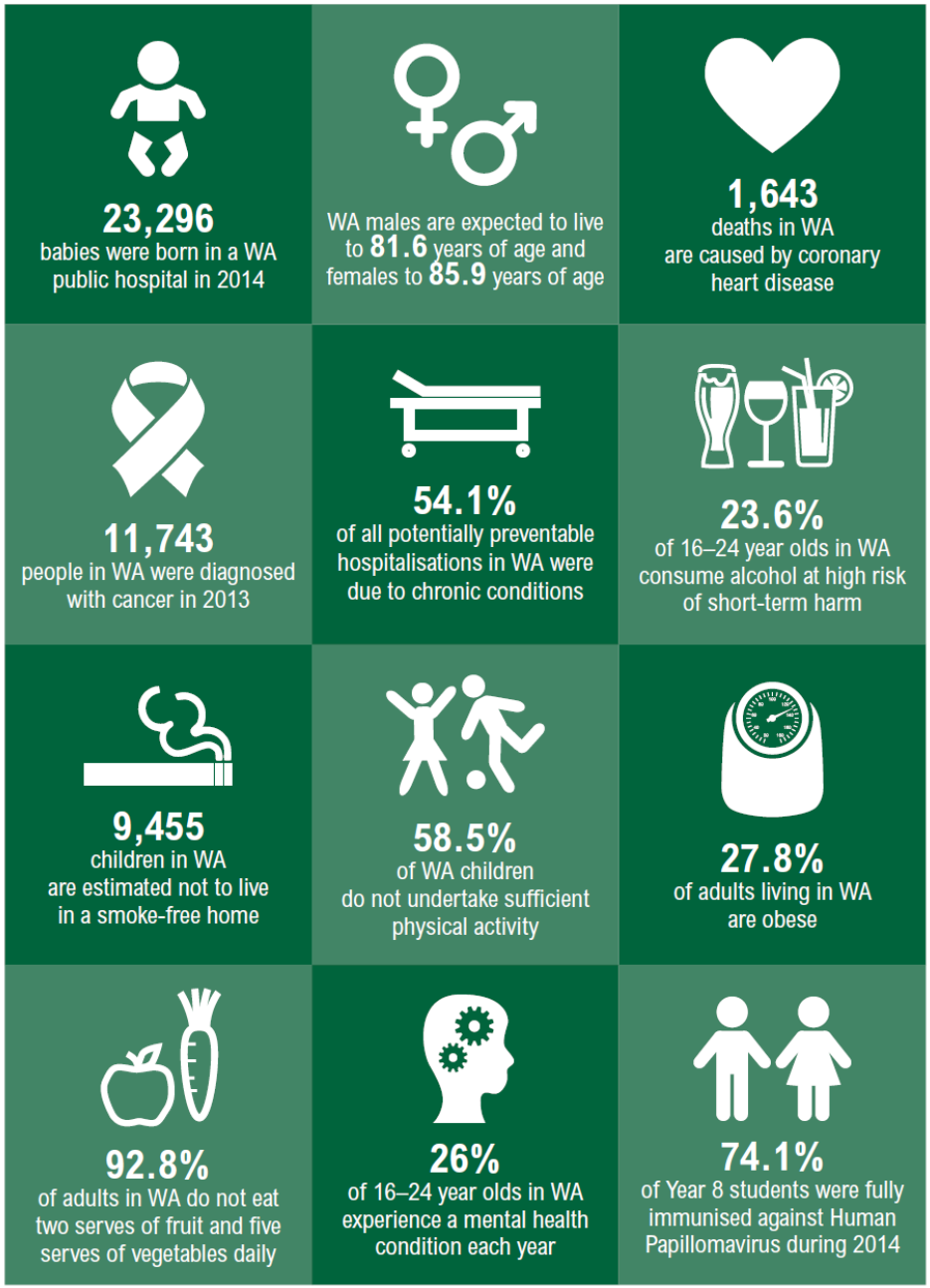
Patient Experience

Clinical Senate
11 December 2015

WA at a glance



WA Patient Satisfaction Survey

The survey looks at the key areas of health care that are important. These may include:

- hospital access (including assistance, special aids, parking and signage)
- the support and reassurance received by patients
- the politeness and consideration with which patients were treated
- patients' confidence in the healthcare professionals
- the provision of pain relief
- whether services met the patients' expectations
- health outcomes
- patients' involvement in decisions about their care and treatment
- waiting room amenities
- the quality and quantity of food.

In 2014-15, 8000 people were surveyed of their experience in a general or maternity hospital or attendance at an emergency department or outpatient clinic.

97 % survey participation rate (1490 emergency patients, 4387 admitted patients, 1222 maternity patients, 934 outpatients interviewed).

