

Coordinated Care Team Demonstration Project Evaluation

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EXECUTIVE SUMMARY

In February 2008, Toronto East General Hospital (TEGH) began a hospital-wide engagement process to plan and design a new and improved model of care called *Coordinated Care Teams* (CCT). Coordinated Care Teams are team-based models of patient care intended to enhance the patient experience and outcome. Under the new model, each CCT team consists of Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working to their full scope of practice, and Patient Care Assistants (PCA) providing support services to patients and health care professionals. The combination and number of each professional on a CCT team has been customized to each patient unit.

An initial group of 50 TEGH employees worked collaboratively to design the model, including front-line RNs, RPNs, support staff, unit managers, doctors and Nursing Practice leaders. To date, three demonstration units have implemented the CCT model of care: Oncology in November 2008, Acute Medicine in January 2009, and Surgery in February 2009. This document describes TEGH's journey of designing and implementing a new model of care, and results from the continuous evaluation of Coordinated Care Teams.

TEGH also believes the CCT model will lead to improved collaboration among team members, better coordination of care, and most of all, better care for patients. Internal evaluation and improvements will be continuous. Outside assessments of the CCT have also been obtained, from experts such as from the former Chief Nursing Officer of Ontario and the Executive Director of the Registered Practical Nurses Association of Ontario.

The results contained in this evaluation report are very positive and include:

Patient Safety

- Reduction in patient falls
- No incidents of past-admission pressure ulcers
- Slight reduction in mortality rate
- Slight reduction in infection rates for MRSA and C.difficile

Patient Satisfaction

- Increases to many measures of patient satisfaction, including a 24% improvement in nurse availability and 36% improvement in response to patient call bells
- Patient complaints have decreased between 58 to 78% on two units

Resource Use

- Up to 60 minutes more direct care per day per patient
- 20% average reduction in overtime use
- 90%+ average reduction in use of agency staff
- Reduction in use of sick time
- Overall cost reduction ranging up to 6% on one unit

Staff and Physician Satisfaction

- Stable staff satisfaction survey scores
- Stable physician satisfaction survey scores

This new model of care has kept the total hours of nursing care provided to each patient at the same level while shifting work between Registered Nurses and Registered Practical Nurses within the scope of their training. In addition, direct care has increased by as much as 60 extra minutes per patient per day due to the introduction of new patient care assistants.

Many of the models of care in hospitals are decades old. Professions such as nursing have undergone a massive educational transformation. Today, graduating Registered Nurses must be degree prepared and graduating Registered Practical Nurses come to their role with a two (2) year college diploma, the same duration of education formerly required of a Registered Nurse. TEGH believes the time is right to re-examine models and create care programs that meet the needs of the modern patient.

An evaluation of the model has been conducted measuring its impact on a number of fronts including quality of care, patient satisfaction, workplace satisfaction and resource impact. The detailed findings of this evaluation follow in this report.

1. INTRODUCTION

In February 2008, Toronto East General Hospital (TEGH) began a hospital-wide engagement process to plan and design a new model of care called, *Coordinated Care Teams* (CCT). Coordinated Care Teams are team-based models of patient care intended to enhance the patient experience. The hope is that through these models there will be improved collaboration among team members and that this will lead to better coordination of care, and most of all, better care for patients.

The health care system often looks to other industries to identify possible new approaches to familiar problems. A common example of this is the use of tools from the airline industry such as check lists and near miss analysis to strengthen patient safety. The airline industry is also a leading example of leveraging the expertise of an entire team to work together for one common goal. One would not expect a professional trained as a pilot to conduct the duties of cabin crew on an airplane, nor would it be the most effective use of the pilot's skills. Similarly, the CCT project creates a structure and process for various professionals to work together to achieve a common goal. A principle of the CCT is that all providers work to their full potential and that the right level of care is provided by the right caregiver at all times.

To date, three demonstration units have implemented the CCT model of care: Oncology (F3) in November 2008, Acute Medicine (B3) in January 2009, and Surgery (B5) in February 2009. This document describes TEGH's journey of designing and implementing a new model of care, and results from the continuous evaluation of Coordinated Care Teams.

