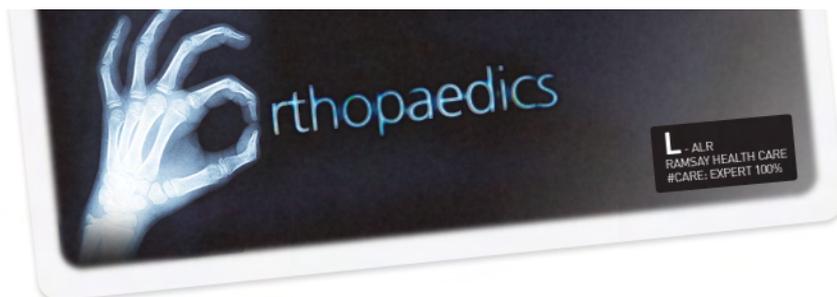


SATISFACTION

Success Story



IMPROVEMENTS TO THE DELIVERY OF ORTHOPAEDIC SERVICES

NORTH SHORE PRIVATE HOSPITAL

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RAMSAY
HEALTH CARE

NORTH SHORE
PRIVATE HOSPITAL

IMPROVEMENTS TO THE DELIVERY OF ORTHOPAEDIC SERVICES

OPPORTUNITY FOR IMPROVEMENT

North Shore Private Hospital (NSPH) is owned by Ramsay Health Care, Australia's largest private hospital operator. The hospital is located on Sydney's north shore, an area with one of the highest concentrations of private hospital beds in Australia. NSPH has 190 beds and eight operating theatres and primarily provides acute surgical services, including cardiothoracic surgery, neurosurgery, obstetrics, hepato-biliary, orthopaedic, plastic, vascular, gynaecological and general surgery. Occupancy rates average 90% per annum.

Neurosurgery, plastics and vascular surgery patients are all cared for on Level 3, a thirty-two bed unit dedicated to these specialties. However, during 2004 to 2006, Level 3's surgical profile substantially changed.

Admissions in their "traditional specialties" all declined over the two year period, while admissions for orthopaedic surgery to Level 3 rose significantly;

- Neurosurgery – 14% decrease in admissions to L3
- Plastic surgery – 23% decrease in admissions to L3
- Vascular surgery – 32% decrease in admissions to L3
- Orthopaedic surgery – 190% increase in admissions to L3

The impact of these changes, in particular the increase in orthopaedic patient admissions was significant and was mostly clearly reflected in our L3 orthopaedic patients' satisfaction scores in 2006 conducted by Press Ganey Associates. Urgent action was obviously needed before satisfaction further eroded affecting in turn visiting medical officer satisfaction and referrals.

Work commenced in late 2006, and the appointment of a new Director of Clinical Services (DCS) and a new L3 Nursing Unit Manager in January 2007 provided fresh eyes, enthusiasm and critical impetus for the review.

IDENTIFICATION OF CAUSES

Two key exploratory meetings were held in early 2007. The CEO and DCS met with L3 staff and separately with the orthopaedic surgeons. The purpose was to highlight the changes in L3's specialty admission profile and patient satisfaction data, come to a common understanding of the barriers preventing the provision of high quality orthopaedic care and identify potential solutions.

These meetings were illuminating! It was obvious the barriers were wide ranging and included clinical, cultural and physical impediments and were not only evident in Level 3 but extended beyond the unit to include other interacting processes which specifically contributed to poor orthopaedic patient service.

Orthopaedic Surgeons' Issues

In discussion with the CEO and Director of Clinical services, orthopaedic surgeons disclosed they were reluctant to have patients admitted to L3 based on patient feedback and their own experience of the ward's service to them. Problems recurred with specific care requirements, such as pain and wound management and post-operative protocols. Relationships were not well developed and the surgeons revealed their belief that L3 nursing staff actively avoided them when they arrived at the ward reception desk for rounds.

Nursing Issues

A situation which exactly mirrored the surgeon's perceptions was also described by nurses on Level 3. In the meeting with the nursing staff on Level 3, it was obvious the staff did not identify themselves or the ward as providing orthopaedic services. Orthopaedic patients, despite gradually and then routinely occupying up to half the ward's beds, were considered as "overflow" and not "what we normally do".

