Care Plan Crusaders

Quality Improvement Project Report Out

TBA

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Define

Describe the area that you have focused on :

We have focused on the timing of Home Care Client Care Plan, having a consistent way that the Care Plan is created by the CC's so that all the Care Plans are created to look the same with all the information in the same areas of every Case Coordinators Care Plan.

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Define

PROBLEM STATEMENT

Our current care plan template are populated with inconsistent client information causing frustration of staff which makes them feel inadequate and overwhelmed in their role and may result in substandard quality of care

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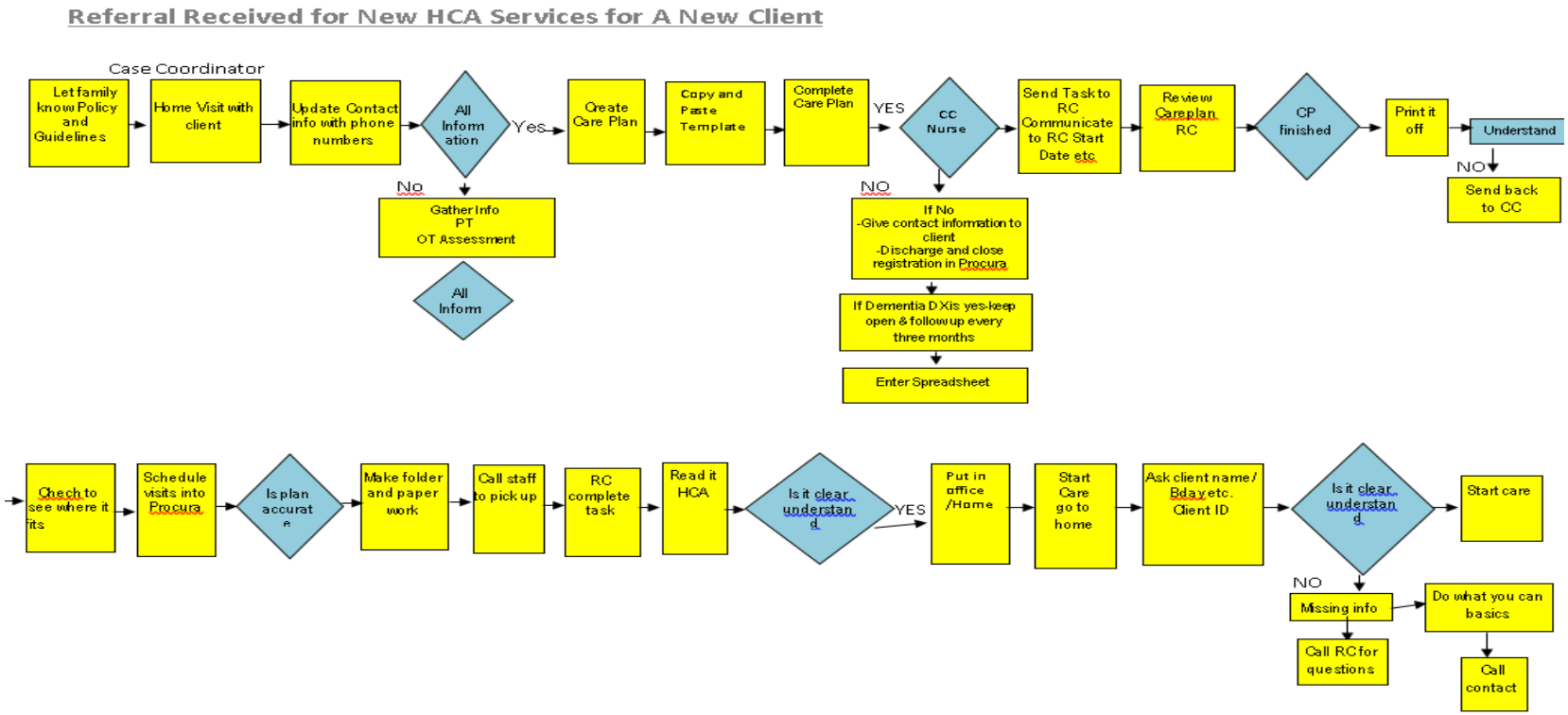
Current state process map.



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Communications Plan

	What questions do you think staff are going to ask?	Craft your response to those questions
1	What is the purpose of this?	To collect data on how everyone formats the Care Plans
2	How will this change anything?	It will give the team information about the average lengths of care plans and will show inefficiencies.
3	Why do I have to change how I create my care plans?	To provide consistency across the program and ensure HCAs can understand care plans and read them efficiently.

Questions and Answers

Problem Statement

Our current care plan templates are populated with inconsistent client information causing frustration of staff which makes them feel inadequate and overwhelmed in their role and may result in substandard quality of care

A3 Report

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Project Details

Organization	To find a standardized format to complete Care Plans		
Project Name	Home Care	Facility	Boundary Trails Health Center
Project Sponsor	Care Plan Standardization	Project Facilitator/Belt Level	Yellow
Project Start Date	Deb Harms/Lorelei Hale	Project Team	Care Plan Crusaders
	November 24, 2017	Project End Date	March 2018

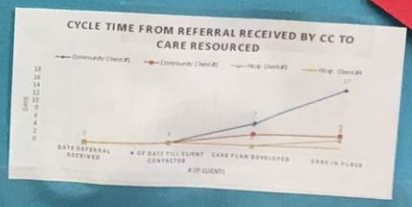
Problem Statement

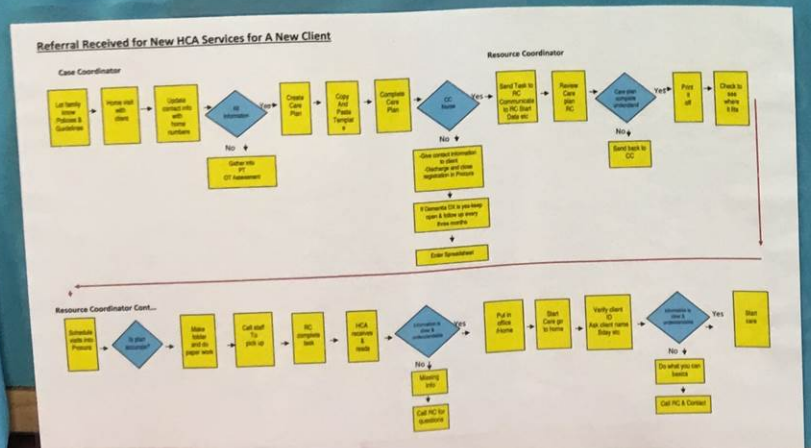
Our current care plan template are populated with inconsistent client information causing frustration of staff which makes them feel inadequate and overwhelmed in their role and may result in substandard quality of care

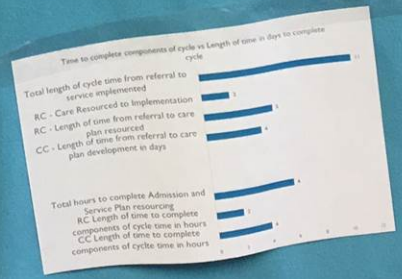
Current State Analysis : What's the Data Story?

