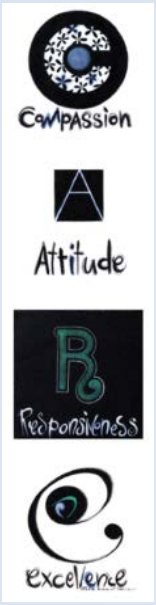
BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

BOPDHB Patient Experience Survey Report

DECEMBER 2015 | 2015 - 2016, QUARTER 2



Any time spent in hospital can be an intimidating event. Families and caregivers are focused on the immediate needs and treatment, and so are the hospital staff. The key focus is not usually what happens when the patient recovers and is ready to leave the hospital.

Yet the way the transition back into the community is handled, whether it is the discharge to a patient's home or somewhere else, is critical to the patients' health and well-being. It can also dramatically improve the outcome for patients as they move to the next phase of care.

Well-designed, targeted care coordination that is delivered to the patient by the right people can improve outcomes for everyone involved. Patients, family caregivers and healthcare providers all play roles in maintaining a patient's health after discharge. Although it's a significant part of the overall care plan, there can be a surprising lack of consistency in both the process and quality of discharge planning.

Julie Robinson, Director of Nursing

Patient Experience Surveys

The quarterly national and the fortnightly BOPDHB Patient Experience Surveys have now been underway for 12 months.

The two surveys have shown us the experiences of over 2500 people who were admitted to Tauranga and Whakatāne hospitals with at least one overnight stay between August 2014 and September 2015.

Overall Results:

Patients are asked to rate their experience on a scale of 1-10 and to enter comments which are a rich source of real time feedback.

Quarterly National Patient Experience Survey

	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015
Communication	8.2	8.5	8.6	8.6
Partnership	8.4	8.6	8.6	8.7
Coordination	8.3	8.6	8.5	8.6
Meeting Needs	8.5	8.7	8.6	8.7
Respondents	95	93	87	99

BOPDHB Fortnightly Patient Experience Survey

	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015	Oct-Dec 2015
Communication	8.5	8.3	8.5	8.5
Partnership	8.4	8.5	8.6	8.7
Coordination	8.4	8.2	8.5	8.6
Meeting Needs	8.8	8.6	8.9	8.9
Respondents	271	455	334	266

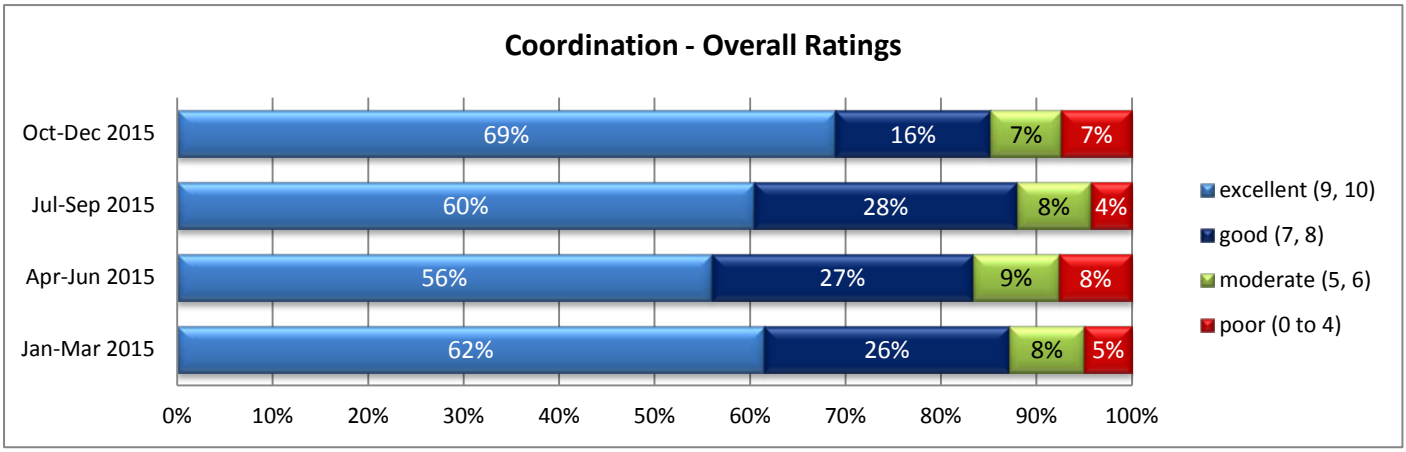
Coordination Domain

"The coordination, integration and transition of care between clinical and support services across different provider settings" (HQSC)

