The Power of Partnerships: patients and staff co-designing bedside care

September 28, 2016
Welcome

With us today:

Host
Jessie Checkley
Senior Improvement Lead, CFHI

Patricia O’Connor
Independent Consultant
Clinical Improvement Advisor, CFHI

Dianne Gaffney
Clinical Improvement Advisor, CFHI

Cathy Bachner
Patient Partner
Huron Perth Healthcare Alliance
On today’s call

- Engage leadership, frontline staff and patient partners in quality improvement.
- Identify the key attributes of engagement-capable environments and winning conditions for partnering with patients.
- Examine leading practices to improve patient and family experience of care including a case example on family presence and participation in care, bedside transfer of accountability and whiteboard use.
- Measure for success and to support spread.
Patient Engagement:

Patient engagement is the involvement of patients and/or family members in decision-making and active participation in a range of activities (e.g. planning, evaluation, care, research, training, and recruitment).

Starting from the premise of expertise by experience, patient engagement involves collaboration and partnership with professionals.

Improved health outcomes & changes in service utilization

Patient & organizational improvements e.g. patient experience, safety and effectiveness

Changes in improvement priorities & resourcing

Carman, et al., Health Affairs, 2013

Factors influencing engagement:
- Patient (beliefs about patient role, health literacy, education)
- Organization (policies and practices, culture)
- Society (social norms, regulations, policy)
Engagement Capable Environments: leadership, staff and patients

- Enlisting and Preparing Patients
  - Asserting patient experience and patient-centered care as key values and goals
  - Communicating patient experiences to staff

- Ensuring leadership support and strategic focus
  - Engaging staff to involve patients

Supporting teams and removing barriers to engaging patients and improving quality
7 Key Attributes of Engagement-Capable Environments

1. Courageous, cohesive leadership who “walk the talk”
2. Recruitment of patient advisors with clear roles & responsibilities, at all levels of decision-making
3. Creation of mutual learning environment for patient advisors, staff and physicians
4. Coaching & facilitation support
5. Continuous feedback loops & outcome measurement, including smart use of technology
6. Resources
7. Partnerships within and beyond your organization e.g. care transition partners, government collaboration
Patient Engagement Leading Practices

1. Including patient partners on decision-making forums that have a direct or indirect impact on care
2. Family presence & Open visitation (policy)
3. Bedside whiteboards
4. Bedside Transfer of Accountability
5. Hourly intentional/comfort rounds
6. Interprofessional Bedside Rounding
7. Patient and Family Advisory Councils
8. Volunteer Ambassador Program
9. Elder friendly practices
10. Joint inter-professional admission processes
11. For Community and Primary care: Chronic disease self-care management
12. Written discharge information including next appointment, medication times and explanation. Contact number if questions.
Partnering with Patients and Families for Quality Improvement: A CFHI collaborative
Collaborative Aim
To build capacity and enhance organizational culture to partner with patients and families in order to improve quality across the healthcare continuum.
Results: Quality of Care Improvements

• **Improved Patient Experience of Care** (21 teams)
• **Built Patient & Family Engagement Infrastructure** (20 teams)
• **Coordination of Care & Transitions** (7 teams)
  • Transfer of accountability at change of shift
  • Transitions from acute to rehab care
  • Multiple admission & discharge process improvements
  • Transition to adulthood for youth with complex conditions or cancer
• **Chronic Disease Self-care Management** (4 teams)
  • Improving healthcare provider skills to support self-care management in diabetic and renal populations
  • Patient engagement resource guide for primary care
  • Recruiting and training patient advisors
Results: Quality of Care Improvements

Timely access to care (3 teams)
• Improved response time and effectiveness of response to patient calls in a busy MS Clinic
• Improved Information about wait times in pediatric rehab
• Cancer care wait times addressed thru re-design of work processes

Peer Mentoring (2 teams)
• Bedside Orientation in pediatrics by experienced parent mentors
• Peer mentoring following upper limb amputation

