A Lean Thinking Approach to Redesigning Care

Janet Compton
General Manager
Peter James Centre and Wantirna Health
In February 2007 the Peter James Centre began a comprehensive program of deliberate improvement to redesign the Model of Service Delivery.
Peter James Centre & Wantirna Health

- Peter James Centre
  - 158 beds including Rehabilitation, Geriatric Evaluation and Management (GEM) and Aged Person’s Mental Health (APMH)
  - Ambulatory and Home Based Rehabilitation

- Wantirna Health
  - 60 beds, GEM and Palliative Care
  - Ambulatory and Home Based Rehabilitation

- Residential Care
  - 90 High care and 30 Low Care beds

- Transition Care
  - 66 beds, 22 Community places
Project Objectives

Patient objectives:
- Improved safety and quality of care
- Improved satisfaction with the care they are provided
- Better patient and/or carer involvement in care planning and decision making

Staff/provider objectives
- Improved staff satisfaction
- Greater degree of clinical specialisation and clinical clustering

Organisation objectives
- Maintenance or improvement in current occupancy rates
- Improved access
- Increased efficiency and effectiveness of care and services
The Change Management Process

Forces against change
- Pressure for Change
- Leadership

Competing Interests
- Vision of desired future state

Lack of Focus
- Capacity for Change
- Active Change Management
- Integration into the organisation

Relative Importance
- Reinforcement & Consolidation

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Pressure for Change

Forces against change

Competing Interests

Lack of Focus

Relative Importance

Vision of desired future state

Capacity for Change

Reinforcement & Consolidation

Forces for change

Leadership

Active Change Management

Integration Into the organisation

= Bottom of the in-tray
Pressure for Change

GEM LOS 2005/06

GEM AVERAGE ADMISSION AND SEPARATION BI SCORES 2005/2006
Forces for change

- Dissatisfaction with the Current State
  - team processes,
  - workload,
  - team meetings,
  - role delineation between disciplines,
  - lack of specialisation and subsequent lack of career path,
  - lack of input into decision making,
Forces Against Change

When faced with a choice between changing and proving there’s no need to change, most people get busy on the proof.

John Kenneth Galbraith
Vision of desired future state

Forces against change

Competing Interests

Lack of Focus

Relative Importance

Pressure for Change + Capacity for Change + Reinforcement & Consolidation = Fast start that fizzes

Forces for change

Leadership

Active Change Management

Integration Into the organisation
Clear Vision

The Model of Service Delivery:

- is person centred and co-ordinated across the continuum;
- is of high quality, effective and safe;
- supports team work and staff satisfaction;
- optimises the use of resources and monitors performance
Leadership

- Maintaining the big picture view;
- Commitment of resource;
- Clear expectation that there would be an outcome;
- Supported facilitators & teams and trusted them;
- Encouraged risk taking;
- Encouraged and gave permission to participate in the process;
- Celebrated successes;
Capacity For Change

Forces against change

Competing Interests

Lack of Focus

Relative Importance

Pressure for change + Vision of desired future state + Reinforcement & Consolidation = Anxiety & False starts

Forces for change

Leadership

Active Change Management

Integration Into the organisation
Strategy for Change

Monitor and provide feedback
Identify area of concern

Project Definition Phase

Sustaining Improvement Phase

Intervention & Impact Phase

National Action Plan knowledge resources

Diagnostic Phase

Analyse current state
Identify opportunities for improvement

Determine possible interventions
Define performance measures
Determine implementation strategies

Plan a change
Do it in a small test
Check its effects
Act on the results

Measure the impact

Reference: The clinician’s toolkit for improving patient care. NSW Health; 2001
Active Change Management

- Australian Continuous Improvement Group (ACIG) were engaged to bring the method and experience of deliberate improvement to the project.
  - Supported and mentored facilitators
  - Kept the process on track.
  - DID NOT find the solutions or make the recommendations.
The projects

- Project Definition Phase
- Diagnostic Phase
- Intervention & Impact Phase
- Sustaining Improvement Phase

Monitor and provide feedback
Identify area of concern

- National Action Plan knowledge resources

- Analyse current state
- Identify opportunities for improvement
- Determine possible interventions
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Plan a change
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Project Definition

The patient’s journey

- Access
- Assessment
- Care Planning & Implementing
- Discharge
The D.I.A.G.N.O.S.E. Method

Define the Issues
Collect Information
Analyse Causes
Generate Solutions
Implement New Processes
Check Outcomes
Sustain the Effort
Diagnostic Tools