2. BACKGROUND

The health care industry has been plagued with human resource shortages with significant focus related to the nursing profession. As nursing resources have become increasingly scarce, the health care system must ensure the appropriate use of such resources to maintain system access for patients in need. According to a 2005 Canadian study, 50% of registered nurses (RNs) and 80% of registered practical nurses (RPNs) do not work to their full scope of practice.¹ These highly skilled and highly trained nursing professionals are not able to focus on the work that they have been trained to do, and are instead spending a significant amount of time on duties not requiring their level of professional skill.

“Many times the night nurse did not respond to my mother’s call bell for hours, this caused much discomfort.”

~Family Member
NRC+Picker Survey

“RNs are mopping floors, emptying garbage, and cleaning bathrooms – this should not be an RN’s task!”

~TEGH Staff Member
NRC+Picker Survey

Internal statistics and anecdotal feedback at Toronto East General Hospital (TEGH) are consistent with the findings from published research. Staff at TEGH have complained that they are not able to practice to their full scope. Use of overtime and agency staff further reflects the need to look for a more sustainable model of care delivery.

The changing scope of practice for RNs and RPNs reflect the historical trend towards higher education for each of these providers. Entry to practice for RN’s is now at the baccalaureate preparation level and RPN’s at the college diploma level. This trend is reflected in the Health Care Education Requirements Timeline in Appendix 1. While the foundational education requirements of the nursing profession have evolved radically through time the fundamental staffing approach in hospitals has remained static. Indeed, many hospitals are still using a decades old approach to staffing in-patient units, one that looks very much like it would have in the 1970’s or 1980’s.

The search for a new model of care is also taking place in several jurisdictions in Canada. Nova Scotia and Newfoundland are implementing wide spread changes to their model throughout the entire province. Key aspects of that model include using assistive personnel and ensuring nurses work to their full potential.

As the approach to nursing education has evolved through time, the theory behind the new model of care suggests that we need to evolve the way in which we use these highly skilled

¹ Baranek, P. (2005). A Review of Scopes of Practice of Health Professions in Canada: A Balancing Act. Toronto, ON: Health Council of Canada.

resources taking advantage of the much higher degree of entry level education. Moreover a commitment to maintaining overall nursing hours per patient day will ensure that the complex needs of patients will always be addresses.

TEGH's commitment to innovation through the CCT project addresses a change to the structure and function of care teams. Under the new model, each CCT core team consists of Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working to their full scope of practice, Patient Care Assistants (PCA) providing support services to patients and other health care professionals. The combination and number of each professional on a CCT core team has been customized to each patient unit, depending on assessed care requirements of the varied patient populations (see Appendix 2 for unit specific composition of core team). Team processes have been redesigned into patient care bundles. These bundles include hourly patient rounding by members of the care team, face-to-face shift exchange, interprofessional bullet rounds and post-discharge phone calls.

TEGH recognized that a change to team structure alone would not result in any tangible improvement to patient care or the work environment. In fact, as a part of a comprehensive literature review it was noted that “it was naïve to have assumed that changes in practice would naturally follow” changes in structure and process.² Therefore, it was recognized that an organizational strategy to guide implementation would be essential, ensuring leadership at all levels of the organization. A critical component of the project implementation has been evaluating key care outcomes, processes, communication practices and relationships among team members.

3. OBJECTIVES

The objectives of the CCT project are to:

1. Deliver **high quality care** within an interprofessional model of care,
2. Ensure every patient is surrounded by a **core team** of providers that utilize a “team lead” role,
3. Enable providers to work to their **full scope** of practice,
4. Ensure care is delivered by the **most appropriate** person at all times, and
5. Ensure a **comprehensive** patient assessment, care plan, and discharge plan.

