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Provision of Health Promotion Information by Physiotherapists to In-Patients in a Tertiary Hospital: A Pilot Study

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ABSTRACT

Purpose: The provision of health promotion information is an important part of the management of hospitalised patients. Allied health practitioners are often involved in the provision of this information. No studies appear to have documented the rate of provision of health promotion material by physiotherapists to hospitalised patients. The aim of this pilot study was to measure the frequency with which health promotion information was provided to in-patients by physiotherapists and to evaluate patients' perception of the effectiveness of this information. Method: Retrospective medical record audits and follow-up telephone interviews were undertaken over an 18 month period for patients who fell into one of the following four diagnostic groups: total hip arthroplasty (THA), after upper limb lymph node biopsy/removal and therefore at risk of upper limb lymphoedema, chronic obstructive pulmonary disease (COPD) or accidental fall requiring admission to hospital. Results: 63 patients participated in the medical record audits and 50 participated in the telephone interviews. The medical record audits revealed that 64% of patients were provided with some health promotion information during their hospitalisation. From the telephone interviews, 88% of patients indicated that they were happy with the information they had received. However, the rate of provision of health promotion material was significantly lower for patients with COPD or those admitted after a fall. Conclusions: While the overall level of provision of health promotion material by physiotherapists was satisfactory, provision of this material to COPD patients and those admitted after a fall needs to become part of physiotherapists' standard clinical practice.

INTRODUCTION

The World Health Organization Ottawa Charter for Health Promotion identifies the need for a reorientation of health services to focus on the promotion of health rather than management of disease, and also reinforces the need to increase awareness of the use of health promotion in hospitals.[1,2] Hospitals are well placed to promote health in view of the central role they play in providing health services within the community.[2] In the 2006-2007 financial year, the total health expenditure by the Australian Government was $94 billion, an estimated rise of $7.3 billion since the previous financial year, and representing 9% of gross domestic product.[3] Over one-third of this expenditure was attributed to hospital services, whereas only 5% was spent on community and public health programs.[3] The increasing health expenditure and high proportion of it attributed to hospitals highlights the need for them to play a central role in health promotion.

The use of health promotion to aid in the prevention of disease has been widely documented and shown to be effective for problems such as smoking, obesity, falls prevention, and chronic obstructive pulmonary disease (COPD) management.[4-9] However, few studies have evaluated the frequency or effectiveness of the provision of health promotion information to hospital in-patients.[10,11] Given the nature and range of patients with whom they interact, physiotherapists are one of the healthcare

professionals who have the opportunity to provide health promotion information to in-patients. A literature search of Medline and CINAHL databases was unable to identify any studies which specifically investigated the frequency and effectiveness of the provision of health promotion information to in-patients by physiotherapists. Thus, the aim of this pilot study was to measure the frequency with which health promotion information was provided to in-patients by physiotherapists and to evaluate patients' perception of the effectiveness of this information.

METHOD

Design

Retrospective medical record audits and follow-up via telephone interviews were conducted at an inner city tertiary hospital, Royal Adelaide Hospital (RAH). Ethical approval was obtained from the RAH Research Ethics Committee.

Participants

Inclusion criteria

Four diagnostic groups were selected for potential inclusion into the study because literature reviews revealed that there was evidence supporting the effectiveness of health promotion in their management and physiotherapy commonly formed part of their in-patient management.[12-16] These diagnostic groups comprised patients:

- after total hip arthroplasty (THA)
- following upper limb lymph node biopsy/removal and therefore at risk of upper limb lymphoedema
- with COPD
- admitted to hospital following an accidental fall.

The names of potential participants were obtained by screening the RAH medical record database for those with a diagnostic code that fell into one of the four eligible groups and who had been seen by a physiotherapist during their period of hospitalisation. Initially this was limited to a six month period from January to June 2007. Each medical record identified was given a sequential number and a sample of medical records was randomly selected from this list and further screened for eligibility. In the event that this time period did not yield a sufficient sample size, the time period was able to be extended.

