

COMMITTEE MEMBERSHIP

CoChairs:
Alison Rowlands
Brenda Morgan

Members:
Nicole Alva
Patrycja Birbaum
Sherri Barton
Stacey Brown
Claudio Martin
Joanne Dickson
Alicia Fluter
Robin Given
Pam Gladysz
Savanna HouserDeacan
Claire Newton
Nikki Nemirovsky
Erin Penstone
Melanie Quinlan
Krista Shea
Gina Souliere

IN THIS ISSUE

Launch	1
Change	1
Proud Past	2
Upcoming Projects?	3
Did You Know?	3
Next Meetings	4
Bereavement Project	4

Patient and Family Experience in CCTC

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CCTC Patient and Family Experience (PAFE) Committee Launches First Newsletter

May 22, 2014 was the inaugural meeting of the CCTC Patient and Family Experience (PAFE) Committee. Initiated to revive and rebrand our former Humanistic Care/EOL Committees, PAFE's goals are to examine ways to promote positive patient and family experiences in CCTC. We will keep you up-to-date on our activities via a monthly newsletter (this being the first).

In our first meeting, we reviewed the needs and experiences of families from the literature, and recapped the many things that we do well in CCTC. Our future activities will build upon these qualities, as well as explore new and innovative ways to be even better!

How will we introduce change?

To avoid suppression of the unbridled enthusiasm within our group, we will be trialing a number of different initiatives at the same time. PAFE Improvement projects and project leaders are listed on Page 2. If you would like to become involved in any of these activities, please connect with the project leader. We also welcome new team PAFE members.

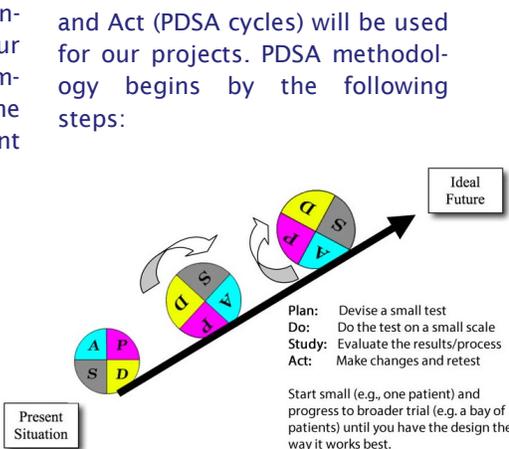
Change methodology adopted by the Canadian ICU Collaborative and Safer Healthcare Now! called Plan, Do, Study

and Act (PDSA cycles) will be used for our projects. PDSA methodology begins by the following steps:

- *Our visiting is open*
- *We involve families*
- *Our team pulls together to ensure patient's receive the best possible care*
- *We put ourselves in the shoes of the family*
- *We share information openly with families, and coordinate physician meetings when needed*
- *Provision of family journals*
- *Access to a "live" person in the waiting room (24-7)*
- *End-of-life care is well done*

The PAFE committee will meet the third Wednesday of each month in the CCTC conference room from 1300-1500 hrs. We welcome interested individuals from all groups within CCTC to participate on the committee or become involved in any of our project teams!

The work of the committee is available in the shared drive:
S://CCTC/shared/Patient and Family



PDSA Cycle Methodology

1. Develop a plan to evaluate an idea (**Plan**)
2. Conduct a small scale test by implementing the plan (**Do**)
3. Evaluate the results (**Study**).
4. Modify the plan and conduct a follow-up test (**Act**)
5. Repeat PDSA cycles with incrementally larger groups until desired outcome is achieved

Figure 1: Incremental QI using PDSA Cycle Methodology

Recapping Our Proud History of Caring

Our patient and family experience improvement initiatives date back to the early 1990's when we introduced open visiting and a co-primary nursing and RRT model. At the time, open visiting was considered to be "out there" and highly progressive! Today, our openness to families is an important part of our culture and source for unit pride.

By the late 1990's, we had our first family website implemented (called FOCIS for Family Oriented Critical-Care Information System), family information brochure and bereavement program.

In ~ 2006, we obtained a one year grant and the support of a MOHLTC Coaching team to enhance our End-of-Life care. Initiatives included the introduction of our family meeting record, process definitions for family meetings and team education. We renewed our commitment to this project by joining the EOL Quality Improvement initiative

In 2007, we began to track patient SDMs to facilitate both our bereavement program and family satisfaction survey. In January 2008, with guest speaker Dr. Harvey Chochinov (psychiatrist, palliative care physician and researcher responsible for the ABCD of Dignity Conserving Care model), we held a 2-day team training workshop. Standard patients were used to teach team-to-family communication skills, providing fuel for subsequent activities.