² White, D., Jackson, K., Besner, J., Suter, E., Doran, D., McGillis Hall, L., & Parent, K. (2009). *Enhancing nursing role effectiveness through job redesign*. Calgary: Alberta Health Services

4. METHODOLOGY

4a. Design of the Coordinated Care Team Model

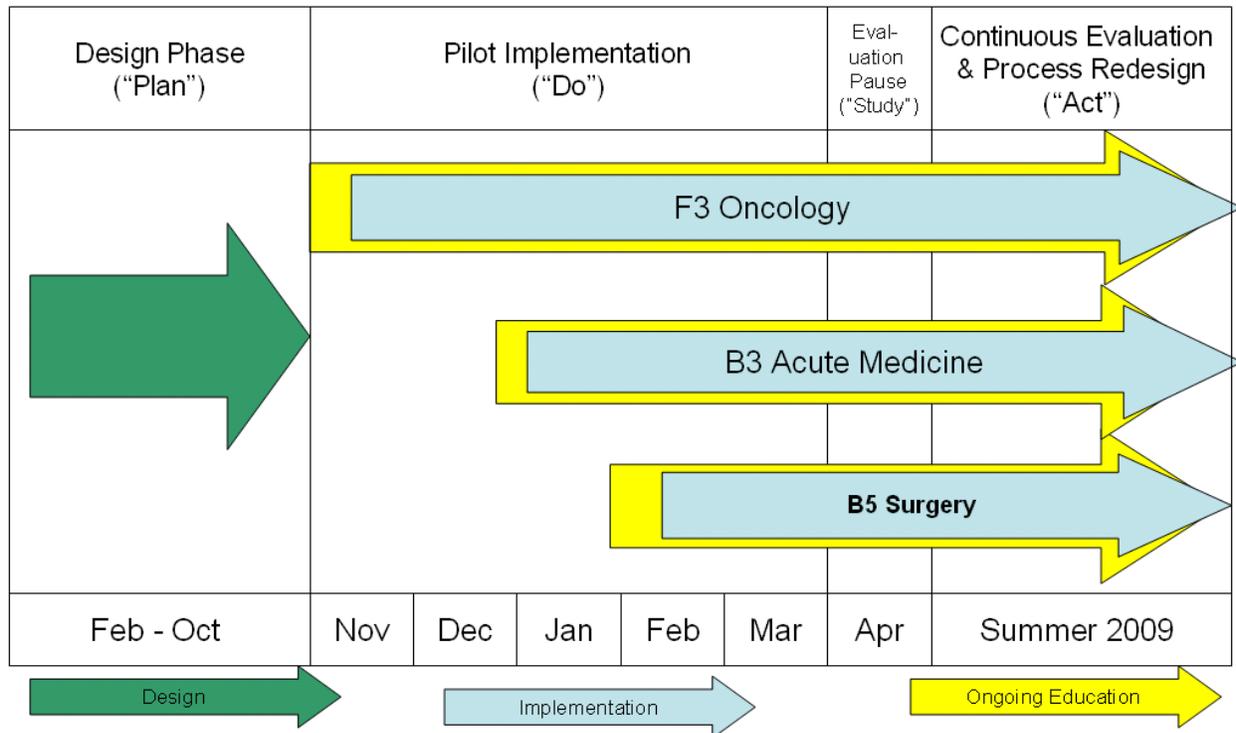
Over a four month period (from February to November 2008), an initial group of 50 TEGH employees from the demonstration units worked collaboratively to design the CCT Model. These 50 staff members included front-line clinical staff (such as RN's and RPN's), support staff, unit managers and Nursing Practice Leaders. In addition, broader consultations with internal and external stakeholder groups were held to generate feedback and strategic direction. For a complete description of Design Team members and stakeholder, see Appendix 3.

Four working groups were then created to support the implementation of the pilot project.. These working groups were responsible for: 1) Human 2) Redesign, 3) Education & Training; and, 4) Change Management through advanced processes and infrastructure.

4b. Implementation

Three units, representing Oncology, Acute Medicine and Surgery were selected to pilot the CCT model of care. The model's implementation has been phased in over a progressive four month period. Two weeks of intense, customized training preceded each unit's implementation date followed by ongoing support during implementation. Skills training was an important component of the two week training.

Figure 1: Overview of Coordinated Care Team Project Cycle



4c. Evaluation of the Model

Prior to implementation, an evaluation framework was selected to monitor patient outcomes and experiences under the new model of care. This framework also ensured that staff perspectives and resource use were included in the evaluation. The evaluation framework is based on the Canadian Nurses Association's "*Evaluation Framework to Determine the Impact of Nursing Staff Mix Decisions*."³

The evaluation framework presents data from a number of sources, including coded data, the registration or Admission Discharge Transfer (ADT) system, human resources, NRC+Picker satisfaction surveys, post-discharge phone calls, and financial records. This is a pre-post mixed methods design with a combination of quantitative and qualitative measures. Comparison units and time periods were selected based on the availability of quality comparison data for the unit and the patient population. In many cases, data has been aggregated in order to protect patient confidentiality due to small case counts.