Exclusion criteria

Patients were excluded from participation if their medical record revealed that their treatment was palliative in nature or they had suffered a major post-operative complication (eg pulmonary embolus, THA implant failure), as it was deemed that the more severe nature of their condition may have affected their hospital management and thus the provision of health promotion information. Patients unable to understand English were excluded because of an inability to organise translation services for the study due to time and resource constraints. Patients with cognitive impairment (eg severe dementia, dense cerebrovascular accident, mental illness) were excluded as these patients might have difficulty recalling information regarding their hospital management during the telephone interview.

Further specific inclusion and exclusion criteria according to each of the four diagnostic groups are presented in each audit tool (Appendix I).

All patients who were identified as being eligible for participation in the study were informed via a letter. Verbal consent was also specifically obtained over the phone prior to beginning the phone interview.

Outcome measures

An audit tool to review the medical records was purpose-designed for this study (Appendix I). A checklist to ensure all relevant sections of the medical records were audited was devised (Appendix I). Audit themes were identified by a literature review of relevant health promotion research and an audit tool was designed by the investigators, other physiotherapists, and physiotherapy students. Further input was sought from appropriate senior clinical physiotherapists at the RAH. Several revisions were made to improve content and clarity. Some checklist items within the audit tools were common to each of the four diagnostic groups, while other items varied between diagnostic groups (Appendix I). To improve consistency in the scoring of the medical record audits, all medical records within each diagnostic group were audited by one investigator only and any uncertainty in score allocation discussed with another investigator.

The questions that comprised the telephone interview were purpose-designed for this study and consisted of eight main questions with a mixture of open and closed questions, and took approximately five minutes to complete (Appendix II).

Sample size

Prior to commencement of the study, a sample of 100 medical records (25 in each patient group) was deemed to be an appropriate yet practicable size, based on previous research that involved medical record audits.[17-19]

Data analysis

Data from the audits and telephone interviews were entered onto a Microsoft Excel spreadsheet, then imported and analysed using the Statistical Package for the Social Sciences (SPSS) Version 14.0. Analyses were predominantly descriptive in nature. Qualitative data from the telephone interviews were reviewed and common themes and issues identified. Frequency counts from key questions were compared between patient groups using the chi-square test. Probability values of less than 0.05 were considered significant.

RESULTS

Due to a considerable number of medical records being excluded, the time period for catchment of medical records was extended to include the 12 months prior to January 2007 (i.e., an 18 month period in total from January 2006 to June 2007). During this time, the total number of medical records that fell into one of the four diagnostic codes, and where the patient had physiotherapy during their period of hospitalisation, was 212. Of this sample, 149 were excluded, with most of these (n = 96) being in the falls group where patients were often discharged to other hospitals or residential care facilities. Thus, the sample size for the medical record audit arm of the study was 63 patients. Telephone interviews were conducted with only 50 of these 63 patients as some were unable to be contacted.