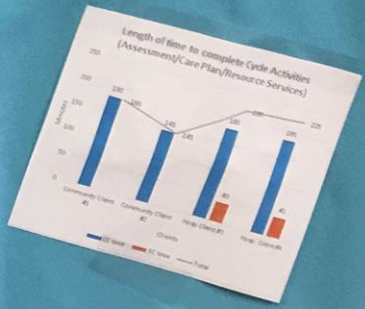
See process map and measurement plan, as well as attached RC/HCA defects

SHAZAM!









Organization	Southern Health Santé Sud
Facility:	Regional Home Care
What is being measured? (what defect, reason or cause)	Care Plan Process and Format
Department / Unit / Location:	Home Care Resource Coordinators

Date	Shift	Defect or Reason / Cause	Count	Total
Mar. 21, 2011	D	Ran out of supplies (this row is an example)	||||| ||||| ||||| |||	18
		Care Plan to Wordy/too many details		
		Care Plan outside the guideline		
		Unclear Language		
		In complete client information		
		Number of interruptions while inputting care		
		send back to CC's for changes		
		Ask CC's for clarification		
		Other		

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HCA Measure

Organization	**Southern Health Santé Sud**
Facility:	Regional Home Care
What is being measured? (what defect, reason or cause)	Care Plan Process and Format
Department / Unit / Location:	Health Care Attendants

Date	Shift	Defect or Reason / Cause	Count	Total
Mar. 21, 2011	D	Ran out of supplies (this row is an example)	||||| ||||| ||||| |||	18
		Care Plan to Wordy/too many details		
		Contact unaware of duties		
		Unclear Language		
		In complete client information		
		Number of Procura errors (double bookings etc)		
		send back to RC's for changes		
		Ask RC's for clarification		
		Client not aware of visit times or changes		
		Missing Med or flow sheets		

Measurement Plan

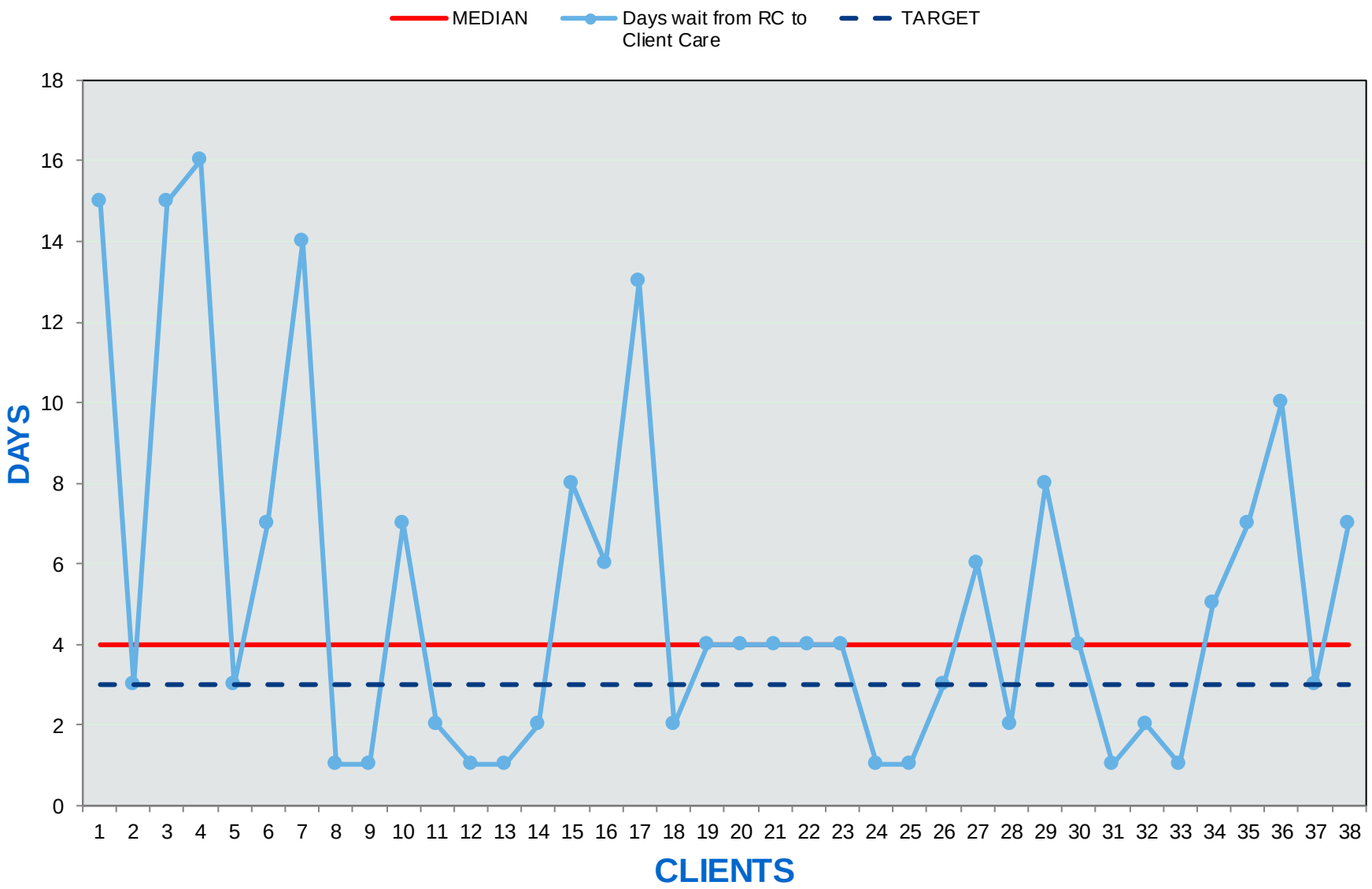
Prepared By:

Organization:	Southern Health/ Sante Sud
Facility:	Home Care Resource Coordinators
Project:	Care Plan Standardization

What?	How?	Where?	Who?	When?
What is being measured?	How will you track the measurement? Tracking sheets, observations, other? Do you need any items to measure? Clock, pedometer, etc.	On which unit/area will the data be collected?	Who is responsible for collecting the measures measurements?	When are the measures being collected?
Number of Care Plans created per Case Coordinator	Tracking Sheet	Selected Home Care offices in the region	Case Coordinators and Resource Coordinators	
Number of defects in Care Plan when it reaches the RC's Desk	Tracking Sheet	Selected Home Care offices in the region	Resource Coordinators	
Number of defects in Care Plan when it reaches the HCA	Tracking Sheet	Selected Home Care offices in the region	Health Care Aids	

Measurement Check Point #1:	
Measurement Check Point #2:	
Measurement Check Point #3:	

Run Chart RC to Care in Home :