WA Patient Satisfaction Survey

Satisfaction with aspects of healthcare

Figure 6: **Satisfaction with aspects of health care by rank of importance, emergency department patients, 16–74 years, 2014–15**

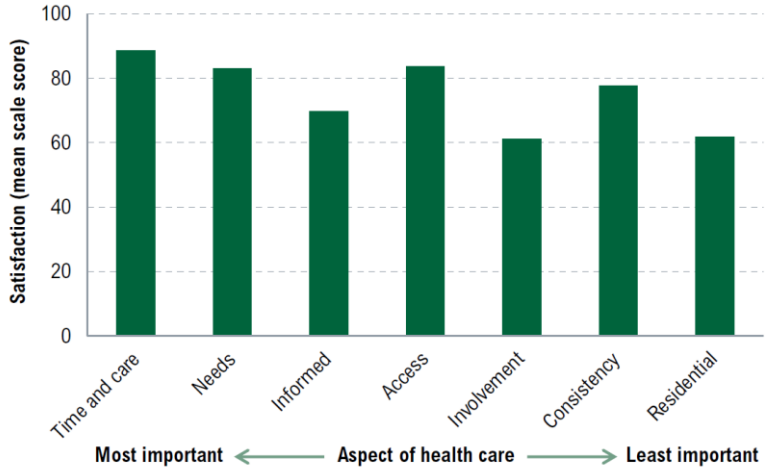


Figure 7: **Satisfaction with aspects of health care by rank of importance, admitted patients, 16–74 years, 2014–15**

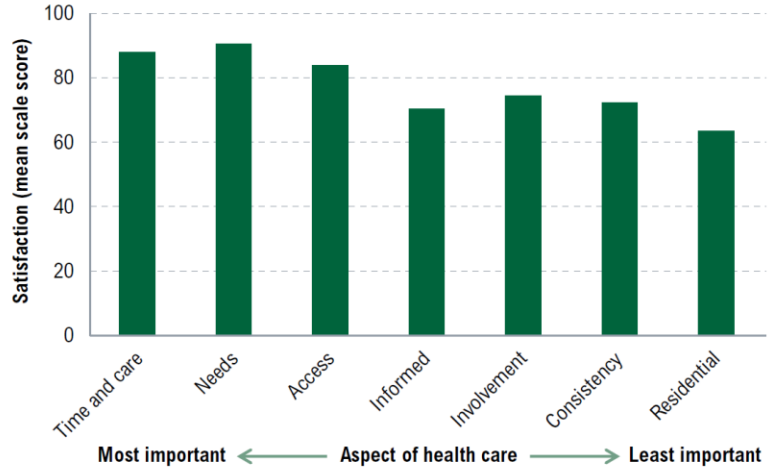
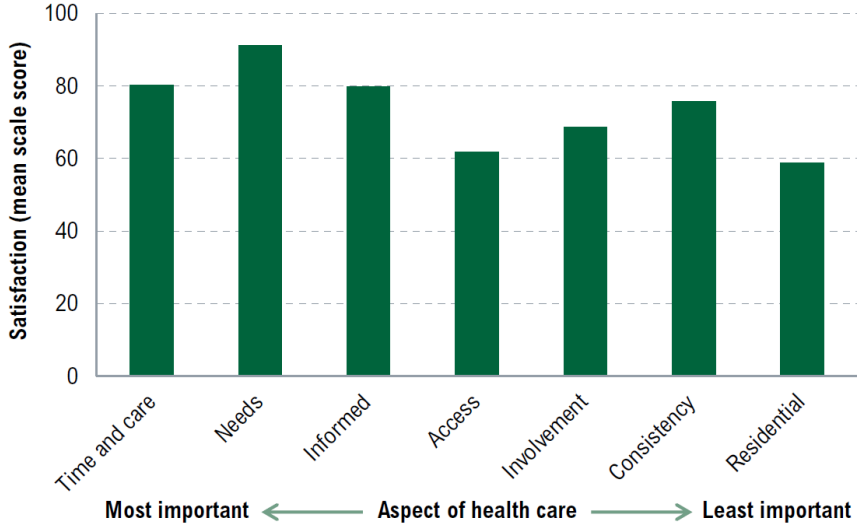
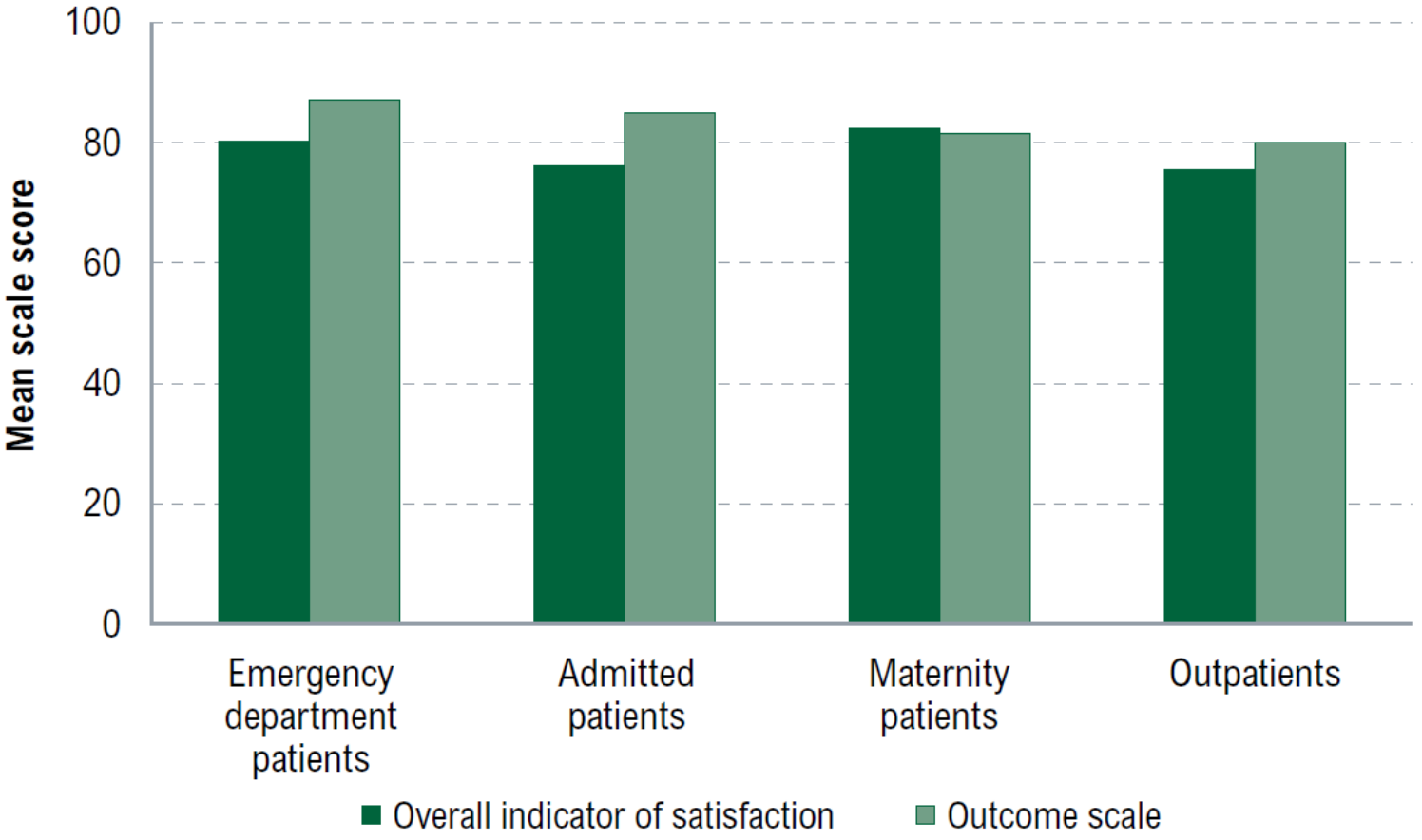


