HACC Case Study
A journey of change

From complex problems to step-by-step solutions

health

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About this story

A large part of moving towards an ASM approach is being able to take staff with you on the journey of 'change'. Change in mindset, change in assessment practice and service system redesign. A vital part of the process is being able to employ a range of staff and having strategies to undertake a continuous improvement approach. At times the tasks seem arduous and the goals insurmountable; however, it's important to keep an eye on the big picture and your focus on the person you're supporting.

The problem

Central Bayside Community Health Service (CBCHS) recently embarked on a change management project to improve the way it assesses clients. Too often staff at CBCHS were seeing clients with chronic conditions, complex issues and multiple needs accessing multiple service providers. CBCHS also saw an increase in referrals from HACC assessment services, which were increasingly complex. These clients were accessing services for a single problem and were consequently given an appointment with a single profession. While referrals may happen for other issues, there was a lack of teamwork and lack of centralised care planning across professions with shared client goals. This meant that many complex clients experienced either duplications in assessment or intervention or missed out on needed services. Many clients weren't given adequate support to pursue their own goals and interests outside the problem they presented with.

The solution

Over the past three years, CBCHS has improved its assessment process by introducing a common assessment. The new assessment was piloted and is now being rolled out across teams. The focus for the past 12 months has been on care planning and teamwork. While the common assessment will continue to be used to identify key issues and problems from the client's perspective, the real need is shared care planning in multidisciplinary teams.

The project

The current project focuses on care planning and teamwork. The overall aim is to build on the assessment project by adding an overarching coordinated care plan underpinned by teamwork. The care plan is developed collaboratively with the person and sets the overall direction, goals and desired outcomes of that person's care. A health practitioner is then appointed to lead the care planning process and act as a key contact for the person. All this work happens within a multidisciplinary team made up of the professions involved in providing that person's care. Case discussion is a key part of teamwork. This work has involved defining and developing tools and processes that will enable care planning to occur. It's about developing a shared understanding of person-centred care along with indicators that demonstrate it is occurring, rather than simply assuming it already happens. Interventions that support consumers to gain skills and confidence in managing their health are a key focus.

Pilot

The working group, made up of a representative of all professions or services in CBCHS, is now piloting the work that has been developed. Each working group member has nominated a client with complex needs accessing multiple service providers, forming a ‘mini team’ around the client. This ‘team’ will be responsible for trialling the common assessment, care plan and case discussion, thereby gaining valuable insights into how this approach could look and work.

The pilot group and staff involved in the mini teams were provided with training in client-centred care practices and techniques that underpin assessment and care planning. The strong focus is on better understanding how to care plan in a team, sharing client goals and being clear about each others’ roles in supporting clients to achieve their goals.

Plan, do, study, act (PDSA)

While the pilot sounds extensive, each month the working group sets a new goal that they will work on and achieve. This enables the work to be broken up into smaller tasks with a clear focus. PDSA cycles have been a great motivator, as staff can see progress each month. It makes the work more manageable and helps foster a ‘can do’ approach. Rather than implementing a change all at once, CBCHS can take it step by step, enabling people to ‘give new things a go’.

Implementing ASM

This work has been a significant support to implementing ASM. As a result of the broader work, it has allowed the occupational therapy team to move ahead in embedding an ASM approach to their work. It has also enabled clinicians to discuss how to go about assessment practices in different ways and identify opportunities for shared care planning.

The outcomes

Staff are beginning to see the value of changing the way they assess clients by asking different questions or asking them in different ways. They are beginning to see the value of team approaches and how this might enable them to work differently and more effectively with clients. For the occupational therapists particularly, assessment practice is different. This means that clients are asked more about the way they see the issues and what is important to them.

Reflection

Do you reflect on your assessment, care planning and practice?

Do you understand how the PDSA approach can be used for quality improvement in your organisation?

Do you make time to reflect on your achievements and communicate this to your team?

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