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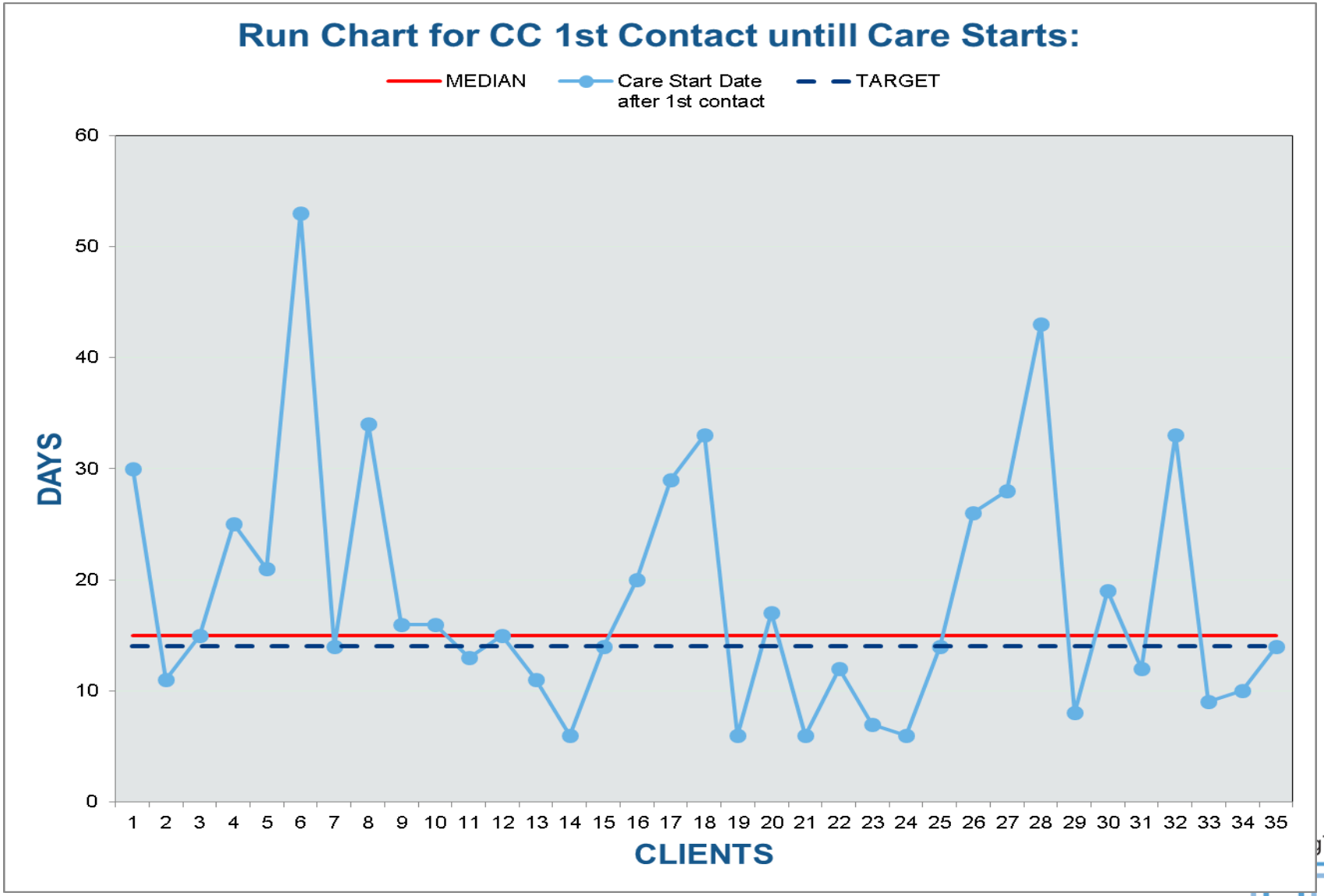
Analyze



Pareto Chart Template

1) Enter the defect / reason / cause in the first column
2) In the second column, enter the frequency (ie, the count) of the times that reason caused the problem.
3) You must "Enable Macros" for this to work. Press **"Ctrl"+"Shift"+Y** (press all three buttons at the same time and your Pareto Chart will appear). If nothing happens, you may need to click on your security warning (above the spreadsheet) and click on "Enable this content".
4) Enter the title of the Pareto Chart in the space provided on this sheet and, on the actual Pareto Chart.

Defect or Reason	Frequency
Incomplete Client Information	1
Contact unaware of duties	3
Care Plan to wordy/to many details/not enough	1
Unclear language	2
Number of Procura Errors	1
Sent back to RC for changes	4
Ask RC for clarification	4
Client not aware of visit times/changes	6
Missing Med/Flow sheets	4
Other	1

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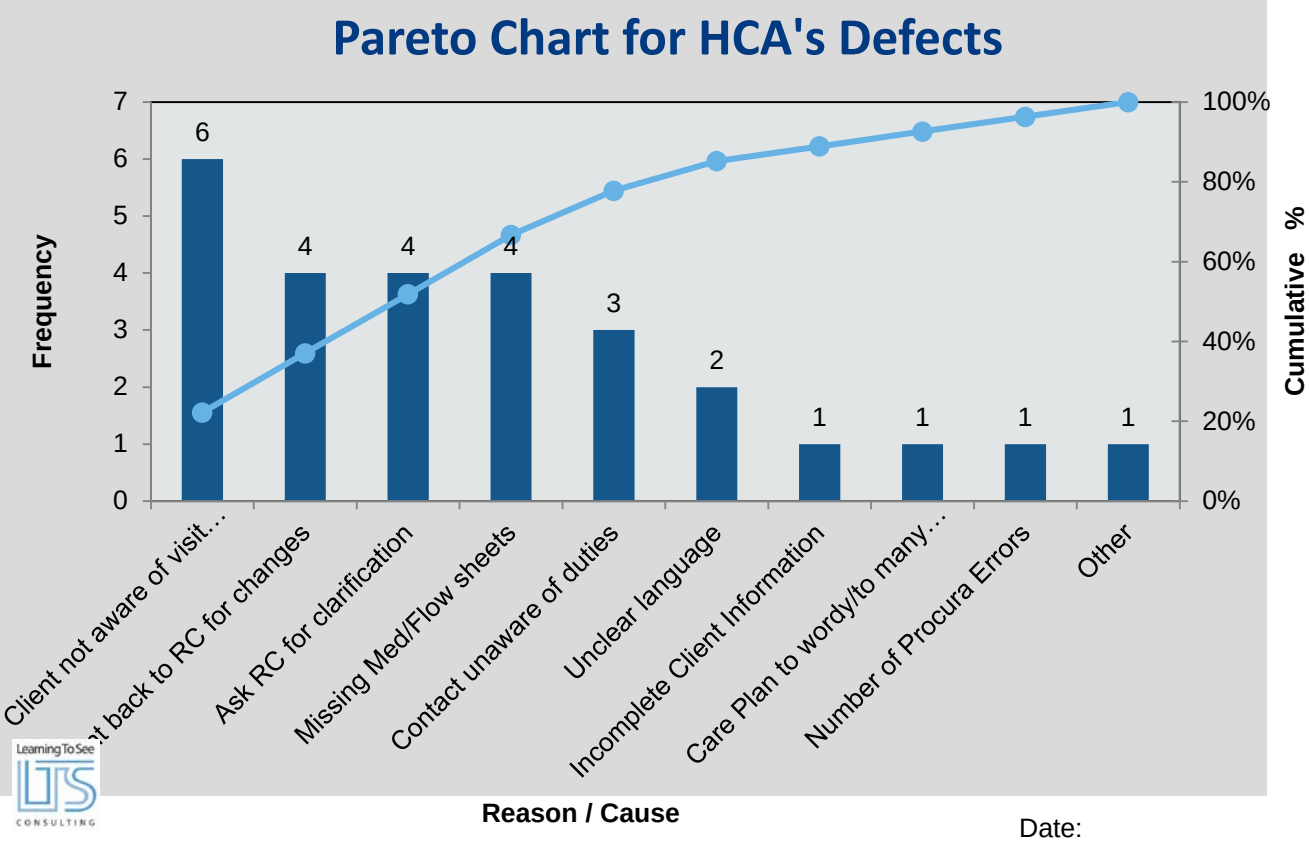
Analyze



