PFCC Implementation/Action Plan for PNRHA

Background:

The current state of our health care system is one of a provider centered and system centered, one in which care is provided to patients and families. We assume that we know what is best for our patients. Patients receive care in a manner we think is best and families are largely left out of the picture.

In the Patient First Review, For Patients' Sake, Commissioner Tony Dagnone recommended that the health system make patient and family centered care (PFCC) the foundation and principle aim of the Saskatchewan health system, through a broad policy framework to be adopted system-wide (Dagnone, 2009).

Responding to this, in the Strategic and Operational Directions for the Health Sector (SOD), regional health authorities (RHA's) and the Saskatchewan Cancer Agency (SCA) have been tasked with developing a PFCC Implementation Plan by March 31, 2012, using the framework as guidance. In the framework, PFCC is defined as an approach to providing respectful, compassionate, culturally responsive care that meets the needs, values, cultural backgrounds and beliefs, and preferences of patients and their family members in diverse backgrounds by working collaboratively with them. To achieve PFCC, the following four core concepts of PFCC must be embedded as core values in the Saskatchewan health system and must be integrated into existing and new strategies and initiatives:
Dignity and Respect
Information Sharing
Participation
Collaboration

The term "patient" means any person who receives services or benefits from any programs within the healthcare system, including individuals who receive care from a hospital or a rehabilitation facility, clients of mental health and addictions programs, or residents in long-term care facilities.

The term "family" refers to one or more persons who are related in any way-biologically, legally or emotionally- to the individual receiving care. In the PFCC approach, the definition of family, as well as the degree of the family's involvement in healthcare, is determined by the patient, provided that he or she is developmentally mature and competent to make such a decision. Families can include not only bonds created by marriage and blood, but also to bonds created by close friendships, commitments, shared households, shared child rearing responsibilities, and romantic attachments.

Executive Sponsor(s): David Fan, CEO, Barbara Jiricka, VP Integrated Health Services, Glennys Uzelman, VP of Primary Health Services, Lionel Chabot, VP Development and Operations, Jerry Keller, VP Finance and Information Management, Irene Denis, VP Corporate Services

Team Leader: Jody Davidson – Director of Quality and Safety

Core Team Members: (Potential Steering Committee Members)
Louise Blais- CNE
Joanne Berry – Board Member
Bonnie O'Grady – Board Chair
Janet Tootoosis-or other physician?
(At least half of the members of the steering committee should be patient and family reps)
Additional teams members to be determined
Patient Family Members: (recommend 1:1 staff:pt family)

Ad Hoc Members:

PFCC Primary Drivers:

1. **Senior leaders commit, support and are accountable for PFCC redesign and implementation**

   AIM: Senior leaders are the driving force behind PFCC

   Secondary Drivers:
   - Decisions of senior leaders, board, management and committees determined by fit with PFCC values: respect and dignity, information sharing, participation and collaboration.
   - Key messages for leaders articulated (so every leader in the organization is giving the same message
   - Leaders are visible in the organization sharing key messages and expectations
   - Clear expectations for the staff are set and communicated
   - Resources (time and salary costs) needed for staff to learn and practice PFCC is allocated and protected
   - Senior leaders understand PFCC and practice leading with PFCC mindset (training required)
   - Leaders model PFCC by including patients and families in their work – strategy, policy development, etc.

Measures to track this process improvement:

- % of decisions at senior leader and board level that involve discussion of fit with PFCC values
- % of leadership committees that involve input or involvement of clients and families at a level they select.
- % family members present at LTC resident/family conferences

2. PFCC education and training for staff and providers

AIM: PFCC education and training exists and is available for all levels of staff and providers experience. Training design and implementation involves patients and families.

