Improving Care Planning practice using PDSA
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Introduction
The Plan, Do, Study, Act (PDSA) Model for Improvement project has been a 12 month project that aims to improve care for clients with chronic and complex conditions through improved systems of practice.

Wimmera Health Care Group (WHCG) aimed to improve their Care Planning Practice within the Hospitals Admissions Risk Program (HARP) and the Diabetes Self Management Program (DSM).

WHCG undertook small rapid cycles of quality improvement during 2011 using the PDSA Model for Improvement. A key feature of the approach was the use of data to measure change and effect.

WHCG has tested a variety of change ideas, embedded good practice and worked hard to grow and sustain work in chronic care systems improvement.

Methods
Built an improvement team
The HARP program and Diabetes Self Management Program came together to form the Wimmera Health Care Group Improvement team in Care Planning.

Identified our key issues
We undertook a file audit across the above programs to determine the quality and quantity of care planning processes and understand our processes.

Implement Change
From this information we implemented small rapid cycles of change in our care planning practices.

- Found a tool for care planning that met all criteria in best practice care planning
- Started using the tool initially with new clients
- Reviewed files on a monthly basis to ensure all active clients now had a care plan
- Changed our practice in sharing Care Plans within each department and with other departments at WHCG.

Embedding Practice
- Educated staff in developing client focused goal setting and care planning
- Initiated a new policy where care coordination plans are accessible to all clinicians.

Management support
We have had significant management support from our Primary Care Management and the Wimmera Primary Care Partnership (PCP) to undertake these improvements.

Results
At the start of the project there was no consistent care planning tool used across our programs. We then identified that the SCTT Care Coordination Plan was the ideal tool to enable all elements of best practice care planning to be used.

Where the Care Plans were used at the start of this project, they were not used in a consistent manner.

However, at the end of the project in October 2011, care planning practice is now significantly improved (please see graph for more details).

Staff now feel more confident in setting client centered goals whereas previously goals were more clinically focused.

Discussion
The success of the program has been in the staff uptake of the PDSA process in making small changes and seeing the results. We will use the PDSA approach to make further improvements and to introduce the care plan work we’ve undertaken into other departments at WHCG.

IT programs have not been useful in sharing care plans electronically across our health service. We would like to see improvement in this area in the near future.

We will use PDSA in 2012 to continue to audit and monitor the use of care plans and in further improvement work.

Next steps will be to liaise with the local general practices to gauge whether they feel receiving care plans from us will be beneficial in the care of clients.

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Conclusions
PDSA improvement cycles are a successful way to implement change in our organisation.

Staff involvement in this quality improvement process means they own the work and the changes are embedded into practice.

Building a good team to do this work at the start of the project is very important.

Having support from management and the Wimmera PCP has been invaluable.

Further information: www.whcg.org.au
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