The data presented in this document reflects the initial results immediately post-implementation on three units. It is important to note that the amount of time since implementation varies among the pilot units. For one unit (F3 Oncology) four full months of implementation data is available, while one unit (B5 Surgery) only has one month. Based on published literature,⁴ the implementation period of a project like CCT is critical to the project. For this reason, a comprehensive and focused evaluation is required at this time. The evaluation of the CCT model will continue with ongoing measurement and feedback integrated into continuous quality improvement initiatives reflected in regular TEGH performance management processes.

³ Canadian Nursing Association (2005). *Evaluation framework to determine the impact of nursing staff mix decisions*. Ottawa: Canadian Nursing Association.

⁴ White, D., Jackson, K., Besner, J., Suter, E., Doran, D., McGillis Hall, L., & Parent, K. (2009). *Enhancing nursing role effectiveness through job redesign*. Calgary: Alberta Health Services

5. RESULTS

Results of the pilot evaluation have been broken down into the following sections: Patient Safety, Patient Satisfaction, Resources, and Staff & Physicians Satisfaction.

5a. Patient Safety

A number of patient safety indicators are included in the evaluation. These are: 1) The number of infection rates; 2) The number of patient falls; 3) The incidence of post-admittance pressure ulcers; and, 4) Changes in rates of patient mortality. While these indicators will continue to be reviewed through regular performance monitoring, they are being analyzed monthly as a part of CCT to ensure that the implementation does not have any adverse effects on patient care. The results to date are very encouraging with results either stable or improving following implementation of the CCT.

Morbidity: Infection Rates Remain Consistent

Prior to the pilot period, there was evidence of patient-to-patient transmission of hospital acquired infections, such as C.difficile. Since the launch of the CCT model, there have been no patient-to-patient transmissions of C.difficile on the pilot units.

The rates for Methicillin Resistant Staphylococcus Aureus (MRSA). and C.difficile are presented in Figure 2. Overall, the rates for the pilot units are slightly lower with the rest of the organization and are below the large community hospital benchmark.

Figure 2. Infection Rates post CCT Implementation

MRSA Rate	
Post Implementation (all 3 units)	0.41
TEGH monthly average during implementation phase	0.56
Large Community Hospitals in GTA	0.80
C. Diff Rate	
Post Implementation (all 3 units)	0.41
TEGH monthly average during implementation phase	0.53
Large Community Hospitals in GTA	0.80

In addition, TEGH has consistently performed better than the established benchmark for nosocomial bacteremias⁵ of MRSA and VRE and we continue to experience no incidents of MRSA and VRE for the entire hospital during the CCT Pilot period.

Morbidity: Decrease in Patient Falls

The number of in-hospital patient falls is an important measure of patient safety recognized in literature and hospital performance reports. TEGH receives quarterly reports of in-hospital falls, and the last report included data up to December 2008. For that month, only one unit had

⁵ A nosocomial bacteremia is a blood stream infection that was acquired after a patient was admitted to the hospital. These numbers are publicly reported on the Ministry of Health & Long-Term Care's website.

implemented the CCT pilot, F3 Oncology. In December, there was only one patient fall reported. This represents a rate of 2.35 falls per 1000 patient days while the internal benchmark for falls is 3.46 falls per 1000 patient days. These results are encouraging; however, this indicator requires ongoing evaluation due to the short observation period in order to determine and confirm sustainable improvement in the number of patient falls.

Morbidity: No Post-Admit Pressure Ulcers

A pressure ulcer that appears on a patient after they are admitted to the hospital is another important and accepted indicator of patient safety. Post-admission ulcers can appear when patients are not tended to on a regular basis and assessed for positioning. During the post implementation period there were **no incidents of post-admission pressure ulcers** on any of the pilot units, while the same period last year one pressure ulcer was noted on two of the pilot units. As with some of the other measures included in this evaluation these encouraging results should be tempered due to the small sample size.

