Triple CCC Project
Shellharbour Hospital
Care Communicate Coordinate

Health
Illawarra Shoalhaven Local Health District

Improving Care Coordination
A Journey Towards Patient Centered Care

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Case for Change

The Medical Respiratory Ward at Shellharbour Hospital was not compliant with NSW Ministry of Health's Policy "Care Coordination: Planning from admission to transfer of care in NSW Public Hospitals". In addition:

- only 20% of patients reported a positive experience with care coordination.
- 68% of staff felt communication needed improvement
- 0% multidisciplinary team (MDT) meetings documented
- 64% of MDT referrals were delayed
- 16% of these referral delays resulted in the patient not being seen by the referred clinician

Goal

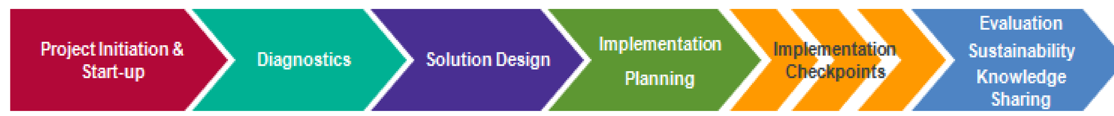
To enhance patient, carer and staff experiences by improving care coordination and interdisciplinary communication within the Medical/Respiratory Ward in alignment with the NSW MoH Whole of Hospital Program and Shellharbour Hospitals Service and Quality /Safety Plan 2013-2023.

Objectives

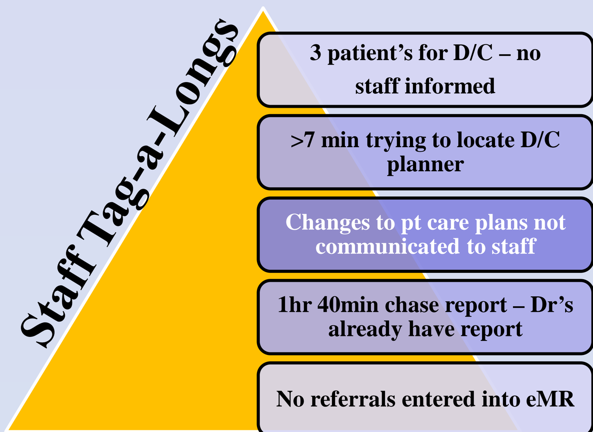
- Improve patient/carer experiences with care coordination from 20% to 50% by April 2015.
- Improve documentation of EDD's in the medical record from 36% to 70% by April 2015.
- Increasing staff awareness of patient's EDD from 8% to 50% by April 2015.
- Increasing the percentage of carers who are informed of an estimated date of d/c prior to the day of D/C from 57% to 70% April, 2015
- Increase number of MDT meetings at the patients bedside from 0% to 50% by April 2015.
- Improve completion of the Transfer of Care Risk Assessment (TCRA) within 24hrs of admission from 60% to 80% by April 2015.
- Improve referrals from 50% to 70% for patients with a positive TCRA by April 2015.
- Reduce the frequency of delays in referral processes (documentation in medical record to eMR entry) from 64% to 44% by April 2015.
- Reduce the median time of referral processes (medical record to eMR) from 6 – 3hrs by April 2015.

Method

This project used Clinical Redesign Methodology

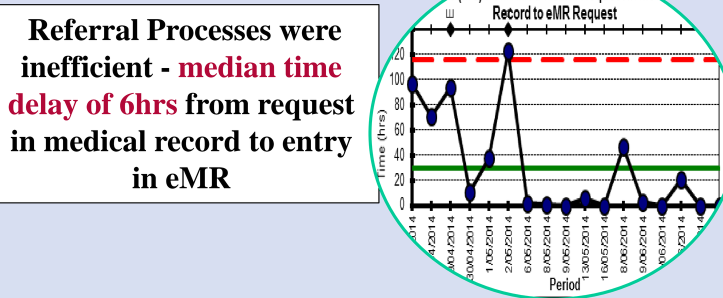


Diagnostics



Medical Record Audit

Referral Processes were inefficient - median time delay of 6hrs from request in medical record to entry in eMR



Surveys

Patients - 43.2% were discharged unexpectedly
Carers - 46.9% did not know there loved ones EDD prior to the day of discharge
Staff – 8% new all patients EDD

