BRINGING CHANGE TO THE FRONTLINE

A REPORT TO NLN MARCH 2009

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GREY BRUCE Health SERVICES

THE FLO COLLABORATIVE

- started in September of 07
- Charged with smoothing and shortening the transition from an acute medical unit to a post discharge destination
- Utilized the Model for Improvement and PDSA as rapid sequence improvements
- 29 collaboratives in the province
- Many, including ours, had collaboration between CCAC and a hospital

Who is Flo?

- The Flo Collaborative uses an analogy
- real Ontario Senior
- 85 year old woman
- Admitted to hosp from her home
- multiple co-morbidities
- Frailty and declining cognitive status necessitate transfer to LTC

TEAM MAKEUP

- each collaborative received the assistance of an Improvement Advisor who was trained in the Model for Improvement by CQHI staff.
- Each team had Senior Champions and Leaders to help facilitate the work within each corporation
- Each team had Co-Leads from each corporation
- The most important part of our team was frontline staff from both corporations (a huge success factor)

THREE FUNDEMENTAL QUESTIONS FOR CHANGE

1. What are we trying to accomplish
2. How will we know that a change is an improvement
3. What changes can we make that will result in improvement

The answers to these questions form the basis of improvement and a framework for "Trial and Learning"

Every system is perfectly designed to achieve exactly the results it gets.

Peter Senge
The Fifth Dimension

INITIAL STATE

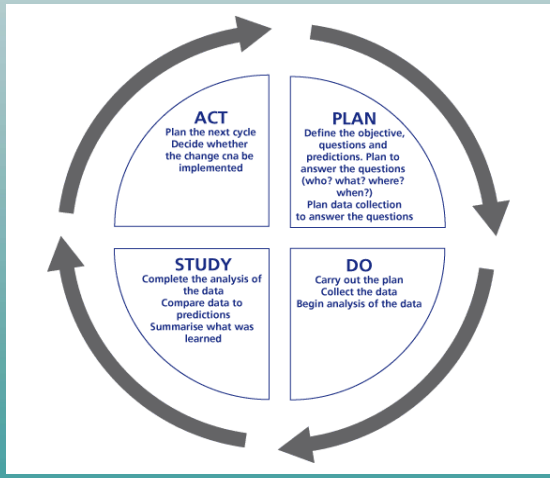
- 28 bed acute medical unit
- unit rounds Wednesday afternoons from 1330-1600
- mix of Hospitalist and GP’s as MRP
- ALOS for Home 4.72
- ALOS for Home with CCAC 10.18
- ALOS for admission to LTC 15.17
- Average of 5 hours notice for discharge

ATTRIBUTES FOR A SMOOTH TRANSITION

- 1. Within 24-48 hours of admission to an inpatient unit, organize patient care around an estimated date of discharge and identify the patient's provisional discharge destination in consultation with the patient and family.
- 2. Within 48-72 hours of admission to an inpatient unit, screen patients for risk factors that may delay transition to subsequent care destinations and develop a plan for managing the identified risks.
- 3. Organize regular and frequent communication within the interdisciplinary team (including patients), and between relevant organizations about transition planning requirements for patients.
- 4. Develop visual triggers that clearly articulate discharge status and required discharge planning activities for each patient on the unit.
- 5. Develop joint transition/admission protocols that clearly define organizational accountability for each step in a standardized process that supports clarity in communication and that eliminates duplication of roles.
- 6. Establish partnerships among care providers to facilitate creative strategies for improving patient transitions from hospital to subsequent care destinations.