Use of technology in direct care to improve (2 teams)
• Transition to adulthood for youth with complex conditions
• Reducing sense of isolation amongst dialysis patients
When you talk, you are only repeating what you know; but when you listen, you learn something new.
Patient Partner – Cathy Bachner
Power of Partnership: Co-Designing Bedside Care
Cathy Bachner – HPHA Patient Partner

Life is like a jigsaw puzzle, there are always pieces that need to be put together
- Unknown
Complex Web of Medical Professionals
Dr. ANGELA COULTER
Co-Producing Health

• Mobilizes people & recognizes their assets, strengths and abilities, not just their needs.

• A partnership of equals between people and professionals.

• Care organizes around the patient,
  • blurring boundaries between health,
  • public health, social care, community
  • and volunteers organizations.

• Solutions designed and delivered
  • with people rather than 'to' or 'for' them.
Message to you from Patient Partners...

✓ Be not afraid
✓ Please avoid tokenism
✓ Explain the goal & our role
✓ ASIA - Avoid Speaking In Acronyms
✓ Promote equality by using first names only
✓ Play to our individual strengths & experiences
✓ Meetings must have Patient Partner present
✓ Provide meeting material ahead of time & include us in all messages
✓ Voting system for decision-making
✓ Cover incurred expenses
Our Journey to Person Centred Care and Patient Engagement...

Dianne Gaffney, Corporate Lead Professional Practice
Cathy Bachner, Patient Partner

Sept. 28, 2016
Our Journey to Person Centred Care and Patient Engagement...

2011 – Unit Action Councils with Patient Partners
2012 – Open Visiting Hours (24/7)
2012 – Bedside Whiteboards (refresh in 2016)
2013 – Patient Experience Steering Committee
2014 – Collaborative Care Model
2015 – Standardized Uniforms
2015 – Bedside Change of Shift Report
HPHA Interprofessional Practice Model

Philosophy Statement:
The Professionals at the HPHA are committed to providing safe, quality patient care through interprofessional collaborative teamwork.

Legend
- Centre Circle – Focus of Care
- Small Circles – Healthcare Providers
- Middle Circles (4) – Key Components
- Outer Circle – Supportive Factors

January 2011
Patient and Family Centred Care – Moving Beyond the Rhetoric

June 1, 2011

Dianne Gaffney, Corporate Lead Professional Practice
In the beginning...

- Very restrictive visiting hours (SARS)
  - 11:00 am to 2:00 pm
  - 4:00 pm to 8:00 pm
- Staff and physicians loved them
- Patients and families...
  Not so much!
Why Change?

• Culture change in organization towards person-centred care and greater involvement of patients and families in care and decision making
• Disconnect between restrictive visiting hours and this new culture
• +++ complaints from patients and families on discharge surveys and community forums
It’s the right thing to do!

- Patients should have the right to determine who they want on their support team, and the time of day that works best for them.
- Encourages and supports the involvement of family and friends as part of patient's support team; important that they are engaged in the care and management of the patient, in accordance with the patient’s wishes.
Our process...

• Literature review and environmental scan
• Presentations and discussions at Nurse Practice Council, Interprofessional Practice Council, Medical staff meetings, Labour Management meetings, Management Team meetings, Board of Directors
• Thorough discussion of the benefits and challenges
Challenges cited...

- Privacy and confidentiality
- Interruption to staff work flow
- Interfere with patients’ rest/sleep
- Infection control concerns
- Security concerns at night
- “When will we get our breaks?”
- “It will take longer to do my rounds if I have to talk to families”
Person-Centred Visiting Guidelines

- Flexible visiting hours based on patient preference
- Encourage dialogue between the patient, their family and healthcare providers about patient care needs, including the presence and support of family members
- Recognize families as partners in care, and the important role they play in the quality of patient care
Statement of Philosophy for Visiting and Family Participation in Care

The HPHA promotes and supports a patient- and family-centred model of care. Patients, their families, and other partners in care are respected as essential members of the health care team, helping to ensure quality and safety.