We took advantage of the post workshop enthusiasm, changing the name of our committee to the "Humanistic Care Committee" to better reflect our goals of improving the patient and family experience across the admission spectrum.

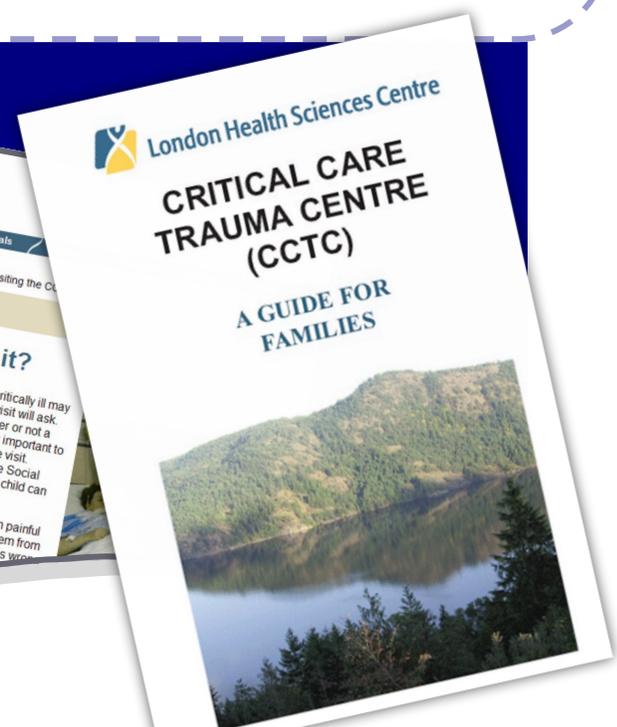
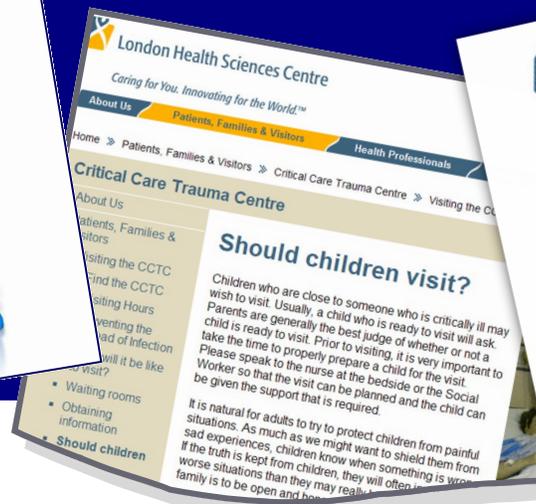
Through the Humanistic Care Committee, we developed process guidelines and a checklist for the withdrawal of life-sustaining treatments and implemented an RN/RRT EOL resource team, family journals). A

standardized order set for the withdrawal of life support was finally launched with HUGO.

At the end of 2012, we implemented our delirium quality project, which included strategies for partnering with families to prevent and manage delirium in critical care.

Now in 2014, we are once again focusing our attention on the patient and family experience. Over the coming months, we will be evaluating and enhancing existing strategies, and testing new ideas to promote quality experiences.

Please read our monthly newsletter to stay informed, and share your ideas on ways that we can all improve care.



Upcoming PAFE QI Projects

Over the coming months, PAFE committee members will examine a number of different strategies to enhance the patient and family experience.

Our initial projects are listed here along with the project leader. If you have suggestions or are interested in becoming involved in any of these initiatives, please contact the project leader.

- ⇒ **Enhance Bereavement Follow-Up Program** (Lead: Pam Gladysz)
- ⇒ **Develop EOL Supply Cart** (Lead: Stacey Brown)
- ⇒ **Promote Visiting Guideline Consistency (CCTC/TOU)** (Lead: Alison Rowlands)
- ⇒ **Develop Child Resource Kit** (Lead: Patrycja Birbaum)
- ⇒ **Shorten Time to Family Access at Patient Admission** (Lead: Melanie Quinlan)
- ⇒ **Improve SDM Identification** (Lead: Patrycja Birbaum)
- ⇒ **Develop Feedback Loop Family Satisfaction Survey** (Lead: Brenda/Alison)
- ⇒ **Introduce Patient Diary** (Lead: Brenda Morgan)
- ⇒ **Establish Assessment Process for Values/Family Needs** (Lead: Brenda/Patrycja)

Did you know?

- Did you know that the CCTC Unit Clerks maintain a database of all CCTC patients that includes the name and address of the patient's SDM, and that this information is obtained from data entered by the RN onto the Kardex ?
- Did you know that the name entered needs to match that of the legal SDM (a POA is automatic; if no POA, SDM is defined by Health Consent Act hierarchy)?
- Did you know that if we discover that the name on the Kardex is not the SDM, both the Kardex and Unit Clerk database needs to be updated?