PDSA

- This methodology was developed by Walter Shewhart and made popular by W. Edwards Deming
- It is simple and intuitive
- Divided into a continuous cycle
  - **P**lan
  - **D**o
  - **S**tudy
  - **A**ct



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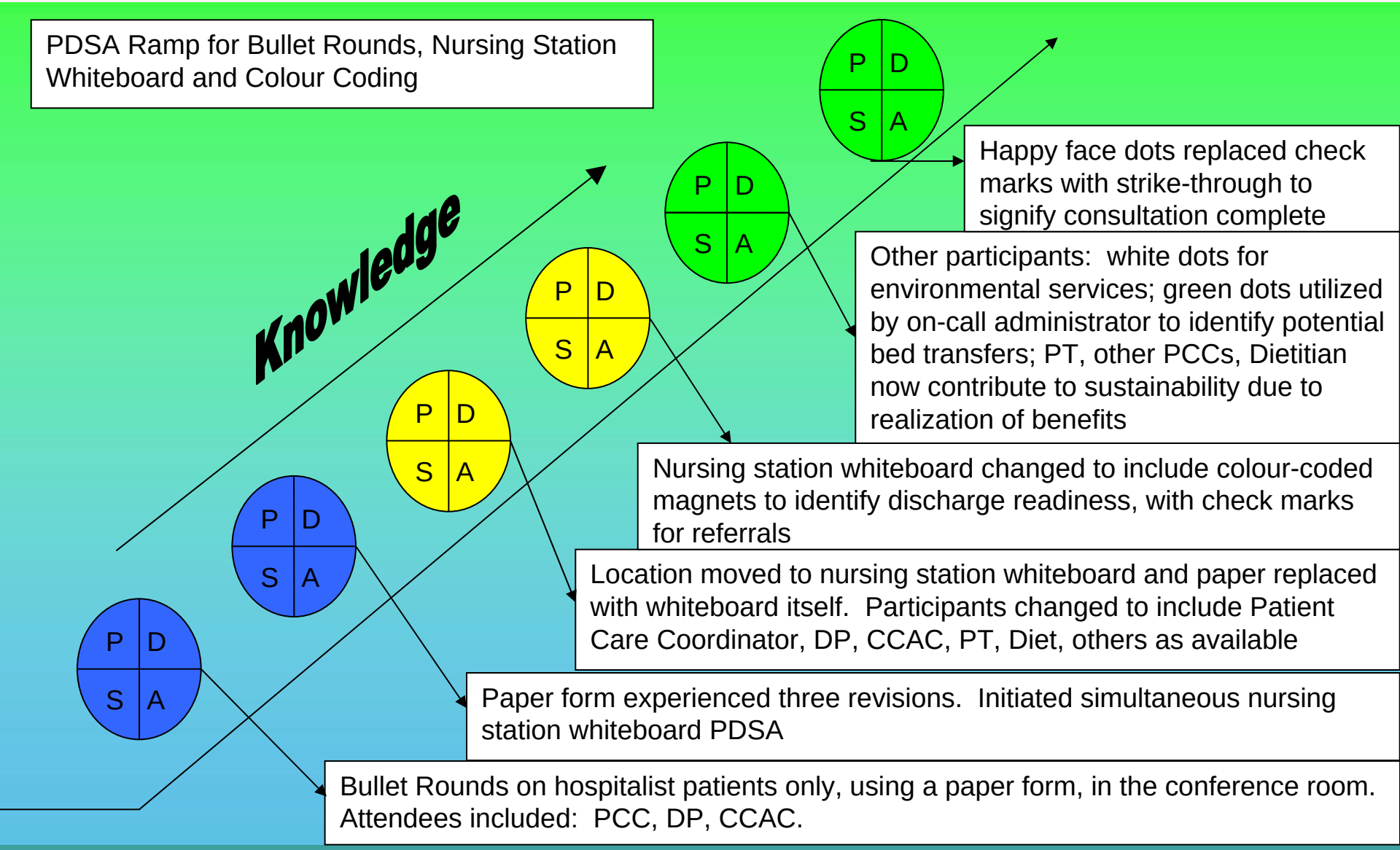

