Project Title

Goal-Oriented Plan of Care (GOPOC) – A Pilot on Chronic Subdural Haemorrhage patients

Project Lead and Members

Project lead: A/Prof Low Shiong Wen

Project members: Dr Ira Sun, Dr Lim Su Lone, Theng Li Ping, Kelly Chan, Lim Kian Chong Chin Chi Hsien, Qiu Huaying, Jessie Chan, Kelvin Lew, Ng Yan Jun, Kristeen Peh

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Medical, Allied Health, Nursing, Administration

Aims

The project team aims to

1. Develop an individualised goal oriented plan of care that is Specific, Measureable, Attainable, Relevant and Time based (SMART) in alignment with best practices by May 2022
2. Reduce patient's average length of stay from 10 days to 7 days by August 2022

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

1. The team likes the approach of documenting goals and putting all key information in one page as it provides a quick summary and aligns the various team members However, the therapists and MSWs raised concerns on transcribing information to the MDM note
2. There are opportunities to collaborate with Medical Informatics to explore solutions to make MDM note data entries easier and promote team collaboration
3. Staff satisfaction improved as the team were more aware about the overall care plan of patients

Conclusion

See poster appended/ below

Project Category

Care & Process Redesign

Quality Improvement, Workflow Redesign, Job Effectiveness

Keywords

Goal-Oriented Plan, SMART goals, Plan of Care

Name and Email of Project Contact Person(s)

Name: Theng Li Ping, Diane

Email: li_ping_theng@nuhs.edu.sg

GOAL-ORIENTED PLAN OF CARE (GOPOC) – A PILOT ON CHRONIC SUBDURAL HAEMORRHAGE PATIENTS

✓ SAFETY ❑ PRODUCTIVITY
✓ QUALITY ❑ COST
✓ PATIENT EXPERIENCE

MEMBERS: A/PROF LOW SHIONG WEN (LEADER), DR IRA SUN, DR LIM SU LONE, THENG LI PING, KELLY CHAN, LIM KIAN CHONG, CHIN CHI HSIEN, QIU HUAYING, JESSIE CHAN, KELVIN LEW, NG YAN JUN, KRISTEEN PEH
SPONSOR: CLIN A/PROF GERALD CHUA

Define Problem, Set Aim

Problem/Opportunity for Improvement

With reference to COP.2.2*, the team currently have plans of care for patients, and they are interdisciplinary comprising of Drs, Nurses, PTs, OTs, MSWs. However the team acknowledged that current plans of care are problem oriented and documented separately. This creates data fatigue as the team gets blind sided with too much information and makes it difficult to see the progression of patients' well-being or understand the goals of care. This has an impact on patient's care delivery through their length of stay as the team clarify on patient's goals.

Hence, the team want to improve the patients' length of stay by writing goals of care for patients and identified Chronic Subdural Haemorrhage (CSDH) patients as the pilot group. Between March 2021 to December 2021, the median Average Length of Stay (ALOS) for CSDH patients was 10 days.

**JCI Hospital Standards, 7th Edition - Care of Patients (COP)*

Aim

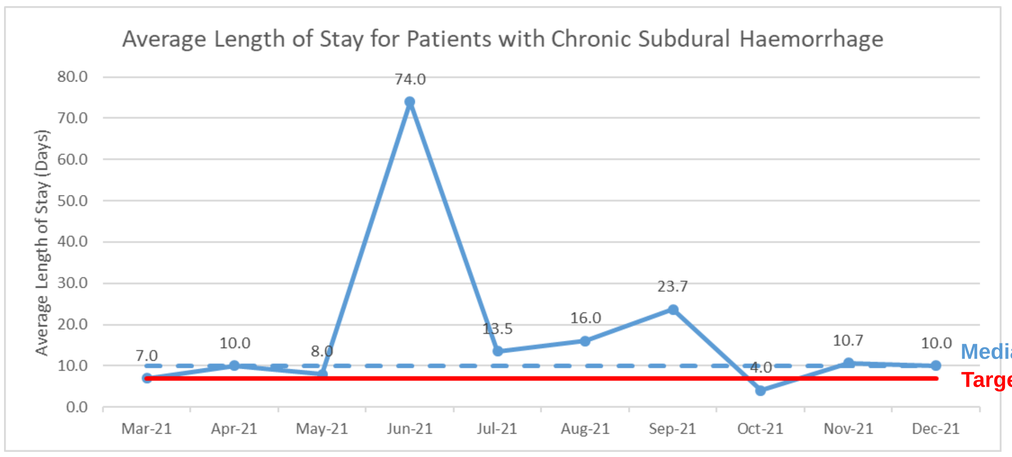
The project team aims to:

1. Develop an individualised goal oriented plan of care that is Specific, Measureable, Attainable, Relevant and Time-based (SMART) in alignment with best practices by May 2022.
2. Reduce patient's average length of stay from 10 days to 7 days by August 2022.

Establish Measures

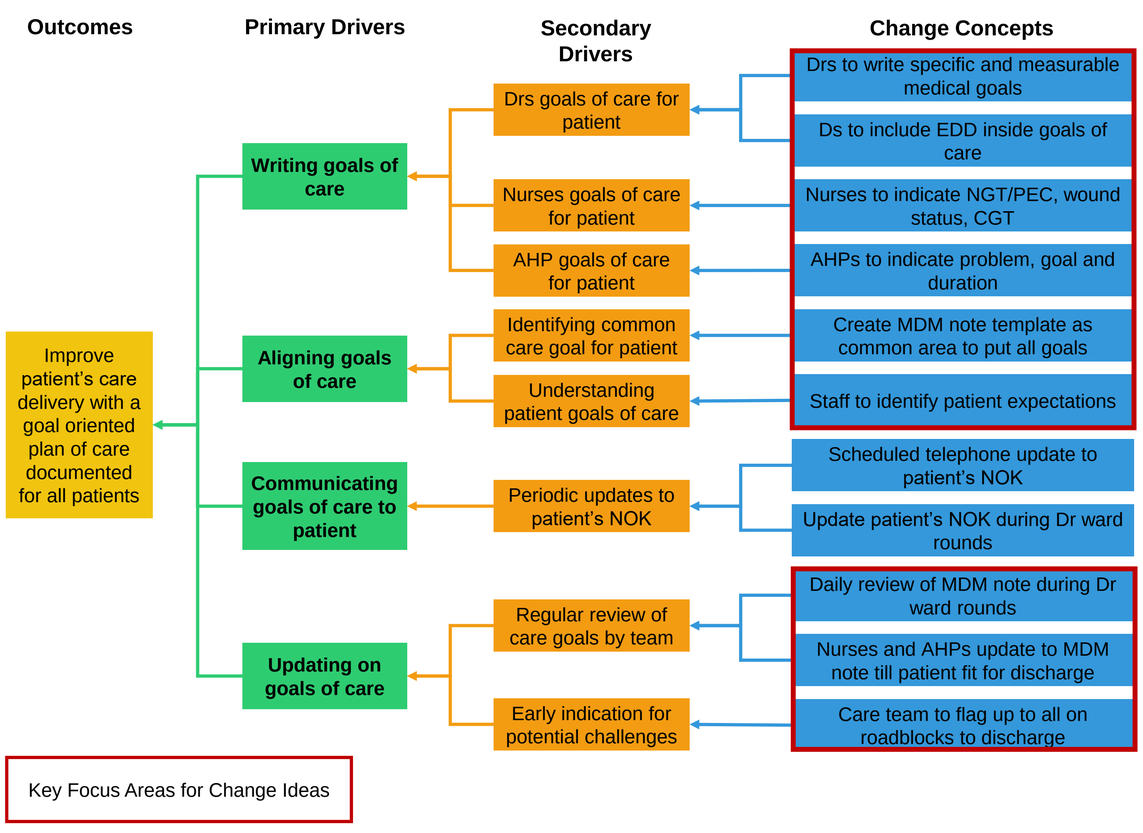
Performance <u>before interventions</u>

Baseline Median on ALOS for CSDH patients from Mar-2021 to Dec-2021 = **10 days**