Table 1. Results of the medical record audits and telephone interviews

	Complete sample	THA	Lymphoedema	COPD	Falls
Medical record audit	**n = 63**	**n = 20**	**n = 20**	**n = 15**	**n = 8**
Mean age (yrs) – mean (SD)	69.1 (11.7)	63.3 (12.8)	66.9 (9.9)	74.5 (8.8)	79.4 (8.3)
Gender – n (%)					
Female	46 (73)	12 (60)	18 (90)	11 (73)	5 (63)
Male	17 (27)	8 (40)	2 (10)	4 (27)	3 (38)
Provided with relevant health promotion booklet – n (%)	40 (64)	15 (75)	20 (100)	4 (27)	1 (13)
Content of booklet explained – n (%)	27 (43)	5 (25)	18 (90)	4 (27)	0 (0)
Educated regarding associated health/risk factors – n (%)	41 (65)	18 (90)	13 (65)	2 (13)	8 (100)
Informed about related classes or clinics – n (%)	N/A	N/A	N/A	3 (20)	2 (25)
Relevant referrals made – n (%)					
Falls / balance class	1 (2)	N/A	N/A	N/A	1 (13)
Physiotherapy	10 (16)	4 (20)	N/A	N/A	6 (75)
Occupational therapy	3 (5)	1 (5)	N/A	N/A	2 (25)
General practitioner	6 (10)	5 (25)	N/A	N/A	1 (13)
Out-patient Clinic	24 (38)	N/A	20 (100)	4 (27)	N/A
Other support services	23 (37)	9 (45)	N/A	11 (73)	3 (38)
Telephone interview	**n = 50**	**n = 20**	**n = 20**	**n = 10**	**n = 0**
Provided with relevant health promotion booklet – n (%)	36 (72)	15 (75)	16 (80)	5 (50)	N/A
Content of booklet explained – n (%)	25 (50)	6 (30)	14 (70)	5 (50)	N/A
Found booklet information useful – n (%)	31 (62)	14 (70)	12 (60)	5 (50)	N/A
Provided with other written / verbal information by a physiotherapist – n (%)	27 (54)	18 (90)	6 (30)	3 (30)	N/A
Provided with further information from other health professionals – n (%)	26 (52)	8 (40)	13 (65)	5 (50)	N/A
Given the opportunity to ask questions – n (%)	41 (82)	16 (80)	17 (85)	8 (80)	N/A
Questions answered adequately – n (%)	33 (66)	11 (55)	16 (80)	6 (60)	N/A
Provided with other resources – n (%)	30 (60)	11 (55)	13 (65)	6 (60)	N/A
Further referrals made to classes as appropriate – n (%)	28 (56)	1 (5)	19 (95)	8 (80)	N/A
Attended these classes – n (%)	20 (40)	0	17 (85)	3 (30)	N/A
Overall happy with education provided in hospital – n (%)	44 (88)	19 (95)	19 (95)	6 (60)	N/A

N/A - not available

The results of the medical record audits and telephone interviews are summarised in Table 1. As can be seen, there was an uneven distribution of patients between the four diagnostic groups, and the sample was predominantly female. According to documentation in the medical records, the majority of the total sample (n = 40; 64%) were provided with relevant health promotion booklets by physiotherapists during their hospital admission, but the content of the booklet was explained less frequently (n = 27; 43%) based on medical record documentation. Similar results were obtained from the telephone interviews, and the majority of these patients (n = 44; 88%) indicated that, overall, they were happy with the education regarding their condition they received while in hospital.

When comparing the four diagnostic groups, it was evident that patients after THA or at risk of lymphoedema had higher rates of provision of relevant health promotion material than patients with COPD or those admitted after a fall. Analyses revealed that these differences were significant based both on medical record documentation (χ^2 = 30.4; p = 0.000) and the telephone interviews (χ^2 = 45.6; p = 0.000).

DISCUSSION

The overall rate of provision of health promotion information to in-patients by physiotherapists in this pilot study, as measured by medical record audits and telephone interviews, was considered reasonable, with provision rates of 64 and 72% respectively reported. However, the provision rate varied significantly between diagnostic groups, with a higher rate seen for patients after THA or at risk of upper limb lymphoedema, than for patients with COPD or admitted after a fall. While the frequency with which explanation regarding the health promotion material was provided was only 50% across the entire sample, the majority of patients (88%) participating in this study were happy with the education they received whilst in hospital. The reason for the low rate of provision of health promotion information to patients with COPD or patients admitted after a fall is not clear, particularly since an inclusion criterion of the study was that the patient had to have received physiotherapy during their hospitalisation. It may reflect our clinical practice whereby provision of health information booklets is part of standard postoperative physiotherapy care for patients after THA or at risk of upper limb lymphoedema. In contrast, our management of patients with COPD or admitted after a fall is less formalised, relying instead on individual physiotherapist's clinical judgement which, rightly or wrongly, may or may not include provision of health promotion information. Additionally, there is considerable variation in what therapists choose to record in medical records, and it may be that the provision of health promotion information, particularly verbal discussion and explanation, may not have been as diligently recorded as the more physical interventions provided by the therapist (eg., assessment, "hands-on" treatment). Hence, the medical records may not have accurately reflected the health promotion information that physiotherapists actually provided.

