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Southern Tasmania Area Health Service

Care Redesign Unit



Our Vision

Patients will receive quality care from a first class workforce.

Our Missions

Build capacity in our people for leading positive change.

Facilitate the development, implementation and delivery of quality care.

Our Strategic Objectives

Build capacity for positive change in our people.

Enable efficient and effective delivery of quality care for our patients.

Improve access to services for our patients.

Our Resources

Our relationships

Our people

Our information

Our networks

Our approach

We consult and involve you and your team so that you continue to own the process and the outcomes.

We build skills and capacity so that you and your team are empowered to make and sustain improvements in your workplace.

We encourage and enable you and your team to try new and better ways of working.

We help you and your team to evaluate your progress and introduce strategies to ensure you continue to improve.

We support you and your team to help you make improvements to the way you work.

Our Values

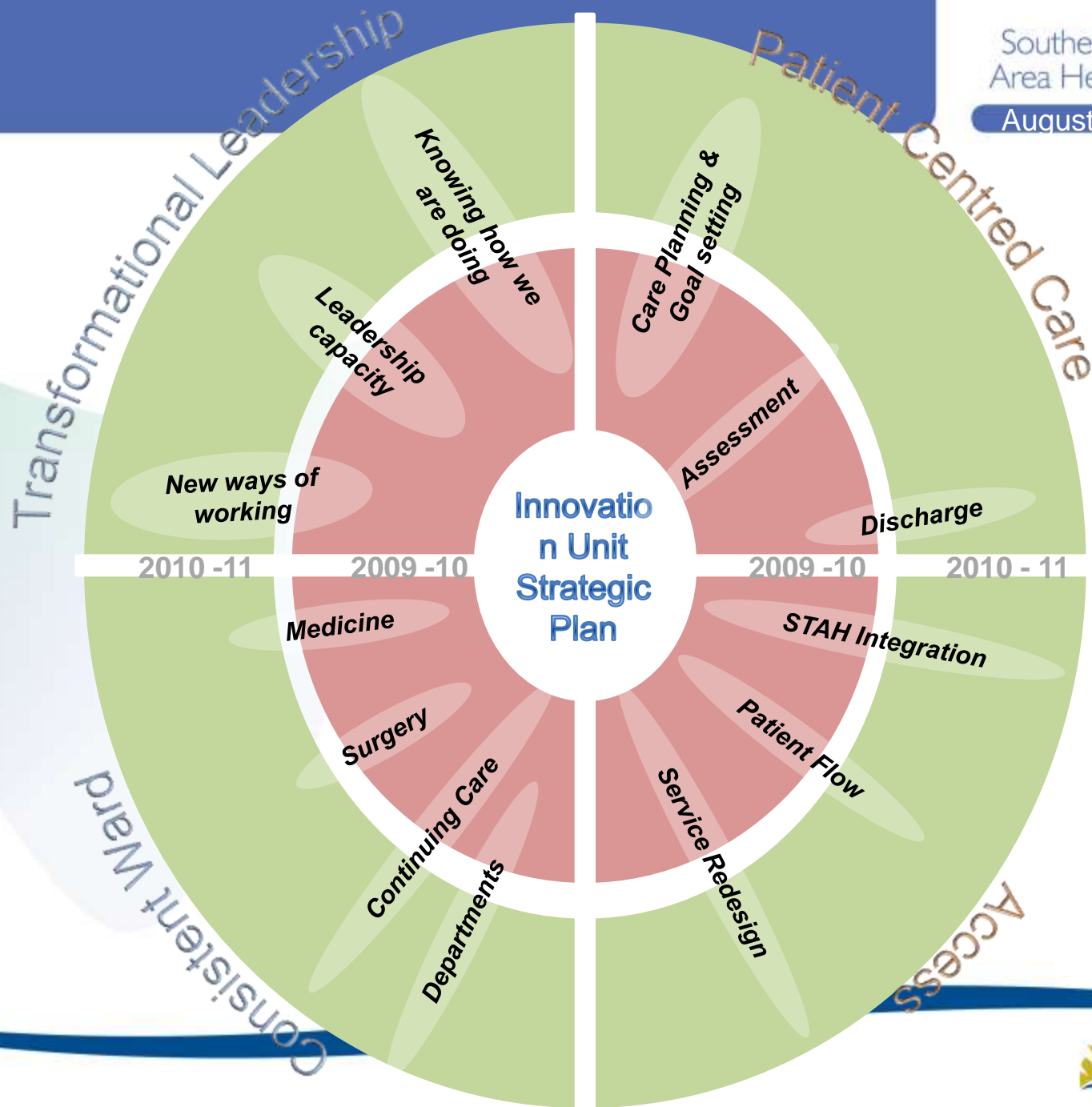
Respect for patients and staff

Building capacity and skills

Enthusiasm and entrepreneurship

Evidence based practice

Leadership and teamwork





- Low compliance rate with existing system
- Patient complaints (eg. foot ulcers) and involvement
- Duplication
- Designed as a Practice Development Initiative
- Implemented in twelve clinical areas and possible extension state-wide



The objective of PARIS is:

- to make early referrals to
- provide quality assurance
- patient-centred care;
- and better patient outcomes

by completing PARIS within 24 hours of the patient's admission.



- Greater knowledge and understanding of patient's assessment and requirements by nursing staff
- Early referrals to Allied Health and other health care workers
- A new tool that will be utilized by the RHH to contribute to reduce Length of Stay (LOS) and to promote patient safety
- Early detection of risk factors during patient's admission and an improved patient's journey



- Literature
- Bench marking
- Local Drivers/ Opinion leaders

PARIS Tool



August 2010

✓ only if this action is required

Initial when action completed

Patient Assessment Referral Information System (PARIS) Page 1 of 2

Tasmania

Ward _____ Medical Unit _____ Date _____

Print Name _____ Designation _____ Initial _____

Affix Patient Label Here

Principle Reason for Admission _____

Estimated Date of Discharge (EDD) _____

Pre Admission Circumstances

Home (with support) Details _____ Alert relevant support service

Nursing Home Details _____ Refer Aged Services Southern Area Team

Supported Accommodation _____ Refer Refugee & Migrant Liaison

Migrant Liaison / Interpreter required _____ Refer Refugee & Migrant Liaison

Advance Care Directives

Has capacity to consent to treatment or alternative care? Yes No then _____ Refer to Social Work

Advance Care Plan in place? Yes _____ No then with patient consent _____

Health Alerts

Allergy identified by patient or carer No Yes _____ Ensure documented on DMR

Diabetes Respiratory Cardiac Renal Dementia Allergy _____ Alert relevant Liaison Service or Speciality