Figure 9: **Satisfaction with aspects of health care by rank of importance, outpatients, 16–74 years, 2014–15**



1 Access – getting into hospital
2 Time and care – the time and attention paid to patient care
3 Consistency – continuity of care
4 Needs – meeting the patient's personal needs
5 Informed – information and communication
6 Involvement – involvement in decisions about care and treatment
7 Residential – residential aspects of the hospital.

WA Patient Satisfaction Survey



There is a relationship between patients' overall satisfaction with health care and how patients rate the outcome of their hospital visit. Figure 10 shows that emergency department patients, admitted patients and outpatients rated the outcome of their visit higher than their overall indicator of satisfaction. This signifies that although patients were satisfied with their experience in WA hospitals, they were more satisfied with the outcome of their hospital visit and the improvement in their condition.

Consumer feedback

Via internet

(data from WACHS YTD, this represents 1% of total complaints received)

Via feedback forms and drop boxes

Customer Liaison Officers

Ministerials, HADSCo, AHPRA

Press Ganey inpatient survey (measures patient satisfaction and experience)

DATIX CIMS/Consumer Feedback Module

Management of specific incident
Communication with team, co-director, patient

Reporting to Hospital Executives
S&Q staffs, Consumer/Community Advisory Committee, MAC

Reporting to DOH, HADSCo

Performance against Standard 2

Jan 2014-Dec 2014

Met with merit	Not met
Consumers/carers involved in health service governance	Consumers/carers actively involved in safety and quality decision making
Health service has mechanisms for engaging consumers/carers in strategic/operational planning	Health service provides orientation and ongoing training for consumers/carers for them to fulfil their partnership role
Consumers/carers feedback on patient information publications	Consumers/carers involved in training clinical workforce
Action taken to incorporate feedback from consumer/carer into publications	Consumers/carers participate in evaluation of patient feedback data
Consumer/carers participate in design and redesign of health services	