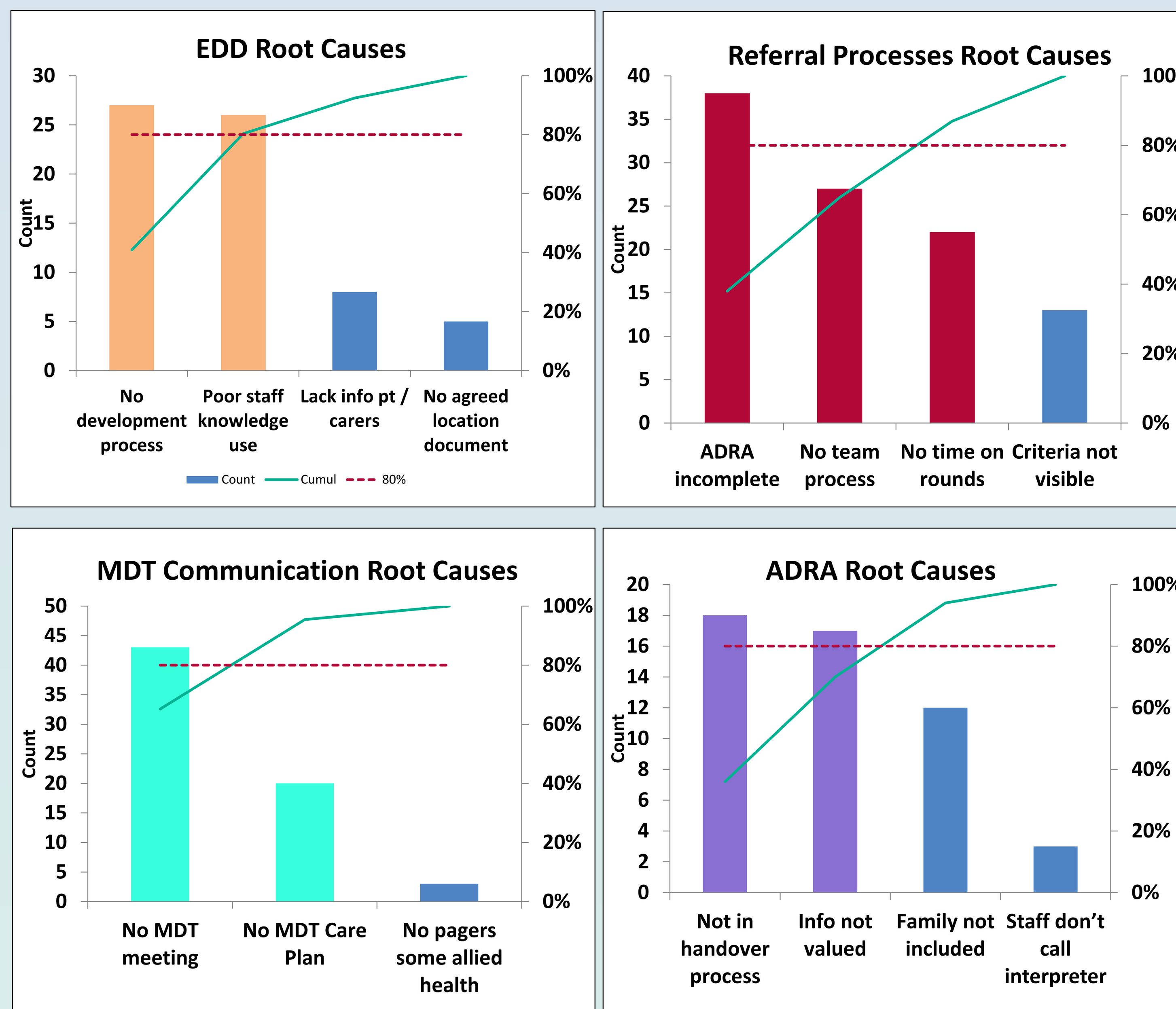
Patient Stories

"When I first went into hospital no one talked to me about how long I would be in for……[Was that important?]….yeah, they should have." **Hessi (Patient)**

Only 20% positive experience

"I did ask to see the social worker …Well I asked 3 times and it didn't happen. In fact the young women Dr suggested it but it didn't occur." **Bill Smith (Patient)**