Compounding the situation, none of the nursing staff were specifically trained, had experience or post-graduate qualifications in nursing orthopaedic patients. There was unwillingness by staff to respond to orthopaedic patients' call bells due to a lack of clinical knowledge. If patients became unhappy with aspects of their care, for example pain management, nursing staff also became increasingly anxious about approaching the orthopaedic surgeon.

This cycle – lack of orthopaedic nursing experience and sub-optimal care leading to an unhappy patient and a disgruntled surgeon – further increased the nurses' reluctance to participate in ward rounds. Staff from Level 4, a dedicated orthopaedic ward, were often called to L3 to intervene or assist in the provision of appropriate orthopaedic care. Some staff were so low in confidence, they specifically requested not to care for orthopaedic patients.

This combination of factors prevented orthopaedic patients from experiencing the same level of clinical care and attention as other patients on Level 3.

Agency Rates

In the last four months of 2006, agency rates for Level 3 averaged 25%. The increase in agency was seen across all wards but was particularly severe in Level 3. Agency nurses were used in all shifts on Level 3 but were continually rostered for night duty; two of the three registered nurses on duty each night were contracted from agencies. Agency nurses were obviously not as familiar with the doctors' or ward's protocols, as committed or involved with the hospital or cognisant of Ramsay's "can do" culture as expressed in our "Ramsay Way".

A review of the patients' and visiting medical officers' complaints involving Level 3 highlighted that these were almost exclusively related to the care delivered during night shifts.

Bed Management Issues

Interestingly, investigation of the causes of poor patient satisfaction, uncovered a similar mind-set in relation to the allocation of orthopaedic patients to Level 3. Despite daily "overflow" of orthopaedic patients to Level 3 because Level 4 was full, all orthopaedic patients were routinely pre-admitted to Level 4.

On the day of admission, "overflow" patients were re-allocated to L3. These last minute changes meant Level 3 was frequently under prepared for the type or number of patients it would receive and patients experienced longer admission waiting times.

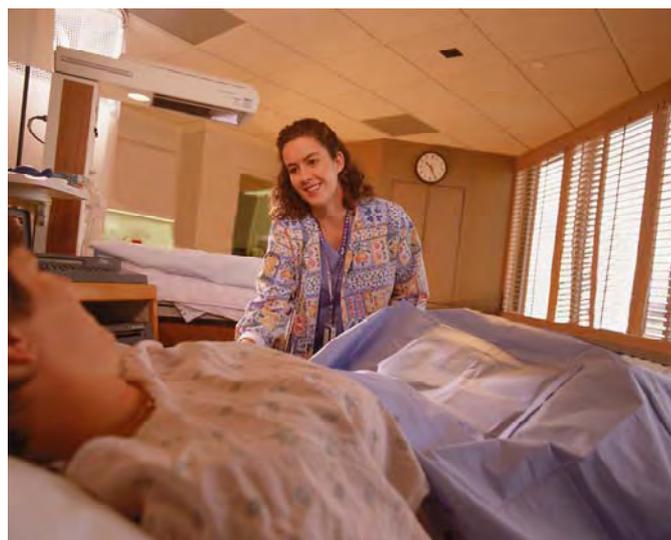
Physiotherapist Issues and equipment needs

Orthopaedic patients need a structured rehabilitation plan, often involving mobility / movement goals. The physiotherapy department is located on level 4, adjacent to the orthopaedic ward on level 4. Specific orthopaedic equipment was not readily accessible for L3 patients and the physiotherapists working on L3 were not as familiar with the post-operative physiotherapy needs of this group of patients.

STRATEGY DEVELOPMENT

The insights gathered during this initial stage determined the development of strategies directed at the confidence and competence of the nursing staff which would in turn reassure patients and VMOs that care was safe and responsive. The plan developed by the hospital was endorsed by the clinical groups with the overarching goal to increase VMO and patient confidence and satisfaction in the orthopaedic services provided by L3. Three major strategies were developed to meet the goal;

1. Create an appropriate environment linked to effective management processes which better serve orthopaedic patients
2. Increase orthopaedic nursing competencies within the unit to deliver high quality care to patients.
3. Reduce nursing agency rate.