Secondary drivers:

- Patients and families involved in designing and delivering training
- Time. Allowing time for staff to participate in workshops/inservices
- Phased approach to education- initially test training approach with one unit and modify until project achieves what is intended
- Complete learning needs assessment re PFCC
- Identify formal and informal learning opportunities for staff in PFCC
- Integrate patient/family stories in every education, regional orientation, staff meetings, PAC, etc
- Incorporate expectations for PFCC into job descriptions, job interviews, performance reviews
- PN Quality Summit 2012 to focus on PFCC

Measures to track this process improvement:

- % staff per unit trained in PFCC: By end of 2012 20% of staff in a designated unit will be trained, by end 2013 90% of staff in a designated unit will be trained.
- # client concerns/ complaints reduced
- % of patients who rate their hospital as a 10
- Level of satisfaction staff have with training and education opportunities
- Level of satisfaction patients and families involved in training design feel their contribution was honored and respected

3. Engagement of patients, families and communities

AIM: patients and families are engaged in their care, and are involved in helping to shape regional initiatives and decision making

Secondary Drivers:

1. Establish a steering committee with 50% comprised of patients clients or family members
2. Involve patients and families in regional corporate planning
3. Have patient and family stories part of each board meeting
4. Have patient and family stories at all educational sessions
5. Have at least one patient/family rep on each regional committee
6. Include patient and family in shift handover at the bedside
7. Have Quality of Care coordinators walk about and survey clients experience while in care
8. Use volunteers/ QCC's etc to conduct satisfaction surveys
9. Include PFCC reps on Primary Health Care teams
10. Lean and RTC have patient or family reps on
11. Include patients and families in all value stream mapping
12. Patient Shadowing

Measures to track this process improvement:

- % of clients satisfied with their involvement in care decisions
- % committees that involve clients and families

4. PFCC Champions exist at all levels of the Organization

AIM: Active champions exist at all levels in the organization but particularly in areas of strategic priority for the organization

Secondary drivers:

1. Build awareness for the role of PFCC champions
2. Create a consistent approach and communication about champions and their role in supporting PFCC implementation
3. Understand role and expectations for PFCC champions
4. Grow and develop staff to take on the role of champion for PFCC
5. Find/recruit or create opportunity for staff to self identify themselves for role of champion
6. Ensure representativeness in selection of PFCC champions
7. Support existing PFCC champions

Measures to track this process improvement:

- # of PFCC champions active in strategic priority areas for the organization
- Experience of staff having support of PFCC champions (% of teams who rate involvement of champions as positive, stories from champions, staff, patients and families that identify champion role as valuable

5. **Effective communication with patients, family, staff and providers through PFCC Champions**

   AIM: Active PFCC champions exist at all levels in the organization but particularly in areas of strategic priority for the organization.

   Secondary Drivers:
   - Build awareness for the role of PFCC champions
   - Create a consistent approach and communication about champions and their role in supporting PFCC implementation
   - Understand role and expectations for PFCC champions
   - Find/recruit or create opportunity for staff to self identify themselves for role of champion
   - Ensure representativeness in selection of PFCC champions
   - Staff visibly display their nametags
   - Whiteboards to be placed in every patient room. This will enable name of staff members to be displayed, as well as components of the care plan.

   Measures to track this improvement:
   - # of units with PFCC champions
   - # PFCC champions active in strategic priority areas for the organization
   - Experience of staff having support of PFCC champions (% of teams who rate involvement of champion as positive, stories from champions, staff patients and families that identify champion role as positive.

6. **Effective communication with staff, patients and families about PFCC journey**

   Aim: Patients, families and staff are aware of PFCC priority in the organization and understand their role in supporting the PFCC redesign strategies.

   Secondary Drivers:
   - Create a communication strategy where both patients, families, and staff are able to dispel myths about PFCC
   - Create motivational messages that resonate with patients, families and staff about why they want to support PFCC
   - Communicate opportunities for staff to increase their awareness and appreciation for what PFCC is (link with education/training driver)
   - Communicate opportunities for staff to increase their skills to implement PFCC into their work areas (link with education/training driver)

Desired Future state for PFCC:

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<td>Understanding and Conviction:
• Leaders outline clear expectations for behaviors and support their words with action – clear signal that patients and families are priority
• Through presentation and stories, leaders
• demonstrate that PFCC is the way all work and decisions are being made here now, not a flavor of the month
• Leaders are one voice in commitment to PFCC focus and action
• PFCC is evident in the Mission and Values statement for the organization
• Patients and Families Rights and Responsibilities posted everywhere

