Engaging a mobile outreach team to standardize and improve services

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What are we trying to accomplish?

Background
The Long Term Care Behavioural Support Outreach Team (LTC BSOT) is a mobile multidisciplinary team consisting of Registered Nurses (RNs) and Personal Support Workers (PSWs). Formed in 2012 as a provincial initiative from Behaviour Support Ontario, Canada, the team services 36 LTC facilities in Toronto and works collaboratively with LTC staff to create and implement behavioural care plans to manage responsive behaviours associated with dementia.

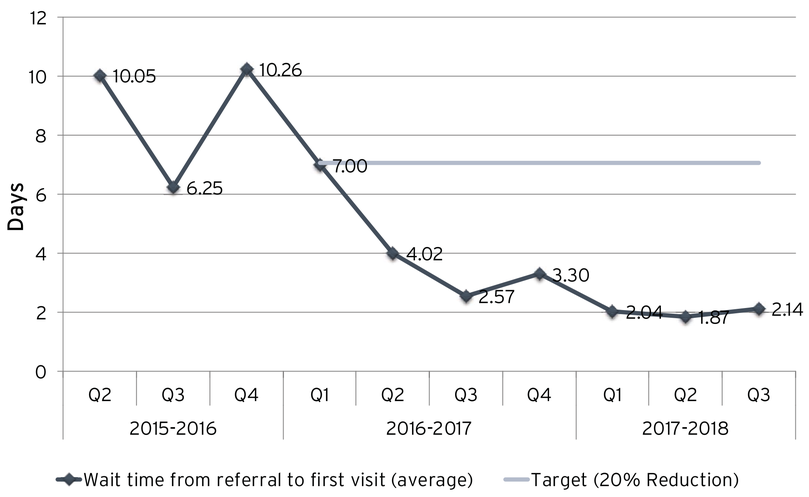
Problem
Impact survey feedback from LTC facilities served indicated difficulty with sustaining behaviour care plans developed by the LTC BSOT upon resident discharge from service. In addition, data review indicated lengthy wait times from referral to first visit and a lack of established baselines for length of stay. There was a high degree of variability in administrative and clinical processes utilised by the team members that needed to be addressed in order to enhance team efficiency and maximize the impact on customers.

Aim
To enhance flow/supported transitions to/from LTC homes by standardizing processes and improving turnaround time from referral to first visit.

How will we know if a change is an improvement?

OUTCOME MEASURES

1. Average wait time from referral to first visit
Average wait time from referral to first visit improved by 77%.



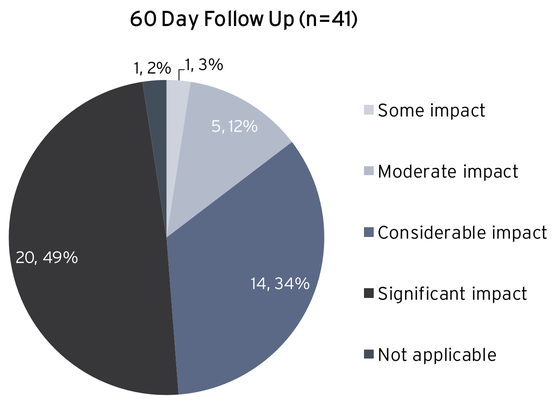
2. Impact of LTC BSOT service
An impact analysis completed in April 2015 with 36 LTC facilities served by the LTC BSOT indicated that behavioural care plans were not sustained once residents were discharged from the service. Post-implementation, the impact of the BSOT was measured through new 30 and 60-day follow-up surveys. Preliminary results indicated that at 60 days post-discharge 86% of facilities felt the BSOT had a considerable or significant impact on their team's confidence and capacity to manage residents with responsive behaviours.

Pre-Implementation
"Generally good recommendations are made, but the impact is stalled by the ability of LTCHs to carry out recommendations"

"We struggle [with] how to communicate the strategies to all staff"

- TC LHIN BSSP Impact Analysis, 2015

Post-Implementation

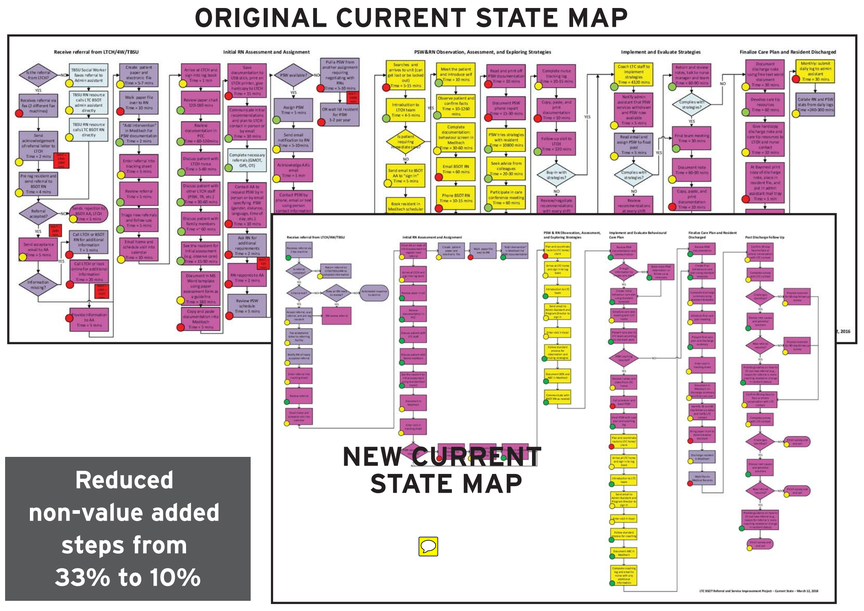


PROCESS MEASURES
1. Registered Nurse adherence to service pathway
2. Personal Support Worker adherence to service pathway

What change can we make that will result in an improvement?