INITIATIVES

1. Creating the Appropriate Environment and Processes

- A section of L3 ward was exclusively designated for orthopaedic patients assuring surgeons, patients and staff of the hospital's commitment to permanently providing these services on L3. Collocating orthopaedic patients in a section of the ward also improved the efficiency of orthopaedic surgeons "rounds".
- Signage throughout the hospital which indicated patients were not on the designated orthopaedic ward was removed and L3 staff were requested to refrain from conveying to patients they were "not on the normal orthopaedic ward".
- A set of orthopaedic admissions for L3 was identified to ensure a consistent case mix and allowed for subsequent skills development for this set. The hospital's bed manager, after hours managers, staff on Level 3 staff and the Level 4 nursing unit manager all contributed to the development of the admission criteria in consultation with the surgeons;
 - Patients undergoing shoulder, elbow, hand and feet surgery were selected for Level 3.
 - Orthopaedic spinal cases were not included to prevent confusion with protocols for patients undergoing neuro-spinal surgery all of whom were admitted to Level 3.
 - All large joint replacements were to be cared for post-operatively on Level 4 because easy access to the physiotherapy department was critical for this group of patients.
- Equipment for orthopaedic patients such as bed frames and ice buckets were purchased and located on L3.
- The theatre lists allocated to specific orthopaedic specialties were amended to ensure an even distribution of those cases to be admitted to L3. Each day the L3 and L4 nursing unit managers meet with the bed manager to review next-day patient admissions to both wards.

- The NUM of L3 was invited as a member of the Orthopaedic Clinical Department meetings, creating the opportunity to strengthen relationships and proactively monitor the success of the strategies with this key group.
- Discharge and pre-discharge planning was better structured and more consistently delivered. From admission, staff became better at involving the hospital's Discharge Coordinator and informing orthopaedic patients in a timely manner about the steps to discharge. This included patients seeing the physiotherapist prior to transfer to rehabilitation, providing information about mobility aids, and organising discharge medications from pharmacy. The Discharge Coordinator in turn provided discharge support and transferred her knowledge to other nurses.

Improving orthopaedic competencies

- An experienced Orthopaedic Clinical Coordinator was appointed full time to L3 to educate and support the nursing staff in early 2007. This was critical to the success of the strategy and reached beyond clinical and equipment skills. It allowed "instant mentoring" particularly in answering patients' questions and preparing for and anticipating needs.
- An education plan was rolled out which included:
 - Identification and funding of relevant external courses
 - Introduction of the "Orthopaedic workbook" which has been completed by all clinical staff and included refresher information on the anatomy and physiology of bones and joints.
 - Competency assessment in areas such as pain, wound and equipment
 - Regular in-services, including by the orthopaedic surgeons, who also provided and created opportunities and encouragement during ward rounds.
- The orthopaedic surgeons' standing orders were published on the hospital intranet for easy access and control for both L3 and L4.
- "Cheat sheets" were placed in bedside folders for common orthopaedic post-operative care requirements.

Reducing Agency Rate

The central tenet in the hospital-wide strategy to reduce agency rates was to create an environment whereby working an agency shift was less attractive than becoming or working more shifts as a permanently employed staff member. Systems which had made booking agency nurses by the Nursing Unit Managers easy were also changed. Agency rate reporting became a daily, weekly and monthly hospital requirement and the focus was shifted to recruitment forecasting and tactics.

- The agency booking system was centralized and located near the DCS's office to better understand and monitor agency bookings.
- NSPH permanent staff, many of whom also worked agency shifts at NSPH, were not hired for agency shifts at NSPH.
- Nursing agency day and evening shifts were reduced, for example from 8 hours to 6 hours.
- Block booking agency staff more than 24 hours in advance was no longer permitted.
- Bookings on a Sunday or public holiday were not permitted without prior approval by the DCS.
- Staff with Assistants-in-Nursing qualifications were booked in place of registered nurses wherever clinically possible.
- Reporting formats were developed to forecast and plan recruitment approaches.
- Other recruitment activities focused on a recruitment bonus scheme (6 RNs in total appointed at NSPH) and direct approaches to RNs working elsewhere (10 RNs).
- Nurse educator hours on the ward were increased to provide additional support and education to recruited staff and ensure relevant clinical competencies in areas such as pre-operative and post-operative care and discharge planning were completed.

The tactic of creating pressure on agency nurses resulted in Level 3 converting two (desired!) agency staff to permanent status and other recruitment activities netted an additional 1.5 full time equivalents.

Monitoring the Plan

The plan was closely monitored over the first half of 2007 via a daily review of L3 patients' comment cards and written complaints. Feedback from the orthopaedic surgeons was sought informally throughout the implementation by the CEO, DCS and NUM to assess the impact of the plan. In addition competency completion and agency rates were closely monitored by the Nurse Manager and Director of Clinical Services.



