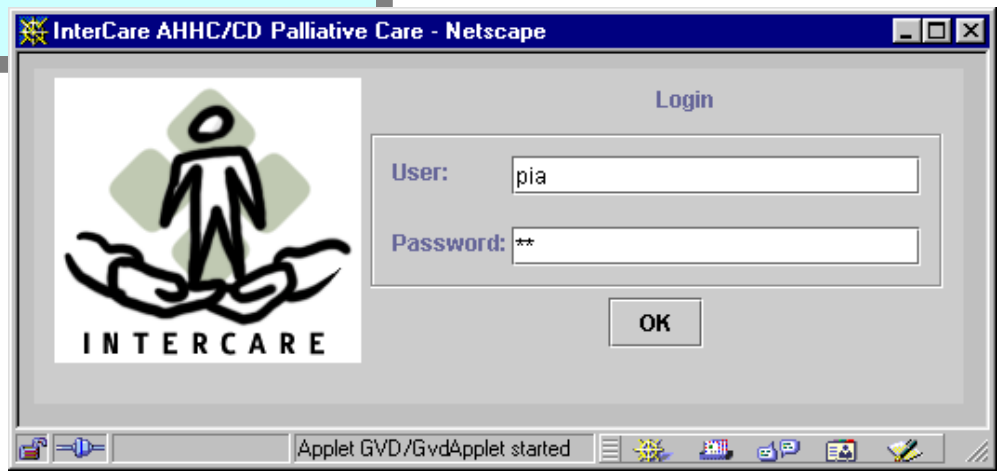
AHHC/CD Demonstration

- Advanced Home Healthcare (AHHC) Application:
  - An application built on top of the CD component to support the needs of a home healthcare cooperating situation - the Palliative unit, Stockholm Nort-East and Östermalm's Home service unit.
- Care Documentation (CD) component:
  - Interoperates with InterCare components EM (Enterprise Manager) and IACS (Information Access Control Service)
  - Generic – may be adjusted to the needs of different healthcare professional categories and units by means of classifications
  - Background reference models: CEN/HISA and NHS/CBS

Starting up

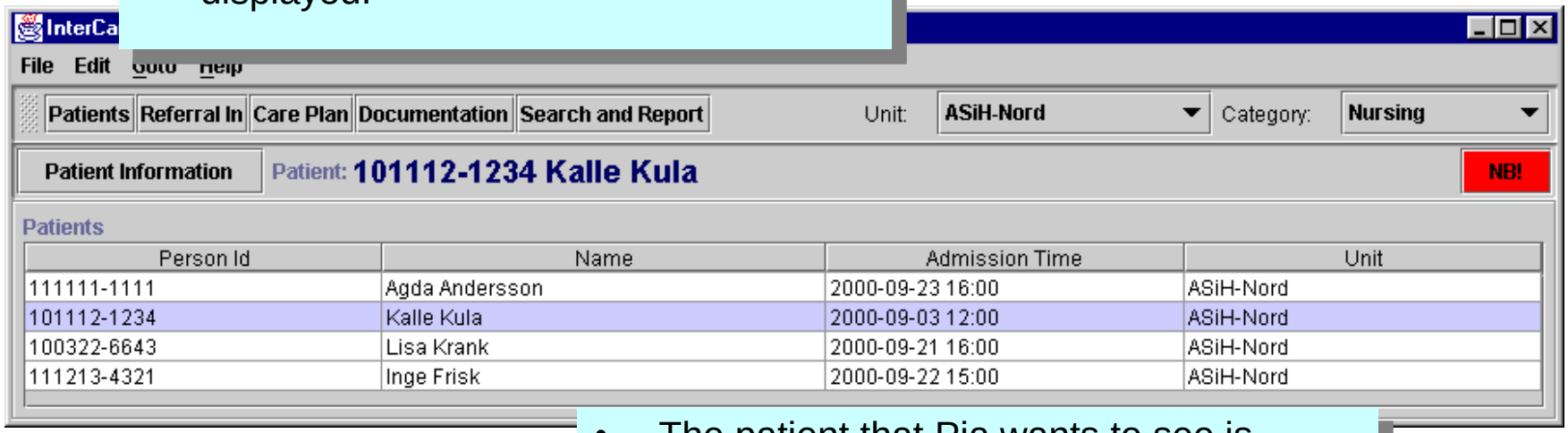
- User authentication
  - Pia logs on and enters here user-id and password.
  - Enterprise Manager, which keeps the id:s and the passwords, is consulted and says OK

Nurse Pia
at Palliative unit



Patients

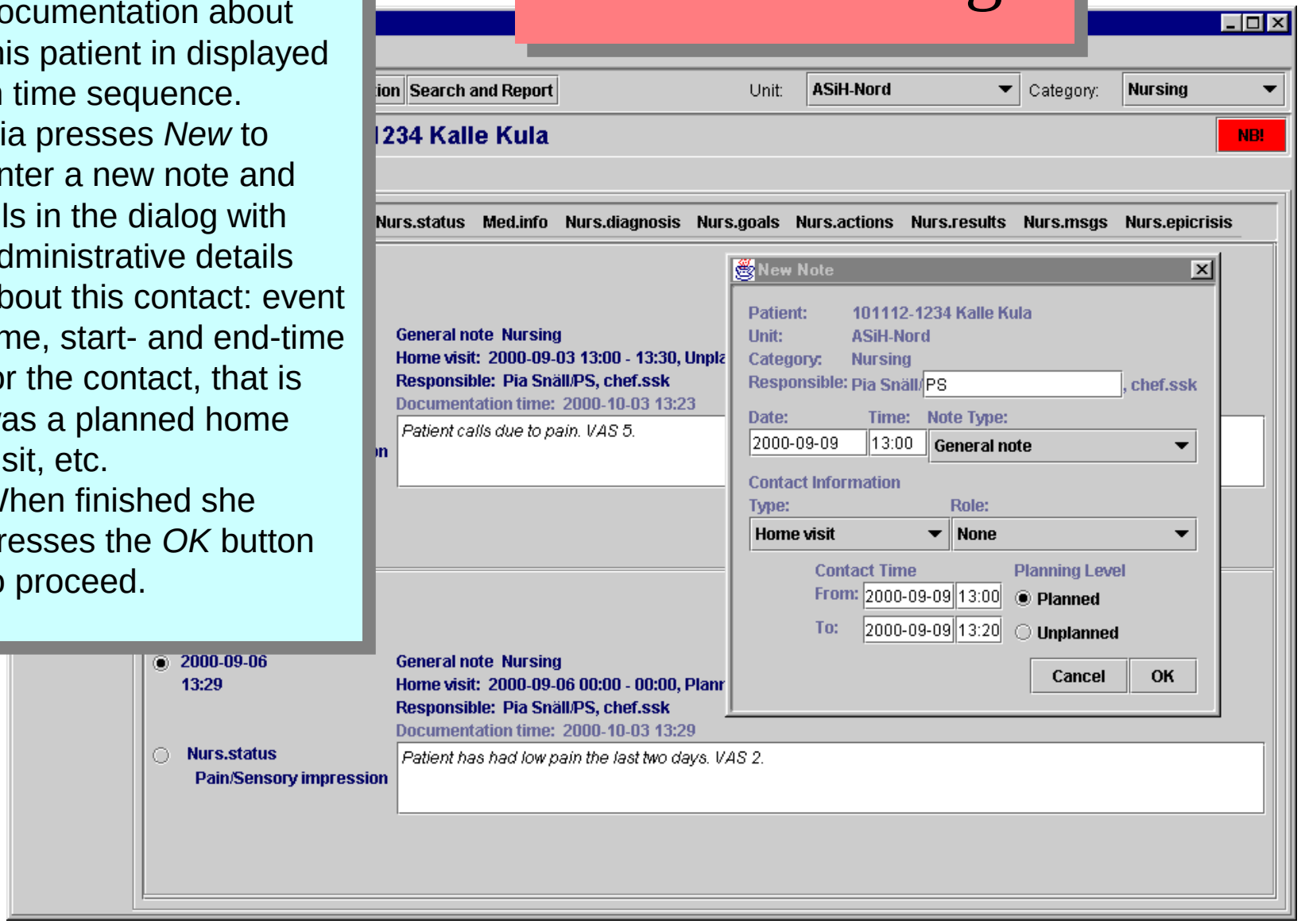
- Pia works for the ASiH-Nord sub-unit and as nurse she documents under the Nursing category. This kind of information is derived from the Enterprise Manager, for the documentation tool to be set in the correct start position.
- After clicking the *Patients* button, the patients which belong to ASiH-Nord are displayed.