- Did you also know that when a patient dies, the Unit Clerk needs to know whether the death occurred while the patient was receiving full treatment, after limits to further escalation in treatments were in place (withholding) or after withdrawal of life-support?

Figure 2: Section for documentation of SDM on Kardex

How is Database Used?

1. Mandatory Trillium reporting Rx at death
2. Bereavement Follow-up Program
3. Family Satisfaction survey

“Patients forget 60 % of what they were told the next day, but they never forget how you made them feel”

The Beryl Institute



All interested CCTC staff are welcome!

Monthly Meetings:

3rd Wednesday of each month

1300-1500 hrs

CCTC Large Conference Room



Don't keep them to yourself!

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Bereavement Program...our first PDSA Cycle

We first began our Bereavement follow-up program in the late 1990s. For several years now, Pam Gladysz has kept this valuable program alive, and we would like to extend our thanks!

Bereavement follow-up packages are mailed out approximately two weeks following the death of a patient. The packages are mailed to the individual identified as the SDM in the Unit Clerk tracking program (one of 3 reasons to ensure that this information is correct).

Package includes a signed sympathy card, a copy of the *Through*

Loss and Transition pathway booklet and information on how to obtain Social Work support. Patrycja Birbaum provides follow-up support and referral if needed.

Until recently, sympathy cards were being placed at the front desk and left for ~one week prior to mailing. The purpose was to give interested staff a chance to sign the card in advance of the mailout. Unfortunately, very few cards were actually being signed, so we needed to find a more successful approach.

We used this challenge to conduct our first Quality Improvement PDSA cycle, testing out the effect of adding the sympathy cards to the Death Packs. While we immediately saw some signed cards returned, we had overlooked the need to remind staff to identify the name of the patient! This quickly led to our second PDSA cycle, which is the addition of an instruction page along with the sympathy card (below).

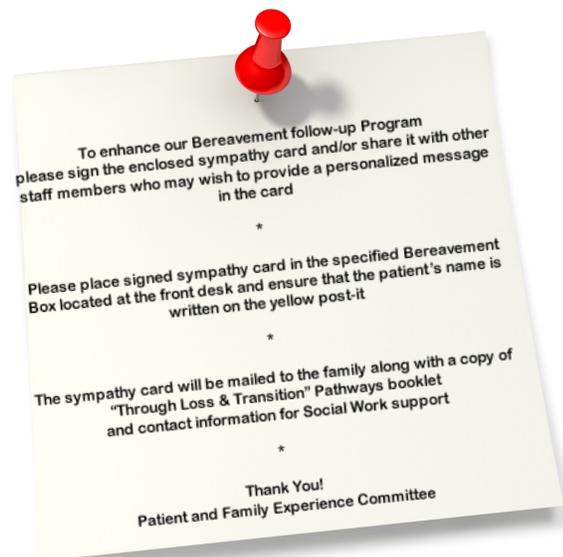
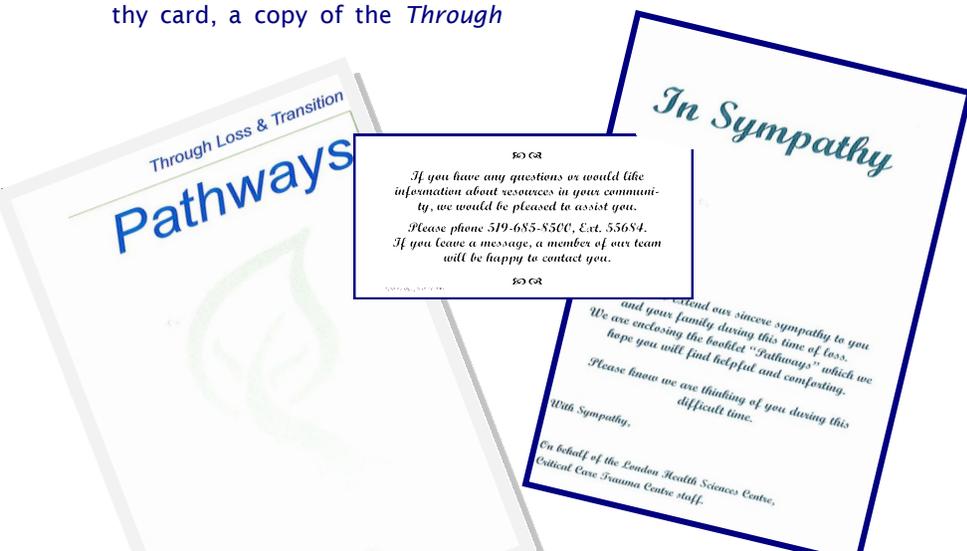


Figure 3. New instructions for sympathy card in Death Pack