January 2021

Charge Nurse

Orientation

Toolkit

SOUTHLAKE
REGIONAL HEALTH CENTRE
Leading edge care. By your side.

January 2021

Charge Nurse Toolkit

Table of Contents

"click on the heading to advance to that section"

5. Admission and Bed Flow

Admission Checklist RCU Finch and Church
Admit a Patient to RCU
Admit/Flip Patient to Acute and ALC
Admit a Patient to Rehab
Criticall

6. Discharge Planning

Acute Care Checklist for Inpatient Repatriation to Long Term Care Homes
Adopting a Common Approach to Transitional Care Planning- HQO
ALC Awaiting LTC
Case Conferences
Discharging a Patient to a LTC Facility
Discharging a Patient to Home
Discharging a Patient to Hospice
Discharging a Patient to the Restorative/Reactivation Care Unit
Discharging a Patient with Home and Community Services
Home First
Nursing process for Discharge Medications
Palliative Discharge Checklist
Printing a MAR from Meditech
Printing Discharge Medications from Meditech
Printing Transfer Medications from Meditech
RCU Information Sheet
Resource Matching and Referral- RM&R
RM&R Matching Patient to Programs and Services
Transitions Pathway Model

7. Pharmacy

Locating Medications after Pharmacy Hours

8. Standard Work

Standard Work for Charge RN –Days
Standard Work for Charge RN -Nights
Standard Work for RN-Days and Nights
Standard Work for RPN-Days and Nights
Standard Work for PSP- Days and Nights

9. IMCR/BPSO

AIDET Tip Sheet
HEARD Tip Sheet
Intentional Hourly Rounding Poster
Bedside Shift Report Checklist
Bedside Shift Report FAQs
Patient Education for Bedside Shift Report
Bedside Shift Report Safety Checklist
Using SBAR for Bedside Shift Report
SBAR Worksheet
SBAR Report Example
BPSO Champion Application

10. Working with Unregulated Care Providers/PSPs

Patient Services Partner Highlight Summary
Patient Services Partner Scope of Role
SBAR for Patient Services Partner
Scope of Practice and Role Working with PSPs

11. Team Based Care Model Articles

Brief History and Evidence to Support Team Nursing Model
Towards a Collaborative Model of Care
Towards a Responsive, Sustainable and Collaborative Model of Care and Toronto's Michael Garron Hospital
Creating and Sustaining a Collaborative Care Model
5 Ways to Foster Teamwork Article

return to Table of Contents

Unit Information

Contact Numbers

Name	Phone	Pager
Manager:		
Clinical Coordinator:		
Educator:		
Scheduler:		
CSM via Locating:	2216	
Occ Health Wellness and Safety:	2402	
IPAC:	1-(289) 221-6986	
IT Help Desk:	2246	
Bed Allocation:	2205	Fax 5809
Health Records:	2315	
Maintenance:	2561	
Portering:	2000	
Security:	2385	
Short Call	2497	

Name	Phone	Pager
Code Red	5555	
Code Blue & other Codes	5555	
CCOT	6666	
CT	2272	Fax 905-952-3064
Fracture Clinic	2315	
Interventional Radiology	2384	
Lab Main Desk	2050	
Lab Tech (stat draws only)		1110
Pharmacy		2071 (afterhours page through locating)
X-ray	2114	
Emerg x-ray	2608	

Clinical Nurse Educators 2021

Name	AREA OF PRACTICE	Ext.
Erin May	CCU, Cardiology	5496
Kristen Antler	OR/ADC	2053
Becky Rasenberg	CVICU/CVS	2658
Krissy Jordan	Birthing Unit/Post Partum	6488
	Corporate/Critical Care	2405
Meghan Garbutt	Medicine (CAN, Pall, Med 6)	6346
Trisha Clarke	Medicine (MACU, RAU)	5364
Heather Foti	Medicine (RNU,MOU,TFU,MCC, TCU)	2991
Joanne Campbell	IV Team	2529
Teresa Compton	MSK, Inpt. Surgery, SACU	2746
Candace Epworth	Preop Clinic, SDA, PACU, SDC, Endo, ADC and Eye Centre	2085
Michelle Bandayrel	Cath Lab, Heart Rhythm and CSSU	2876
Rebecca Sanderson	Emergency	5367
Carrie Webb	Emergency	
Marcia Westover	ICU	2359
Rehnuma Tabassum	Mental Health	5020
Amanda Holt	Paediatrics/NICU	5366
Cynthia Heron	Cancer Centre	6520
Natalie McBride	VNT	2672
Chad Peitsch	RCU (Humber and Church)	
Ali Beidaghdar	TCU	

Manager/Coordinator/Educator List

Units	Manager	Coordinator	Educator
ICU	Barb Fowler		Marcia Westover
CVIVU/CVS	Melissa McBurney	Julie Tunnicliff Christine Fitzpatrick	Becky Rasenberg
CICU/CAM/PCI	Amanda Darwood	Julie Tunnicliff Christine Fitzpatrick	Erin May
MSK/SUR/SSC	Judith Fanakan	Elizabeth Birch	Teresa Compton
CANCER CARE			Meghan Garbutt
MEDICINE	Karen Wessel		Meghan Garbutt
MCC/TCU	Sandra Osmond		Heather Foti
RAU	Katrina Scott		Tricia Clarke
MACU	Betty Perkins		Tricia Clarke
RNU	Tammy Rogers		Heather Foti
VNT	Diane Cole		Natalie McBride
RCU/CHU	Magdalena Stapinski		Chad Peitsch
Southlake@Home/ALC	Samantha Hennigar		
OR/PACU	Csaba Szotyori	Christine Madill	Kristin Antler
ADC/Endo/Eye Institute/RT/IV	Audrey Gyles		Candace Epworth
Emergency Dept	Jen McQuaig	Kim Nelson	Carrie Neuman/ Rebecca Sanderson
Birthing/PPU	Sheena Shannon	Sandra Payne	Krissy Jordan
Paeds/NICU	Stephanie Simson	Sandra Payne	Amanda Holt
Mental Health Adult	Aga Dojczewska		Rehnuma Tabassum
Mental Health Child	Sherri Miller		
Mental Health O/P	Janet Giannini		
Cath Lab/CSSU	Leanne Blair		Michelle Bandayrel
Heart Rhythm/ Electrophysiology	Matt McNamara		Michelle Bandayrel

return to Table of Contents

Charge Nurse Role

Shift to Shift Charge Nurse Report

Things to Consider in Your Hand Off:

Staffing Concerns	Sick calls- status of coverage Agency staff, VNTs, RN/RPN, Summer Care Provider, PSP
Patient Concerns	Medical acuity (i.e. CCOT involvement) IV therapies (administration or monitoring) Patients with aggression/violence Mental Health forms, constant observation, 1:1 needs-PSP, Nursing or Security Family concerns/issues
Equipment or Technology Concerns	IT interruptions Downtime documentation Shortage of needed equipment Required lab equipment (i.e. biopsy trays)
Previous Shift Concerns	Issues that were required to be elevated to Manager or CSM
Other Concerns	Unresolved narcotic discrepancies Pharmacy issues

Charge Nurse Accountabilities

The Charge Nurse is an experienced Registered Nurse who, upon a successful expression of interest, works under the direction of the Clinical Program Manager to coordinate high quality patient and staff experience on an assigned unit for an agreed upon schedule rotation. The Charge Nurse works collaboratively with the Clinical Program Manager, physicians, all members of the health care team and all other programs, departments, services, and hospital partners as required to ensure the day to day clinical efficiency of the unit, ultimately allowing the unit to accomplish its goal of providing "Leading Edge Care. By Your Side."

A charge nurse is accountable to the level of a reasonably prudent charge nurse:

- Have an understanding of the scope of practice of the providers on the shift
- Assign patients to care providers ensuring that assignments are appropriate to each care provider
- Ongoing communication with the team regarding patient status, care, and concerns
- Overall monitoring and oversight of the clinical area
- Providing support when requested
- Escalating concerns to manager/supervisor as needed
- Ensuring staff who are new to the area are aware of unit geography
- Additional requirements under the Occupational Health and Safety Act

The charge nurse can:

- Accept at face value a staff members competency/scope/knowledge, as indicated by that staff member, unless there is reason to believe otherwise

The charge nurse is not accountable for

- "The decisions or actions of other care providers when there was no way of knowing about those actions." (CNO)

The Charge Nurse:

1. Ensures sustainment of corporate and unit quality initiatives (IMCR, Back to Basics) such as bedside shift report and completion of bedside communication care boards 100% of the time
2. Ensures unit specific rounding is completed 100% of the time, i.e. bullet rounds, bedside rounds, QBP rounds. Participates in daily rounding for patients –focus on safety, mobility, service excellence and service recovery for any issues
3. Leads/delegates safety huddles daily
4. Responds in real time to patient/family concerns and escalates to Manager as required
5. Ensures availability of equipment/supplies and safety equipment at all times (suction, O2, lifts, bed surfaces)
6. Follows up in real time for all patient/staff incidents 100% of the time
7. Ensures compliance to accurate completion of unit specific communication tools (Kardex, chart checks, etc.)
8. Completes and oversees nursing workload assignments based on acuity, complexity, geography, environmental supports, and staff's experience
9. Collaborates with team to optimize patient flow, timely admission and discharge. Supports staff with discharges and works with team to seamlessly transition complex discharges. Utilizes Transitions Pathway Model to guide discharge process
10. Ensures medication reconciliation process is completed in a timely fashion

11. Serves as a clinical resource to staff on the unit to optimize problem solving and has knowledge of clinical resources that may be required (supplies, policies, tests, etc.)
12. Assigns breaks, supports staff to attend scheduled breaks, and notifies CSM/Manager to assist when staff not able to attend breaks

Charge Nurse Role and the Patient Services Partner (PSP)

The Charge Nurse is accountable to:

- Have an understanding of the scope of practice/role of the providers on the shift
- Assign patients to staff ensuring that assignments are appropriate to each care provider; ensure that all staff have equitable distribution of work within their scope
- Be the primary point person to the PSP-assign daily work, provide oversight to workload
- Engage in ongoing communication with the PSP regarding patient status, care, and concerns
- Provide overall monitoring and oversight of the clinical area
- Provide support when requested or when realizing the need to assist
- Ensure PSPs who are new to the area are aware of unit geography and have a basic orientation to the unit

January 2021

SOUTHLAKE REGIONAL HEALTH CENTRE CHARGE NURSE COMPETENCY MANUAL

Professional Practice

SOUTHLAKE REGIONAL HEALTH CENTER

Contents

ORIENTATION PROCESS

The Southlake Regional Health Centre (Southlake) Charge Registered Nurse (CN) works within the Standards of Nursing Practice as determined by the College of Nurses, Regulated Health Professions Act, July 1996, Regulations, Nursing Act (Bill 57), the Guidelines of Ethical Behaviour, and policies and practices of the hospital. Charge Nurses lead through role modelling professional and organizational core competencies to positively affect patient and staff experiences.

The RN will be provided orientation through a buddied peer-peer based learning process, to the role of the CN.

Upon successful orientation, the CN will have the knowledge, skill, and judgement to support the clinical activity and staff in the area they are assigned and ensure the day to day clinical efficiency of the unit flow and processes.

Competency in Leadership, Service Excellence and Recovery, Direct Care and Safety, Communication and Collaboration, Human Resources, and Materials Management is required to be an effective CN. The CN has a positive impact on patient outcomes and patient and employee satisfaction, due to their oversight and leadership of the unit/department. Leadership requires self-knowledge (understanding one's beliefs and values and being aware of how one's behaviour affects others), respect, trust, integrity, shared vision, learning, participation, good communication techniques and the ability to be a change facilitator. (CNO, Professional Standards, 2002)

This orientation tool kit provides a competency based practice checklist to ensure the CN orientation meets the needs of the new unit leader.

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
Leadership, Interconnectedness & Emotional Intelligence	• Leadership and therapeutic relationship skills as evidenced by the Charge Nurse providing, facilitating and promoting the best possible care to the patient. • Six basic styles of leadership (visionary, coach, affiliative, democratic, pacesetting, commanding). Each makes use of the key components of emotional intelligence in difference combinations. The best leaders don't know just one style of leadership- they are skilled at several, and have the flexibility to switch between styles as the circumstances dictate.	CNO Professional Standards and Therapeutic Nurse-Client Relationship practice standards. Just in time mentoring and coaching of teachable moments by peer mentor and/or formal leader Selected Articles on leadership		
	• Emotional intelligence (EI) – the ability to manage ourselves and our relationships effectively– consists of four fundamental capabilities: self-awareness, self-management, social awareness, and social skill. Each capability, in turn, is composed of specific sets of competencies.	Role modelling professional values, beliefs and attributes from the CNO and Southlake's Strategic Plan Consistently uses reflective practice and solicitation of feedback. Provides constructive feedback to promote professional growth of		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
		other members of the health care team Selected Articles on EI		
	• Makes decisions and practices in an ethical and professional manner	CNO Ethics Standard CNO Code of Conduct		
	• Maintains positive and collaborative working relationships within the interprofessional health care team	Acts as a role model and mentor to less experienced team members and students		
	• Uses facilitation, critical thinking and problem-solving skills in routine and urgent situations	Providing direction to, collaborating with, and sharing knowledge and expertise with novices, students and unregulated care providers Taking action to resolve conflict and developing innovative solutions to practice issues		
Service Excellence &	• Works with a service excellence focus	CNO Code of Conduct,		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
Recovery		Confidentiality and Privacy, Ethics, Therapeutic Nurse-Client Relationship standards Use of service recovery techniques such as HEARD or HEAT		
	• Conducts daily purposeful rounding and communicates regularly with patients, family and health care providers in order to offer the best patient care experience	CNO Therapeutic Nurse-Client Relationship practice standard		
	• Acquires knowledge of the Calls to Action of the Truth and Reconciliation Commission of Canada	CNO Entry to Practice Guideline for Registered Nurses, 2018 and Code of Conduct standard		
	• Takes action to support culturally safe practice environments	CNO Entry to Practice Guideline for Registered Nurses, 2018 and Code of Conduct standard		
	• Adapts practice to meet client care needs within a continually changing health care system	Self-reflection Peer feedback		
Direct Care & Safety	• The Charge Nurse is able to perform and model a comprehensive health assessment of the	Focused assessment Treatments and		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
	patient in a timely and efficient manner	Medications common to the unit Southlake Standards of Care Policies and procedures Learning packages SOLS BPSO –BPGs		
	• The Charge Nurse is familiar with the various medications, treatments, and diagnoses most often admitted to the unit.	Textbooks Journal articles Competency testing Learning packages Online resources		
	• They are able to manage the care of a patient assignment in collaboration with the inter-professional team	Interprofessional education Time management tools Textbooks Journal articles Competency testing Learning packages		
	• The Charge Nurse uses their knowledge of treatments to educate patients, families, and support persons as required	Textbooks Journal articles Competency testing Learning packages		
	• The Charge Nurse models all aspects of the CNO	College of Nurses of Ontario		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
	Practice Standards and competencies for nursing practice	website		
	• The Charge Nurse models the standards and principles of safe handling and disposal of bodily fluids, and contaminated equipment and items.	IPAC Occupational Health Wellness and Safety policies and procedures		
	• Directs and modifies the assignment of the regulated and unregulated staff based on patient acuity, complexity, geography, volumes, clinical skill set of staff, and any other circumstance as required to ensure the safety of patients and staff.	Acuity tools CNO RN and RPN Practice: the Client, the Nurse and the Environment, Working with Unregulated Care Providers PSP toolkit Summer Care Provider education slides		
	• Functions in accordance with established hospital policy and procedures, i.e. various codes.	Southlake policies and procedures		
	• Identifies priorities and co-ordinates patient care activities. Delegates or assigns tasks to the nursing team	CNO Decisions about Procedures and Authority CNO Authorizing		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
		Mechanisms		
	• Oversees the care of all patients in the unit ensuring timeliness to safe and efficient care. Performs or ensures process of medication reconciliation is complete and works to bring patients to successful discharge through effective care planning as a component of each patient's care.	Time Management tools Textbooks Journal articles Competency testing Learning packages Southlake policies and procedures		
	• Provides support to the inter-professional team in the performance of their duties ensuring conformity with recognized standards and policies and procedures.	Southlake policies and procedures		
	• Collaborates with the management team to maintain a safe environment for patients, staff, volunteers and physicians.	Southlake policies and procedures		
	• Contributes to the ongoing education of staff through instruction, reassurance and guidance, and assigning attendance for education.	Southlake policies and procedures		
	• Actively participates and leads team in variety of projects as assigned by the management team.	CNO Professional Standards and Therapeutic Nurse-		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
		Client Relationship practice standards.		
	• Integrates continuous quality improvement principles and activities into nursing practice	CNO Professional Standards and Therapeutic Nurse-Client Relationship practice standards.		
	• Participates in creating and maintaining a healthy, respectful, and psychologically safe workplace	CNO Code of Conduct		
	• Recognizes the impact of organizational culture and acts to enhance the quality of a professional and safe practice environment	CNO Code of Conduct, Ethics standard		
Communication & Collaboration	• Continuously evaluates patient flow and modifies approach as the needs of the unit change in order to deliver quality patient care	Self-reflection Peer feedback		
	• Leads or delegates quality safety huddle	CNO Professional Standards		
	• Actively participates in team conferences and assists others in guiding, directing and planning	Key Stakeholders		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
	the care of patients.			
	• Facilitates co-ordination of patient care, as well as inter and intra departmental co-operation to ensure timely flow of patients through department. Encourages referrals to appropriate internal and external resources.	Interprofessional team Community Stakeholders and partners Patient and Family		
	• Observes, records and reports symptoms, care of and conditions of patients to members of the healthcare team as it relates to the care plan	CNO Documentation and Medication standard		
	• Participates in innovative client-centred care models	Southlake policies and procedures Strategic plan CNO standards		
	• Demonstrates knowledge of the health care system and its impact on client care and professional practice	Public Hospitals Act RHPA Nursing Act CNO standards		
Human Resources	• Assists in the orientation of new staff members.	CNO Professional Standards Southlake Preceptor Workshop		
	• Effectively utilizes and coordinates staffing	Coaching and mentoring		

Charge Nurse

COMPETENCY	INDICATOR	RESOURCES	INITIAL	
	assignments in accordance with the collective agreement	from the Manager or designate Collective Agreements ONA, SEIU		
Materials Management	• Reviews supply list for ongoing needs and coordinates with team to obtain items	Communicates with distribution department to identify supply needs/deficiencies		
	• Uses and allocates resources wisely	Self-reflection		

Point-of-Care Leadership Tips and Tools for Nurses

Purpose:

This Tips and Tools guide is designed to assist you in identifying and better understanding the concept of leadership at the point-of-care. The information is based on the **Healthy Work Environment Best Practice Guideline:** *Developing and Sustaining Nursing Leadership, Second Edition.*

Why is this important?:

Nurses providing leadership at the point-of-care are a critical part of safe patient care now and of effective nursing leadership in the future. Point-of-care leadership can have a positive impact on clinical practice and work environments by increasing quality, safe patient care, job satisfaction and nurse retention (Abraham 2011), as well as introducing all nurses to leadership behaviours that are important in all roles.

The facts

- Point-of-care leadership is differentiated from other types of leadership in that the leadership activities relate directly or indirectly to the care process, and are carried out by point-of-care nurses who are not in a formal administrative role.
- Leadership at the point-of-care includes direct clinical work wherein nurses play a key role in clinical decision making and use evidence-based interventions in the development and implementation of care plans.
- Leadership at the point-of-care also refers to additional activities taken on by clinical nurses who engage others in clinical practice change, practice research, quality improvement or evaluation.
- Point-of-care leadership includes modeling, leading and advocating for quality, safe patient care based on the best evidence.

ia BPG
INTERNATIONAL AFFAIRS & BEST PRACTICE GUIDELINES

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

What does this mean for you?

- It is important to know that leadership behaviours are expected of all nurses regardless of their title or position.
- A first step in point-of-care leadership development is gaining awareness of what point-of-care leadership is, and its requirement as a College of Nurses of Ontario (CNO) Practice Standard (CNO, 2002).
- Point-of-care leadership skills can be developed by taking advantage of organizational supports that may be in place, or that nurses may seek out, such as education, peer support, mentoring and feedback. Identify potential leadership opportunities and take steps to gain support to engage in them.
- Point-of-care leadership can also be developed through specific activities that offer the opportunity to grow and develop as a leader. Some examples: leading a guideline implementation team; leading adoption of a new process in care; presenting at nursing rounds; presenting at a team meeting; acting as a champion for a new practice; or working on a special project.

How can I demonstrate point-of-care leadership in my role?

Effective point-of-care leaders incorporate specific behavioural competencies that are learned over time (Doran et al., 2012). Examples of such behaviours used within a normal working day include

- Effectively communicating patient assessment data.
- Articulating the patient's perspectives to other members of the health-care team.
- Clarifying information for patients and their families.
- Ensuring patients are empowered to make informed decisions about their care (Patrick et al., 2011).
- Using knowledge, clinical expertise, and patient perspectives to offer alternate points of view, seek clarification for current practices, and/or explore changes in practice.
- Engaging in project implementation, change management, interprofessional collaboration, and research analysis and improving processes of care.
- Acting as an interprofessional liaison to facilitate assimilation of information by all care providers.

Leadership at the point-of-care is evident in the following five practices, central to RNAO's Healthy Work Environment BPG. These are a part of leadership in all roles:

1. **Building relationships and trust.**
2. **Empowering others.**
3. **Contributing to an environment that supports knowledge integration.**
4. **Leading, supporting and sustaining change.**
5. **Balancing complexities of the system and managing competing priorities (e.g. work-life balance).**

Point-of-Care Leadership

The following specific behaviours are examples of point-of-care leadership in each of the five practices.

1. Building Relationships and Trust

- Ensuring that patients and their family's needs are assessed and effectively communicated, and that interventions are coordinated.
- Truly acting as advocates for patients, families, other point-of-care providers, and navigators of health-care delivery.

- Routinely interacting and communicating with patients to monitor, assess and prioritize patient needs.
- Providing evidence-based and client centered discharge education, ensuring appropriate follow-up to improve clinical outcomes and decrease re-admissions.

- Communicating patient findings based on clinical assessment and evidence based best practice.
- Communicating with the patient, family and interprofessional team to determine needs and changes that are not based solely on the patient's medical diagnosis, but broader health needs including social determinants of health.
- Developing and utilizing communication skills targeted to teams, integrating safe patient care.
- Empowering patients to partner in their care by providing information and support and ensuring that their voice and information is understood.

- Utilizing evidenced-based practices and organizational resources to address conflict.
- Advocating for patient and other point-of-care providers using conflict resolution skills and knowledge dissemination.

- Participating as leaders for nursing on interprofessional teams.
- Advocating for patients within the interprofessional team.
- Working collaboratively on nursing and interprofessional teams

- Assuming responsibility for specific patients based on scope of practice for the nursing profession.
- Understanding the influence the nurse has on patients and delivering care in a professional, respectful manner.
- Actively participating in professional activities including peer and other feedback to enhance skills and acquire new knowledge.

- Applying evidenced-based practices at the point-of-care while assessing, implementing and evaluating care.

2. Empowering others

- Seeking out and advocating for continual learning opportunities for point-of-care staff.
- Critically reflecting on personal use of empowering behaviours.
- Seeking feedback on empowering behaviours.
- Sharing power with others.

- Leading education for patients through the use of appropriate teaching resources.
- Using experience as a learning opportunity.
- Coaching, mentoring and guiding.
- Providing both negative and positive feedback constructively.

Point-of-Care Leadership (cont.)

2. Empowering others (cont.)

- Utilizing systems and technology at the point-of-care to facilitate evidenced-based care and improved outcomes for patients/clients.
- Monitoring and collecting indicators to assess the safety and quality of patient/client care.

- Acting as liaison between interprofessional team members and consultant for other nurses.

- Identifying ways to save costs at the point-of-care, and bringing these to the attention of management.
- Implementing system-wide initiatives that improve quality, effectiveness and efficiency.
- Delegating and using resources appropriately at the point-of-care.

- Promoting the contribution of nursing to patient/client and organizational outcomes.

- Providing and acquiring appropriate information for decisions relevant to the patient/client.
- Acting as an advocate for patients and their families in the hospital and when accessing other community based services.

3. Contributing to an environment that supports knowledge integration

- Applying nursing process in leading the care of the patient/client.
- Providing opportunities to share knowledge on patient/client progress.
- Leading and sharing interventions for patients and clients through patient-care conferences.
- Managing personal growth by objectively challenging behaviour and beliefs.

- Assessing reports, lab results, to evaluate patient/client status, and sharing knowledge with other team members.
- Taking initiative to consult with experts to support the patient/client in achieving optimal care and outcomes.

- Engaging with other health-care professionals to improve efficiency in existing organizational processes.
- Providing open, timely communication to patient/client, family and the interprofessional team.
- Recognizing patient/client family cultural differences in communication and the influence perceptions of hierarchy may have on communication.
- Encouraging collaborative problem solving.

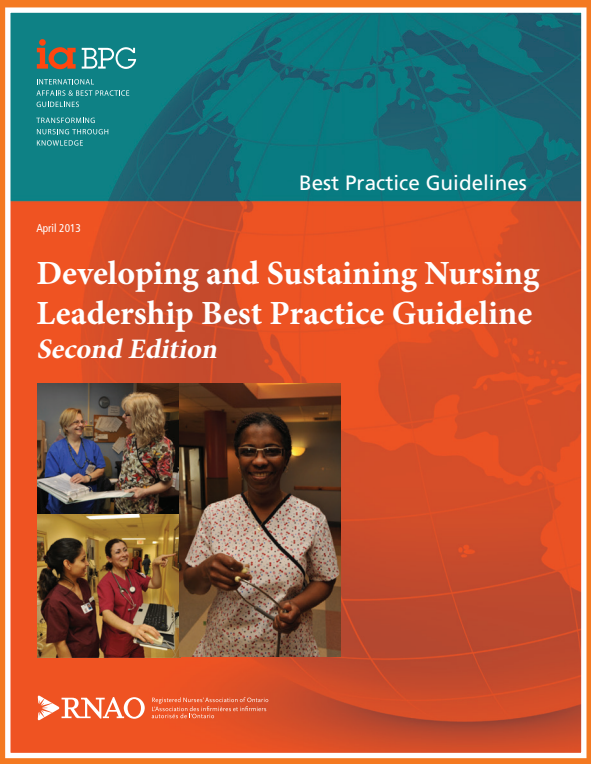
- Facilitating problem solving, decision making and improvement of patient flow.
- Providing effective feedback and seeking same.
- Engaging interprofessional team in improving quality of care and ensuring effective allocation of resources.
- Demonstrating a strong sense of individual responsibility for quality monitoring at point-of-care.
- Providing time for patient/family to discuss plan of care and involving the interprofessional team.
- Using reflective practice to generate and validate knowledge.

- Participating in benchmarking and implementing best practices.

Point-of-Care Leadership (cont.)

4. Leading, supporting and sustaining change
• Acting as an advocate and assessor for patients, clients and staff. • Effecting change through advocacy for patients and clients. • Challenging assumptions to reflect patient-centered care. • Reflecting on personal attitudes and skills regarding change and change management. • Critically applying evidence to change initiatives.
• Facilitating communication with health-care service providers outside the hospital. • Demonstrating commitment to the change.
• Participating in strategic planning for the ward or specialty area. • Respecting and recognizes the expertise and individual talents that have contributed to the change.
• Providing expert advice and connecting with health services. • Providing regular communication to patients, clients and families on changes that may influence/impact? care.
• Soliciting feedback using approved methods (i.e. patient/client survey). • Working with interprofessional team to provide feedback on changes.
• Engaging with new staff and assisting as they learn to anticipate patient needs related to the change. • Becoming familiar with change theories and championing necessary change.

5. Balancing complexities of the system and managing competing priorities
• Using values clarification to identify personal values, values of others and the values of the organization. • Separating personal values from professional responsibilities.
• Seeking confirmation of professional decisions by consulting peers.
• Providing advice on appropriate care. • Developing flexibility in nursing practices responding to changing patient/client and organizational needs while providing safe evidence-based care.
• Sharing expertise and providing insight on new care techniques. • Leading patient care by setting priorities and adjusting care to reflect them.
• Facilitating debriefing sessions for staff and contributing to their knowledge. • Collecting data to advocate for resources. • Identifying equipment and staffing needs.
• Monitoring the effects of decisions on patients and clients.



Link to the full version of this guideline

Developing and Sustaining Nursing Leadership, Second Edition BPG
www.RNAO.ca/bpg/nursingleadership

May 2014

return to Table of Contents

Tools

CHARGE NURSE ORIENTATION CHECKLIST FOR: **Generic**			
		INITIAL WHEN COMPLETED WITH DATE	
Manager/Coordinator: How to contact			
CSM - how to reach and hours of work			
Manager/Director on Call			
Temporary Overflow Units and Location			
UNIT LAYOUT/BREAKS/CULTURE			
STAFFING: assess for adequate staffing	Teams		
	D Mon - Fri		
	D Sat/Sun		
	N		
ASSIGNMENT for D shift	Isolation/ Restraints/ Workload Increase		
Considerations	Team Based Care		
	Orientation/buddies		
	Overflow Areas		
	Sick Calls/ELOA		
	Equipment		
CHARTS	Orders		
	Chart Checks		
MPV	Legend		
	Work assignment -porters		
MEDITECH	Printing daily worklist		
	Order Entry		
	Chart Reconciliation		
	Biomed Request		
	Repair/Maintenance requests		
	Supplies required for the day		
	Checking blood products		
	Printing lab labels		
	Printing patient labels		
CODES	Review all codes		
	Difficult Intubation		
	Emergency Carts		
ADMISSIONS	What is needed in report?		
	From ED		
	Direct Admit from another hosptial /Clinic		
TRANSFERS	From another unit		
	To another unit		
	To another facility		
	To OR		
DISCHARGE	Regular		
	Ambulance		
	Pkgs for transfer		
	MT # Login / paper alternative		
	Faxing to Family Dr (CPSO DR SEARCH)		
	Home instructions		
	Community Care		
PHARMACY	MARS / TRASFER MEDS / D/C MEDS		
	Accudose		
	LEXICOMP		
	Med Reconciliation		

DETERIORATION OF A PATIENT	Signs and symptoms		
	Who to call/ when to call		
	CCOT 6666, RT 7043		
PATIENT DEATH	Trillium		
	Packages		
	Coronor		
WORK ORDERS	Maintenance		
	Biomed		
	IT tickets		
VERSUS	Safepoint		
SCHEDULING			
DAILY UNIT CLERK FLOWSHEET			

Unit Orientation Checklist

Please complete the following and return to Educator

Name: _____ *Date:* _____ *Unit:* _____

	Replies/Comments	Initials
Locate Clinical Manager- office door number?		
Locate Educator's office number?		
What is the door number for the staff room/lounge? Do you have access?		
Staff Bathroom location? Do you have access?		
Schedule location • What is the ESP login?		
Find a shift change form.		
Process of calling in sick or absent • Who to call?		
Unit extension?		
Locate the Assignment Board. How many staff are on today? • Name of 1 Nurse. Say hello		
Who is the Nurse in Charge? • Name? Say hello! • How can you identify them?		
Locate Quality Safety Huddle Board. Name one initiative on it?		
Pneumatic tube station • How to use it? • What is the unit station number? • Name one thing that can't go in it?		
Where is the main call bell system located? • How to answer a call bell?		

• Can you page overhead? • How do you communicate to staff in the patient room?		
Patient Care Boards • Provide 3 key components displayed on the care boards.		
Pantry		
• Ice Machine • Patient Fridge • Snacks. Name one snack with a patients name on it and date?		
Out and About on the Unit	**Replies/Comments**	**Initials**
Supplies		
Locate clean supply rooms (room #'s)		
LogiD system • White and red tags • Ask a team member to describe how to ensure supplies are restocked • How to locate supplies • Find the Dri Flo Pads code # • Find the Medium size Brief code# • Find Peri Pads code #		
Sage Products (personal Hygiene) • Name 3 products available for personal hygiene.		
Locate shower rooms • Is there a shower chair present? • Is there a call bell system present?		
Dirty Utility rooms		
• Room location • Biohazard garbage • Battery disposal • Linen hampers		
Identify the MPV board location		
MPV board display • Find a room with white and brown		

stripes? • What does this mean If the room is white what does it mean?		
Infection Control		
Where can you find Personal Protective Equipment (PPE)? • Find two areas • Name 3 items		
Name two places where you can find information on patient isolation requirements, COVID-19 requirements		
Where are the MRSA, VRE and ESBL swabs located?		
Out and About on the Unit	Replies/Comments	Initials
Did you find any rooms with a red sign on the door? • What does this indicate?		
What identifiers can I find in the patient area, when the patient is identified as a high risk for falls?		
Green sign above patients bed (locate) • SLP recommendations. Name 2. • Food texture/liquid modification • Why is this important?		
Equipment		
Identify the following equipment location • Transfer Board • Over Bed Lift/Hoyer Lift/ Sling • Scale: Standing and Wheelchair • Code Cart • IV pumps • Bladder Scanner • Commodes • Portable oxygen tank • Wheelchairs • Stretchers		

• Walkers • Blanket warmer • Clean linen cart • Pillows • How do you locate equipment through the VERSUS system? Unit login?		
Patient's Room		
Patient room readiness/safety • Call bell – ensure its plugged and is functioning • Code blue button • Bed controls/alarms • Check one patient's brakes • Emergency call bell in bathroom • Are rooms free of clutter?		
Admission/Transfers/Tests		
Does the unit have a test/procedure board?		