In terms of the study design, we chose to undertake a retrospective study to avoid the potential for physiotherapists to change their practice, which could have occurred if we had undertaken a prospective study. Limitations of our study included the relatively small sample size, particularly within each diagnostic group, which fell below our expectations and limits the ability to generalise our findings. However, we did not think it was appropriate to further extend the catchment period, as we considered the ability of patients to recall information for the phone interview beyond 18 months would be poor. Additionally, a large number of subjects were excluded from the audit, particularly within the falls category where many patients were excluded for reasons such as transfer to other in-patient rehabilitation facilities or residential care following their admission at the RAH. Thus, particularly for patients in the falls group, our sample is unlikely to be representative of the target population. We found it difficult to contact some patients for the telephone interview (particularly those within the falls category where we were unable to contact any of the 8 patients) which accounts for the drop in sample size between the medical record audits and telephone interviews. While a written follow-up questionnaire mailed to patients post-discharge may have been more appropriate – in that it would have allowed subjects more time to consider their answers in an impersonal setting – we chose to do a telephone interview in an attempt to achieve a higher response rate. Pleasingly, similar results were obtained between the medical record audits and telephone interviews for key questions that were used in both arms of the study (ie., provided with health promotion booklet, content of the booklet explained).

Our results have important clinical implications for our daily clinical physiotherapy practice and are also relevant for other allied health practitioners. In terms of our own practice, our standard of documentation of the provision of health promotion material needs to improve. Additionally, the distribution of health promotion material needs to further increase, particularly for patients with COPD or those admitted following a fall, where it should become standard clinical practice. Based on the current findings, it is recommended that physiotherapists receive specific education regarding the principles behind the different health promotion theories, including the need to increase the time spent addressing health promotion with patients, and the need to ensure that sufficient time is provided to assess patients' understanding of information provided and allow patients to ask questions. Further research should be undertaken to confirm the results of this pilot study by repeating the current study with a larger sample and/or measuring provision rates of health promotion material by physiotherapists in other healthcare centres. Additionally, research

could be undertaken to measure how often other allied health practitioners provide health promotion information to in-patients, and the perceived effectiveness of this information. Including interviews with therapists to assess if they accurately recorded their provision of health promotion information, along with their strategies for reassessment of patient understanding, would also be of value.

In conclusion, this pilot study found that while appropriate health promotion material was provided by physiotherapists to a majority of in-patients with appropriate diagnoses, this was quite variable between different patient diagnostic groups. Based on these results, we recommend that healthcare staff receive regular education about the importance of health promotion in order that they fully understand the need for provision and explanation of relevant health promotion material to hospitalised patients as part of standard clinical practice.

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Appendix I
MEDICAL RECORD AUDITS

Royal Adelaide Hospital - Health Promotion Documentation Audit

Section 1: FALLS PREVENTION (General Medical Wards)

Fall: Any event which involves coming to rest inadvertently on the ground or lower level and other than as a consequence of sustaining; a violent blow, loss of consciousness, sudden onset of paralysis (e.g. stroke or epileptic seizure).

Instructions

The medical record audit consists of three parts (A, B, C). Part A outlines the criteria used to determine inclusion of medical records into the audit. Part B is for the entry of patient information and includes the audit checklist items. For each item, location within the medical records where the relevant information was found is to be stated. Part C outlines the sections of the medical records that should be examined in order to extract information relevant to the audit and acts as a final checklist so no relevant documentation is missed.

Part A: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Patients presenting with injuries resulting from a fall	Cognitively impaired (e.g. Severe dementia, dense CVA, mental illness)
Patients reporting multiple falls (≥1) in the last year.	Significant medical problems: - Severe stroke - Palliative care patient - Other
	Patients discharged to: - High level care facility - Rural hospital - Private hospital - Other public hospital - Inpatient rehabilitation
	Patients not independently mobile (with or without a walking aid)
	Patients unable to speak English

Part B: Health Promotion Inpatient Admission Audit

Patient Details

ID (UR Number)	
Date of Admission	
Date of Discharge	
Age	
Gender	
Diagnosis	
Significant Surgery(s) or Procedure(s)	
Discharge Destination	

