Enhancing patient care processes for subacute elderly patients in Darling Downs Health

Initiative Type

Model of Care

Status

Deliver

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Summary

Taking a clinical redesign approach to General Medicine care at Toowoomba Hospital, clinical leaders across Medical, Nursing and Allied Health collaboratively analysed the issues, drilling down

to the key problems and prioritising those which could - realistically - be addressed, and then developed solutions. The solutions generally followed simple principles

- creating an evidence-based format for multi-disciplinary meetings that both demanded recognition of patient dysfunction and contributions from all parties, as well as directing consideration towards restorative care
- creation of an efficient weekly meeting schedule that differentiated quick daily huddles from more involved weekly multidisciplinary meetings
- implementation of a sticker documentation process aligned with the new meeting format
- environmental strategies that encouraged team input into care-planning as well as role and person awareness
- implementation of a senior, transdisciplinary Allied Health role to provide over-arching expert clinical guidance, as well as advocacy and support for Allied Health clinicians
- providing a training session to enhance the capacity of Medical Officers to provide appropriate, detailed and timely referrals to Allied Health - tailored specifically for elderly subacute patients. The initiatives were well supported, based both on the responses of multidisciplinary staff within surveys and interviews, and on their ongoing acceptance and utilisation. Covert observation within meetings identified high levels of quality in communication and general care-planning, attention to patient function, efficiency, and participation by Allied Health clinicians.

These strategies are relevant to any care-planning process and, generally, are easily adopted.

Key dates

Apr 2022

Implementation sites

Darling Downs Hospital and Health Service

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Aim

Enhance patient care processes, Allied Health clinician satisfaction and patient outcomes for subacute elderly patients with Darling Downs Health.

Benefits

Multidisciplinary staff perceived that the strategies had facilitated:

- better communication
- better teamwork
- better identification of functional loss for patients
- identification of patients at high-risk
- improved prioritisation of patients requiring Allied Health care
- improved overall planning of patient care
- reduction in the risk of patient re-admission

Background

Multidisciplinary care planning and initiation for patients under General Medicine teams at Toowoomba Hospital was challenging, with referrals that were often delayed, lacking in detail or inappropriate; team care-planning discussions could be irrelevant, inefficient and repetitive; issues relating to patient function were not recognised; care-planning did not address how to reduce re-admission risk; and Allied Health staff felt under-valued and over-criticised and that their collective voice was not being heard.

Solutions Implemented

A clinical redesign framework was utilised to collaboratively analyse current systems and processes, identify key underlying problems, prioritise issues that could be realistically addressed, and design and trial solutions. Specific activities included Big Picture Mapping, Root Cause Analysis, analysis of systems data, staff surveys and interviews, a patient and carer focus group, and behavioural mapping. Inclusion of clinical leaders across Medical, Nursing and Allied Health was crucial.
The solutions included:
1. An evidence-based format for care-planning discussions which allocated specific sections for Medical, Nursing and Allied Health clinicians. This format also contained directions towards patient function and reduction of re-admission risk.
2. Creation of a weekly meeting schedule for each General Medicine team, combining weekly 30-minute multi-disciplinary team meetings (optimally timed for each team's day of intake) and 15-minute huddles on the remaining four days of the week.
3. Implementation of new sticker documentation for multidisciplinary team meetings, with content that was specifically aligned with the new meeting format (see above).
4. Environmental strategies: all meeting attendees to; sit at a large central table; place a discipline nameplate in front of them during meetings, and; wear their name badge.
5. Extension of a senior, transdisciplinary Allied Health role ('Allied Health Clinical Leader - Hospital Operations Centre') to provide over-arching expert clinical guidance, as well as leadership, advocacy and support for all Allied Health clinicians attending all multidisciplinary meetings. This role is also responsible for ongoing monitoring of compliance with the meeting strategies as well as orienting and education any new medical or Allied Health staff.
6. Provision of a training session to Medical Officers to enhance their self-efficacy and capacity to complete appropriate, detailed and timely referrals to Allied Health. The creation of a PowerPoint resource tailored specifically for elderly subacute patients and aligned with updated referral criteria for each Allied Health and the utilisation of a smartphone app supported this strategy.
7. Creation of Allied Health staffing models within each discipline to optimise a single clinician's first-hand awareness of patients under each General Medicine team (this strategy was limited it its ability to be utilised, given associated inefficiencies in providing patient care).