Patient Assignment Decision Guide

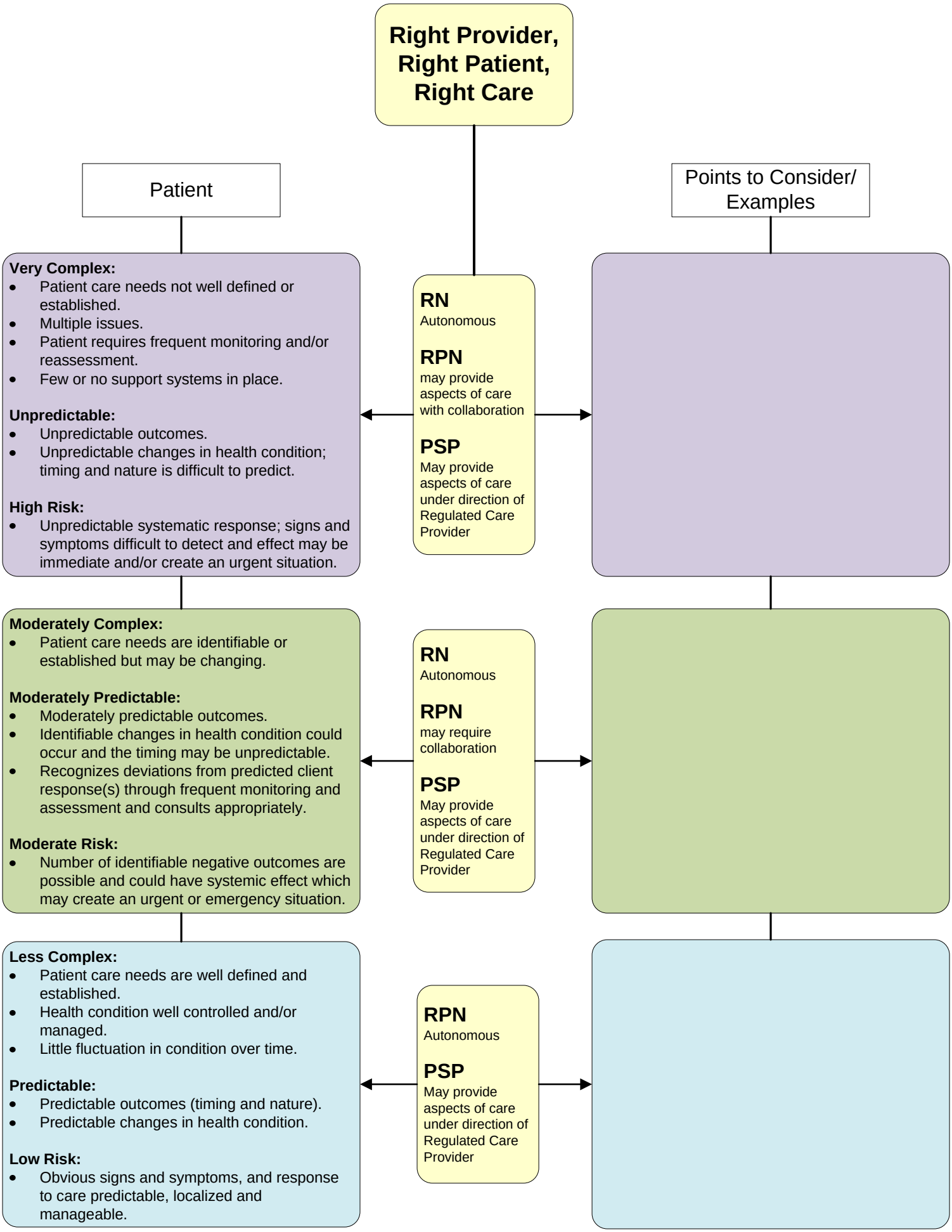
	Overall Care Requirements				Circumstances		
	Knowledge / Critical Thinking	**Complexity of Patient's Needs**	**Predictability (patient's physical stability)**	**Special Skills**	**Autonomy**	**Resource Individuals Available**	**Competency (Opportunity to maintain competency)**
RN	Critical thinking over a **wide range** of signs, symptoms or responses & potential outcomes.	**Fluctuating** care needs with **no support** systems	Condition is **unstable**	**Complex** skills	Establish, revise and work within written policy parameters and plan of care; **independently** decides when to collaborate / consult	**Not physically present and** / or readily available. Care provider is the only source of client status information	**RARE:** RN: Can only perform if resources individuals are available RPN: May not perform **OCCASIONALLY:** RN: Can only perform if resources individuals are available RPN: May perform if resources to consult / intervene are immediately available and autonomy requirement falls within RPN scope. **FREQUENTLY:** **RN: May perform within scope of practice** **RPN: May perform within scope of practice**
RPN	Critical thinking over a **narrow range** of signs, symptoms or responses & **predictable** outcomes.	**Identified** care needs **with support systems**	Condition is **stable**	**Uncomplex** skills (eg. glucometer; tracheostomy care)	Work within written policy parameters; **independent** decision making; understands scope and consults when changes in acuity/ predictability	**Physically present** to intervene, assume responsibility of care and/or provide direct supervision. Resource individual has first hand knowledge of client status	
Collaborative	Critical thinking over a **defined range** of signs, symptoms or responses & potential outcomes, and notify another to deal with **predictable** outcomes	**Identified** care needs with **no** support system	Condition is **potentially unstable**	**Moderately complex** skills (eg. immediate post-op tracheostomy care)	Work / participates in the development of written policies / parameters and plan of care; **makes decision in collaboration** with the resource individual	**Physically present,** available to consult / intervene if necessary. Rely on **care provider notification** for assistance	

Adapted from Humber River Regional

Team Assignment Sheet

Circle Shift: Days Evenings Nights Date:_____

: _____ **Break:**_____ :_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Assess/Document Rooms:**_____ **Other:**_____ **To Follow Up:**	:_____ , **Break:**_____ :_____ :_____ :_____ :_____ :_____ :_____ :_____
:_____ , **Break:**_____ :_____ :_____ :_____ :_____ :_____ :_____ :_____	:_____ , **Break:**_____ :_____ :_____ :_____ :_____ :_____ :_____ :_____


Right Provider, Right Patient, Right Care
Patient
Points to Consider/ Examples
Very Complex:
Patient care needs not well defined or established.
Multiple issues.
Patient requires frequent monitoring and/or reassessment.
Few or no support systems in place.
Unpredictable:
Unpredictable outcomes.
Unpredictable changes in health condition; timing and nature is difficult to predict.
High Risk:
Unpredictable systematic response; signs and symptoms difficult to detect and effect may be immediate and/or create an urgent situation.
RN
Autonomous
RPN
may provide aspects of care with collaboration
PSP
May provide aspects of care under direction of Regulated Care Provider
Moderately Complex:
Patient care needs are identifiable or established but may be changing.
Moderately Predictable:
Moderately predictable outcomes.
Identifiable changes in health condition could occur and the timing may be unpredictable.
Recognizes deviations from predicted client response(s) through frequent monitoring and assessment and consults appropriately.
Moderate Risk:
Number of identifiable negative outcomes are possible and could have systemic effect which may create an urgent or emergency situation.
RN
Autonomous
RPN
may require collaboration
PSP
May provide aspects of care under direction of Regulated Care Provider
Less Complex:
Patient care needs are well defined and established.
Health condition well controlled and/or managed.
Little fluctuation in condition over time.
Predictable:
Predictable outcomes (timing and nature).
Predictable changes in health condition.
Low Risk:
Obvious signs and symptoms, and response to care predictable, localized and manageable.
RPN
Autonomous
PSP
May provide aspects of care under direction of Regulated Care Provider

STAFF MIX DECISION FRAMEWORK

FACTORS TO CONSIDER
Including but not limited to:

CLIENT
- Healthcare needs
- Acuity, complexity, predictability, stability, variability and dependency
- Type:
  - Individual
  - Family
  - Group
- Community/Population
- Cohort:
  - Numbers
  - Range of Conditions
  - Fluctuations in mix
- Continuity of Care Provider

STAFF
- Healthcare Providers:
  - Numbers
  - Availability
  - Education
  - Competencies
  - Experience
- Teamwork and collaboration
- Clinical support and consultation
- Continuity of assignment
- Continuity of care

ORGANIZATION
- Interprofessional care delivery model
- Physical environment
- Resources and support model
- Practice setting
- Legislation and Regulations
  - Workplace Health and Safety
  - Policies
  - Collective Agreements
  - Vision, Mission, and Nursing Philosophy
  - Leadership Support

PLAN
ASSESS
IMPLEMENT

- BASE DECISIONS ON INTERPROFESSIONAL CARE DELIVERY MODELS AND EVIDENCE
- MAKE DECISIONS WITH THE SUPPORT OF SYSTEM INFORMATION
- BASE DECISIONS ON CLIENT CARE NEEDS
- SUSTAIN IMPLEMENTATION WITH ORGANIZATIONAL COMPONENTS AND LEADERSHIP
- INVOLVE DIRECT CARE PROVIDERS AND INTERPROFESSIONAL LEADERSHIP

EVALUATE

SOUTHLAKE
REGIONAL HEALTH CENTRE

OUTCOME INDICATORS
Including but not limited to:

CLIENT
- Safety/Quality of Care:
  - Access to care provider
  - Morbidity
  - Mortality
  - Patient Safety Incidents
  - Readmissions
  - Quality of Life/functional independence/self-care management
  - Satisfaction
  - Continuity of care

STAFF
- Quality of work life:
  - Satisfaction
  - Engagement
  - Leadership
  - Professional Development
  - Optimization of scopes practice
  - Evidence informed care
  - Work relationships
  - Fatigue
  - Overtime
  - Absenteeism
  - Illness and injury
  - Turnover

ORGANIZATION
- Evidence informed practice:
  - Access
  - Safety/Quality of care
  - Length of stay
  - Patient safety incidents
  - Readmissions
  - Supervisors span of control
  - Quality of work environment: recruitment and retention
  - Case/service cost

Southlake Therapeutic Surface Selection Tool

Prevention

	Braden	Southlake Owned: Use Southlake resources prior to rental	Rental
Low to high risk no breakdown	9 or greater	**AccuMax**	use owned surface
Comfort - Palliative		**AccuMax**	use owned surface
High risk with immobility	9-12 and/or Mobility 1-2	**P500**	First Step Select – Cirrus (300lb) First Step All in One (400lb)
Very high risk	9 or less	**P500**	First Step All In One (400lb)

Treatment

Wound	Mobility	Owned	Rental
Stage 1or 2 pressure injuries or blisters on multiple sites	1 or 2	**AccuMax or P500**	use owned surface
Stage 3 or 4, Unstageable or multiple sites Edema or diaphoresis (low Air Loss)	1 or 2	**AccuMax (small stg 3 but good mobility) P500**	First Step Select-Cirrus(300lb) Therakair Visio - (350lbs) First Step All in One(400lb)

Obese

	Mobility	Owned	Rental
*Southlake surfaces are safe up to 500lb. *Rent if over 500 lb. *AtmosAir is similar to AccuMax *Maxxair is similar to P500	9 or higher	**AccuMax** **P500** (500lb) **Total Care Bariatric** (500lb) for width	Citadel Plus (1000lb) + Atmos Air Plus
	9 or less Stage 1 or 2 Pressure Injury	**P500** (500lb) **Total Care Bariatric** (500lb)	Citadel Plus (1000lb) + Atmos Air Plus or Maxxair ETS (air)
	9 or less low mobility Stage 3,4, multiple Pressure Injuries	**Total Care Bariatric** (500lb)	Citadel Plus (1000lb) + Maxxair ETS (air)

Revised by A Klein Mar. 2019

Special Purpose

Post flap procedures (Contact Wound Care)			Therapulse ATP or
Severe pulmonary complications (ICU&MD order)		**Progressa (ICU only)** **Total Care Sport (ICU only)**	Triadyne II Proventa (350lbs) (proning suface)
ICU Surface			Citadel C200 500lbs (plus Skin IQ rental)

Sleep Surface at Southlake

1. **Always used Southlake own resources prior to rental where possible/available**

2. Therapeutic surfaces do not eliminate the need for a turning and repositioning routine or other prevention interventions.

3. **AccuMax** is the new standardized surface at Southlake. This therapeutic surface suitable for patients with moderate risk, those with Stage 1 and 2 Pressure Injuries and for Palliative Care. Some are loose, and some are integrated into the bed frame. The have AccuMax printed at the side or the foot of the bed.

4. The hospital currently owns about 36 **P500** surfaces. This is a therapeutic surface with low air loss and is better or equal to the air surfaces that units tend to rent. Most P500s have been electronically tagged and can be located through the Versus system by searching P500. Flat and fitted sheets can be used on these surfaces however the air will not pass through the brown cloth incontinent pads; Ultrasorb pads should be used.

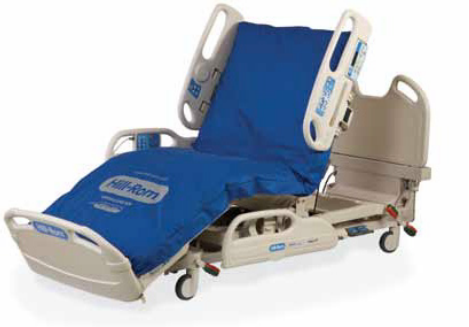
Nurse should:

- check the P500 surfaces on their own units to see if they are being properly utilized
- look to see if there is one available in the CES room
- contact other units to free up a surface if possible

Ways to identify a P500 are:

1. P500 is stencilled on the footboard
2. The mattress is bright blue
3. The bottom of the mattress says P500
4. If you look behind the headboard you will see the black sensor

Please send P500 and Bariatric surfaces to the CES room when patients are discharged or mobility improves, or find another patient on your unit who would benefit from a therapeutic surface.

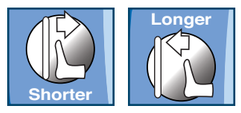
AccuMax	
P500	
Total Care Bariatric	

VersaCare® Bed Tips

FLEXAFOOT™ MECHANISM

- Allows the caregiver to customize the overall length of the bed and sleep surface to fit the patient.
- The bed and surface can be retracted up to 11" (28 cm) which also aids the caregiver during transport (i.e. small elevators, smaller turning radius).
- Designed to help reduce patient migration to the foot-end of the bed.
- Integrated surface automatically adjusts to the length of the bed as FlexAfoot™ mechanism is activated.

TO ACTIVATE:



- Press and hold the foot **Shorter** control to retract the foot section.
- Press and hold the foot **Longer** control to extend the foot section.

LOWCHAIR® POSITION

- Allows the patient to be placed into a chair position, while maintaining low height.

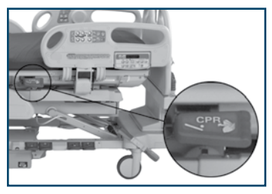
TO ACTIVATE:

- Set the brake.
- Press the **Enable Control** and then the **Chair** button.

ONESTEP® CPR & EMERGENCY TRENDELENBURG

- If using an integrated air surface (VersaCare A.I.R.® or VersaCare® P500), the surface automatically goes into Max Inflate for 30 minutes. After 30 minutes, the surface will go into Normal/Standard mode.
- A cardiac arrest board is required. The headboard can be used in place of the cardiac arrest board.

TO ACTIVATE CPR:



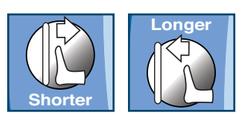
- Pull and hold the handle.
- Hold the handle until the head and knee sections come to a stop in the flat position and the foot section stops raising.
- Release the handle.

TO ACTIVATE EMERGENCY TRENDELENBURG:

- Pull and hold the handle.
- Hold the handle until the head and knee sections come to a stop in the flat position and the foot section stops raising.
- Continue to hold the handle until the desired angle is reached (up to 15°).

PATIENT REPOSITIONING

- Two easy ways to help maintain patient positioning:
  - + Patient Hip Indicators – located on both sides of the bed to show you where the patient's hips belong.
  - + FlexAfoot™ Mechanism – allows for customized bed length so the footboard can be retracted/extended up to 11". This right-sizes the bed to prevent patients from sliding down in bed.



PATIENT REPOSITIONING – BOOST® FUNCTION

- If your patient needs to be repositioned, use the Boost® feature to make it easier for you by placing the bed in the ideal position to reposition your patient.
- Pressing the Boost® button will:
  - + Max Inflate the mattress.
  - + Flatten the bed.
  - + Put the bed at the ideal working height.
  - + Place the bed in 7 degrees Reverse Trendelenburg.

TO ACTIVATE:

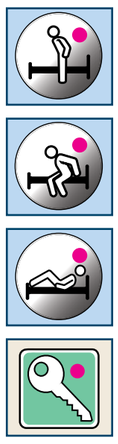
- + Press the **Boost®** button on the siderail.

TO DEACTIVATE:

- + Press the bed flat button to return the bed to flat position.

BED EXIT ALARM – 3 MODE PATIENT POSITION MONITOR

- The bed exit alarm will notify the caregiver when:
  - + **Out of Bed:** patient's weight shifts significantly off the frame of the bed.
  - + **Exiting:** patient moves away from the center of the bed towards an egress point.
  - + **Patient Position:** patient moves toward either siderail or moves away from the head section, such as sitting up in bed.



TO ACTIVATE:

- Ensure patient is on the bed.
- Press the enable control.
- Press the desired mode control. When the system beeps one time and the indicator stays on solid, the system is armed.

TO DEACTIVATE:

- Press the **Enable Control**.
- Press the desired mode control. When the system beeps one time and the indicator light is gone, the system is deactivated.

ZEROING THE SCALE

- The scale should be zeroed prior to placing a patient on the bed.
- Be sure to put ALL linens, pillows, and equipment on the bed prior to zeroing the scale.

HOW TO ZERO THE SCALE:

- Press the **Enable Control**.
- Press and hold the **Zero Control** until 00.0 is shown (HOLD will be displayed until 00.0 is shown) and then release the control.
- NOTE: After releasing the control, the scale display will show 'CALC'. Do not touch the bed until the display stops flashing 'CALC' and shows 0.0.

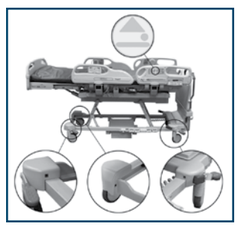
WEIGHING A PATIENT

- Be sure the scale has been zeroed with linens, pillows, and other equipment on the bed prior to weighing the patient.

HOW TO WEIGH A PATIENT:

- Make sure the patient is centered on the bed.
- Ensure the bed is clear of all obstructions (lines, tubing, walls, etc).
- Press the weigh button.
- On release of the weigh control, the bed gets the current patient's weight. It is shown in lb for 10 seconds, then kg for 5 seconds and then repeats.

OBSTACLE DETECT® FEATURE



- The Obstacle Detect system runs along the three open sides of the bed frame.
- The system recognizes objects that are between the upper frame and the base frame.
- If an object is identified while the bed sleep deck is lowering, the bed will:
  - + Stop lowering.
  - + Raise automatically for 2 seconds.
  - + Bed not down indicator on both sides of the bed will flash.

VASCULAR POSITION

- Allows for the patient's legs to be placed above the level of their sternum.

TO ACTIVATE:

- Lower the head section to the desired position.
- Raise the knee section to the desired position.
- Use the Trendelenburg control to position the sleep deck to the desired position.

TO DEACTIVATE:

- Use the Reverse Trendelenburg control to return the bed frame to the horizontal position.
- Use the bed flat to return the sleep deck to the flat position.

HANDSFREE® FOOT PEDALS

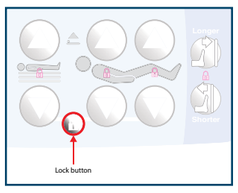
- Foot pedals allow the caregiver to raise and lower the head of the bed and the height of the bed without using their hands.

TO ACTIVATE:

- Step down on any pedal for 1-3 seconds.
- Release the pedal.
- Step down on the pedal of the desired function until the desired function is achieved.

LOCKOUT CONTROLS

- Located on the caregiver siderail control panel, the lockout controls allow the caregiver to disable the bed articulating functions to prevent patient positioning features from being used.
- Features that can be locked out:
  - + Bed high/low.
  - + Head up/down.
  - + Knee up/down.
  - + Adjustable bed length.



TO ACTIVATE:

- Simultaneously press the **Lock** button and the specific lockout control desired (either up or down).
- Both patient and caregiver controls are locked out.
- An audible alarm sounds when a lockout is activated.
- An amber light will illuminate on the lock for the feature that you want locked out – this signifies that the feature is locked out.

TO DEACTIVATE:

- Simultaneously press the **Lock** button and the specific lockout control desired (either up or down).
- An audible alarm sounds and the amber light disappears when a lockout is deactivated.

LINE MANAGERS

- Simplify and organize patient lines to avoid entanglement or pinching.
- Flexible and can be bent in any position.
- **NOTE: Do not wrap cords around the line managers.**

SLEEP MODE

- Sleep mode temporarily disables the air system to allow patients who are sensitive to sleep surface movement to sleep.
- Air pressure in the mattress is monitored, but the air pump will not run unless the air pressure falls below or above a preset level.
- **NOTE: Sleep mode remains active for 8 hours. After 8 hours, the surface will revert back to Pressure Relief/Normal Mode.**

TO ACTIVATE:

- Press the **Enable Control**.
- Simultaneously press the Left Turn Assist and Right Turn Assist control and hold for 5 seconds. After 5 seconds, the right and left Turn Assist indicators will illuminate.

TO DEACTIVATE:

- Press the Enable Control.
- Press any surface control.
- **NOTE: Sleep mode remains active for 8 hours. After 8 hours, the surface will revert back to Pressure Relief/Normal Mode.**

HEAD-OF-BED (HOB) ANGLE ALARM

- Visually confirm the head-of-bed is elevated 30 degrees or higher to comply with protocols.
- HOB angle alarm can be easily set to notify caregivers if the HOB is lowered less than 30°.

TO ACTIVATE:

- Raise the head-of-bed above 30°.
- Press the **Enable Key**.
- Press the 30° head-of-bed button. The green button will light up to indicate the alarm has been set.

TO DEACTIVATE:

- Press the **Enable Key**.
- Press the 30° head-of-bed button. The green indicator will go off.

TURN ASSIST

- Assists with turning the patient for linen changes, dressing changes, bedpanning, back care and other nursing procedures.
- Siderails must be in the up position to activate Turn Assist.
- Once Turn Assist is initiated, you may lower a siderail to facilitate patient care. The bed will alarm as a precaution.
- Turn Assist can be activated from either side of the bed.

TO ACTIVATE:

- Press the **Enable Control** and then either **Left Turn** or **Right Turn** on the siderail.

MAX INFLATE

- Maximizes the firmness of the primary section of the patient surface.
- Assists in patient surface-to-surface transfers and/or repositioning.
- Bed will stay in Max Inflate for 30 minutes before returning to normal/standard state.

TO ACTIVATE:

- Press the **Enable Control** and then press the **Max Inflate** button on the siderail.

TO DEACTIVATE:

- Press the enable control and then press the **Pressure Relief/Normal** button.

FOR COMPLETE INSTRUCTIONS ON HOW TO OPERATE THE VERSACARE® BED, SEE USER'S MANUAL.

ORDER NUMBER 174461 rev 2 14-MAR-2014 ENG – US

Zinc Number US-AC-1113-0583

www.hill-rom.com

USA 800-445-3730
CANADA 800-267-2337

Enhancing outcomes for patients and their caregivers.®

Hill-Rom®

January 2021

Quick Links to Southlake Resources

Links to Intranet

Escalation of a Concern Regarding the Immediate Safety of a Patient as it Relates to Patient Care

Interpretation and Translation Services

RNAO Best Practice Spotlight Organization

Trillium Gift of Life Resources

Links to CNO Supporting Documents

Code of Conduct

http://www.cno.org/globalassets/docs/prac/49040_code-of-conduct.pdf

Decisions about Procedures and Authority

http://www.cno.org/globalassets/docs/prac/41071_decisions.pdf

Confidentiality and Privacy- Personal Health Information

http://www.cno.org/globalassets/docs/prac/41069_privacy.pdf

Professional Standards, Revised 2002

http://www.cno.org/globalassets/docs/prac/41006_profstds.pdf

Conflict Prevention and Management

http://www.cno.org/globalassets/docs/prac/47004_conflict_prev.pdf

RN and RPN Practice: the client, the nurse, and the environment

http://www.cno.org/globalassets/docs/prac/41062.pdf

Working with Unregulated Care Providers

http://www.cno.org/globalassets/docs/prac/41014_workingucp.pdf

Resolving Complaints: A Guide for Nurses

http://www.cno.org/globalassets/docs/ih/42018_resproguide.pdf

Entry to Practice Competencies for RNs

http://www.cno.org/globalassets/docs/reg/41037_entrytopracitic_final.pdf

Entry to Practice Competencies for RNs- in effect 2020

http://www.cno.org/globalassets/docs/reg/41037-entry-to-practice-competencies-2020.pdf

Entry to Practice Competencies for RPNs

http://www.cno.org/globalassets/docs/reg/41042_entrypracrpn.pdf

return to Table of Contents

Unit Processes

Booking an Ambulance

For non-emergent transport call:

Voyageur at 1-855-263-7163

- Provide date and time of transport, reason for transport, patient's weight, any precautions, whether patient requires oxygen therapy, code status
- Ensure PTAC is done (by a unit clerk or some VNT's) PTAC is only for patients being transferred to another facility
- Assemble discharge/transfer package including discharge summary, ministry DNR (if applicable), transfer report, current MARS, any pertinent lab or diagnostic reports

For Emergency/Critical transport

call: EMS at 1-800-461-4304

Or

Orange at 1-800-251-6543 (H.O.)

SERVICES WHERE WE NEED TO BOOK PORTERS

1. AMBULATORY DAYCARE
2. ECHO/TEE (CARDIAC DIAGNOSTICS)
3. SURGICAL ADMISSIONS (OR)
4. FRACTURE CLINIC
5. NUCLEAR MEDIC INE
6. BONE SCAN/GALLIUM SCAN
7. DI RM#2 VIDEO SWALLOW STUDY
8. CANCER CENTRE FOR RADIATION
9. MAB, MAMMOGRAMS

SERVICES THAT BOOK THEIR OWN PORTERS

1. MRI
2. CT
3. X-RAY
4. ULTRASOUND

Ordering Cots for Care Partners Staying Over night

Cots have RFID tags and can be tracked on Versus for availability.

Please note cots are 29 inches wide by 72 inches in length.

Care Partners are expected to provide pillow and linen.

- The unit may call 2000 to request a cot once visiting hours are over (2100hrs)
- If call is made to 2000 prior to visiting hours being over then call will be pre logged for cot delivery at 2100hrs.
- The cots will remain on the unit if a Care Partner stays over night for longer than one night.
- Once the cot is no longer needed then a call is placed through to 2000 for pickup to the CESS room.
- Transport will bring the cot to the CESS room and leave on soiled side to be cleaned.
- The call will be logged as a material call and not be placed before patient/specimen calls.

HOW TO ADD A PHYSICIAN CONSULT

- Open patient's chart
- Go to orders
- Click on new orders
- Go into category groups
- Click on consult physicians
- Select appropriate field from drop down menu
- Click on red edit box
- Under consult provider, begin typing consulting physician's name
- Select desired physician
- Fill in "reason for consult"
- Indicate whether or not you have contacted the consult provider
- Click ok
- Click save
- Call or page the physician to notify them of the impending consult

When the Unit Clerk is Away ...

Below are a few hints and tips for the times when there is no clerk available:

- You can page someone yourself, by using the paging system at ext. 2600. Just follow the prompts
- You can call distribution directly at ext. 2439 and explain that you don't have a clerk and can't access the system. They will help you.
- Anyone can complete a work order or biomed order request. Simply open the app and sign in using your Southlake login.
- Do you need maintenance after hours? Call ext.7074
- While you cannot complete a PTAC, you can ready the information required for a PTAC; patients' weight, 02 requirements, any precautions…
- Need a number for another department or a physician? Call ext. 2216

HOW TO TRANSFER A CALL

- Without putting the call on hold, push the conference button
- Enter the extension you are transferring to
- When the party at the desired extension picks up, push the conference button again and hang up the phone

Finding Equipment Using the Versus System

Assessment - Integumentary

Username: SUR
Password: SUR

Search: P500
Kangaroo
Bladder Scanner

Badge	ID	Location	Item	Manufacturer	Model
13606	BED1	E-4 PPU Pt Rm 4023	Bed, Versacare P50	Hill-Rom	P3200
10251	BED11	E-4 PPU Hall by Pt Rm 40	Bed, Versacare P50	Hill-Rom	P3200
10259	BED12	C-3 RNU Activity Rm 3411	Bed, Versacare P50	Hill-Rom	P3200
10265	BED13	C-6 CAN Rm 6513	Bed, Versacare P50	Hill-Rom	P3200
10336	BED14	C-3 RNU Pt Rm 3616	Bed, Versacare P50	Hill-Rom	P3200
10289	BED15	C-6 MED Hall by Rm 6604	Bed, Versacare P50	Hill-Rom	P3200
14031	BED16	C-3 RNU Soiled Rm 3624	Bed, Versacare P50	Hill-Rom	P3200
14022	BED17	E-3 MCC Pt Rm 3035	Bed, Versacare P50	Hill-Rom	P3200
10258	BED18	C-3 Hall by Central Elevat	Bed, Versacare P50	Hill-Rom	P3200
14022	BED19	C-3 RNU Activity Rm 3411	Bed, Versacare P50	Hill-Rom	P3200
12110	BED2	E-5 SUR Pt Rm 5038	Bed, Versacare P50	Hill-Rom	P3200
9215	BED20	C-3 MSK Pt Rm 3524	Bed, Versacare P50	Hill-Rom	P3200
10252	BED21	C-3 RNU Pt Rm 3621	Bed, Versacare P50	Hill-Rom	P3200
11335	BED22	C-5 CVS Patient Rm 5602	Bed, Versacare P50	Hill-Rom	P3200
14032	BED23	C-6 MED Rm 6630	Bed, Versacare P50	Hill-Rom	P3200
10295	BED24	C-6 CAN Rm 6508	Bed, Versacare P50	Hill-Rom	P3200
11329	BED25	E-3 MCC Hall by 3031	Bed, Versacare P50	Hill-Rom	P3200
13583	BED26	C-3 MSK Pt Rm 3518	Bed, Versacare P50	Hill-Rom	P3200
10294	BED27	E-3 MACU Hall by 3223	Bed, Versacare P50	Hill-Rom	P3200
10263	BED28	E-3 MACU Hall by 3244	Bed, Versacare P50	Hill-Rom	P3200
13612	BED3	C-6 CAN Rm 6529	Bed, Versacare P50	Hill-Rom	P3200
10282	BED30	E-3 MCC Pt Rm 3029	Bed, Versacare P50	Hill-Rom	P3200

SOUTHLAKE REGIONAL HEALTH CENTRE
Loading edge care. By your side.

return to Table of Contents

Admission

and

Bed Flow

January 2021

Checklist for Admission to RCU Finch and Church Sites

- Try to choose a patient who is truly restorative. We have more than half of our patients waiting for LTC. These patients will decrease our turnover.
- Must be cognitively able/willing to participate in daily programming.
- Patient must have signed ALC orders. Please ensure correct diet order.
- Medication reconciliation transfer of care signed by MD (no outpatient prescriptions)
- NOTIFY PHARMACY that the patient will be transferred to RCU. We only receive our medications here 3x weekly so this is important step. Pharmacy will need to send enough medication until our regular delivery.
- IPAC swabs for MRSA/VRE/CPE/ESBL must be done and resulted negative within 72 hours prior to transfer. We can accommodate some MRSA, ESBL. IPAC to be consulted to cohort any patients. NO CPE/VRE or airborne precautions.
- If the patient is waiting for LTC, please initiate co-pay.
- No patients receiving dialysis.
- No patient with PICC/CVAD/CADD (this may be re-evaluated in future)
- No cardiac monitoring
- No patients requiring RT support (tracheostomy)
- No patients with unmanaged behaviours; no patients using restraints
- No exit seeking (units are not locked)
- No patients requiring bariatric equipment (unless mobile and have their own)
- Please call the unit to give report to the accepting nurse.

Finch: 416-747-3211 Church: 416-243-4416 (use the SEND report not long transfer form)

- Please book transportation to the unit so that the patient will arrive before 2200 hours.
    - Finch site: 2111 Finch Ave West, North York Reactivation Care Centre/ Level 5 East. Phone: 416-747-3211; Fax: 416-747-3214
    - Church site: 200 Church Street, Weston ON Reactivation Care Centre. Phone: 416-243-4416; Fax: 416-243-4417
- Please contact Manager or Charge Nurse and CSM on weekends to discuss and organize transfer of patients before they leave the main site

Admission to RCU Process:

What is changing?

Effective Monday September 23rd, 2019, patients will be referred to RCU by:

- Clicking the "transfer to ALC Unit", entering referral date, and adding a comment "please assess for RCU" in the Pathway section in iPlan.
- For patients who are close to being ready for referral to RCU, click the "Transfer to ALC Unit", entering referral date, and adding a comment e.g. "please assess for RCU for admission next week" in the Pathway section in iPlan.

This action will trigger a RCU Coordinator to assess the patient for suitability.

Should the RCU Coordinator require further information, the unit Charge Nurse/Discharge Planner/Social Worker will be contacted directly.

How will I know that my patient was accepted/declined?

The RCU Coordinator will enter a comment in the Discharge Planning section in iPlan stating that the patient is:

- Accepted
- Declined for the following reason(s)

How quickly should I expect a bed offer for my patient?

At RCU, the interprofessional teams are working diligently to discharge patients to the community as quickly as possible. Currently, we have no waitlist. Please assess your patients on admission for RCU suitability.

If the RCU has a waitlist, the RCU Coordinator will accept or decline the patient within 24-48 hours of referral in order to facilitate the referring team's ability to make a plan for transfer or make alternate arrangement for discharge planning.

My patient has been declined by RCU but my team would like to challenge this decision. How do I start this process?

Please email the RCU Coordinator and RCU Manager requesting another review of your patient, including reasons why the patient meets the RCU criteria. If required, a teleconference will be set up by the RCU Manager between the teams.

What can I tell the patient/family before the transfer to RCU?

At RCU, you (or your family member) will be assessed by the interprofessional team and a care plan will be designed specifically for you. You will not have one on one therapy on a daily basis, however, group therapy and recreational therapy (e.g. movies, cognitive games) sessions are available every day.

When you reach your goals or when you no longer progress in your functional gains, the interprofessional team will meet with you and your family to discuss next steps in discharge planning.

More information can be found in the RCU information booklet.

HOW TO FLIP A PATIENT

1. Make sure there is a doctor's order to flip the patient
2. Look up existing orders (DET/LABS/DIAGNOSTICS) and consults and write them on the ALC form for the doctor to sign
3. Print medication transfer form from Meditech for doctor to sign
4. Order transfer/bed request in Meditech so Bed Allocation can complete the flip. (if flipping to rehab, bed number should have an 'R' beside it. If flipping to acute bed number should have 'A' beside it)
5. Once Bed Allocation has completed flip in Meditech, a new chart will print
6. File old chart at back of chart binder and refile new chart
7. Label all ALC and medication transfer forms with new patient label and scan down to Pharmacy
8. Re-enter all previous orders into Meditech

Process to Admit to Rehab

When admitting to a rehab bed – MUST have ALC orders and transfer medications signed from sending unit.

If decision to flip from acute to rehab on RNU:

- Neuro Rehab will email team (team includes nursing, MD, NP, Unit Clerks and Neuro Team) who is appropriate from an Neuro Rehab perspective to flip
- Nursing/MD/NP to respond with decision to flip via email or verbally (this to ensure a verbal order)
    - If No-Patient remains acute
    - If Yes-verbal order for the decision to flip on patients chart. Print transfer meds and verbal order as per acute MAR. Verbal order ALC orders and attached "Flip to Rehab" checklist along with signed transfer meds and give chart to Unit Clerk to complete flip

UNIT CLERK ROLE

- Once transfer meds and ALC orders signed by Nursing/MD/NP and "Flip to Rehab" checklist attached, chart to be given to Unit Clerk.
- Complete "Flip to Rehab" Checklist
- Unit Clerk may print out transfer meds and ensure ALC orders and Transfer Meds completed and signed by Nursing/MD/NP along with a written order. Attach "Flip to Rehab" checklist

CRITICALL

Patient Referral Process for Life or Limb from Southlake

1. If Southlake does not have the required clinical services to care for a patient with a life or limb threatening condition and therapeutic options are needed within the next 4 hours, the referring physician contacts CritiCall at 1-800-668-4357.
2. The referring physician designates and requests a "Life or Limb" transfer.
3. CritiCall will facilitate the "Life or Limb" transfer to the closest, most appropriate institution and facilitate consultation.
4. The physician-to-physician consultation and the final triage decision will be made by the consulting physician.
5. When a decision to transfer out of Southlake is made, the clinical team will arrange transport for this patient utilizing the most appropriate mode of transport (EMS, Orange and/or Private).
6. The Charge Nurse and/or designate will facilitate organization of the transfer of medical information/chart.

Repatriation Process to Southlake

1. Bed allocation will review any “incoming” requests from the CritiCall Repatriation Tool and/or from the requesting hospital’s Bed Allocation department.
2. The Bed Flow manager and Bed Allocation clerk will review the request and determine to “accept” or “not accept” via the PHRS repatriation tool and following dialogue and confirmation between the requesting hospital and Southlake.
3. If “accepted” Bed Allocation will place a direct request on the MPV and indicate the time of request.
4. Physician to physician conversation must occur prior to “acceptance” of repatriated patient.
5. It is the responsibility of Southlake to accept all referrals back, regardless of “life or limb” designation, within a best window time period of 48 hours. It is the responsibility of the Bed Flow Manager and Bed Allocation department to ensure appropriate bed placement.
6. Request for repatriation will be reviewed at the twice daily bed flow meetings with the appropriate manager of the clinical unit.
7. If the request for repatriation is “not accepted” for whatever reason (physician services), the Bed Flow manager or designate must indicate the rationale via the drop-down screen in PHRS system.
8. Follow-up conversation will occur between Bed Flow managers at Southlake and the sending

hospital if required.

return to Table of Contents

Discharge Planning

Acute Care Checklist for Inpatient Repatriation to Long Term Care Homes

Long Term Care (LTC) Homes will receive their residents back to the Home between the hours of 0900-1700 as a rule. If an individual cannot be transferred within the hours specified, hospitals must consult with the LTC Home to make special arrangements. Please use this checklist to ensure all requirements are fulfilled prior to sending a resident back to their LTC Home. ***Section A*** includes requirements for repatriations happening at all times. ***Section B*** includes **additional** requirements specific to weekend (Saturdays & Sundays) repatriations.