Falls Audit Checklist

	Item	Yes	No	NA	Where documented
1a	Was it documented that the RAH falls prevention booklet was provided?	□	□	□	_____ _____
1b	Were any other booklets provided? Which ones?_____ _____	□	□	□	_____ _____ _____ _____
1c	Was it documented that the content of the information booklet was explained?	□	□	□	_____
2a	Was it documented that falls risk factors were identified? Which ones?_____ _____ (e.g. Falls history, >3 medications, psychotropic medications, fear of falling, gait or balance impairment, RAH nursing staff falls risk score)	□	□	□	_____ _____ _____ _____ _____ _____

Section 1, Falls: page 2 of 5

Falls Audit Checklist - continued

	Item	Yes	No	NA	Where documented
3a	Was it documented that the patient was encouraged to enrol in falls and balance exercise classes?	□	□	□	_____ _____ _____
3b	Was it documented that a contact was provided or a referral was made to a falls and balance class? Where/how referred? _____ _____ _____ (eg. referred directly by RAH physio, GP to refer to community class)	□	□	□	_____ _____ _____ _____ _____ _____
4a	Was it documented that the patient was educated regarding strategies to minimise falls? Which ones? _____ (e.g. Moving from sit to stand slowly, not mobilising in the dark, avoiding uneven/slippery surfaces, wearing appropriate footwear)	□	□	□	_____ _____ _____ _____ _____
	Was it documented that referrals were made where appropriate to:				_____ _____
5a	Physiotherapist (eg. for balance and gait assessment)	□	□	□	_____ _____ _____
5b	Occupational Therapist (eg. for home assessment)	□	□	□	_____ _____
5c	General Practitioner (eg. for further information regarding community groups, medical assessment)	□	□	□	_____ _____ _____
5d	High or Low level care institution Other_____	□	□	□	_____ _____ _____

Section 1, Falls: page 3 of 5

Falls Audit Checklist - continued

	Item	Yes	No	NA	Where documented
6a	Was it documented that the patient was provided information and/or referral for conditions increasing falls risk if relevant? For which conditions? _____ _____ (e.g. Osteoporosis, Arthritis, Parkinson's Disease, impaired vision, impaired hearing, dizziness)	□	□	□	_____ _____ _____ _____ _____ _____ _____
7a	Was it documented that the use of hip protectors were discussed?	□	□	□	_____ _____ _____
7b	Was it documented that the cost of hip protectors were discussed and order forms were provided?	□	□	□	_____ _____

Was any other health promotion information provided? _____
_____
_____
_____
_____
_____

Part C: Medical Record Checklist

	Medical Record Section	Reviewed	Not Found
1	Correspondence		
	Letters from/to GP	□	□
	Internal hospital letters	□	□
	Referral from Outpatient Department (and outpatient attendance)	□	□
	Rehabilitation Summaries	□	□
	Other _____		
2	Admission		
	In-patient Registration (MR 10.0)	□	□
	Casemix summary (MR 12.0)	□	□
	Inpatient Progress Notes (MR 40.0)	□	□
	Initial nursing note	□	□
	Home team admission note (e.g. Orthopaedics, Endocrine, Thoracic Medicine)	□	□
	Physiotherapy notes (initial, progress, discharge)	□	□
	Operation Record (MR 70.0)	□	□
	Falls risk score (MR40.0)	□	□
3	Discharge Letters		
	Doctor's letter (MR 14.0)	□	□
	Allied Health Professional's letter (MR 18.2)	□	□
4	Ambulatory:		
	Outpatient physiotherapy case note entries	□	□
	Clinics attended	□	□

Royal Adelaide Hospital

Health Promotion Documentation Audit

Section 2: TOTAL HIP REPLACEMENT (THR) (Orthopaedic Wards)

THR: Surgical procedure to replace the hip joint with a new artificial joint

Instructions

The medical record audit consists of three parts (A, B, C). Part A outlines the criteria used to determine inclusion of medical records into the audit. Part B requires the entry of patient information and includes the audit checklist items. For each item, location within the medical records where the relevant information was found must be stated. Part C outlines the sections of the medical records that should be examined in order to extract information relevant to the audit.