Date:

Resource Coordinator Defect Data

1) Enter the defect / reason / cause in the first column
2) In the second column, enter the frequency (ie, the count) of the times that reason caused the problem.
3) You must "Enable Macros" for this to work. Press **"Ctrl"+"Shift"+Y** (press all three buttons at the same time and your Pareto Chart will appear). If nothing happens, you may need to click on your security warning (above the spreadsheet) and click on "Enable this content".
4) Enter the title of the Pareto Chart in the space provided on this sheet and, on the actual Pareto Chart.

Defect or Reason	Frequency
Care Plan to wordy/to many details/not enough	1
Care Plan outside of guideline (Emails sent instead of tasks)	5
Unclear language	0
Incomplete client info	1
Number of interuptions while inputting (Average)	10
Care Plan sent back to CC (changes needed)	4
Clarification needed from CC	3
Other	9

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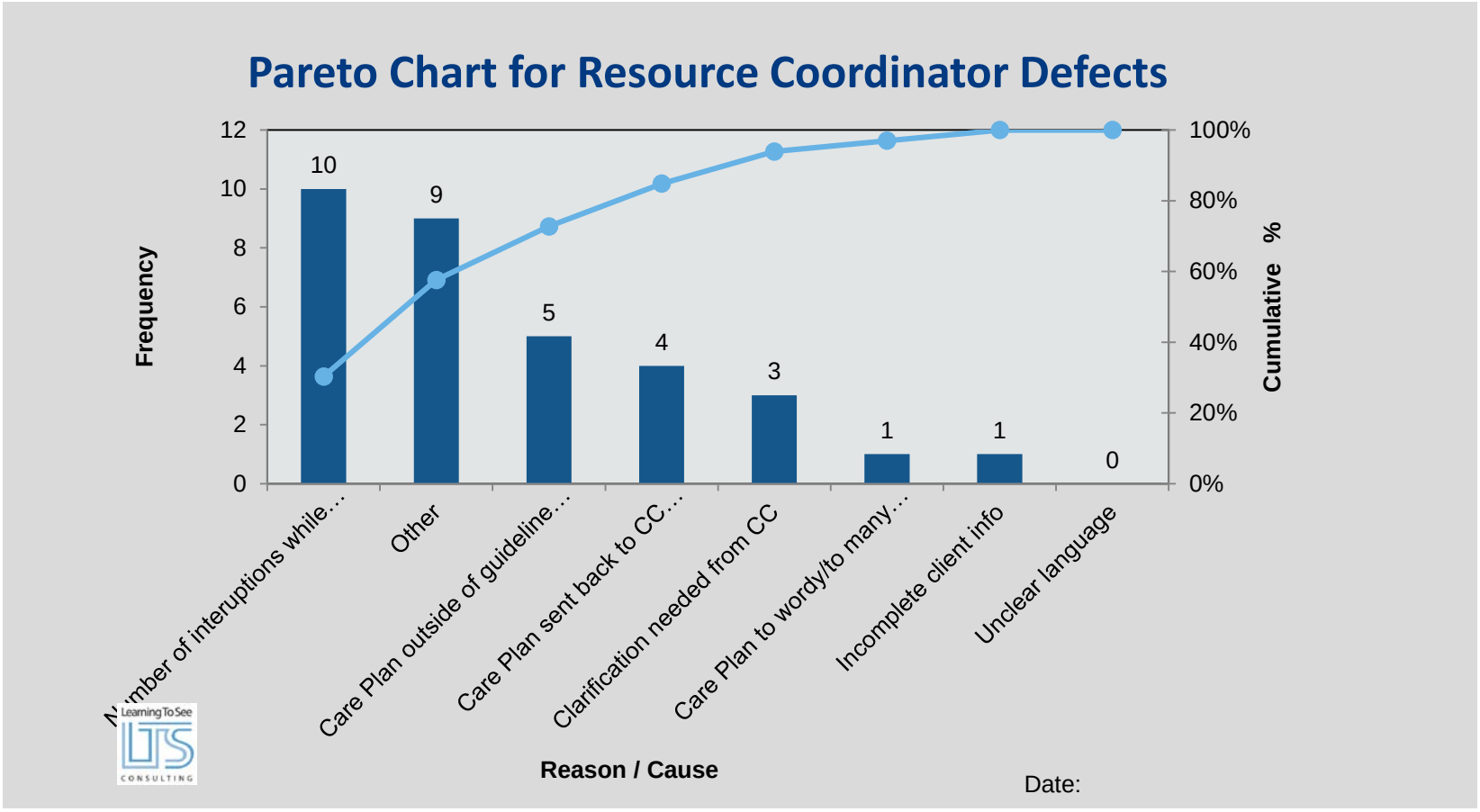
Pareto Chart for Resource Coordinator Defects
Frequency
Cumulative %
12
10
8
6
4
2
0
100%
80%
60%
40%
20%
0%
10
9
5
4
3
1
1
0
Number of interuptions while…
Other
Care Plan outside of guideline…
Care Plan sent back to CC…
Clarification needed from CC
Care Plan to wordy/to many…
Incomplete client info
Unclear language
Reason / Cause
Date:

Measures of Central Tendencies

	Amount of Days	Number of Care Plans
Mode 1	6	4
	7	1
	8	1
	9	1
	10	1
	11	1
	12	1
	13	1
Mode 2	14	4
	15	2
	16	2
	17	1
	18	1
	19	1
	20	1
	22	2
	23	1
	25	2
	28	1
	33	2
	36	1
	53	1