- Patients define their “family”/support team and how they will be involved in care, care planning, and decision-making. Their “team” provides support, comfort, and important information during ambulatory care experiences, inpatient care experiences, emergency room visits, and in the transition to home and community care.
To address staff and physician concerns...

• The number of people welcomed at the bedside at any one time will be determined in collaboration with the patient and family. In situations where there are shared rooms, this negotiation will include the other patient, his or her family, and other partners in care.

• Visiting may be interrupted to provide appropriate patient care, and to protect the privacy of the patient and/or other patients in the same room
Implementation/Communication Plan

- Consultation with NPC, IPPC, Management Team, Infection Control, Senior Leadership Team, Medical staff meetings, Security, HPHA Board
- Consultation with UHN, review of other hospital’s visiting guidelines
- In-SITES article
- Departmental meetings
- E-mail communication to all staff, physicians and volunteers
Implementation/Communication Plan

- Pre-Admit Clinic and Pre-Natal Clinic
- Letter to clergy
- Press release (newspaper and radio interviews)
- Patient and Family Handbook
- HPHA Switchboards
- HPHA Website
- Family Physicians Offices
Lessons Learned...

1. Needs to be aligned with organizations strategic direction and priorities
2. Preceded by education on Person-Centred Care
3. Thorough stakeholder analysis (e.g. Security and Facilities Management)
4. All patient care areas need to be included; no exceptions
5. Discuss patient preferences in pre-admit
6. Communicate, communicate, and then communicate!
7. Increase in staff comfort level in working together with patients and families with increased exposure
8. Lead the way to increased partnership between staff, physicians, patients and families in all aspects of organization
Partnering with Patients and Families to Bring Shift Report to the Bedside: A Recipe for Success!

July 27, 2016
7th International Conference on Patient- and Family-Centered Care.

Dianne Gaffney, MSc., RD
Donnalene Tuer-Hodes, RN, MScN
Cathy Bachner, BASc., BEd (Patient Partner)
Project Team:

- VP Partnerships and Patient Experience (Executive Sponsor)
- Corporate Lead Professional Practice (Project Lead)
- Director Decision Support (Evaluation Lead)
- Patient Lead
- Family Member
- Front-Line RNs and RPNs
- Program Managers and Directors for two pilot units
- Faculty Advisor, CFHI (Patty O'Connor)
Exceptional People, Exceptional Care!

Bedside TOA Project – Meaningful Patient Partnership at Every Stage!

- Engaging patient partners on the research team:
  - Funding Application
  - Project Team
  - Staff Education

- Engaging patients on the unit in evaluation
- Engaging patients in bedside TOA
Previous State of TOA in the HPHA

• Transfer of accountability (TOA) between nurses at change of shift is **not standardized across** our organization

• Variations in methods and quality of information exchange during TOA

• **Does not occur at the bedside** so no engagement of patients and families in the process
Why is this an issue?

An estimated 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off. (1)

The Joint Commission Center for Transforming Healthcare, 2010
Benefits of Bedside TOA...

✓ ↑ Patient Safety (↓ medication errors, pressure ulcers and falls) \(^{(2-5)}\)

✓ ↑ Patient Satisfaction \(^{(7-12)}\)

✓ ↑ Staff Satisfaction \(^{(3,5,6,8,11)}\)
But what about the nurses’ concerns???

- **Confidentiality** of patient information?
- **Repetitive**...I can find that information in the EHR.
- This will take **too much time**!
- What do we do about **isolation patients**?
- What if the **next shift** doesn’t show up **on time**?

(3,5,6,8,11,13)
What were we aiming to improve?