Public sites achieving met with merit included Women and Newborn Health Service (2.1.1), Armadale Kelmscott HS (2.1.1, 2.2.1, 2.4.1, 2.5.1), Swan Kalamunda HS (2.4.1, 2.6.2), Rockingham Peel Group (2.1.1)

Source: Licensing Accreditation Regulatory Unit

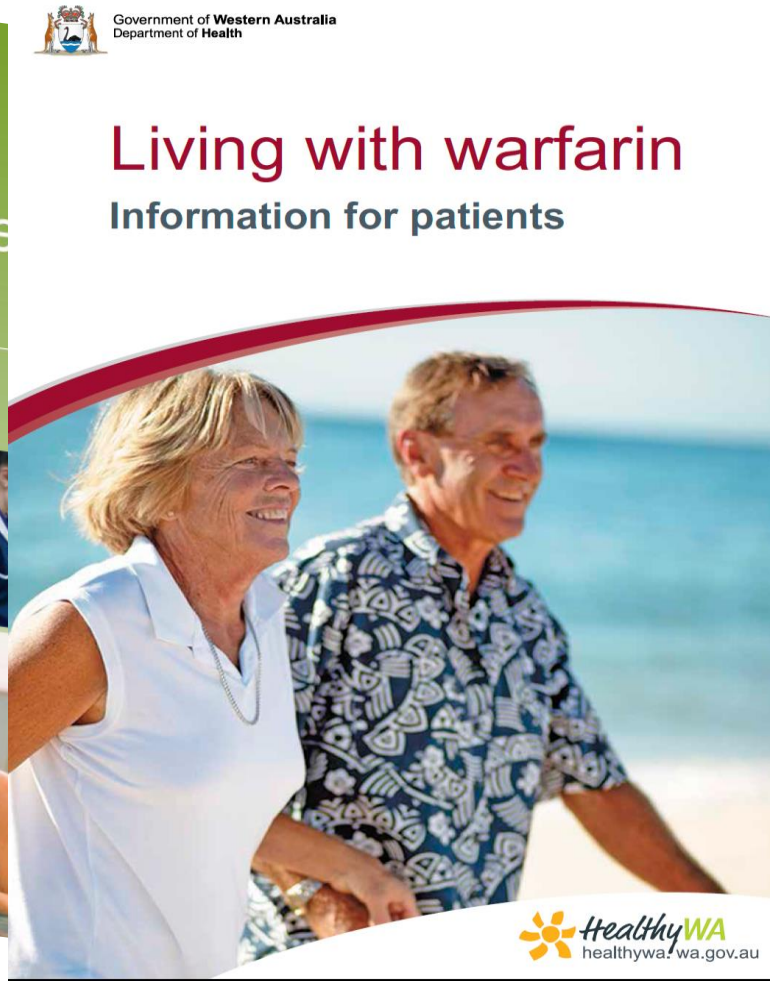
Summary

- Core elements of standard 2 met but work to address developmental goals needed.
- Patients mostly satisfied with care but we could improve in informing and involving patients in their treatment.
- Less defensive approach to patient feedback.
- Tools to measure patient outcomes.

Other resources:

Procedure specific information sheets

Patient Stories – personal stories and where to get help information



Tasmania
Explore the possibilities

MEDICAL GOALS OF CARE (GOC) PLAN

TASMANIAN HEALTH ORGANISATION
☐ North ☐ North West ☐ South

PT ID

FAMILY NAME..... D.O.B.....
OTHER NAMES..... SEX
ADDRESS..... MARITAL STATUS
..... REL.
LABEL

FT174800

This form is to communicate the medical decision for appropriate treatment goals of care for this patient. Chose A, B, C or D. If changes are made, this form must be crossed through, marked void and a new form completed.

DIAGNOSIS:

NO LIMITATION OF TREATMENT:	**Hospital**	**Community**
A. The goal of care is CURATIVE or RESTORATIVE. Treatment aim is PROLONGING LIFE ☐ For CPR and all appropriate life-sustaining treatments →	CODE BLUE	For full resuscitation
LIMITATION OF MEDICAL TREATMENT:		
☐ Patient has an advanced care directive and / or has requested the following treatment limitations: *Please specify:*		
B. The goal of care is CURATIVE or RESTORATIVE with limitations: ☐ **NOT FOR CPR** but is for all respiratory support measures → ☐ **NOT FOR CPR or INTUBATION** but is for other active management → *Specific notes:*	For CODE BLUE and MET calls For MET calls NOT for CODE BLUE	For treatment and transfer to hospital
C. The goal of care is PALLIATIVE. Treatment aim is quality of life ☐ **NOT FOR CPR OR INTUBATION** → *Specific notes:*	MET call ☐ YES MET call ☐ NO	Contact GP planning
D. The goal of care is COMFORT DURING THE DYING PROCESS ☐ **NOT FOR CPR or INTUBATION** →	For terminal care NOT for CODE BLU NOT for MET	