Part A: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Patients following THR (primary or revision)	Cognitively impaired (e.g. Severe dementia, dense CVA, mental illness)
	Significant medical problems: - Severe stroke - Palliative care patient - Other
	Significant post-operative complications: Prosthetic failure Pulmonary Embolism Other
	Patients discharged to: - High level care facility - Rural or Private hospital - Other public hospital - Inpatient rehabilitation
	Patients unable to speak English

Part B: Health Promotion Inpatient Admission Audit

Patient Details

ID (UR Number)	
Date of Admission	
Date of Discharge	
Age	
Gender	
Diagnosis	
Significant surgery(s) or procedure(s)	
Discharge Destination	

THR Audit Checklist

	Item	Yes	No	NA	Where documented
1a	Was it documented that a RAH Total Hip Replacement: Post-operative management booklet was provided?	□	□	□	_____
1b	Was it documented that any other booklets were provided? Which one? _____ _____ _____ (e.g. RAH THR: Post-operative management booklet, Healthy steps information sheet, RAH falls prevention sheet, hip protectors booklet)	□	□	□	_____
1c	Was it documented that the content of the information booklet was explained?	□	□	□	_____

THR Audit Checklist - continued

	Item	Yes	No	NA	Where documented
2a	Was it documented that the patient was taught specific strategies to minimise the risk of dislocation? Which strategies? _____ _____ _____ _____ _____ (e.g. Sit to stand, stand to sit (sliding leg out), turning correctly while mobilising, getting out of bed, dressing, picking objects up from the floor)	□	□	□	_____ _____ _____ _____ _____ _____ _____ _____
	Was it documented that referrals were made where appropriate to:				_____ _____ _____
3a	Physiotherapist (e.g. for balance and gait assessment)	□	□	□	_____
3b	Occupational Therapist (e.g. for home assessment)	□	□	□	_____
3c	General Practitioner (e.g. for further information regarding community groups, medical assessment)	□	□	□	_____
	Other _____	□	□	□	_____ _____
4a	Was it documented that availability of support services/local organisations was discussed?	□	□	□	_____ _____ _____
4b	Was it documented that contact information (e.g. telephone, website) were given?	□	□	□	_____ _____

Was any other health promotion information provided? _____

_____

_____

Part C: Medical Record Checklist

	Medical Record Section	Reviewed	Not Found
1	Correspondence		
	Letters from/to GP	□	□
	Internal hospital letters	□	□
	Referral from Outpatient Department (and outpatient attendance)	□	□
	Rehabilitation Summaries	□	□
	Other _____		
2	Admission		
	In-patient Registration (MR 10.0)	□	□
	Casemix summary (MR 12.0)	□	□
	Inpatient Progress Notes (MR 40.0)	□	□
	Initial nursing note		
	Home team admission note (e.g. Orthopaedics, Endocrine, Thoracic Medicine)		
	Physiotherapy notes (initial, progress, discharge)		
	Operation Record (MR 70.0)	□	□
	Falls risk score (MR40.0)	□	□
3	Discharge Letters		
	Doctor's letter (MR 14.0)	□	□
	Allied Health Professional's letter (MR 18.2)	□	□
4	Ambulatory:		
	Outpatient physiotherapy case note entries	□	□
	Clinics attended	□	□

Royal Adelaide Hospital

Health Promotion Documentation Audit

Section 3: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) (Respiratory Wards)

COPD: A disease process involving progressive chronic airway inflammation and airflow obstruction because of chronic bronchitis, emphysema, or both.

Instructions

The medical record audit consists of three parts (A, B, C). Part A outlines the criteria used to determine inclusion of medical records into the audit. Part B requires the entry of patient information and includes the audit checklist items. For each item, location within the medical records where the relevant information was found must be stated. Part C outlines the sections of the medical records that should be examined in order to extract information relevant to the audit.

Part A: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Patients with COPD at any stage of the disease	Cognitively impaired (e.g. Severe dementia, dense CVA, mental illness)
Patients following an acute exacerbation of COPD	Significant medical problems: - Severe stroke - Palliative care patient - Other
Patients must be symptomatic (e.g. be limited by dyspnoea)	Patients discharged to: High level care facility Rural hospital Private hospital Other public hospital
Patients must have adequate cognitive function to learn and adapt	Patients transferred to in-patient rehabilitation
	Patients unable to speak English