- Improve patient safety; decrease med errors, adverse events related to sub-optimal communications at TOA

- Enhance patient satisfaction through personal introduction of next nurse at TOA, and engagement in information exchange with the nurses

- Improve nurses’ ability to prioritize their care for the patients on their assignment through access to greater information about their patients early in their shift
2 Pilot Sites:

1) Inpatient Medicine/CCC Unit
   St. Marys Memorial Hospital
   ➢ 20 bed unit - 10 Acute care medicine beds
      - 10 CCC beds

1) Inpatient Surgery Unit, Stratford General Hospital
   ➢ 32 bed unit - 25 Surgery beds
      - 7 CCC beds
Mandatory 2 hour interactive education session for all RNs and RPNs on the two pilot units which included:

- Discussion about bedside TOA
- Benefits and challenges of bedside TOA
- Introduction and feedback on the SBAR tool
- Practice scenarios – simulation exercise
- Patient Partner participated in the sessions and simulation
### SITUATION

**Intro. Statement:**

“Good morning/evening (patient’s name)”. We will be doing a quick shift change report. Is it OK with you if we do this here with you? (If “no”, then give report at communication station.) We will first discuss an overview of your care, and then together we will all discuss the plans for the day to see if it sounds correct to you. If you have any more questions, your nurse “_________” will discuss this during your morning care. Are you okay if we begin?” (Ask permission from patient for family/visitors to stay for report)

- Pull curtain if in semi-private/ward room
- Update Whiteboard

### BACKGROUND

- Diagnosis/date of surgery
- Admission/Physician MRP
- Confirm armband and allergies

### ASSESSMENT

- **Visual Safety Check:** isolation/call bell within reach/restraints/side rails/falls risk/re-positioning schedule
- **Brief** Head to toe focused assessments outside WNL.
- **Cognitive status**
- **Pain management/PRN Meds**
- **IV:** site, solution, rate, TBA, pump check
- **View and review findings:** drains, foley (output), dressings/incisions/wounds, Oxygen therapy
- **Review abnormal findings:** V/S, critical lab values
- **Gastrointestinal:** diet, fluid restrictions, N/V, last BM
- **Genitourinary:** toileting routine, continence issues, output
- **Mobility status** (including ambulation aides)

### RECOMMENDATION

- **Outstanding issues to be addressed that day:** meds/orders unclear, pt concerns
- **Plan for the day:** going for tests (CT, U/S), O.R. (NPO), drains coming out, discharge plans/barriers
- **Ensure immediate needs** are met and inform approximate time that nurse will return.
What can you do to help?
Keep track of urgent concerns you wish to raise during your NURSE’S bedside shift report.

Keep track of any questions you wish to ask your DOCTOR.

Exceptional People, Exceptional Care!
HPHA VISION
We will improve the health and well-being of the people we serve by leading the development of a sustainable, fully integrated, rural health system.
Tips for addressing Confidentiality Concerns...

✓ We give the patient control of whether or not TOA happens at the bedside.

✓ At the beginning of the patient’s stay, they are given an information pamphlet which provides details about TOA; Pamphlet includes a space for patients to record questions or concerns for nurses or doctors. Sensitive information can be written down and then shared.

✓ At the beginning of each TOA, patients and families are asked if they would like to participate at the bedside and if there are sensitive issues they would like to keep private.

✓ The patient identifies if there are significant others that they would like to be present during TOA. They can also identify who should not be present during TOA.

✓ Curtains are closed in semi-private and ward rooms.

✓ The College of Nurses of Ontario (CNO) encourages nurses to exchange patient information at the bedside while acknowledging the personal and potentially sensitive nature of patient health information. Nurses use professional judgement when they deliver sensitive information at the bedside.
Implementation

- Start small – 2 nurses at a time
- Test procedures and bedside quick reference tool
- Measure time required for report
- In the moment feedback from staff and patients
- Then, implement with all staff
Evaluation Plan

- Repeated measures mixed method evaluative research design (quantitative and qualitative approaches).