Understanding and conviction from the PFCC Framework:
• Communicate effectively with all healthcare providers about PFCC vision, goals and expectations
• Leaders report on the measuring and monitoring progress in adopting PFCC
• (Expect and Support) integration of PFCC into LEAN, RTC, patient safety and primary health care services
• Encourage and support patients and families to be active participants in their own care.</td>
<td>Reinforcing Mechanisms:
• PFCC values and practices are incorporated into orientation
• Include patients and families in development of new policies
• Policies and procedures give staff the ability to act on people’s wishes
• PFCC practices and values written into job descriptions
• Shine the light on all levels of staff illuminating successes with PFCC
• Performance reviews as a feedback loop to encourage staff to practice PFCC
• Quantitative and qualitative measures that help us see progress on PFCC

Reinforcing Mechanisms from the PFCC Framework:
• Incorporate PFCC concepts into development of policies, initiatives and programs
• Incorporate PFCC values and skills into HR procedures – hiring, orientating, recruiting, evaluating staff performance
• Improvement teams, leadership teams, policy development teams all have patient and family participation</td>
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<td>Skills Required for change:
• Problem solving, listening, interpersonal communication
• Respect for and ability to listen to the voice of the patient through stories, feedback, and data from patient experience surveys
• Cultural awareness training</td>
<td>Role Modeling:
• Leaders take the time to listen to staff about their experiences with PFCC
• Leadership walkabouts to focus on ideas from staff for PFCC
• Leaders recognize champions for PFCC
• Support informal leaders in taking risks
• Leaders tap into PFCC practices that are going well and learn from these experiences
• Servant leadership that works to remove barriers to staff implementing PFCC</td>
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Skills Required for Change from PFCC Framework: • Provide PFCC education and training to all staff at all levels of the organization • Incorporate PFCC practices and values into school curricula	Role Modeling from PFCC Framework: • Create a system of champions for PFCC • Provide patients and families with unbiased complete information about their care in a way that they can understand • Engage patients and families in development, implementation, and evaluation of programs and initiatives

Strategic Operational Plan for Adoption of PFCC for PNRHA:

Implementation Steps	Timelines 2012-2017	Progress Measures	
Develop 5 year implementation plan for PFCC	Board approved plan by March 31, 2012 Annual review- by Jan 31 of each year	Annual review of PFCC implementation plan by CSQI and PFCC Steering Committee	
Meet with Board members and VP's provide education on PFCC	Target date: June 30, 2012		
Develop Steering committee	Target date: September 30, 2012	1. Steering committee developed 2. Terms of Reference Defined	
Develop Education Plan to roll out to all staff in the region	Education will be ongoing throughout the 5 years	1. Education plan developed 2. % of staff who have attended an education session	Annual/biannual PN Quality Summit
Establish qualifications for a coordinator position.	Responsibility of Steering Committee: To be completed by Dec 31, 2012		
Advertise and hire coordinator	Jan 2013		
Establish Champions for each site	Ongoing	# of units with PFCC champions	

Implementation Steps	Timelines 2012-2017	Progress Measures	
Integrate patients and families in every education, regional orientation, staff meetings, etc	Ongoing	% of leadership committees that involve input or involvement of clients and families at a level they select. % of families who attend LTC resident/family conferences	
Meetings to be held with every department/ manager to present regional PFCC implementation plan and discuss how they will implement and make a plan for their department/unit to adopt principles of PFCC. Assessment of current PFCC activities to also take place.	Ongoing		
QCC's to do patient rounds in all sites	Started: ongoing	% of client care concerns	
Patient shadowing	July 2012	# patients shadowed, qualitative responses	
Whiteboards to be placed in all patient rooms in acute care	Target completion June 30, 2012	# rooms with whiteboards	
Name tags to be worn and visible by all staff	Started, ongoing	Audits to be completed with Quality and Safety Audits : % staff wearing name tags	

Implementation Steps	Timelines 2012-2017	Progress Measures	
Development of a communication strategy for PFCC	Target completion date: Dec 31, 2012	Completed communication plan	
Hourly rounds	To start in 2014/15	# units implementing hourly rounds	
Patient/ family involvement in doctor's rounds/ Bedside report	To start in 2015/16	# physicians participating in bedside report/rounds LTC: # of family members who participate in resident conferences	
"Open visiting hours"	To start 13/14	# units wards with altered visiting hours	
Volunteers in ER	May 31/12	# volunteers Pt satisfaction survey results	
Development of patient advisory committees	To begin Spring 2013	# of advisory committees	
Patient and family reps on regional committees	Ongoing	# of patients/families participating on committees, value streams	