PDSA Ramp for Bullet Rounds, Nursing Station Whiteboard and Colour Coding
Knowledge
P D S A
P D S A
P D S A
P D S A
P D S A
Bullet Rounds on hospitalist patients only, using a paper form, in the conference room. Attendees included: PCC, DP, CCAC.
Paper form experienced three revisions. Initiated simultaneous nursing station whiteboard PDSA
Location moved to nursing station whiteboard and paper replaced with whiteboard itself. Participants changed to include Patient Care Coordinator, DP, CCAC, PT, Diet, others as available
Nursing station whiteboard changed to include colour-coded magnets to identify discharge readiness, with check marks for referrals
Other participants: white dots for environmental services; green dots utilized by on-call administrator to identify potential bed transfers; PT, other PCCs, Dietitian now contribute to sustainability due to realization of benefits
Happy face dots replaced check marks with strike-through to signify consultation complete

Filter For All PDSAs

Date:

PDSA #:

Objective:

Filter #	Filter Question	Yes	No	What can we do about it?
1	Does it reduce workload?			
2	Did we provide opportunity for feedback?			
3	Did we ask for participation?			
4	Do we have a front-line change champion?			
5	Do we have a management change champion?			
6	Will staff see instant gratification?			
7	Will Flo see instant gratification?			
8	Will it work in an HR shortage?			
9	Is the timeline reasonable to yield results?			
10	Does it allow for variances in personalities/work approach?			
11	Is there a communication plan that's transparent?			

Pass ? Fail ?

If pass achieved, then:

Suggestions for intermittent positive reinforcement:

Suggestions for steps to ensure momentum is maintained and participation continues:

OUR FIRST PDSA CYCLES

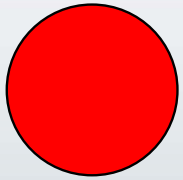
Nursing Station Whiteboard January 2008

Nursing Station Whiteboard May 2008

Nursing Station Whiteboard August 2008

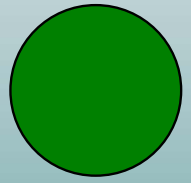
DISCHARGE COLOURS:

Discharge is likely to occur in:

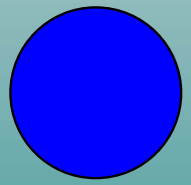


More than 3 days

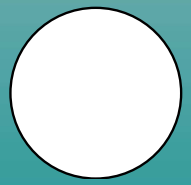
2 – 3 Days



24 hours (please make appropriate arrangements)



Waiting for…(bed at “x”)



Discharge Today

Physician's EDD form

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Stick Patient Label Here

Date: _____

Please indicate your patient's estimated stay in number of days: _____ days

Please indicate the most likely discharge destination for your patient:

Home _____

Home with family: _____

Home with CCAC support: _____

Home with CCAC – IV Meds: _____ (requires minir

TRIAL

Rehab: _____

Convalescent Care: _____

Permanently altered living arrangement:

Rest/Retirement Home (including lodges): _____

Long Term Care Home (Nursing Home): _____

Other: _____

Concerns/Barriers to discharge:

_____

_____

_____

_____

Discharge Destination Matrix

Discharge Destination Matrix

Eligibility Criteria (October, 2008)	Home			Homeless	Rehab		Community & Social Support							RH	Palliative Care
	Home	Home with CCAC Support	Home with Private and Community Supports	Shelters for Homeless	Acute IP Rehab Short Term Acute IP Rehab Med. Term Acute IP Rehab Long Term Slow Stream Rehab TCP	External Specialized/Rehab eg ABI, SCR	Long term care	Convalescent care	Group Homes	Supportive housing	Mental Health Supportive Housing(Boarding)	Physical Disability Participation Lodge	Out of County Complex Continuing Care	Rest/Retirement home	Out of County Hospice
General															
Medically Stable	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Valid Consent	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Age 18+					●	●	●	●		●	●	●	●		
Valid OHIP		●					●	●							●
All inpatient Medical Investigations completed	●	●	●	●	●	●	●	●	●	●	●	●		●	●
Able to direct own care				●				●	●	●	●	●			
Expected D/C Destination is home/RH	●	●	●		●			●	●	●				●	
Homeless				●											
Manageable behaviours	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Meets activity tolerance					●	●		●	●	●	●				
Willing and Motivated to Participate		●			●	●		●	●	●	●				
Able to Learn & Follow Instructions	●	●	●		●	●		●	●	●	●	●		●	●
Hospital discharge plan established	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Reason for stay															
Caregiver relief													●	●	
Altered health status(temporary)								●					●	●	
Potential to return to previous level of functioning or increase current level(see Rehab Admission Criteria)					●	●		●			●	●	●	●	
Long stay admission							●		●	●			●	●	
Length of stay															
90 days or less					●	●		●							●
Financial resources															
Access to financial resources to supplement community services			●						●	●	●			●	
CoPayment/Rent required							●		●	●			●	●	?
Care needs															
Nursing care needs > 3 hours /day													●		
Consent to -Do Not Recusitate															●
Need for Personal Support/attendant services provided over a 24 hr period							●	●	●	●			●	●	●
Care needs cannot be met at home or in other setting with the available resources							●			●	●	●	●	●	●
Behavioural Programs							Ltd								

Patient Room Whiteboard

LTC application process pre-Flo

Timeline to LTC bed offer Pre FLO starting on the Day ALC order written (usually 5-7 days after admission)and allowing maximum allowed times.

Day1	Day2	Day3	Day4	Day5	Day6	Day7	Day8	Day9	Day10	Day11	Day12	Day13	Day14	Day15	Day16	Day17
DP sets family meeting																
			Patient/Family explores options, tours etc ---------→													
									Patient and family make choices							
			CCAC assess capacity							CCAC completes RAI and send application the LTC Homes						
												LTC Homes accept application ------→				
																Ready for a bed offer

17 days for the process plus 5-7 days of acute care = ALOS of 22 -24 days

LTC application process post-Flo

Timeline to LTC Home placement starting on the day that LTC is identified as the probable discharge destination, usually 48 hours after admission, until awaiting bed offer

Day 1	Day2	Day3	Day4	Day5	Day6	Day7	Day8	Day9	Day10	Day11	Day12	Day13	Day14	Day15	Day16	Day17
LTC identified																
	DP meets with family															
		Family explore options														
			CCAC confirms capacity													
					Patient/family make choices											
					CCAC RAI assessment if ALC											
							Application to LTC homes									
								LTC Homes accept application								
											Bed offer					

Families are allowed 5 days to research LTC Homes now usually take 3
LTC Homes are allowed 5 days to accept application now usually take 1-3
ALOS to readiness for bed offer 12 days

ALC/LTC Application Filter

Patient for Placement in Long Term Care Home?

1. Is the patient in restraints?
    a. Pinel restraint*? Immediate referral to OT/PT.
    b. Lap tray? Is it being used as restraint? Referral to OT/PT
    c. Geri Chair? Can they function in wheelchair? Referral to OT/PT

2. Is the patient exhibiting verbal and/or physical aggression
    a. Physical aggression – may block LTCH application, assessment options? Medication options? Psychogeriatric assessment?
    b. Verbal aggression – if severe, may block LTCH application.

3. Is the patient's pain under control?

4. Are the patient's medications listed in ODB?
    If no/unknown, referral to Pharmacy for review

5. Does the patient have a PICC line?
    a. Can it be discontinued prior to placement?
    b. Will CCAC and facility need to time to arrange training of staff?

