Team assessment and action plan at Island Bay Medical Centre

The Primary Care Team Assessment (PCTA) was completed by a cross section of the team at Island Bay Medical Centre (IBMC). Responses were received from GPs practice nurses and reception/admin staff. Analysis of the data showed consistently high scores – Consolidating and advanced in the following areas:

- Engaged Leadership
- Population management
- Data driven improvement
- Continuity of care
- Good communication with patients
- Broad range of services provided by nurses
- Involving patients in decision making
- Development of care plans

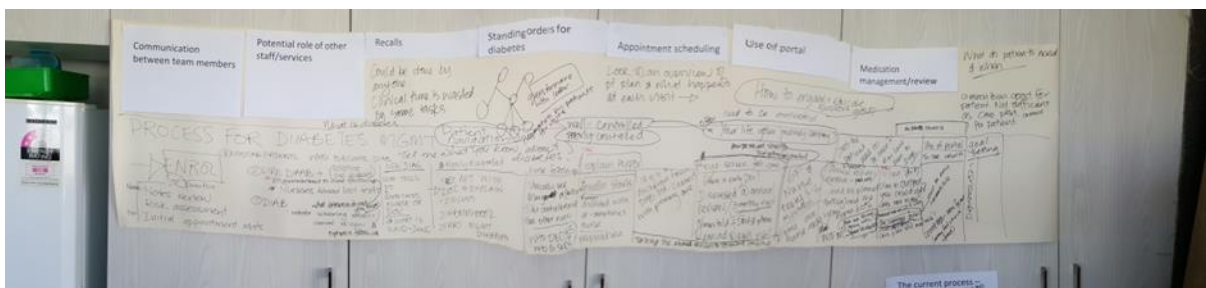
However, in other areas there was wide range of responses – beginning, improving, consolidating, advanced. These areas include:

- Workflows for clinical teams
- Medication management
- Access to pharmacy support
- Access to behavioural or mental health services
- Linking patients to community support and services
- The role of health workers
- Staff effectiveness at building patient understanding
- The principles of patient-centred care

An all of practice workshop was organised where the results were fed back and discussed. Two main issues were identified through the discussion

- There had been a significant turnover of staff at IBMC over the preceding year to eighteen months. The introduction of new team members brought new ideas and different ways of doing things and this in turn led to variability in service delivery and resource utilisation.
- The team had consistently scored themselves highly for 'development of care plans'. Through the discussion it became clear that there were differing views around what is meant by a 'care plan' as opposed to a 'treatment plan'.

Most of the issues that had a wide range of responses in the PCTA are fundamental components of care planning. Given this the group participated in a facilitated discussion around their current diabetes annual review (DAR) care planning process.



Issues and opportunities

The following issues and opportunities were identified:

- Some tasks do not require clinical input and clinical time is wasted on these
- Maybe useful to look a patient plan and identify what happens at each visit
- How are patients supported to prepare for regular diabetes appointments?
- Children with diabetes treated by DHB then discharged at 18 – transfer to primary care not well supported. Young person may have no other reason to visit a GP and is used to DHB system of recall so may not initiate contact with GP
- Annual reviews can seem like a massive undertaking for patient and nurse. About 60% of people eligible for annual review complete them. Could be more forward looking rather than review of last year
- The need for a regular visit can be discussed with a nurse – if someone has been to the DHB recently, they may not need their recall appointment
- We need to be using a consistent care plan for diabetes. IT must be easy to use and access. The common form is good for patients but not sufficient as care plan - also need clear information for clinical team (e.g. Compass new form, the promise, care-pad plan). Need goal setting, able to add information such as foot check results
- Often need to repeat information as it becomes more relevant to people (e.g. re-explain hypos after their first hypo)
- Better follow-up re eye-screening (why it is important and making sure it's done – especially when it can become a problem if not managed well with young people)
- Good question to check prior knowledge - 'Tell me what you know about your diabetes already?'
- Using 'teach back' to check understanding.

This list was narrowed down and priority problems identified:

- DAR can seem like a massive undertaking for patient and nurse
- DAR could be more proactive. May be useful to plan and identify what happens at each visit
- How are patients supported to prepare for their regular visits?
- The need for regular review can be negotiated between the patient and nurse, this should be flexible and reactive to individual's needs.
- There is a need for consistent care planning.
- Better follow up re retinal screening and foot checks
- Some tasks do not require clinical input time is wasted on this – recalls

The Island Bay Medical Centre Care Planning (starting with diabetes) Implementation Action Plan was developed.