Mortality: No Changes in Patient Mortality

A hospital's overall mortality rate is a high-level quality indicator that is monitored by most organizations. Using a mortality measure such as the Hospital Standardized Mortality Ratio (HSMR) at the unit level is not possible due to the unavailability of data. However, as mortality is a key component of the evaluation framework and such an important measure of patient safety, raw mortality rates for the three units has been monitored. The rate for all three units do not show a significant change in mortality compared to the same units last year; however, the mortality rate for all three units combined is trending downward. (Fig. 3)

Figure 3: Raw Mortality Rates

Mortality Rate	
Post Implementation (all 3 units)	7.2%
Pre Implementation (all 3 units)	9.5%

5b. Patient Satisfaction

Patients of the CCT pilot units were asked three survey questions during a post-discharge phone call related to availability of nurses and timeliness of assistance. Responses were compared to the same data from NRC+Picker survey's from the same time period last year. The results indicate that **patient satisfaction increased** during the post CCT implementation time periods on all three units. Response rates and time periods for these questions can be found in Appendix 4.

Figure 4. Patient satisfaction survey results

How would you rate the availability of your nurse? (%)	F3		B3		B5	
	Pre (A3)	Post	Pre	Post	Pre	Post
Excellent, Very Good, or Good	72	96	72	77	90	97
Fair or Poor	28	4	27	23	10	3

When you need help getting to the bathroom, did you get help in time? (%)	F3		B3		B5	
	Pre (A3)	Post	Pre	Post	Pre	Post
Always	53	89	43	68	50	86
Sometimes	23	6	21	23	28	12
Never	23	6	36	9	22	1

In general, after you used the call button, was the amount of time you waited for help reasonable? (%)	F3		B3		B5	
	Pre (A3)	Post	Pre	Post	Pre	Post
Always	61	85	64	31*	47	83
Sometimes	24	8	18	53	47	16
Never	16	8	18	16	5	1

* Caution: data from this unit shows call bell use is significantly lower than on other units. Further analysis required to determine possible reasons.

Patient complaints have **decreased between 58 to 78%** on two units when compared to the same time period in 2008. One unit (B5 Surgery) did not have any complaints during the same time period last year, nor have they had any complaints since CCT implementation.

In addition to the quantifiable indicators used to measure the implementation of the CCT pilot project, supervisor and manager rounding of patients supports the noticeable improvement to the patient experience revealed in the data. Patients and families have acknowledged that hourly rounding is occurring; personal needs are being met; patients know the names of their care providers; and, the immediate availability of the care team reduces their anxiety.

One patient describes their care on the unit: "Couldn't be better... when I ring this [call bell] someone is here within seconds."
 ~CCT Pilot Project Patient

5c. Resources

The amount of direct patient care hours, cost of the model, overtime costs, the use of agency staff and sick time pay for RNs and RPNs have also been monitored on the CCT pilot units during the implementation phase.

Nursing Hours

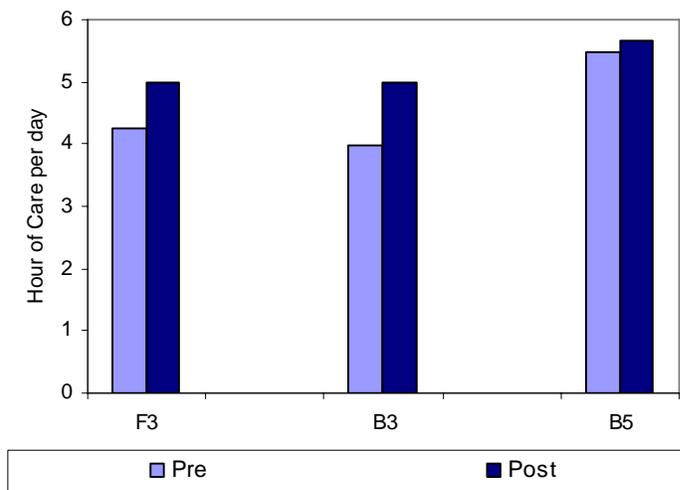
One of the parameters of the new model was to hold total nursing hours constant while shifting the total allocation of hours between RN's and RPN's. The preliminary results show that this parameter has been maintained averaging 4.1 hours per patient day both before and after the model was introduced.