Reason for limitation of medical treatment:	☐ medical grounds	☐ patie
Discussed with:	☐ patient	☐ per
PRINT DOCTOR'S NAME:	**DESIGNATION:**	
SIGNATURE:	**DATE:** DD / MM / YYYY	
GP / consultant responsible:: PRINT NAME	GP / consultant informed: ☐ YES ☐ NO	

This form is endorsed for ambulance transfer, and for the home or care facility.

Abbreviation key:	CPR = cardio-pulmonary resuscitation	GP = general practitioner	MET = medical emergency team

THO-S 97748 09/14 FEB14 M1

GOALS

Clinical focus

Goals of care: a clinical framework for limitation of medical treatment

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Summary

- A novel clinical framework called "goals of care" (GOC) has been designed as a replacement for not-for-resuscitation orders. The aim is to improve decision making and documentation relating to limitations of medical treatment.
- Clinicians assign a patient's situation to one of three phases of care — curative or restorative, palliative, or terminal — according to an assessment of likely treatment outcomes. This applies to all admitted patients, and the default position is the curative or restorative phase.
- GOC helps identify patients who wish to decline treatments that might otherwise be given, such as treatment with blood products. This includes patients for whom specific limitations apply because of their beliefs.
- GOC has been introduced at Royal Hobart Hospital, Tasmania, and at Northern Health, Melbourne. So far, audit data and staff feedback have been favourable. There have been no reported major incidents or complaints in which GOC has been causally implicated in an adverse outcome.

The development of clear, effective and consistent clinical processes for decision making relating to limitations of medical treatment and documentation of the decisions is an ongoing challenge for all health care systems.

We propose a clinical framework called "goals of care" (GOC). This approach has been introduced and audited in two Australian health services (Royal Hobart Hospital, Tasmanian Health Organisation — South, and Northern Health, Melbourne, Victoria) and is being considered elsewhere. It is influenced by the Physician Orders for Life Sustaining Treatment approach (http://www.polst.org), which is widely used in the United States, coupled with the innovation of assigning each patient episode to one of three treatment categories based on the overall medical treatment goals for that patient at that time.

The three-phase model

Medical decision making is based on determining the GOC for the patient. The patient's situation is assigned to one of three phases of care according to a realistic assessment of the probable outcomes of medical treatment. These phases are clinically defined intentional categories that take heed of, but are quite distinct from, personal goals expressed by patients. Patients can move from one category to another during their illness trajectory. The phases are curative or restorative, palliative, and terminal;[1] they are based on phases that were first described in 1990.[2] The distinguishing features of each phase are shown in the Box.