Immuno-suppressed Pregnant Fistula VAD _____

Weight

Weight _____ kg

Height _____ cm

Nutrition

> 5kg unintentional weight loss No Yes

> 7 days poor appetite / nausea / vomiting No Yes

Malabsorption / Diarrhoea No Yes

Food allergy No Yes

Recent Dx Intestinal disorder No Yes

Requires enteral feeding No Yes

Swallow

New swallowing difficulties? No Yes

New aspiration pneumonia No Yes

Consistent coughs on swallowing No Yes

Oral Care

Poor oral hygiene? No Yes

Alterations to oral mucosa? No Yes

Chemo / Radiation / Marrow transplant - last 7 days? No Yes

Elimination

Continent (Urinary) Yes No

Continent (Faecal) Yes No

Stoma No If Yes then _____

History of constipation / current opioid use? No If Yes then _____

Food Service

Special dietary requirements? No Yes Type _____

Verbal Comm

New problems speaking No Yes

New difficulty understanding simple instructions No Yes

PATIENT ASSESSMENT

PATIENT ASSESSMENT

Mobility & Falls

Prescribed 4 or more tablets? No Yes

Dizziness on standing up / unsteady on feet? No Yes

Difficulty getting in and out of the chair? No Yes

Hold onto walls or furniture when walking? No Yes

Fall in the last 12 months? No Yes

Manual Handling

Complex manual handling requirements? No Yes

Bariatric equipment required? No Yes

Activities of Daily Living

Requires assistance moving in bed? No Yes

Requires help getting in & out of a bed / chair? No Yes

Requires help walking? No Yes

Concern re ability to manage on discharge? No Yes

Concern re home environment / equipment? No Yes

Self Management

Is inability to cope a reason for admission? No Yes

Concern re pts ability to manage affairs? No Yes

Previous request for ACAT assessment is there cognitive impairment? No Yes

New inability to manage independently? No Yes

Caring responsibilities for others? No Yes

Infection Control

Infection precautions required? No Yes

Single room required? No Yes

Travel history: Specify _____

Emotion, Cognition & Behaviour

Acute change in mental state No Yes

Difficulty focusing and inattention No Yes

Disorganized Thinking or Altered level of consciousness No Yes

Memory/ cognitive impairment No Yes

Known history of mental illness No Yes

Immediate risk to self and others No Yes

Acute stress/ anxiety No Yes

Known diagnosis of depression No Yes

Feeling down or depressed No Yes

Skin Integrity

New or Existing wound? No If Yes then _____

Braden Scale Score _____

Foot Health

Are you concerned about foot health? No Yes

Pain

Chronic / ongoing pain prior to admission? No Yes

Pharmacy

Is patient on Warfarin therapy? No Yes

When making telephonic referrals, this is the minimum information you need to provide:

✓ Your Name ✓ Your ward ✓ Patient Name ✓ Patient URN ✓ Medical team looking after patient ✓ Reason for referral ✓ Priority

Date Assessment Completed _____



- The following tools are available to assist with assessing patients:
 - Braden Tool
 - Pressure Ulcer Risk Management Flow Chart
 - Oral assessment tool
 - FRAT
 - Podiatry Screening Tool
 - Chronic Pain Assessment Tool



