Mini Mapping Patient Guide for General Practice

START HERE → ISSUE: **Unplanned Hospital Admission**

PATIENT NAME: **ABCD**

DETAILS OF EPISODE OF CARE: **5 Days inpatient for High Blood Pressure and Leg Ulcer Infection**

D.O.B **19/12/1900**

☐ **Planned** ✓ **Unplanned**

Mapping Action	Guide	Details of incident	Current In place Care @ General Practice	Gaps / Changes Identified in Care	Update/Change of Care Required
Identify Health Issues	Primary Health Issues Secondary Health Issues Emotional and mental health status	*T2 Diabetes* *Foot Ulcers - 12 months* *Mild depression = ongoing pain*	*GP Care Plan in place* *Diabetes Annual Cycle of Care in place*	*High Blood Pressure new Condition*	***Referral to Mental Health Service Required*** ***Review possible reasons for High Blood Pressure***
Current Issue for Mapping	☐ Hospitalisation ☐ Ambulance Attendance at home ☐ Pharmacy presentation with health problem ☐ Escalation in symptom/s ☐ Social Issues: Transport /Carers ☐ New symptom/s (Identify)	*Hospitalisation 5 days one week ago* *High Blood Pressure & Ulcer infection* *GP not notified of admission*	*Patient presented to regular GP without discharge summary 2 days post discharge*	*No electronic Discharge Summary Received at practice* *Change of medication at hospital and new medication for blood pressure added at hospital* *Community Nurse care added during hospital admission*	***Contact hospital for Discharge Summary with details of medication/pathology*** ***GP to link to community care nurse to lead treatment plan for ulcers***
Medication	☐ Prescriptions current ☐ Managing medications – taking as prescribed ☐ Over the counter medications ☐ Home Medicine Review	*Antibiotics prescribed by GP and changed at hospital.*	*Insulin prescribed by GP*	*No current Home Medicine Review (HMRR) undertaken* *Patient taking caffeine based energy tablets*	***HMMR*** ***Stop caffeine based energy tables - contraindicated with high Blood Pressure may be trigger***
Identify Patients Health Team *List providers*	☐ Family ☐ GP ☐ Pharmacy ☐ Allied Health	*Husband and two engaged adult children* *Regular GP and Practice Team* *Diabetes Educator*	*GP link to community Nurse wound management program* *Pharmacy – South City*	*Requires referral to Mental Clinician for counselling* *No mental health clinician on care team*	***Pharmacy polypharmacy with over the counter medication requires review*** ***GP to link to community***

Australian Government
Department of Health

APCC program is funded by the Australian Government Department of Health

	☐ Mental Health Clinician ☐ Hospital Health Professionals ☐ Community Health Professionals ☐ Complimentary Health Providers				***care nurse to lead treatment plan for ulcers***
Patient Self Care	☐ Physical Activity ☐ Social Network /Interactions ☐ Healthy Eating ☐ Smoking Status ☐ Alcohol Consumption ☐ Illness Understanding ☐ Transport Requirements	*Ballroom dancing 2 x week* *Poor Diet - High Sugar* *Smoker* *Non Drinker* *Additional Education about smoking and diabetes*	*Referral to Diabetes Educator in place* *Weight 110kg*	*Weight in morbidly obsess range* *Smoking addiction*	***Requires referral to dietitian of lifestyle modification program for weight reduction*** ***Smoking cessation intervention requires review and action***
Care Coordination *Review & Update*	☐ Care Plan in pace and current ☐ Hardcopy given to patient ☐ eHealth Record Summary Uploaded ☐ Discharge Summary Review and actions taken to address incident ☐ Health Assessment ☐ Advanced Health Care Directive	*Patient didn't have Care Plan for hospital – hard copy* *No Discharge Summary with patient of sent electronically 5 days post discharge*	*Care Plan developed but out of date and not held by patient*	*Care plan out of date – medication not current* *Patient not registered for eHealth* *No Health Summary uploaded* *Timeliness of Discharge Summary from Hospital not acceptable*	***Update all areas of GP Care Plan*** ***Ensure Patient has copy of Care Plan*** ***Register Patient for eHealth Record and uploaded Summary*** ***Contact hospital about Discharge Summary***
END HERE →	**ACTIONS →** **REFER:** Patient to counselling to address depression **REVIEW:** Possible reasons for High Blood Pressure **CONTACT:** Hospital for Discharge Summary with details of medication/pathology **LINK:** To community care nurse to lead treatment plan for ulcers **REVIEW:** Pharmacy polypharmacy issues High BP/ Smoking/ Diabetes/over the counter medication **REFER:** To dietitian of lifestyle modification program for weight reduction **INTERVENTION:** Smoking cessation intervention requires review and action **UPDATE:** All areas of GP Care Plan and ensure Patient has copy of Care Plan **REGISTER:** Patient for Health Record and uploaded Summary **CONTACT**: Hospital about Discharge Summary timeliness				