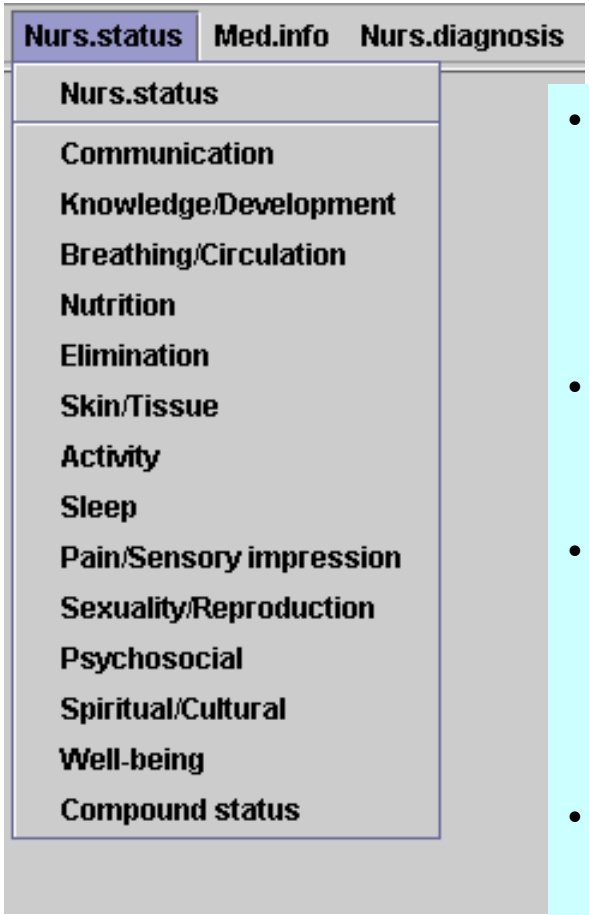
- The patient that Pia wants to see is selected in the list of patients, and is made the current patient.
- Pia has just made a visit to this patient's home and wants to document her observations. She presses the *Documentation* button.

Documenting

- The existing nursing documentation about this patient in displayed in time sequence.
- Pia presses *New* to enter a new note and fills in the dialog with administrative details about this contact: event time, start- and end-time for the contact, that is was a planned home visit, etc.
- When finished she presses the *OK* button to proceed.

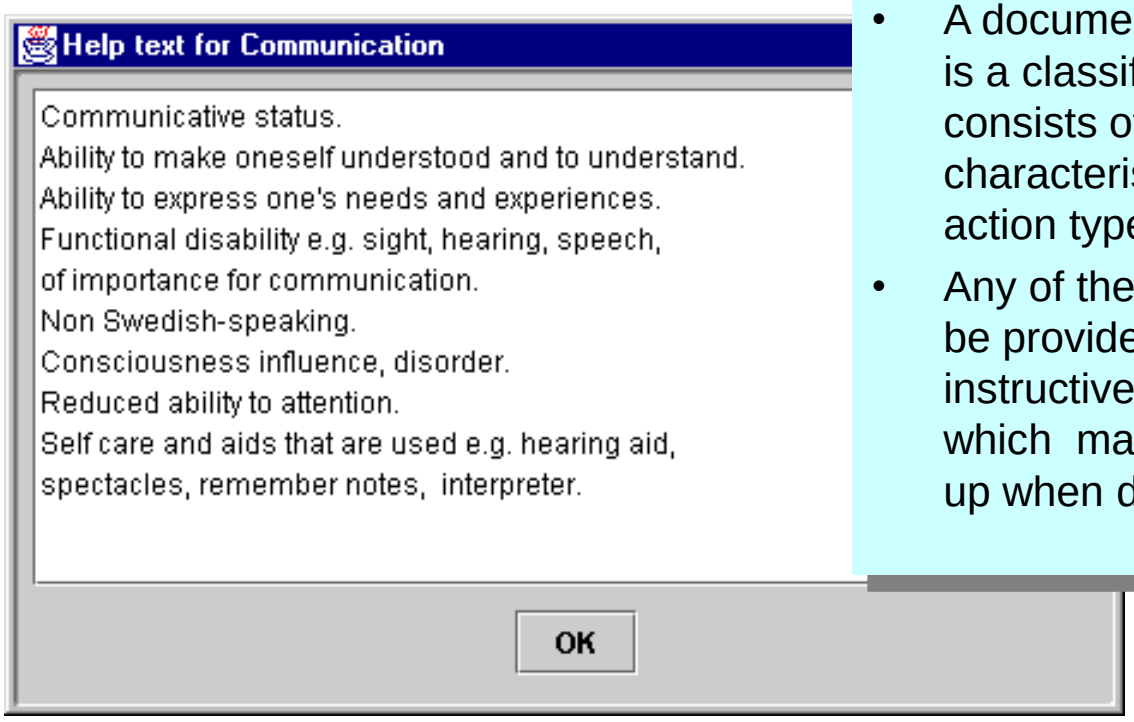


Nursing documentation model



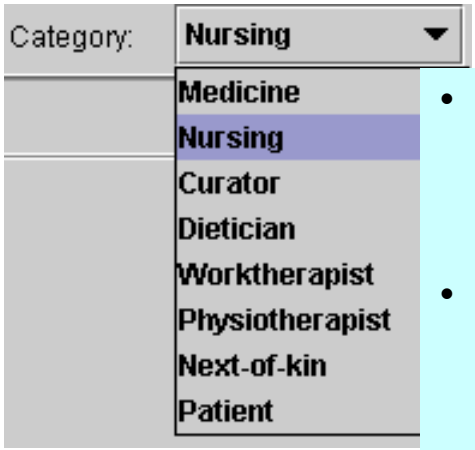
- The menu bar presents the main aspects of the documentation model, which the nurses at the unit have agreed to use.
- Each menu contains the used sub-aspects, which could be at several levels.
- She selects *Nursing Status* and *Pain/Sensory impression* and fills in her observations about the patient's pain status.
- When finished, she saves and signs what she has documented.