PARIS

- ↑ Acceptance & Compliance
- ↑ Diversity of referrals
- ↓ Time to intervention

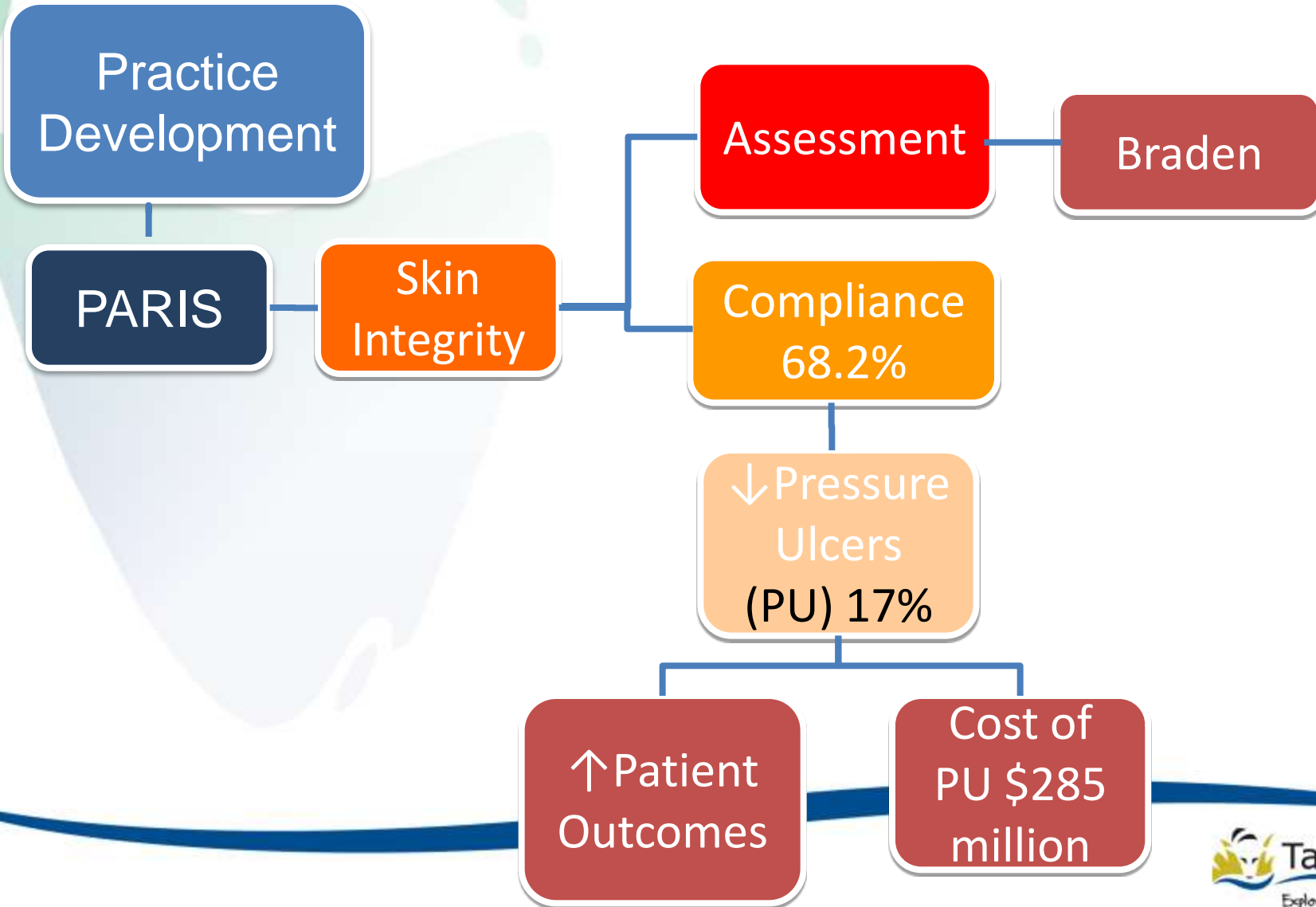
Care Plan

- ↑ Visibility and access
- ↑ Integration with handover
- ↑ Documentation quality
- Collect nursing sensitive indicators

Discharge

- Standardised
- Improved Communication
- Early Planning

How it works





- 60 patients randomly audited from DMR, 30 patients PRE-PARIS and 30 Patients POST- PARIS

POST PARIS:

- 26 patients referred from PARIS on admission
- 56 referrals made
- Average days from admission to referral 1.73 days compared to 3.04 days PRE-PARIS (n = 30)
- ? Effect on LOS



- Total audit 1106 patients (June 2009 –June 2010)
- Weight 18%
- Skin integrity 40%

Last two months

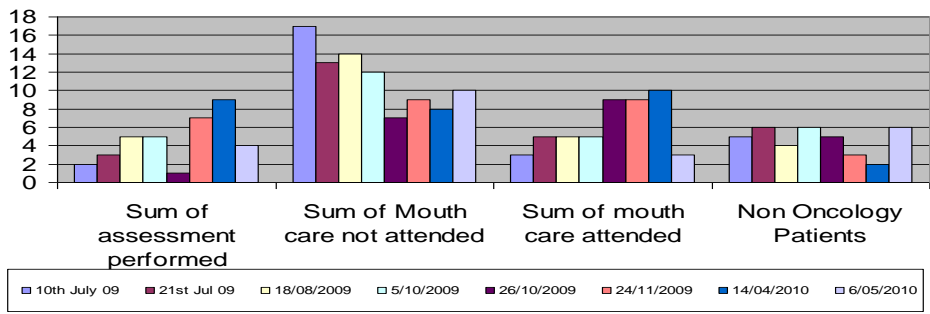
- Weight 31%
- Skin integrity 68%
- Sample group n=120

A-3 - What is it?