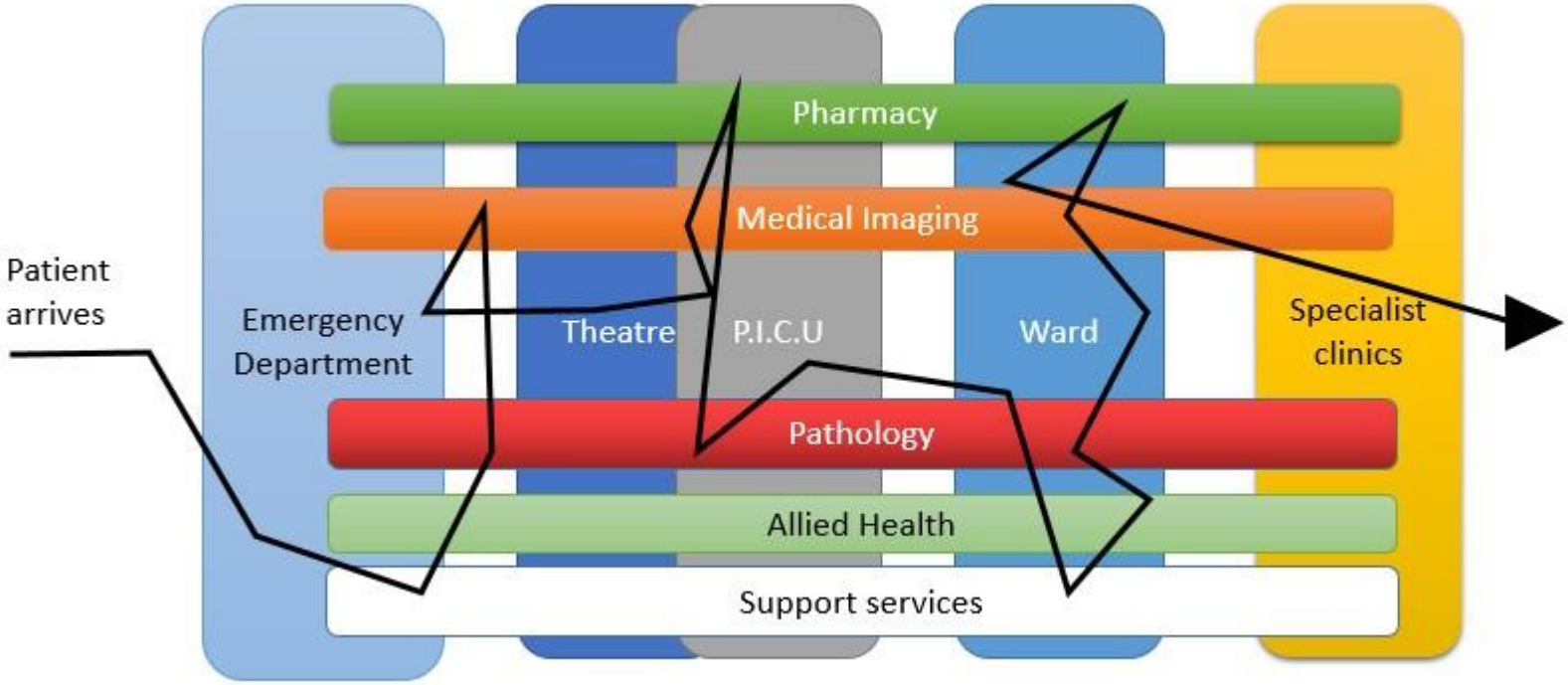
The patient assessment is shared with the patient or substitute decisionmaker (SDM) and, if agreed, a GOC plan form is completed and placed in the alerts section of the patient's medical record. A GOC plan is a medical order that clarifies limitations of medical treatment for a present condition; it is not the same as an advance directive, which is usually made by a person, in his or her own "voice", to inform medical decision making for future episodes of impaired capacity. Goals are revised in the light of changes in medical condition, and appropriate limitations are then documented on a new form. A GOC plan replaces institutional or community-based not-for-resuscitation (NFR) orders.

We documented GOC plans using an original form (Appendix 1; online at mja.com.au), which has been used at Royal Hobart Hospital for the past 3 years. A second, revised form (Appendix 2; online at mja.com.au) is now being introduced more widely in Tasmania, after extensive experience and feedback from clinicians, medical records staff and others. It is simpler and has been modified for use in all settings, including homes and nursing homes.

The original developmental work was done in Hobart after the Royal Hobart Hospital completed a Respecting Patient Choices pilot site project in 2008. This project put a sharp focus on decision making at the end of life across the whole hospital community.

In 2010, a project officer position was created to enable the development of GOC as part of a statewide Healthy Dying Initiative. Based on the principles of health-promoting palliative care, this initiative aimed to empower the whole community, including the health sector, to deal with death in a more direct, open and therefore "healthy" way. Clinical decision making at the end of life was identified as a priority for policy and procedural reform. There were three initial components of the Healthy Dying Initiative: GOC, advance directive redesign and promotion, and encouragement of health-promoting activities relating to death and dying. The project officer, a non-clinician with extensive experience in community development, helped design the GOC form, develop the policy protocol for

The patient journey through hospital systems



The patient experience is a direct result of how the different hospital systems interact and the way staff work within these systems to provide patient care.

Please note: The purpose of this diagram is to demonstrate the large number of systems that a patient could pass through on their healthcare journey.

Source: Royal Children's Hospital Melbourne

Journey Board

Journey Board is a discharge manage
health staff. It is a web-based applicat
patients on a ward and makes it easy

Journey Board provides information
referrals, discharge goals and barrie

It supports multidisciplinary care an
referral making. The use of icons, c
need additional care before discha

Journey Board was introduced at

Digital Medical Record

WA Health has implemented a digital me
and eForms capability. Fiona Stanley H
electronic medical record system. It wi
and Busselton Health Campus.

Through BOSSNet clinicians record
online. These notes can be read b

The technology will also be used
used to store and make available
report documents.

WebPAS

WebPAS is a patient administration system which will be progressively introduced across all WA Health sites. It is currently operating in the Southwest and Great Southern regions, Fremantle Hospital, Fiona Stanley Hospital, Princess Margaret Hospital, Swan District Hospital and Kalamunda Hospital.

Introducing a common patient administration system will help standardise business processes and produce consistent information. Clinicians will be able to access information on a patient from any site. Reducing duplication will also improve patient safety outcomes.