Documentation model instructions



- A documentation model is a classification, which consists of health characteristic types and action types.
- Any of these types can be provided with instructive descriptions, which may be picked up when documenting.

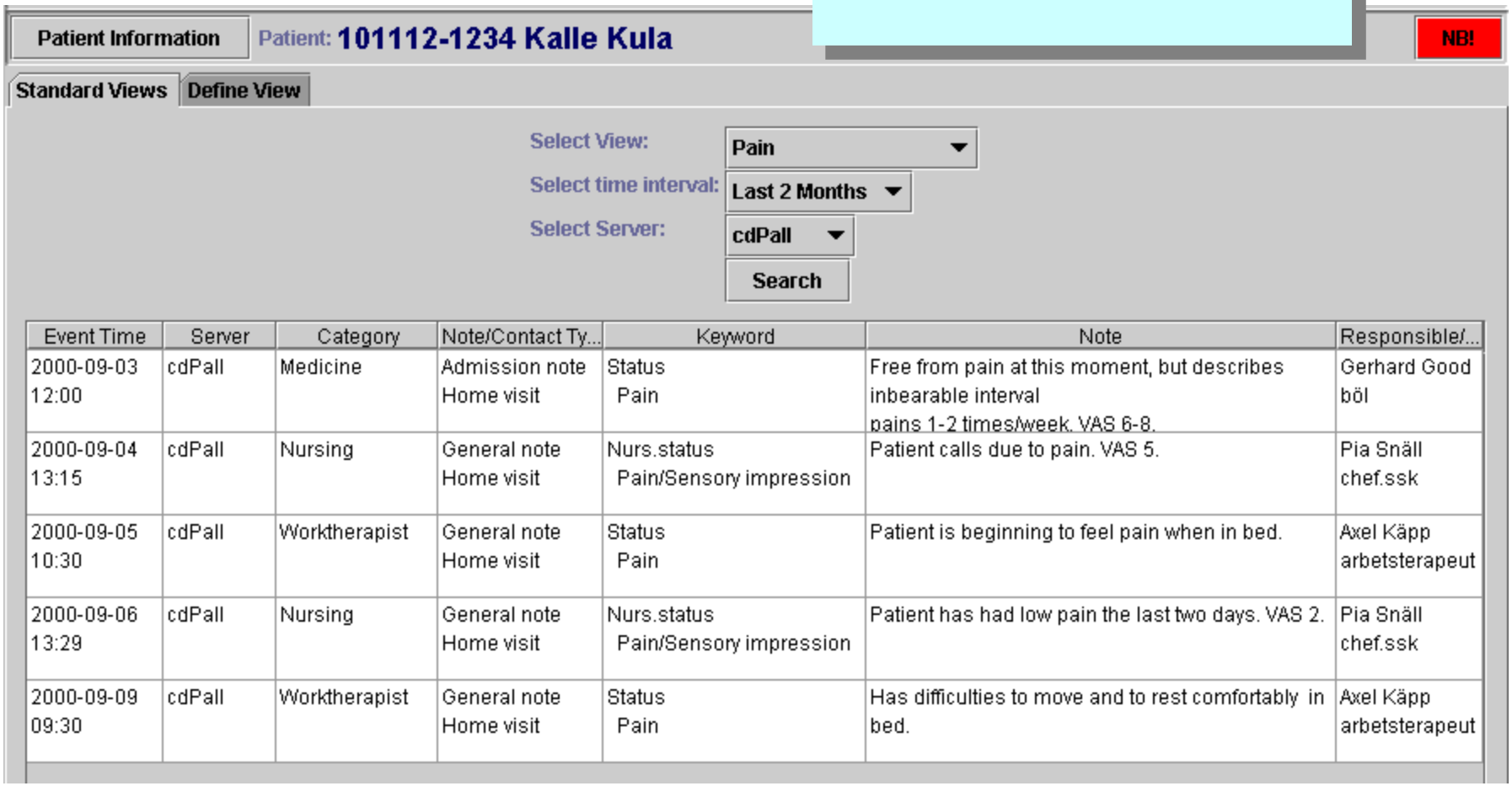
Documentation models



- At this unit there are several categories of healthcare professionals working: doctors, nurses, dieticians, work therapists, physiotherapists, curators, etc.
- Also note that it is possible for non-professional care givers (relatives, etc) and the patient him/herself to document, using simple documentation models.
- As seen, each category documents separately according to their agreed documentation model
- The work, though, is performed team-orientedly
- To support the need to get a comprehensive view over category/unit borders of what is documented was highly prioritized by the care teams