Strategy A3 Theme	
What strategic objectives do we need to achieve this year? <ul style="list-style-type: none">•How did we do last year?•What's our history?	What's our action plan to achieve these objectives (who, what, when, where and how)?
<ul style="list-style-type: none">•What did we do last year?•What worked and didn't work?•What have we learned?	
<ul style="list-style-type: none">•What do we need to do to achieve this year's strategic objectives?•How will these actions benefit us?	<ul style="list-style-type: none">•Are there any unresolved issues?•Do you need any help with anything?•Anything bothering you?

Mouth Care 1B South



Reflection on last year’s activities

Activity	Rating	Key results/issues
Formulation of mouth care working group	●	Group review evidence based mouth care practices
Investigation and analysis of evidence based mouth care assessment tools	●	Selection of evidence mouth care assessment tool for RHH
Development of mouth care management flowchart post oral assessment	●	Working group developed evidence management pro-forma.
Implementation of formal mouth care assessment for all oncology inpatients	●	Inconsistent application of mouth care assessment and patients performing mouth care with oncology patients

Rationale for this year’s activities

In 2009 and to May 2010 there has been inconsistent application of mouth care assessment, education and checking of whether patients consistently perform mouth care; which can potentially affect patient outcomes.

In 2010 1BSouth need to:

1. Standardise mouth care assessment and performance of mouth care into daily nursing care routines.
2. Develop mouth care education information for patients

Signatures:

This year’s action plan

Goals	Activities	Month											
		M	J	J	A	S	O	N	D				
Target 100% mouth care assessment/performed	1. Mouth care on all oncology patients 2. Record mouth care assessment results on handover sheet 3. Check if mouth care assess done when checking charts 4. Standardise mouth care with routine observations 5. Weekly audits	■	■	■	■	■	■	■	■	■	■	■	■
Complete “Simple Steps” to mouth care	1. Neutropenia working group to complete	■	■										
Develop “Mouth Care Pamphlet”	1. Neutropenia working group to complete	■	■										

Follow-up/Unresolved issues

1. Review audits in 1 month to determine whether standardisation of mouth care assessment and patients performing mouth care has been achieved against identified target.
2. Neutropenia working group to finalise Simple Steps to mouth care and complete draft of mouth care pamphlet.

Manager: Katherine Montgomerie

Author: Katrina Hodge

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- Succinct understanding of what a patient is like to look after
- Able to begin discharge planning activities right from the time of admission
- Time –priorities of patients’ needs vs documentation
- Availability of Allied Health to review patient in timely manner



- **Describing the health care experience**
 - What triggered the need for healthcare?
 - What were the steps along the way?
 - What did you see, hear, feel?
- **What were the most positive aspects of your health care experience**
 - Was there any part of your experience that was particularly reassuring for you or your partner?
 - How did the situation affect you emotionally and physically?
- **What did not work so well for you during your health care? What constructive criticism can you offer us so we can improve things?**
 - Was there anything you expected that did not happen?
 - What were you most concerned about?
 - How did the situation affect you emotionally and physically?
 - How could the situation be changed?
 - What could make a difference?



- Patient/Client involvement (Interviews)
- Electronic tool
- Paediatric tool
- Awareness of patients' living environment
- Road trips



- Dennis, P. (2006) *Getting the right things done: A leader's guide to planning and execution*, The Lean Enterprise Institute, Cambridge, USA.
- Shook J. (2009) *Managing to learn: Using the A3 management process to solve problems, gain agreement, mentor and lead*, The Lean Enterprise Institute, Cambridge, USA.
- Australian Resource Centre for Healthcare Innovations (ARCHI) 2010 collect Patient and Carer Stories http://www.archi.net.au/e-library/patientexperience/collect_stories (viewed July 8 2010)
- Capturing Patient and Carer Stories www.archi.net.au (viewed July 8 2010).
- Moore, Z.E.H. & Cowman S. (2009) Risk assessment tools for the prevention of pressure ulcers, *Cochrane Database of Systematic Reviews, Issue 4*, The Cochrane Collaboration: John Wiley & Sons, Ltd.