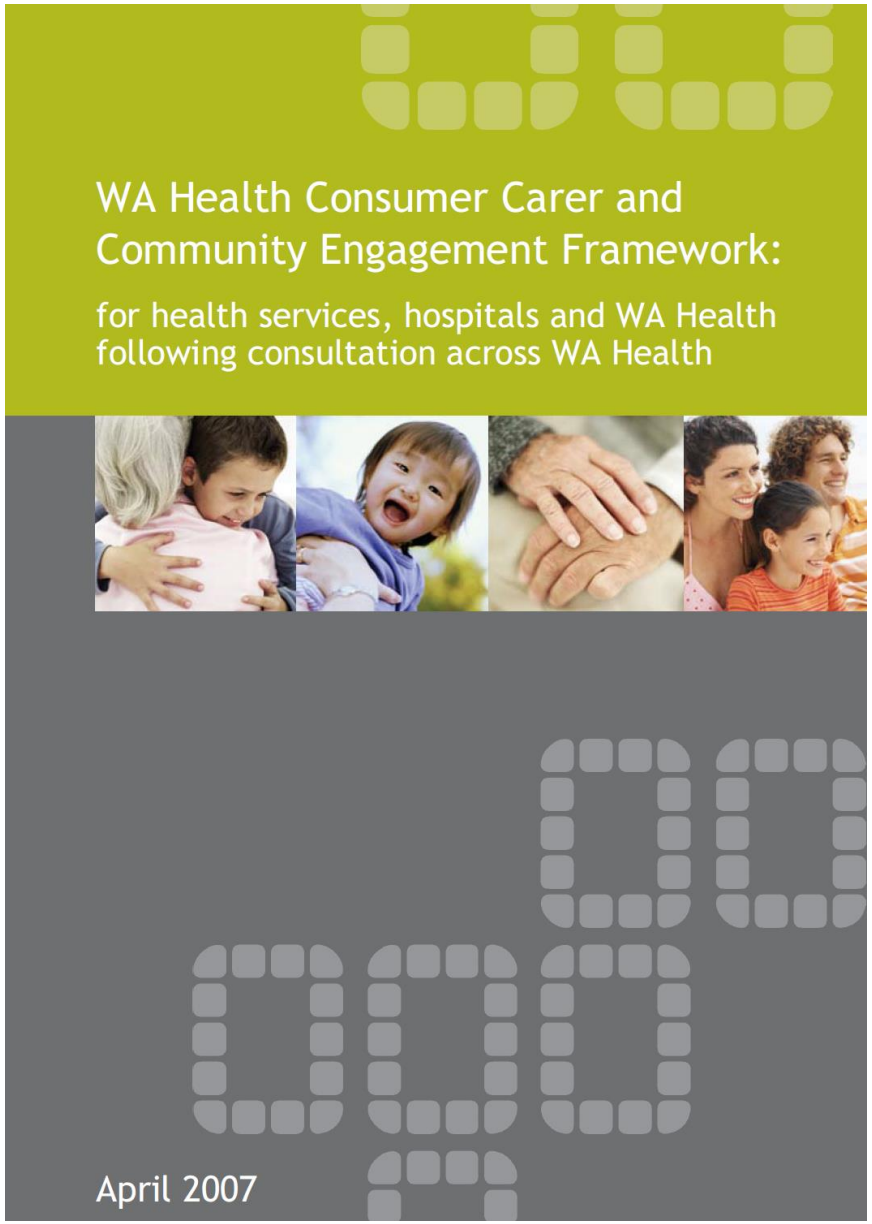
As a single billing system, it will also improve revenue collection and deliver cost savings.

Continuum of care

- NaCS (Notifications and Clinical Summaries) – capacity to be uploaded to patient's e-health record
- Continuity of medication management – between hospital and community settings
- Telehealth
- Community focused complex care coordination teams

Our challenge

- Providing seamlessness in services within a devolved governance model
- Whose responsibility is it to identify and address gaps?
- How do we ensure responsiveness to addressing barriers to continuity of care?



Workshop 9 December 2015

- Overwhelming consensus on continued need and work to refresh
- Opportunity to engage across health siloes
- Opportunity to create consistency and standardisation across the system
- Need a shared vision and guiding principles from which action plans can be developed.
- 4th C for the clinician?

Expert Advisory Group

on discrimination, bullying and sexual harassment

Advising the Royal Australasian College of Surgeons

Report to RACS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Report to the Royal Australasian College of Surgeons

1. EAG Statement

Every patient has a right to expect that their healthcare is uncompromised by discrimination, bullying and sexual harassment in the practice of surgery.

Every surgical Trainee has a right to an education free of discrimination, bullying and sexual harassment.