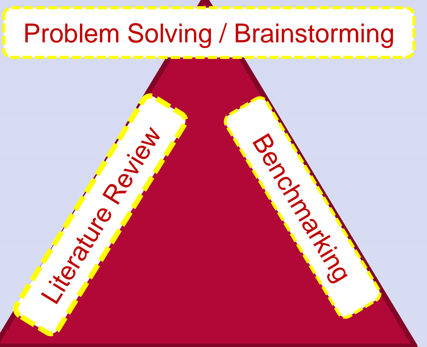
Root cause analysis was conducted for each issue



Planning & Implementing Solutions

Brainstorming solutions with staff (Dr's= 20 Nurses = 22 Allied = 8)

Solution Triangulation



Designed and Implemented New Model of Care

A new care coordination model was developed which included:

- Daily MDT meetings at the electronic patient journey board (ePJB),
- Development and updating of EDD's during ePJB meetings,
- Form to document MDT ePJB meetings,
- Computer on wheels for ward rounds,
- Entering of referrals in 'real time',
- Structured post intake ward rounds (medicine & nurse participation), agreed start time & completion of safety checklist on round,
- Structured interdisciplinary bedside rounds (SIBR) incorporating a safety checklist within a MDT care plan,
- Structured communication scripts to improve team efficiency

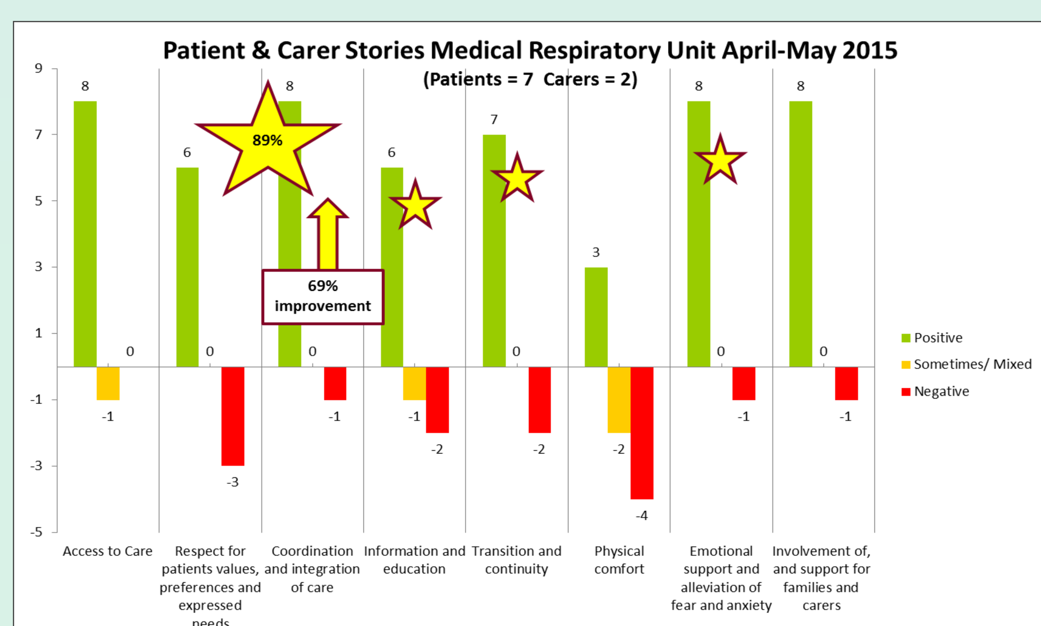
Sustaining Change

- Business rules for new processes and forms developed
- Nursing, medical and allied health clinical competencies and education resources
- Developing ward champions
- New position "Patient Journey Facilitator" to continue spread across all wards
- Project governance committee to continue

Results

Repeat patient / carer stories (n=9) identified significant improvements in care coordination as well as improvements in information, transition and emotional support..