The Agency for Healthcare Research and Quality (AHRQ) describes care coordination as involving deliberate organisation of patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

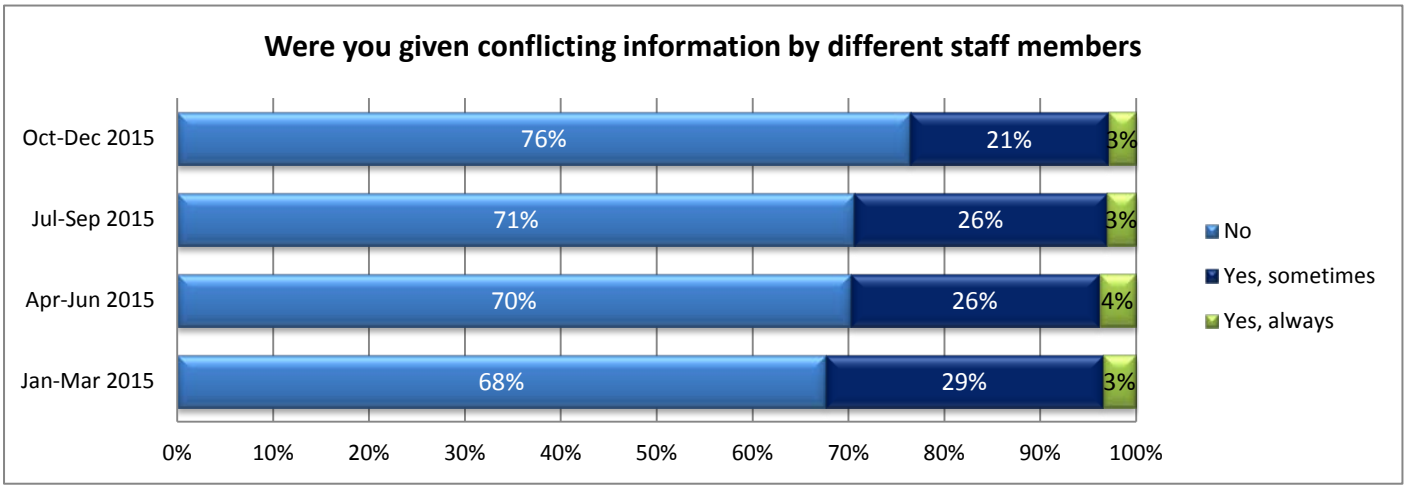
Coordination – The coordination, integration and transition of care between clinical and support services across different provider settings

- Treatment just flowed smoothly from my admission examination operation and recovery.
- Just the changeover lapse was a little disappointing and not having the drip put in according to doctor's chart. Nurses came and went but no one took responsibility early on on the general ward.
- I know my case was not considered as being urgent but to me it was urgent when in pain, but the care given was tops.
- Different doctors had different opinions on my condition and me being discharged or receiving more treatment. This was confusing.
- At no time was I worried about my condition or the future of my health, everyone worked in conjunction with each other for my betterment.



Were you given conflicting information by different staff members, e.g. one staff member would tell you one thing and then another would tell you something different? (Rating from 0 to 10, Poor to Excellent)

- Doctor telling me he was going to treat me with one thing and nurses telling me something else. This arose when the drug in question had two different names.
- All involved in my care knew what was happening. I was not left to guess and felt the staff weren't either.
- The physiotherapy department seems to be out of step with the rest of the medical team.
- Self-explanatory, I heard no conflicting information.
- My first doctor indicated a pathway he intended to follow, and was to confirm this on the Monday morning rounds. He never turned up on the Monday, and my care was then transferred to another doctor. This was very poorly handled and was the worst aspect of my entire hospital stay. In saying that, other than this incident all the rest of my care and hospital experience was excellent.
- Just confusion between staff members as to what was happening.

