# Manaaki Hauora-Supporting Wellness
## Learning Session 3
## Tuesday 10 November 2015

**Collaborative Name:**
**Healing at Home – Self Management Together**

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# Aim

By December 2016, we aim to ensure that at least 500 high service reliant patients with long term conditions in  patients in Manukau Locality will have a personal care plan in place.

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Version 2 - 9th September 2015

# Driver Diagram: Healing at Home

| AIM Measures | Primary Drivers | Secondary Drivers | Change Concepts | Change Ideas |
|---|---|---|---|---|

**AIM:** By 1 December 2016 we aim to ensure that at least 500 high service reliant patients with long term conditions in the Manukau Locality have a personal self-care plan

**Measures:**
- Outcome measures
- •
- Process measures
- Balancing measures

## Primary Driver: Patient Engaged and Activate

- **Support**
  - Identify Whaanau/Family/care team members to be involved in care/conversations
  - Link with appropriate Healthcare providers (eg GP/Nurse/DN/NGO's
  - Develop/link with Peer support networks – Develop Peer Support Programme
- **Knowledge**
  - Develop tailored care plan
  - Patient level information about condition provided
  - Create Action plans
  - Information about condition and medications at patient level
  - Information about Preventative measures the patient can take
- **Motivation**
  - Link with peer support network
  - Goal setting conversations

## Primary Driver: Support Systems

- Family members involved in care
- Community Groups
- Social groups
- Peer Support
- Specialist services to access – eg Kidney Society, Blind foundation

## Primary Driver: Staff enabled

- **Knowledge**
  - Update orientation to include training/information on goal setting conversation and patient engagement process on first visit
  - Regular staff training/upskilling around goal setting conversations
  - Training around documentation of care plans
- **Motivation**
- **Support**
  - utilise POD meetings to support less confident staff around decision making
  - Training on Cultural awareness and sensitivity
  - Develop/test tools to help with goal setting conversations (Eg CHAT tool)
  - Standardise handover procedure
  - Have mobile internet access available to DN's

# Change Package

| Secondary drivers (Theory of change) | Change concepts & change ideas tested | Evidence of Improvement |
|---|---|---|
| Engaging and activating patients through improving their **Knowledge** | ▪ Develop a tailor made care plan for each patient<br>▪ Provide information about conditions in ways the patient can understand<br>▪ Create Action plans<br>▪ Provide written information about preventative measures the patient can take | Testing of a patent held care planning folder is under way. Two PDSA's are planned asking for feedback on the folders from those outside of the working group. This will help determine the best content and layout of the folder. Data collection is ongoing |
| Engaging and activating patients through **Motivation** | ▪ Having goal setting conversations and setting patient centred goals | Being tested currently as part of the care planning process using the patient folder. Anecdotal reports from one nurse using the folder is that she's already seen benefit |

# Achievements to Date

- ***Completed***
- *Agreed Vision Statement*
- *Agreed Aim*
- *Self management Assessment - Completed by all clinicians in PHHC ( May)*
- *Process Chart identifying what is not working well and improvements that can be made to support Self Management*
- *Driver diagram with change ideas*
- *Project charter and Communication plan*
- *Audit of a sample of high reliant wound care patients to gain baseline data*

- ***Underway***
- *Trial of Patient Folder*
- *Trial change packages with PDSA cycles*
- *Training on Patients focused Goal Setting and Care Planning*

# Patient/ Whaanau stories - Themes

***Healthcare professionals they can trust and relate to***

- Cultural awareness and sensitivity.
- Care and empathy.
- Engaging: show them they matter, an opportunity to build the relationship.
- Effective communication
- Knowledgeable, with good assessment skills.
- Being prepared for the visit
- Continuity of care where possible

***"A visit from the District Nurse can be the highlight of my day."***

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# Patients stories - Acquiring Knowledge

- Informed about medications
- Hearing from others who have been there and have the same condition
- Taking an active interest in one's condition and talking to those in the know, reading up, asking questions, etc
- Understanding and focusing on what's within one's control
- Informed of preventative measures the patient can take

# PDSA cycles testing is underway

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# Patient Folder

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# Most successful PDSA cycles

- Interviews with patients prior to starting PDSA's help to inform some of the work we're doing.

- Development and trialling of Patient Folder to support Self management. One nurse in the working group has tested on 2 patients to see if content is appropriate,

- *The first PDSA testing the patient folder has been the most successful to date. The folder prompted the nurse to have a goal setting conversation with the patient, which uncovered that the patient's main goal was be able to have a shower. The patient had been a client under the service for several years and no one had realises she couldn't shower herself. This PDSA has helped to create belief that this is the right thing to be doing.*

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# Measures Summary

**Measures for First Self-Management cohort - High Reliance Wound Care Patients**

1. Number of HV visits in last year and again 1 year after process implemented
2. Number of ED presentations in past 12 months and again 1 year after implementation
3. Time between visits i.e. average time between visits at baseline and at 1 year
4. Change in patient self-assessment scores (as measured by PACIC)
5. Change in Clinician self-assessment score (as measured by MPACIC)
6. How many patients have a patient focused goals?
7. How many patients have a patient folder
8. How many patients have a document care plan
9. How many clinicians have undergone health literacy training
10. How long does it take to complete a care plan?

- Number of visits between starting and signing off on care plan
- Time taken each visit to work on care plan

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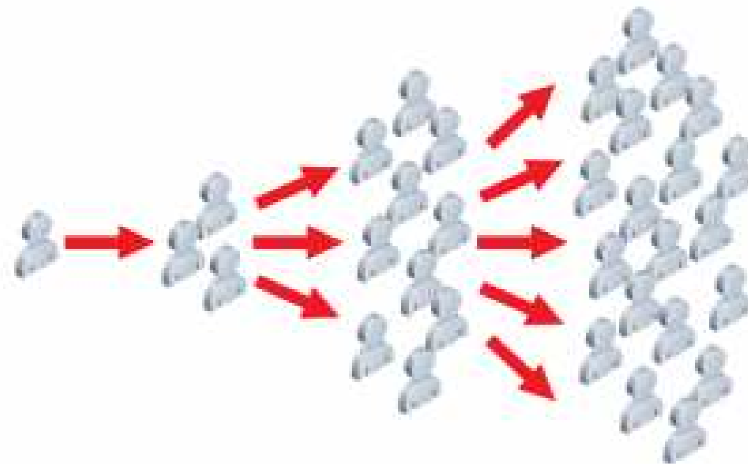
# Potential for Spread

Currently the folder is being trialled on existing Wound Care Clients within CMH DHB  Community Health Service (CHS)Teams.  Once the content and layout are finalised it is intended that all wound care patients who are able to self manage will have a care planning folder

Use of the folder could potentially be extended to all Long term care clients under care of CHS



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# Highlights and Lowlights

***Highlights***

- The work completed over the past 6 weeks around the care planning folder has really set the direction for the project.
- Although we don't have much data yet, several PDSA's are planned to capture more to continue improving the care planning folder.
- Increased knowledge of the methodology of the working group members

***Lowlights***

- Changing working group members has slowed initial progress

*Brandon Bennett joining the group and supporting the group to refocus on the objective and "solve for one"*

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# Collaborative Team Members

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