Example action plan

Island Bay Medical Centre redesign of Diabetes Annual Review and introducing care planning.

1. **Interventions.**	Steps to achieve
Implementation of the new DAR/ LTC plan – see below	• Plan reviewed by LTC subgroup – changes as needed • Define roles • Present plan to wider practice team
Implement the common form.	• Staff education on the common form, its use in LTC management and how to utilise. • Organise BPAC to come and provide a staff education session.
Development of screening terms to prompt and plan for components of the DAR to be covered.	• Develop tool • Educate staff how to use as part of the implementation plan.
Regular review of diabetes disease registries through IT systems. Identify those who are not on a LTC program and those with suboptimal clinical outcomes as per our practice plan	• Define the roles/ responsibilities • Use of Practice outreach nurse to facilitate engagement for those hard to reach and high needs. • Consider home visits for plan of care.
Define roles and responsibilities within the practice team to ensure consistent use of the teams skills for when an individual requires it.	• HCA in LTC care • Reception / admin • Specialist diabetes nurses • LTC nurses • GP • Outreach nurse • Wider multidisciplinary team: podiatrist, endocrinologist, pharmacy, dietician
Consistent advocating for SM programs available within the community to facilitate timely enrolment when individuals are ready • Make this part of routine visits. • Use of IT tools to communicate upcoming SM programs. Txt/ MMH – emails.	• Txt email notification to all diabetics advising of programmes date/times/contact • Team members to discuss SM programs at consults and add reminders via the task bar when programs become available for those who do not use Txt/ email. • Key team members to identify when these SM programs are through regular review of Compass health provider portal and feed back to team members.
Use of additional SM support and education packages individualised to the patients behaviours, belief and needs.	• See plan: LTC 4 as and when required if patients want appointments scheduled close together to support SM. • Consistent use of asking patents what they already know. • Use of IT tools MMH/ txt to assess problem and accomplishments

2. REDESIGN

PLAN current LTC patients Action	Time	By who
Diabetic patient will enrol in the new model of care	60min	LTC nurse enrols client / HCA
• Pre consultation questionnaire is sent to patient before appointment (may be done over the phone if literacy is an issue) discussing new model of care • Bloods?		LTC nurse/ HCA
LTC annual care planning appointment: Plan of care	60min	GP 15-30min Nurse 60 min
Standard pre-consult checks – height, weight, BP, BSL, BMI.		Nurse/ HCA
Cover patient concerns/ review questionnaire with patient (may or may not be diabetes / LTC related)		Nurse/ GP
Review common form to ensure consistent care		Nurse/GP
Foot check : High risk feet to be checked at each consecutive appointment		Nurse
Plan appointments in conjunction with the clients: What aspects of the DAR are to be covered when, in response to patient need. Plan testing such as bloods as required or needed.	LTC 1: annual review only LTC 2: review every 6 months LTC 3: review every 3 months	
Consider additional LTC 4 appointments on top of the regular appointments – using the LTC funding pool/ These can be used for extra SM support, education, stabilisation as required by the patient. Appointments can be 30-60 min up to 4 extra a year on top of routine LTC program. If these are used consider outreach funding pool. Consider MDT input	The above aspects may take considerable time. Utilising LTC4 is a way to overcome this. It could also be used for the planning of care part. LTC 4 can be 30-60 min appointment as as required	
collaborative development goals / care plan	Give a written hand out with goals and planned care.	Nurse
LTC 3: review every 3/12 +/- LTC 4	30min	
Review patient goals/ concerns Review planned care as per LTC 1 Review and complete components of Common form. Review management options.		GP/nurse