Views across categories and units

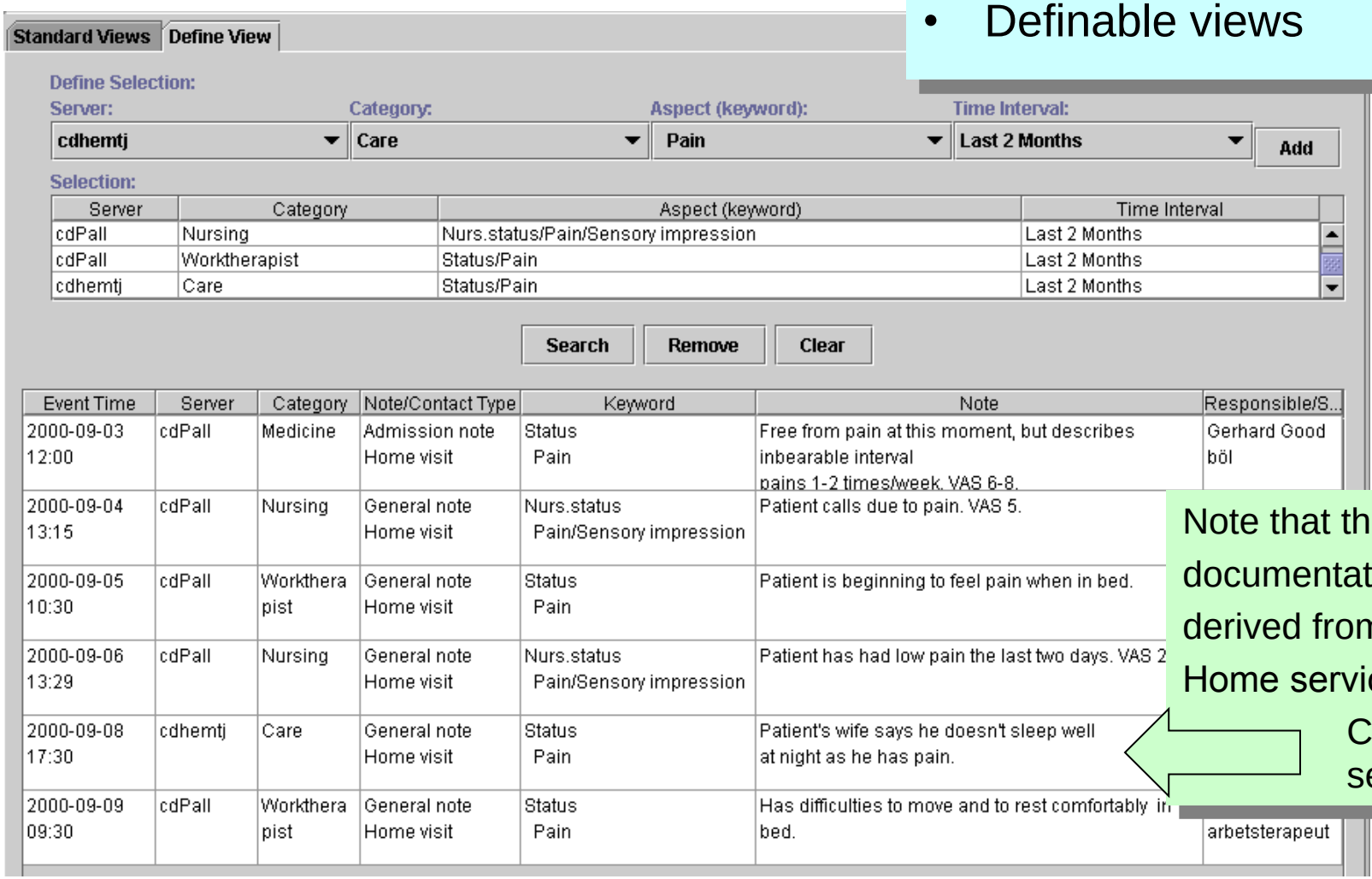
- Standard views



Event Time	Server	Category	Note/Contact Ty...	Keyword	Note	Responsible/...
2000-09-03 12:00	cdPall	Medicine	Admission note Home visit	Status Pain	Free from pain at this moment, but describes inbearable interval pains 1-2 times/week. VAS 6-8.	Gerhard Good böl
2000-09-04 13:15	cdPall	Nursing	General note Home visit	Nurs.status Pain/Sensory impression	Patient calls due to pain. VAS 5.	Pia Snäll chef.ssk
2000-09-05 10:30	cdPall	Worktherapist	General note Home visit	Status Pain	Patient is beginning to feel pain when in bed.	Axel Käpp arbetsterapeut
2000-09-06 13:29	cdPall	Nursing	General note Home visit	Nurs.status Pain/Sensory impression	Patient has had low pain the last two days. VAS 2.	Pia Snäll chef.ssk
2000-09-09 09:30	cdPall	Worktherapist	General note Home visit	Status Pain	Has difficulties to move and to rest comfortably in bed.	Axel Käpp arbetsterapeut

Views across categories and units

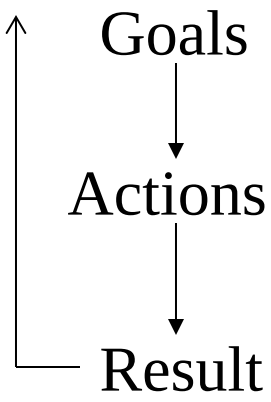
- Definable views



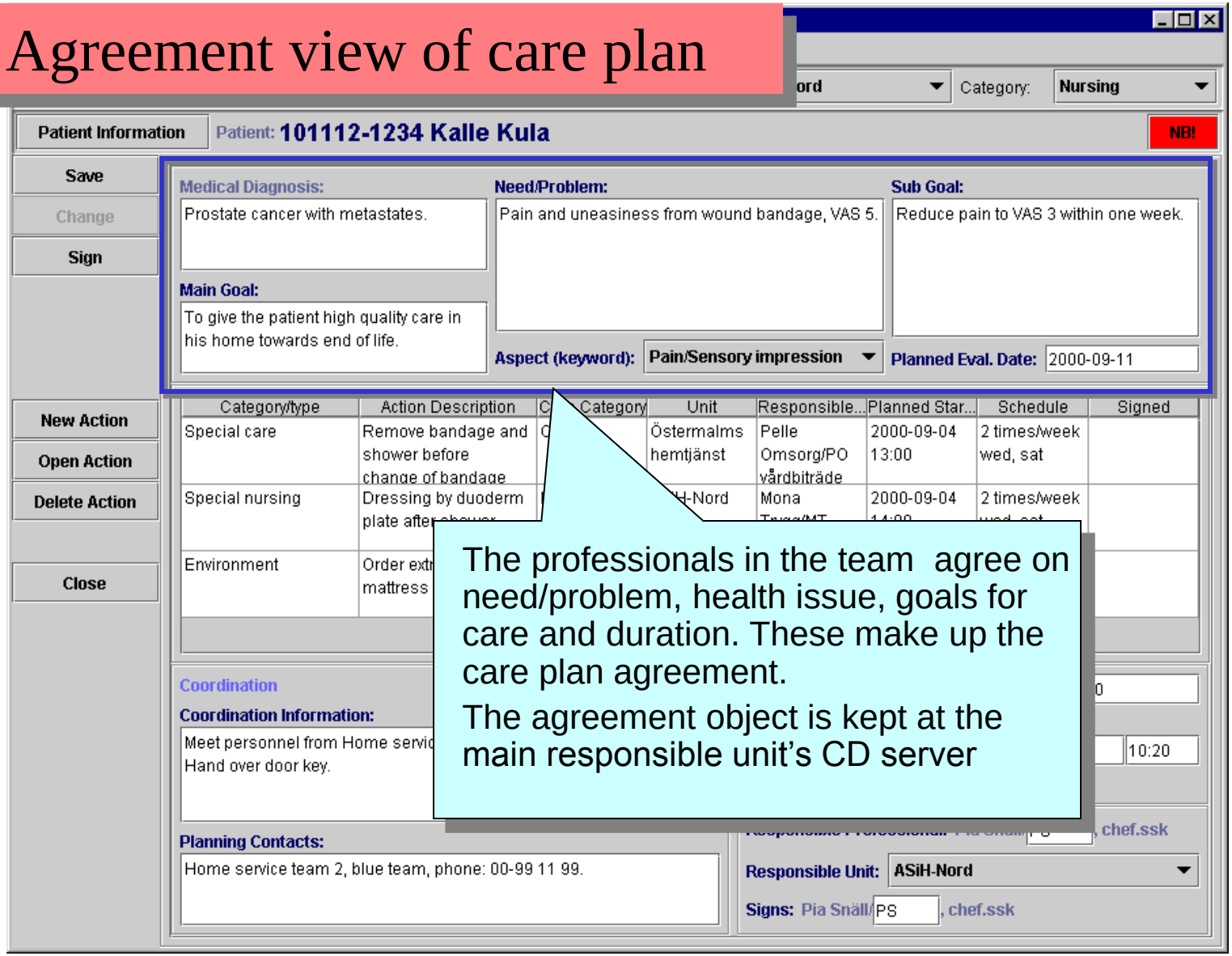
Note that this documentation is derived from the Home service' CD server