Process Tools
- Process Mapping
- Stakeholder Analysis
- Surveys

Data Tools
- Audits
- Analysis of Documentation
Issues & Evidence

Referrals Missing Information
- 53% no medications,
- 78% no GP details

Rework
- 45 minutes collecting data

Inappropriate Referrals
Last Week’s TERRORIST ATTACK

[Handwritten diagram with connections between words such as 'Access', 'Assessment', 'Care Planning & Implementing', and 'Discharge', and terms like 'Doctors', 'Nurses', 'Social Work', 'Pharmacist', 'Caregivers', and 'Physician'].
<table>
<thead>
<tr>
<th>Data Field</th>
<th>No. of Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Hx</td>
<td>16</td>
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<tr>
<td>Past Hx</td>
<td>14</td>
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<tr>
<td>Goals</td>
<td>12</td>
</tr>
<tr>
<td>Transfer Skills</td>
<td>10</td>
</tr>
<tr>
<td>Strength</td>
<td>8</td>
</tr>
<tr>
<td>ROM</td>
<td>6</td>
</tr>
<tr>
<td>Medication</td>
<td>5</td>
</tr>
<tr>
<td>Gait Tests</td>
<td>4</td>
</tr>
<tr>
<td>Mobility</td>
<td>3</td>
</tr>
<tr>
<td>Mobility/Discomfort</td>
<td>2</td>
</tr>
<tr>
<td>Pain &amp; Discomfort</td>
<td>2</td>
</tr>
<tr>
<td>Elimination/Bowels</td>
<td>2</td>
</tr>
<tr>
<td>Vision/Swallowing/Person to Contact</td>
<td>2</td>
</tr>
<tr>
<td>Nutrition/Food/Hygiene</td>
<td>2</td>
</tr>
<tr>
<td>Functional Activities</td>
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</table>

- **47 forms**
- **215 data fields**
# Weekly Team Meeting Statistics

<table>
<thead>
<tr>
<th></th>
<th>East Ward</th>
<th>Centre Ward</th>
<th>West Ward</th>
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</thead>
<tbody>
<tr>
<td>Meeting Length</td>
<td>2.2 hrs</td>
<td>3.3 hrs</td>
<td>3.8 hrs</td>
</tr>
<tr>
<td>Staff Hours</td>
<td>34.5 hrs</td>
<td>26.5 hrs</td>
<td>46.8 hrs</td>
</tr>
</tbody>
</table>

Total staff hours = 107.8 per week

= $5390 per week

### Communication about care

<table>
<thead>
<tr>
<th></th>
<th>Verbal information</th>
<th>Written information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- [Graph showing communication breakdown]
Issues & Evidence

- 7 different discharge summaries
- Only the medical discharge summary routinely sent to GP
- 15 different referral forms to other service providers
Recommendations

**Access**
- Implement an awareness raising campaign
- Determine criteria for admission to services
- Implement handover of information from Acute to Sub-acute
- Implement trial of nurse initiated admission
- Implement new communication practices

**Assessment**
- Implementation of a single referral form
- Implementation of a single assessment form
- Determine the most effective way of providing information to patients
- Implement a standard method for disseminating assessment information

**Care Planning**
- Implement a single written patient care plan
- Develop key contact role for interdisciplinary team
- Redesign the team meeting process.

**Discharge**
- Implement an interdisciplinary approach to discharge planning, including a single discharge summary
- Reduce duplication of information
- Routinely call patients post discharge to evaluate effectiveness of discharge
Implementation Projects

PROJECT RECOMMENDATIONS

Access
Assessment
Care Planning & Implementing
Discharge

Single Assessment Process
Develop, implement and evaluate a single assessment process

Communication
Develop a communication process for patients and families

Team Meeting
Implement a team meeting process that is person centred

Goal Setting
Develop goal setting that is patient centred and clearly documented
A New Way of Thinking

Person Focussed Care

Patient

Doctor

Nurse

PT

OT

SW

SP

Person Centred Care

Patient

Doctor

Nurse

PT

OT

SW

SP

DT
Department of Human Services Policy
Improving Care for Older People

- Adopt a strong person-centred approach to the provision of care and services
- Better understand the complexity of older people’s health care needs
- Improve integration within Health Services’ community based programs and between Health Services and ongoing support services

Person centred goal setting tool

- Person focus not discipline focus
- Language to enhance patient input and interaction
- Functionally based aligned with Domains
- Links with all aspects of the patient journey
A single assessment document

- No unnecessary duplication of effort
- Reduced pressure on clients
- Targeted assessment
Key Contact Person

Communication Folder
Team Meetings now have

- a set Agenda to follow
- a designated Chairperson
- a Scribe to record the discussion
- guidelines on how to run meetings
Running effective meetings training

Documentation in line with patient goals
<table>
<thead>
<tr>
<th>Issue</th>
<th>How it was Then</th>
<th>What it is like now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Forms</td>
<td>47</td>
<td>7</td>
</tr>
<tr>
<td>Data Fields</td>
<td>215</td>
<td>75</td>
</tr>
<tr>
<td>Information Duplication</td>
<td>Up to 16 times</td>
<td>No unnecessary duplication</td>
</tr>
<tr>
<td>Goals</td>
<td>Discipline focused</td>
<td>Person centred, functionally based and multidisciplinary</td>
</tr>
<tr>
<td>Documentation of Team Meeting Outputs</td>
<td>Minimal</td>
<td>Clear, concise, in line with person centred goals and functional domains</td>
</tr>
<tr>
<td>Key Contact Person</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Results

<table>
<thead>
<tr>
<th></th>
<th>How it was Then</th>
<th>What it is like now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Separations</td>
<td>1315</td>
<td>1773</td>
</tr>
<tr>
<td>Average Length to Stay</td>
<td>26.56 days</td>
<td>24.84 days</td>
</tr>
</tbody>
</table>
Forces against change

Competing Interests

Lack of Focus

Relative Importance

Pressure for Change

Vision of desired future state

Capacity for Change

Leadership

Active Change Management

Integration Into the organisation

Revert to the old ways
It isn’t the change that does you in, it is the transitions.

**Change** is situational, the new boss, the new technology, the new building.

**Transition** is the psychological process people go through to come to terms with the new situation.
Change Champions
Reinforcement & Consolidation

Continuous Improvement

Plan
Do
Act
Check

Progress

Standardization

Time
Thank you.