

### **Model of Care Initiative in Nova Scotia Updated June 2010**

As we provide updates on the Model of Care Initiative in Nova Scotia (MOCINS), we will continue to include stories from people across the province who are implementing the new Collaborative Care Model on the frontlines. 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 a story from the IWK's Family Newborn Adult Surgery (FNASU).**

Change is nothing new for the staff of the IWK's Family Newborn Adult Surgery Unit (FNASU). Every day, about half of the patient population returns home to be replaced by new moms, babies, and women's surgery patients. This creates unique challenges for nursing, housekeeping and support staff, and sets the unit apart from most other medical and surgical units in the province.

Over time, the patients' needs have changed as well. "When you look at this patient population, they would traditionally be thought of as well, healthy women," said Jocelyn Vine, vice president of patient care. "In fact, they are actually less healthy than in the past. Women are giving birth later in life, and many of the moms we see have more complex medical conditions than in the past, including obesity and related illnesses."

High patient turnover rates and a 10 to 15 per cent increase in volume over the last year and a half present further challenges for the staff of FNASU. Family newborn patients typically stay for one and a half to two days, with a longer stay for c-sections. This means that nurses, as well as housekeepers and other staff, spent a significant amount of time preparing patients and families for discharge, and readying rooms for the next mom and baby.

With changing patient care needs, ongoing turn-over and growing budget pressures from overtime and sick time, the health centre realized that the unit could benefit significantly from another change – to a new model of care delivery.

Nova Scotia's new provincial Collaborative Care Model was developed by more than 50 front line staff, allied health professionals, managers and administrators from across the province as part of the Model of Care Initiative. The new model is based on the principle of providing patient-centered, high quality, safe, and cost-effective, care.

After initial assessments, it was decided that the staff and leadership on FNASU had the potential to do great things with the province's new Collaborative Care Model. As the only maternal newborn unit in phase one of the Model of Care in Nova Scotia Initiative, success on this unit would also provide an

excellent model for other maternal newborn units in the later phases – an appropriate role for an academic health sciences centre.

The model has been implemented on the unit over the past two years, and initial results are very positive. It hasn't always been an easy road though, even with the strong leadership of project lead Heather Simmons, unit manager Barbara Whynot, and supportive physicians including Dr. Carolyn Thomson and Dr. Tony Armson.

“Staff responses to the concept of the Collaborative Care Model on the unit were mixed at first,” said Heather Simmons, Models of Care Lead at the IWK “They wanted to understand what it meant for their patients and for themselves, and they wanted to be part of the processes.” This was perfect because engaging staff as active participants in the change process was a key feature of the provincial Model of Care Initiative.

“I have to say I was very nervous when I first heard about Models of Care on our unit in the beginning. I did not know where it would take the RN in the future,” said Charlotte Guyomard, Registered Nurse, Family Newborn Adult Surgery Unit. “I quickly learned that it would mean more of a leadership role and I really liked that. I personally feel that I had a say in the process and that has led to greater satisfaction with the transition.”

Ms. Simmons saw the planning and implementation process as an opportunity to look at whether the unit was really meeting the needs of patients and families, as well as staff. She also knew that in order for the model to be a success on the unit, staff needed to be involved in the planning.

“The change to a Collaborative Care Model wouldn't have been possible without Barbara Whynot's leadership, and the full engagement of unit staff in the process,” said Ms. Simmons. “Everyone wanted to understand the model and what it would mean for them and their patients, so we put a lot of effort into communicating with unit staff, physicians and the leadership team.”

A key step in implementing the model was to identify the patient population, and then determine how the people, processes, and technology could be changed to better meet the needs of the patients and their families.

“We saw this as an opportunity to look closely at how we provide care,” said Ms. Simmons. “Together we looked at our patient population data, had focus groups and then asked what they would need to make the new model work. That resulted in education sessions, reference tools such as the collaborative care guidelines, and other supports to help them lead the process.”

The biggest challenge was changing from an all-RN staff (since 1992) to a collaborative care team with a mix of care providers. The concerns raised were not unexpected. Staff wanted to understand the scope of practice of each provider, whether RN layoffs would be required (they weren't), and how adding licensed practical nurses (LPNs) and support staff would affect the day to day activities of the care providers on the unit.

What the patient population data showed was that, despite an increase in more complex patients, there are still a significant percentage of stable patients with less complex needs that are well within the scope of practice of a licensed practical nurse. Introducing LPNs to care for these patients allowed the RNs to focus on the more complex care needs of patients. Currently, the nursing staff ratio is slightly higher than two RN's to one LPN.

“I feel better able to work within my scope of practice, and my time is better spent focusing on more complex issues,” said Ms. Guyomard, RN, FNASU. “I really think we have done a great job making our unit run like a team. It's not us and them – it is our whole team working together so our families flourish, not just cope.”

Introducing LPNs to care for stable patients was the first step, but staff also identified a number of daily tasks that took a significant amount of time and didn't require nursing skills. The introduction of LPNs into RN vacancies saved the unit over \$430,000 a year - allowing the unit to add three new support roles to the care team.

A Care Team Assistant role was added to help prepare families to go home by providing support, car seat preparation and personal care. They also help with post surgery ambulation.

“In the past, when a father came to pick up his baby with the car seat still in the box from the baby shower, a nurse could spend an hour assembling the car seat and teaching the parents how to use it,” said Ms. Vine. “This is important, but it doesn't require nursing skills. Now care team assistants are trained to do that, and to provide many other supports.”

A Lead Hand role was also funded through the cost savings, and the addition, along with a change in Ward Clerk coverage, resulted in improved processes that in turn resulted in savings in the supplies budget.

Reassigned savings also allowed for investment in bariatric equipment for larger patients and a new call bell system for both staff and patient safety. Additionally investments were made in staff education (particularly as new members were introduced into the care team), supporting effective communication and teamwork.

So is the Collaborative Care Model working on this unit? Through surveys and data tracking, Heather Simmons has seen an increase in job satisfaction among RNs, LPNs, unit aides and ward clerks. She has also seen a decrease in overtime, sick time and absenteeism. Family satisfaction went from 81 per cent to 84 per cent. Staff vacancies are no longer an issue.

There is more work to be done, particularly on strengthening documentation systems and other process improvements to help the entire system work more efficiently, said Ms. Simmons.

“This has been a good process. We know there have been some bumps in the road, and we may hit more as we move forward, but this ongoing process needs to be part of the culture of the health centre.”

The Collaborative Care Model will be implemented on six more units in the second phase of the provincial Model of Care initiative. Further, the IWK has recently reinforced its commitment to the Models of Care project, by declaring MOC implementation to be one of four new strategic priorities for the organization in 2010/2011.