Care Planning

- Individual care plans may be created for patients
- A care plan is created at a planning conference
- The professionals in the team agree on problem, health issue, goals for care and duration. These make up the care plan agreement.
- The plan may comprise actions from several professional categories from one or more units
- The agreement object is kept at the main responsible unit's CD server
- The action objects are distributed over participating units' CD-servers according to responsibility



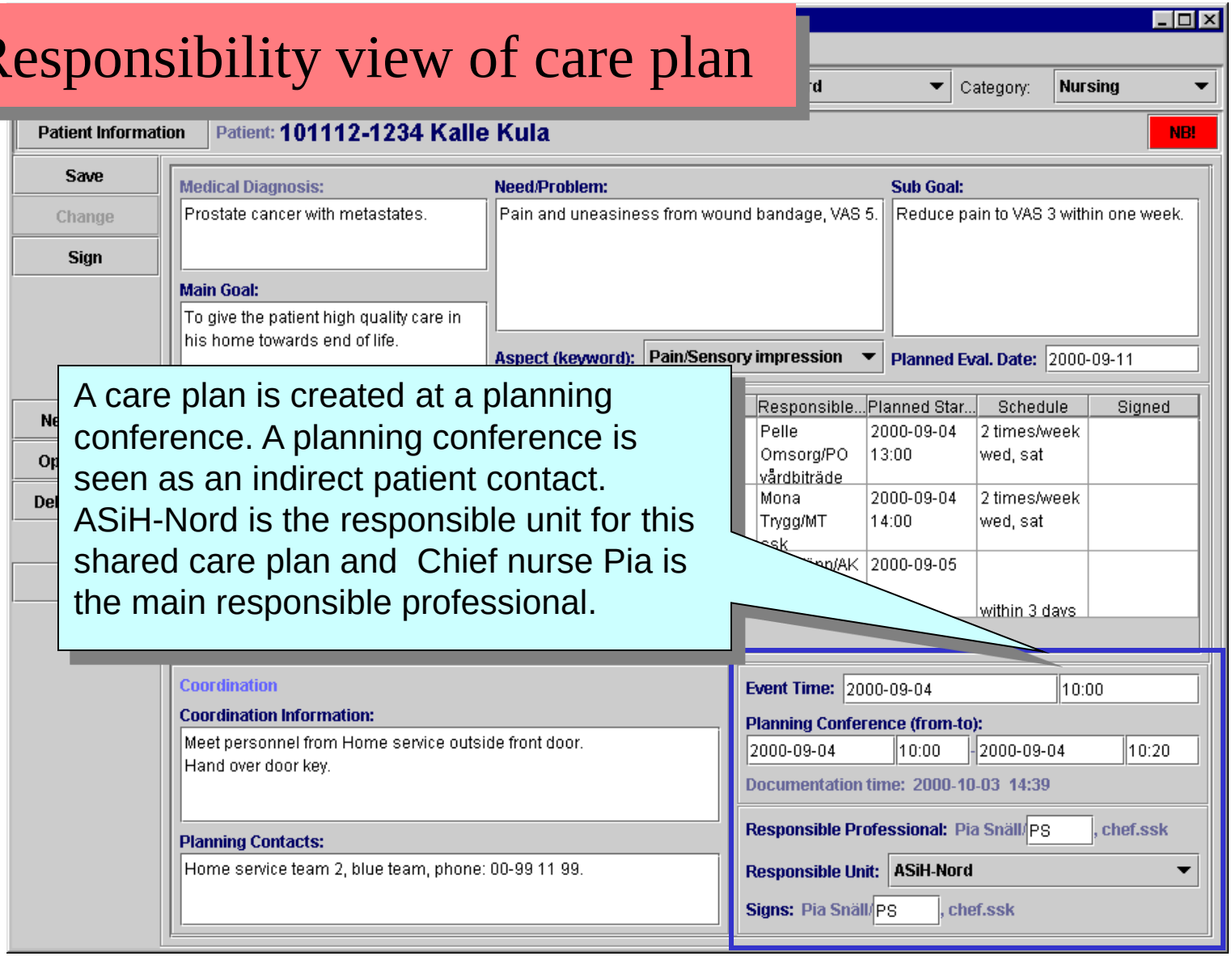
Agreement view of care plan



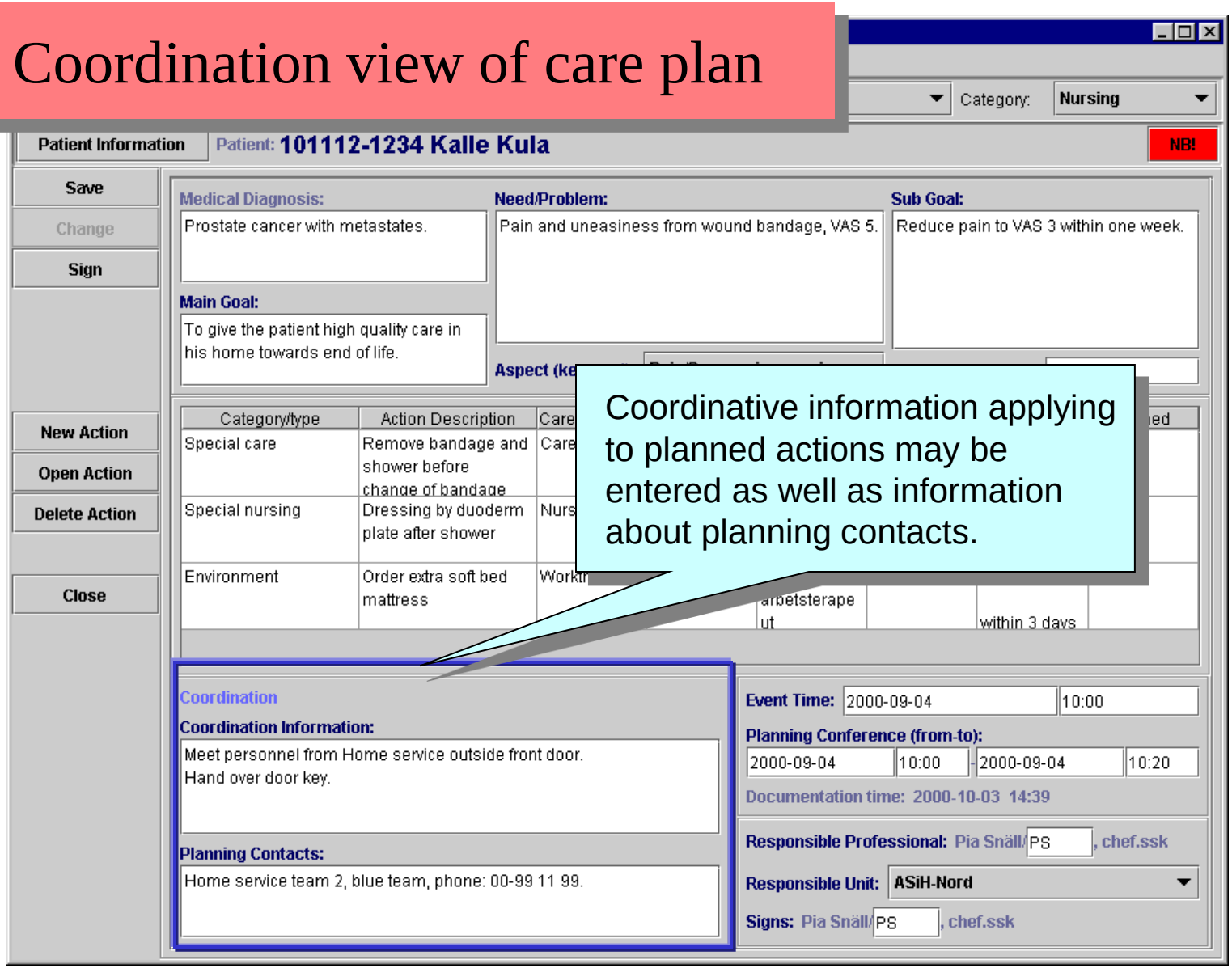
The professionals in the team agree on need/problem, health issue, goals for care and duration. These make up the care plan agreement.