Requirements – Section A
▪ Notification of the LTC Home that the resident has a discharge planned within 4 hours of discharge ▪ A nurse to nurse report is optimal
▪ Notification of the Next of Kin of the discharge
Things to send with the patient: ☐ Current Medication Orders ☐ Treatment Orders ☐ Diet Orders ☐ For Resident on ***new*** enteral feed – send RD assessment 72 hours prior to discharge, so arrangements can be made to order the correct product ☐ Lab results ☐ Consultation notes ☐ For Residents with *New* Wound treatments – send the dressing order and Specialist Wound Assessment, if applicable, 72 hours prior to discharge so arrangements can be made to order the correct product. ☐ For Residents with a *New* Ostomy – send the Ostomy Supply order and Specialist Wound Assessment, if applicable, 72 hours prior to discharge, so arrangements can be made to order the correct product. ☐ All Follow Up appointments. ☐ Discharge summary notes
Additional Weekend Requirements – Section B
☐ A change in treatment, requiring **new medications**, the hospital must **send up to 72hrs supply** of the medications for the resident. (LTC Homes have limited access to new medications during the weekend hours)
☐ For Residents with ***New* Wound** treatments – send the dressing order and ET assessment, if applicable, Check with the home to see if they stock the supplies otherwise **send up to 72hrs supply** while product is ordered by home.
☐ For Residents with a ***New* Ostomy** – send the Ostomy Supply order and ET assessment, if applicable and **send up to 72hrs supply** while the ostomy product is ordered by home.
☐ Residents being discharged with a **new IV** will not be accepted during a weekend unless arrangements have been made Monday to Friday with the home.

Adopting a Common Approach to Transitional Care Planning:
Helping Health Links Improve Transitions and Coordination of Care

Ontario

Ontario
Health Quality Ontario

Table of Contents

Introduction

This document, *Adopting a Common Approach to Transitional Care Planning*, is a tool to promote standardization in transitional care practices, within and across Health Links, for complex patients. The importance of robust transitional care planning and the benefits of using common approaches to the transition process are described within this guide.

This guide recommends a total of nine practices for transitional care, which are divided into three main categories:

a) Pre-Transition Practices

1. Pre-transition planning is incorporated as a standard of care for complex patients admitted to a health care facility
2. Patients and caregivers are involved as partners in the transition planning process
3. Individualized comprehensive assessments and care plans are developed for complex patients on admission

b) Transition Planning Practices

4. Individualized transitional care plans are developed on admission for patients with complex needs
5. Protocols are established to ensure medication reconciliation at key transition points
6. Families/caregivers are provided with information and resources to support their transition

c) Assessing Post-Transition Risk and Activating Post-Transition Follow-up

7. Standardized risk assessment tools are used to assess and stratify complex patients
8. Appointments are booked with the patient's primary care provider
9. Complex patients receive a follow up phone call within 48 hours of discharge from hospital

Below, the underlying principles supporting the adoption of a common approach to transitional care planning across Health Links are noted. Each of the nine practices are also listed and accompanied by descriptions of ideas for implementation that build on recurrent themes and approaches described in the relevant literature and are currently being used in Ontario.

Securing the buy-in of Health Link and Local Health Integration Network (LHIN) leaders is crucial to success. Likewise, the importance of clarifying accountability within and among providers cannot be over-emphasized. It is recommended that each Health Link establish a mechanism, such as a working group, which will help to ensure that buy-in is achieved and accountabilities are clarified.

Finally, two system-wide goals to improve transitional care planning for complex patients are described below. These goals should continue to be pursued as related work, and are in addition to the nine practices that are the focus of this guide.

Background

A key focus of Health Links is to provide better care for the top one to five percent of the population whose needs represent the majority of health care spending.[1] Many of these individuals have complex and/or multiple chronic conditions and would benefit from improved coordination of care and better supports when transitioning from one part of the health care system to another. While this document is specifically designed for use by Health Links, the principles and practices are applicable and beneficial for all patients, at any transition of care.

> *"Health Links will encourage greater collaboration between existing local health care providers, including family care providers, specialists, hospitals, long-term care, home care and other community supports."*
>
> – Ministry of Health & Long-Term Care, Backgrounder announcing Health Links, December 2012

Supporting Health Links

Health Quality Ontario (HQO) is supporting the implementation of Health Links by partnering with health organizations and researchers to facilitate the widespread adoption of clinical and organizational practices that will achieve the goal of long-term, transformative change in Ontario's health system.

In May 2013, the Transformation Secretariat of the Ministry of Health and Long Term Care (MOHLTC) asked Health Quality Ontario (HQO) to start a consensus building process aimed at improving and standardizing approaches to transitional care planning.[2]

Purpose of the Guide

This document is one of many resources intended to provide guidance to Health Link teams. The guide will facilitate the adoption of a consistent approach to transitional care planning for complex patients. It is meant to complement other publications, resources, activities and supports provided by HQO, the ministry, and others, e.g., *The Registered Nurses Association of Ontario Clinical Practice Guidelines for Transitions in Care* (expected release 2014).

The proposed principles and approaches in this guide build on best practice evidence and experiences, as well as information that was compiled in the HQO bestPATH *Transitions in Care* Improvement Package. The ultimate goal in profiling these standards is to guide Health Service Providers (HSPs) in the adoption of a common approach to discharge planning that will facilitate smoother transitions of care between HSPs to improve care for complex patients.

It is important to acknowledge that a number of HSPs and organizations have achieved many of the approaches in this guide. Others are in the process of implementing reforms consistent with these approaches and/or are providing leadership in developing new practices. Some of these practices have been described in documents recently released by the Ontario Hospital Association and HQO.[3]

---

[1] The definition and identification of complex patients will vary at the local level but might include, for example, a person with severe heart failure and chronic obstructive pulmonary disease who has early dementia. Learn more here.

[2] The term "discharge planning" is strongly linked to the concepts of coordination of care and transition planning. Learn more by reading bestPATH's Transitions of Care Improvement Package

[3] Ontario Hospital Association (Spring 2013). *Achieving Patient Experience Excellence in Ontario: An Idea Book*. Retrieved from: http://www.oha.com/CurrentIssues/keyinitiatives/Patient%20Experience/Documents/Final%20-%20Idea%20book.pdf

Why Transitional Care Planning?

> *"Recent Ontario data shows that only 59% of hospital patients knew which danger signs to watch for after going home from hospital. 80% knew whom to call if they needed assistance, and only 52% knew when to resume their usual activities."*
>
> - Health Quality Ontario, *Quality Monitor*, 2012

Studies have found that improvements in hospital discharge planning can dramatically improve outcomes for patients as they move to the next level of care. Although discharge planning is a significant part of the overall care plan, there is a surprising lack of consistency in both the process and quality of transitional care planning and documentation across the health care system. In fact, transitional care planning varies from hospital to hospital, across other parts of the care continuum, and often within organizations as well.

While variation will continue to exist in Health Links in every region, they all have a common set of goals that include:

1. A focus on patient-centred care with strong mechanisms in place for the patient/family voice to be heard.
2. A commitment to build on existing delivery organizations and leverage current capacity and best practices.
3. Representation across sectors with joint accountability for attainment of results.
4. Common targets and metrics to support implementation and evaluation.

Improving transitional care planning is a critical lever to achieving these goals and ensuring that patients move smoothly from one part of the care continuum to another; whether patients are discharged home from hospital, referred to an outpatient/ambulatory care program, or transferred to a rehabilitation facility or to another health care setting.

> *"A good discharge plan improves patient satisfaction and prevents readmissions."*
>
> - Agency for Health Care Research & Quality

Embracing a Common Approach to Transitional Care Planning

The practices outlined in this guide provide a starting point for discussions about what should be included in a common approach to transitional care planning across Health Links. Standardizing approaches to transitional care planning processes across the care continuum and across Health Links is important, as it will:

a) Promote high quality and safe care across the health care continuum

b) Promote early identification and assessment of patients requiring assistance with planning for discharge

c) Facilitate collaboration with the patient/substitute decision-maker, family and health care team, including the primary care provider, to facilitate transitional care planning

d) Recommend options for the continuing care of the patient and refer to other levels of care (accommodation), programs or services that meet the patient's assessed needs and preferences

e) Foster relationships with community agencies and care facilities to improve coordination of care, address gaps in service delivery and improve transition planning

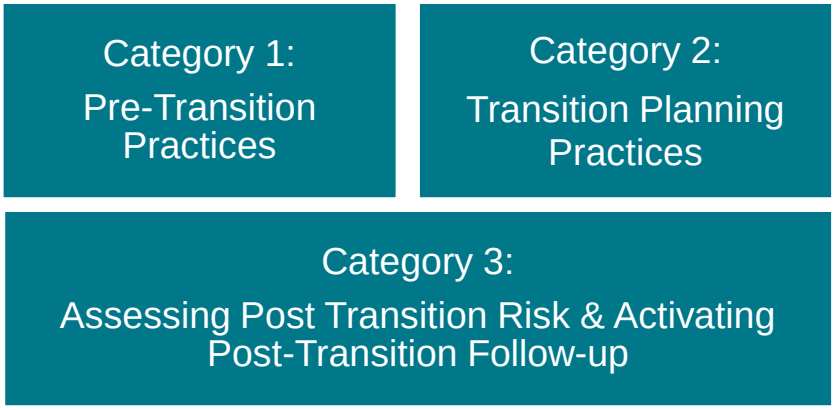
f) Provide support and encouragement to patients and families during the stages of assessment and transition

g) Optimize the appropriate use of health system resources by delivering appropriate care in the right place at the right time[4]

> *"Discharge planning is a concept fundamental to quality patient care and healthcare system sustainability and it is reasonable to expect a common industry standard."*
>
> – Toronto Central LHIN Discharge Planning Task Force, August 2011

The practices proposed represent a distillation of some of the common themes found in related literature, as well as in the many practical handbooks that have been developed in other jurisdictions to improve transition practices.[5] Many were identified based on previous work undertaken by HQO, which built on research and knowledge about 'leading practices' related to transitional care planning in Ontario and other jurisdictions.

There are nine practices which are intended to be adopted as a 'package'. The practices are divided into the following three categories:



Each practice includes a brief description of ideas for implementation that build on recurrent themes and approaches described in relevant literature and are being used in current practice. There are some

[4] Adapted from goals outlined in the Canadian Association of Discharge Planning and Continuity of Care (CADPACC): Guidelines and Standards for Discharge Planning Coordinators, May 1995.

[5] An additional literature review was also undertaken to supplement and validate earlier findings. Search terms included "discharge planning," "best practices in discharge planning," "transition planning", "best practices in transition planning." Appendix A includes a list of some of the documents identified through this search.

documentation and scoring tools (provided within the appendices) that have been used and/or are currently being tested that may be helpful to implementation.

Underlying Principles Supporting the Adoption of a Common Approach to Transitional Care Planning Across Health Links

The practices are underpinned by the following principles, which articulate a commitment shared among Health Links to improve transitions of care between HSPs and across the care continuum:

1. Practices and approaches to transitional care planning will be patient-centred
2. A commitment to optimize high quality care, patient safety, and the appropriate use of system resources (e.g., minimizing readmissions and emergency room [ER[visits)
3. Transition planning from a hospital will be initiated upon admission and is an iterative process that will continue throughout the patient's service provision with the goal of discharging the patient to a level of care and setting that promotes their ability to achieve the highest possible level of functioning
4. Transitional care planning will be culturally sensitive and done in a dignified and holistic manner (i.e., include medical, physical, emotional, spiritual, and social needs as identified by the patient)
5. Universal principles of health literacy will be applied and will include standard processes for assessing and documenting the learning needs of patients/caregivers.[6] The method of teach back being employed with patients/substitute decision-makers and caregivers preparing for care transitions should be considered[7]
6. A commitment to work toward adoption of these practices to ensure that every patient receives care according to leading practices as they relate to:
    - Pre-Transition
    - Transition Planning
    - Assessing Post-Transition Risk & Activating Post-Transition Follow Up
7. Adoption of policies and practices in all hospitals (i.e., acute, rehabilitation, complex continuing care), community –based agencies (including CCACs), and long-term care will ensure that the philosophy of transitional care planning is reflected in:
    - Care policies and practices (e.g., admission policies, discharge policies, Alternate Level of Care (ALC) policies)
    - Operating and emergency preparedness procedures
    - Recruitment, education and promotion of staff
    - Strategic/operational planning and evaluation
    - Senior management oversight and reporting
8. Recognition of the integral role played by all HSPs in the facilitation of transitional care planning as part of coordinated and collaborative care planning, across the health care continuum
9. A willingness to measure performance against a common set of indicators to track progress in adoption of the practices over time

[6] For example, written materials should be reader-friendly (i.e., plain language, larger font, short sentences, short paragraphs, no medical jargon, lots of white space, use visual aids)

[7] Teach back is part of an overall strategy to strengthen health literacy. It involves patients (or their families/caregivers) in conveying an understanding of health services, care, procedures or instructions to patients (or their families/caregivers) via verbal and non-verbal means, and ensuring that they are able to communicate this information to other care providers.

Best Practice Goals and Change Concepts

Category 1: Pre-Transition Practices

Overarching Goals

- To include patients/families as partners in transitional care planning
- To ensure that individualized care plans (including specific care goals informed by the patients/ caregivers) are developed and shared on admission amongst the patients' team and used to build an individualized comprehensive transition plan

"Individualized pre-discharge planning should be a multi-component intervention, including some combination of the following: patient education component; patient-centred discharge instructions; and coordination/communication with family physicians and other appropriate community-based services."

- Ontario Health Technology Advisory Committee (OHTAC), April 2013

Proposed Practices

Each Health Link should adopt the following:

Practice	Description/Ideas for Change
1) Pre-transition planning is incorporated as a standard of care for complex patients admitted to a health care facility	Goals of pre-transition planning should be focused on: ▪ Proactively identifying ongoing care needs and identifying and mitigating possible gaps in care related to transitions ▪ Identifying available resources (human, educational etc.) needed to support transitional care planning ▪ Ensuring patients/caregivers understand the medical information/ precautions for their conditions ▪ Ensuring patients receive consistent messaging from all HSPs. ▪ Improving coordination/communication with the patient's primary care provider(s)
2) Patients and caregivers are involved as partners in the transitional care planning process	▪ Patients are encouraged and provided the opportunity to make their wishes known ▪ Patients and their family/caregiver(s) are engaged to provide the transitional care planning team with important information to support development of the transition plan ▪ Schedule face-to-face and real time transition conversations with the patient and their family/caregiver(s)
3) Individualized comprehensive assessments and care plans are developed for complex patients on admission	▪ The following information/assessments have been deemed vital to informing the transition process as well as a coordinated care plan and ideally will be initiated immediately upon entering the service. Existing coordinated care plans for Health Link patients should both inform this episodic plan as well as be adapted for the patient's current status. Please note that each Health Link will need to define the process of data collection including information technology and human resources ▪ Information/assessments include: Clinical status and prescribed interventions; social status and support network; cognitive and psychological status; clinical functional status; environmental factors; existing advanced directives; ability to cope/quality of life; healthcare goals and preferences; cultural values and beliefs; preferred language of communication

	▪ Assess and document the individual's level of health literacy (i.e., the person's ability to understand written or verbal information relating to their health and healthcare needs); include the person's level of health literacy regarding their transitional care plan(s) ▪ Assess the capabilities and willingness of the individual and their caregiver(s) in providing post-transition care ▪ Assess and document the individual's post-facility care preferences and needs (e.g., living arrangement preferences, social and cultural supports, clinical status and prescribed interventions, and diet) ▪ Assess and document the individual's risk of readmission using a standardized screening tool (e.g., LACE index) and include this information in the care and transition plan(s) ▪ Create Best Possible Medication History (BPMH) and reconcile medications; incorporate into transition plans ▪ Ensure that the primary care provider (or their delegate, as appropriate within their scope of practice) and the CCAC (if the patient is an existing client) are notified immediately upon the decision to admit. If the patient is not a CCAC client but will need a CCAC referral, notify the CCAC as soon as this decision is made

Category 2: Transition Planning Practices

Overarching Goals

- To support Health Links establish standardized processes for medication reconciliation to ensure that patients understand how to manage their medications
- To improve coordination/communication with patients and their families/caregivers, primary care providers and other appropriate HSPs.

Proposed Practices

Each Health Link should promote the following:

Practice	Description/Ideas for Change
4) Individualized transitional care plans are developed on admission for patients with complex needs	Transitional care plans should be developed using a standardized approach. The plan should: ▪ Include essential education on health conditions, medications and instructions to the patient ▪ Be easy to read (i.e. use plain language) ▪ Involve patients and families/caregivers in the development of the plan ▪ Include a CCAC referral as appropriate *At time of transition:* ▪ Real time transition conversations with the patient and their family/caregiver(s) should occur ▪ Provide a hard copy of the individualized transition plan to the patient and their family/caregiver at the time of transition ▪ (If hospital): Confirm CCAC service is activated ▪ Provide documentation on individualized care and transition plans to the primary care provider and most responsible provider(s) at the next stage of care ▪ Provide an updated post-transition medication regimen; review with the patient and their family/caregiver(s) at the time of transition. ▪ Confirm patient's (and/or their family/caregivers') comprehension of the information discussed (document level of understanding of the patient) ▪ Support patients and their families/caregivers in coordinating and/or activating post-transition resources, as required, based on earlier assessment of needs
5) Protocols are established to ensure medication reconciliation at key transition points	▪ Medication reconciliation refers to the process of obtaining a complete and accurate list of each patient's current medications (including name, dosage, frequency, etc.) and using that list when writing transitional medication orders[8] ***Complete medication reconciliation at care transitions*** ▪ Include the patient and their family/caregiver, pharmacists from the individual's local pharmacy and, where possible the primary care team to ensure a complete and accurate medication history ▪ Assess the patient's knowledge of medications on transition ▪ Reconcile medications. Use BPMH to create and/or compare to other transitional care plans ▪ Reconcile medications prior to discharge and include reconciled medication lists as part of the discharge summary which is given to

[8] According to *Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel, November 2011*: "The ultimate goal of medication reconciliation is to prevent adverse drug events at all interfaces of care, for all patients."

	all of the health service providers who will provide care following discharge ***Provision of a post-transition medication list to patient/caregiver*** ▪ Medication list provided to the patient/caregiver using non-medical language, clearly describing which medications have been added, changed or discontinued as compared to the BPMH taken on admission. Consider checklists or non-written cues (use of symbols or pictograms) to help the patient take their medications as prescribed ▪ Key information about medications to be taken post transition, including: purpose of medication; dosage of medication; when to take medication; how to take medication; and how to obtain medication ***Assessment of the need for post-transition medication reconciliation and review with the patient and their family/caregiver at time of transition*** ▪ Include recommended schedule for next medication reconciliation as required and include in the transition summary
6) Families/caregivers are provided with information and resources to support their transition	***At a minimum the patient and their family should be provided with a patient-friendly transition plan that includes:*** ▪ An instruction sheet including advice on when "normal" activities can be resumed ▪ A reconciled medication list ▪ Dates for follow up appointments and any follow up tests. ▪ A name, position and contact number of the individual involved in their transition plan who can be contacted after transition ***Where appropriate/required, additional information should be provided regarding*** ▪ When to change bandages/ dressings ▪ What can and cannot be consumed ▪ Any special equipment or supplies needed (e.g., walker, oxygen) and how access will be facilitated ***Verify, using teach back, that the person understands:*** ▪ How to recognize worsening symptoms ▪ When and how to seek help, and from whom ▪ When, how and why to take the medications, and conduct other elements of the self-care plan ▪ Scheduled appointments (when, where, why and with whom)

Category 3: Assessing Post-Transition Risk & Activating Post-Transition Follow-Up

Overarching Goals

- To ensure that patients at high risk for readmission and ER visits are proactively identified
- To ensure that a care plan is individualized in preparation for successful transition
- To ensure that transition plans are in place and followed so that the patient's care is coordinated between one caregiver and another
- To ensure that every member of the care team (including personal support workers, nurses, etc.) can easily collaborate with patient/family and care team members on a real-time basis

Proposed Practices

Each Health Link should adopt the following:

Practice	Description/Ideas for Change
7) Standardized risk assessment tools are used to assess and stratify complex patients	▪ Patients with complex needs should be assessed and stratified as close as possible to admission so that issues can be addressed prior to transition and/or arranged post transition based on their risk level for readmission to the current setting ▪ Each Health Link should agree on adoption/utilization of a standard risk tool that will be used by organizations within their network to identify individuals who are at risk for readmission to hospital post transition. *Note: It is recommended that adoption of a standardized tool build on existing screening tools that have been developed by organizations working on the risk of patient readmission to acute care post discharge*[9] ▪ Each patient should be assigned targeted interventions based on their risks
8) Appointments are booked with the patient's primary care provider	▪ Each HSP/health care organization should put in place standardized processes to ensure that prior to transition a follow up appointment(s) is scheduled for patients with their primary care provider post transition ▪ **For hospitals**: Ideally, a conversation should take place between the most responsible physician (MRP) in the facility and the patient's primary care provider in the community with a focus on the following goals: to support a smooth transition in the transfer of care; to clarify the reason for admission; and to provide advice on the recommended follow up care/monitoring required post transition
9) Complex patients receive a follow up phone call within 48 hours of discharge from hospital	▪ Calls should be made by a community and/or hospital care provider using a standard survey with a focus on the following goals: to monitor patient progress; to establish community networks for meeting patient needs; to enhance patient education and self-management training; to provide follow up/reinforcement of the transition plan; and to include the CCAC referral process through the Resource Matching and Referral Initiative

[9] See Appendix B for an example of a standardized assessment tool.

Disseminating & Implementing the Common Practices

A key success factor in implementing a common approach to transitional care planning will be to ensure that the leadership of each Health Link and LHIN promotes 'buy-in' amongst HSPs, administrators, and patients/caregivers with respect to these practices. Another important issue is the need to clarify and detail the accountabilities of all those involved in transitional care planning and processes.

It is recommended that each Health Link establish a mechanism (e.g., working group, committee) to provide a focal point for these activities and oversight to support implementation. This group should also focus on developing strategies to advance the adoption of the practices. For example:

- Establishing and nurturing the role of champions within organizations/Health Links who are leading initiatives to standardize approaches related to transitional care planning
- Enhancing awareness and conducting widespread communications on how the adoption of a common approach to transitional care planning will support patient, organizational and system-wide goals (e.g., improvements in patient care, reduction in readmission rates, length of stay, ALC)

Additional Goals

In addition to work that will be undertaken to endorse the practices in this guide, there is also interest in advancing two additional, system-wide goals to improve transitional care planning for complex patients:

1) **Adoption of a standardized discharge summary template for use among all health care organizations that perform discharge planning.**[10]

In early 2013, the GTA Health Information Collaborative CEO group approved the template design of a standardized discharge summary and the implementation of the template across the Toronto Central LHIN sites under the leadership of St. Michael's Hospital.[11] The advantages of a standardized discharge summary template are summarized in the table below:

Advantages of a standardized discharge summary	
For patients	▪ Fewer adverse health events as a result of increased communication between care providers ▪ Seamless transitions in care ▪ More knowledge about important discharge aspects
For organizations	▪ Supported and improved communication and coordination between and within the community/primary care providers, hospital, post-discharge care providers and patients and families ▪ Improved methods to support care transition ▪ Improved continuity and coordination of care, and reduced medical errors ▪ Increased patient satisfaction and reduced hospital readmissions and patient complications ▪ Reduced requests for additional information
For the health care system	▪ Improved health outcomes of complex patients with high cost care needs ▪ Appropriate transitions in care focusing on patient experience ▪ Reduced hospital re-admission rates and visits to ER ▪ Lowered healthcare costs

2) **System-wide implementation of designated supports for complex patients in the post-transition follow-up period.**

Implementation of this concept may include the introduction of transition coordinators/coaches and/or greater clarity regarding the roles and accountabilities of organizations in managing transitions and coordination of care.

---

[10] See Appendix C for examples of discharge summary templates

[11] St. Michael's Hospital. *Backgrounder: Standardized Discharge Summary Template Development and TC LHIN Implementation*. (PowerPoint presentation [unpublished], 2013).

Conclusion

Effective transitional care planning should be a routine part of health care delivery. It should also be part of an overall health care plan for each patient, which spans not only admission to a facility, but also their overall care (which occurs primarily in the community).[12]

This document is intended to promote the standardization of transition practices within and across Health Links and is designed to be a tool for improving transition planning and the coordination of care for complex patients.

For more information on how to implement effective transitional care planning, please see the appendices, or visit www.hqontario.ca

[12] Department of Veterans' Affairs (2005). *Discharge Planning: Resource Kit*. Australia. Retrieved from: http://www.dva.gov.au/service_providers/dental_allied/discharge_planners/Documents/dprk.pdf

Tools & Resources

Health Quality Ontario tools and resources:

bestPATH - *Transitions of Care: Evidence Informed Improvement Package*

This document was developed as a tool to introduce examples of change concepts designed to improve the transitioning of individuals between care providers and environments. Download the Improvement Package.

***Discharge Planning in Chronic Conditions: An Evidence-Based Analysis*. Ontario Health Technology Assessment Series. 2013 September; 13 (4):1–72.**

This report summarizes the results of a standard systematic literature search for studies published from January 1, 2004 until December 31, 2011. The objective of the review was to determine if discharge planning is effective at reducing health resource utilization and improving outcomes compared with standard care alone. Download the full report.

***Optimizing Chronic Disease Management in the Community (Outpatient) Setting (OCDM): An Evidentiary Framework*. Ontario Health Technology Assessment Series. 2013 September; 13(3): 1-78**

This analysis sets out to answer the following question: What evidence-based community services are effective and cost-effective for optimizing chronic disease management among adults? The focus was on adults with at least one of the following high-burden, chronic conditions: chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), atrial fibrillation, heart failure, stroke, diabetes or chronic wounds. Download the full report.

Quality Compass

An online, comprehensive evidence-informed searchable tool centered around priority health care topics with a focus on best practices, change ideas linked with indicators, targets and measures, tools and resources to bridge gaps in care and improve the uptake of best practices. Visit Quality Compass

Ministry of Health & Long-Term Care resource:

Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel, November 2011.

In September 2010, the ministry convened an Avoidable Hospitalization (AH) Advisory Panel and named Dr. G. Ross Baker as the chair. The Panel had a mandate to identify system-wide AH best practice guidance, form and content of an AH improvement practices inventory, and measures and an evaluation framework for AH initiatives. Dr. Baker and his Panel have completed their work and submitted their report, *Enhancing the Continuum of Care,* to the ministry. Download the full report.

Ontario Hospital Association (OHA) resource:

Achieving Patient Experience Excellence in Ontario: An Idea Book (Spring 2013)

The Idea Book highlights outstanding improvement projects and develops case studies to help other hospitals achieve similar successes. The Idea Book is about engagement on three levels: the community of care (LHINs, CACCs), hospital staff, and the patients and their families. The idea book was developed with the support of the Ministry of Health & Long-Term Care and supports the notion of delivering a better patient experience by inspiring others to undertake similar projects. It is also part of the OHA's continued commitment to supporting hospitals improve the patient experience. Download the Idea Book.

Other tools and resources:

The Department of Health (UK) Discharge Summary Implementation Toolkit

In August 2010, the United Kingdom's Clinical Data Standards Assurance program began a project to deliver a national, clinically-assured electronic Discharge Summary (DS), which focuses on the DS which is sent from an acute medical/surgical team to the GP within 24 hours of the patient being discharged. This DS was intended to be structured, standardized and generic thus, having the ability to be sent electronically from any acute hospital electronic health record (EHR) system. A toolkit was produced to facilitate the implementation of this work in a consistent manner. The toolkit contains case studies and short video clips from organizations who successfully implemented the 24 hour Discharge Summary. Download the toolkit.

Canadian Foundation for Healthcare Improvement: Improving Treatment for Seniors in Acute Care

Recent work supported by the Canadian Foundation for Healthcare Improvement focuses on an early intervention strategy that identifies five key areas of patient care for seniors that need to occur within the first 48 hours of admission. Results of the pilot project suggest that this process will result in quicker recovery and discharge of older patients from the hospital. Download a briefing on this work.

The RARE (Reducing Avoidable Readmissions Effectively) Campaign

This initiative focuses on engaging hospitals and care providers in Minnesota (across the continuum of care) to prevent 6,000 avoidable hospital readmissions within 30 days of hospital discharge between July 1, 2011 and December 31, 2013. The RARE Campaign builds upon and expands work that has been going on for several years by many hospitals, medical groups, health plans and the Operating, Supporting and Community Partners. The campaign focuses on five key areas:

- Comprehensive discharge planning
- Medication management
- Patient and family engagement
- Transition care support
- Transition communications

Re-Engineered Discharge (RED) Toolkit. Agency for Healthcare Research and Quality

The Project RED (Re-Engineered Discharge) intervention is a patient-centered, standardized approach to discharge planning. Initially developed through research conducted by Dr. Brian Jack of the Boston University Medical Center and funded by the Agency for Healthcare Research and Quality (AHRQ), Project RED improves patient preparedness for self-care and reduces preventable readmissions. The *AHRQ* developed the RED Toolkit to help hospitals reduce readmission rates. Download the toolkit.

The S.M.A.R.T Discharge Protocol

SMART Discharge protocol is a framework that can be applied to discharge processes to ensure key areas are always addressed during hospitalization and at discharge, which can reduce readmissions. SMART is an acronym for: **S**ymptoms, **M**edications, **A**ppointments, **R**esults, **T**alk. Download the SMART Discharge Protocol Self-Learning Packet.

Appendices

Listed below are some of the tools that are currently being tested in the field and within other jurisdictions. The intent here is to provide a non-exhaustive set of examples from which to choose. There are also other tools that are currently being tested or in use that are not included in this guide. The primary focus of this guide is to establish common standards for discharge planning and is not intended to be a toolkit.

Please note that each example listed below will require discussion, testing and adaptation to suit the specific and unique approach of each Health Link.

A. Risk Assessment Tools

A1. Ottawa Hospital Research Institute (OHRI): LACE Index Scoring Tool for Risk Assessment of Death and Readmission

Status: Several Hospitals Across the province are using this tool.

Note that there are other risk assessments in the environment and this is just one example.

Ottawa Hospital Research Institute
LACE Index Scoring Tool for Risk Assessment of Death and Readmission

Step 1. Length of Stay
Length of stay (including day of admission and discharge): _____ days

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7

L

Step 2. Acuity of Admission
Was the patient admitted to hospital via the emergency department?
If yes, enter "3" in Box A, otherwise enter "0" in Box A

A

Step 3. Comorbidities

Condition (definitions and notes on reverse)	Score (circle as appropriate)
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes without complications	+1
Congestive heart failure	+2
Diabetes with end organ damage	+2
Chronic pulmonary disease	+2
Mild liver disease	+2
Any tumor (including lymphoma or leukemia)	+2
Dementia	+3
Connective tissue disease	+3
AIDS	+4
Moderate or severe liver disease	+4
Metastatic solid tumor	+6
TOTAL	

If the TOTAL score is between 0 and 3 enter the score into Box C. If the score is 4 or higher, enter 5 into Box C

C

Step 4. Emergency department visits
How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? _____
Enter this number or 4 (whichever is smaller) in Box E

E

Add numbers in Box L, Box A, Box C, Box E to generate LACE score and enter into box below. If the patient has a LACE score that is greater than or equal to 10, the patient can be referred to the virtual ward. (Note: A *virtual ward* uses the systems and staffing of hospital care, but without the physical building: staff provide preventative care for patients in their own homes. If your hospital does not support a virtual ward, proceed to treat patient as a high risk individual.)

LACE

Shared with permission from Carl van Walraven (lead author) on July 3, 2012.

A2. Blaylock Discharge Planning Risk Assessment Screen

NORTHUMBERLAND HILLS HOSPITAL

Blaylock Discharge Planning Risk Assessment Screen

PATIENT ID

Circle all that apply and total. Refer to scoring index for recommendations regarding discharge planning.