Average RN/RPN Hours per Patient Day	
Pre Model	4.15
Post Model	4.12

Patient Care Hours: More Time to Devoted to Care for Patients

During the design phase of the CCT project, it was estimated that the number of direct patient care hours would increase by an average of 52 minutes per day on the three units. So far, all pilot units have seen an increase in total patient care hours, captured under Hours per Patient Day (HPPD). B3 had the largest increase of 60 minutes, or 25%; F3 had an increase of 41 minutes, or 18%; while B5 had 8 more minutes or 4% added per day. As time in the CCT model of care progresses, the HPPD will continue to be monitored.

Figure 5. Patient Care Hours Pre & Post-Implementation



Overtime, Agency & Illness: Improvements Make for a Better Work Environment

Overtime, agency use, and illness pay were tracked for RNs and RPNs on F3, B3 and B5 in order to monitor the work life experience. The monthly averages from the pilot units were compared with pre-pilot average monthly rates for the same units prior to CCT implementation. Hours attributed to modified workers were removed for all of the pre- and post- averages for sick time. (Figure 7) Due to the confounding impact of mid-month starts of the pilots, and the need for staff to attend CCT training, data collection began in the second month of each pilot unit for overtime and agency use.

Figure 7: Changes to Overtime, Agency Use and Sick Time per unit

Unit	Overtime	Agency Use	Sick Time
F3	Decreased 31.9%	Decreased 88.8%	Decreased 55.9%
B3	Decreased 13.0%	Decreased 100.0%	Decreased 20.8%
B5	Decreased 20.2%	Decreased 100.0%	Increased 8.5%

As with any change of this magnitude, initial increases in overtime, agency use and sick time were expected and visible in the immediate weeks post implementation. However, as time progresses in the CCT pilot units, the initial increases have reduced drastically. This important measure helps demonstrate that staff is effectively able to manage their work environment, while the quality of work life is not eroded under the new model of care.

Nursing Resource Team: Decreasing Reliance on NRT staff

Another measure of resource-use monitored during the implementation phase is the use of the Nursing Resource Team (NRT).⁶ The use of the NRT has decreased slightly since implementation; however, ongoing monitoring of NRT use is required.

Staff Turnover: Having a Stable Workforce

Turnover on the units has been minimal and demonstrates stability of the workforce. In fact, there has been no turnover among the nursing staff while there have been two PCAs that returned to their previous role in the NRT due to schedule conflicts.

Cost of the Model: Sustainable Costs

The cost difference of the staffing model was calculated by comparing the direct care costs in the base model to the current CCT team consisting of RN, RPN, and PCA. (Figure 6.) It is

⁶ The Nursing Resource Team (NRT) is a pool of staff that provides coverage and replacement of unit based staff as required.

believed that this is due in large part to the reduction in agency, overtime and sick time usage on the pilot units.

Figure 6. % Cost reductions per unit

Unit	Cost Reduction (%)
F3	0
B3	6
B5	6

5d. Staff & Physician Satisfaction

Staff Feedback

An electronic staff satisfaction survey has been utilized as one way to gauge staff perception of CCT during the implementation phase. The 22-question survey was distributed a number of times throughout implementation to determine trends and changes in staff perception of the model's efficacy. Detailed response rate information by unit and position breakdown can be found in Appendix 5.

"This program is wonderful. The patient's needs are being met every hour. We hardly hear any call bells and we don't have families standing at the nurses station asking questions."
~TEGH Staff

The results of the staff satisfaction survey indicate positive satisfaction levels with "role clarity", "manageability of workload over time" and "departmental communication" for two of the units.⁷ By March, 100% of the respondents from F3 strongly agreed or agreed that they "had confidence in each other to provide good patient care". Another trend that increased over time was the amount of respondents that indicated that they were proud to work in this model of care. This indicates that as teams adjust and learn to work in the CCT model of care, employee satisfaction and confidence in each other seems to increase.