The agreement object is kept at the main responsible unit's CD server

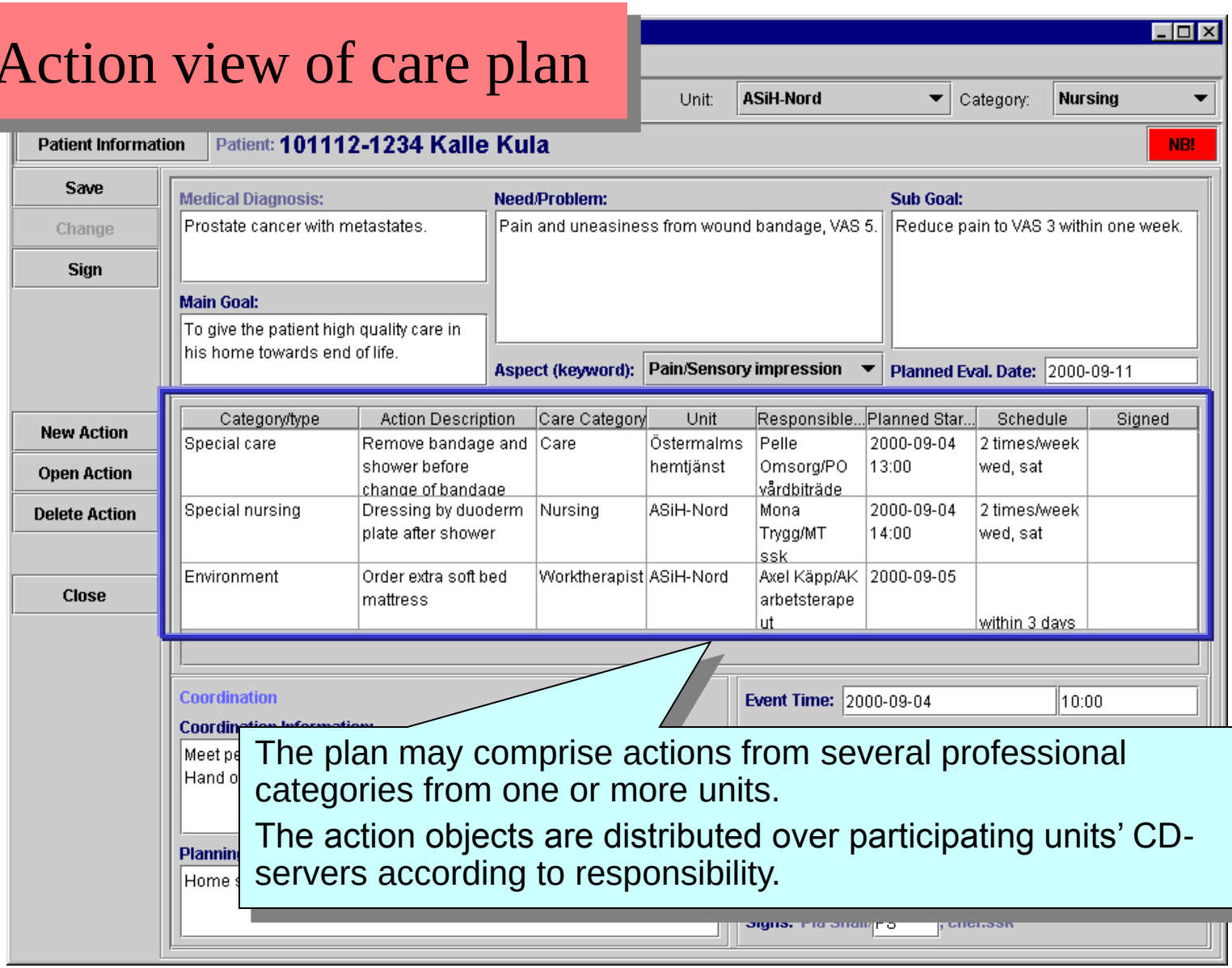
Responsibility view of care plan



Coordination view of care plan



Action view of care plan



The plan may comprise actions from several professional categories from one or more units.

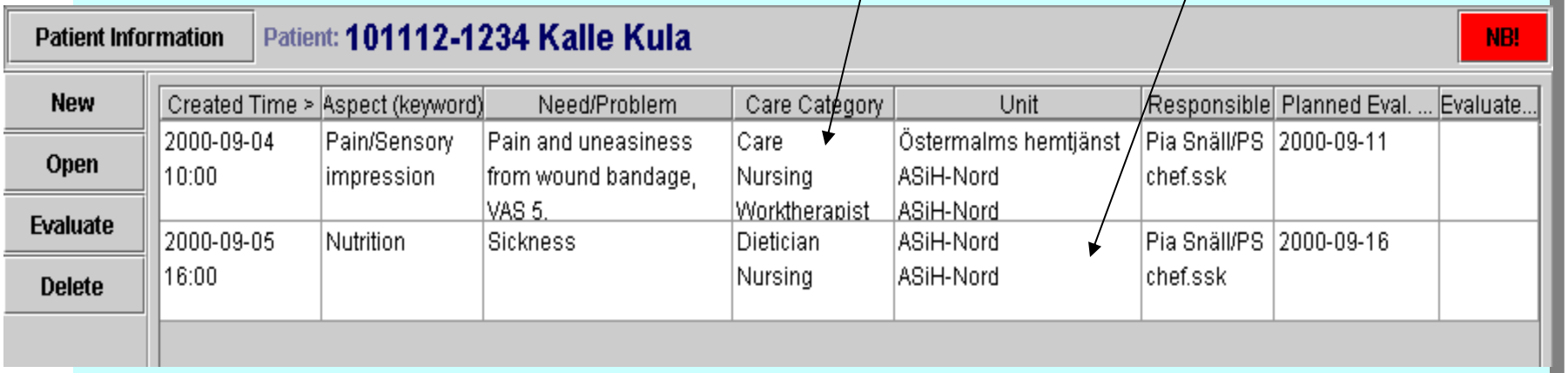
The action objects are distributed over participating units' CD-servers according to responsibility.