Analyse Problem

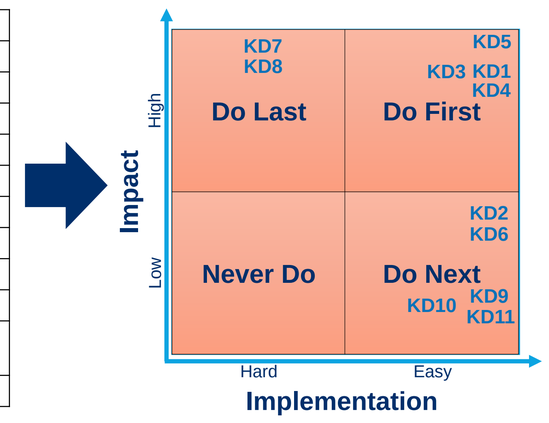
Key Drivers Contributing to Goal-Oriented Plan of Care



Select Changes

Prioritising Key Drivers for Testing using Impact vs Implementation Matrix

Key Drivers Selected for Testing	
KD1	Drs to write specific and measurable medical goals
KD2	Ds to include EDD inside goals of care
KD3	Nurses to indicate NGT/PEC, wound status, CGT
KD4	AHPs to indicate problem, goal and duration
KD5	Create MDM note template as common area to put all goals
KD6	Staff to identify patient expectations
KD7	Scheduled telephone update to patient's NOK
KD8	Update patient's NOK during Dr ward rounds
KD9	Daily review of MDM note during Dr ward rounds
KD10	Nurses and AHPs update to MDM note till patient fit for discharge
KD11	Care team to flag up to all on roadblocks to discharge



Test & Implement Changes

PDSA Cycles

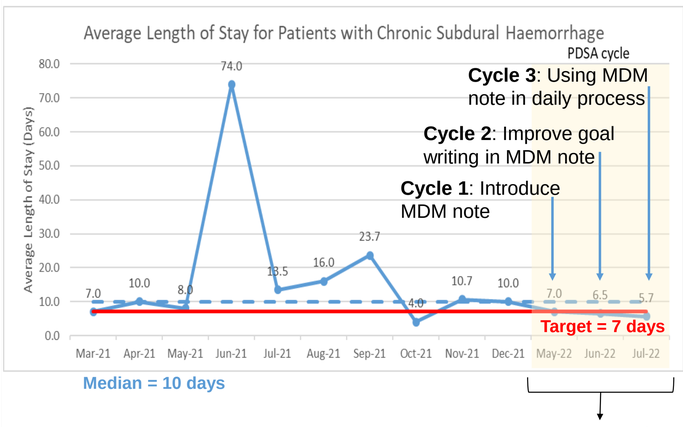
CYCLE	PLAN	DO	STUDY	ACT
1 (Create MDM note template)	**Change**: The team to introduce MDM note (KD1, KD3, KD4, KD5) in Epic to input patient goals. **Prediction:** With goals of care written concisely on a common page, communication within care team is prompt and should help improve patient's length of stay.	**What happened:** 1. The team discussed on MDM note components and Diane created SmartPhrase to generate MDM note in Epic. 2. The team tried out the MDM note on 3 CSDH patients presented to ward B12 in May 22.	**Observations gathered:** 1. MDM note gave an overview of goals from various care team members. **Unexpected Encounters:** 1. Drs feedback on the challenge of writing "Goals". 2. "Patient Expectations" were not filled as it was not clear.	<u>**Adapt**</u> this change. **Plan for next cycle:** 1. Team to seek expertise on writing of goals.
2 (Improve goal writing in MDM note)	**Change**: The team to look at how the goals written in the MDM note can be better (KD2, KD6). **Prediction**: With clearer goals of care, the care team can understand the patient's needs better and work towards a common goal.	**What happened:** 1. Project team sought JCI Consultants opinion on alignment to JCI standards. 2. Project team discussed on measurable (quantitative) and achievable targets for Drs and AHPs. 3. The team tried out on 2 CSDH patients presented to ward B12 in Jun 22.	**Observations gathered:** 1. EDD indication helped care team plan better for patient's discharge. 2. Rehab duration gave indication of patient's readiness for discharge / refer to JCH. **Unexpected Encounters:** 1. The team found potential gaps in instances where the MDM note is not updated.	<u>**Adapt**</u> this change. **Plan for next cycle:** 1. Build the use of MDM note into daily process 2. Team to review and update MDM note on progress of patient's conditions based on written goals.
3 (Using MDM note in daily process)	**Change**: Drs use the MDM note in their daily process (KD9, KD10, KD11). **Prediction**: With clear guidelines of using the MDM note in daily process, the team can visualise better how the goals of care will benefit them.	**What happened:** 1. Nurses furnished more information in MDM note (e.g. CGT) 2. The team continued using the MDM note on 3 CSDH patients presented to ward B12 in Jul 22.	**Observations gathered:** 1. Project team felt comfortable with the use of MDM note **Unexpected Encounters:** 1. Therapists and MSWs face challenge to transcribe information in various NGEMR notes.	<u>**Adopt**</u> this change. **Plan for next cycle:** 1. Scale up to show sustainability. 2. Collaborate with MI to explore easier solutions for MDM note entries.