Age	55 years or less	0
	56-64 years	1
	65-79 years	2
	80+ years	3
Living Situation/Social Support	Lives only with spouse	0
	Lives with family	1
	Lives alone with family support	2
	Lives alone with friend's support	3
	Lives alone with no support	4
	Nursing home/residential care	5
Number of Previous Admissions/ Emergency Room Visits	None in the last 3 months	0
	One in the last 3 months	1
	Two in the last 3 months	2
	More than two in the last 3 months	3
Number of Active Medical Problems	Up to three medical problems	0
	Three to five medical problems	1
	More than five medical problems	2
Number of Drugs	Fewer than three drugs	0
	Three to five drugs	1
	More than five drugs	2
Cognition	Oriented	0
	Disoriented to some spheres (person, place, self, time) some of the time	1
	Disoriented to some spheres (person, place, self, time) all of the time	2
	Disoriented to all spheres (person, place, self, time) and some of the time	3
	Disoriented to all spheres (person, place, self, time) all of the time	4
	Comatose	5

Functional Status	Independent in activities of daily living and instrumental activities of daily living	0
	Dependent in:	
	Eating/Feeding	1
	Bathing/Grooming	1
	Toileting	1
	Transferring	1
	Incontinent of bowel function	1
	Incontinent of bladder function	1
	Meal Preparation	1
	Responsible for own medication administration	1
	Handling own finances	1
	Grocery Shopping	1
	Transportation	1
Behaviour Pattern	Appropriate	0
	Wandering	1
	Agitated	1
	Confused	1
	Other	1
Mobility	Ambulatory	0
	Ambulatory with mechanical assistance	1
	Ambulatory with human assistance	2
	Nonambulatory	3
Sensory Deficits	None	0
	Visual or hearing deficits	1
	Visual and hearing deficits	2

Total Score: _____ **Signature:**_____ **Date:**_____

SCORING INDEX	
0-10	At risk for home care services
11-19	At risk for discharge planning
>20	At risk for placement other than home

RECOMMENDED CONSULTS

Physician Order NOT Required		Physician Order Required	
☐ Social Work	☐ Wound Care	☐ Physio	☐ Dietitian
☐ CCAC Case Mgr	☐ Pharmacist	☐ Speech	
☐ Geriatric CNS	☐ Respiratory T.	☐ Occupational Therapist	

REQUIRED ACTIONS

	Enter score into Meditech "Blaylock D/C Risk Screen". **NOTE:** An alert will be sent to CCAC Case Manager for all patients scoring 11+ who were not admitted from LTC
	For consults not requiring a physician order, enter consult request into Meditech Order Entry and put "✓" on whiteboard
	For consults requiring physician order, complete a green communication form to request physician order and put "A" on whiteboard

Rev Oct 2011 *Blaylock A. & Cason C.L. 1992*

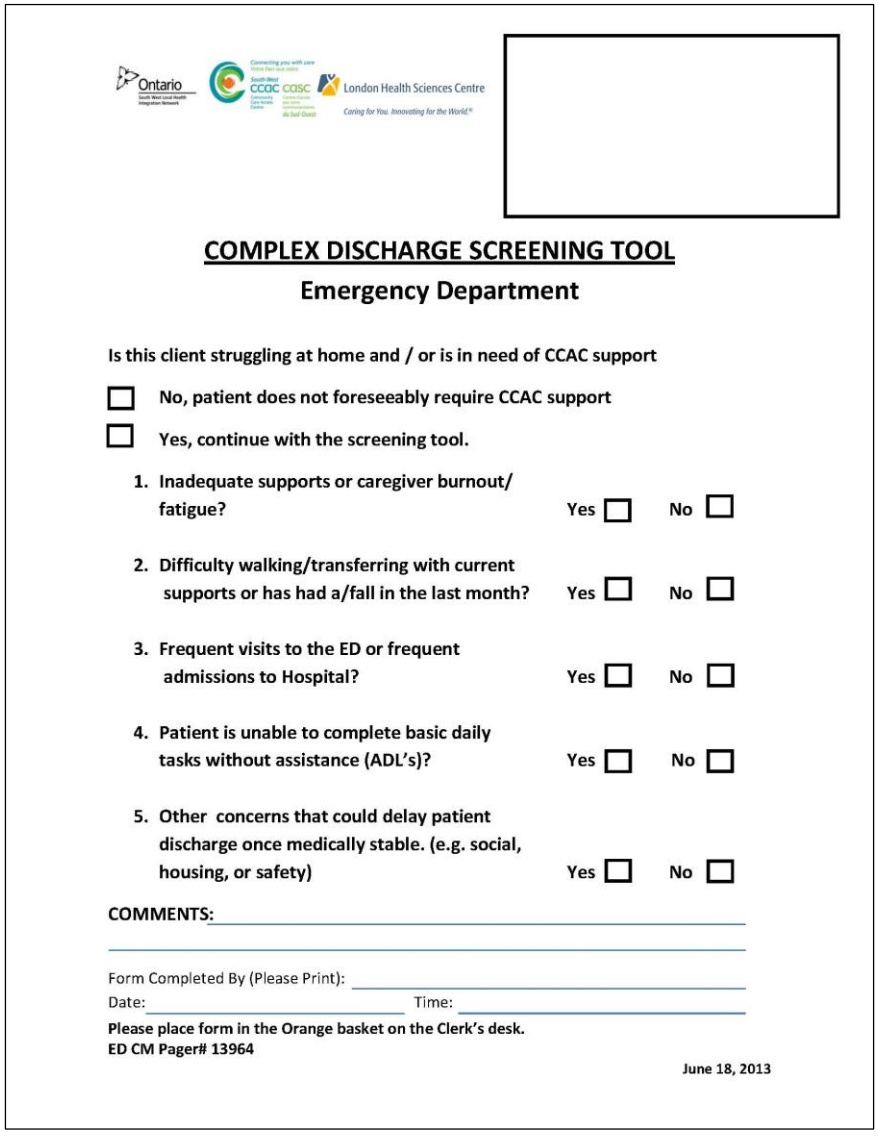
CCAC Case Manager Enter consult in Meditech	- **If Blaylock Score is 11+ and patient not from LTC, enter a CCAC Alert into Meditech** - Services and supports required to transition home - Long Term Care applications - Arrangements for home equipment and supplies
Geriatric Clinical Nurse Specialist (CNS) Enter consult in Meditech	- Comprehensive gerontology focused assessments and recommendations - Promotion of cognitive and physical functioning
Nurse	- Promotes health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function for assigned patients. - Facilitates and supports processes that promote holistic approaches that assess the patient's medical, functional, cultural, emotional, and psycho-social needs from admission to discharge.
Occupational Therapist (OT) Request Order	- Mobility and activities of daily living (ADLs) independence including home safety, discharge readiness and home accessiblity - Physical, cognitive and/or perceptual impairment - Wound care consultation re: therapeutic mattresses/surfaces - Hospital/home equipment needs (recommendation and provision for), including: wheelchairs, walkers, assistive devices - Energy conservation/work simplification education - Care planning/discharge planning consultation including post acute care referral
Physiotherapist (PT) Request Order	- Mobility/physicial impairment including range of motion, strength, mobility/transfers, cardio-respiratory function - Care planning/discharge planning consultation including post acute care referral
Pharmacist Enter consult into Meditech	- General assessment/consultation regarding medications - Other consultations related to pain/PCA, self medicaiton, teaching, TPN, allergies, medication reconciliation, Medication Administration Record (MAR), patient leave, dysphagia
Registered Dietitian (RD) Request Order	- Nutritional assessment, care planning, monitoring, education and counselling - Writes orders/recommendations for the therapeutic diets, supplements, Enteral/Parenteral nutrition, medications (i.e. insulin, phosphate binders, multivatimins etc) - Completes nutrition related application forms such as Ontario Disability Support Program (ODSP) Special Diet Application form and Ontario Drug Benefit (ODB)
Respiratory Therapist (RT) Request Order	- Respiratory function including inhaled pharmacotherapy, secretion management, dyspnea management - Home oxygen assessments from chronic (ABG) and palliative patient discharges - Titration of oxygent therapy/determination of appropriate resting and exertion oxygen requirements - Arraging Pulmonary function Testing (PFT), sleep studies, CPAP/BiPAP therapy - patient Education regarding Respiratory disease management - Assist with obtaining difficult oximetry
Social Worker (SW) Enter Consult into Meditech	- Psychological and emotional well being related to adjustment to changes in health status - Patient/family advocacy - Bio-Psychosocial assessment - Patient care and discharge planning consultation
Speech Language Pathologist (SLP) Request Order	- Communication impairment including expressive language, comprehension, speech, voice, reading and/or writing - Cognitive skills affecting communication such as memory, attention and reasoning skills - Dysphagia Team - swallowing impairment (together with Occupational Therapy, Dietician)

B. Discharge Screening

Complex Discharge Screening Tool: Emergency Department to Homecare

There is a subset of individuals who enter hospital for an acute care episode that are at risk of having a complex discharge, and are therefore at risk of staying in hospital and becoming ALC. Identifying patients at risk ensures earlier discussions between health care team members, CCAC, clients and their family to ensure that everyone is working together to facilitate a return home with appropriate supports once acute care is no longer required.

The process for identifying these patients is now supported through the use of the Complex Discharge Screening Tool that was developed for use within the South West. The Complex Discharge Screening Tool was developed based on a comprehensive review of several screening tools currently in use across the province used to identify clients at risk of complex discharge. In almost all other Home First implementations across the province, some form of a screening tool is used. In the South West, the tool is administered by hospital staff at the time of admission to hospital, and if positive, generates an automatic electronic referral for a CCAC Assessment. Extensive analysis of the tool and validation of the accuracy of the results have been completed to ensure it is appropriately identifying complex clients.[13]



Ontario

London Health Sciences Centre

Caring for You. Innovating for the World.

COMPLEX DISCHARGE SCREENING TOOL

Emergency Department

Is this client struggling at home and / or is in need of CCAC support

☐ **No, patient does not foreseeably require CCAC support**

☐ **Yes, continue with the screening tool.**

1. **Inadequate supports or caregiver burnout/ fatigue?** **Yes** ☐ **No** ☐
2. **Difficulty walking/transferring with current supports or has had a/fall in the last month?** **Yes** ☐ **No** ☐
3. **Frequent visits to the ED or frequent admissions to Hospital?** **Yes** ☐ **No** ☐
4. **Patient is unable to complete basic daily tasks without assistance (ADL's)?** **Yes** ☐ **No** ☐
5. **Other concerns that could delay patient discharge once medically stable. (e.g. social, housing, or safety)** **Yes** ☐ **No** ☐

COMMENTS: _____

_____

Form Completed By (Please Print): _____

Date: _____ Time: _____

Please place form in the Orange basket on the Clerk's desk.
ED CM Pager# 13964

June 18, 2013

[13] South West Local Health Integration Network (LHIN). *Access to Care: Home First Year in Review 2012*. Retrieved from: http://www.ccac-ont.ca/Upload/sw/General/Home%20First/Home_First_Review_April2013.pdf

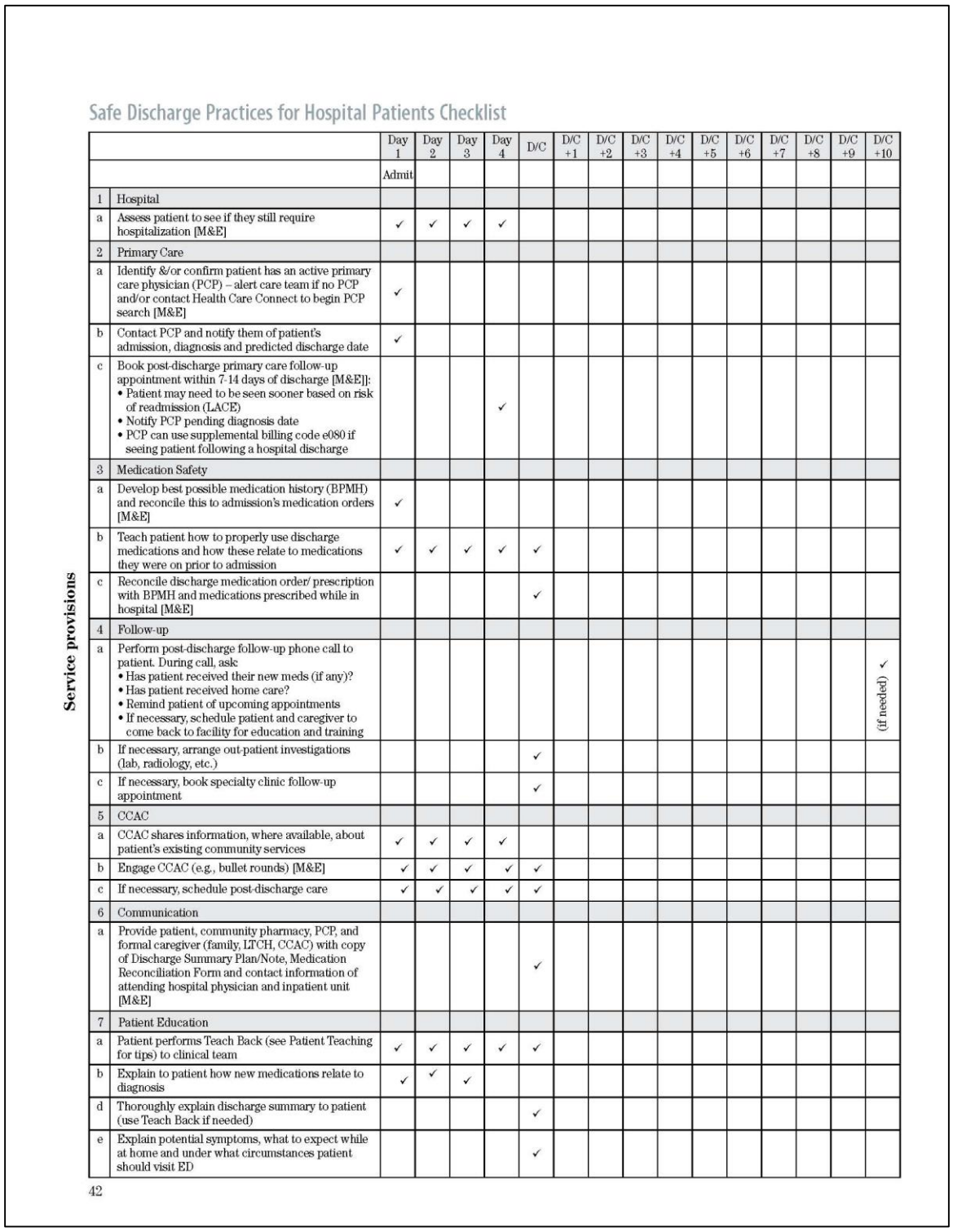
C. Discharge Summary Templates

C1. Toronto Central LHIN Standardized Discharge Summary Template

Standardized Discharge Summary Template

Data Elements	Definitions/Explanations
Patient (Demographics)	
Patient name	
Patient identifier (Medical Record Number)	MRN is the hospital Medical Record Number
Date of Birth (DOB)	
Gender	
Primary Care Provider	
Visit (Encounter)	
Admit date	
Discharge Date	
Discharge Diagnosis	
Most Responsible Health Care Provider name and contact information	The provider who is responsible for the care and treatment of the patient for the majority of the visit.
Completed by (if not completed by MRHCP)	
Date Completed	
Patient Encounter type	Default-Inpatient. (The Discharge Summary Template only applies to encounter type of Inpatient. Inpatient is defined as occupying a designated bed.)
Discharge Disposition	This identifies the location where the patient was discharged to. Eg Home, Home with Support Services, Transfer to Acute Care Institution (named) or Death.
Encounter Location/Org	
Hospital/Service Name	Hospital Name
Hospital/Service Type	Describes the basic type or category of the service delivery location. Eg, Acute Care or Rehab
Alert Indicators	
Allergies (Yes, None known)	If Yes, list all medication allergies and describe reaction.
Course While in Hospital	
Presenting Complaint(s)	
Summary of key results	
Investigations	
Interventions	
Advance directives	
Adverse Events and complications	An event that results in unintended harm to the patient and is related to the care and/or services provided to the patient rather than to the patient's underlying condition.
Diagnosis	
Other Conditions Impacting Hospital Stay	A condition that coexists at the time of admission or develops subsequently and requires treatment beyond the preexisting condition, or increases the length of stay by at least 24 hours or significantly affects the treatment received.
Other Conditions	
Discharge Plan	
All medications at discharge	This is for home medications to be continued, home medications, which have been discontinued, and newly prescribed medications.
Follow-up instructions for patient	Include follow up scheduled by current provider.
Follow-up Plan recommended to be implemented by the receiving provider	
Referrals	These are referrals that have been initiated by the sender.
Copied to with contact information:	

C2: Avoidable Hospitalization Advisory Panel, November 2011
Status: Requires field testing and evaluation



Safe Discharge Practices for Hospital Patients Checklist

Service provisions

		Day 1	Day 2	Day 3	Day 4	D/C	D/C +1	D/C +2	D/C +3	D/C +4	D/C +5	D/C +6	D/C +7	D/C +8	D/C +9	D/C +10
		Admit														
1	Hospital															
a	Assess patient to see if they still require hospitalization [M&E]	✓	✓	✓	✓											
2	Primary Care															
a	Identify &/or confirm patient has an active primary care physician (PCP) – alert care team if no PCP and/or contact Health Care Connect to begin PCP search [M&E]	✓														
b	Contact PCP and notify them of patient's admission, diagnosis and predicted discharge date	✓														
c	Book post-discharge primary care follow-up appointment within 7-14 days of discharge [M&E]]: • Patient may need to be seen sooner based on risk of readmission (LACE) • Notify PCP pending diagnosis date • PCP can use supplemental billing code e080 if seeing patient following a hospital discharge				✓											
3	Medication Safety															
a	Develop best possible medication history (BPMH) and reconcile this to admission's medication orders [M&E]	✓														
b	Teach patient how to properly use discharge medications and how these relate to medications they were on prior to admission	✓	✓	✓	✓	✓										
c	Reconcile discharge medication order/ prescription with BPMH and medications prescribed while in hospital [M&E]					✓										
4	Follow-up															
a	Perform post-discharge follow-up phone call to patient. During call, ask: • Has patient received their new meds (if any)? • Has patient received home care? • Remind patient of upcoming appointments • If necessary, schedule patient and caregiver to come back to facility for education and training															✓ (if needed)
b	If necessary, arrange out-patient investigations (lab, radiology, etc.)					✓										
c	If necessary, book specialty clinic follow-up appointment					✓										
5	CCAC															
a	CCAC shares information, where available, about patient's existing community services	✓	✓	✓	✓											
b	Engage CCAC (e.g., bullet rounds) [M&E]	✓	✓	✓	✓	✓										
c	If necessary, schedule post-discharge care	✓	✓	✓	✓	✓										
6	Communication															
a	Provide patient, community pharmacy, PCP, and formal caregiver (family, LTCH, CCAC) with copy of Discharge Summary Plan/Note, Medication Reconciliation Form and contact information of attending hospital physician and inpatient unit [M&E]					✓										
7	Patient Education															
a	Patient performs Teach Back (see Patient Teaching for tips) to clinical team	✓	✓	✓	✓	✓										
b	Explain to patient how new medications relate to diagnosis	✓	✓	✓												
d	Thoroughly explain discharge summary to patient (use Teach Back if needed)					✓										
e	Explain potential symptoms, what to expect while at home and under what circumstances patient should visit ED					✓										

42

References

Avoidable Hospitalization Advisory Panel (November 2011). *Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel.* Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf

Canadian Association of Discharge Planning and Continuity of Care (May 1995). *Guidelines and Standards for Discharge Planning Coordinators*

Department of Veterans' Affairs (2005). *Discharge Planning: Resource Kit*. Australia. Retrieved from: http://www.dva.gov.au/service_providers/dental_allied/discharge_planners/Documents/dprk.pdf

Health Quality Ontario (November 2012). bestPATH: Transitions of Care Improvement Practice. Retrieved from: http://www.hqontario.ca/Portals/0/Documents/bp/bp-improve-pkg-transitions-interactive-en.pdf

Ontario Hospital Association (Spring 2013). *Achieving Patient Experience Excellence in Ontario: An Idea Book*. Retrieved from: http://www.oha.com/CurrentIssues/keyinitiatives/Patient%20Experience/Documents/Final%20-%20Idea%20book.pdf

Silversides, Ann & Laupacis, Andreas (February 28, 2013). *Health Links: Ontario's bid to provide more efficient and effective care for its sickest citizens*. Healthy Debate. Retrieved from: http://healthydebate.ca/2013/02/topic/innovation/the-ontario-health-links-initiative-what-is-it

South West Local Health Integration Network (LHIN). *Access to Care: Home First Year in Review 2012*. Retrieved from: http://www.ccac-ont.ca/Upload/sw/General/Home%20First/Home_First_Review_April2013.pdf

St. Michael's Hospital (2013). *Backgrounder: Standardized Discharge Summary Template Development and TC LHIN Implementation*, (PowerPoint presentation [unpublished])


Ontario


Ontario
Health Quality Ontario

DISCHARGE PLANNING: ALC AWAITING LONG-TERM

Purpose:

- To enable SRHC to meet the acute care needs of the communities it serves.
- To describe the Discharge Planning process.
- To outline the steps each member of the Clinical Team uses and describe the available assistance from LHIN and Administration, as required.

Responsibility:

- Registered Nurse
- Social Worker
- Discharge Planner
- Managers
- Directors
- Vice-Presidents
- Bed Allocation
- Physician

Process:

1. The members of the interdisciplinary health care team will undertake the process of discharge planning as early as possible after admission and invite/expect the patient/SDM/Power of Attorney (for care) to be involved in developing the assessment and discharge plan. Any one of the following individuals (Physician, Discharge Planner/Social Worker, Charge Nurse/Resource Nurse or the Clinical Utilization Reviewer) will take the leadership role in this process. Discharge screening on a daily basis, using the utilization tool, will assist in this process.

Preparation:

2. The Most Responsible Physician (MRP) documents the plan of care and expected discharge date on the chart within 24 hours of admission and then updates this information as the plan changes. The Unit Clerk notifies Bed Allocation of the expected date of discharge. Bed Allocation will use this date to plan patient flow.
3. The Discharge Planner/Social Worker will meet with patient/SDM/Power of Attorney (for care) as necessary to assess all of the appropriate resources that may be required by the patient upon discharge.
4. Before the initial meeting with the patient/SDM/Power of Attorney (for care), the Discharge Planner/Social Worker discusses the patient's needs with the physician and the interdisciplinary team.

Selecting a Bed:

5. If it is anticipated that a LTCH will be required, the following process will occur:

    - Prior to meeting with the patient/SDM/Power of Attorney (for care), the

Discharge Planner/Social Worker will determine, in collaboration with the LHIN Placement Services Coordinator, the clinically suitable, available beds.

- The Discharge Planner/Social Worker will present to the patient/SDM/Power of Attorney (for care) a list of clinically suitable, available beds for consideration. The patient/SDM/Power of Attorney (for care) will be expected to apply to three (3) homes within three (3) business days of this discussion. One of the three choices must be from the list of homes currently having a clinically suitable, available bed and one choice is from a short waiting list of homes (0-3 months) of the patient's choice. The Social Worker/Discharge Planner will work collaboratively with the LHIN to ensure the patient/SDM/Power of Attorney (for care) has the appropriate and necessary information regarding long-term care placement and the selected choices.
- The Discharge Planner/Social Worker, in conjunction with LHIN Placement Services, will guide and support the patient/SDM/Power of Attorney (for care) in selecting and applying for appropriate LTCHs to meet the patient's needs. Information will be given about the waiting list process for homes that, although they may be the preferred choice of the patient, do not have an available bed at the time of the patient's hospital discharge.
- At this time, the Discharge Planner/Social Worker will review the hospital Discharge Planning Policy and Procedure with the patient/SDM/Power of Attorney (for care). The Discharge Planner/Social Worker will also review with the patient/SDM/Power of Attorney (for care) the brochure "Moving to a Long- Term Care Home" and will review and complete the form "Patient Plan for Next Stage of Care" with the patient/SDM/Power of Attorney (for care). If the patient/SDM/Power of Attorney (for care) refuses to sign the form "Patient Plan for Next Stage of Care", then follow the procedure for a patient refusing transfer and include a notation on the form and in the patient chart.
- The Discharge Planner/Social Worker will submit the completed forms to LHIN Placement Services within three (3) business days of the meeting.

Waiting for First Choice of Bed:

6. The Discharge Planner/Social Worker, in conjunction with LHIN Placement Services, shall notify the patient/SDM/Power of Attorney (for care), attending physician and health care team of the home with the first clinically appropriate, available bed. The time, date, person contacted and method of notification used will be recorded in the health record.

Transportation and use of Ambulance

7. If at the time of discharge the patient requires an ambulance for clinical reasons, SRHC will provide and assume charges for this service. If, however, the patient's medical and physical condition does not require an ambulance, but it is the patient/SDM/Power of Attorney (for care)'s preference to use one, then the patient/SDM/Power of Attorney (for care) is financially responsible for the cost of the ambulance. The patient/SDM/Power of Attorney (for care) will be directed to the Finance Department where the information of the patient/SDM/Power of Attorney (for care)'s credit card will be taken. The costs will be finalized and the Finance Department will

prepare an invoice and submit it to the patient/SDM/Power of Attorney (for care). The Clinical Support Coordinator will facilitate this process on weekends and holidays.

8. Upon discharge, all patients admitted from a LTCH to SRHC will be expected to return to their LTCH within the 21-day period or the 45-day period for Psychiatric patients. If the LTCH is in an out-break situation, then the patient will return or be admitted to that LTCH as soon as the LTCH is able to accept patients, regardless of the time periods mentioned above.

Discharge Planning - Patient Refusing Transfer

Should the patient/SDM/Power of Attorney (for care) refuse to be involved in the discharge planning process or to accept the first clinically appropriate, available bed:

1. The refusal is received by the Discharge Planner/Social Worker and so documented in the health record.
2. The Discharge Planner/Social Worker shall notify the Manager/Delegate that business day. The Discharge Planner/Social Worker and Manager/Delegate will contact the patient/SDM/Power of Attorney (for care) in person, or by phone, to review the Discharge Policy. The time and details of all contacts are to be recorded in the health record.

Fees:

3. Should the patient/SDM/Power of Attorney (for care) continue to refuse the bed offer and/or to be involved in the discharge planning process, the Vice President/Director/ Delegate/Discharge Planner/Social Worker will meet with the patient/SDM/Power of Attorney (for care) by 1200 hours the next business day to educate and emphasize the hospital policy with the patient/SDM/Power of Attorney (for care) and to work to resolve the issue by determining a discharge plan acceptable to all concerned. Should the bed offer continue to be refused, the patient/SDM/Power of Attorney (for care) will be advised that they will be charged $750 per day until discharge. The Vice-President/Director together with the interdisciplinary team and patient/SDM/Power of Attorney (for care) will arrange alternate discharge plans and/or follow appropriate legal recourse to facilitate the transfer of the patient to a more appropriate home. (Refer to Appendix 1 to Procedure AD10 (a): "Moving to a Long-Term Care Home" and Appendix 2 to Procedure AD 10 (a): "Patient Plan for Next Stage of Care").
4. A discharge decision/solution will be determined in collaboration with the discharge policy and senior administration and shared with the patient/SDM/Power of Attorney (for care) to the extent possible within confidentiality guidelines.
5. The decision will be reviewed daily with the Vice-President, Director, Manager and clinical team. The advice of appropriate team members, such as the Chief of Medicine or Staff, Risk Manager and/or legal counsel, will be sought as needed.

January 2021

Case Conferences

Goal of a Case Conference:

The main goals of the case conference is to promote communication with patient/family and interdisciplinary team for best patient outcomes, to facilitate the discharge process and to decrease length of stay (LOS).

Roles:

Patient/Family: focus is on the patient and best outcomes as per their medical condition. Support is provided to patient and family as required and tailored to their unique needs.

Physician: sharing of medical information pertaining to patient's condition/status.

Nursing: provides information regarding skin/wound updates, continence, behaviour, medication effectiveness (clinical documentation), vital signs, response to treatments.

Physiotherapist: updates on mobility issues.

Occupational Therapy: updates on ADL progression and cognition reports.

Speech Language Therapist: updates on speech, swallowing and communication.

LHIN case manager: provides education regarding availability of home services, convalescence or LTC referrals (as per each patient's needs as identified in case conference).

Charge Nurse: organizes above team for case conference and provides ongoing support to family/patient as required.

Social Worker: Social issues, high social support needs, need for rehab/transitional care to home. Requires targeted transition planning.

Discharge Planner: High social support needs, need for rehab/transitional care to home. Requires targeted transition planning.

DISCHARGE PATIENT TO A LTC FACILITY

1) Call the LTC facility and advise them of the patient's discharge/admission. Obtain their fax number.
2) Call the family and advise them of patient discharge date and time.
3) Family to arrange transfer to residence. Give family the pamphlet "Non Urgent Patient Transportation" (Voyageur) or if the patient already has a contract with Mobility Trans they can call and make arrangements for transfer.
4) Have the Unit Clerk do a PTAC form and photocopy (one for chart, one to go with package of info going with patient, one to go with patient for medics and facility). A PTAC form is needed when transferring a patient from one facility to another.
5) Fill out a Ministry of Health DNR Confirmation From (if the patient is DNR) if the patient is being transferred via ambulance/Voyageur and give to the paramedics. They will request one if the patient is a DNR.
6) Fill out the Patient Transfer Record (long sheet). Copies 1 & 2 go with the patient; pink copy stays with the chart.
7) Photocopy and send any Advance Directives (DNR, POA)
8) Photocopy the Discharge Summary which has any follow up appointments. Photocopy goes with the patient and the original stays on the chart.
9) Have Unit Clerk or yourself print off a Discharge Rx for MD to sign (photocopy, original goes with the patient and photocopy goes with the chart). Fax the Rx to the facility, or Pharmacy (as they request); some facilities just want the patient's MARs faxed.
10) Photocopy transcripts, med list, lab results, X/R results, etc. and put in a package to go with the patient for the facility. Some facilities would like them faxed. Send hard copy with Rx and D/C Summary.
11) Photocopy any directions such as Wound Care, SLP, Dietician, Physio, etc. and send with patient (LTC facilities do their own wound care).
12) If the patient is to receive CLHIN services such as intravenous antibiotics, enter the order for CLHIN in Meditech and do the RM&R. Get MD to fill out any Medical Orders and fax to CLHIN. Speak to CLHIN re: services and the LTC facility.
13) LTC PATIENTS ARE TO HAVE A NLOT TEAM REFERRAL MADE (NURSE LED OUTREACH TEAM) IF REQUIRED (COMPLICTED PATIENT). Enter this in Meditech. Enter "RMR" in Meditech under "order entry". Fill out a RM&R for the NLOT team to follow up/monitor the patients approximately four weeks after discharge. Call the NLOT team at extension 6317 and advise them of the referral.
14) Advice the family that a referral has been made and that they will visit the patient about 4 weeks after discharge for follow up.
15) LTC facilities like to have their patients discharge from hospital and in their facility before noon.

CLHIN DOES NOT DO WOUND CARE IN LTC FACILITIES. The staff at the facility are expected to look after any wound care needs.

CLHIN DOES LOOK AFTER ANY IV ANTIBIOTICS, and PICC line care.

DISCHARGE PATIENT TO HOME

1) Notify patient's family of discharge date and time.
2) Inquire as to who will be picking patient up. If transportation is needed, family is to arrange. Give pamphlet Non Urgent Transportation (Voyageur) or if patient has a contract with Mobility Trans then they can call them and arrange but they must already have a contract with them.
3) If patient needs assistance home, can offer Home At Last/CHATS (if are a senior or if have mental health issues).
4) Have the Unit Clerk/ or yourself obtain a Discharge RX for MD to sign. Photocopy it, original goes with the patient and photocopy stays with the chart. As the patient if they would like their Rx faxed to their pharmacy. If so obtain contact info, speak to the pharmacist before faxing. Send original hard copy with the patient.
5) Photocopy the Discharge Summary with patient follow up appointments. The original stays on the chart and the photocopy goes with the patient.
6) If the patient is in need of an O2 tank to go home call Respiratory at ext. #7043 to arrange (the hospital deals with Pro Resp). If this is a new Rx for O2 MD must sign an Rx.
7) If CLHIN services are needed be sure to enter the order on Meditech charting and then fill out the RM&R. If going home with Home First Services LHIN/CCAC needs three to five days to arrange. If the patient already has CLHIN services and has been in the hospital less than 14 days, can enter resumption of services. If over 14 days, then have to open a new file.
8) If needed fill out CLHIN for Rapid Response Nurse to visit patient at home 24 hours post discharge (if patient has COPD/CHF or if they have a chronic illness). Send a copy of transcripts, med, labs, X/R, U/ S, MRI, CT, etc. and fax to CLHIN with Rapid Response Nurse on fax.
9) If the patient will need Physio/OT/SLP/Dietician/SW in the community may need to have their input on the RM&R before sending it to CLHIN. May need to photocopy notes from chart for i.e.: wound care, dietician, SLP, etc. Photocopy notes and fax to CLHIN.
10) If the patient has a diagnosis of COPD/CHF can enroll them in Telehealth Home Care. Enter in the RM&R and then fax MARS to the team.
11) If the patient is elderly with multiple medical conditions then send a referral to the Geriatric Outreach team. Fax the referral and call them to let them know. Do not have to fax transcripts, etc. unless the patient has cancer treatments, or has Psychiatric issues. They may not have access to this info.
12) If the patient has IV antibiotics/meds, PICC line, Foley catheter, wound care then need Medical Orders filled out and signed by MD. Fax this to CLHIN.

NOTES

If the patient suffers from a chronic illness i.e.: diabetes and needs extra support at home to manage their health then a referral can be made to the Registered Nurse Health Coach Program. Call 905-895-4521 ext. #5615 or 5616 and give patient information.

If the patient needs extra care besides what CLHIN can give them then give them info sheet with private care services or pamphlets.

Make sure to get Rx signed by MD for patient.

If a patient is being transferred to another floor then a transfer Rx signed by MD is needed.

TCU and Cancer Care are considered Acute Care.

January 2021

DISCHARGE PATIENT TO HOSPICE

1) Enter RM&R for Hospice and include; PSW, RN, Equipment, etc.
2) Fill out HPC TEAMS CENTRAL LHIN (Stronach Regional Cancer Centre) referral form – MD to fill out their info and sign, then FAX to 905-830-5978
3) Fill out the Palliative Care Common Referral Form – RN and MD to fill out and sign then FAX to CLHIN at 905-952-2405 (they may ask for other information to be sent also).
4) MD to fill out and sign the Palliative Care Symptom Relief Kit (SRK) Prescription and then FAX to CLHIN at 905-952-2405.
5) If patient requires a CADD PUMP, MD to enter info and sign – FAX to CLHIN at 905-952-2405.
6) There is also the EDITH package for patients who decide to go home for End of Life care. It is a yellow booklet (Palliative Care Plan for Expected Death --- PLEASE DO NOT CALL 911) It includes; the Expected Death in the Home Form, Do Not Resuscitate Confirmation Form, and Medical Certificate of Death).
7) Call the Hospice to check for bed availability –fax the Palliative Care Common Referral Form to them. (Margaret Bahen Hospice 905-967-1500, FAX: 905-967-1515)
8) If sending a patient to another Hospice outside of Newmarket, call and speak to staff and obtain their FAX number.
9) Residential Hospices; Hill House (Richmond Hill), Margaret Bahen (Newmarket). Matthews House (Alliston), Hospice Simcoe (Barrie), -- can check www.centralhealthline.ca for more info.

January 2021

DISCHARGE PATIENT TO THE RESTORATIVE/REACTIVATION CARE UNIT

The Restorative Care/Reactivation Care Units have two sites. There are thirty patients at the Finch site and thirty patients at the Church Street site. The RCU units are comprised of patients designated ALC, that do not require acute care but require a longer time to improve their independence and quality of life and optimize their remaining strengths and abilities.

There are patients also who are waiting for Long Term Care beds that have LTC choices with shorter wait times.

- Referrals are made through iPlan by clicking on “Transfer to ALC Unit”.
- The MD must sign ALC orders (two pages).
- Call Pharmacy to let them know that patient will be tranferr3ed to RCU. They need a few hours to get medications ready to go with patient. Scan the Rx to Pharmacy.
- The staff is to send five days of MD orders (photocopied) with patient.
- If they haven’t had IPAC swabs for MRSA/VRE/CPE/ESBL within 72 hours of transfer make sure they are done. They can accommodate some MRSA/ESBL patients but no VRE/CPE.
- Make sure the family is aware of the transfer.
- Transportation is paid by the hospital. Ask the Unit Clerk to book Voyageur Non Urgent Transport (1-855-263-7163). You will also need a PTAC number.
- The staff is to call the RCU and give a verbal report. They can also use the “SEND” report.

ALSO SEE ADMISSION CHECKLIST TO RCU FINCH AND CHURCH

Discharge a Patient with Home and Community Services (LHIN/CCAC)

1) Enter the order for CLHIN services in Meditech.
2) Fill out the RM&R.
3) If patient has COPD or CHF (or any problem of concern) then add to RM&R-FAX a copy of transcripts and meds, labs, X/R to CLHIN for the Rapid Response team to visit patient 24-48 hours post D/C for F/U. Just mark Rapid Response team on FAX face sheet.
4) If patient has a PICC line and is going home with PICC then fill out RM&R for PICC line care and must have MEDICAL ORDER sheet signed by MD and a copy of PICC line insertion from MD orders on chart and fax it with RM&R so that they will have type of line and length (in case it gets pulled out). If PICC not inserted in hospital mark on RM&R not new insertion.
5) If patient is going home with IV antibiotics must have the date and time of last does and date and time of the next dose. Must have a MEDICAL ORDER sheet signed by MD and faxed to CLHIN.
6) If a patient is being discharged and needs wound care then fill out RM&R (mark wound care as per best practice) and photocopy the Wound Care Nurse's notes along with MEDICAL ORDER sheet and fax to CLHIN.
7) If a patient has a foley catheter then RM&R must be filled out the Medical Orders signed by MD and faxed to CLHIN. You will need to document size, date inserted/changed.
8) If a patient needs bloodwork done at home, fill out RM&R for CLHIN and get the MD to fill out lab requisition and fax to CLHIN. Send hard copy home with patient, leave a photocopy on the chart. Call CLHIN and let them know.
9) If the patient already had CLHIN services and does not need increased hours or services just chart on RM&R resumption of services.
10) If a patient is in hospital more than 14 days and has CLHIN services then those services will be cancelled. If still need CLHIN when going have to start a new RM&R.
11) If a patient has higher needs of care when going home can do a RM&R for Home First.
12) If the patient has higher needs of care when going home can do a RM&R for Home First.
13) If the patient needs home O2 get the MD to sign an RX for home O2. Call RT to arrange and bring a tank for patient to go home with.
14) If a family feels they need extra care over and above CLHIN services, give them information sheet on private pay services; can also give them the CHATS information sheet as they offer a number of services.
15) If a family feels the patient needs a Respite bed, give information on residences that offer that service and advise them that they have to pay privately for this.
16) Respite beds are available at different retirement homes. The family has to go and visit these facilities, get prices and make arrangements themselves. The Retirement Home will send someone in to assess the patient to see if they provide the care needed.
17) If a family feels the patient needs a Long Term Care bed then advise them of Home First policy. Crisis placement is faster if patient is coming from home or a Retirement Home as opposed to a hospital bed. Any discussions of LTC application must be directed to Management.
18) If approved by Management to wait in hospital for LTC then put in order for RM&R in Meditech and fill out RM&R (application for Long Term Care). A MOH Medical will have to be done for CLHIN.