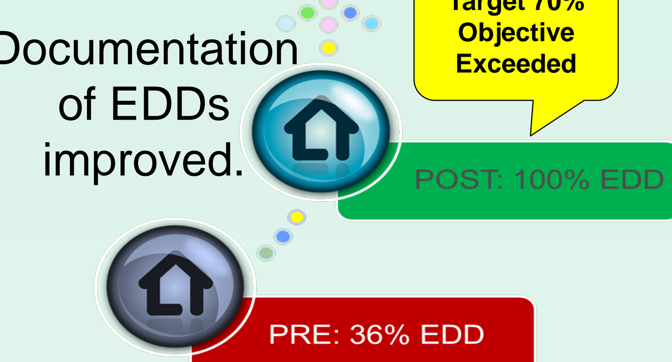
89% Patients had a POSITIVE experience with care coordination



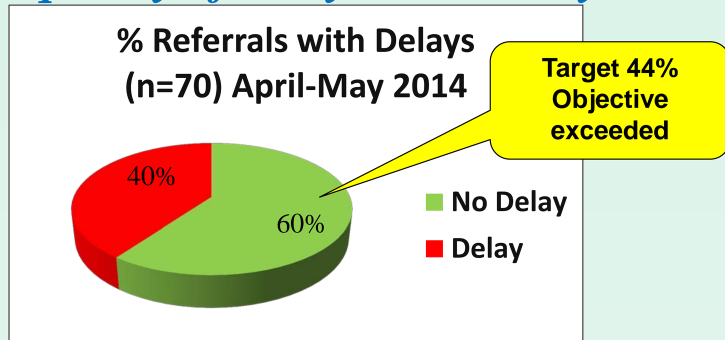
"The coordination of my care was excellent. There is only one word for it…..excellent" **Charlie (Patient)**

"It was excellent, I got to hear what everyone had to say and tell them what Dad is normally like at home. I also know he will be discharged home tomorrow and I can prepare for that." **Daisy, Carer**

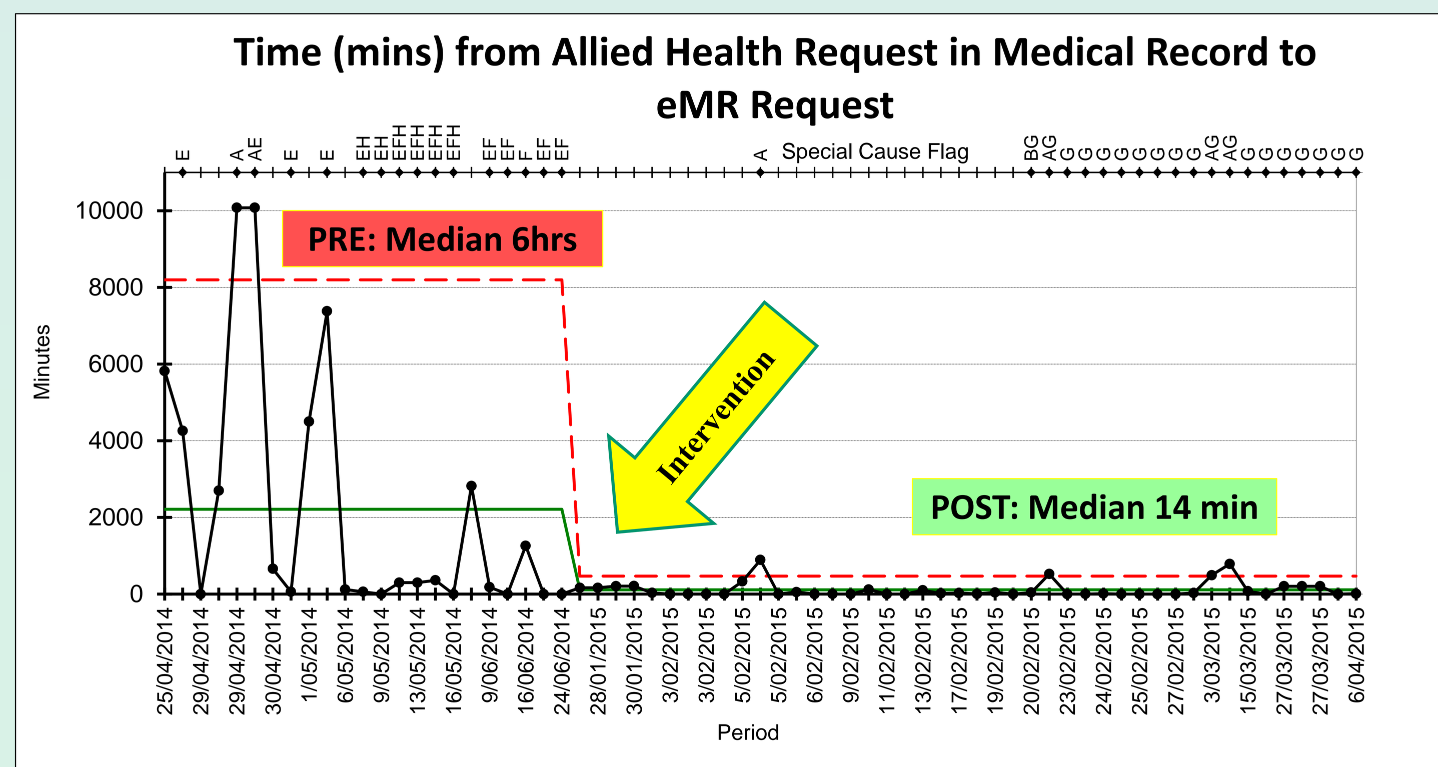
Documentation of EDDs improved.