6. Does the patient have an infectious disease**?
    a. If yes, fax lab report to CCAC
    b. If being tested, positive results to CCAC ASAP

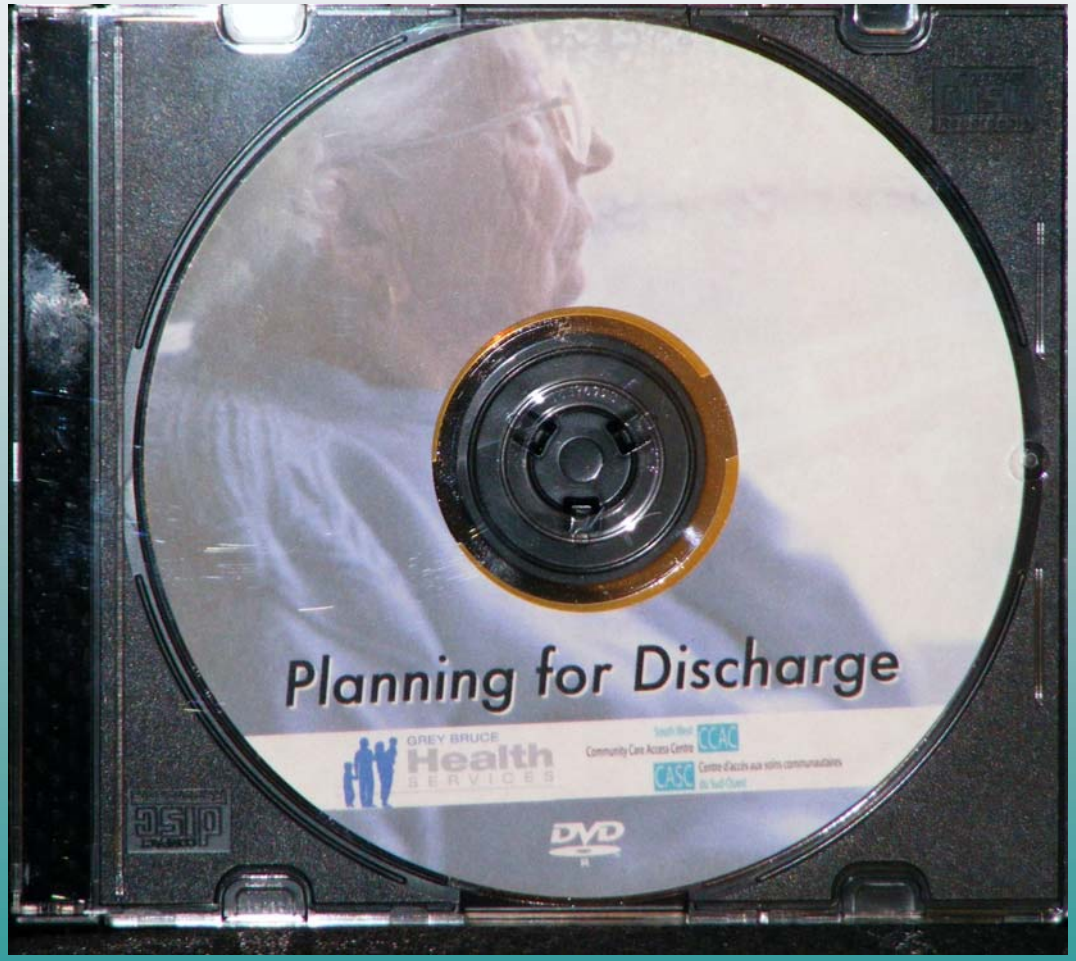
7. Multiple/Complex medical needs? Discuss placement needs with CCAC ASAP.

8. Bariatric patient (over 350 lbs)? Discuss placement needs with CCAC ASAP.

*LTCH will not take a patient in Pinel restraint. CCAC can not begin placement process until 72 hours after Pinel has been discontinued.