Among the qualitative comments provided by respondents, concerns related to workload, learning needs and leadership clarity were illuminated. Concerns about workload were most salient during the first month of implementation and, as shown with F3, tend to decrease in later months. Workload statistics of CCT units have also been reviewed and do not reveal an increase in actual workload. Modifications to the assignment of work have been tested and support has been provided to enhance the leadership of the teams.

Comments related to learning needs and leadership clarity were mixed, with some requesting more training and some feeling that there was too much time spent on training. Some reported a very "solid" and professional team dynamic, while others reported difficulties with specific interpersonal relationships.

The feedback provided by staff in the surveys is a critical evaluation tool used in the continued support and implementation of CCT. For a summary of staff feedback provided that has been used to influence CCT implementation, please see Appendix 6.

Physicians

The trends in physician satisfaction were similar to staff. Overall, physicians were fairly neutral in their quantitative responses, with the majority (n=6) saying they neither agree nor disagree with the following statements:

- The quality of patient care has improved.
- The number of patient complaints that I have received has decreased.
- The CCT model has increased our ability to work effectively as a team.

⁷ Represents trends from F3 Oncology and B3 Acute Medicine. B5 Surgery only has 1 sampling at this time, trends cannot be determined as only one round of survey's have been collected.

However, it should be noted that physicians who neither agreed nor disagreed with the statement, ‘the number of patient complaints that I receive have decreased’ went further to indicate that they did not receive any complaints from patients prior to the CCT model's implementation.

Positive perceptions from physicians improved through time following implementation. Ongoing engagement of physicians will be required in the implementation of CCT.

“The team work is bringing them [staff] together, it’s wonderful... I have not heard a single patient complaint”
-TEGH Front Line Physician

6. DISCUSSION AND RECOMMENDATIONS

The move to a coordinated care team model represents a significant shift in how staff provide care to patients and families at Toronto East General Hospital. This model represents not only a change for each provider but also a change in how the team communicates and collaborates on patient care. Because this is such a significant change many new processes and structures have been instituted to the care delivery model. The staff and physicians on the model unit are to be commended for their efforts and enthusiasm while engaging in such a significant change. The results to date are very encouraged.

In recognition of this continuous quality improvement initiative, metrics are continuously evaluated and feedback is taken seriously and suggestions are incorporated into the model. This is a fine example of a “Plan Do Study Act” (PDSA) cycle, meaning continuous evaluation and ongoing data updates all the while pausing to reflect with our stakeholders and improving as we go.

At this juncture the results are substantive enough to continue to pilot the existing units and move on to further pilot units over the summer.

7. APPENDICIES

Appendix 1. Health Care Education Requirements Timeline

Healthcare Professionals Education Entry to Practice					
	1960s	1970s	1980s	1990s	2000s
RN	1960s 2 year college or 3 year hospital diploma program	1970s 2 or 3 year community college diploma			2005 4 year baccalaureate university degree
RPN	1967 "RNA" certification - regulated 35 week program				2005 2 year community college diploma
PSW	Health Care Aide - 500 hours of learning			1997 Personal Support Worker - 1 year community college program	

Appendix 2: Unit Composition of Core Team

Day shift core team composition for CCT Pilot Units:

B3 – Medicine: 1RN 2 RPN 1 PCA

B5 – Surgery: 2RN 1 RPN 1 PCA
(two teams) 2RN 1 RPN 1 PCA

F3 – Oncology: 1RN 2 RPN 1 PCA

Appendix 3: Design Team & Stakeholders

50 Design Team members included representation from:

- Registered Nurses
- Registered Practical Nurses
- Social Workers
- Occupational Therapists
- Physical Therapist
- Speech Language Pathologists
- Dietitians
- Pharmacists
- Respiratory Therapists
- Physicians
- Physician Assistants
- OT/PT Assistants
- Diagnostic Imaging Assistants
- Nursing Practice Leaders
- Medical Laboratory Technologists
- Support Services representatives
- Managers of Medicine Health Service
- Manager of Surgery Health Service
- Manager of Organizational Learning & Change
- Director of Medicine Health Service
- Director of Surgery Health Service
- Chief Nursing Officer & Vice President Patient Programs
- Utilization Management Specialist
- CCT Project Manager
- Human Resources