Shared Care Plans

Shared between Palliative unit and Home service unit

Local to Palliative unit

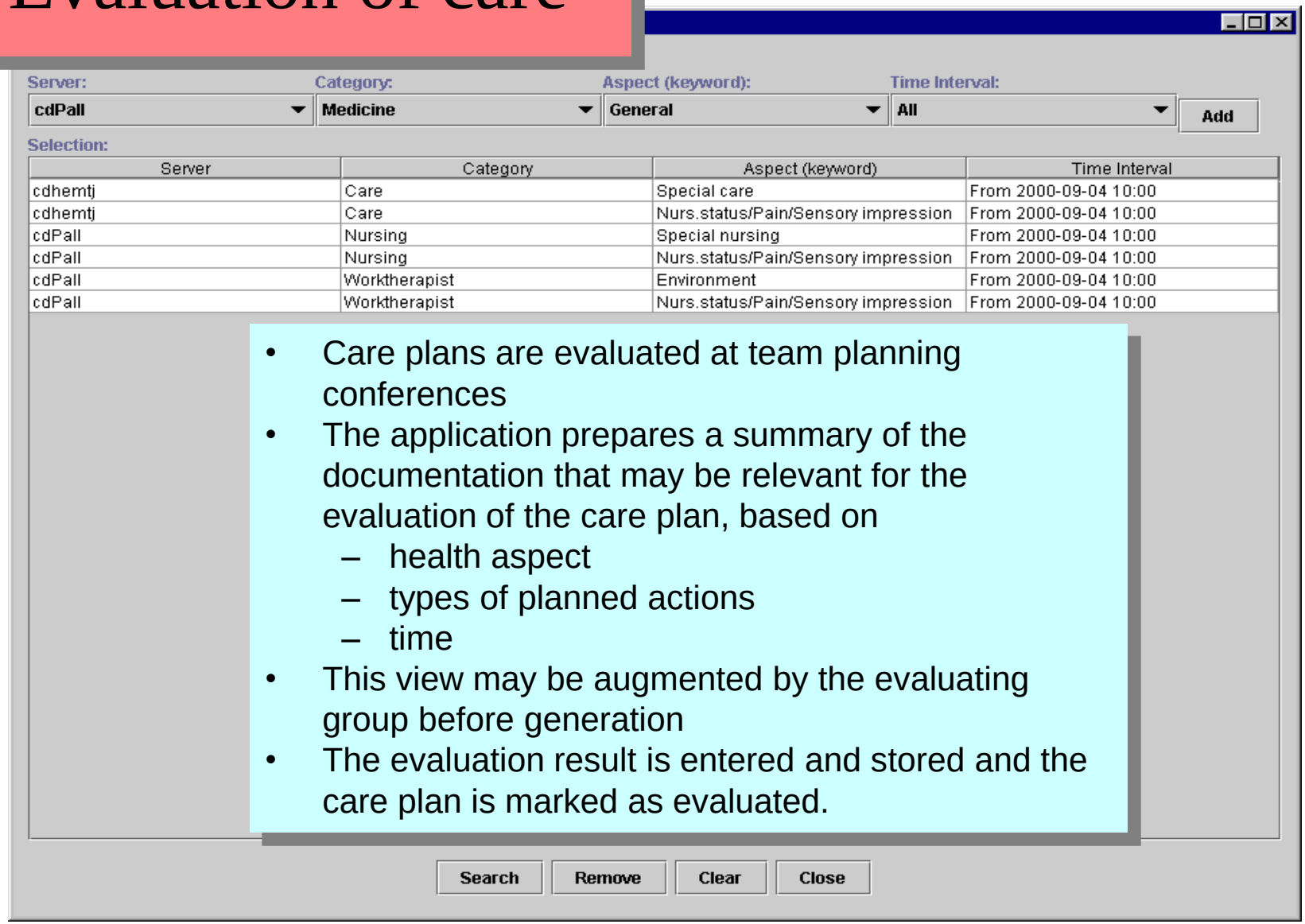
- The care plans for a particular patient are put together in a care plan summary.



Created Time >	Aspect (keyword)	Need/Problem	Care Category	Unit	Responsible	Planned Eval. ...	Evaluate...
2000-09-04 10:00	Pain/Sensory impression	Pain and uneasiness from wound bandage, VAS 5.	Care Nursing Worktherapist	Östermalms hemtjänst ASiH-Nord ASiH-Nord	Pia Snäll/PS chef.ssk	2000-09-11	
2000-09-05 16:00	Nutrition	Sickness	Dietician Nursing	ASiH-Nord ASiH-Nord	Pia Snäll/PS chef.ssk	2000-09-16	

- The summary shows the care plans that are local to the unit and the care plans that are shared between units.
- A care plan that is shared between Palliative unit and the Home service unit thus is presented at both units in addition to the plans that are local to each unit.