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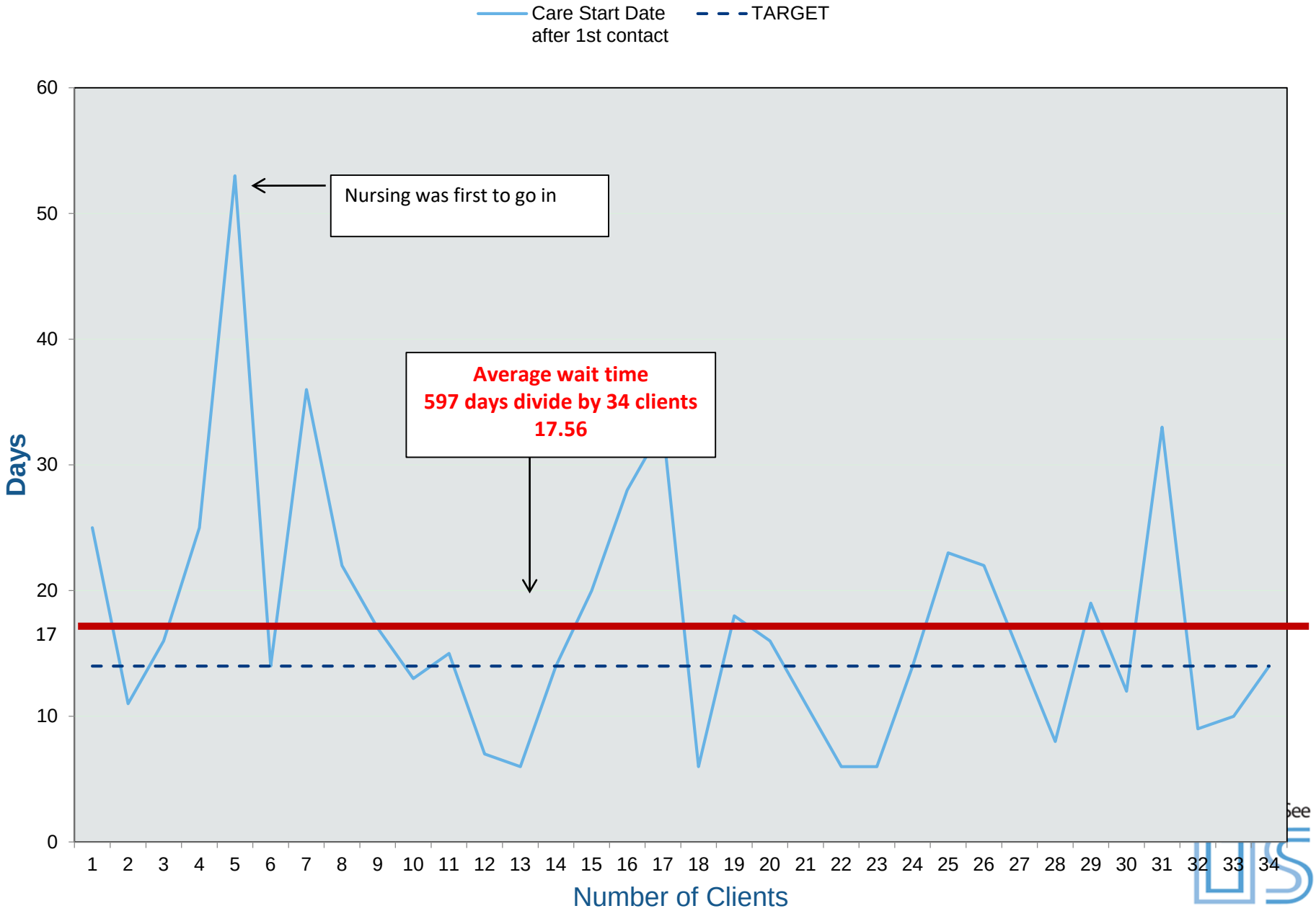
Total Days from CC to Care starting in Clients Home



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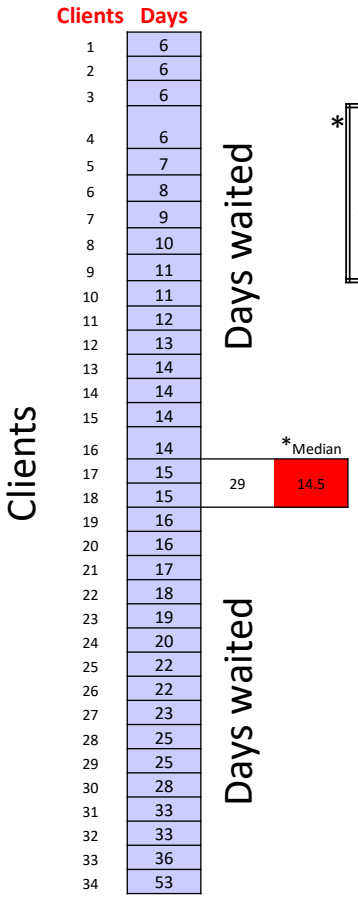
Analyze



Clients	Days
1	6
2	6
3	6
4	6
5	7
6	8
7	9
8	10
9	11
10	11
11	12
12	13
13	14
14	14
15	14
16	14
17	15
18	15
19	16
20	16
21	17
22	18
23	19
24	20
25	22
26	22
27	23
28	25
29	25
30	28
31	33
32	33
33	36
34	53

MEDIAN

* The middle most values added together and divided by 2. This gives us the Median