- Three data collection periods:
  - T1 - approximately 1 month prior to implementing bedside TOA
  - T2 - 4 months following the introduction of bedside TOA
  - T3 - 8 months following the introduction of bedside TOA
Results: Patient Outcomes

Canadian Patient Experiences Survey:
Increase in mean score for “Care from Nurses” sub-scale from T2 (3.65) to T3 (3.94), p = 0.05 *

SGH Care from Nurses Subscale

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.83</td>
<td>3.65</td>
<td>3.94</td>
</tr>
</tbody>
</table>

p = 0.05 *
Results: Staff Outcomes

1) Global Measure of Work Satisfaction

*Note: SMMH T2 to T3 change is significant, p=0.019
Run Time Metric – Time required for Bedside TOA

Prior to implementation of Bedside TOA:

- Average time for change of shift report was **28.5 minutes** in total.

4 months after implementation:

- Average time for change of shift report with Bedside TOA was **24.8 minutes** in total
- Therefore, Bedside TOA reduces time required for change of shift report by approximately **4 minutes**.

Exceptional People, Exceptional Care!
What are the Patients saying about TOA?

“It was helpful to be included. I feel it is a good idea; I had previous surgery here and this didn’t happen.”

“Yes, it’s very good to hear the nurses talk with me instead of in an office somewhere with “sh/sh” sounds.”

“It relieves my concerns that I am being well looked after.”

“Comfort knowing everyone’s on the same page.”

“No issues with confidentiality. Depends on sensitivity of what it is; depends on patient and situation. Discuss often already with other patients in the room, so no issues.”

“I feel that it is very beneficial, and I like it. I know that I am up to speed on everything.”
What are the nurses saying about TOA?

“It went well because I knew the patients from the previous day.”

“Good that we are getting to know the patient assignment early; quick look.”

“I feel safer when I see my patients right away at the beginning of the shift, because I know which ones will be safe while I look after others.”

“It is challenging when patients ask to be toileted and for other care needs during bedside report.”

“Like meeting the patients and eyeballing at start of the shift; helps me to prioritize care.”

“More manageable with 5 patients and fewer isolations.”
Lessons Learned...

1. Inclusion of patient and family member and staff in all aspects of project
2. Communication of daily metrics – verbal and on Huddle Boards
3. Visible senior leadership support
4. Include role playing in education sessions; include your patients and family members and staff if possible
5. Daily observations by leaders during at least first 3 months of implementation
Lessons Learned...

6. PDSA cycles at beginning of implementation invaluable!
7. Reinforces use of Bedside Whiteboards
8. Active listening to staff concerns and responsiveness are very important.
9. Sustaining practice change is difficult! Team Leaders and Managers need to monitor daily and reinforce with staff that this is a practice expectation.
The Reality of Change

Who wants change?

Who wants to change?

Who wants to lead the change?
Questions?

Please submit your questions/comments electronically using the “Chat Box” on the bottom of your webinar screen.
Now we’d like to hear from you….

How do you see yourself moving forward on your journey into partnering with patients/families?

Please submit your comments electronically using the “Chat Box” on the bottom of your webinar screen.
Looking for tools and resources to support you in patient engagement?

Start your journey with the Patient Engagement Resource Hub and App!

Our online resources can help with the assessment, design, implementation, and evaluation of your initiative.

For more information: cfhi-fcass.ca/ResourceHub
Resources


- CFHI’s Partnering with Patients and Families for Quality Improvement Collaborative http://www.cfhi-fcass.ca/WhatWeDo.aspx


References


Upcoming Webinars

October 6th - Harkness and Healthcare: Canadian Harkness Fellowship 2017-2018

October 12th - Mental Wellness Teams for Indigenous Communities

October 19th - Improving Transitions from Child to Adult Care

Full Lineup:
http://www.cfhi-fcass.ca/WhatWeDo/on-call/upcoming
Thank you!