Using a Lean approach, the BSOT analyzed the current state, identified opportunities and countermeasures, and drafted a future state. Throughout the project a core working group of RNs and PSWs, with management and Quality Improvement support, met bi-weekly to monitor progress, identify barriers and problem solve.

ORIGINAL CURRENT STATE MAP



Reduced non-value added steps from 33% to 10%

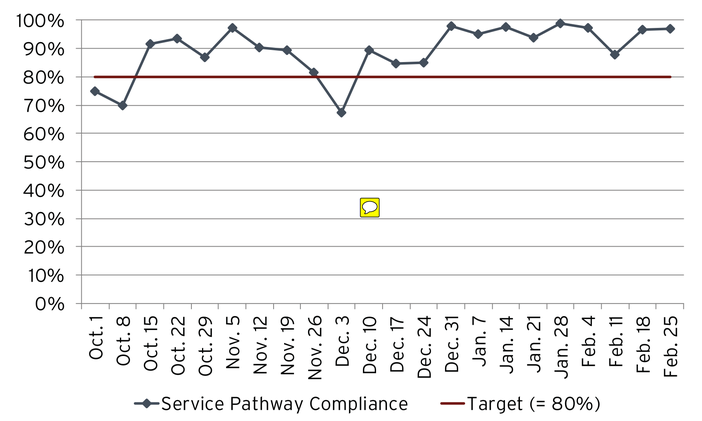
Twelve priority opportunities were identified and interventions were designed by BSOT working groups. Just-do-its included job descriptions, upskilling, standard assessment and observation tools, care plans and discharge template, follow up surveys, orientation binders, and LTC information packages.

PDSA 1: REFERRAL FORM
New referral form developed and tested with 5 LTC homes. Usability evaluated based on feedback from homes and LTC BSOT. Through testing, fields for critical information were added and formatting changes were made to the form.

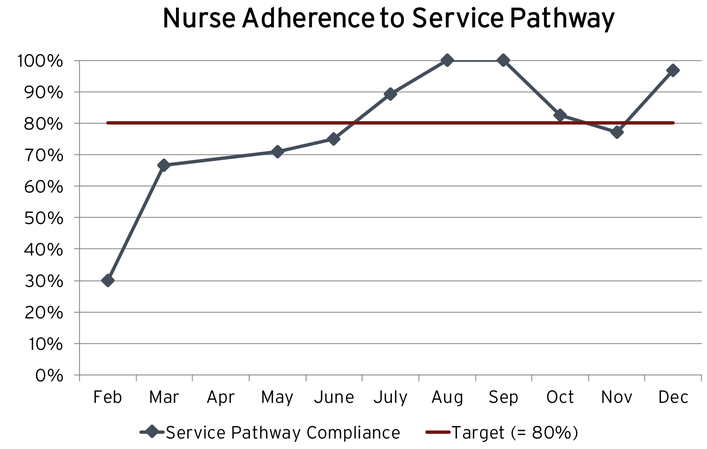
PDSA 2: SERVICE PATHWAY
New service pathway developed and tested with 3 LTC homes with high referral and utilization rates. Adherence to standard protocol measured. Through testing, new communication strategies identified for LTC homes; standardized templates and standard work created; and guidelines developed for non-standard cases.

SPREAD
Upon completion of service pathway testing, a spread plan was developed and the service pathway was rolled out to the remaining 33 LTC homes and all LTC BSOT team members. Adherence to the standard protocol was monitored by the team.

PSW Adherence to Service Pathway



Nurse Adherence to Service Pathway



What next?

Lessons learned
- Change doesn't happen overnight.
- Strive for progress, not perfection.
- Standardization does not reduce the ability to work autonomously but provides clinicians with a foundation to support their clinical judgement.
- With the right support and leadership, teams can be empowered to take ownership and drive change. Leadership qualities that facilitated change were: having a vision for change; setting SMART goals and deadlines; setting clear expectations; and consistentpresence/involvement in managing the project
- Opportunity to further improve LTC BSOT services: engage residents and families in the quality improvement journey.

Messages for others
- For mobile teams it is essential to build systems that support consistent communication and processes for collaborating with stakeholders to ensure consistent quality of service.
- Quality improvement doesn't have to be complicated. The BSOT started by designing and implementing basic interventions that targeted key leverage points and produced significant results.

Future directions
- Identify opportunities to engage LTC residents/family in method of service.
- Develop pathway for transitions in collaboration with cross-sectoral partners.

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