19) If family is applying for LTC the PATIENT HAS TO CONSENT unless they are incapable, in which case then the SDM or POA for health care can sign.

LHIN/CCAC SERVICES

HOME FIRST

- Is for patients with higher care needs.
- Includes an Occupational Therapist (OT) to go in and assess home safety and advise what equipment may be needed in the home.
- The OT can also send a referral for a Physiotherapist to go in to help patient with rehab.
- Up to 21 hours (possibly 56 hours) of PSW care per week, sometimes more (patient can divide the hours up as they feel they need i.e.: 1 hour, 3 times per day or 2 hours in the AM and 1 hour later in the day, whatever). This is only for ninety days.
- Nursing care as needed to F/U, Rapid Response Nurse, or IV Ax, or PICC line care, etc.
- They can have 3 pieces of equipment to go home with them for free for first 30-60 days. (i.e.: hospital bed, commode, walker, rollator, etc.)

LHIN/CCAC Services

- IV antibiotics/meds/hydration/PICC line or Port care by a RN
- Wound care services by a RN
- Foley catheter care by a RN (or any drains, lines)
- PSW (Personal Support Worker) to support any care needs, meal assist
- F/U by RN for people with chronic diseases (Rapid Response Nurse)
- Home safety by an Occupational Therapist
- Rehab by a Physio Therapist
- Speech Language Pathologist for any swallowing/diet concerns
- Dietician for any nutritional needs
- Mental Health Nurse if needed
- Respiratory Therapist if needed
- Telehome Health Care for patients with COPD or CHF

Home First Program

Home First is a program which allows ALC designated patients to safely return home to continue their recovery. It allows patients and families to make long-term plans in the comfort of their home. This program provides enhanced home care services for up to 90 days. The Hospital LHIN Case Manager works closely with the Hospital health care team including the Social Worker, nurse, or discharge planner to assess eligibility for the *Home First* program.

Eligibility Criteria:

- Patient is age 65 or older, but younger patients are eligible on a case-by-case basis.
- Eligible for LHIN service
- Identified as ALC in an acute care hospital (medically stable). This includes patients who are ALC patients for Rehab, Complex Continuing Care or Convalescent Care.
- The patient resides in an appropriate home environment (space and safety) and it has been determined that the patient can live safely at home with enhanced services
- Family member or caregiver who lives with the patient is willing to support the *Home First* plan of care

Program Highlights

- Program is time limited to 90 days
- Eligible for up to 56 hours per week of PSW support
- As needed, OT visits within 3 days of discharge home
- Mandatory RN visit within 24 hours of discharge
- Mandatory MMSS referral with a Pharmacist visiting
- Up to 4 nursing visits daily
- Equipment loan from LHIN catalogue as needed or for up to 90 days
- Intensive Case Management with designated Case Managers who can make frequent home visits

NURSING PROCESS FOR DISCHARGE MEDICATIONS

Discharge teaching:

- Discuss with the pharmacist, whether the pharmacist needs to see the patient. If not, the nurse will:
  - Review original prescription with the patient
  - Provide education on any changes to home meds or any new meds prescribed
  - Give scripts to patient; original script to patient for their pharmacy

OR

- Fax to patient's pharmacy. If faxed do not give original to patient, keep on chart and mark as faxed.
- Copy of prescription (marked COPY) to patient. This copy is for patient/caregiver reference and education and to bring to their next visit with their family practitioner.
- Nurse should recommend that patient visit their family practitioner within 3-5 days post discharge
- Ensure that a copy of the prescription (marked COPY) is left on the chart

Documentation:

- Open patient's chart on Meditech and open the worklist
- Find BPMH – Med Rec Documentation. This will be on your worklist as it is used by all staff during the admission
- Select BPMH- Med Rec Documentation and hit Document to begin charting. Document in Med Rec on Admission section only
- If you provide medication counselling (e.g. when to take next dose or answer questions about the medications), you may also document in the Medication Counselling section
- Save and Exit

January 2021

Palliative Discharge Checklist

- ☐ **LHIN/CCAC**
  - CADD & Orders
  - OT equipment i.e.: Hospital bed, commode, walker wheelchair
  - PSW
  - Nursing
  - Palliative symptom relief kit
  - Home palliative physician
    - Southlake Team
    - HPC
    - Family doctor
    - CHLIN out of area palliative team

- ☐ **HPC Referral**

- ☐ **EDITH Protocol**

HOW TO PRINT A MAR FROM MEDITECH CHEAT SHEET

1. From the Main Menu click on Clinical
2. Click on Clinical Custom Reports
3. Click on Medication/MAR Reports
4. Click on Medication Administration Record (MAR)
5. Go to "patient" and enter patient's name. Click Enter
6. Select your patient
7. Click on ok, then close. MAR will now print

Note:

These MARs are very long (many pages) due to the fact that there are only 2 medications per page.

HOW TO PRINT DISCHARGE MEDS FROM MEDITECH CHEAT SHEET

1. From the main menu, click on Clinical
2. Click on Custom Reports
3. Click on Medication/MAR Reports
4. Click on Discharge Prescription
5. Enter patient's name, click ok
6. Select and click on your patient
7. Highlight "preview", then click ok
8. Click on "Discharge Prescription Ready to View"
9. On preview screen, click on Printer in upper right corner
10. Click print

HOW TO PRINT TRANSFER MEDS FROM MEDITECH CHEAT SHEET

1. From the Main Menu, click on clinical
2. Click on Custom Reports
3. Click on Medication/MAR Reports
4. Click on Med Transfer Order Report
5. Enter patient's name
6. Select patient then click ok
7. Highlight "preview", click ok
8. Click on highlighted "Medication Transfer Order Report"
9. On preview screen, click on printer in upper right corner
10. Click on print box

January 2021

RESTORATIVE CARE UNIT INFORMATION SHEET

Programs/Criteria

Functional Goal:

Reactivation and progression to disposition.

Time-Limit:

Dependent on patient progress.

Therapy Intensity:

Maintenance: 30-45 mins/sessions – 3x/week

Rehab: 30-45 mins/sessions 3-5x/week

Therapy Setting:

Group **AND** 1:1

Population:

Adult and geriatric medically stable ALC with medically managed comorbidities.

Exclusion Criteria:

- Advanced dementia (MOCA score less than 12/30)
- Active chemo/radiation
- Dialysis
- Tracheostomy
- Cardiac monitoring
- Uncontrolled responsive behaviours

NOTE: patients with the below care requirements will be accepted to RCU on a case by case basis:

- Responsive behaviours
- VAC dressing
- Bariatrics: weight >300lbs and/or requiring greater than 20 inch seating
- Isolation precautions excluding patients from group activities
- PICC/CVAD

Nursing Care:

Requires up to 3-4 hours of nursing care daily including medication, wound management, IV therapy, and ADL assistance.

Discharge Plan:

Definitive discharge plan in place. If approved for ALC to LTC in hospital, must have short wait list choices of 6 months or less.

1) Rooms are very small--- bathrooms are small ---cannot get W/C into BR.
2) Do not have negative pressure rooms.
3) Only have two private rooms --- no bariatric beds --- rooms are semi private.
4) Only have one wide W/C.
5) Not a huge storage room there.
6) Limited number of equipment.
7) Visitor bathroom is large --- automatic door opener.
8) Precautions: ESBL OK --- Droplet OK --- MRSA maybe --- VRE cannot accept.
9) If had C Diff and is resolved may take that patient --- IPAC will monitor.
10) If swabs were negative last time taken then can send patient.
11) Will take patient with: ostomies, foleys, and IV therapy. Will not take PICC lines, Ports, or any patient with behaviours.
12) Will take stable cardiac patients --- can do an EKG if needed.
13) Physio fully staffed.
14) Do have a Dietician, OT, PT, PTA, Recreation Therapist, SW, SLP, Pharmacist, Home and Community Care Coordinator, Volunteers.
15) Monday to Friday have an NP on site --- MDs who cover: Dr. Liu, Dr. Srour, and Dr. Jivraj.
16) In the event of a medical emergency, the patient will be transferred to Humber River Hospital.
17) New RM&R has height and weight.
18) If patient/family refuse RCU then escalate to Management.
19) Parking for families is flat rate $5.00, or can arrange through CHATS to visit 3 times per week $5.00 each way.
20) There is also a shuttle that departs from the Aurora Walmart/404 Center 135 First Commerce Drive, Aurora that takes place Mondays, Wednesdays and Fridays leaving at 1030 hours and returning at 1430 hours.
21) If patient has an appointment and needs transportation RCU pays for it.
22) If patient is being discharged family can pick them up --- if unable to and patient going to RH or home they can use Home At Last.
23) If sending a patient who is waiting for LTC --- send a patient that has LTC choices with shorter wait times.
24) There is a new pamphlet “Welcome to Southlake Restorative Care Units” that can be given to patients and families.

January 2021

Resource Matching and Referral (RM&R)

If you need to obtain forms for RM&R such as Medical Orders, MOH, etc., go to Southlake Regional Health Center intranet.

Under “Resources” scroll down to Resource Matching and Referral and click on it (or click this link).

Go to “Documents and Tools” – under this heading are forms used for RM&R and information.

You can click on forms listed there and print them. You can also go to next title RMR Downtime Forms for forms not listed there.

Go to “RMR Downtime Forms” you will see a username and password.

Click on the “RMR Downtime Forms”, enter username and password.

When screen opens you will see a screen to you left. At the top you will see “Forms for all hospitals”. Click on this.

It will open and you can print which forms you will need i.e.; MOH, Palliative Care Symptom Relief Kit, Medical Orders, etc.

Further Information:

RM&R - Ontario Toronto Central Local Health Integration Network

RM&R Matching an Acute Admitted Patient to Most Appropriate Programs and Services

1. **Return to Community:**

Home with supports (CLHIN Care), Outpatient Neuro Rehab Clinic, Private Pay Supports, RH, LTC, etc.

2. **External Rehab Application:**

Specialized rehab e.g., spinal cord, long term vent, complex continuing care

3. **RNU BED:**

- High intensity rehab tolerance (2+ hrs/d)
- Max LOS 30 days
- Requires 2 or more rehab services (PT, OT, SLP, Rec, RD, SW)
- Established discharge location
- Cognition to support active participation & carryover in therapy
- Neurological diagnosis

4. **MCC ASSESS & RESTORE BED:**

- Slow stream rehab or reconditioning
- Max LOS 55 days
- Requires 2 or more rehab services (PT, OT, SLP, Rec, RD, SW)
- 65yrs+ or geriatric medical needs
- Established discharge location (not LTC)
- Cognition to support active participation & carryover
- Able to participate in group programming

RCU BED:

- Slow stream reconditioning and/or ALC for community
- Max LOS 90 days
- Requires 2 or more rehab services (PT, OT, Rec, RD, SW, SLP follow up)
- Able to participate in group programming MOCA 15/30
- Wheelchair size 20 inches or less

Can't:*

- Be bariatric
- Be on isolation precautions
- Have a trach or PICC
- Require daily SLP intervention
- Require ongoing diagnostic testing

MCC BED:

- Slow stream rehab tolerance (30 min/d 3x/wk)
- Complex medical needs (i.e., trach, wound)

- Max LOS 90 days
- Requires 2 or more rehab services (PT, OT, Rec, RD, SW)

Goal: patient attends above program or services and then returns to community or most appropriate destination.

SOUTHLAKE REGIONAL HEALTH CENTRE

Southlake Transition Pathways

Transitional Planning –*Starts on Admission*

In Hospital Patient

Triggers

HIGH NEEDS PATHWAY

Discharge planner/ Social Worker

- Targeted Transition Planning
- Preferred destination Home with Supports
- As needed transitional care - Restorative Care, Complex Care, Rehab
- Example Southlake@home
- MCC/RCU
- Post d/c RN/PT/OT/ PSW needs
- Home assessment
- Patient functional optimization needed
- Discharge Planner/Social Work

BLAYLOCK SCORE = 13+

- High social support needs
- > 65yo , lives alone or with other elder
- Multiple comorbidities & medications
- High need for rehab/ transitional care to home

ENHANCED PATHWAY

Frontline Nurse with support PRN

- Home with time limited supports (Nursing, PT, PTA, etc.,)
- Assessment indicates high functional status pre admit
- Nursing/PSW support time limited
- Transition to OP services and or transition to home with limited services
- Example - Nurse led clinic supports
- Frontline Nurse may require support from Charge Nurse or Social Worker
- Charge without assignment

BLAYLOCK SCORE = 8 - 15

- Some home care needs (Nursing/PSW/Allied Health) for short time period
- Low social support required to be put into place

SUPPORT PATHWAY

Frontline Nurse

- Direct to home with focus on self management
- Patient education and follow up instructions by interprofessional team
- May only require OP service
- Frontline Nurse

BLAYLOCK SCORE = 0 - 10

- Few medications
- < 65yo
- No social support needs
- Self management-no interventions to be put in place by hospital

Social Work and Allied Health Resources

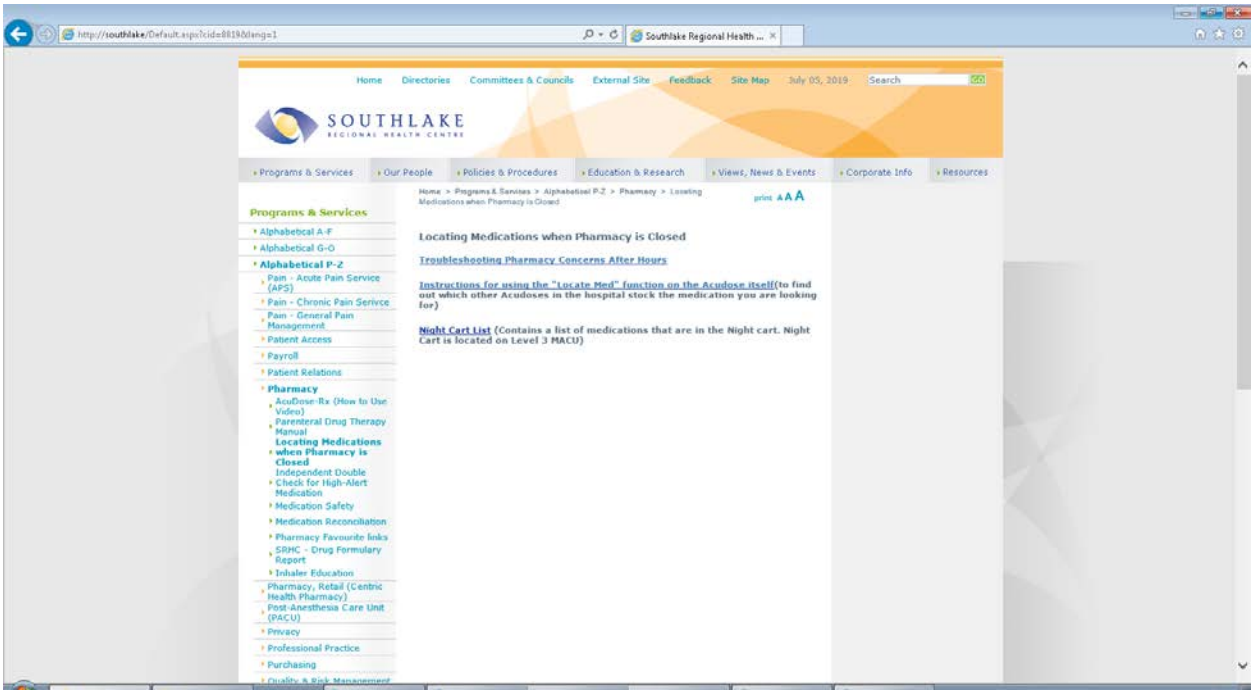
return to Table of Contents

Pharmacy

July 2019 – **LOCATING MEDICATIONS AFTER PHARMACY HOURS**

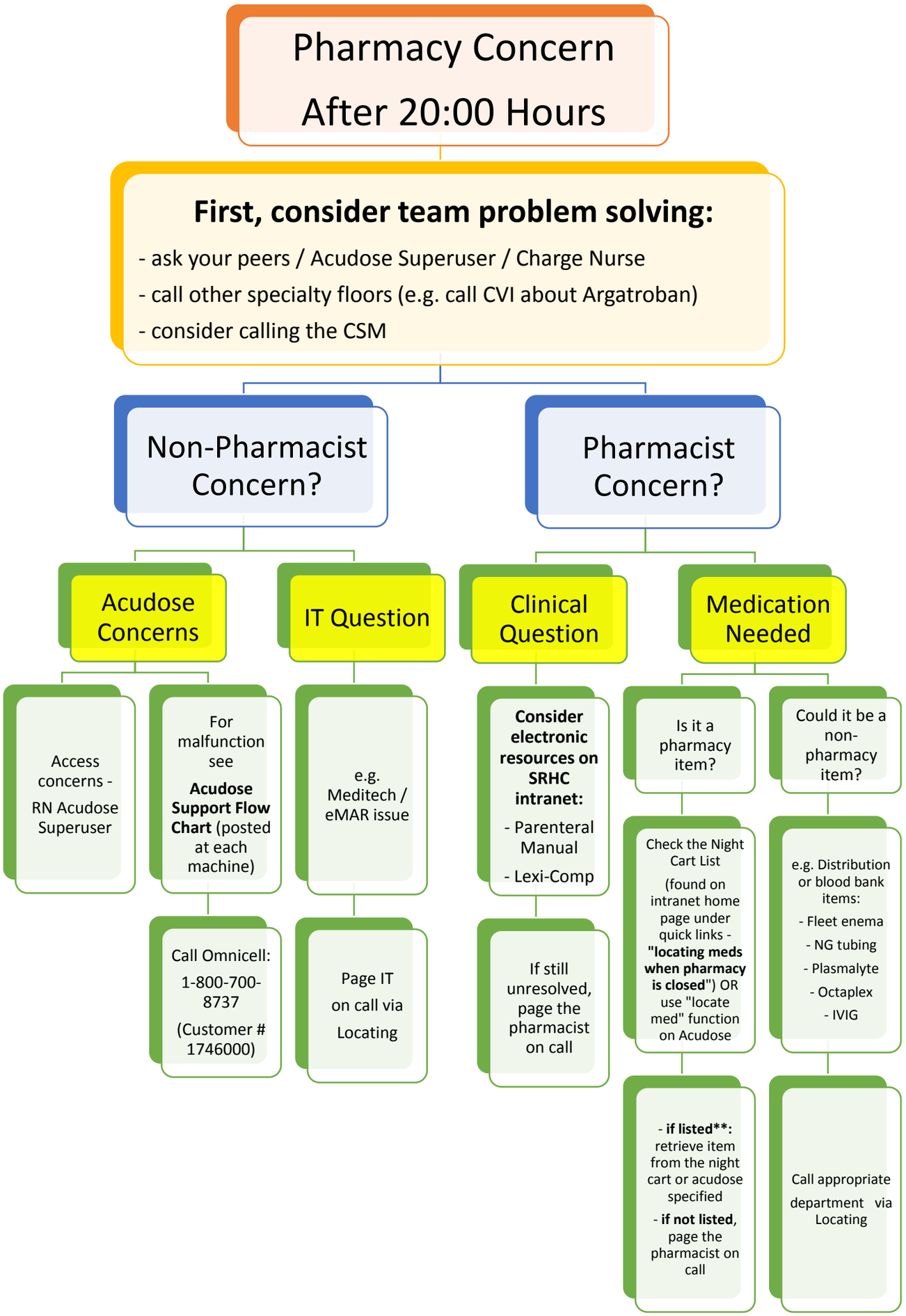
Pharmacy processes orders until 2000h, 7 days a week.
Before leaving - screens for any urgent needs for the orders not yet entered.
Pharmacist is on call through locating until 0730h the next morning, 7 days a week. They should primarily be called for clinical questions, other resources are available for locating required doses of medications.
Pharmacy Technicians are on site until 2300h but they are focused on 24h medication exchange.

Resources while the Pharmacy department is closed -2 documents attached but the night cart list changes so needs to be accessed online:
Intranet:



Trouble Shooting Pharmacy Concerns After Hours

- Pharmacy Hours **(a pharmacist is on-site) are 07:30 - 20:00 Hours** x 7 days per week
- **After 20:00 Hours: page the on-call pharmacist (who is off-site)** via Locating (ext. 2216)
- **Note:** *Pharmacy technicians are in hospital until 23:00 hours but are dedicated to bin filling/cart delivery after 20:00 hours*

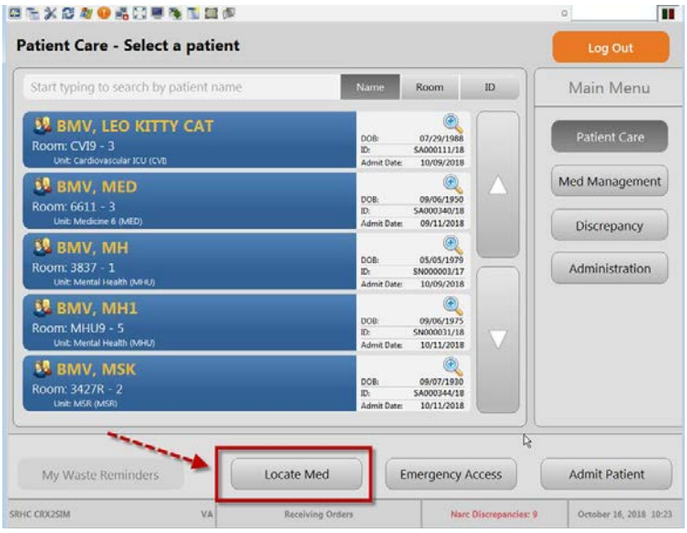


****Note:** Drug names are always listed as they appear in the Acudose (e.g. sulfa/trim is called cotrimoxazole)

NEW ACUDOSE FEATURE AFTER UPGRADE ON OCTOBER 23 2018

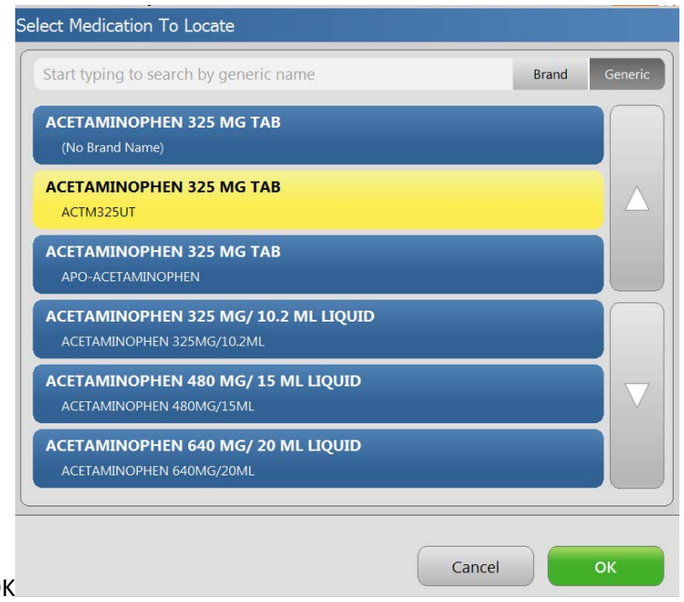
TO HELP YOU LOCATE STOCK IN ANOTHER ACUDOSE AFTER HOURS:

- Click the **Locate Med** button



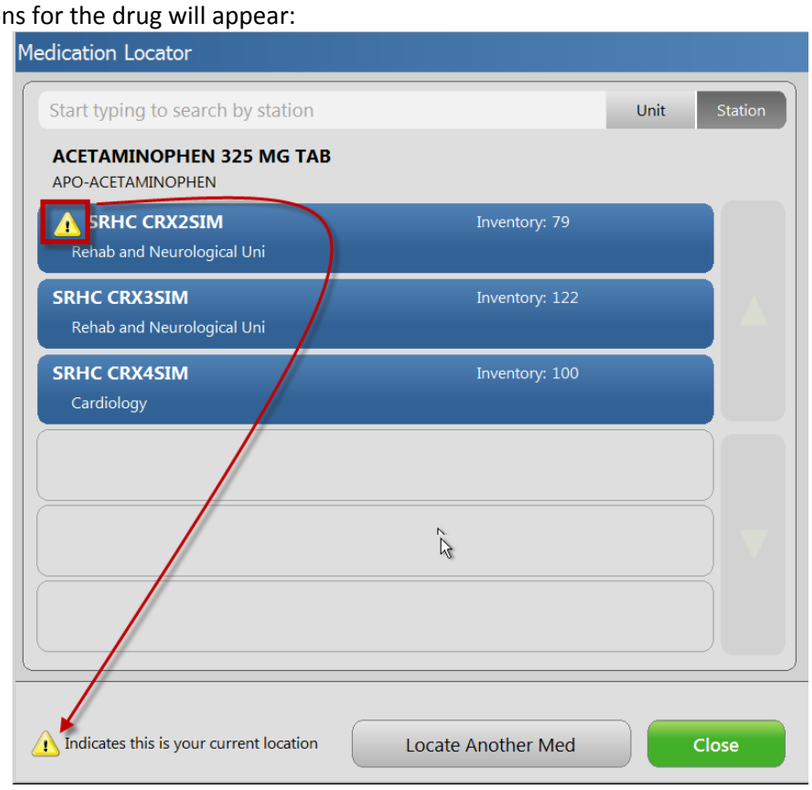
The next screen is displayed.

- The clinician can start typing the name of the medication they are trying to find.
- They can also use the up and down arrows.



- Click OK

- A list of locations for the drug will appear:



Issue Resolution Flow
Southlake Regional Health Centre

Possible AcuDose Issues

Password won't work or you can't login **Call ext. 5137 or 2144**	The AcuDose does not stock the **narcotic or controlled substance** you need. **Call ext. 2187, option 2**	There is no medication in the **Acudose** pocket **Call ext. 2187, option 1 then 2**	All other issues **Call ext. 2187, option 3**

How to Handle a Cabinet Error

Is the Pharmacy Open?
Monday – Friday
0730-2000
Sat/Sun/Holidays
0800-2000

YES →

Call Ext.2187, option 3
Pharmacy will work to resolve the issue →

NOTE:
- During regular hours, Pharmacy will call Omnicell if they cannot resolve the issue.
- Pharmacy will coordinate how to dispense medications to the nursing unit until the issue is resolved

NO ↓

Nursing will call Omnicell:

Omnicell Help Desk
Phone#: 1-800-700-8737 (select option #2 AcuDose Support)

Customer #: 1746000

Cabinet Name:

→ **PLEASE PAGE THE PHARMACIST ON CALL IF A SERVICE TECHNICIAN NEEDS TO BE DISPATCHED**

Issue Resolution Flow
Southlake Regional Health Centre

Anaesthesia-Rx

Possible A-cart Issues

Password won't work or you can't login **Call ext. 5137 or 2144**	You require a **narcotic or controlled substance** **Call ext. 2187, option 2**	There is no medication in the pocket **Call ext. 2187, option 1 then 2**	All other issues **Call ext. 2187, option 3**

How to Handle a Cart Error

Is the Pharmacy Open?
Monday – Friday
0730-2000
Sat/Sun/Holidays
0800-2000

YES →

Call Ext.2187, option 3
Pharmacy will work to resolve the issue →

NOTE:
- During regular hours, Pharmacy will call Omnicell if they cannot resolve the issue.
- Pharmacy will coordinate how to dispense medications until the issue is resolved

NO ↓

Nursing will call Omnicell:

Omnicell Help Desk
Phone#: 1-800-700-8737 (select option #3 Anaesthesia Rx Support)

Customer #: 1746000

Cabinet Name:

→ **PLEASE PAGE THE PHARMACIST ON CALL IF A SERVICE TECHNICIAN NEEDS TO BE DISPATCHED**

return to Table of Contents

Standard Work

Generic STANDARD WORK for: Charge RN (Days)
Sample

Hour	Task
Start of Shift 07:30	• Print assignment sheet • Receive report from off going Charge Nurse • Resolve staffing issues • Have a working knowledge and oversight for the shift's priorities and activities for the day • Facilitate admissions and discharges and work to address issues impeding flow • Unit oversight for efficient and effective discharge planning • Attend case conferences or family meetings as required throughout shift • Work with community stakeholders and facilitates referrals to community resources as required throughout shift
08:00	• Check in with unit teams re: patient acuity/complexity and appropriate assignment • Round on patients and families in unit • Communicate with patients and families ensuring service excellence and service recovery if needed ongoing throughout shift • Hourly rounding as able • Acknowledge new meds as required
09:00	• Communicate with Manager, Clinical Coordinator, Staffing Scheduler re: staffing, patient flow, acuity, complexity, workload increase or vacancy coverage needs • Assist with discharge plan for upcoming discharges; facilitate discharges by assisting unit staff as needed • Actively support team to ensure bed flow
10:00	• Update assignment board with staffing changes as required
11:00	• Ensure breaks were taken • Support team with direct care as needed • Lead quality safety huddles
12:00	• Check in with patients and staff
13:00	• Ensure staff is completing Kardex updates, chart checks, etc. • Coordinate with Manager, Clinical Coordinator, Staffing Scheduler short call re: filling staffing vacancies
14:00	• Assignment board for nights
15:00	• Workspace/unit function improvement time- 5S Lean Methodology to Sort, Set, Shine, Standardize, Sustain • Equipment repairs, ordering, rentals, etc.
16:00	• Review patient acuity and complexity with day staff
17:00	• Create staff assignment for nights • Update team whiteboard
18:00	• Ensure team duties completed • Coordinate with Staffing Scheduler, CSM re: filling staffing vacancies • Update bed allocation
19:30	• Report to oncoming Charge Nurse

On Demand
• Consult and collaborate with interprofessional team, staff, patients, and families • Facilitate bed moves, patient transfers, admissions, discharges • Death- care of deceased-assist with process and/or direct care • Codes – assumes a leadership role • Wandering 1:1 patients in the hall at nursing station-facilitate care of • Contact CCOT • Skills- assist staff as needed: catheter insertions – for retention, Bladder scan, NG lead weight insertion and straight drain, POC, Nebulizers, IV starts, etc. • Falls – assessment, CT or X-ray scan • Respiratory distress • Restraints – policy – followed • Medication Reconciliation • Narcotic count • Eyewash station checks • RM&R • Support new team members with orientation to unit in collaboration with Educator and preceptor • Support volunteers on unit • Support Back to Basics initiatives –BSSR, hourly rounding, team based care, and care board communication • Takes full or partial assignment as required and as unit needs dictate-see Standard Work RN • Liason for student activity within the unit • Ethical professional role model

Standard UnitRoutine

Unit Task	Key Components	Impact to the Patient	Frequency
5S	An organizational process to Sort, Set, Shine, Standardize, and Sustain (bring order and organization to the unit) based on LEAN methodology	Increased nursing time at the bedside with patients Decreased Hospital Acquired Infections	Q shift
Shift to Shift Assignment	Formal shift "hand off" process utilizing standard tools to determine acuity with assigned nurses and care providers working in teams	Decreased patient harm incidents Rapid identification of changing status on "hand off" Essential and critical information for continuity of care shared with nursing team using "common language Wrap around care: Right provider providing the right care	Q shift
Bedside Shift Report	Team rounds with oncoming shift to relay pertinent information – standardized tool SBAR	Patient and family-centred	Q shift
In-Room White Boards	Communicates real time information to patients and their families EDD updated	Improved communication Increased patient satisfaction Discharge goal	Q shift
Bullet Rounds	Daily bullet rounds (1 min PP) inclusive of the care team to discuss the plan of care and barriers to discharge	Length of stay admission within target Improved preparation for discharge – goal planning 48 hours prior	Daily
Safety Huddles	Conducted by Charge Nurse within 1 hour of shift change to communicate potential issues to the team; one in 5 minutes or less	Decreased patient harm incidents Patient and unit issues addressed or escalated in real time	Q Shift
Leader Rounding	Charge Nurses connect with each patient once during their stay, ask questions regarding their experience	Patient Satisfaction Opportunities to acknowledge outstanding staff or to develop service recovery plan if necessary	Daily
Hourly Rounding	Proactive rounding on patients hourly	Decrease falls Decrease pressure injuries Increase patient satisfaction	Hourly
Transfer of	Verbal and written process used for	Decreased Patient Harm incidents	At each point

Accountability	all patients “transferred” to another unit, program.	Safe patient transfers and increased communication between sending and receiving physician/nurse	of transfer

Generic STANDARD WORK for: Charge RN (Nights)
Sample

Hour	Task
Start of Shift 19:30	• Print assignment sheet • Receive report from off going Charge Nurse and report for assigned patients using bedside shift report (BSSR) and care board communication • Resolve staffing issues • Have a working knowledge and oversight for the shift's priorities and activities for the night • Facilitate admissions and discharges and work to address issues impeding flow • Unit oversight for efficient and effective discharge planning • Receive report on own patient assignment
20:00	• Check in with unit teams re: patient acuity, complexity and appropriate assignment • Hourly 4P rounding - Pain, Potty, Positioning, Possessions • Assessment (Head to Toe) • Medication Administration • Glucometer checks within assignment • Ensure that HS snacks have been given • Round on patients and families in unit • Communicate with patients and families ensuring service excellence and service recovery if needed
21:00	• Hourly 4P rounding • Report to CSM with staffing update, patient flow, acuity, complexity, WI or vacancy needs • Check orders needing to be co-signed • Prepare patients for HS • Support staff with evening discharges • Actively support team to ensure bed flow
22:00	• Hourly 4P rounding • Update assignment board with staffing changes as required • Charting, write reports • Acknowledge new meds as required • Check if any meds still to be given (e.g. hs sedation and analgesics) • Emptying catheter bags
23:00	• Hourly 4P rounding • Ensure breaks were taken • Support team with direct care
00:00	• Hourly 4P rounding • Sick calls – communicate with CSM • 24 hour Med Review
1:00	• Hourly 4P rounding • Nightly checks- fridge temperature, POC glucometer QC, code cart check, equipment repairs needed, equipment plugged in

Generic STANDARD WORK for: Charge RN (Nights)
Sample

Hour	Task
2:00	• Hourly 4P rounding • Medications • Hourly rounding • Assignment board for next day
3:00	• Hourly 4P rounding
4:00	• Hourly 4P rounding
5:00	• Hourly 4P rounding • Review patient acuity/complexity with night staff teams • Create staff assignment for days • Update team whiteboard • Medications • Hang new feeding bags
6:00	• Hourly 4P rounding • Ensure night duties completed • Empty catheters • Finish charting I&O • Coordinate with CSM filling staffing vacancies • Update bed allocation
7:30	• Report to on coming Charge Nurse using BSSR and care board communication • BSSR to nurse accepting patient assignment