Internal Stakeholder Consultations

- Five staff focus groups with staff on pilot units
- TEGH Community Advisory Committee
- Two health professions staff focus groups
- Updates at Administrative Management Meetings (management meetings)
- Updates at Open Forums (all staff meetings)
- Updates at Nursing Practice Council
- Updates at Professional Practice Council
- Updates to Unit Based Partnership Councils
- Updates at Medical Advisory Committee
- Internal Ontario Nurses Association Members(ONA)
- Internal Service Employees International Union Members (SEIU)

Appendix 4. Response Rates & Times from Patient Satisfaction Surveys

Survey Question	Answers	F3		B3		B5	
		A3 Pre %	Post %	Pre %	Post %	Pre %	Post %
Weeks of Pilot Data (as of 31/03/09)		24	18	24	11	24	6
Total Number of Respondents		45	52	40	52	32	136
Response Rate		32.6%	80%	28.0%	57%	42.7%	66%

Appendix 5: Response Rates from Staff Satisfaction Surveys

	Total Replied to Survey	F3				B3		B5	NRT			
		Dec	Jan	Feb	Mar	Feb	Mar	Mar	Dec	Jan	Feb	Mar
RN	46	2	4	1	1	8	6	10	3	2	2	7
RPN	24	2	0	5	1	1	4	6	0	0	2	3
PCA	8	1	0	3	0	1	1	0	0	0	1	1
Allied Health	9	2	0	0	2	1	2	1				
Other	11	4	1	0	2	2	1	1				
Total		12	5	9	6	13	14	18	3	2	5	11

Appendix 6: Ongoing feedback incorporated into CCT model

Based on preliminary feedback on the model and the implementation process, we have already made the following changes to the pilot process:

What We Heard	How We are Responding
<p>There is a need for ongoing educational support to help with the increased scope of practice for RNs and RPNs</p>	<p>Increased Nursing Practice Leader/Specialist presence for educational support for RNs and RPNs during the initial stages of implementation.</p> <p>We are also considering an RPN Coach position to support practice enhancement for the RPNs.</p>
<p>There is a need for increased time on nursing skills during orientation and training</p>	<p>Provided extra training on F3. Incorporated extra skills training time into the curriculum for B3 and B5.</p>
<p>There is a need for increased emphasis on decision making and leadership skills for the RNs</p>	<p>Included additional emphasis on leadership and decision making for RNs in B3 and B5 training. Providing ongoing developmental support for individual RNs via the NPLs and supervisors on the units.</p>
<p>There is a need for ongoing work on interpersonal relationships and team cohesion</p>	<p>Working to support partnership councils as the venue to create and sustain healthy work relationships.</p>
<p>“RPNs are being assigned more patients and RNs are not providing direct patient care”.</p> <p>This was a concern about the distribution of workload, particularly the distribution of direct patient care.</p>	<p>Clarification on the idea of “assignment” and shared accountability. It is not the intention of the model that RNs will no longer provide direct patient care. Instead, teams negotiate accountability for direct patient care tasks depending on the complexity of the patient, the experience of the practitioner, and the amount of environmental supports.</p> <p>RNs are expected to provide direct patient care. The process working group is establishing language and policies that will make this clearer. Teams continue to evolve in their understanding and appreciation of scope of practice and</p>

<p>On B5 it was clarified that there were not enough relief staff trained in CCT in February. The RNs found they had to spend more time than expected providing direct support to the RPNs from NRT</p>	<p>collaborative practice.</p> <p>Increased staff trained in CCT from NRT</p>
<p>Challenge of understanding role and role clarity</p>	<p>Although the perception of role clarity improved over time, the fluidity of the model did generate some confusion for people in the early stages of change.</p> <p>The feedback from teams is that they need to practice within this model to generate role clarity over time.</p> <p>The staff of each of the pilot units, through the feedback mechanisms, have contributed many tips and hints that have resulted from their learning on how to conduct the activities inherent in their roles in the new environment. These are being made into a handbook to assist nurses in their new roles</p>
<p>Unequal distribution of work between shifts, creating larger burden on the day shift</p>	<p>Pharmacy reviewed medication administration practices on F3, making the observation that the majority of dose administrations occurred in the morning.</p> <p>Recommendations were given to increase efficiency and balance the workload more effectively throughout the day.</p>