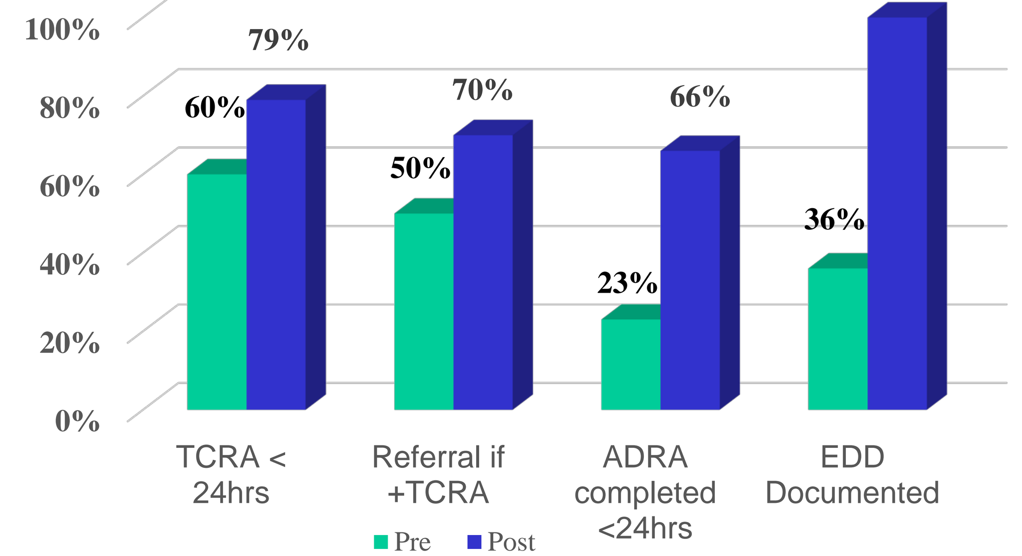
Frequency of delays reduced by 24%



Referral process became well controlled - median time of referral (medical record to eMR) fell from 6hrs to14minutes.



Completion rates and MDT referral from ADRA improved.



Additional Benefits

The Post Intake Checklist improved patient safety and documentation:

- Removal rates of IVC's not in use increased by 83% [Control (n=12): 17%, Intervention (n=11): 100%]
- IVC dwell time reduced by 1 day [Control (n=13): median 2 days, Intervention (n=11): median < 1 day].
- Documentation of an 'IVC removal plan' increased by 32% [Control (n=26): 8%, Intervention (n=26): 42%].
- Documentation of end of life care plans was 64% higher [Control (n=30): 3%, Intervention (n=30): 67%]
- Rates of DVT prophylaxis were 25% higher in the Post Intake Ward round group [Control (n=30): 42%, Intervention (n=30):67%].

Staff experience improved

"Overall, it [new care coordination model] has just made medical respiratory unit a better communication hub...and I think just among staff everyone just communicates better. **Tom, Physio**

Conclusion

This project transformed care delivery on this ward, improving safety, patient, carer and staff satisfaction. The model of care and resources are transferrable to any clinical environment.

"It truly was…. It was one of the best hospital experiences we've ever had…and we've had a few. You don't really expect ….you're expectations aren't great of the environment or the people or any of that because everybody's just doing their job and you sort of sit in the corner and let them do it. But this was much more inclusive. And more friendly and more personable. It was just better." **Susie, Carer**

Acknowledgements

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Shelly Lupton:	NUM Medical Respiratory Ward	Chris Colmer	Physiotherapist
Kristi Kilborn:	CNE Medical Respiratory Ward	Suzanne Payne:	ISLHD Clinical Redesign Coordinator

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