On Demand
• Consult and collaborate with interprofessional team, staff, patients, and families • Facilitate bed moves, patient transfers, admissions, discharges • Death- care of deceased-assist with process and/or direct care • Codes –assume leadership role • Wandering 1:1 patients in the hall at nursing station-facilitate care of • Contact CCOT • Skills- assist staff as needed: catheter insertions – for retention, Bladder scan, NG lead weight insertion and straight drain, POC, Nebulizers, IV starts,etc. • Falls – assessment, CT or X-ray scan • Respiratory distress • Restraints – policy – followed • Medication Reconciliation • Narcotic count • Eyewash station checks • RM&R • Support new team members with orientation to unit in collaboration with Educator and preceptor • Support volunteers on unit

- Support Back to Basics initiatives –BSSR, hourly rounding, team based care, and care board communication
- Takes full or partial assignment as required and as unit needs dictate
- Liason for student activity within the unit
- Ethical professional role model

STANDARD WORK – REGISTERED NURSE
Sample

Hour	Task	Break
Start of Shift 07:30	• Introduce self to patient- AIDET • Bedside shift report (BSSR)– verbal face to face report to be given • Check Allergy bands, ID bands, falls risk band • Check suction, oxygen set-up, bed function • Organize team shift assignment and work plan-ensure appropriate acuity for team members and need for collaboration, consultation, co-care-assist team with high acuity patients by taking on aspect of care for unpredictable, unstable patients as required • Review and update care board -date, name and goals for the day • Acknowledge new meds as required • Glucometer checks • Daily assessment of catheter need/removal • Assess appropriate intervention implemented on care board for: pressure ulcers, risk patients for falls, CAM, mobility, discharge • Team review of work assignment and patient updates occur regularly throughout shift- assess need for collaboration, consultation, co-care for patient changes in acuity	
08:30	• Hourly 4P rounding - Pain, Potty, Positioning, Possessions • Assessment (Head to Toe) • Medication Administration • Participate as team member in patient breakfast; ADL; up to chair; mobilization and ambulation; bathing and oral care throughout shift • Collaborates with interprofessional team- assessment updates, care planning	
09:30	• Hourly 4P rounding • Follow-up on outstanding tests, check blood work, test results • Charting • Wound dressing changes • Determine expected date of discharge and required tests, meetings, goals needed	
10:30	• Hourly 4P rounding • Chart Check- Acknowledge new orders for MARs • Charting • Assist patients: ADL; up to chair; mobilization and ambulation; bathing and oral care • Low to moderately complex discharges with health teaching, med reconciliation • Lead quality safety huddle in absence of Manager or Charge Nurse	
11:30	• Hourly 4P rounding • Blood glucose check • Team review of work assignment and patient update- assess need for	

Hour	Task	Break
	collaboration, consultation, co-care for patient changes in acuity	
12:30	• Hourly 4P rounding • Assist PSP getting patients up in chair for lunch; 1 registered staff required for mechanical lift • Medication administration • Feed patients as required	
13:30	• Hourly 4P rounding • Health teaching (patient and family education) • Charting • Wound dressing changes • Acknowledge new orders for MARS	
14:30	• Hourly 4P rounding • Charting • Receive admissions –med rec, best possible medication history, assessments, orders, interventions • Attend in-services	
15:30	• Hourly 4P rounding	
16:30	• Hourly 4P rounding • Assist PSP getting patients up in chair for supper; 1 registered staff required for mechanical lift • Medication administration • Glucometer checks	
17:30	• Hourly 4P rounding • Feed patients as required • Acknowledge new meds as required • Health teaching/emotional support	
18:30	• Hourly 4P rounding • Finish charting, I&O • Oral care	
19:30 Change of Shift	• Introduce self to patient- AIDET • Bedside shift report (BSSR) – verbal face to face report to be given • Check Allergy bands, ID bands, falls risk band • Check suction, oxygen set-up, bed function • Organize team shift assignment and work plan-ensure appropriate acuity for team members and need for collaboration, consultation, co-care-assist team with high acuity patients by taking on aspect of care for unpredictable, unstable patients as required • Review and update care board -date, name and goals for the day • Acknowledge new meds as required • Assess appropriate intervention implemented on care board for: pressure ulcers, risk patients for falls, CAM, mobility, discharge	

Hour	Task	Break
	• Team review of work assignment and patient updates occur regularly throughout shift- assess need for collaboration, consultation, co-care for patient changes in acuity	
20:30	• Hourly 4P rounding • Medication administration • Glucometer checks • Ensure that HS snacks have been given	
21:30	• Hourly 4P rounding • Check orders needing to be co-signed • Prepare patients for HS	
22:30	• Hourly 4P rounding • Charting, write reports • Acknowledge new meds as required • Pain assessment and meds • Confirm all required meds given (e.g. hs sedation and analgesics)	
23:30	• Hourly 4P rounding	
00:30	• Upload glucometer/ Hi/Low check QA	
01:30	• Hourly 4P rounding • 24 hour Med Review / Use report sheets to check for entered bloodwork & outstanding tests	
02:30	• Hourly 4P rounding • Medication administration	
03:30	• Hourly 4P rounding	
04:30	• Hourly 4P rounding • Document • Stock med carts • Add forms to charts; complete online forms	
05:30	• Hourly 4P rounding • Medication administration • Print census • Hang new feeding bags	
06:30	• Hourly 4P rounding • Nurse to determine team work assignment for day shift PSP • Empty catheters • Finish charting, I&O	

Admission
• Initial admission assessment including: o Admission Assessment Intervention o Fall risk assessment o Braden scale

- Delirium risk assessment (CAM)
- Give and review educational pamphlets for falls prevention and pressure ulcer prevention to patient and family
- Ensure appropriate arm band (i.e. high risk for falls) and 2 client ID checks with any intervention
- MRSA/VRE Swabs
- Take report, VS, Review orders

Transfer

- Complete Transfer of Accountability
- SBAR transfer report
- Notify family
- SEND report on admit/transfer intervention
- Escort patient if required

As needed (PRN)

- Treatment e.g. insulin, dressing changes, Trach care, IV administration
- Patient/Family Teaching
- Family meetings/phone calls
- Call doctor
- Call for consults
- Provide emotional support to patient/family
- Weigh patient
- Ostomy
- Blood transfusions
- Central line care
- Bladder scan/in and out catheterization
- Assist porter with transferring patients
- Transporting patients to diagnostics/off unit/outside appointments
- Assist MD with procedures
- Prepare patients for tests/OR/hemodialysis
- Collect specimens/blood and send to lab
- Assess IV access
- Preceptor students
- Unit Council rep
- Training
- Codes –leadership role

Deceased Care

- Notify family
- Notify MD/ MD to sign death certificate
- Notify TGLN
- Document
- Body care

- Discharge patient in computer

STANDARD WORK – REGISTERED PRACTICAL NURSE
Sample

Hour	Task	Break
Start of Shift 07:30	• Introduce self to patient- AIDET • Bedside shift report (BSSR) – verbal face to face report to be given • Check Allergy bands, ID bands, falls risk band • Check suction, oxygen set-up, bed function • Confirm team shift assignment and work plan • Review and update care board -date, name and goals for the day • Acknowledge new meds as required • Glucometer checks • Daily assessment of catheter need/removal • Assess appropriate intervention implemented on white board for: pressure ulcers, risk patients for falls, CAM, mobility, discharge • Team review of work assignment and patient updates occur regularly throughout shift- assess need for collaboration, consultation, co-care for patient changes in acuity	
08:30	• Hourly 4P rounding- Pain, Potty, Positioning, Possessions • Assessment (Head to Toe) • Medication Administration • Participate as team member in patient breakfast; ADL; up to chair; mobilization and ambulation; bathing and oral care • Collaborates with interprofessional team- assessment updates, care planning	
09:30	• Hourly 4P rounding • Follow-up on outstanding tests, check blood work, test results • Charting • Wound dressing changes • Determine expected date of discharge and required tests, meetings, goals needed	
10:30	• Hourly 4P rounding • Chart Check - Acknowledge new meds as required • Charting • Assist PSP with patients: ADL; up to chair; mobilization and ambulation; bathing and oral care • Low to moderately complex discharges with health teaching, med rec • Attend quality safety huddle	
11:30	• Hourly 4P rounding • Blood glucose check • Team review of work assignment and patient update- assess need for collaboration, consultation, co-care for patient changes in acuity	
12:30	• Hourly 4P rounding • Assist patients up in chair for lunch; 2 staff required for mechanical lift of which 1 must be regulated health professional	

Hour	Task	Break
	• Medication administration • Feed patients as required	
13:30	• Hourly 4P rounding • Health teaching (patient and family education) • Charting • Wound dressing changes	
14:30	• Hourly 4P rounding • Charting • Receive admissions –med rec, assessments, orders, interventions • Attend in-services	
15:30	• Hourly 4P rounding • Team review of work assignment and patient update- assess need for collaboration, consultation, co-care for patient changes in acuity	
16:30	• Hourly 4P rounding • Assist PSP getting patients up in chair for supper; 1 registered staff required for mechanical lift • Medication administration • Glucometer checks	
17:30	• Hourly 4P rounding • Feed patients as required • Check MAR and new orders • Health teaching/emotional support	
18:30	• Hourly 4P rounding • Finish charting I&O, BM • Oral care • Charting	
19:30 Change of Shift	• Introduce self to patient- AIDET • Bedside shift report (BSSR) – verbal face to face report to be given • Check Allergy bands, ID bands, falls risk band • Check suction, oxygen set-up, bed function • Confirm team shift assignment and work plan • Review and update care board -date, name and goals for the day • Acknowledge new meds as required • Glucometer checks • Assess appropriate intervention implemented on white board for: pressure ulcers, risk patients for falls, CAM, mobility, discharge	
20:30	• Hourly 4P rounding • Medication administration • Glucometer checks • Ensure that HS snacks have been given	
21:30	• Hourly 4P rounding • Prepare patients for HS	

Hour	Task	Break
22:30	• Hourly 4P rounding • Charting, write reports • Pain assessment and meds • Confirm all required meds given (e.g. hs sedation and analgesics)	
23:30	• Hourly 4P rounding	
00:30	• Upload glucometer/ Hi/Low check QA	
01:30	• Hourly 4P rounding • 24 hour Med Review/ Use report sheets to check for entered bloodwork & outstanding tests	
02:30	• Hourly 4P rounding • Medication administration	
03:30	• Hourly 4P rounding	
04:30	• Hourly 4P rounding • Document • Stock med carts • Add forms to charts; complete online forms	
05:30	• Hourly 4P rounding • Medication administration • Print census • Hang new feeding bags	
06:30	• Hourly 4P rounding • Nurse to determine team work assignment for day shift PSP • Empty catheters • Finish charting, I&O	

Admission

- Initial admission assessment including:
  - Admission Assessment intervention
  - Fall risk assessment
  - Braden scale
  - Delirium risk assessment (CAM)
- Give and review educational pamphlets for falls prevention and pressure ulcer prevention to patient and family
- Ensure appropriate arm band (i.e. high risk for falls) and 2 client ID
- MRSA/VRE Swabs
- Take report, VS, Review orders

Transfer

- Complete Transfer of Accountability
- SBAR transfer report
- Notify family

- SEND report under admit/transfer intervention
- Escort patient if required

As Needed (PRN)

- Treatment e.g. insulin, dressing changes, Trach care, IV administration
- Patient/Family Teaching
- Family meetings/phone calls
- Call doctor
- Call for consults
- Provide emotional support to patient/family
- Weigh patient
- Ostomy
- Blood transfusions
- Central line care
- Bladder scan/in and out catheterization
- Assist porter with transferring patients
- Transporting patients to diagnostics/off unit/outside appointments
- Assist MD with procedures
- Prepare patients for tests/OR/hemodialysis
- Collect specimens/blood and send to lab
- Assess IV access
- Preceptor students
- Unit Council rep
- Training
- Codes

Deceased Care

- Notify family
- Notify MD/ MD to sign death certificate
- Notify TGLN
- Document
- Body care
- Discharge patient in computer

Standard Work for PSP
Sample

Hour	Task
0730 Shift Change	• Attend bedside shift report (BSSR). Answer patient call bells and phone calls as required • Identify the team break assigned for this shift • Review and update care board -date, name, add patient or family questions to the board • Lead hourly 4P rounding for the shift –Pain, Potty, Positioning, Possessions-work in pairs, report pain or abnormal to most responsible nurse • AM care, ADLs • Answer call bells throughout shift • Document • Fill bedside water cups if no patient restrictions • Patient toilet/incontinence/repositioning rounds • Attend team review of work assignment and patient updates occur regularly throughout shift- need for collaboration, consultation, co-care for patient changes in acuity
0830	• Participate as team member in patient breakfast; ADL; up to chair; mobilization and ambulation; bathing and oral care; mechanical lift work with a registered staff • Set up meal trays and feed patients • Document • Answer call bells • Hourly 4P Rounding
0930	• Hourly 4P Rounding • Pick up isolation meal trays • Answer call bells • Greet family and answer questions or direct to appropriate staff • Patient toilet/incontinence repositioning rounds • ADL; up to chair; mobilization and ambulation; bathing and oral care
1030	• Hourly 4P Rounding • Fill bedside water cups if no restrictions • Pick up trays • Answer call bells • Reposition, mobilize, ambulate patients • ADL; up to chair; mobilization and ambulation; bathing and oral care
1130	• Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • ADL; up to chair; mobilization and ambulation; bathing and oral care • Spend social time with patients • Answer call bells • Document
1230	• Hourly 4P Rounding

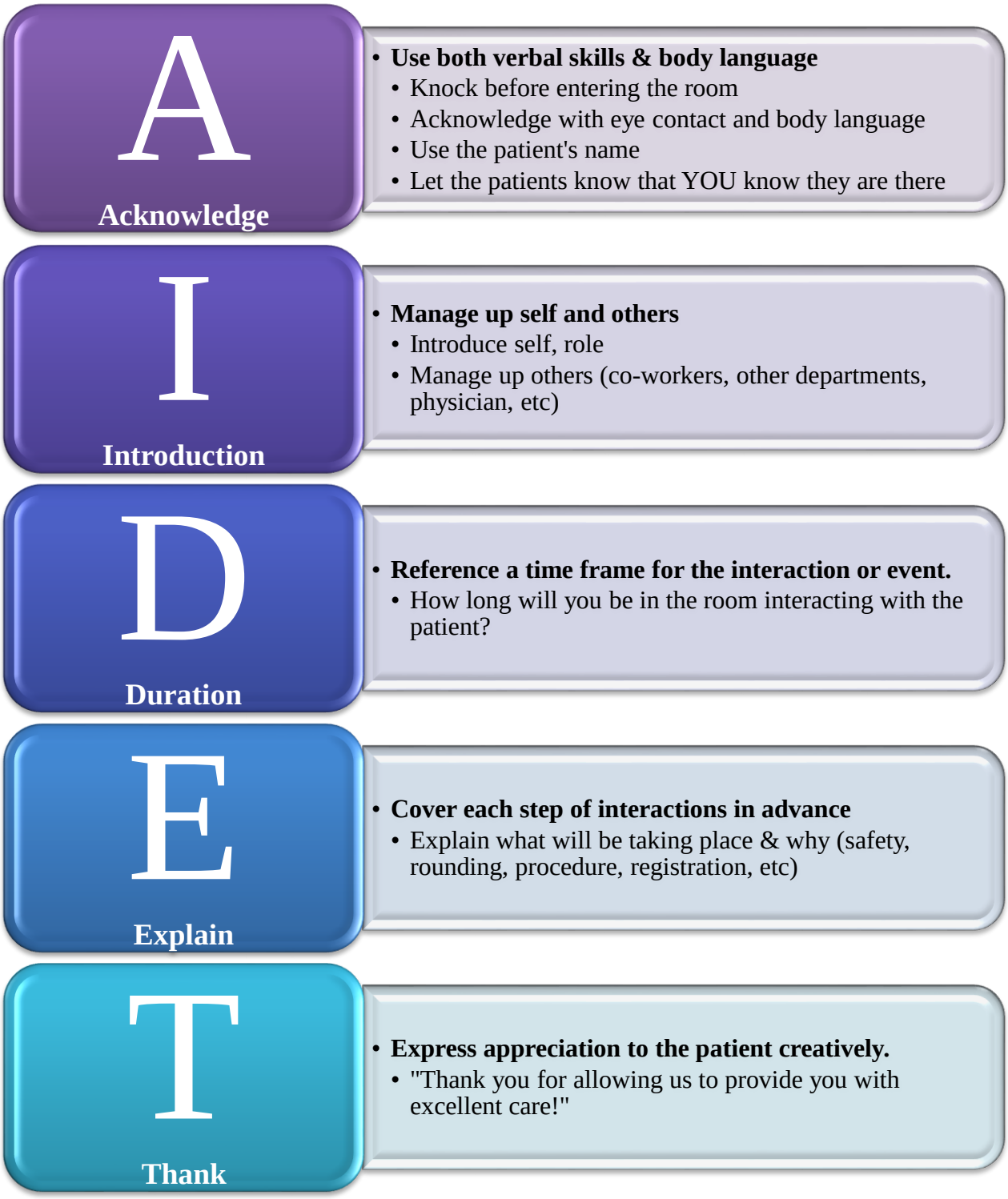
Hour	Task
	• Set up meal trays and feed patients • Deliver and pick up trays to isolation rooms • Document • Fill bedside water cups if no restrictions • Answer call bells
1330	• Hourly 4P Rounding • Transfer patients back to bed after lunch • Document • Patient toilet/incontinence repositioning rounds • Spend social time with patients • Answer call bells
1430	• Hourly 4P Rounding • Fill bedside water cups if no restrictions • Change linens and ensure tidy room • Stock blanket warmer • Document • Spend social time with patients • Answer call bells
1530	• Hourly 4P Rounding • Stock and check isolation gowns / isolation equipment • Ambulate patients • Patient toilet/incontinence repositioning rounds • Answer call bells • Document
1630	• Hourly 4P Rounding • Set up for dinner; patients up to chair • Deliver isolation trays • Answer call bells • Document
1730	• Hourly 4P Rounding • Answer call bells • Feed patients / pick up isolation trays • Patient toilet/incontinence repositioning rounds • Document
1830	• Hourly 4P Rounding

Hour	Task
	• Resettle patients back in bed • Answer call bells • Stock isolation gowns • Linen emptied • Document • Spend social time with patients
1930 Shift Change	• Attend bedside shift report (BSSR). Answer patient call bells and phone calls as required • Identify the team break assigned for this shift • Review and update care board -date, name, add patient or family questions to the board Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • Stock supplies • Answer call bells/phones • De-clutter halls • Spend social time with patients • HS and oral care
2030	• Hourly 4P Rounding • Diabetic snacks • HS and oral care • Answer call bells/phones • Document
2130	• Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • HS and oral care • Answer call bells/phones • Document
2230	• Hourly 4P Rounding • HS and oral care
2330	• Review and update care board -date, name, add patient or family questions to the board • Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • Fill bedside water cups if no restrictions • Answer call bells/phones • Document
0030	• Hourly 4P Rounding • Answer call bells/phones • Document
0130	• Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds

Hour	Task
	• Answer call bells/phones • Document
0230	• Hourly 4P Rounding • Answer call bells/phones • Document
0330	• Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • Answer call bells/phones • Document
0430	• Hourly 4P Rounding • Answer call bells/phones • Document
0530	• Hourly 4P Rounding • Patient toilet/incontinence repositioning rounds • Answer call bells/phones • Document
0630	• Hourly 4P Rounding • Fill bedside water cups if no restrictions • Answer call bells/phones • Document

return to Table of Contents

Interprofessional Model Of Care Redesign (IMCR) & Best Practice Spotlight Organization (BPSO) Initiatives


A
Acknowledge
• Use both verbal skills & body language
• Knock before entering the room
• Acknowledge with eye contact and body language
• Use the patient's name
• Let the patients know that YOU know they are there
I
Introduction
• Manage up self and others
• Introduce self, role
• Manage up others (co-workers, other departments, physician, etc)
D
Duration
• Reference a time frame for the interaction or event.
• How long will you be in the room interacting with the patient?
E
Explain
• Cover each step of interactions in advance
• Explain what will be taking place & why (safety, rounding, procedure, registration, etc)
T
Thank
• Express appreciation to the patient creatively.
• "Thank you for allowing us to provide you with excellent care!"

H.E.A.R.D.

H — Hear them out

- Acknowledge, maintain eye contact, be aware of body language
- Listen to understand, determine expectation/s, do not interrupt
- Acknowledge their perception
- Reflect back using "I" statements
- Remain calm, professional and do not take comments personally
- **Key Phrases...**
  - *"I'm sorry about this upset; please help me to understand what has happened..."*
  - *I'm sorry to hear that, if I've understood you correctly..."*
  - *Please tell me more..."*

E — Empathize

- Provide your full attention
- Remain aware of your tone and non-vebal behaviours
- Maintain person's self-esteem and dignity
- Reflect and validate their feelings
- Manage up others (co-workers, other departments, physician, etc)
- **Key Phrases...**
  - *"From what you've told me I can certainly understand your issue/concern.."*
  - *I'm so glad that you've brought forward your concerns' you time with me has helped me to understand and appreciate how frustrating this has been..."*

A — Acknowledge

- Express regrets, apologize for their 'experience', this is not assuming responsibilty or accepting blame
- Remain aware of your role/boundaries and align your interventions and actions accordingly
- Thank them for their patience and feedback
- **Key Phrases...**
  - *"I'm sorry/I truly regret that we've haven't met your expectations.."*
  - *"What would be helpful right now/today?"*
  - *I/We want to make things better..."*
  - *"Thank you for your patience and for letting me see what I/We can do.."*

R — Respond

- Determine current needs and take responsbility to initiate the appropriate action/s and or delegate
- Outline next steps/solutions, provide information regarding realistic timelines and, if possible, provide updates
- Check back to determine satisfaction, escalate higher if necessary
- Use key words from the Real-Time Survey
- **Key Phrases...**
  - *"What would you like to see happen next?"*
  - *"Here's what I/we are able to do now..."*
  - *"You can expect....over the next few hours/day etc..."*
  - *"I'm sorry, now that I more fully understand your concern I need to invlve (name and position), I will do that now and check back with you..."*

D — Document

- Document the concern(s) and your interventions
- Communicate to others as an FYI for consistency in communication and intervention
- Lessons learned - root cause analysis, identiy and implement improvement actions, share learnings

Intentional Rounding

✓ Pain

☐How is your pain on scale of 0-10?

☐Do you need pain medication?

✓ Personal Needs

☐Do you need to use the bathroom?

☐Do you need to be changed?

✓ Position

☐Are you comfortable?

(Do you need to change position or get up?)

✓ Placement

☐Do you have everything you need within reach?

(Bedside table, Call bell, Water, Glasses, Urinal, etc.)

❖ Can I help you with anything else before I leave?

We will return within an hour to check on you

Bedside Shift Report Checklist

- ☐ Perform hand hygiene
- ☐ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ☐ Open the medical record or access the electronic work station in the patient's room.
- ☐ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

  S = Situation. What is going on with the patient? What are the current vital signs?

  B = Background. What is the pertinent patient history?

  A = Assessment. What is the patient's problem now?

  R = Recommendation. What does the patient need?
- ☐ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubing, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ☐ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, discharge, transfer, med rec, consent, etc.)
  - Other (family meetings, etc.):_____
- ☐ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - o "What could have gone better during the last 12 hours?"
    - o "Tell us how your pain is."
    - o "Tell us how much you walked today."
    - o "Do you have any concerns about safety?'
    - o "Do you have any worries you would like to share?"
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - o "What do you want to happen during the next 12 hours?"
    - o Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from AHRQ

January 2021

Bedside Shift Report

Frequently Asked Questions (FAQ's)

Q: ***What about Confidentiality and Breech of Privacy?***

A: The college of Nurses of Ontario (CNO) encourages nurses to exchange patient information at the bedside while acknowledging the personal and potentially sensitive nature of patient health information.

PHIPA supports bedside reporting as long as the purpose is to improve or maintain quality of care.

Strategies: Ask patient permission to give report at bedside, clarify if patient wants visitors present, close the curtains, stand at the head of the bed, and discuss only pertinent information.

Q: What if there is more than one patient in the room?

A: First, obtain consent. Second, maintain confidentiality as much as possible by pulling the curtain, standing by the head of the bed and speaking in a low tone of voice with your back towards other patients. Discuss only relevant information that the oncoming nurse needs to know to start their shift.

Remember, information the nurse feels is sensitive or that the patient is not aware of is to be shared at a later time in an appropriately confidential place

At all times your clinical judgment prevails.

Q: ***What if the patient/family has a lot of questions?***

A: If the questions require detailed responses, inform the patient/family you are happy to answer all of their questions and will be back to see them after report is complete.

Strategies:

"That's a great question. I can look into that for you once we are done giving shift report…"

"I would be happy to help you with that just as soon as we are done report"

Q: What if my patient is sleeping – should I wake them?

A: Ask patients at bedtime or before you settle them for rest if they would like to be awakened to participate in their bedside report.

Patients have the right to refuse but are informed a bedside safety check will still be conducted.

If you are unable/forget to ask the patient, perform report outside of the room but always complete safety checks. Ask patient preference the next time they are awake.

Q: ***Will report take longer?***

A: Research indicates that bedside shift report takes less time because of the following:

- Reduces irrelevant or subjective comments
- Reduces inconsistent information
- Eliminates missing or incorrect elements
- Should take no longer than 3-5 minutes per patient

Strategies: Review the chart before entering the room, discuss only pertinent health information, consider report by exception, keep consistency in patient assignments as much as possible, and be on time for your shift

Q: ***What if the on-coming nurse is late?***

A: Shift report is very important and except in unforeseen circumstances, it is expected staff are available and on time for report. It is the responsibility of each nurse to verbally report to the next shift as per the College of Nurses Standards. If the situation involves a nurse who is consistently late, this fact must be relayed to the Clinical Manager for follow-up.

Q: ***If the patient refuses to participate in bedside shift report, do I still need to go into the room?****

A: Yes. In this case, report would be given outside of the room in a confidential space. Both nurses must then go to the patient's bedside together and complete a safety check.

Q: ***My patient is on isolation, do I still have to give report at the bedside?****

A: Yes. If the patient has agreed to participate in bedside shift report, the nurses should put on the appropriate PPE and enter the room for report. Regardless of whether or not permission was given for bedside shift report, the two nurses must still enter the room to conduct a safety check.

Q: ***My patient is confused or delirious; do I still have to give report at the bedside?****

A: Yes. Bedside shift report provides an opportunity to cue, orient and reduce the anxiety of patients suffering from altered mental states. Confusion, agitation, or deliriums are not reasons to automatically omit the bedside shirt report. However, clinical judgment should still prevail. If it is determined bedside shirt report is not appropriate, a safety check must still be completed.

Q: How are nurses supported while bedside shift report is taking place?*

A: Nurses taking part in bedside shift report should not be interrupted unless absolutely necessary to ensure patient handover is done safely and efficiently. To minimize interruptions, have strategies in place. For example, have volunteers answer phone calls or send them to voicemail, warn patients that bedside shift report is about to happen, if there is a float nurse have them attend to call bells, etc.

*Adapted from: The Ottawa Hospital, NTA-BSR Frequently Asked Questions

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9
TEL 905-895-4521
TTY 905-952-3062

SHOCKINGLY EXCELLENT
SOUTHLAKEREGIONAL.ORG
TWITTER: @SOUTHLAKE_NEWS
FACEBOOK: SOUTHLAKE REGIONAL HEALTH CENTRE
YOUTUBE: SOUTHLAKERHC
DONATE: SOUTHLAKEFOUNDATION.CA

Bed Side Shift Report- If you have any other questions ask your nurse!

What is Bedside Shift Report?

Bed Side Shift Report is an opportunity to involve patients at Southlake in their care. Nurses share information with each other and their patients at times when there is a change in shift (nurses coming on and going off duty.) This process occurs individually with each patient right at the side of their bed.

What are the goals of Bed Side Shift Report?

- to create a standard way for information to be shared between care providers to promote safety as information is shared, questions clarified and plans discussed
- to allow our patients and staff to work together as a team!

What are the benefits of Bed Side Shift Report?

- It increases patient safety having your team members hand over at the bedside
- it increases staff satisfaction as relationships between staff are fostered
- studies show that having team members discuss information increases staff accountability

What can I expect during Bedside Shift Report?

Patients and family members can expect to meet with their team of off-going and on-coming nurses to:

- hear and discuss care updates and progress
- introduce the oncoming nurse to your patient/family. Provide opportunities to involve our patients/families in care updates

Do I have a choice in participating in Bedside Shift Report?

Yes! You are invited to take part in Bedside Shift Report, but the choice is yours. It is important to note that your care information may be heard by others in your room, and you may hear information pertaining to your room-mates. If you have concerns about this please talk to a member of the team. The team will be mindful of sensitive issues. If you do not wish to participate your team will still come to your bedside to perform a safety check:

Patients and family members can expect to meet with their team of off-going and on-coming nurses to:

- Verify information on arm band such allergies,
- Confirm medications
- Ensure equipment in your room is available and in good working order
- Check that your bed is safe-it is plugged in, your brakes on and your call bell is within reach

BEDSIDE SHIFT REPORT :

I wish to be involved: YES ☐

NO ☐

I wish to be woken: YES ☐

☐

NO

Safety Checklist

a. Verification of the arm band, allergies, fall risk, VAT

b. Confirm IV /NG site, solutions and infusions rates

c. Oxygen and suction available and working. Other equipment reviewed and working.

d. Bed check - brakes on, call bell within reach, side rails up

Using SBAR for Bedside Shift Report

S Situation	**Outgoing Provider** • Informs patient– *"I am leaving now and Jane will be taking care of you next shift. Jane is____ so I am leaving you in good hands."* **Incoming Provider** • Introduces self using NOD (name, occupation and duty). Updates whiteboard (if available). Asks patient for their name and date of birth, while checking the patient's ID tag.
B Background	**Outgoing Provider** • Include the patient – "It 's time for me to give my report to Jane and we would like to do this at your bedside so that you can be included. This will give you a chance to ask questions and to add information, which will help Jane to take care of you. Because we need to do this for all of our patients, we only have a few minutes. If you need more time, Jane will come back later. " **Incoming Provider** • "Do we have your permission?"
A Assessment	**Outgoing Provider** • Provide information – provide a brief status update including the patient's primary complaint and what treatment/medications have occurred to date with a focus on the last shift and any follow-up that needs to occur. **Incoming Provider** • Review chart/check documentation. • Conduct a quick physical exam (if necessary) and check all IV sites/pumps for accuracy. • Assess patient's pain using a pain scale.
R Recom-mendation	**Outgoing Provider** • Review all orders and the plan of care with incoming provider (tests, treatments, medication therapy, IV sites/meds). • Include relevant medications that have been ordered and any ancillary or support services; e.g., physiotherapy, radiology. • Ask the patient, "Do you have any questions? Is there anything else Jane needs to know at this time?" **Incoming Provider** • Validate treatment orders/plan of care. Asks outgoing provider and patient/family if they have any additional comment/questions. • Thank the patient. Checks to ensure the patient understands the plan of care and is comfortable.

This Practical Wisdom Adapted from:
Baker, S., & McGowan, N. (2010). Bedside shift report improves patient safety and nurse accountability. *Journal of Emergency Nursing*, *36(4)*, 355-358.
Griffin, T. (2010). Bringing change-of-shift report to the bedside: A patient- and family-centered approach. *Journal of Perinatal and Neonatal Nursing*, *24(4)*, 348-353.

FOCUS ON THE PROBLEM
BE CONCISE

S

B

A

R

SITUATION

Date _____

State your **name and agency**
I am calling about: **(Patient Name)**

The **problem** I am calling about is: (briefly state problem, when happened/started, and how severe. Code status would be helpful.
Notes: _____

BACKGROUND

State the **primary and pertinent diagnosis & the date of admission to agency.**

Relate the **complaint** given by the patient. Pay special attention to emotional/ **mental status.**

List current medications, allergies, most recent vital signs, most recent lab results or treatments.

Notes: _____

ASSESSMENT

Give conclusions about the situation. Words like "might be" or "could be" are helpful. A diagnosis is not necessary. Relate how severe the problem might be.

Describe changes from prior assessment:

Weight	Blood Pressure	Blood Sugar
Mental Status	Temperature	Pain
Neuro changes	Respiratory rate/quality	Wound
Musculoskeletal	Pulse rate/quality	GI/GU (Nausea / Vomiting / Diarrhea / Output)

Notes: _____

RECOMMENDATION: Say what you think would be helpful or what needs to be done.

- ❑ Change treatment to:_____
- ❑ Adjust medications for: _____
- ❑ Place telehealth monitor? _____
- ❑ Obtain consult for discipline (e.g., PT, OT, ST, WOCN, SN, SW, etc.)

  _____
- ❑ Have the patient come in to see you at your office today or within 24 hrs? _____
- ❑ Transfer the patient to hospital? _____

Increase visit frequency to: _____
Any labs / tests needed? _____
Make sure to clarify under what circumstances and when the physician wants us to call again.

_____

Notes: _____


•Orient patient and family to team nursing and bedside report
•Obtain verbal consent to participate in report on admission and PRN
•Update care board every shift with date, team members, plan, questions acknowledged
•Verification of arm band, allergies, falls risk, VAT
•Confirm IV sites, solutions and infusion rates
•Oxygen and suction available and working, equipment check
•Bed brakes on, rails up, call bell in reach
patient experience
safety
accountability
communication
•Be aware and respectful of each others time
•Promote safety and communication by helping to limit interuptions
•Promote team nursing by participating
•Provide succinct and accurate handover
•Date and reason for admission
•Relevant past medical history
•Tests/procedures that have been completed and results
•Plan of care, "To Do" this shift
•Relevant info (i.e. assist, code status)
•Report sensitive info privately

SBAR Worksheet

Not a permanent chart form

Have your Chart, MAR & Kardex with you before you call.

Situation

- Reason for call _____
- Code status _____

Background

- Admission diagnosis _____
- Pertinent PMH _____
- Relevant recent treatments_____

Assessment

- V/S BP_____ HR ___ RR___ O2 sat____ T____ In_____ Out_____
- Lab results _____
- Breath sounds _____
- Other pertinent info _____
- I think the problem is _____

Recommendation

Do you think the physician should:

- Come to see the patient at this time? _____
- Consultant? _____
- Transfer to ICU? _____
- Speak to patient/family re: code status? _____
- Order these tests? _____
- Other_____

- If patient does not improve, when would you like us to call you again?
  _____

Document both the change in patient condition and the physician notification

Notes from Conversation _____
_____
_____
_____
_____
_____

Bedside Shift Report: SBAR Example

Situation: “Mr. Smith presented to ED with shortness of breath and chest pain…”

Background: “He has a history of COPD and hypertension. He is a pack a day smoker, and has an appointment with a cardiologist next week due to ongoing episodes of chest pain with exertion…”

Assessment: “He is SOBOE, vital signs are within normal limits, however respirations are sitting between 22-26/min. Currently he has no pain, and is on 2L/O2 via N/P for an SPO2 of 95%. Slight expiratory wheeze noted. NSR noted on monitor all shift…”

Recommendations: “Awaiting chest x-ray and bloodwork results. Booked for an echo sometime this morning. Is due for his routine medications at 08:00.”

Southlake Regional Health Centre and BPSO
Excellence Every Time

Become a Best Practice Champion

Become a Best Practice Champion and be part of the implementation of RNAO Best Practice Guidelines (BPGs) into practice. Southlake wholeheartedly supports the role and commitment of Champions to participate in your development as a Champion and also your participation in implementation activities of BPGs. As a RNAO Best Practice Champion you will stay informed; participate in preparing your unit for BPG implementation; be an active mentor and resource during the BPG implementation phase on your unit; and engage in post-implementation activities. Champions may be chose to be generalists or work closely with a specific guideline.

Are you interested in becoming a Best Practice Champion? Complete and submit the expression of interest to (All members of the interprofessional team are welcome to apply).

