

# **Connecting Care National Collaborative**

## **West Coast District Health Board**

# Aim

By December 2019 the West Coast DHB will have in place a safe, effective and inclusive transition of care process between inpatient and community teams

## Goals

- 90% of patients discharged from inpatient setting are seen within 7 days
- Re-admission rates within one month are reduced by 50%
- 75% of discharged patients have completed Marama real time survey
- 90% of patients have family/whanau involvement in discharge process

# Project Team

Paula Mason - CNM IPU/TACT

Elaine Neesam – Buller District Manager

Emma Smith - Grey District Manager

Sue Brown - PRIMHD Coordinator

Joe Hall - Consumer Advisor

Di Aitken - Supporting Families

Rachelle Hunt - Occupational Therapist

Rosalie Waghorn - Quality Manager

# Engage

## Statements from Consumer Feedback

- *“I was not offered time to involve my family”*
- *“My family meeting was sprung on me, no time to prepare”*
- *“My community case manager was not present”*
- *“I did not know who my community case manager was”*
- *“I did not understand the language they were using”*

# Capture

- Weekly feedback in IPU whanau meeting
- Complaints
- Interviewing
- Marama real time feedback
- RCA (Root Cause Analysis)

# Understand

- We need collaboration to change
- We need to increase consumer involvement
- We need to enhance workplace culture between teams
- We need to find an invested person with lived experience to contribute to project team

## Co-design themes

# We are siloed!

# Ideas generation

- IPU whanau meeting weekly
- Safe wards
- Relational security
- Primary Nursing
- Early engagement of community teams
- Consumer feedback into IPU information booklet



# Measures

## Outcome

- The number (%) of patients discharged from our inpatient unit who according to them and their family/whanau describe that they received safe, inclusive and appropriate information about their discharge and ongoing care provision.

## Process Measure

- The number (%) of patients who received inclusive family involvement & counselling prior to discharge.
- Number of patients with complete discharge documentation processes
- Number of patients who are seen within 7 days post discharge

## Balance Measure

- No additional workload for staff resulting from the changes made to the patient journey
- Include any baseline data for your chosen outcome measure if available

## Shared Learning

# Power of the consumer voice