The team meeting in sub-acute in-patient services;
changing to an issues-based approach.

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Service overview

- Continuing Care sector, Sub-acute and Rehabilitation in-patient service
- 7 units across 3 sites – Kingston (Cheltenham), Dandenong Hospital, Casey Hospital (Berwick)
- 177 Sub-acute IP beds
- Large ambulatory care service

Sub-acute 2020 program

- Looking to the future and ….

  redesigning our care processes to ensure that we deliver the right care, in the right place at the right time.

- Care Planning & Transition Management

Review of clinical decision-making systems, processes and documentation for team meetings and ward rounds

Baseline Qualitative Study

The baseline qualitative study carried out with clinical staff in April/May 2005 showed, in relation to team meetings:

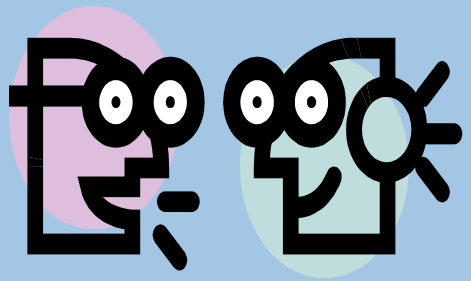
- team meeting processes are not articulated and were unstructured and inconsistent across units
- no structure to support patient-centred goal-setting, in spite of it being regarded as important
- Documentation was not uniform across all units
- staff do not base their practice on Models of Care
- an inconsistent approach to discharge planning

Previous practice

- Run by medical consultant in general
- Some teams had team meeting documentation; most wrote a summary into the progress notes
- Structure, if any, revolved around activity-level function
- Round-the-table circuit – each discipline spoke when asked and often just gave a report
- Only one team set goals

Why issues-based?

- Patient-centred not discipline-centred
- Top-down approach
- Focuses on patient issues that need to be resolved, outcome-focussed
- A complete issues list that is formulated early in the admission drives goal-setting and may act as a checklist



Patient Issues

"A list of patient-related issues that are barriers to discharge, rehabilitation issues, or barriers to participation in a rehabilitation programme."

- "Weight loss
- Depression – not eating, poor motivation
- Hip pain that prevents walking
- Currently PWB and requiring assistance
- Requires assist x1 for personal care
- Unable to prepare snacks or meals
- Falls risk
- Lives alone; daughter 1 hr away; ?stable d/ch destination"

Change process (1)

Working parties designed :-

1) Team meeting protocol: purpose, frequency, who attends, logistics (what is said/done, what is not said/done)

2) New team documentation supportive of Models of Care: patient issues list, patient/family communication sheet, team goal setting sheet

3) Processes outside the team meeting for formulating a patient-centred issues list

Change process (2)

- Education for staff
- Models of care (patient-centredness & ICF)
- New documents
- Simulated team meetings

- Project Manager attended team meetings

- Leadership Groups: modelling, mentoring

- Trial on 3 units → review/revise → re-implement

New practice

New patient:

1. Introduce the patient - Medical staff
2. List of patient issues -Key Liaison Person presents this to the team (completed by team members prior to the meeting)
3. Patient's needs/aims Key Liaison Person presents this, and those of family if approp. (gathered by KLP prior to the meeting)
4. Team 'unpackages' those needs/aims and discusses their own findings and expectations of outcome
5. Rehabilitation goals –formulated by the team in light of the above, informed by Issues List
6. KLP returns to patient/family and discusses plans and goals

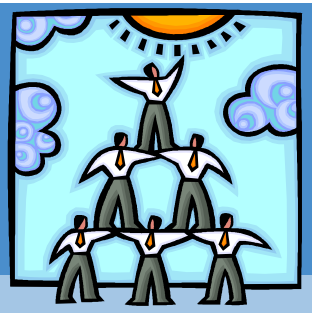
Results

- Hard for teams to switch from the ‘mobility, transfers, cognition, PADL, DADL’ etc to patient-centred issues
- Goal-setting in team meetings was popular and with education, successful
- Documentation that req’d completion prior to the team meeting often not done (e.g. the Issues List) – team processes outside the meeting are harder to change
- Highly dependent on senior staff in the team drawing team members into the new processes
- Now partially embedded

Challenges

- Contributing to a ‘team’ sheet before the team meeting
- Formulating patient-centred issues
- Staff reported they felt “offended” at the suggestion they might need help with managing the change. This implied they were expected to fail.
- Staff reported they wanted more ‘procedural’ training not background, models of care etc. Yet those who had difficulty with the theory and purpose of the change had greater resistance

Hints for success



- Remember you are changing the clinical reasoning process for a range of different clinicians – this is not easy!
- Get rid of all old documentation
- Decide how you will get a list of patient issues formulated
- Documentation must support the process
- Teams with structure already, do better
- Strong leadership and buy-in from senior staff on the team and discipline managers