

2008/2009

**SOUTH CANTERBURY
DISTRICT HEALTH BOARD**



**PROPOSAL FOR THE SIX MONTH
IMPLEMENTATION PHASE OF RELEASING
TIME TO CARE
- THE PRODUCTIVE WARD MODEL IN
ADULT INPATIENT SERVICES AT SCDHB**

[BUILDING STRONG FOUNDATIONS & SUSTAINING CHANGE]

Implementing a structured, health related approach to utilise the principles of 'Lean Thinking'. This proposal supports the lean philosophy and offers a credible structure that engages front line clinical staff to take control and improve the clinical environment for the betterment of patient care (who remain the focus in this approach) but also for themselves.

RELEASING TIME TO CARE – THE PRODUCTIVE WARD

1.0 Background

2.0 Risk Minimisation

3.0 Desired Outcomes

4.0 Proposed Process

5.0 Options

6.0 Success Barriers/Factors

7.0 Cost

8.0 Key Performance Indicators

9.0 Recommendation

10.0 Appendix

1.0 Background

In 2006 a clinical tool kit named the *Releasing Time to Care – The Productive Ward* was published by the National Health Service Institute for Innovation & Improvement in the UK. In August this year the Clinical Nurse Manager for the AT&R unit joined a small group of selected roles from across nine DHBs to attend the master training course on this model in Manchester, UK. This training opportunity and associated travel costs was funded by the Ministry of Health with the expectation that participating DHBs would return and implement this methodology in a selected service.

Releasing Time to Care - The Productive Ward model supports the principles of lean thinking¹ which is also the basis of the national Quality Improvement Committee (QIC), *Optimising the Patient Journey* initiative. The Releasing Time to Care - The Productive Ward model offers a systematic way of delivering safe, high quality care which focuses on patient flow, elimination of waste, reduction of non-value patient activity and standardisation of process. Through the achievement of these key outcomes an increase in time for direct patient care enables clinicians to create and maintain safe and more reliable care systems as well as improving both workplace staff satisfaction and morale.

There are 4 key dimensions which form the foundation for this model:

1. improved patient safety and reliability of care
2. improved patient well being
3. improved efficiency of care
4. improved staff well being

In October this year an interested group of staff visited Canterbury DHB to view their Releasing Time to Care – The Productive Ward pilot in action. Discussions with front line staff in Christchurch demonstrated the obvious level of ownership of practice and environmental changes achieved to date and verified the user friendliness and acceptance of this approach in empowering staff to initiate improvements.

2.0 Minimisation of current risk factors through implementing the Productive Ward model

- Empowerment of staff to act i.e. implement small changes without seeking permission results in issues being addressed or opportunities for improvement realised more quickly. This model provides staff with the tools to affect change which in turn creates a culture of continuous quality improvement
- Initiation of staff suggested solutions and ownership of change by front line staff increases the chance of a successful outcome
- Streamlining routine activity increases direct patient care time e.g. observation frequency and the detection of the deteriorating patient
- Communication issues relating to the patient's plan of care especially in relation to preparedness for discharge are addressed
- Standardisation of process, equipment and layout allows the safe mobilisation of staff between units

¹ The term Lean thinking is reference to the NHS adaptation of the Toyota way for application in the health system and is wholly based on the principles captured in that production plan methodology.

- Transparent information i.e. the open display of performance and clinical indicator data creates a culture which supports open disclosure and professional debate which in turn engenders public confidence
- Satisfaction for staff improves morale and reduces staff turnover, which in turn reduces costs, associated with recruitment and orientation. Consistency in the health team also improves efficiency and reduces the potential for clinical error
- Reduced incidence of complaints as all staff are involved in providing an efficient service to the patient and are aware of their roles within the team

3.0 Desired outcomes from implementing the Productive Ward model

- To create a culture which affirms the key principle that the patient's time is the most important
- To reduce patient incident rates
- To develop teams of self starting, self managing staff empowered to act i.e. quality improvement activities done by staff rather than to staff or with staff
- To increase the amount of direct care time spent with the patient i.e. value added activity, allowing patients to get better, quicker
- To identify and eliminate all forms of waste in the ward setting
- To improve patient levels of satisfaction
- To reduce patient length of stay
- To review how 'work is done' and determine the more appropriate model of nursing care for the setting
- To facilitate the 'patients voice' during any process redesign
- To educate and equip all staff aligned to the ward with tools to identify, affect and monitor improvement
- To develop a system where maintaining high quality and continuous improvement is a part of everyone's day to day working practice
- To improve staff levels of satisfaction and reduce staff turnover
- To improve clinical leadership, teamwork and communication within the clinical setting