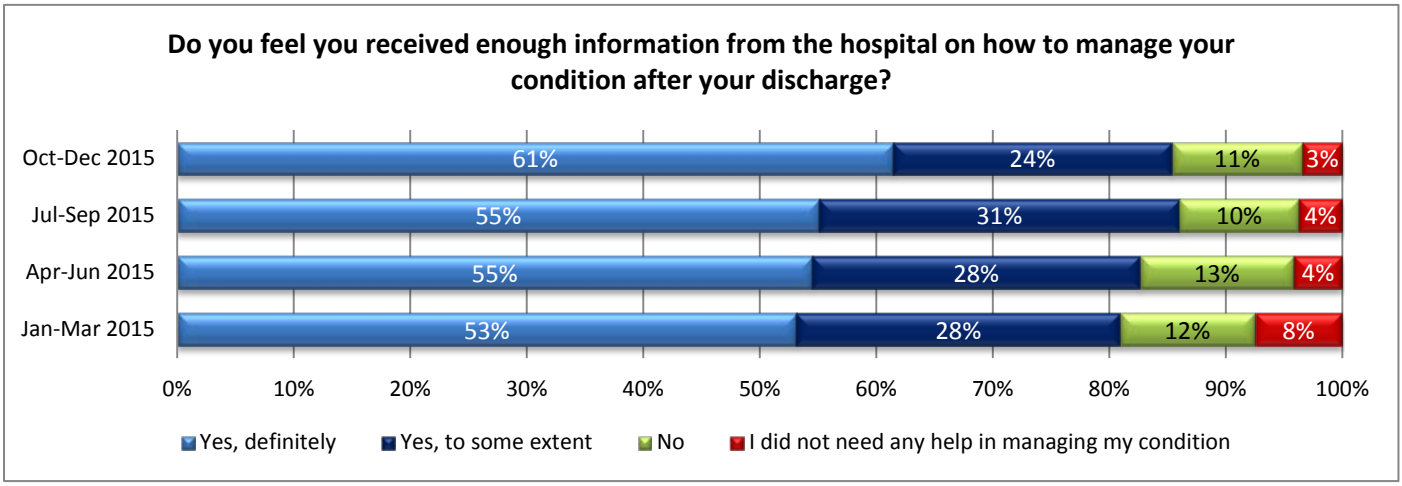


Do you feel you received enough information from the hospital on how to manage your condition after your discharge?

Hospital discharge is a complex process involving the patient, their family and the whole multidisciplinary team. The discharge and aftercare planning process begins at admission and continues throughout a patient's hospital stay.

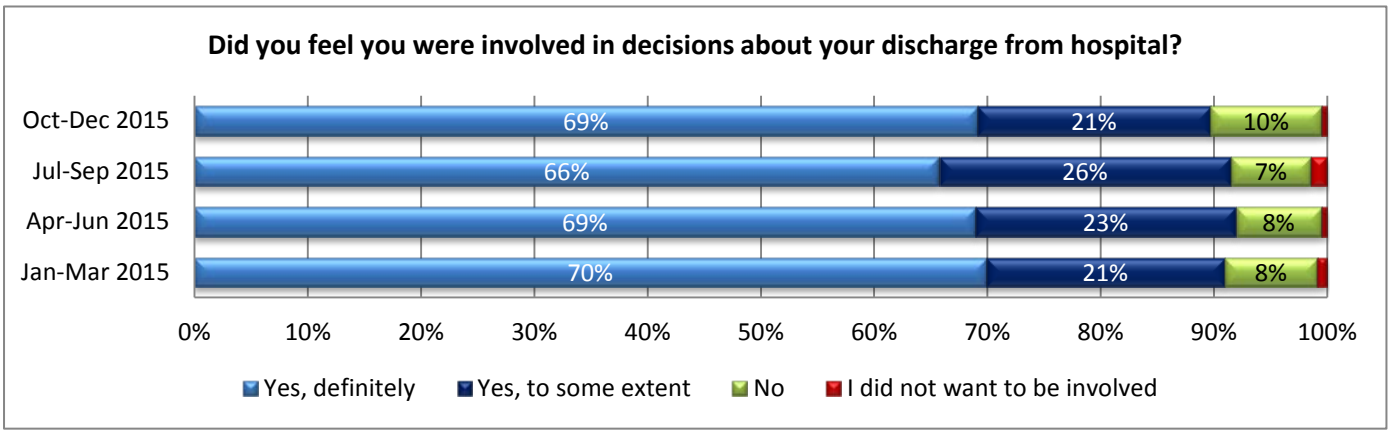
Discharge instructions provide critical information for patients to manage their own care and are a handover of care to other healthcare providers. These instructions are typically free-text and not easy for patients to understand and remember.

- Your staff are your best asset. My doctor was sent a full report. I was not allowed to leave until I have all assistance people.
- My husband and I left knowing exactly what I needed to do as well as booklets.
- Nursing staff explained what to expect once discharged, with the physio team outlining the required exercises to be done at home after discharge.