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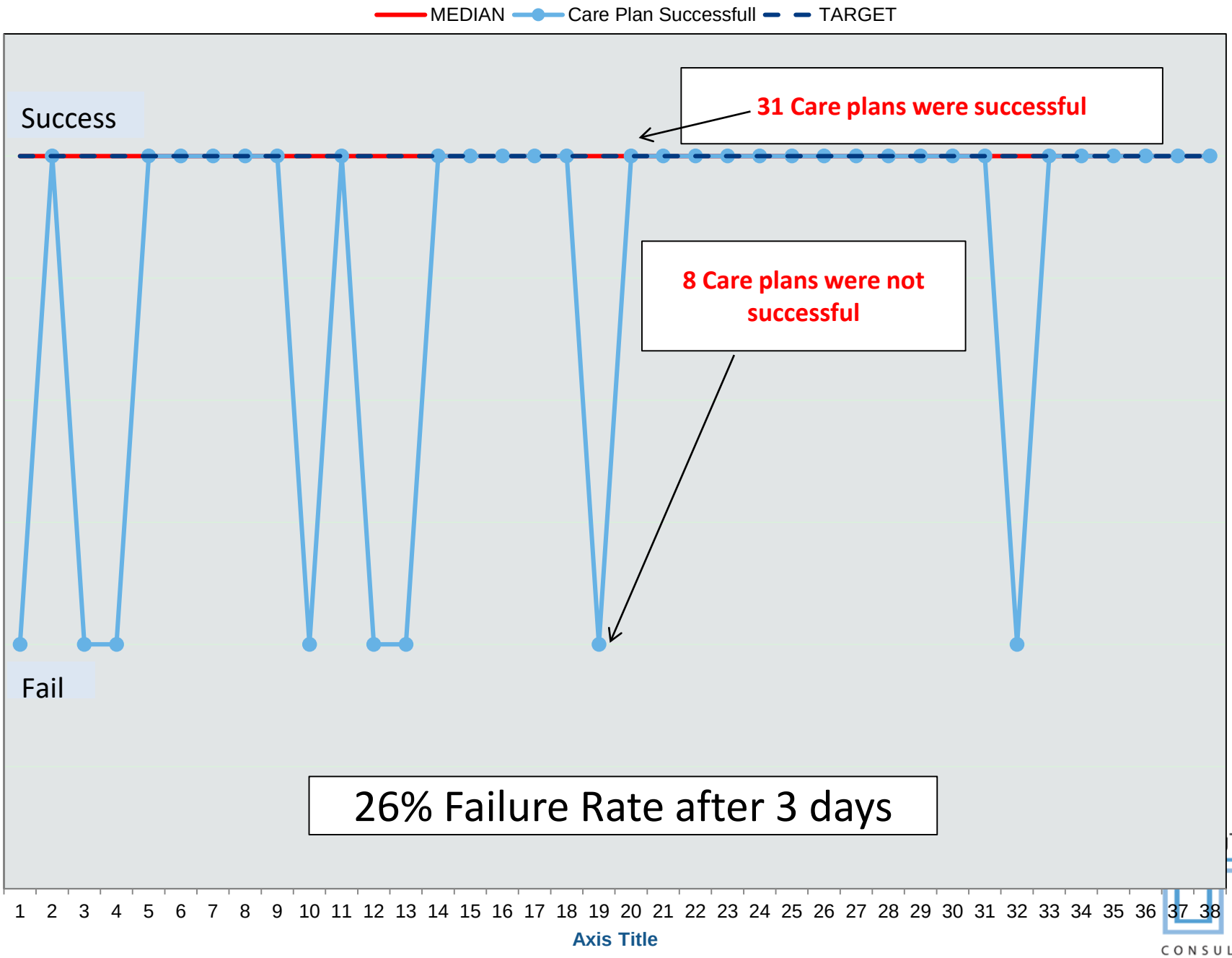
Run Chart RC to Care in Home :



Comments from CC's and RC's

RC left verbal message for CC Claudia Penner Wed, Mar 21/18 "Client needs grab bar on wall across from shower head or different bath chair. To weak to be stepping into and out of."	
Care plan needs to be updated to tub bath due to family providing a safe tub chair. Verbal message left for Claudia Penner on Wed Mar 21.	When RC called family to notify of bath day and time, daughter mentioned that CC stated a safe bath chair needed to be provided until then, client would have a sponge bath. At time of call, bath chair had been provided. RC gave HCA direction to give tub bath is she felt chair was safe.
	Moisturizing lotion actually prescription, not OTC. Client ++ uncomfortable with peri care. Discharge pending delivery of Hosp Bed. RC started care plan and made blue folder. Left specific instructions for CC Glenda re: what needed to be done as RC away
Cancelled due to weather	
DSN will go in Feb 26 AM visit t HCA to begin @ HS	Client was 1st seen by DSN for Coban Treatment
March 24 2018 RC notified client of start date and time and client forgot	
	Waited to hear back from CC re: bath equipment as per task. Hadn't so I scheduled clients' bath on March 22nd. CC notified family RE: bath and equipment.
	Waiting to get medication info from the Dr. in order to schedule DSN to go in Feb 22/18
	Client MN and JN are a married couple-scheduling was done for both clients.
HCA reports she really does not need escorts	
!st visit was a disaster. Client had to be lowered to the floor, can't walk. No wheel chair, or transfer belt.	
As of Thursday April 4 we already need to remove noon and early PM visits	
HCA had a few comments see attached.	
March 24, 2018 careplan directs to ensure supper med, there are no supper meds in blister pac. HS meds in Blister Pac, care plan does not direct to ensure HS Meds.	
Care plan needs to be updated to tub bath due to family providing a safe tub chair. Verbal message left for Claudia Penner on Wed, Mar 21 RE: below. When RC called family to notify of bath day and time, daughter mentioned that CC stated a safe bath chair	
Family was not available to meet for WASA until Feb 22/18 therefore Care Plan could not be sent sooner to RC.	
Referral received by coverage during CC's sick leave on Jan 12 and no action tajken during CC's absence. Appointment scheduled twice (Feb 1 & 9) by CC after return from sick leave but client cancelled both times due to illness.	
No referral yet	Carrie sent a email along with this saying that Diana did not know to fill out the first part
Client admitted back into hospital 2 days later	
Increased care as of March 16/18	
Removed bath after 1st week as does his own. Issues with cream	
April 28 got notification client not going home	
No confirmed discharge date from hospital yet.	
Started off with Friday visit but did not work for family. Worked out better for Weds visits.	
Going to see client for med ensure and clients had no meds for first visit, meds there for 2nd visit, 3rd visit blister pack was missing unable to give meds.	
equipment in place	
April 18 client left mas with HC, mesg forwarede to Claudia Pn	
All good 1st Bath no issues 2nd bath 02 tank issues	

Improve

Aim statement

Increase our target 80% of all clients will receive care, within

3 to 4 days of receiving care plan. to implementation of care,the care plan and date set to complete the (WASA) are all in place prior to RC starting the implementation of care.

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Improve

PDSA 1

Description
Case Coordinators will not send over the task for a new Care Plan until it is complete and the client is ready for Home Care, or has a definitive start date.

Date implemented : July 23, 2018

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Improve

PDSA 2

Description
That all Case Coordinators use the approved standardized Care Plan format.