4.0 Proposed Process

Implementation requires the following three main management, coordination/education and facilitation positions

- Project Manager who provides the strategic direction and overview for the project. This will be encompassed within the General Manager Quality & Risk current role.
- Project Leader who introduces and coordinates the release of the model to selected wards, educates staff in the tool set and provides support and advice for the clinical champions. It is proposed to second the Clinical Nurse Manager of the AT&R Unit who undertook the training to fill this role.
- Clinical Champion working in the clinical setting who are a senior registered nurse in each ward, engaged in the project who facilitate defining a vision for the ward, undertaking the diagnostics in their respective areas, coordinating planned changes to the environment or staff practice and monitoring and evaluating to assess that any change implemented is in deed an improvement

A set of baseline tools will be utilised at the introduction of the model to each ward. These relate to patient satisfaction, staff satisfaction, safety climate and selected performance measures baseline data. This information establishes the platform for change and allows

comparative information to evaluate the success of the project. The toolbox includes three diagnostic modules, which includes all the tools required for capturing data/information as well as a number of patient related activities, which provide guidance in affecting change. A diagrammatic representation of this is attached for you information (refer appendix 1).

It is proposed that the implementation of Releasing Time to Care – The Productive Ward is phased as follows:

- AT&R ward February – July 2009
- Medical ward April – September 2009
- Surgical ward June – November 2009

These will run simultaneously with the local Optimising the Patient Journey project on Timeliness of Discharge Summaries which is currently underway to meet the requirements of the scheduled national collaborative learning events. It is also unknown at this stage whether additional quality improvement activity will be required with the implementation of phase two of the national Optimising the Patient Journey Initiative – Primary/Secondary interface for Chronic Conditions due to be launched in February 2009.

5.0 Options for ward selection

1. Implement Releasing Time to Care – The Productive Ward model in the 24 bed medical inpatient ward only

Benefit: Focused resource approach. Minimises risk of distraction associated with change to one clinical site.

2. Implement Releasing Time to Care – The Productive Ward model in the 24 bed medical inpatient ward and the 24 bed AT&R unit simultaneously

Benefit: Standardisation of approach across the medical continuum to maximise combined impact in two closely related teams. Peer support for clinical champions between the two selected wards.

3. Implement Releasing Time to Care – The Productive Ward model in the 24 bed medical inpatient ward, the 24 bed AT&R unit and the 40 bed surgical ward simultaneously

Benefit: Standardisation of approach across all adult inpatient wards. Extended peer support and combined learning opportunities for clinical champions. All personal health inpatient units regarded as equal to the opportunity for change and improvement. Demonstrates complete organisational commitment to Releasing Time to Care – The Productive Ward model.

6.0 Success Barriers/Factors

- Timing of the implementation phasing should option 2 of 3 be selected
- Staff buy-in and commitment to process
- Staff training in the model and associated tools including ability to source external training providers
- Maintaining clinical leadership capacity
- Sustainability of process improvements following implementation phase

7.0 Six month Implementation Phase costs for each option are outlined below:

Advice has been received from the Ministry of Health that we are assured a minimum of 24 free licenses (i.e. one ward). This number may increase dependent on national DHB demand for the 1000 licenses purchased by the Ministry of Health. Additional licenses are available for purchase at \$48/bed.

Option 1 – Medical inpatient ward only			
SMO	0.2 FTE	4 months	\$16,000
Productive Ward Leader	0.5 FTE	6 months	\$ 24,000
Clinical Champion	0.5FTE	6 months	\$ 20,500
Productive Ward Licenses	MoH funded	One off	-
Training Provider costs	Estimated	One off	\$6,000
Sundry	Release time for staff training, equipment, facility alterations		\$12,000
Total cost of option 1			\$78,500