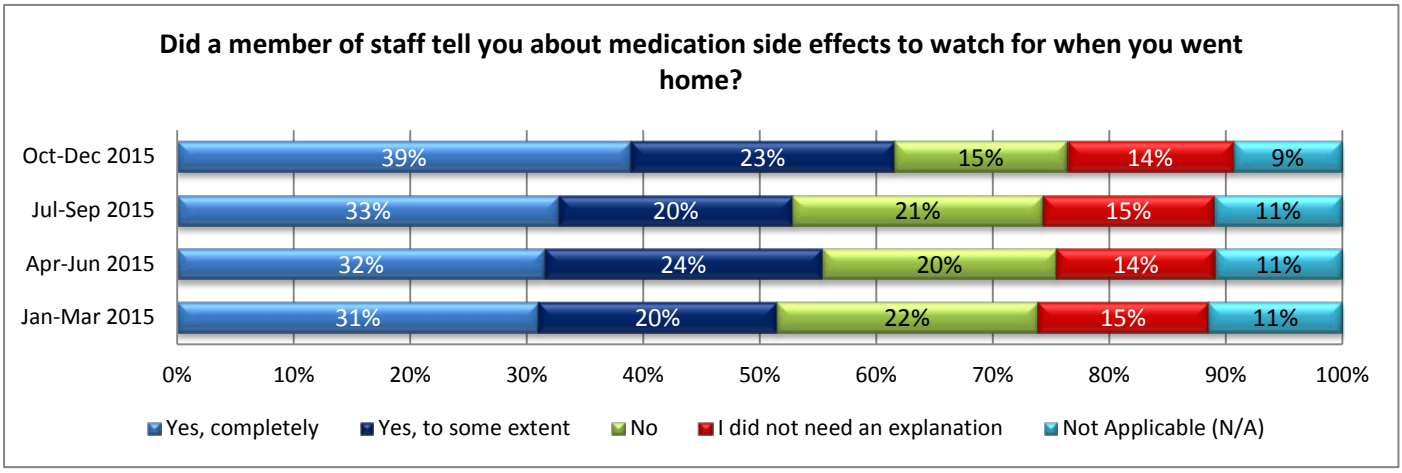
Did you feel you were involved in decisions about your discharge from hospital? - Partnership Domain

- There could have been more talk about what I needed to do when I came home. I had to make an appointment with my doctor to discuss ongoing issues.
- Staff were aware that my family were visiting and then after they went home informed me of an earlier decision to discharge. This meant that my very busy daughter had to return to get me during family meal time.
- The doctor involved made sure (by way of a phonecall the next day) in my being able to pick up the injections required through the local pharmacy - because I couldn't take them home with me as the hospital or Auckland computer was down when I was discharged.
- No home care options were discussed because I had neighbours staying with me but neighbours were due to relocate four days after I was discharged. A friend came down from Auckland and stayed an extra four days and I found someone to assist with housekeeping for a few weeks ($150).



Did a member of staff tell you about medication side effects to watch for when you went home? - Communication Domain

- It was explained why the changes to my medications were being made and the alternatives if these didn't work. Also how my own doctor was to be involved.
- The staff were very open in their communication with me. They gave a good explanation of any medications or procedures they were doing for me.
- Each time medication was administered it was explained in full.
- I feel that I wasn't given any options on what medication I should have been taking or sent home with. I was asked what other meds I took regularly but was never given any during my stay, or was I supposed to have had someone bring my in from home?



Through sharing others experience we can connect the reality of stroke...

...this is the underpinning theme for our monthly presentation whereby a patient and their family give an account of their stroke journey.

Professionals often talk about expert patients. Expert patients' programmes can only be successfully created by allowing patients who have experienced the journey to talk about it. With professionals supporting but mainly listening, we can afford ourselves a prime feedback opportunity and the combined experience can be taken in by other stroke patients.

- Information can be overwhelming and depressing
- Our family had a stroke and our grandkids were in the middle of it.
- I stayed with Graeme the first seven days; I needed to know he was safe.
- Advice becomes confusing, it's personal you know and we are looking for hope.
- Are you people aware of crashing trolleys and loud voices at night.
- We could tell what the duty was going to be like by the faces and language coming out of handover meeting.
- Think of each day, one day at a time.
- The humiliation gradually got better; you have to channel your own self talk.
- Celebrate little successes.
- Don't give up on physio.
- You can choose your attitude.
- It's ok to have a bad day.
- Emotions can't rule me but the internal struggle is overwhelming.
- Mundane rehab is so important.
- You need to sign up early on the journey for the long haul.
- There's power in prayer, family and social media (Facebook).

As health professionals we listened and we heard:

Graeme concluded the session by jogging across the room, demonstrating he had achieved one of his goals. A huge milestone given he had multiple functional limitations secondary to hemiparesis, visual disturbance and recent knee joint replacement, prior to his stroke.

He expressed his eternal thankfulness to us for aiding and supporting his recovery.

Trish Blattman, Clinical Nurse Specialist and the staff of the Acute Stroke Unit