** Infectious disease will not stop placement in LTCH but may affect bed placement in shared accommodation situation.

GBHS DVD



Admission Database/Kardex

Date	ACTIVITIES
	❑ Bed rest
	❑ Dangle
	❑ Chair
	❑ BRP x ____ assist
	❑ Commode x ____ assist
	❑ Ambulate x ____ assist
	❑ Walker/Cane
	HYGIENE
	❑ Bed bath
	❑ Assist
	❑ Self
	❑ Tub/Shower-Day _____
	❑ Shave
	❑ Oral Care
	❑ Peri Care
	❑ Cath Care
	MONITORING
	❑ TPR O R A
	❑ B/P ❑ Lying/Standing
	❑ Apex
	❑ O_2 Sats
	❑ HR
	❑ Cardiac Monitoring

Date	SAFETY NEEDS
	❑ Side rails ❑ HS only
	❑ Mechanical Lift
	❑ Other/Specify:
	PROSTHESIS
	❑ Dentures: U L P
	❑ Hearing Aid
	❑ Glasses
	❑ Contacts
	❑ Eye
	❑ Limb
	SPECIAL NEEDS
	❑ O_2 _____
	❑ Suction
	❑ Weight
	❑ Intake ❑ Output
	❑ Positioning
	ELIMINATION
	❑ Catheter size
	❑ Bladder irrig.
	❑ Ostomy Type: _____
	❑ Incont ❑ Invol

Date	DIET
	Type:
	❑ Swallowing Screening
	❑ NPO ❑ Ice chips
	❑ Diabetic
	❑ Fluids: ❑ Restrict
	❑ Push
	Feed: ❑ Assist
	❑ Total
	❑ Set up tray
	❑ Special feedings
	❑ Enteral feedings:
	Type: _____
	Flush with _____ mL
	Rate: _____ mL/h

Date	TREATMENTS
	❑ Drain ❑ Packing ❑ Sutures ❑ Anti-Embolic
	❑ Pneumatic leggings pump

Date	Consult/Referral

Date	IV THERAPY

SPECIMEN COLLECTION	Date to be done

DAILY TESTS
Bld. Glucose Monitoring
Test Frequency: _____

D.I. TESTS	Date to be done	LAB TESTS

ASSESSMENT SCORES:

❑ BRADEN SCALE
If score ≤ 14 refer to: ❑ Dietitian ❑ OT

❑ BLAYLOCK RISK SCREEN
If score > 10 refer to: DP/CCAC
> 20 consider LTC

❑ MORSE FALLS ASSESSMENT
If score is > 25 or
if gait score is > 10 refer to PT

❑ DYSPHAGIA SCREEN
Follow algorithm for Dietitian/SLP referral

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❑ Lions Head ❑ Markdale ❑ Meaford ❑ Owen Sound ❑ Southampton ❑ Tobermory ❑ Wiarton

EDD:

Story Behind the Slides

- Positive culture change on the floor
- Engaged Interdisciplinary Team
- Metrics moving in positive direction
  - 11.3% decrease in ALOS for Discharged Home
  - 13.4% decrease in ALOS for Home with HC
  - Decrease numbers of patients discharge home and to LTC homes with simultaneous increase in numbers discharged with HC!
  - 19 % decrease in # home
  - 19.4 % increase in # home with HC
  - 5 % decrease in # to LTC homes
  - Average Bed Turns at 3.9 turns per room per month for all of 08

What do front line staff think?

- Hugely positive and measured satisfaction rates with:
  - Our rollout model
  - The patient room whiteboards
  - The DVD
  - The nursing station whiteboard
  - Bullet rounds
  - Colour coding
- Limited satisfaction with the new admission database/kardex, but a willingness to keep trying

What do the “other” frontline staff think? (Physicians)

- “This is the common sense approach I have been looking for”
- “I have difficulty now making plans with my patients when there is no whiteboard”
- “Well done, this is a huge body of work and it has direct applications and has already shown results”
- “Keep it up, we don’t like to share but you are helping us get there”

Lessons Learned

- Get data before starting a project, don't decide on a project based on a "one off"
- START WITH THE STAFF,START WITH THE STAFF,START WITH THE STAFF!
- No project has a hope of success unless those that are to do the work see the value and commit to the trying
- Select your measures of success based on your problem indicators and measure continuously using process and outcome measurements
- Include balance measures to make sure your success is not causing another problem
- Communicate data the good and the bad
- Plan for sustainability from the beginning

Coming together is a beginning

Keeping together is progress

Working together is success

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