Get It Together

for people with multidisciplinary health care needs in the community setting

Chronic and Complex Care, Primary Care and Community Health

December 2017

NSW GOVERNMENT Health
Nepean Blue Mountains Local Health District

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Case for Change

People with complicated health problems often experience fragmented care. Many of our clients have multidisciplinary care needs but there is currently no consistent or formal process to plan and review care together with all the disciplines involved, resulting in confusion for clients, their carers and staff.

Our project pulls the team together around their clients because it has been shown that when people are included in their care, they have better health and wellbeing and interdisciplinary care planning improves health outcomes through improved coordination of care.

Goal: To improve the client journey through coordinated person-centred care for clients with multidisciplinary needs

Objectives:

1. To increase Care Plans listing all disciplines involved from 8% to 50% by December 2018
2. To increase Care Plans present in the electronic record from 57% to 75% by December 2017
3. To increase Care Plans given to the client from 50% to 90% by December 2017

Method

Staff Surveys
(n=70) 80% response

Staff Solution Focus Groups / Brainstorming (x8 sessions):
- Nursing (n=24)
- Occupational Therapy (n=11)
- Physio, Podiatrist & Allied Health Assistant (n=11)
- Dietetics (n= 4)
- Social Work (n=1)
- Steering Committee (n=7)

Solution voting
Steering committee (n=7)
Allied health and nursing) (n=7)

Client & carer interviews (n=7)

Persona – Ruby
Developed through 7 client stories and used to reflect the effect that solutions may have on her.

Multi-D Probability Report (n=526)

Care Plan File audit (n=95)

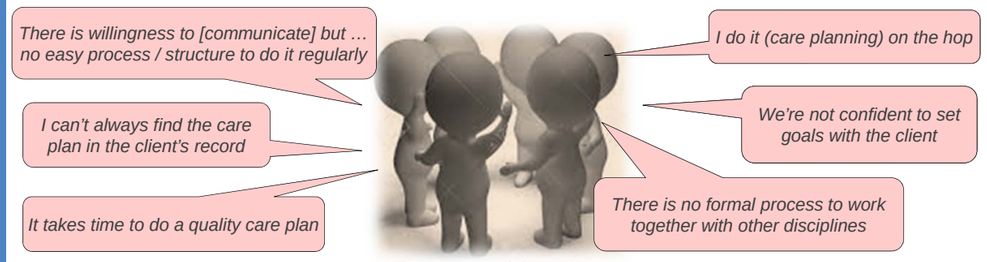
Literature Review
ACI Innovation Exchange, Cochrane Library, Medline, Joanna Briggs Institute and Government reports

Diagnostics

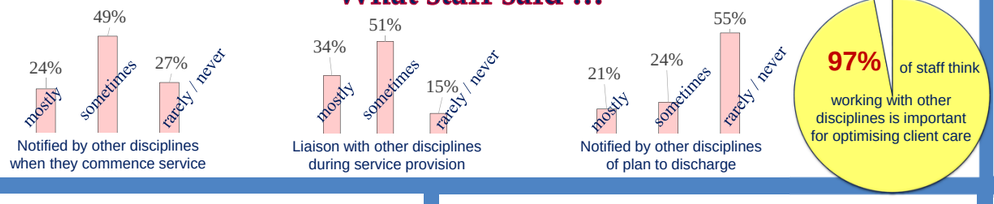
What Ruby said …

Multidisciplinary Care Plan Audit **- clients with 3 or more disciplines [n= 95]**

% of clients with a Care Plan scanned into file	57% (n = 60)
% of Care Plans with each discipline documented under "My Community Health Care Team"	8%
% of Care Plan with Case Manager identified	53%
% of Care Plans with GP details documented	75%
% of goals documented in Care Plan are SMART	4%
% of Care Plans with a Review Date documented	21%
% of Care Plans that are ticked off as being given to the client/carer	49%
% of Care Plans that are ticked off as being given to the GP	12%



What staff said …



Implementation

Solution 1
Quick win
Care Plan naming & scanning process
To ensure Multidisciplinary Care Plans are prioritised for same day scanning and distinguished from other types of care plans

Solution 2
Quick win
Printing Care Plans on coloured paper
Easily identifiable for client and staff in the home setting

Solution 3
Quick win
Nursing area lists made available to all staff
Easier staff identification and reduce clinician time wasted from trying to find the right clinician

Solution 4

Interdisciplinary Care Pathways for specific conditions incorporating client centred care planning and a case review process

The first pathway to be developed will be for the treatment of venous leg ulcers as evidence shows that an interdisciplinary team approach to wound management improves client outcomes

Benefits
- Clients feel included in their care planning process; improving their journey with the service
- There will be a coordinated approach to care planning and service delivery
- Improved multidisciplinary communication and collaboration

Progress on Solutions
- Nursing Area list trialled at two sites from September 2017. Evaluation in early 2018.
- Care Plans printed on coloured paper trialled at one site from December 2017. Evaluation March 2018
- Standardised naming convention and scanning process for implementation early 2018. Evaluation 3 months following
- A multidisciplinary working group will be established early 2018 to develop and implement an Interdisciplinary Care Pathway for Venous Leg Ulcers

Sustaining Change

Procedures will be updated to reflect this changed practice. Staff education will incorporate new interdisciplinary ways of working in partnership with clients and carers. Care Plan Audits will be integrated into the Documentation Audit to meet the National Safety and Quality Health Service Standards.

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Conclusion

Once these proposed changes have been trialled and refined, they will be implemented across all sites within the District's Chronic and Complex Care Service. Other LHD Community Health Services may find it useful to adapt these solutions to their local area.