Date Implemented: July 23, 1018

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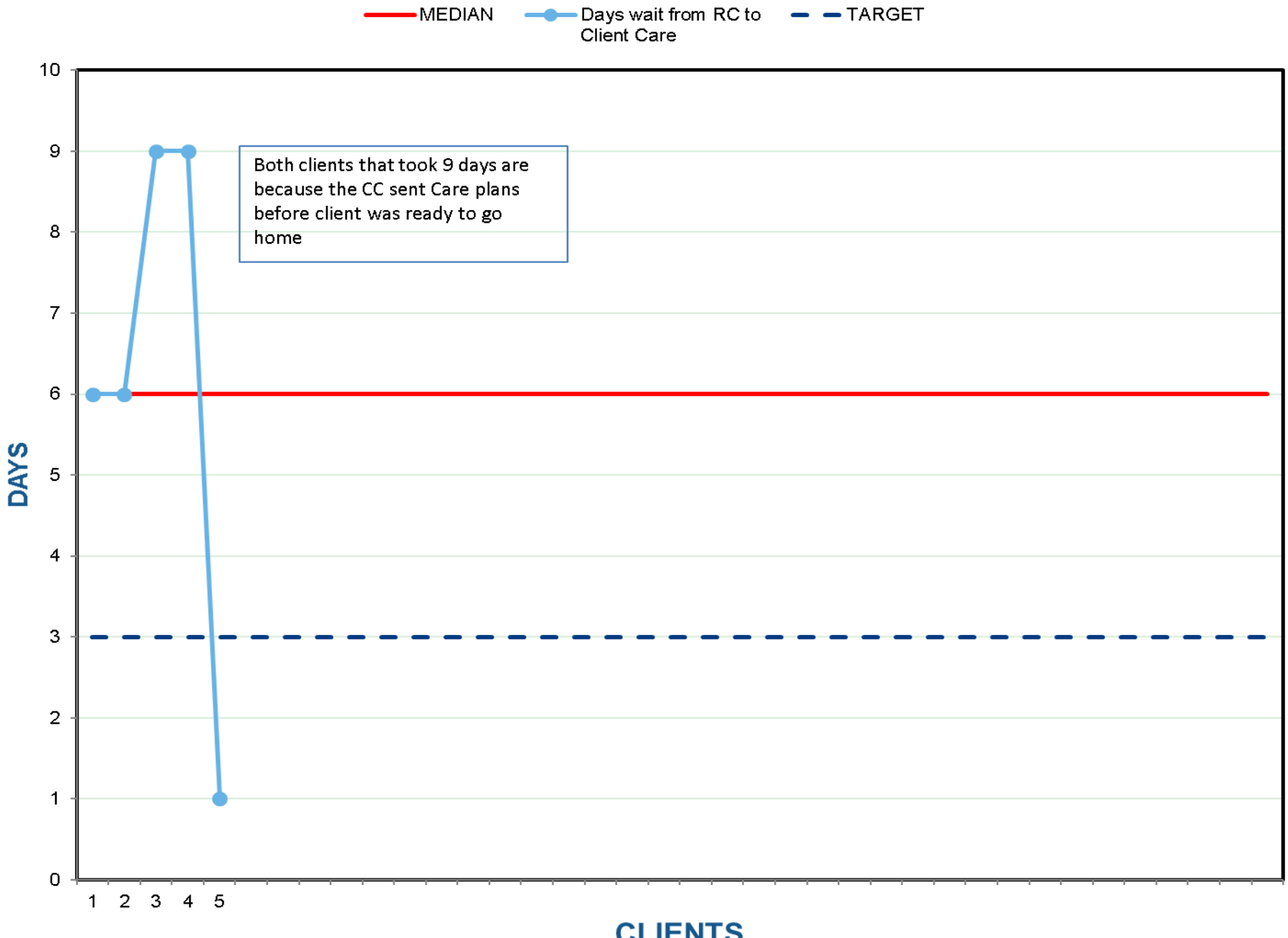
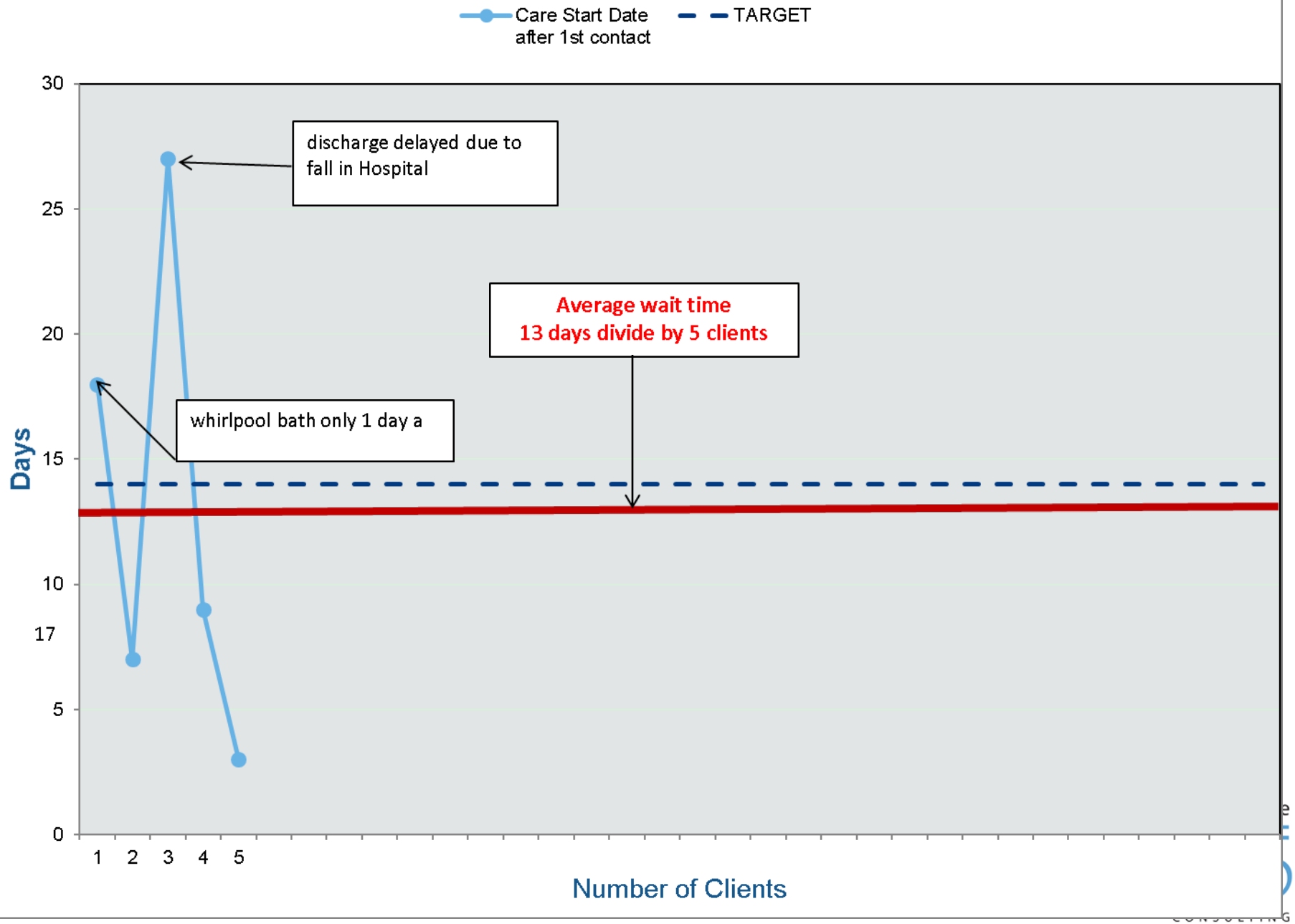
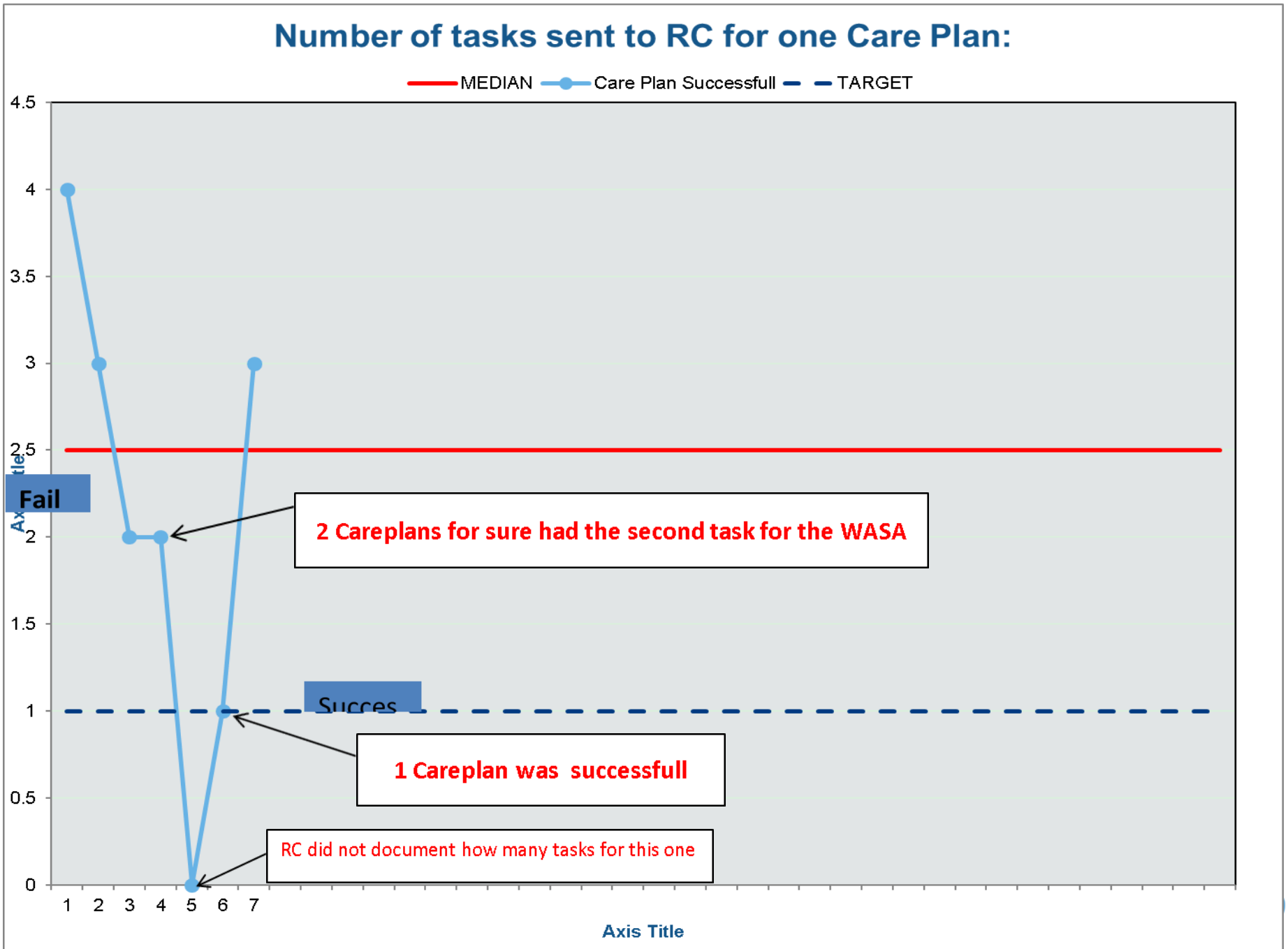
Run Chart RC to Care in Home :