Part B: Health Promotion Inpatient Admission Audit

Patient Details

ID (UR Number)	
Date of Admission	
Date of Discharge	
Age	
Gender	
Diagnosis	
Significant surgery(s) or procedure(s)	
Discharge Destination	

COPD Audit Checklist

	Item	Yes	No	NA	Where documented
1a	Was it documented that an information booklet on COPD/other relevant pulmonary conditions was provided?	□	□	□	_____ _____ _____
1b	Was it documented that the content of the information booklet was explained?	□	□	□	_____ _____
2a	Was it documented that Pulmonary Rehabilitation was discussed with the patient?	□	□	□	_____ _____ _____
2b	Was it documented that patient was referred for Pulmonary Rehabilitation classes or equivalent service (Respiratory/Chest Clinic) when required? Where at:_____ (e.g. RAH outpatient, other metropolitan hospital, rural hospital, local community)	□	□	□	_____ _____ _____ _____ _____

Section 3, COPD: page 2 of 4

COPD Audit Checklist - continued

	Item	Yes	No	NA	Where documented
3a	Was it documented that the benefits of exercise were explained?	□	□	□	_____ _____
3b	Was it documented that the exercises were demonstrated/taught to the patient?	□	□	□	_____ _____
4a	Was it documented that availability of support services/local organisations was discussed?	□	□	□	_____ _____
4b	Was it documented that contact information (e.g. telephone, website) were given?	□	□	□	_____ _____
5a	Was it documented that advice to cease smoking and/or Quit Smoking information booklet was given?	□	□	□	_____ _____ _____
5b	Was it documented that patient had Health Promotion appointment for quit smoking advice?	□	□	□	_____ _____ _____

Was any other health promotion information provided? _____

_____

_____

_____

_____

_____

Section 3, COPD: page 3 of 4

Part C: Medical Record Checklist

	Medical Record Section	Reviewed	Not Found
1	Correspondence		
	Letters from/to GP	□	□
	Internal hospital letters	□	□
	Referral from Outpatient Department (and outpatient attendance)	□	□
	Rehabilitation Summaries	□	□
	Other _____		
2	Admission		
	In-patient Registration (MR 10.0)	□	□
	Casemix summary (MR 12.0)	□	□
	Inpatient Progress Notes (MR 40.0)	□	□
	Initial nursing note		
	Home team admission note (e.g. Orthopaedics, Endocrine, Thoracic Medicine)		
	Physiotherapy notes (initial, progress, discharge)		
	Operation Record (MR 70.0)	□	□
	Falls risk score (MR 40.0)	□	□
3	Discharge Letters		
	Doctor's letter (MR 14.0)	□	□
	Allied Health Professional's letter (MR 18.2)	□	□
4	Ambulatory:		
	Outpatient physiotherapy case note entries	□	□
	Clinics attended (relevant to health promotion e.g. PT and Obesity Clinic)	□	□

Royal Adelaide Hospital

Health Promotion Documentation Audit

Section 4: LYMPHOEDEMA

Lymphoedema: A primary or secondary condition characterised by the accumulation of lymph in soft tissue and the resultant swelling caused by inflammation, obstruction or removal of lymph channels.

Instructions

The medical record audit consists of three parts (A, B, C). Part A outlines the criteria used to determine inclusion of medical records into the audit. Part B requires the entry of patient information and includes the audit checklist items. For each item, location within the medical records where the relevant information was found must be stated. Part C outlines the sections of the medical records that should be examined in order to extract information relevant to the audit.

Part A: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Axillary lymph node dissection/clearance	Cognitively impaired (e.g. Severe dementia, dense CVA, mental illness)
Pelvic lymph node dissection/clearance	Significant medical problems: - Severe stroke - Palliative care patient - Other
Sentinel node biopsy	Patients discharged to: - High level care facility - Rural hospital - Private hospital - Other public hospital
	Patients unable to speak English

Part B: Health Promotion Inpatient Admission Audit

Patient Details

ID (UR Number)	
Date of Admission	
Date of Discharge	
Age	
Gender	
Diagnosis	
Significant Surgery(s) or procedure(s)	
Discharge Destination	