Option 2 – Medical inpatient ward and AT&R wards			
SMO	0.2 FTE	4 months	\$16,000
Productive Ward Leader	0.5 FTE	9 months	\$36,000
Clinical Champion	1.0 FTE	6 months	\$41,000
Productive Ward Licenses	\$48/bed for 24 AT&R unit	One off	\$1,152
Training Provider costs	Estimated	One off	\$13,000
Sundry	Release time for staff training, equipment, facility alterations		\$24,000
Total cost of option 2			\$131,152

Option 3 – medical and surgical inpatient units and AT&R unit			
SMO	0.2 FTE	4 months	\$16,000
Productive Ward Leader	0.5 FTE	9 months	\$36,000
Clinical Champion	1.5FTE	6 months	\$61,500
Productive Ward Licenses	\$48/bed for 24 bed AT&R unit and 40 bed surgical inpatient unit	One off	\$3,072
Training Provider costs	Estimated	One off	\$19,500
Sundry	Release time for staff training, equipment, facility alterations		\$36,000
Total cost of option 3			\$172,072

Consideration will also need to be given to educator and administrative support required from the Staff Development Unit in the roll out of the staff education aligned to implementing this model. Budget has been included for contracted external training resource. It is anticipated that this may be sourced from CDHB.

Following the initial trial period it is anticipated that a successful implementation phase would release in the selected ward/s involved in the implementation phase for active participation in quality activities.

Performance and clinical indicator auditing which is essential for the monitoring sustainability of improvements is already a requirement for Clinical Nurse Managers with responsibility of maintenance of implemented processes absorbed within this role.

8.0 Key Performance Indicators

Measurement of the desired outputs that will arise from implementation of the Releasing Time to Care – The Productive Ward modules are considered under the four key outcomes of the model.

The targets set for either increasing or reducing rates following analysis of baseline data by ward

1. Improved patient safety and reliability of care
 - < % of patient falls
 - < % of blood stream infections
 - < % of medication errors
2. Improved patient experience
 - < % of consumer complaints relating to service provision and discharge planning
 - > % of patient satisfaction for selected criteria

3. Improved efficiency of care

- > % direct patient care time
- < average patient length of stay
- > % of patients who are discharged before 1200hrs
- < variance between actual date of discharge against planned date of discharge
- < % medical patients who overflow to the surgical unit, impacting on the ability to conduct elective surgery
- < cost monitoring of ward consumables, therapeutics etc

4. Improved staff well being

- > % staff satisfaction for selected criteria
- = % staff turnover
- < % unplanned staff absences

9.0 Recommendation

SCDHBs accepts and aims all improvement activity to meet the definition of quality as follows:

“Doing the right thing for the right person, at the right time and getting it right first time and every time”. Donaldson & Gray 1997.

It is proposed that adoption of the Releasing Time to Care – The Productive Ward model fully supports this philosophy and offers a credible structure that engages front line clinical staff to take control and improve the clinical environment for the betterment of patient care (who remain the focus of this approach) and for themselves. Positive results have been reported both from the UK experience and more importantly early indications from the CDHB pilots are also most encouraging. CDHB has indicated that they are willing to provide advice during SCDHB's implementation of this model.

SCDHB is committed to engaging in the national Quality Improvement Committees initiatives including the one relating to Optimising the Patient Journey. As we were unsuccessful in our application to be a pilot site for the *Whai Manaki* programme and associated coaching resource The Releasing Time to Care – The Productive Ward model provides an alternative approach to meeting the intent of this national initiative. This model provides a more structured, health related approach to utilising the principles of lean thinking which underpin this national initiative and can be utilised to meet our obligations for participation in this national initiative.

Timing of the implementation phasing is a major success factor that requires consideration should option 2 or 3 be selected. From the CDHB experience it can be noted that careful timing of their roll out and the selection of pilot wards were critical considerations in their success. In order to consolidate the critical mass of staff buy in at SCDHB it is recommended that the Clinical Nurse Managers of the Medical and Surgical wards visit CDHB and spend some time with staff on those wards engaged in their pilot to gain an overview of the model in action.

As the Clinical Nurse Manager has been trained as a 'Master Trainer' in The Releasing Time to Care – The Productive Ward it is recommended that she be seconded for a period of six months to fill the role of project leader.

It is recommended that approval is granted for the implementation of option 3 (medical, ATR and surgical inpatient wards) as this option demonstrates a complete organisational commitment to The Releasing Time to Care – The Productive Ward.

03 December 2008