RESULTS

Patient Satisfaction

The 2007 Press Ganey results indicated the plan had been a resounding success. Satisfaction scores for L3's orthopaedic inpatients improved in areas such as communication, clinical care, information, team work and responsiveness.

Identifying which patients would be routinely admitted, changing the bed allocation and communication processes and assigning set beds to orthopaedics has improved the patients' pre-admission and admission experience.

The increased confidence and competency of staff is reflected in marked improvements about communication to patients and their families about their condition, treatment and discharge instructions. The increased confidence to be able to care for orthopaedic patients is reflected in increases of over 10 points in their response to call bells, pain control and meeting special needs.

Patients also experienced a greater level of communication and team spirit from the whole clinical team. Communication between doctors and nurses improved 16.2%.

ORTHOPAEDIC PATIENTS – LEVEL 3	Increases in score 2006 to 2007*
Waiting time for admission to ward	12.2
Pre-admission prepare you for stay	16.7
Pre-admission clinic prepare you for home	13.9
Courtesy of the nurses	12.2
Promptness response to call	16.2
Nurses' attitude toward requests	13.1
Attention to special/personal needs	9.6
Information for the family re: condition/treatment	14.1
Communication between Dr & nurses re care	16.2
Instructions care at home	15.9
Help arranging home care services	16.7
How well your pain was controlled	11.7
Staff worked together care for you	10.8
Extent better understand of med problem	19.5

* Survey periods: 1/7/2006 – 30/09/2006, n= 9; 1/5/2007 – 31/8/2007, n= 11

In addition, no written or verbal complaints had been received by orthopaedic patients cared for on L3 since the introduction of the plan to actively manage the overflow of orthopaedic patients to L3.

Agency Rates

Level Three's agency rate steadily declined from its peak of 27% in November 2006. By November 07, the rate was 5.5 %. During the first half of 2008 the rate has been consistently maintained at approximately 3% and the decrease has allowed energy and resources to be directed at clinical and service improvements rather than agency staff orientation, monitoring and support.

Nursing Competencies

In 2008, nursing staff self-evaluated their competency to deliver orthopaedic care (Table 1). All staff reported an improved ability to manage clinical issues such as pain and wounds. Anticipation of patients' needs and information provision to their patients and families were also assessed as having improved.

Level 3 Nurses Self evaluation of orthopaedic competencies (n=10)	Pain management	Wound management	Orthopaedic knowledge for patients and their family	Anticipating orthopaedic Patient needs	Discharge planning specific to orthopaedic patient needs
Moderate to significant to improvement in competency level	100%	90%	90%	90%	70%
Minimal improvement in competency level	-	10%	10%	10%	30%

Orthopaedic Surgeon Satisfaction

Nurses' assessment of their own competency levels was supported by feedback from NSPH's orthopaedic surgeons. In 2008, when questioned specifically about nursing pain and wound management and the nurses' ability to apply post-operative orders, the doctors reported experiencing less problems and a more proactive approach to most clinical variances; "I have no issues – and that's what I want."

The head of the Orthopaedic Department and several key surgeons acknowledged significant improvements particularly in the nurses' attitude and response to participating in ward rounds; "They know my name and I'm treated like I belong in the ward, rather than just being a "visitor"; "Their attitude is great"; "They are more approachable and actively willing to go on rounds now." Surgeon feedback at the bi annual Orthopaedic Department meetings has been positive stating the plan is working well

Orthopaedic admissions to the hospital and L3 continue to increase. The hospital, ward and medical staff are delighted in the outcome and the results have acted as a positive feedback loop, further enhancing L3's confidence in providing safe, high quality care. Opportunities for improvement still exist; for example the surgeons have asked for a more proactive approach to pain management for some patients. The relationships and culture which underpin success, such as team work, trust and avenues of communication are now well established and will ensure better care and service in the future. As one of our orthopaedic surgeons said recently, "I work at St Elsewhere's and there is an air of defeatism. I come here and I know I am part of winning team."

2010 Update:

North Shore Private Hospital's patient satisfaction continues to climb. In 2006 the Orthopaedics results were positioned at the 9th percentile when compared to Press Ganey's national (private hospitals) orthopaedics benchmark. The percentile rank in 2010 had climbed to the 85th percentile.