



Kōrero mai: Patient, family and whānau escalation of care

Case study by Capital & Coast DHB

Context

In recent years, family-led escalation processes have been introduced by health care institutions, internationally and in Aotearoa New Zealand, to complement existing clinical escalation pathways.

Using a co-design methodology, our aim was to identify and understand the barriers and concerns patients, family and whānau have about escalation of care at Capital & Coast District Health Board (CCDHB). This approach informed a design process that complemented patient, family, and whānau escalation of care with our existing clinical escalation pathway.

Aim

We aimed to complete testing by May 2019.

Start up



The co-design team at Wellington hospital. From back left: Sarah Jackson, Laura Ellis, Sheila Becker, Sarah Imray, Robert Dano, Lynne Maher, John Tait and Donna McLennan. Absent: Chris Andersen, Anne Pedersen and Richard Perry.

Recruitment of the team began in August 2018. Anne Pedersen, patient safety coordinator, and Sarah Imray, clinical nurse specialist of the Patient-at-risk team, led this. To identify consumers who had feedback about their experiences of the escalation of care process, we reviewed recent complaints and compliments, and contacted and invited people to join us at a workshop in 2018. This resulted in Sheila and John joining our team.

After discussing the initiative with ward charge nurse managers, we were able to recruit two wards to pilot the work, along with identified representatives who would work closely with the project team. Following a discussion with the clinical recognition and response committee, we were also able to recruit a medical consultant. A discussion with our quality team resulted in their support of the project, including the allocation of an executive lead. The Health Quality & Safety Commission (the Commission) lead for the national Kōrero mai programme also joined our team. See Table 1 for a summary of the team.

Once the team was established, we had a preliminary meeting to introduce all members, establish roles and expectations of team members, and to ensure privacy forms, permission forms and reimbursement forms for our consumers were completed.

In September 2018, seven members of the team participated in a workshop, ‘Understanding experiences and co-designing solutions’, which provided a helpful overview of the process and tools that we would use. During this day we also started some planning for the project and developed a Gantt chart to identify stages and tasks to be undertaken (see [Appendix 1](#)).

Table 1: Kōrero mai team members and roles

| Name of team member | Role |
|---------------------|---|
| Sarah Imray | Project lead |
| Anne Pedersen | Patient safety coordinator |
| Sarah Jackson | Executive lead |
| Laura Ellis | Advisor, consumer engagement, hospital improvement team |
| Donna McLennan | Charge nurse manager, general surgical ward (7N) |
| Robert Dano | Registered nurse, general medical ward (5S) |
| Chris Andersen | Medical consultant |
| Sheila Beckers | Consumer |
| John Tait | Consumer |

Engage

After identifying project team members we continued engagement by developing ‘elevator pitches’ (see [Appendix 2](#)). The pitches were designed to be short and concise. They also provided a base on which we could elaborate when talking to people. The project lead discussed the project with senior nurses, and both ward representatives used the pitches when talking to their peers. We engaged with consumers at face-to-face meetings and by email at various stages.

It was agreed that along with team members meeting together, we would also communicate with updates and other information using email. At this stage we also shared a link to [an article in the New Zealand Listener magazine](#), which was a great read supporting the need for the Kōrero mai project.

In November 2018 the Commission held its first deteriorating patient conference in Auckland. It was a fantastic event, that allowed all DHBs to showcase their progress with implementing the patient deterioration programme. Three team members attended the conference, including our consumer Sheila, who was generously funded by the Commission. Together we heard the heart-wrenching story of Matt, a 15-year-old boy who died post-appendectomy. The story was told by his mother, who is also a nurse, and there was not a dry eye in the room. You can listen to Matt's story [here](#).

Following the conference Sheila Beckers kindly wrote a reflection on her thoughts, which included the following:

'Wow... the key message in all presentations, was that deteriorating patients and their loved ones do matter. Matt's story and the experience of Marama Tauranga, whose son suffered peritonitis due to assumption and fob-offs from clinicians, should be told in every medical/nursing training program, and in all DHB professional workshops throughout New Zealand... Communication is key. Listening as well as talking.'

To read Sheila's full reflection, see [Appendix 3](#).



Anne Pedersen, Sheila Beckers and Sarah Imray at the Commission's deteriorating patient conference November 2018.

Capture

We began collecting our data by using a combination of observation and questions set within the Commission template (see [Appendix 4](#)). Through these methods we were able to observe the interaction between clinicians and the patient and whānau as the patients are admitted to a ward, and then explore the level of confidence that the patient and their whānau have in using a call bell or other methods to call for help.

The two ward representatives led this data-capture on their respective wards. We achieved data saturation quite quickly. The results were all very positive and both pilot wards were praised for their approach to welcoming new patients. While this was very helpful learning,

we wondered if the consumers and family members felt confident about raising any concerns with a member of the ward team. We undertook a second round of data capture using the same methods and templates but this time it was led by the two consumer members of the team.

One of the consumers, John, reflected that ‘... overall I found this an extremely positive and worthwhile exercise’.

We achieved data saturation quickly and again the results were very positive. However, this time we were also able to extract some data we could elaborate on.