Total Days from CC to Care starting in Clients Home




Number of tasks sent to RC for one Care Plan:
MEDIAN
Care Plan Successfull
TARGET
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
1 2 3 4 5 6 7
Axis Title
Fail
Succes
2 Careplans for sure had the second task for the WASA
1 Careplan was successfull
RC did not document how many tasks for this one

Improve

Aim statement

Increase our target 80% of all clients will receive care, within 3 to 4 days of receiving care plan, to implementation of care, the care plan and date set to complete the (WASA) are all in place prior to RC starting the implementation of care.

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Improve

Summary of the improvement data.

- *I did not receive any information back from the RC's regarding the change to how the Care Plans look.*
- *I personally saw change from my CC and noticed that some CC's were still putting to much information on the older care plans when changes needed to be done, they did not change to the new format.*
- *HCA's report that they found the new format much easier to read and it took them less time to read over the care plan when entering the home to provide care, giving them more one on one time with the client.*

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Improve

Staff comments and customer feedback on the improvements

- *CC's felt that is was going to take the RC longer to get care set up in the home.*
- *Many CC's did not change the way they sent the tasks to the RC's*
- *Most RC's were willing to try only starting to work on the new Care Plan when they knew the client was ready to head home or had a definite discharge date from facility.*
- *One RC thought that it was a good idea and when CC's are re writing care plan they should be implementing the revised process*
- *It was reported that some care plans are quite complicated so will result in longer than 5 pages*

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Improve

Improvements Achieved

Project Name: Care Plan Cusaders
Project Facilitator: Jodi McLean

Cost Savings	HCA s feel they will save 5min in each client's home by having less to read on the care plans: • 5min X 1057146visits per year= 5285730 ÷60 = 88095x $14.513 = $1,278,522 HCA untrained • 5min X1057164visits per year= 5285730 ÷ 60 = 88095 x $21.075 = $1,856,602 HCA trained RC's feel that they will save approximately 3hrs per care plan with the changes: • 3hrs x 1100 care plans per yr. =3300 x $31.418 = $103,679.40 CC's report that they feel they will save about 8min on each care plan when implementing the changes: • 8min x 1100 care plans = 8800 ÷ 60 = 146 x $ 40 = $5866.00 Total dollars annually to be reinvested inpatient care. . = $1,567,562 + $103,679 + $5866 = **$** 1,677,107
Patient Safety	•
Cycle Time	• We did not measure cycle times; we have figured out approximate cost savings after discussing with staff how much time they feel they will safe when these changes are made. See above cost savings.
Other……	•

Control

Standardize the Work in Care Plan Development and Care Plan Changes.

- *Policies and Procedures*
- *Check list: Case Coordinator admission note*
- *Audits*
- *Continue to measure*
  - *Admission of client through implementation of care is on CC audit*
  - *One task – measure quarterly*
- Training
  - CC training
  - HCA training
  - RC training
- Standard Work
  - Standard format for all Care Plans
  - RC's will not call in all changes to message managers, HCAs are expected to read all care plans at all visits.

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Lessons Learned

- *Case Coordinators experience challenges having to obtain discharge dates from hospital*
- *Some staff feel that they are being punished when they do thing the correct way*
- *Some feel that it will take longer and want a skeleton care plan to work on ahead of time*
- *Different employees preform functions differently at both the Case Coordinator and Resource Coordinator levels*
- *WASA is completed at a different time than the care plan so will result in two tasks*
- *Client status changes will affect the ability to have only one task for care plan*
- *HCA's feel the new format was an improvement*

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Next Steps

This new format will be implemented to all Case Coordinators and Resource Coordinators in the Southern Health Santé Sud over the next few months.

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The Team!

[*insert picture of team here*]

[*Jodi McLean, Joanne Picton, Doris Penner, Elva Dyck, Desiree Harder, Tanya Remple, Monica Piasta, Lorelei Hale, Debbie Harms and Ron Morrice*]

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