Model of Care Initiative in Nova Scotia
Update September 2009
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With this and many of the future updates on the Model of Care Initiative in Nova Scotia (MOCINS), we will include stories from people across the province who are implementing the new Collaborative Care Model on the front lines. Through their stories, we hope to document the challenges, opportunities and triumphs of working differently to provide patient-centered, high quality, safe and cost effective care. These stories are yours to learn from, be inspired by and to share with others in your health district, with patients and their families and even with your neighbours and friends. The following story and others like it are tools to help increase understanding of the Collaborative Care Model among health care providers and administrators in each DHA.

Here is Connie Gregory's, Brett MacDougall's and Dr. Kevin Orrell's shared story of transformation at the Cape Breton Regional Hospital

"We really didn't have a choice but to change the way care was provided on 3A. We were faced with high turnover, high overtime, RN shortages and low staff morale," says Connie Gregory, director of nursing.

Now, the number of patient safety incidents has lessened significantly, length of stay is shorter by as much as 2.5 days for some procedures, staff satisfaction is higher, turnover is lower and the team has been at full complement for a number of months.

"We haven't changed the world, but we've made a number of small changes and a few big ones that are making a difference," says Brett MacDougall, unit manager. "It isn't an easy or quick process, but early indicators show it's working for patients and for us. The core team on 3A has been committed all along and it shows."

It all started before the provincial model of care efforts. With the full support of senior leadership, namely the vice-president and CEO, and spurred on by concerns and issues brought forward by unit staff, Connie lead an effort to explore different models of care and their potential for "working" on 3A. "We weren't looking for a miracle, but something that would lead us in a better direction," says Connie.

Meanwhile, Brett joined the 3A team as unit manager. With his enthusiasm to make things better for staff and for patients, the unit began the slow but sure process of changing the way it delivered care.

"We introduced a clinical lead position and team-based nursing as a result of Connie's findings," says Brett. "Our first steps were to survey patients' needs, group patients according to their needs, form teams based on patient needs and assign each team to a group of patients. These were radical changes for us."

At about the time 3A began to make changes, a team of health care professionals, including Evelyn Schaller, vice-president of patient services at the Cape Breton District Health Authority, was pulled together to design Nova Scotia's new model of care. The model of care, now termed Collaborative Care Model, was and is, to be implemented in acute care settings across the province.

"The timing couldn't have been better," says Connie. "The provincial model of care work has helped us to broaden our efforts beyond nursing care models and to include allied health professionals, physicians and others in doing things differently."

One of the physicians who got engaged is Dr. Kevin Orrell, an orthopaedic surgeon who sees patients on 3A. "I wanted to be informed of changes on the unit so that I could be sure they weren't negatively affecting my patients," he says. "That definitely hasn't been the outcome. In fact, my job has gotten easier because of better communication among team members, higher levels of knowledge about patient's care and needs among more team members, a greater focus on patients' needs, and patients who are better informed and who, in my mind, are receiving better care. All of this is truly impressive."

Dr. Orrell notes that his role in implementing a collaborative care model on 3A has been to ask questions when needed and not stand in the way of changes that he sees as benefitting patients. "My advice to other physicians whose units are making changes as per the model of care initiative would be to build trusting relationships with the unit-based health care teams, ask questions as needed and don't stand in the way," he says.

As part of the transition to a collaborative care model (still a work in progress), the 3A team reorganized their medication room to improve efficiency, weeded out extra supplies, assessed current equipment and added new equipment such as portable blood pressure monitors and mechanical lifts (acquired through grant monies).

The team has also streamlined a number of processes and procedures, from adding a contents list and procedure instructions to their central line and chest tube bins to working with rehabilitation services to enable rehab assessments to be done on the unit. Such changes, and many others from the simple to more complex, were done with full staff input and cooperation and to improve patient care.

As another measure, the team has implemented daily team meetings to go over patient needs, status, goals and a plan for the next 48 hours of care.

Perhaps the biggest change was the addition of a preadmission clinic. Nursing staff, allied health professionals and physicians provide information and advice to patients who will soon undergo an orthopaedic procedure. The clinic covers what to expect before, during and after the procedure, the role of the health care team and the role of the patients in their recovery.

"The staff on 3A have shown great leadership in being willing to take a new road in the delivery of patient care," says John Malcom, CEO, Cape Breton District Health Authority. "A team approach that increases the involvement of patients and is based on full use of the talents of all members not only improves the quality and safety of the services but also the quality of worklife- a winning combination."