If you would like more information about the Best Practice Spotlight Organization, or becoming a Best Practice Champion, contact:

Carol Williams, Manager, Professional Practice, BPSO Lead cwilliams@southlakeregional.org

Julie Schmidt, Project Lead, Professional Practice, BPSO Co-Lead jschmidt@southlakeregional.org

BEST PRACTICE CHAMPIONS EXPRESSION OF INTEREST FORM

First Name: _____ Last Name: _____

Profession: _____ Email: _____

Unit/Department: _____

I am interested in becoming a BPG Champion because…:

_____

_____

_____

_____

_____

Applicant's Signature:_____ Date: _____

Please return completed form to:
Julie Schmid,t Professional Practice, BPSO Co-Lead
Mailbox: 101 jschmidt@southlakeregional.org

Adapted with permission from Mackenzie Health, Richmond Hill, ON

return to Table of Contents

Working with Unregulated Care Providers/PSPs

SOUTHLAKE
REGIONAL HEALTH CENTRE

Patient Services Partner (PSP)

The Patient Services Partner (PSP) role will be welcomed to the Southlake healthcare team with onboarding starting in November 2017. The Patient Services Partners are members of the SEIU; they are considered unregulated in that they do not belong to a regulatory college. The following information is meant to assist in providing clarity about the PSP role:

- All patients will have a nurse assigned who has accountability to assess and develop a patient plan of care. The PSP will work within the team and will never have sole responsibility of the patient.
- The PSP will have no delegated acts at this time.
  For example, a PSP can not be delegated to give suppositories.
- The focus of each unit will influence the PSP role function.
  For example, Medicine=ambulation, Mental Health=constant observation for safety.
- Charge Nurses will assign patients to teams ensuring that assignments are appropriate to each care provider; ensuring that all staff has equitable distribution of work within their scope of role.
- The PSP should be considered ahead of a security guard for Patient Observer/Constant Observation; availability of the PSP and patient needs are to be considered.
- Documentation –PSPs will document the care they provide in Meditech.
- According to the College of Nurses of Ontario, Regulated Care Providers are not accountable for a PSP's action if they had no way of knowing that the error was to occur.
  For example, a PSP is competent to feed patients, but in error feeds a patient waiting for a swallowing assessment.
- All team members are accountable to ensure the safety and well-being of the patient as the top priority.

PSP Caregiver (ADLs) Patient Observer	Scope of Role	Patient Outcomes
Patient	Hygiene, toileting, oral care, feeding, refreshing bedside water containers, assisting ambulation, range of motion, constant observation for falls, elopement, suicidal, and removing medical devices risk, violent/aggressive (if extreme, security guard is assigned observer role or if episodic, security attends when needed)	Quality of care experience, comfort, support function, decrease falls, prevent pressure injuries, maintain urinary continence, minimize catheter use, increase patient mobility, support nutritional status and hydration, decrease use of restraints, improve safety, decrease risk
Team	Hourly rounding, communication with nurse accountable for patient, bedside shift report, AIDET, care board and SBAR communication, collaboration, team based care, maximized scope for all	Support patient experience, decrease patient anxiety, improve patient experience, decrease risk of negative outcomes
Unit	Stocking supplies, gathering equipment, cleaning or disinfecting equipment	Efficiencies for staff, decrease delays in patient care

PSP Scope of Role: Benefits to Patient Experience/Outcomes and Linkage to Back to Basics

PSP Scope of Role	Benefit to Patient Experience/Outcomes; Linkage to Back to Basics
PSPs participate as valued members of the health care team providing direct patient care and generally supporting Activities of Daily Living (ADL)	
• Hygiene	• Supports patient comfort, quality of care experience
• Performing pre-established range of motion exercises (active and passive)	• Opportunity to support/improve patients' pre-hospitalized function • Prevent falls/pressure injuries
• Ambulate patient and assist with lift/transfers/turning • Toileting, perineal care with or without catheter, empty ostomy bags	• Opportunity to maintain/improve functional abilities • Prevent falls/pressure injuries • Supports hospital initiatives to prevent hospital acquired urinary incontinence, minimize catheter use, increases patient mobility
• Oral care including denture care • Excludes any trach care	• Focus on oral hygiene will decrease risks to patients associated with high oral bacterial load
• Urine and stool specimen collection and labelling as per unit decision	• Supports health goals with timely interventions
• Assist patients with meals, setting up and feeding patients	• Supports nutritional status, impact to skin and wound healing
• Freshen bedside water containers	• Supports adequate hydration, patient comfort
• Stocking supplies e.g. isolation supplies outside patient's rooms	• Provide efficiencies for staff when unit is adequately stocked, decrease delays in patient care and increases time available for direct care
• Hourly rounding for: Pain, Possessions, Position, Personal Care	• Supports patient experience, decreases patient anxiety, increase in quality of care experience, decrease in risk and negative outcomes like falls and pressure injury
• Communicate with assigned nurse re: any concerns	• Opportunity for increased communication using bedside shift report, care board, and face to face communication
• Collaborate as a Health Care team member	• Holistic care from an interprofessional team • Participate in bedside shift report
• Role of patient watch/observer/sitter	• Opportunity for improved safety, decreased falls and use of restraints and prevention of pressure injuries

PSP Role Supports IMCR Deliverables and Best Practice Spotlight Organization Initiatives

<table>
<tr><td>Elevate the Patient Experience</td><td>AIDET
Hourly Rounding
Bedside Shift Report
Access to Care-right time, right provider</td></tr>
<tr><td colspan="2">Patient and family experience seamless, safe and effective care throughout their experience at Southlake

Interprofessional Team based care is an essential component of the patient experience</td></tr>
<tr><td>Build a Culture of Interprofessional Care
Developing and Sustaining Interprofessional Health Care
Person and Family Centred Care</td><td>PSPs work alongside the interprofessional team
Interprofessional education
Care board communication</td></tr>
<tr><td colspan="2">All health care providers are considered equal and valued members of patient care teams</td></tr>
<tr><td>Maximum Scope</td><td>Education-Understanding Maximum Scope
Corporate Standardization of Roles
Role Clarification</td></tr>
<tr><td colspan="2">The skills and scope of practice of all health care providers are utilized to their fullest extent</td></tr>
<tr><td>Healthy Work Environment</td><td>Team Composition-unique to patient care needs
Team based model of care-hands on patient care</td></tr>
<tr><td colspan="2">Southlake provides a stimulating, rewarding work environment, with a culture that fosters continuous growth and development for all</td></tr>
</table>

SBAR Worksheet For PSP

Not a permanent chart form

Have your Chart, Kardex and EMR available

Situation	I am speaking about patient _____ The patient's code status is _____ The problem I wish to share with you is _____
Background	Admission diagnosis _____ Pertinent past medical history _____ Relevant observations regarding patient's status are _____
Assess	In____ Out____ Pain_____ The patient's mental status is: □ A&OX3 □Confused □Cooperative □Non-cooperative □Agitated □Combative □Lethargic and unable to swallow □Stupor, swallowing status unknown □Comatose □Eyes closed □Not responding to stimuli I am concerned about _____
Recommendation	Can you come with me to see the patient? Can you speak to the family with me? When would you like me to update you again about this patient?

Notes:

Scope of Practice and Role

Working with Patient Services Partners

SOUTHLAKE
REGIONAL HEALTH CENTRE
Leading edge care. By your side.

Overview

- What does scope mean?
  - ➢Scope of practice
  - ➢Scope of role
- Understanding the role of the Patient Services Partner (PSP)
- Accountability

What is Scope or Scope of Role?

Scope of Practice:

The maximum level of practice of a regulated health professional as determined by legislation, regulation, organization and individual. Accountability is to patient, regulatory college, and employer.

Scope of Role:

The maximum level of activities of a unregulated position as determined by legislation and the employer. Accountability is to patient and employer.

Unregulated Care Providers

- **Unregulated Providers have been an important part of the care team at Southlake for many years and include:**
- Physician Assistants
- Child and Youth Counsellors
- OTA/PTAs
- Perfusionists
- Anaesthesia Assistants
- Patient Services Partners

SOUTHLAKE
REGIONAL HEALTH CENTRE
Leading edge care. By your side.

Scope of Role

- Scope of role is determined by an organization in response to organizational need, within the boundaries of legislation, such as the Public Hospitals Act and the Regulated Health Professions Act

- Activities are assigned, or in the case of a controlled act, delegated through Southlake's formal delegation process

- Scope of role cannot supersede any boundaries set out by legislation

Care Providers-What's the difference?

RN	RPN	PSP
• Regulated by RHPA • 4 year degree • May care autonomously for clients with complex needs in unpredictable settings • Title protection: RN, nurse • Accountable to Patient, CNO, and Employer	• Regulated by RHPA • 2 year diploma • Care autonomously for predictable clients with stable environments • May work collaboratively in less stable environments with more complex patients • Title protection: RPN, nurse • Accountable to Patient, CNO, and Employer	• Unregulated • Education varies • May work in a variety of settings. Cares for patients within scope of role and under direction of a Regulated Care Provider • No title protection • Accountable to Patient and Employer

Scope of Role of a PSP

PSPs participate as valued members of the health care team providing direct patient care, generally supporting Activities of Daily Living (ADL):

- Hygiene, bathing
- Toileting, perineal care with or without catheter
- Oral care, denture care, excluding any trach care
- Assisting, setting up and/or feeding patients
- Freshening bedside water containers
- Stocking supplies
- Ambulating patients and assisting with lift/transfers/turning
- Performing pre-established range of motion exercises (active and passive)
- Hourly rounding
- Communicating with assigned nurse regarding concerns
- Collaborating as a health care team member

Accountability

- Employers are accountable for developing a position guide that outlines scope of role*
- Nurses are accountable for knowing that the assignments/tasks are within the scope of role for a PSP*

All patients will have a nurse assigned and will never be the sole responsibility of the PSP

Errors

- Regulated Care Providers must ensure PSPs have knowledge/competence to perform their role, therefore, when an error is made by an unregulated care provider, the context of the situation is important
- Regulated Care Providers are not accountable for a PSP's action if they have fulfilled their responsibilities to ensure the PSP was competent and they had no way of knowing that the error was to occur
- All team members are accountable to ensure the safety and well-being of the patient as the top priority

Remember…

- Your accountability is always yours
- No one can assume responsibility for your actions
- Know your limits
- Respect your colleagues' limits

All members of the Health Care Team work together, and in collaboration with each other and our patients and families, for the best possible outcomes

References

- Colleges of Nurses of Ontario 2013 Working with Unregulated Care Providers
- Federation of Health Regulatory Colleges of Ontario (FHRCO) FHRCO
- Public Hospitals Act Public Hosptials Act
- Regulated Health Professions Act RHPA

return to Table of Contents

Team Based Care Model

Resources

Brief History and Evidence to Support Team Nursing Model

Melissa Pestill

Throughout the history of nursing there have been a number of past models of care. Ranging from functional and team nursing, where a number of nurses were responsible for each patient, to that of primary, modular, and relationship nursing; where the general concept of *one nurse for every patient* was adapted (Kalisch & Schoville, 2012). The 1960s and 1970s saw the full transition into the primary nursing model in most hospitals; one nurse was responsible for a specific patient (and all of his/her care) for the duration of the shift (Kalisch & Schoville, 2012). The concept of this model lies in the nurse being solely responsible for his/her patients; allowing for more one on one time with that patient, thereby contributing to the belief it will increase patient centered care (Kalisch & Schoville, 2012).

In contrast to this belief, there has been recent awareness that the primary nurse model of care has contributed to a decrease in quality of care, lower staff and patient satisfaction and increase incidence of errors (Kalisch & Schoville, 2012). The realization that no single nurse possesses the complete knowledge and skill to provide the full scope of care that today's (much more acute) patient requires is evident (Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011). The Institute of Medicine emphasized the importance of teamwork in the healthcare setting, citing that a lack of teamwork contributes to medical errors resulting in approximately 98,000 preventable deaths annually (Kohn, et al., 2000). The improved option; nurses should provide patient care as team, by combining their experience and skill, nurses can produce not only better quality care but also decrease the

risk to patients and improve satisfaction scores (Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011).

Despite the common view that team nursing does not work, research has shown that through an informed orientation and implementation program, it can change the philosophy of a unit from that of an individual - patient is 'mine' - attitude to that of the - patients are 'ours' - conceptualization of a shared responsibility (Kalisch & Schoville, 2012). This change in model of care must be accompanied by a change in culture; including collegiality, trust, mutual respect and a thorough understanding of the roles and scope of practices of all members of the team (CNA, 2012). Implementation topics should also include communication, team building, and conflict resolution, in addition to the importance of peer-to-peer feedback (Kalisch & Schoville, 2012; Ferguson & Cioffi, 2011; Hall, et al. 2012).

The Registered Nurses Association of Ontario (RNAO) has two relevant best practice guidelines (BPGs): Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational and system outcomes (RNAO, 2015b), and Developing and Sustaining Effective Staffing and Workload Practices (RNAO, 2015c). Each of these evidence-based guidelines is part of a series of BPGs that focus on healthy work environments, with the goal to support healthy work environments in healthcare (RNAO, 2015). With these combined resources, in addition to current literature, implementing an evidence-based, team-nursing model of care would contribute to best practice, increase staff wellbeing and improve patient outcomes.

References

Canadian Nurses Association (CAN) (2012). Staff Mix Decision-making Framework for Quality Nursing Care. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/staff_mix_framework_2012_e.pdf?la=en

Ferguson, L. and Cioffi, J. (2011). Team nursing: experiences of nurse managers in acute care settings. *Australian Journal of Advanced Nursing,* 28(4), 5-11.

Hall, C., McCutcheono, Deuter, K., and Matricciani, L. (2012). Evaluating and improving a model of nursing care delivery: A process of partnership. *The Australian Journal of Nursing Practice, Scholarship & Research,* 19(4), 203-210.

Kalisch, B. and Schoville, R. (2012). It takes a team: Challenging the belief that each patient should be cared from by just one nurse. *American Journal of Nursing,* 112(12), 38-42.

Kohn LT, et al., editors. (2000). To err is human: building a safer health system. Washington, DC: National Academy Press.

Registered Nurses Association of Ontario (RNAO) (2015a). Best Practice Guidelines. Retrieved from www.rnao.org

Registered Nurses Association of Ontario (RNAO) (2015b). Developing and Sustaining Effective Staffing and Workload Practices. Retrieved from http://rnao.ca/sites/rnao-ca/files/Developing_and_Sustaining_Effective_Staffing_and_Workload_Practices.pdf

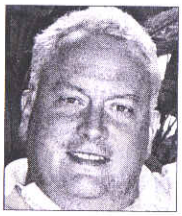
Registered Nurses Association of Ontario (RNAO) (2015c). Developing and Sustaining Interprofessional Health Care: Optimizing patient, organizational and system

outcomes. Retrieved from http://rnao.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf

REGULAR ARTICLE

Towards a collaborative model of care

by Brad Campbell, Marla Fryers, Rob Devitt, and Kathy Vestal



Brad Campbell, is the President of Corpus Sanchez International Consultancy, Toronto, Ontario. Brad was Associate Director of the Hay Health Care Consulting Group, senior director with Vancouver Hospital & Health Sciences Centre, and held positions at hospitals in Vancouver, Toronto, Fredericton and Halifax.

Marla Fryers, RN, MScN is the Vice President of Programs and Chief Nursing Officer at the Toronto East General Hospital. Marla served as VP, Child Health at Children's and Women's Health Center in Vancouver, and held the first Chief of Nursing role at the Hospital for Sick Children in Toronto.

Rob Devitt, MHA, BA (Honours), CHE, ACHE, is the Chief Executive Officer of the Toronto East General Hospital. Rob is the interim CEO of E-Health Ontario, and has led peer reviews of Barrie, Royal Victoria Hospital, and Grand River Kitchener. Rob previously served as President and CEO of Peterborough Regional Health Centre and Queensway-Carleton Hospital.

Kathy Vestal, RN, PhD, FAAN, FACHE, is the Executive Vice President & Principal at Corpus Sanchez International. Prior to consulting, Kathie held executive positions at Northwestern Hospital in Chicago and the Memorial Hermann Health system in Houston, Texas. Kathie has a PhD in leadership and management, an MS and a Bachelor of Science in Nursing.

Abstract

The current crisis in Canada's health care system calls for transformational change in the way we deliver care. The Collaborative Model of Care is not a new concept, but has not been implemented in Canadian acute care hospitals until recently. Toronto East General Hospital developed and piloted a collaborative care model on three acute units and initial results are promising in terms of improved patient safety, patient satisfaction, job satisfaction and improved use of resources.

Résumé

La crise actuelle au sein du système de santé canadien justifie des changements transformationnels à la prestation des soins. Le modèle coopératif des soins n'est pas un nouveau concept, mais il n'a été mis en œuvre que récemment dans les hôpitaux canadiens de soins de courte durée. Le *Toronto East General Hospital* a mis au point et piloté un modèle coopératif des soins dans trois unités de soins de courte durée, et les résultats initiaux sont prometteurs pour ce qui est de l'amélioration de la sécurité des patients, de leur satisfaction, de la satisfaction au travail et de la bonification de l'utilisation des ressources.

Albert Einstein is often quoted as saying that "the significant problems we face today cannot be solved by the same level of thinking we were at when we created them." Never a truer statement has been uttered with regard to the crisis we face today in the delivery of patient care in acute care hospitals.

The Canadian health care system is stressed to capacity[1-3] due to a number of pressing concerns, including the changing demographics of both patients and care providers,[4] rising health care costs[5] and health care provider recruitment and retention issues.

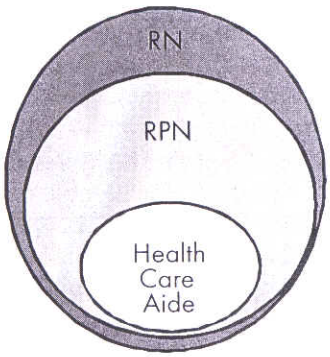
The demographic challenges are well known: as the large population bulge of "baby boomers" approach their senior years, demand for health care services is expected to increase in tandem with a surge in retirements from health care professions. As the largest single health care profession, nursing faces significant human resource shortages.[6]

There are also indications of job dissatisfaction among nurses. For instance, absenteeism among Registered Nurses (RNs) is very high. Nearly 10,000 full-time equivalent positions were taken up with absenteeism in 2005 – a rate that is 58% higher than the average full-time Canadian worker.[7] There is a pressing need to focus on good practice environments where staff are valued and enjoy their work.

How did we get here?

Understanding the current crisis and preparing to deal with it requires a look back at past decisions that shape health care delivery today.

In the 1970s and 1980s, Canadian hospitals moved towards two models of care delivery: Total Nursing Care and all-RN staffing. Total Nursing Care reflected a drive to have individual staff responsible for the total nursing needs of the patients assigned to them for the course of their shift. This was



The Scopes of Practice of both the LPN, RPN and HCA are subsumed in the larger scope of practice defined for the RN.

But in the absence of the other roles, the RN must take on tasks previously performed by others.

Maximum flexibility or devaluing of the RN role?

Figure 1. Scopes of practice, LPN, RPN and HCA.

also the early days of utilization management efforts, which was leading to shorter lengths of stay by reducing or eliminating lower acuity patient days.

The end result was that the average patient was perceived to be sicker and by extension, unstable, which presented a barrier for the Licensed Practical Nurse (LPN) or Registered Practical Nurse (RPN) to be responsible for the total needs of the patient (as the LPN/RPN scope calls for the patient to be "stable"). As the scope of practice of both the LPN and the health care aide were subsumed within the Registered Nurse (RN) scope of practice (see Figure 1), it was generally agreed that the individual with the highest scope provided the most flexibility in moving towards the model of Total Nursing Care. This led to the second emerging model – the all-RN staff.

The all-RN staffing approach was intended to demonstrate the increased value of the registered nurse as a critical member from the care team; in fact, it complicated matters further because the RN role, in some hospitals, became task oriented and overburdened by tasks previously undertaken by individuals with less training. As a result, the scope of the nurse's work changed. According to a 2005 Canadian study, 50% of registered nurses and 80% of registered practical nurses do not work to full scope.[8]

A number of other events were also happening at or about the same time that complicated the situation.

Changing leadership structures

Hospitals were facing resource pressures and many decided to flatten management structures and broaden spans of control for frontline managers. The reduction in frontline leadership roles resulted in reduced support for bedside teams. By eliminating the team and going to an all-RN staff, managers no longer had to deal with the complex issues associated with professional boundaries, team dynamics and inter-personal conflict.

Increase in nursing education levels

The movement to have all registered nurses earn a baccalaureate by 2000 created a new hierarchy for bedside nurses where the BScN RN had "superior" assessment skills to the diploma RN. This created tension among RNs and added to ongoing challenges and confusion surrounding the delivery of nursing care.

The 12-hour shift

The push for the 12-hour shift added yet another dimension to the problems at the bedside. The transition from 8- to 12-hour shifts (with its rotation of two days, followed by two nights and four to five days off for most RNs) disrupted the overall continuity of care and further eroded effective communication and teamwork in the broader care team.

Shifting focus of RNs

The 12-hour shift necessitated hospitals to overlay new roles to enhance coordination of care during a patient's stay. These roles bore a variety of titles, including patient care coordinators, team leaders, clinical leaders and assistant head nurse and case/care managers. These individuals tended to work only Monday to Friday on the day shift and became the focus of overall care planning and communication. They served as the Medical Doctors' (MD) primary contact, but in doing so, the MD had less or no contact with the bedside nurse, who in turn, had little or no need to coordinate the care plans for the patients assigned to them on any given shift. The focus of the RN then naturally evolved to completing tasks and away from the cognitive work that is required and included in their scope of practice.

Declining popularity of nursing as a career

Perhaps the largest single complicating factor was the reality that the world was changing for young people entering university in the 1970s and '80s. Previous male-dominated professions such as medicine were increasingly opening their enrolment ranks to women. In addition, other health professions such as pharmacy, physiotherapy and occupational therapy were increasingly being viewed alternatives to nursing.[9] The result is a missing generation of nurses; consequently, we are now projecting a massive loss from the workforce as "baby boomers" retire and there are fewer "generation X" nurses behind them to fill in the gap.[10]

A fully integrated model of care

The challenge of health human resources requires, as Einstein says, some new thinking about old problems. Several jurisdictions in Canada are changing the way they deliver nursing care by developing and implementing Collaborative Care Models or related models.[a]

[a] Nova Scotia has developed and implemented (on pilot sites in each health district) a province-wide Collaborative Care Model. Evaluation in Nova Scotia is not complete. Prince Edward Island is preparing to implement a newly designed provincial Collaborative Care Model. Other provinces, such as Ontario and Alberta, have similar models in various stages of design, planning or implementation in individual health regions, hospitals or hospital units.

Dr. Jeanne Besner, Chair of the Health Council of Canada, defines the Collaborative Care Model as grounded in the principles of integrated, collaborative, patient-centred practice, which is designed to "promote the active participation of several health care disciplines and professions. It enhances patient, family, and community centred goals and values, provides mechanisms for continuous communication among health care providers, optimizes staff decision-making (within and across disciplines) and fosters respect for contributions of all providers."[11]

The general principles of collaborative care include working to full scope of practice, clear delineation of roles, working within a team under a collaborative model, a clear leadership and coordination role and the opportunity to expand roles in the future.

Toronto East General Hospital (TEGH) recognized the need for radical changes to the model of care and are now moving toward an integrated model that leverages resources to provide high-quality, safe, efficient and effective care using good work processes, information and available technology. This Collaborative Care Model (called the Coordinated Care Team model at TEGH) clarifies roles, defines partnerships and ensures that all necessary disciplines are part of the care continuum.

An overall care coordination role is a key element of the model. At TEGH, the Registered Nurse Team Lead oversees a comprehensive plan for comprehensive care and timely discharge that enables ongoing continuity of care within a community teaching hospital setting. Under this model, a comprehensive assessment, plan of care and plan for discharge are developed within the admission process. While the primary patient relationship with the team is led by the registered nurse, care is supported by both licensed and unlicensed providers and is safe, comprehensive and appropriate.

The patient-centred Collaborative Care Model also requires that selected essential services be available seven days a week without disruption. When help is needed, the most appropriate provider delivers the required services, without professional barriers or turf issues that can cause breakdowns in care or ineffective handoffs of responsibility. With greater opportunity to manage their own needs, patients work with other partners in the care delivery system to support the goal of self-care and independence.

The Collaborative Care Model involves four inter-related components working as a single coordinated care delivery model.

The patient and family are at the centre of this model. They have a clearer role within the team, are more involved in decision-making surrounding their own care and may be involved in delivering some parts of their own care, such as administering medication. Acknowledging the legitimate role of the patient in his/her own care will require a shift in many professionals' thinking.

The Core Team are the care providers who are involved in all aspects of the care plan and/or may be continually involved with the patient. The focus is on responsive care by the right provider to ensure high-quality care and an excellent patient experience.

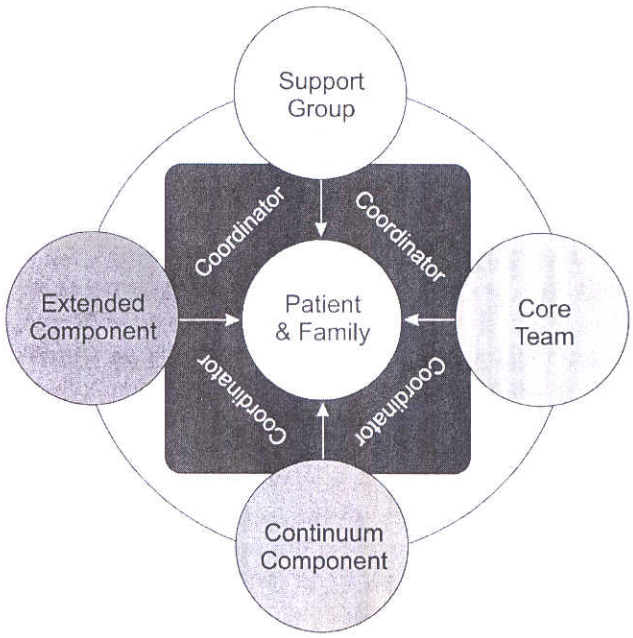


Figure 2. The Collaborative Care Model.

The Continuum component is the link between community-based services and the hospital-based care team. Their focus is on ensuring that community supports (such as home care) are in place to ensure a smooth and safe transition from hospital to community.

The Extended component is involved with the patient for focused periods of time. The team would include consulting professionals who are involved to varying degrees to support the development and execution of the care plan.

The Support components include unit clerks, housekeeping/environmental services and porters. Their roles may be redesigned to better fit into a coordinated team environment.

The transition to a Collaborative Care Model requires that roles be adapted. For instance, physicians are members of the care team, but not necessarily the team director. They collaborate with nurses, other MDs and allied health professionals.

The inclusion of patient care bundles

A literature review[12] has identified four activities in addition to direct care types of nursing activities that can be bundled together to improve patient care: hourly rounding, bedside shift reports, individual care and discharge phone calls. This collection of activities was implemented in the roll out of the coordinated care team at Toronto East General Hospital.

Hourly rounding is very common in hospital nursing units in the United States. It is shared by registered staff and nursing aides with the registered staff doing the even hours and aides the odd hours. It is used as a strategy to reduce noise and interruption caused by unnecessary call lights, call light use and increase patient satisfaction scores, and falls and skin breakdown.[13]

Appropriate skill mix combined with the implementation of hourly rounding and bedside reporting increase patient safety as well as both patient and staff satisfaction.[14-16]

The adoption of patient care bundles within a collaborative care setting is proving to be effective in improving patient outcomes, increasing patient satisfaction and more effectively using valuable human resources.[17-20]

Toronto East General Hospital introduced patient care bundles between November 2008 and March 2009 as an important element of the Coordinated Care Team model on three demonstration units. The Coordinated Care Model (including patient care bundles) was implemented on an oncology unit in November 2008, an acute medicine unit in January 2009 and a surgery unit in March 2009.

The first phase of project evaluation was recently completed using an evaluation framework that monitors patient outcomes and experiences, staff perspectives and resource use. The evaluation data include coded data, the registration or Admission Discharge Transfer (ADT) system, human resources, NRC+Picker satisfaction surveys, post-discharge phone calls and financial records.[21]

The evaluation report results reflect data collected immediately following implementation on each of the three units. Due to staggered implementation of the model, the timeframe for data collection varied among the units, from one to four months. Even with the short timeframe, the results related to patient safety, patient satisfaction, resource use and staff and physician satisfaction are very encouraging.

Patient safety is an important indicator of quality care. Notable findings in this area include a patient falls rate well below the internal benchmark for the first month of implementation (2.35 falls per 1,000 patient days compared to an internal benchmark of 3.46 falls per 1,000 patient days), no incidents of post-admission pressure ulcers, a slight reduction in infection rates for Methicillin-resistant Staphylococcus Aureus (commonly known as MRSA) and c. difficile when compared with a similar period the previous year and a downward trend in mortality for all three units combined compared to the same units the previous year.

Patient satisfaction has increased, with a decrease in patient complaints of 58% and 78% on two units. In addition, the evaluation report notes a 24% improvement in nurse availability and a 36% improvement in response to patient call bells.

Staff and physician satisfaction scores remained stable, possibly reflecting the adjustment period required for care providers to work comfortably together in the new model.

Use of resources also showed improvement, with up to 60 minutes more direct care per day per patient, 20% reduction in overtime use, more than 90% reduction in use of agency staff, a slight reduction in use of sick time and an overall cost reduction of as much as 6% on one unit.

It is interesting to note that the use of sick time decreased significantly as units progressed with implementation of the model. For example, the surgery unit, where the model was most recently introduced, saw an increase in use of sick time of 8.5% in the first month. By comparison, the acute medicine and oncology units have noted a decrease in use of sick time of 20.8% and 55.9%, respectively.

While it is still too early to draw conclusions, results are certainly promising enough to continue the model on existing pilot units and expand it to other units in the coming months.

Making the transition to operational reality

As data continues to be analyzed at TEGH, and as Collaborative Care Models continue to be implemented and evaluated in other parts of the country, the impact of such models on patient safety, improved patient outcomes, patient and provider satisfaction and the effective and efficient use of resources will become much clearer.

While the Collaborative Care Model holds tremendous promise, it is important to note that introducing a new model of care is just one element of the transformation that must occur for Canadian health care to be effective, efficient and sustainable.

The challenge for health care leaders is to move beyond the belief that the status quo is acceptable if only more money and more resources are provided.

The ultimate goal should be to create a transformed health care system that treats the health status of the population as the gold standard for all aspects of programming, service delivery and resource allocation. Linked with this is the emerging priority focused on inter-professional education to truly enable inter-professional care.[22] As the system evolves in this direction, work around Collaborative Care models is a key starting point.

References

1. Romanow Roy J. Building on values: The future of health care in Canada. Ottawa, ON: Commission on the Future of Health Care in Canada;2002.
2. Kirby Michael. The health of Canadians – The federal role. Ottawa, ON: The Standing Senate Committee on Social Affairs, Science and Technology;2002.
3. Fyke Ken. MEDICARE - Commission on Medicare Final Report. Regina, SK: The Commission on Medicare;2001.
4. Statistics Canada. Population projections for Canada, provinces and territories, 2005 to 2031. Ottawa, ON: Author: December 2005.
5. Canadian Institute for Health Information. National health expenditure trends 1975–2007. Ottawa, ON: Author;2007.
6. Canadian Nurses Association. Signposts for nursing: The Canadian Nurses Association looks ahead. Ottawa, ON: Author;2008.
7. Canadian Nurses Association. Towards 2020: Strengthening Canada's health human resources – Trends in RN absenteeism and overtime, 1987-2005. Ottawa, ON: Author;2006.
8. Statistics Canada. National survey of work and health of nurses. Ottawa, ON: Author;December 2006.
9. Staiger DO, Auerbach DI, Buerhaus PI. Expanding career opportunities for women and the declining interest in nursing as a career. Nursing Economics 2000;18:230-236.

10. Canadian Nurses Association. Tested solutions for eliminating Canada's registered nurse shortage. Ottawa, ON: Author;2009.
11. Besner Jeanne. Presentation to the Nova Scotia Model of Care Design Team. Health System and Workforce Optimization: An approach to improving population/patient, provider and system outcomes Halifax, NS;April 2008.
12. Volcy Marie. A literature review on nursing staffing mix and nursing bundle services. Toronto, ON: Toronto East General Hospital;2007.
13. Meade CM, Bursell AL, Ketelsen Lyn. Effects of nursing rounds on patients' call light use, satisfaction, and safety. American Journal of Nursing 2006;106(9):58-70.
14. Studer Quint. Results that last: Hardwiring behaviors that will take your company to the top. John Wiley and Sons;Hoboken, NJ;2007
15. Zwarenstein M, Reeves S, Russell A, Kenaszchuk C, Gotlib Conn L, Miller K-L, et al. Structuring communication relationships for interprofessional teamwork (SCRIPT): A cluster randomized controlled trial. Epub; September 18, 2007.
16. Vazirani S, Hays RD, Shapiro MF, Cowan M. Effect of a multidisciplinary intervention on communication and collaboration among physicians and nurses. American Journal of Critical Care 2005;14(1):71-77.
17. Setia N, Meade C. Bundling the value of discharge telephone calls and leader rounding. The Journal of Nursing Administration 2009;39(3):138-141.
18. Dutton RP, Cooper C, Jones A, Leone S, Kramer ME, Scalea TM. Daily multidisciplinary rounds shorten length of stay for trauma patients. Journal of Trauma 2003;55(5):913-919.
19. Studer Quint. The Studer Group. Discharge phone calls deliver quality care, higher patient satisfaction; 1 May 2006 [cited 25 Sept 2009]. Available from: http://www.studergroup.com/dotCMS/knowledgeAssetDetail?inode=434773
20. Forster A, Murff H, Peterson J, Gandhi T, Bates D. The incidence and severity of adverse events effecting patients after discharge from the hospital. Journal of General Internal Medicine 2003;138(3):161-167.
21. Toronto East General Hospital. Coordinated Care Team model demonstration project evaluation. Toronto, ON: Toronto East General Hospital;2009.
22. Oandasan, I., D'Amour, D., Zwarenstein, M., Barker, K., Purden, M., Beaulieu, M., Reeves, S., Nasmith, L., Bosco, C., Ginsburg, L., Tregunno, D. (2004). Interprofessional Education for Collaborative, Patient-Centred Practice. Ottawa: Health Canada.

Towards a Responsive, Sustainable and Collaborative Model of Care at Toronto's Michael Garron Hospital

Irene Andress, Sharon Navarro, Stephanie Collier, Sarah Coppinger and Priya Herne

Abstract

In 2008, Michael Garron Hospital, transformed its approach to care delivery. The rationale: to improve quality, increase safety and boost patient and staff engagement and satisfaction. The *Coordinated Care Team* (CCT) model has enabled nurses to not only work to their full scopes of practice within a team of interprofessional providers and unlicensed staff, but also helped create a culture of safety and patient-centredness in a value-driven context. Critics suggest a need for more evaluation and evidence of efficacy. This article provides a rationale, discussion and evaluation of the CCT model based on data curated from implementation to 2016.

Background

As a large community hospital, Michael Garron Hospital (MGH), formerly Toronto East General, serves an economically and culturally diverse population. To better meet the needs of its community, MGH transformed the way it delivers care in 2008. The *Coordinated Care Team* (CCT) model focuses on an interprofessional, collaborative approach that teams Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Interprofessional Practitioners (IPPs) with unlicensed care providers (UCPs). Together these "care teams" focus on collaborating in support of a shared vision (Stoner 2013).