Evaluation and Results

There was good evidence that the strategies led to enhanced multidisciplinary teamwork, communication, and care-planning. Comparisons of Allied Health clinicians' responses on repeat survey items from pre- to post-implementation identified significant improvements in care-planning processes:
- Planning of patient care is useful/appropriate: 'strongly agree' 16.7% to 45.8%
- Planning of patient care is timely: 25.0% to 63.7%Within the multidisciplinary survey, utilisation of a specific format for multidisciplinary meetings was identified as being effective in that it 'enabled better identification of functional loss' (65.3% agreed or strongly agreed), it 'helped identify patients at high-risk of poor outcomes and/or re-admission' (80.0%) and led to 'improved overall planning of patient care' (74.2%). Survey responses also suggested that collaborative functioning of the multidisciplinary team was enhanced - there was consensus that the utilisation of a specific format facilitated better communication (74.2%), teamwork (73.3%) and participation by all team members (66.5%). This is supported within the Allied Health staff surveys, with 63.3% reporting that it 'helped me to contribute to the discussions'. In regards to the environmental strategies, communication and teamwork appear

to have been directly and positively impacted - the majority of respondents either strongly agreed or agreed that changes to the environment had facilitated better communication (67.6%) and participation by all team members (61.3%) and created better awareness of team members and their roles (77.4%). Covert observations provided independent confirmation that meetings were functioning at a high level: the quality of communication (mean = 4.55/5); participation by AH attendees (mean = 4.55/5); efficiency (mean = 4.64/5); quality of care-planning (mean = 4.64/5); attention to patient function (mean = 4.64/5), and; overall effectiveness (mean = 4.55/5). Attendance of Allied Health clinicians at multidisciplinary meetings was also observed to be generally high following the implementation of the strategies, particularly for the larger teams: Social Work 83.9%, Occupational Therapy 96.8% and Physiotherapy 100%.The development of a senior transdisciplinary Allied Health support role was perceived to be effective - multidisciplinary respondents reported that this strategy had facilitated better care planning (77.4% strongly agreed or agreed) and helped to maintain consistent processes within meetings (74.2%). Amongst Allied Health clinicians, 83%.32 agreed that utilisation of this role had 'supported Allied Health clinicians, for example, orientation for new staff, advocacy, prioritisation'•. Overall more than half (58.3%) of multidisciplinary staff believed that the multidisciplinary meetings were more effective following the introduction of the strategies. Moreover, the strategies were accepted for ongoing use by all General Medicine teams, across multiple wards, with high rates of endorsement:

- use of a specific format for multidisciplinary meetings (81.48% 'strongly supported' or 'supported')
- environmental strategies (77.78%)
- expansion of the Allied Health Clinical Leader role (77.78%)
- a weekly schedule for meetings (55.55%)
- utilisation of teams-based Allied Health staffing models (59.26%)Support for ongoing use of sticker documentation was less clear (44.44%, with 28% neutral) and as a result, subsequent modifications to the sticker documentation process have been made in response to feedback. Allocation of Allied Health staff to medical teams was not universally supported (59.30%). Behavioural mapping data highlighted the inefficiencies in this staffing model: compared to a co-located medical ward, this model was associated with marked increases in travel time between wards (+56 minutes per day) and waste activities (+64 minutes), with reductions in face-to-face care (-43 minutes).In regard to referrals to Allied Health, there was positive feedback about the training activity that was completed: 75.0% of attendees rated the effectiveness of the presenter as either 'quite' or 'extremely' effective and 92.8% of attendees indicated that they had better awareness of how (to use the 'Med App') to make better referrals. A repeat referral audit post-implementation demonstrated, however, that quality of referrals to AH still need to improve further.