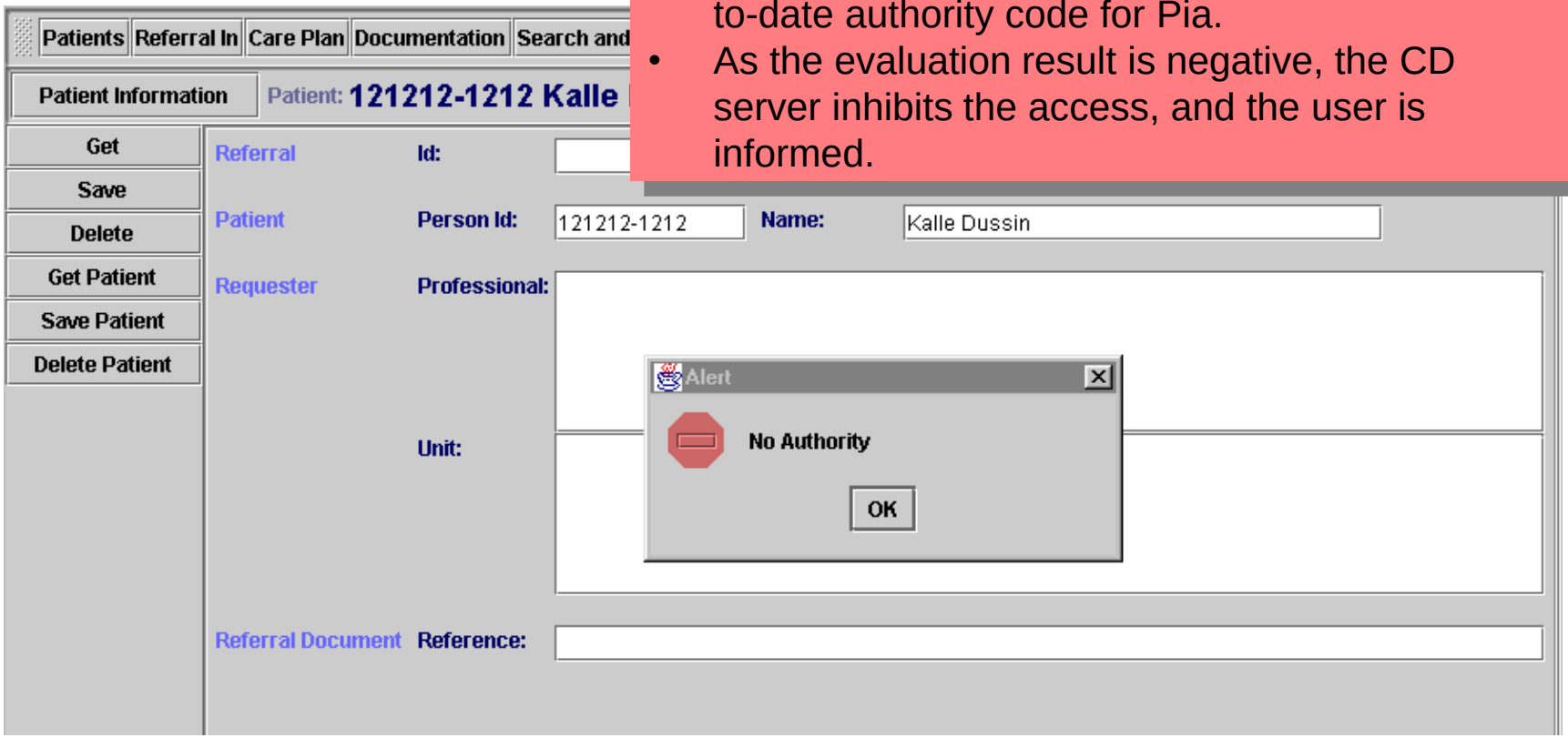
Evaluation of care



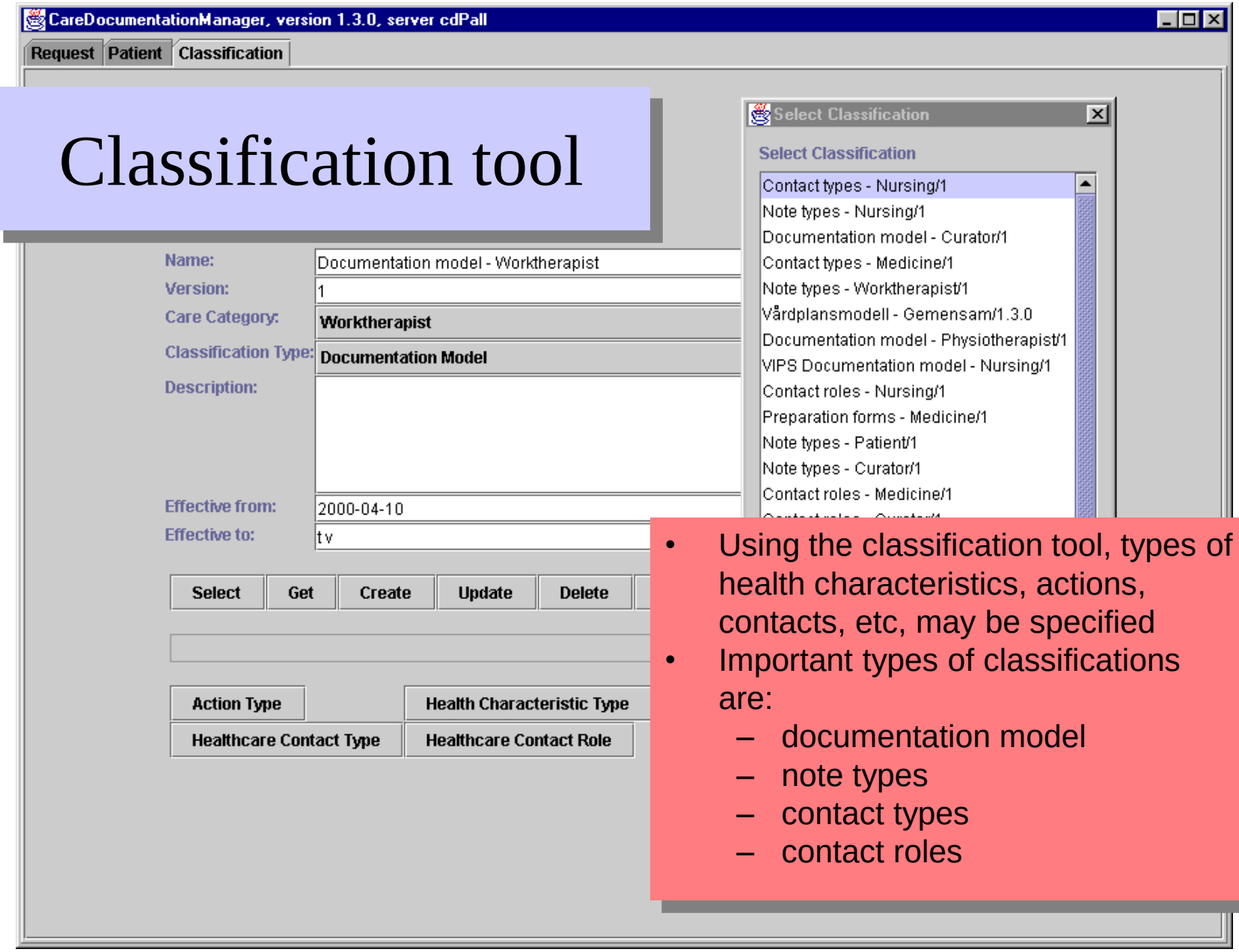
- Care plans are evaluated at team planning conferences
- The application prepares a summary of the documentation that may be relevant for the evaluation of the care plan, based on
  - health aspect
  - types of planned actions
  - time
- This view may be augmented by the evaluating group before generation
- The evaluation result is entered and stored and the care plan is marked as evaluated.

Authorisation

- Pia tries to delete an existing patient. Before the delete request is executed, the CD server consults IACS (Information Access Control Service), which evaluates the rules defined for the ”delete patient” operation. IACS in turn consults the Enterprise Manager for the up-to-date authority code for Pia.
- As the evaluation result is negative, the CD server inhibits the access, and the user is informed.



Classification tool



- Using the classification tool, types of health characteristics, actions, contacts, etc, may be specified
- Important types of classifications are:
  - documentation model
  - note types
  - contact types
  - contact roles

Concluding

- This demo has shown a selected part of the functionality of the AHHC/CD application, including
  - documenting according to locally agreed models
  - cross-category, cross-unit view specification and generation
  - shared care planning
  - access control, and
  - building dedicated applications using the classification tool.
- Interoperation between InterCare components: CD Server, Enterprise Manager, Access Decision Server (IACS).