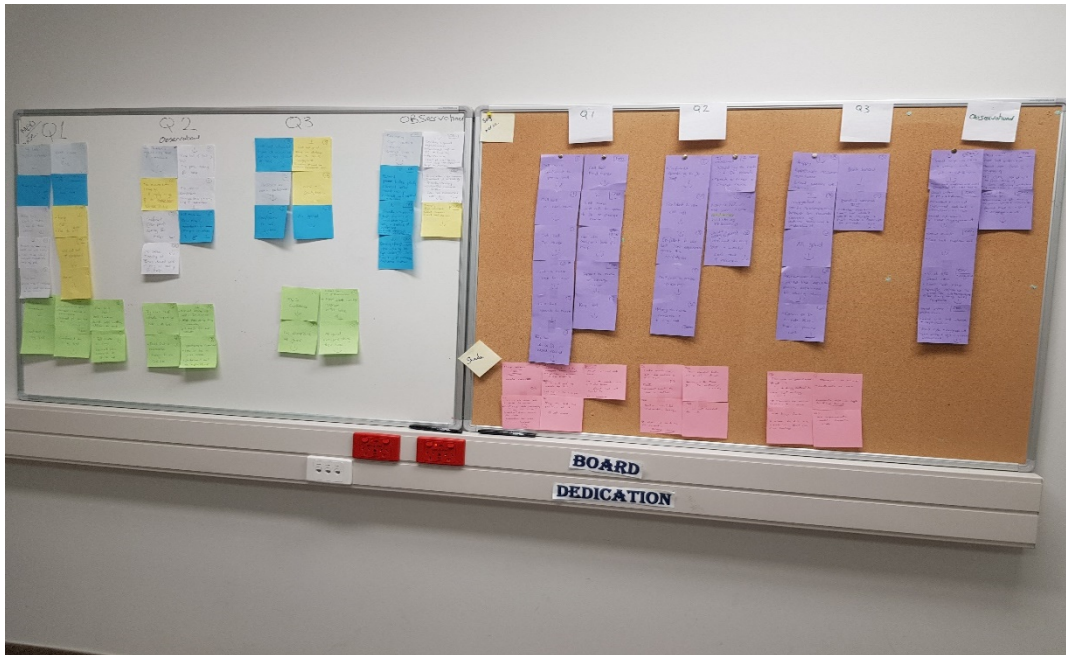
Understand

We held a journey mapping workshop to analyse and understand what the data was showing us. We extracted the key words from the information we had gathered.



Members of the co-design team having a working lunch during the workshop (lunch funded by the Commission).

Although it was difficult to obtain specific ideas for improvements, we were able to make suggestions for the future. We divided the answers into medical and surgical, to analyse if there was any difference between the two specialities. We also analysed the data obtained from the ward representatives and our consumers. For a full review of the findings, see [Appendix 5](#). Key elements from the information formed the basis of the poster ([Appendix 6](#)).



The image above shows how we divided the answers. On the left are answers from the medical ward with the consumer responses in green. On the right are answers from the surgical ward with the consumer responses in pink.

Implementation

Following on from the workshop we designed a poster ([Appendix 6](#)) that was trialled for a month on the two pilot wards. The ward representatives provided education to their colleagues and the patient-at-risk nurses. The difference with this trial and trials undertaken at other DHBs was that patients were given a phone number for the patient-at-risk nurses.

During the trial we had one referral. It was an elderly lady who was concerned that she was going to be discharged straight home, when she wanted to go to Hutt Hospital first. The ward was already actively planning a safe discharge to the Hutt when she was reviewed by the patient-at-risk team. The PAR nurse and primary team reassured her that she would have an additional two days at Hutt hospital, and the lady was discharged to Hutt Hospital later that day.

We decided that we would do some more interviews on the ward, aiming to gauge patient and whānau reactions to the posters. The questions were designed by Sarah Imray and the interviews conducted by Sheila and John. For a full review of the findings, see [Appendix 7](#).

The results of the interviews were really informative. It was obvious that the design of the poster did not effectively relay the information. Following this we had another workshop looking at how we should progress.



Co-design team analysing the result of the interviews post-trial.

At the workshop we discussed ideas on how to promote the Kōrero mai service. We decided that alongside a poster redesign, we would design business cards to be distributed at the time of admission. We planned to audit later. We also identified suitable positions across the hospital to display posters.

We had the poster and business cards redesigned and went to two pilot wards to ask patients for their opinion. We then launched the final designs. We launched Kōrero mai across the DHB in October 2019 and audited 12 months later. The audit report is currently being written. See [Appendix 8 for final poster design](#).

Appendices

[Appendix 1: Gantt chart](#)

[Appendix 2: Elevator pitches](#)

[Appendix 3: Sheila Becker's reflection of the Commission conference](#)

[Appendix 4: Commission questionnaire template](#)

[Appendix 5: Data spreadsheet](#)

[Appendix 6: Kōrero mai trial poster](#)

[Appendix 7: Post-trial data](#)

[Appendix 8: Final poster design](#)

Kōrero mai is a Health Quality & Safety Commission initiative in partnership with participating DHBs. This case study is reproduced with permission of Capital & Coast DHB. The Commission would like to thank the co-design team involved for sharing their example.



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We would also like to thank our partner, Ko Awatea, for its support:

