Implementation of CCDM

Ward 25 (General Medicine)
Palmerston North Hospital

Caroline Dodsworth, Charge Nurse
The way things were.....

Ward Efficiency Graph

Utilisation %

Hours Per Patient Day (HPPD)

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LEGEND
- Required Inpatient Clinical Hours
- Actual Inpatient Clinical Hours Worked
- # Monthly Productivity [Ratio Actual To Required]
The way things were.....
Moving forward

- September 2011-

Expression of Interest for Data Collection/ Work Analysis to inform Capacity Demand Management - First Ward

Guinea Pigs 😊
But How Do We Do It?

• Doing what we do best- we talked! And talked. And talked.

• Blank page- literally 😊
Proposed Model of Care-consideration for:

- Seasonal roster
- Delirium/ cohort Room
- Admission/discharge nurse
- Night shift
- 2\textsuperscript{nd} cohort room or specialised patients
Ward 25: PROGRESS on Mix and Match Part 1 & 2 Care Capacity Demand Management Report

- Seasonal roster developed by staff in partnership with NZNO.

- Auditing to demonstrate consistent best practice.

- Develop new model of care for delirium room ensuring RN or EN is in attendance and HCA floats between delirium patients and other ward duties depending on need
Ward 25: PROGRESS on Mix and Match Part 1 & 2 Care Capacity Demand Management Report

- Development of hospital-wide constant observation process improvements.

- Ensure patients are classified as correct “patient type” in Trendcare (following consultation with Trendcare Australia)

- Identify patients who are discharged 1-2 days following admission from MAPU/ED. Explore & test options for different models of care.
Comments from the team

• “There was excellent communication during the process; ward staff were included and actively involved”.

• “Charge Nurse, Associate Charge Nurses, Management and NZNO delegates were professional and supportive, and assisted with propelling the process forward- staff joined in at “grass roots level”.”
More comments....

- “There was initial fear, anger and distrust at the process. It was generally seen as a “lip-service” situation and “what was going to happen with the data?””

- “But as the process developed it was an eye opener to be able to quantify the many interruptions during the shift. It also highlighted and reinforced what nurses already knew due to many interruptions- less time was being spent in patient care”.
...And more comments

- "The nurses also gained further insight into peaks and troughs of ward work".

- "The process of reporting back the data seemed to take a long time. This resulted in a slight drop in momentum."

- "On the feedback days many staff came in on their days off to participate- there was ownership of the ward and the staff".
CCDM & RTC

“The ward started Releasing Time to Care at the same time as CCDM and this was a lot of work. Although I think we should have started with CCDM and then RTC, they have both very positive processes. Releasing Time to Care was a very positive process but it got a bit lost in CCDM and was a bit overwhelming”.
“There is less pressure on the qualified staff, especially on the morning shift. Discharges happen in a more timely manner, and the discharge of complex patients requiring +++ RN time is now smoother.”
Safe Staffing

“The constant drive of bed occupancy and staffing in medical wards is a continuous balance. For staff to be involved in determining how FTE is used across shifts is momentous. They felt listened to. Everyone had a voice and an opportunity to be heard in this valuable process...”
And finally.....

- “Since CCDM it feels like I’ve actually met the patients, & I don’t go home with that horrible feeling that I’ve missed something”
Lessons Learned

- It takes time- a whole lot of time!
- Get the ground work right
- Understand care rationing
- Communicate, communicate, communicate
The End (or just the beginning)

- With thanks to the amazing nursing team of Ward 25 without whom CCDM would not have worked.