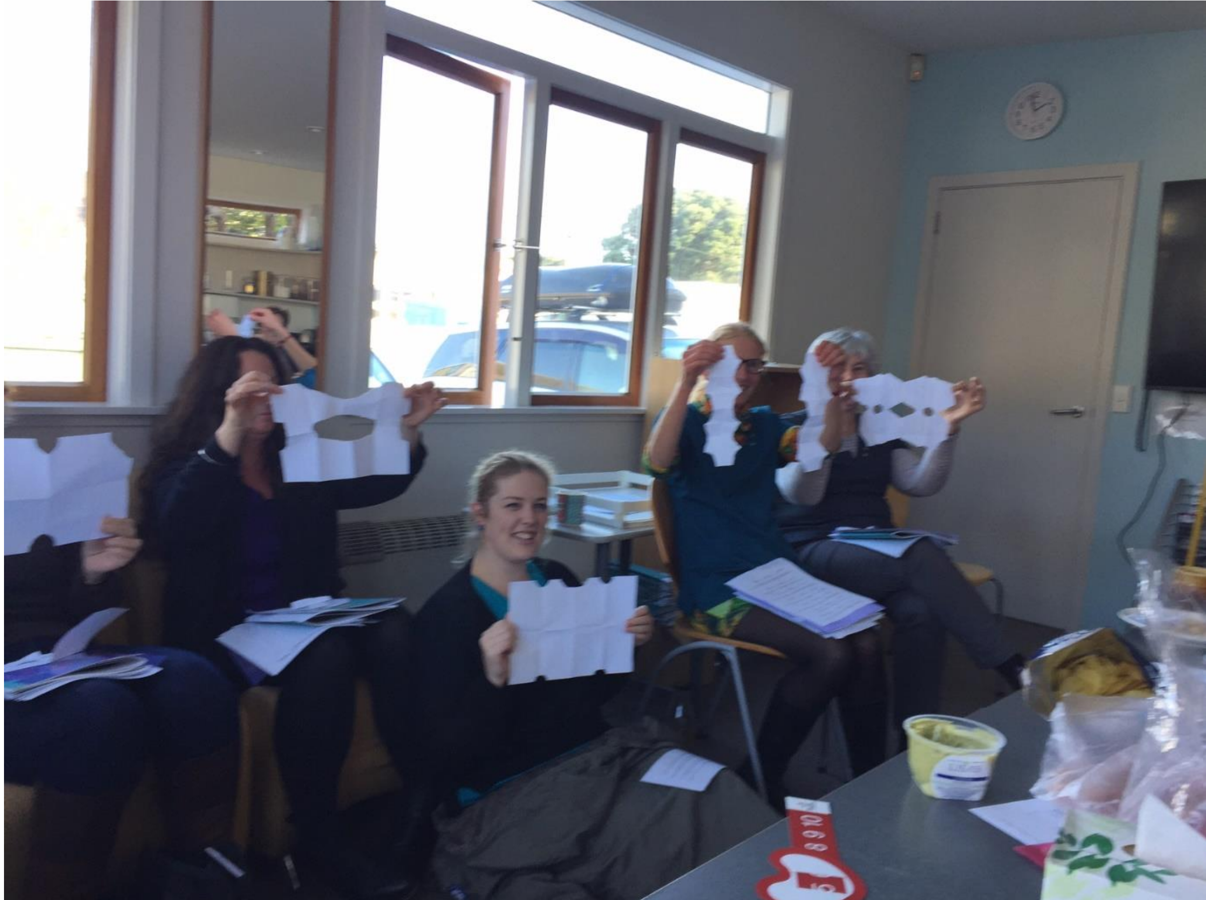
LTC 2: 6 month review +/1 LTC 4		
As above for LTC 3		Nurse +/- GP
LTC 1: +/- DAR and LTC4		
As above for those who are well controlled and can SM effectively.		Nurse +/- GP
DAR 9-12 months after care planning appointment.		
Address: patient concerns. Gaps that haven't been covered yet. Use common form and screening term.	45min	Nurse: could be with specialist diabetes nurse if a number of complex concerns identified.
DAR should be a planned appointment taking away the need for recalls. If they are due for the DAR review before the 9/12 reschedule recall to 9/12 after the LTC For those well controlled it may not be required.	This may affect data for DAR for the first year, initially creating a drop. However, knowing there is more consistent approach it may or may not be able to be completed before the date it is due.	

Action Plan Timeline

	Nov/Dec 2016	Jan/feb 2017	March 2017	April 2017	May 2017	June 2017	July-Dec	Jan 2018	May 2018
Define problem, understand current process and practice (process mapping w/s)									
Identify project team, establish regular project meeting times (clear diaries)									
Identify tools and resource requirements for practice									
Education sessions for staff of care planning and components:									
Whole team engagement and preparation for new process and roles									
Start new process with LTC diabetic patients who are enrolled for their ITC 1 care planning appointment.									
Establish regular review (PDSA), change as needed									
Review outcome measures (PHO defined and project specific)									
1 Year review									

Current plans

Island Bay MC now have an established working group of GPs nurses and admin staff who meet regularly and are steadily developing/trialling new policy, process, tools, and resources. The nurse leader coordinates this work. There is a schedule of ongoing education that includes internal updates and externally facilitated workshops.



Externally facilitated care planning training session at Island Bay MC. June 2017 showing how differently we all interpret the same instructions. (This highlighted for the team the importance of the ABCs – Ask, Build, Check where Check = **"Check you've been clear")**