MDM Note reflecting goals on a single page for team members to update progress of patient.

Main Caregiver: Self
Living Arrangements: Stays with wife and children
Referrals made: PT / OT

Staff Group	Inputs	Fit for home (Yes/No) / EDD
Patient	Personal expectations: Aim to achieve at least limited community ambulation, back to premorbid, able to go out with friends again.	
Doctors	Goals of care: Back to baseline Able to walk well and be independent Medically fit for discharge	Transferring to JCH Today 28/6/2022
Nurses	Any potential discharge issues identified during admission?: No *If yes, to inform team to refer to MSW.* Wound care management/education: - to keep dressing dry and intact - STO POD 10 (2/7/2022) Nursing Caregiver Training (CGT): NA	Yes
Physiotherapists (PT)	**Problems** **OT:** Pt likely close to baseline function. Requires SBA for BADLs and functional mobility. Limited by fair dynamic standing balance. **PT:** Current function appears slightly below baseline, requires SBA-CGA for functional mobility unaided, limited by reduced dynamic standing balance.	No
Occupational Therapists (OT)	**Goals and duration** **OT:** Pt will likely benefit from ~2/52 IP rehab, aim BADLs independent. **PT:** Patient would benefit from ~2-3/52 inpatient rehab to maximise function and aim limited comm amb +/- appropriate walking aid.	
Medical Social Worker (MSW)	Recommended discharge destination: Long term care plan:	NA
Questions to clarify/roadblocks to discharge from all stakeholders: *Eg. Patient's family requested for update*		

Performance <u>after interventions</u>



Spread Changes, Learning Points

Strategies to spread change after implementation

1. The overall outcome of the pilot is promising where we see improvements in ALOS with 3 points below the median line and showing smaller variation. This is an indication that the process is somewhat stable.
2. Project Team agreed to scale up the pilot and test on more CSDH patients in the next few months to demonstrate sustainability.

Key learnings from this project

1. The team likes the approach of documenting goals and putting all key information in one page as it provides a quick summary and aligns the various team members. However, the therapists and MSWs raised concerns on transcribing information from patient summary (which is displayed through the discharge milestone module in Epic) to the MDM note.
2. There are opportunities to collaborate with Medical Informatics to explore solutions to make MDM note data entries easier and promote team collaboration.
3. Staff satisfaction improved as the team were more aware about the overall care plan of patients.

Ng Teng Fong General Hospital

Jurong Community Hospital