The following is the third in a series about MGH's implementation of the CCT model. Despite many articles that correlate higher mortality and morbidity with care models that are *not* all-RN, the CCT approach has provided the foundation for multiple improvements that include high-quality, safe care and increased patient and staff satisfaction within a value-driven context. Currently at MGH, the CCT model of care can be found in medicine, surgery, mental health and complex continuing care. In areas where patient outcomes are less predictable and more complex, such as the family birthing centre, intensive care unit, post acute recovery room, operating rooms and in some parts of the emergency department, an all-RN nursing model of care exists. This article will present an evaluation of the CCT approach using relevant data collected at implementation and during 2015/2016.

The Imperative for Change at MGH

By 2007, staff shortages and increased workloads that stemmed from recruitment and retention issues began to affect nursing morale. Concurrently, changing educational requirements for both RNs and RPNs led to questions around scope of practice. This created a wide variation in job descriptions for similar roles even within MGH.

Amidst rising costs, lagging quality of care and staff engagement, patient satisfaction declined. Within this challenged context, MGH faced a need to stabilize the practice environment. Engaging with front-line staff, the leadership planned and implemented a fundamental shift in care delivery.

Towards a Sustainable, Collaborative Care Model at MGH

MGH's journey started with a review of several frameworks to guide the work in defining scopes of practice and assigning work to various professional/non-professional groups (Campbell et al. 2009). Initially, MGH focused on the College of Nurses of Ontario's (CNO) *Three-Factor Framework*. This guideline set practice expectations, provided direction for MGH's nursing competency framework and supported staff in making care decisions specific to their professional responsibilities (CNO 2014). The *Synergy* model suggested by the American Association of Critical Nursing (n.d.) also provided some guidance. This approach is based on the foundation that "synergy" is reached when the needs and complexity of patients and their families are matched to a nurse's competencies.

Under the CCT approach, patients are assigned to care teams that include an RN Team Lead, additional RNs and RPNs and an appropriate number of UCPs such as Personal Care Assistants (PCAs). RN Team Leads assume the primary leadership role as the "quarterback" within the care team. Much like in a traditional football game, as "quarterback," the RN Team Lead guides the team, assigning the "Most Responsible Nurse," leading patient handover at shift changes and supporting shared care with RPNs when a patient's condition is fluctuating. As the "quarterback" of the care team, the RN Team Lead also coordinates the work of the health professions and often takes the lead helping patients and families as they navigate through their care journey.

RPNs continue to work autonomously within their scope of practice, delivering care to stable patients and working collaboratively with RNs to meet the care needs of more highly complex patients (CNO 2014). PCAs are always supervised by both RNs and RPNs. Within the model, all team members manage best practice "Care Bundles" including bedside shift report, hourly rounding, daily interprofessional team minute rounds and post discharge phone calls. These "Care Bundles" promote patient safety by ensuring continuity of care.

Determining Appropriate Staff Mix

Currently, the RN to RPN mix is 1:2. At implementation, this mix was determined by assessing the overall acuity of the patient population using CNO's *Three-Factor Framework*. More recently, the model and staff mix was further validated using the Patient Care Needs Assessment (PCNA) tool developed by Blastorah et al. The PCNA tool used a number of indicators to assess patient complexity, stability and predictability to not only substantiate the staff mix, but also the staff-to-patient mix (Blastorah et al. 2010).

Generally, the RN/RPN staff-to-patient ratio is 1:5. In addition, IPPs, including physicians, physician assistants, social workers, physiotherapists and respiratory therapists support unit-specific teams. This customization and flexibility allows the team structure to adapt and reflects the unique needs of the patients they serve.

As a result, the CCT model facilitates a consistent and better match of staffing to patients' needs. According to Needleman et al. (2011) this concept of matching staffing to patient need is a key component to the steady improvement of nursing sensitive metrics and decreased patient mortality at MGH. Using the PCNA tool, a recent audit of patient acuity on one of MGH's medicine units indicated that 1.5% of patients were highly unstable, complex and at an increased risk for adverse outcomes – patients that need complete RN care.

When a patient becomes more complex and unpredictable, the CCT model allows for increased collaboration from speciality RNs, including Nurse Practitioners, Clinical Nurse Specialists and the Critical Care Outreach Team. However, the highly adaptive nature of the model, where more or fewer RNs can be leveraged given patient complexity and acuity, allows managers to adjust the staffing mix to match the patient population, ensuring patients receive the "right" provider given their acuity. Staffing adjustments are made by the RN Team Leads or supervisor on a shift-to-shift basis.

Evidence suggests this collaborative approach is crucial in dynamically shifting healthcare environments and is seen as the foundation of creative solutions and innovation (Stoner 2013). Since implementation, the model has evolved to include quality improvement initiatives that have contributed to improved communication including bedside handovers, team huddles and daily interprofessional minute rounds. These touch points allow each member of the team to critically assess the needs of the patients and contribute to the team process by problem-solving together, while valuing each other's unique professional perspectives (MacPhee et al. 2014).

Evaluation: How does CCT Stack Up?

Canadian Institute for Health Information (CIHI) data from 2009 to 2016 show that MGH has achieved improvements in higher quality patient care and increased patient and staff satisfaction. Numerous other system improvements, including electronic health records, were implemented during this time frame (Table 1).

TABLE 1.
Michael Garron Hospital satisfaction indicators

Satisfaction indicators		Years		
Indicator	**Description**	**2008/2009 (%)**	**2015/2016 (%)**	**% Change**
Staff satisfaction	Overall staff satisfaction	53.2	72.1*	35.5
Patient satisfaction	Overall patient satisfaction	88.4	97.1	9.8

*For the reporting period of January–December 2015, $n = 1,194$ with a response rate of 51.0%.

For all of the care indicators, the trend over time illustrates a culture of continuous improvement and better health outcomes ...

Increasing quality and patient safety has always been the cornerstone of the CCT model. Since implementation, MGH has increased patient care hours from 6.3 hours per patient day in 2009 to 6.9 in 2016. Over the same period, sick and overtime costs have fluctuated, but remained stable with an increase of 1.0% in expenses and 4.9% in paid hours in 2016 compared to 2009. The total turnover rate has declined from 8.3% in 2009 to 6.9% in 2016, slightly lower than the total weighted average of all Ontario hospitals. This rate indicates both voluntary and involuntary turnover and illustrates a movement toward sound recruitment and retention practices.

Recent CIHI performance data indicate that MGH achieved "better than" and "same as" the national average on a number of care indicators directly related to nursing. For all of the care indicators, the trend over time illustrates a culture of continuous improvement and better health outcomes (Table 2).

The Economic Indicators illustrate that since 2009, the CCT approach has enabled more patient care hours with minimal change in salary costs (Table 3). This is a result of the increased use of RPNs and PCAs. In fact, increases in costs of care relative to worked hours can be explained by rate increases. Though critics of this care delivery model point to the "de-skilling" of the MGH workforce, the CCT model enables nurses to work to their full scope of practice while better matching staff to patient need.

Key Learnings from the MGH Journey

The role of leadership

Leadership plays a crucial role not only in implementing the CCT model, but also in spreading and sustaining it. To prepare for this change, supervisors, managers and directors were engaged early and provided a forum for dialogue. They were supported by labour relations and communications specialists who also helped to guide teams through staffing changes (Fryers et al. 2012). Today, this dialogue continues and issues and challenges are addressed promptly as a group and by senior leadership.

Emphasizing teamwork and continuous communication matters

Poor communication and teamwork is one of the leading causes of adverse events and a contributing factor to patient safety incidents (CPSI 2011). The CCT approach not only emphasizes the notion of working collaboratively toward a shared goal of safe, high-quality, patient-centred care, but also places a strong focus on continuous communication.

In fact, a collaborative leadership approach enables decision-making at all levels and in multiple decision processes. Here, team members have the opportunity to engage in frequent face-to-face interactions and information exchanges that are crucial to fostering a safe culture (MacPhee et al. 2014).

Though communication gaps and failures still occur, they are often a sign of a breakdown in collaboration. In theory, a collaborative approach works well when each member is clear about their role. Since implementation, MGH has engaged staff on role clarity which has become a continuous process that also ensures the sustainability of the CCT model.

TABLE 2.
Care indicators

Care indicators		Years		
Indicator	**Description**	**2008/2009**	**2015/2016**	**% Change**
Raw mortality (deaths)	Annual number of deaths on the units	440	274	–37.7
Raw mortality rate	The rate of deaths relative to all discharges calculated by number of deaths/total separations	5.6	2.7	–51.8
30-Day in-hospital mortality following acute myocardial infarction	The rate of in-hospital death by any cause occurring within 30 days of first admission with a diagnosis of acute myocardial infarction	9.9	5.0	–49.5
30-Day in-hospital mortality following stroke	The rate of in-hospital death by any cause occurring within 30 days of first admission with a diagnosis of stroke	14.9	3.9	–73.8
Nursing-sensitive adverse events for surgical patients	The rate of nursing-sensitive adverse events per 1,000 surgical discharges*	40.9	23.5	–42.5
Nursing-sensitive adverse events for medical patients	The rate of nursing-sensitive adverse events per 1,000 medical discharges*	31.5	16.7	–47.0
Falls with harm[§]	The rate of falls with harm per 1,000 patient days	0.8 (2013)	0.4	–50.0

*Adverse events include urinary tract infections, pressure ulcers, in-hospital fractures and pneumonia. §This indicator changed in 2013 from "all falls" to "falls with harm." 2013 is shown as the base year.
Source: CIHI 2012, 2016.

TABLE 3.
Michael Garron Hospital economic indicators

Economic indicators		Years		
Indicator	**Description**	**2008/2009**	**2015/2016**	**% Change**
Direct patient care cost per patient day	Cost of worked hours, including overtime, per patient day	$223	$258*	15.7
Direct patient care hours per patient day	Worked hours, including overtime	6.3	6.9	9.5

*The 2016 comparative rate is $226 after adjusting for rate increases.

Supporting the leadership development of RN team leads

A major key to sustaining the model involves the need to better support RN Team Leads. In general, nurses are often inadequately prepared for leadership and leading teams (Gaudine and Lamb 2015). In fact, the MGH experience has shown that some RN Team Leads working within a care team are not as effective as they should be. This may be a result of the varied education levels of nurses at MGH, as well as career stages (novice to expert). Greater support is needed to ensure these RN Team Leads are able, not only to support their team in advocating for changing needs, but also to help sustain the CCT approach.

Given this insight, MGH has implemented a number of strategies to support RN Team Leads. These include: easier access to data that enables the RN Team Lead to be a critical contributor to rounds focused on transition planning and discharges and training related to improving overall communication through standardized techniques such as situation, background, assessment and recommendation (SBAR).

Conclusion

Overall, evaluation of the performance data illustrates a success story at MGH: positive health outcomes, increased patient and staff satisfaction and a financially viable model of care. When such a collaborative care model is thoughtfully and strategically implemented, a culture of high-quality and safe patient care can exist amidst a reality of limited financial resources. Though the transformation of care began almost a decade ago, the process continues to be iterative and adaptive. Others looking to implement such a model should appreciate that the successful MGH experience is a result of continuous process improvement and customization based on solid principles. HQ

References

American Association of Critical-Care Nurses. n.d. *Clinical Resources: Synergy Model.* Retrieved May 25, 2017. <https://www.aacn.org/nursing-excellence/aacn-standards/synergy-model>.

Blastorah, M., K. Alvarado, L. Duhn, F. Flint, P. McGrath and S. VanDeVelde-Coke. 2010. "Development and Evaluation of an RN/RPN Utilization Toolkit." *Nursing Leadership* 23(Special Issue): 33–50. doi:10.12927/cjnl.2010.21733.

Canadian Institute for Health Information (CIHI). 2016. *Additional Hospital Indicators.* Retrieved December 22, 2016. <https://www.cihi.ca/en/cihi-health-indicators#_Reports_and_Analyses>.

Canadian Institute for Health Information (CIHI). 2012. *The Canadian Hospital Reporting Project.* Toronto, ON: Author.

Campbell, B., M. Fryers, R. Devitt and K. Vestal. 2009. "Towards a Collaborative Model of Care." *Healthcare Management Forum* 22: 27–31.

College of Nurses of Ontario (CNO). 2014. *RN and RPN Practice: The Client, the Nurse and the Environment.* Toronto, ON: Author. Retrieved February 4, 2017. <http://www.cno.org/globalassets/docs/prac/41062.pdf>.

Canadian Patient Safety Institute (CPSI). 2011. *Canadian Framework for Teamwork and Communication.* Edmonton, AL: Canadian Patient Safety Institute.

Fryers, M., L. Young and P. Rowland. 2012. "Creating and Sustaining a Collaborative Model of Care." *Healthcare Management Forum* 25: 20–25.

Gaudine, A. and M. Lamb. 2015. *Nursing Leadership and Management: Working in Canadian Health Care Organizations.* Toronto, ON: Pearson Canada Incorporated.

MacPhee, M., L.-L. Chang and F. C.-S. Havaei. 2014. "A Descriptive Account of an Inter-Professional Collaborative Leadership Project." *Administrative Sciences* 4: 373–99.

Needleman, J., P. Buerhaus, V.S. Pankratz, C.L. Leibson, S.R. Stevens and M. Harris. 2011. "Nurse Staffing and Inpatient Hospital Mortality." *New England Journal of Medicine* 364: 1037–45.

Stoner, J.L. 2013. *Let's Stop Confusing Cooperation and Teamwork with Collaboration.* Berkeley, CA: Seapoint Centre for Collaborative Leadership. Retrieved November 3, 2016. <http://seapointcenter.com/cooperation-teamwork-and-collaboration/>.

About the Authors

Irene Andress, RN, MN, is a member of the senior leadership team and vice president, Patient Experience, Health Professions & Chief Nursing Executive at Michael Garron Hospital in Toronto.

Sharon Navarro, MHSc, CHE, is a quality & patient safety specialist at Michael Garron Hospital in Toronto.

Stephanie Collier, CPA, CGA, MPH, is a manager of decision support at Michael Garron Hospital in Toronto.

Sarah Coppinger, RN, BScN, is a manager of nursing affairs and practice lead for the Nursing Resource Team at Michael Garron Hospital in Toronto. She is also an MN candidate.

Priya Herne, RN, MN, CNCC(C), is a patient care manager at Michael Garron Hospital in Toronto.

ORIGINAL ARTICLE

Creating and sustaining a collaborative model of care

Marla Fryers, MScN; Linda Young, MScN, EdD; Paula Rowland, BHSc(OT), MA

Abstract—For the past 3 years, Toronto East General Hospital staff and leadership have been involved in the design, implementation, and evaluation of a transformational change to the model of patient care. The purpose of the new model is to enhance quality, safety, and patient satisfaction through a redefinition of our approach to the patient experience. The evaluation framework for the Coordinated Care Team (CCT) model of care addressed safety and quality outcomes, patient satisfaction, staff and physician satisfaction, and resource impact. Results of the evaluation suggest that the introduction of the CCT model using the patient care bundle can have a significant impact on the patient experience through enhanced access to bedside care as well as improved quality and safety outcomes. This article is a follow-up to the article on the development of the model published in *Forum* (Fall 2009). It extends upon the previous article through an overview of the model as it evolved, a discussion of the first-year evaluation for three pilot units, and lessons learned regarding the change process.

Changing a care delivery model involves major transformational work. In a system that is constantly challenged to adapt to changing population needs, advances in medical science and technology, and new legislative requirements, the introduction of a new model of care across a hospital can be daunting. At the same time, the need to assure the optimal use of resources to maintain or enhance the quality of care in healthcare institutions is essential.

In 2008, Toronto East General Hospital (TEGH), a 515-bed acute care community teaching hospital undertook a redesign of the model of care delivery to address challenges associated with staffing shortages and staff and patient satisfaction. The design, rationale, and early evaluation results were described in a previous publication.[1] This article describes the Coordinated Care Team (CCT) model, providing evaluation results and lessons learned after 1 year of implementation.

THE CCT MODEL

Designing the model

Under the leadership of the Vice President Programs and Chief Nursing Officer, a large group of staff and management collaboratively designed the CCT model of care based on several sources from the scholarly and practice literature.[2–8] Guiding principles projected that the new model would meet the needs of the population served; provide a clear delineation of roles and responsibilities for all healthcare providers; leverage redesigned work processes and technology; enhance quality, safety, and patient satisfaction; and foster workplace wellness and enhance staff satisfaction. In the new model, staff would work to their full scope of practice. Overall, the model was expected to achieve positive patient, provider, and system outcomes.

Description of the CCT model

The CCT model is based on inter-professional teamwork and a proficient level of coordination among team members. Both core team and extended teams are identified in the model. Core team members typically include registered nurses, registered practical nurses, and patient care assistants. Extended team members include allied health professionals, physician assistants, and physicians.

Membership on the core team and extended teams reflects the unique needs of the patient population cared for by the unit. The CCT model was initially implemented on oncology, acute medicine, and surgical units over a 4-month period. Figure 1 depicts the composition of the core team on the three pilot units.

Enhanced inter-professional dialogue and the introduction of the patient care bundle are important components of the model. The patient care bundle includes the following: (1) hourly patient care rounds by members of the core team on each patient, (2) daily inter-professional rounds to improve care coordination and team communications, (3) face-to-face inter-professional exchange between shifts, and (4) post-discharge telephone calls to patients within 48 hours of discharge. Based on work by Studer,[8] the patient care hourly rounds are structured to address the "4 P's" with each patient. The "4 P's" refer to (1) positioning, (2) personal needs including assistance to the bathroom, (3) pain, and (4) the placement of personal items within reach.[8]

From the Toronto East General Hospital, Toronto, Ontario, Canada.
Corresponding author: Marla Fryers, MScN, Toronto East General Hospital, 825 Coxwell Avenue, Toronto, Ontario M4C 3E7, Canada (e-mail: mfryers@tsh.to).
Healthcare Management Forum 2012 25:20–25
0840-4704/$ - see front matter

doi:10.1016/j.hcmf.2011.11.001

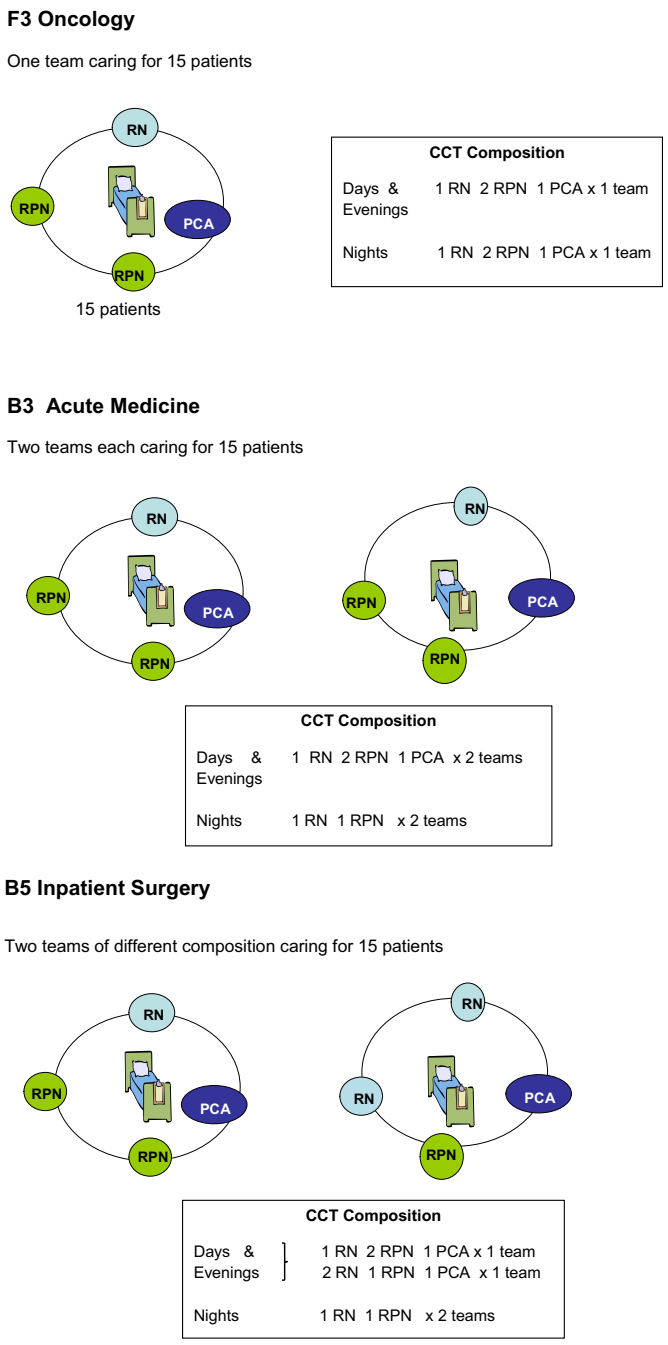


Figure 1. Composition of core team on pilot units.

CCT MODEL PILOT UNIT EVALUATION

The Canadian Nurses Association's *Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions*[6] guided the development of the evaluation in the context of the parameters of the TEGH strategic plan. The evaluation set out to understand the adequacy of the CCT implementation process; assess the need for additional tools or strategies to support implementation; examine the impact of the model on patient safety, patient satisfaction, staff, and physician satisfaction and resource utilization; and determine if the objectives of the model were being met.

Three evaluations were written for the model: at 2 to 3 months, at 5 to 6 months, and at 1 year. This report pertains to the year 1 evaluation for the three pilot units. Table 1 provides background information on each of the pilot units.

Four priority areas provided focus for the collection of quantitative and qualitative data: (1) patient safety, (2) patient satisfaction, (3) staff and physician satisfaction, and (4) resource utilization. To ensure that there was a sizable dataset for making observations, quantitative results for the three units were aggregated for a pre-implementation rate that was compared with the rate post-implementation. Results are presented in relation to each priority area.

Patient safety

Indicators selected for monitoring the impact of the CCT model on patient safety included rates for falls, pressure ulcers, infections, and medication incidents. The evaluation involved comparing monthly rates for 1 year before implementation with those of 1 year after implementation. Data on safety indicators were taken from incident reports and the discharge abstract data. Results show improvement on all measures as presented in Table 2.

Patient satisfaction

Post-discharge telephone calls made by trained staff within 48 hours of discharge were implemented with the CCT model of care. Patient satisfaction was evaluated by comparing responses to three questions on post-discharge telephone calls with previous National Research Corporation (NRC) Picker Patient Satisfaction Survey responses to the questions. A total of 572 patients provided feedback (17.7%). Patient complaints registered with the patient relations office over the 2-year pre-/post-period were also used to evaluate patient satisfaction. Results are described in Table 3.

Although overall scores showed improvement, unit specific data indicated that the medical unit was struggling with the response time to call bells. Consequently, additional staff members were added to the day shift, resulting in an improvement in patient satisfaction scores. From a qualitative perspective, patients' comments made during discharge telephone calls highlighted the benefits of the CCT model as follows:

1. Attentiveness: "Nurses were very attentive and the person who provided personal care was wonderful . . . the care was great!"
2. Quality of care: "I am in awe of the wonderful nursing care I received while I was there as a patient."
3. Teamwork: "All the nurses were excellent. I liked knowing that the team knew my case well."

Table 1. Overview of pilot units

	Oncology	*Acute Medicine*	*Surgery*	*Total/Average*
Beds	15	30	29	74
Patient discharges	533	662	2,025	3,220
Patient days	5,433	9,560	8,213	23,206
Average length of stay	10.2	13.1	4.0	7.2
Average resource intensity weight	1.86	2.08	1.32	1.75
Occupancy rate (%)	99	87	78	86

Data based on discharge abstract database for 12 months post-implementation.

4. Support: "They all made us feel welcomed. The nurses all introduced themselves ... If we are ever readmitted, we want to go back to this unit."

Patients suggested that patient satisfaction could be enhanced by more informed discharge planning, improving staff communication skills, decreasing noise at night, and shorter stays in emergency.

Staff and physician satisfaction

The evaluation of staff satisfaction was based on two or more focus groups held on each unit on different shifts. A total of 39 staff (41%) participated, including 16 registered nurses, 10 registered practical nurses, 10 personal care assistants, and three others (allied health professionals or clerical staff).

Responses were analysed under five areas of focus identified from the transcripts including adjusting to a new way of working, team functioning, the impact on patients and families, unit processes and workload, and scope of practice.

1. Adjusting to a new way of working: most staff indicated that they are comfortable in the new model of care rating their comfort level as 7 to 9 on a scale of 1 to 10, where 10 means absolutely comfortable. Their comments highlighted the need to learn "new ways to work" as well as the challenges of working with some nurses who "are reluctant to let go of the previous model and their past role."
2. Team functioning: the staff identified that they are more aware of the need to work together and to rely on each other. They observed that good inter-personal relations including respect, effective communication, recognizing each other's strengths, supporting each other, explaining things, and celebrating contribute to optimal team functioning. Continuity in team membership and physicians or physician assistant participation in rounds was highly beneficial to workflow and team effectiveness. Suggestions for improvement included more relationship building on some teams and further development of communications skills.
3. Impact on patients and families: benefits to the CCT model included access to staff, hourly rounding, teamwork, and patient satisfaction. Staff commented "Patients are accessing different staff, they appreciate talking to different people" and "there is increased patient satisfaction because we are working as one, it's more fluid ... someone is always there with the patient."
4. Unit processes and workload: staff underlined the value of a strong team leader who could rebalance work assignments, noting the difference this made to team effectiveness and staff satisfaction. Unpredictable work such as demands from patients or families, changing patient acuity, and volume surges associated with patient flow were often a stressor for teams. Workload challenges meant that sometimes teams were not able to complete patient rounds on an hourly basis. Workload stress was more evident when other changes occurred in close succession with CCT.
5. Scope of practice: some nurses were not practicing at full scope 1 year after implementation. Gaps included

Table 2. Patient safety indicators

Indicator	*1-year pre-CCT implementation*	*1-year post CCT implementation*	*Difference*
Falls (rate per 1,000 patient days)	7.1	4.9	Reduced by 31%
Post admit pressure ulcers >70 years of age (rate per 1,000 patient days)	0.25	0.17	Reduced by 32%
Medication incidents (rate per 1,000 doses)	0.64	0.43	Reduced by 33%
Patient to patient transmission of infection (rate per 1,000 patient days)	0.18	0.13	Reduced by 28%

Table 3. Patient satisfaction

	1-year pre-CCT implementation	*1-year post CCT implementation*	*Difference*
Availability of nurse rated as good, very good, or excellent (% patients reporting)	78	89	Improved by 14%
Always had help to bathroom on time (% patients reporting)	49	77	Improved by 57%
Time waiting for call bell response was always reasonable (% patients reporting)	57	68	Improved by 19%
Patient complaints (number of complaints)	43	33	Reduced by 23%

team leadership and organizational skills, competence with nursing skills such as intravenous starts, and the development of critical thinking skills associated with expanded scope.

Physician evaluation data were unavailable at 1 year because of a low response rate to the electronic survey. Data at 6 months (N = 14) indicated modest improvements in quality of care (29%), teamwork (50%), and reduction in patient complaints (14%). Areas for ongoing development at 6 months included ease of access to information from nurses and making appropriate referrals to allied team members. Physicians continue to be supportive of the change.

Resource utilization

Measures used to assess the resource impact of the CCT model included changes in overtime, agency use, illness hours, the use of constant care aids, and direct patient-care hours. Pre-/post-comparisons used data from financial and payroll systems. Results are identified in Table 4.

The CCT model provided an average increase of 66 minutes of care per patient per day. Increases in the use of overtime and agency staff were attributed to the need to backfill staff during CCT training and are expected to stabilize over time. Constant care aids were needed less frequently to monitor confused patients or those identified as a falls risk.

Table 4. Resource utilization

Indicator	*1-year pre-CCT implementation*	*1-year post CCT implementation*	*Difference*
Direct patient care, hours	116,861	142,476	Increased by 22%
Illness hours	5,366	4,850	Decreased by 10%
Agency	$22,270	$23,741	Increased by 6.8%
Overtime	$103,389	$126,762	Increased by 23%
Constant care aids	$246,127	$86,413	Decreased by 65%

DISCUSSION

The evaluation results provide evidence that the CCT model as implemented at TEGH has been beneficial for patient care in relation to patient safety outcomes and patient satisfaction measures. These improvements are in keeping with reports of success with similar changes in other hospitals.[8–11]

Staff feedback underlined the time it takes to adapt to the new model and the challenges remaining after 1 year. Ongoing education, coaching, and guidance are still needed to assist staff with achieving the full scope of practice, managing workload issues, enhancing team leader effectiveness, and facilitating inter-professional collaboration. Although specific team leader workshops have been implemented, additional work is still required.

TEGH has implemented the CCT model on a total of 13 inpatient units including general and specialty units across the hospital. A modified model is also used in the emergency department. CCT indicators are being assessed through the corporate scorecard to monitor sustainability.

LESSONS LEARNED

Designing, implementing, evaluating, and sustaining this change has been a complex endeavour involving the input and commitment of a diverse range of stakeholders. The following "lessons learned" are an indication of the leadership strategies required to implement and sustain this kind of organizational change.

Support from all levels of the organization throughout design, implementation, evaluation, and sustainability

The change process required to implement the CCT model has been substantive. Implementation of the model cannot be successful without consistent engagement from all levels of the organization. This includes support from the board, the executive team, directors, managers, supervisors, and frontline service providers throughout the change.

Support includes ensuring time for dialogue and reflection to understand and manage the emergent change process. Monthly meetings with directors, managers, and supervisors from all levels provided a forum for this dialogue throughout planning and implementation. Support also involves ongoing communication and guiding teams through staffing changes and project management revisions. Support from labour relations and communications staff is critical to the success of the change.

Adequate resources for all phases

For the change to CCT, organizational leaders need to secure the appropriate resources to allow for design work, ongoing training for frontline staff, and project evaluation. Each of these required a significant investment of human resources, coordination, and focused effort that should not be underestimated.

In addition, frontline staff must be actively engaged in ongoing rapid improvement cycles to refine unit practices to support meaningful implementation of the CCT model. Unit level customization includes refining the language and schedules for hourly patient rounds and the processes for initial and inter-professional rounds. Successful customization requires an investment of time and an enhancement of skills related to quality improvement work for both managers and frontline staff.

Service-oriented design

Service-oriented principles guided the design of this project from its inception. A collective orientation toward the needs of the patient allowed for creativity in design and freedom from intra- and inter-professional tensions that emerge in provider centric conversations. Refocusing discussions on the principles of service-oriented design was an essential success factor throughout the project.

Change leadership and program evaluation

As already mentioned, this change requires an emergent approach. As TEGH moved from design to implementation to sustainability, the needs of staff shifted. The success of the model relies on the ability for staff and management to continually learn from the implementation process and to be sensitive to changing trends. For the purposes of this project, the program evaluation design was based on the principles of collective learning. This framing allowed TEGH to be responsive to the emerging data and to make course corrections along the way.

This approach required a significant volume of continual data collection to access timely information. Data were drawn from several sources throughout the hospital, thereby requiring a substantial effort to ensure the timely, coordinated, and accurate flow of information for the evaluation. To manage this complexity, it was necessary to assign a dedicated resource to oversee the program evaluation.

Finally, while providing a coherent fit with our change leadership strategy, this developmental approach made for a difficult translation into venues expecting a summative evaluation in the very early stages of implementation. Setting realistic expectations with stakeholders regarding the evaluation strategy with ongoing communication is essential.

NEXT STEPS

The implementation of the CCT model attended to the structures and processes of our model of care. Our change strategy has also provided the foundation for staff and management to make full use of the tools, technologies, and resources associated with continuous quality improvement to further refine inter-professional teamwork and enhance the patient experience. Units have begun the process of adopting and implementing organized unit initiatives, patient at-a-glance boards, and daily inter-professional huddles to review key metrics related to patient care.

In the coming months, we will continue to evolve our model of care by streamlining admission, care planning, and discharge planning processes based on inter-professional standards of practice. These changes will provide the groundwork for leveraging technology to improve workload management through the implementation of redesigned documentation tools and an electronic patient record.

CONCLUSIONS

The CCT model was created through a collective design process, providing a model of care that is sensitive to existing trends while being customized to the local context of TEGH. The change required to implement and sustain this model is highly complex, and the success of the emergent change strategy is reliant on support from all levels of the organization, ensuring resources to support the change process and maintaining a service-oriented design and collective learning. The improvements in patient, provider, and organizational outcomes provide a compelling argument that increased quality can be achieved with innovative thinking applied within existing resources. Looking ahead, the CCT model lays the foundation for leveraging inter-professional teamwork and technology to enhance the patient experience.

ACKNOWLEDGMENTS

The authors would like to acknowledge the extensive contributions made by staff and physicians at TEGH to the design, implementation, and evaluation of the CCT model.

REFERENCES

1. Campbell B, Fryers M, Devitt R, et al. Towards a collaborative model of care. *Healthc Manage Forum* 2009;22:27–31.
2. Bauman A, Blythe J, Baxter P, et al. Registered practical nurses: an overview of education and practice. *A report to the Implementation Task Force, Ontario Ministry of Health and Long Term Care*. Toronto: Government of Ontario; 2009.
3. College of Nurses of Ontario. *Practice Expectations: A Guide for the Utilization of RNs and RPNs*. Toronto, ON: Author; 2002.
4. College of Nurses of Ontario. *Utilization of unregulated Care Providers (UCPs): A Guide to Making Decisions*. Toronto, ON: Author; 2008.
5. College of Nurses of Ontario. The Regulated Health Professions Act Part B: Scope of Practice, Controlled Acts Model. Toronto, ON: Author; 2003.
6. Canadian Nurses Association. *Framework to Determine the Impact of Staff Mix Decisions*. Ottawa, ON: Author; 2006.
7. Pan-Canadian Planning Committee on Unregulated Health Workers. *Maximizing Health Human Resources: Valuing Unregulated Health Workers*. Highlights of the 2009 Pan-Canadian Symposium: Ottawa, ON: Canadian Nurses Association; 2009.
8. Studer Q. *Results That Last: Hardwiring Behaviors That Will Take Your Company to the Top*. Hoboken, NJ: John Wiley and Sons; 2008.
9. Kimball B, Cherner D, Joynt J, et al. The quest for new innovative care delivery models. *J Nurs Adm* 2007;37: 392–8.
10. Meade CM, Bursell AL, Ketelsen L. Effects of nursing rounds on patient's light use, satisfaction, and safety. *Am J Nurs* 2006;106:58–70.
11. Setia N, Meade C. Bundling the value of discharge telephone calls and Leader rounding. *J Nurs Adm* 2009;39:138–141.

5 ways to foster teamwork … even if you're not a boss

You can help streamline work flow in your department by encouraging teamwork among staff—even if you're not a manager. Here's how.

1. **Start the wave**.

    - Be the first to help another nurse with a difficult patient.
    - Assist with activities of daily living, bathe the patient, or do whatever your colleague needs to stay on schedule. You'll soon find the favor returned.

2. **Be a mentor**.

    - Take new nurses under your wing and help them feel at home in your department.
    - Offer to be a resource if their preceptor is unavailable. By demonstrating to them that you're a team player, you'll encourage them to follow suit.

3. **Ask for help when you need it**.

    - If you find yourself falling behind in your schedule, ask a colleague for assistance. That way, you won't become frustrated when you think of all the other things still left on your to-do list.

4. **Think ahead**.

    - Have as much ready for the next shift as possible. For example, place another bag of intravenous solution in your patient's room if the current bag is almost empty, or leave a spare set of sheets in your patient's room for middle-of-the-night bed changes.

5. **Be prompt for report**.

    - Unless you're in the middle of an emergency, give report when the next shift is ready for it. Nothing is more frustrating than starting a shift behind schedule. Finish what you were doing when you're done with report.

In the meantime, don't expect the concept of teamwork to take off overnight. It takes practice, commitment, and lots of promotion. But it's also contagious. Once the concept begins to stick, you'll see a new and improved attitude in your unit. At that point, you can congratulate yourself on a job well done.

Adapted from:

MEINECKE, JUDY RN; Nursing2003: January 2003 - Volume 33 - Issue - p 20