Lymphoedema Audit Checklist

	Item	Yes	No	NA	Where documented
1a	Was it documented that an information booklet regarding lymphoedema prevention and care was provided?	□	□	□	_____ _____ _____
1b	Was it documented that the content of the information booklet was explained?	□	□	□	_____ _____ _____

Section 4, Lymphoedema: page 2 of 4

Lymphoedema Audit Checklist - continued

	Item	Yes	No	NA	Where documented
2a	Was it documented that the patient was advised of the signs and symptoms of lymphoedema?	□	□	□	_____
2b	Was it documented that a referral was made to a lymphoedema clinic if the patient had signs or symptoms of lymphoedema? Which health professional made the referral? _____ (e.g. medical staff, nursing staff) Where was the referral to?_____ _____ _____ (e.g. Physiotherapy clinic at RAH, other metropolitan hospital, rural hospital, private physiotherapy clinic)	□	□	□	_____

Was any other health promotion information provided? _____
_____
_____
_____
_____
_____

Section 4, Lymphoedema: page 3 of 4

Part C: Medical Record Checklist

	Medical Record Section	Reviewed	Not Found
1	Correspondence		
	Letters from/to GP	□	□
	Internal hospital letters	□	□
	Referral from Outpatient Department (and outpatient attendance)	□	□
	Rehabilitation Summaries	□	□
	Other _____		
2	Admission		
	In-patient Registration (MR 10.0)	□	□
	Casemix summary (MR 12.0)	□	□
	Inpatient Progress Notes (MR 40.0)	□	□
	Initial nursing note		
	Home team admission note (e.g. Orthopaedics, Endocrine, Thoracic Medicine)		
	Physiotherapy notes (initial, progress, discharge)		
	Operation Record (MR 70.0)	□	□
	Falls risk score (MR 40.0)	□	□
3	Discharge Letters		
	Doctor's letter (MR 14.0)	□	□
	Allied Health Professional's letter (MR 18.2)	□	□
4	Ambulatory:		
	Outpatient case note entries	□	□
	Clinics attended	□	□

Section 4, Lymphoedema: page 4 of 4

Appendix II

Royal Adelaide Hospital – Telephone Participant Questionnaire

TYPE OF ADMISSION _____

ID _____

AGE _____

GENDER _____

DATE OF ADMISSION _____

DATE OF DISCHARGE _____

Introductory Speech

Good morning/afternoon

My name is _____. I am a 4th year Physiotherapy student. I am currently doing a Health Promotion project at the Royal Adelaide Hospital in order to determine whether adequate health promotion information is given to the patients by physiotherapists. As part of the project I am contacting previous patients in order to obtain their opinions on the provision of health promotion by physiotherapists during their stay in the hospital.

No personal information is being used and the questionnaire should take about five minutes to complete. You can also withdraw from the questionnaire at any point.

Would you be happy to be involved in this project and answer a few questions?

	Question	Yes	No	Comments
1a	Were you provided with an information booklet regarding _____? (*choose appropriate to the patient group*: falls, THR, COPD/Pulmonary Rehabilitation, lymphoedema)			_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
1b	Was the content of the booklet and its relevance to your condition explained to you?			
1c	Did you find the information in the booklet useful? Why/why not?			

Patient Interview, continued

	Question	Yes	No	Comments
2a	Were you given any other written or verbal information by a physiotherapist? If so, what information was it?			
3a	Were you given any further information from other health professionals (Doctors, nurses)? By which health professionals?			
4a 4b	Was there an opportunity for you to ask questions (either about the contents of the booklet or other information given)? If yes: Where those questions answered adequately?			
5a	Were you provided with sources, such as phone numbers, addresses, websites, where you could obtain further information or further support?			

Patient Interview, continued

	Question	Yes	No	Comments
6a	Were any further referrals made for you or where you encouraged to enrol into any specific classes? (*choose appropriate to the patient group)* - out patient appointments - group exercise classes - GP appointments - balance and/or gait assessment - pulmonary rehabilitation classes - falls and balance classes - lymphoedema clinic			
6b	Did you attend these? If no, why?			
7a	Overall, were you happy with the education you were provided with in hospital regarding your condition? How could it be improved?			
8a	Would you like us to send you any further information?			

That's the end of the questionnaire. Thank you very much for your time.