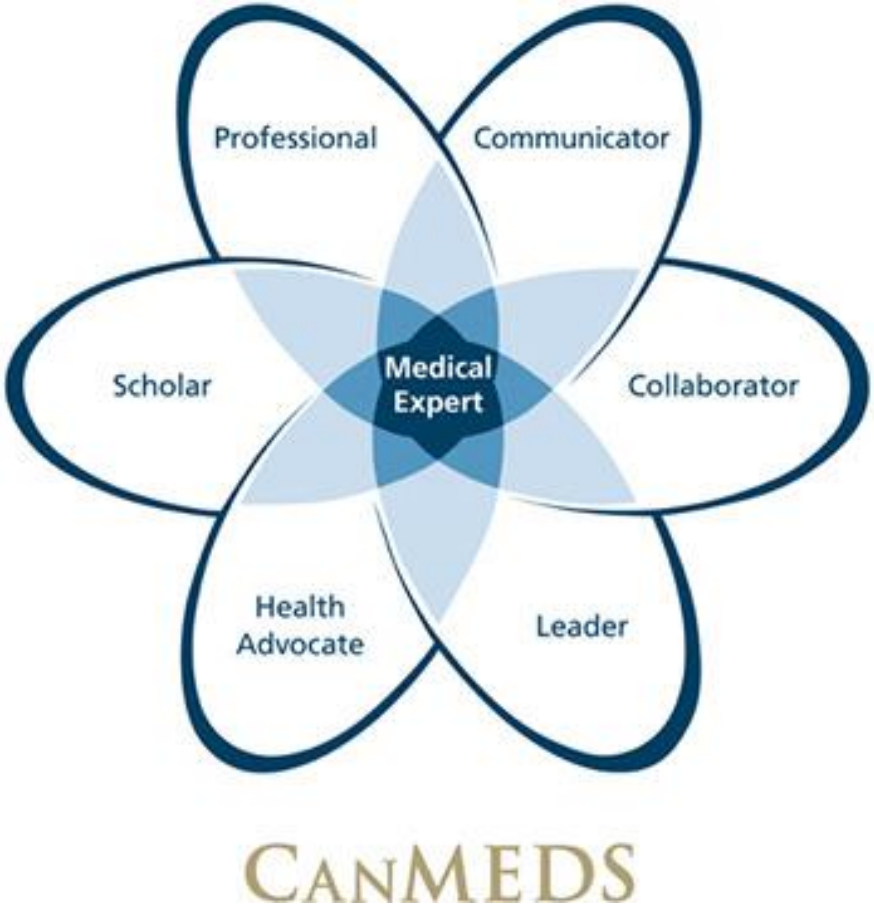
Every International Medical Graduate has a right to be assessed on their merits, free of discrimination, bullying and sexual harassment.

And every healthcare worker – including every surgeon – has a right to a workplace free of discrimination, bullying and sexual harassment.

In this workplace, patient safety is the absolute and common priority. Teams work together effectively, respecting the skills, experience and contribution of each member. The success of surgical teams is measured by the safety of the workplace and training post, and by the extent to which all team members recognise that what they achieve together is more valuable than anything they can achieve on their own.

Workplaces like this exist now in some places in Australia and New Zealand. But they are a long way from the everyday reality of most people involved in the practice of surgery.

- Increasing focus on medical engagement and leadership



- Focus on aptitude and attitude vs competency
- Focus on performance management

PATIENT **EXPERIENCE** → QUALITY ← STAFF **ENGAGEMENT**

The available evidence suggests that measures of patient experience are robust, distinctive indicators of health care quality.

Manary et al, New England Journal of Medicine. 2013[16]

Evidence shows that better patient experience scores linked to

- Lower readmission rates[1]
- Lower cost per case[2]
- Shorter length of stay[2]

Patients with lower anexiety

- Feel less pain and their surgical wounds recover more quickly[7]

Good communication improves

- Compliance with post discharge instructions[3]
- Safety - patients point out potential adverse effects[4]
- Blood pressure[5]
- Self management[3]
- Emotional health[4]
- Number of complaints. Evidence shows tone-of-voice is key factor in complaint levels[6]

Variation between hospitals in patient perception of quality of care is driven 91% by human factors[18]

There is a clear relationship between the wellbeing of staff and patients' wellbeing

Boorman, 2009, Kings Fund 2012[17]

A **5% increase** in staff working in 'real teams' associated with a **3.3% drop** in mortality rates[12] Equivalent to **40 people per year** in average hospital.

Hospitals with higher staff engagement have

- Lower mortality[8]
- Fewer hospital acquired infections[9]
- Better outcomes[8]
- Significantly fewer mistakes[10]

5:1.

In the most successful teams people get 5 times more appreciative comments about their work than critical comments[20]

Rudeness between staff in hospitals, reduces cognitive function, and increases the likelihood of safety incidents[13]

Hospitals with higher levels of staff engagement deliver a better patient experience[19]