Turning a challenge into an asset:
Implementation of Person-centered Care Pathway
Incorporating Recovery Principles for Psychiatric In-Patients

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Healthcare Paradigm Shift

Patient-centered care as one of the six aims for improvement for the healthcare system.

(Institute of Medicine, 2001)
Healthcare Paradigm Shift

Providing a person-centered service based on effective treatment and the recovery of the individual
Challenges Imposed by Paradigm Shift

- Sharing of power & responsibility
- Holistic care; addressing patient’s needs, preferences & value
- Staff readiness & competence to practice
- Collaborative partnership
- Changing role expectation
- Patient & family participation
With a Care Pathway, What We Want to Achieve?

1. **Provide a guide** to explain the most appropriate pathway to take care inpatients during hospitalization.

2. **Standardize the key elements of care** based on patients’/carers’ needs as well as the person-centered and recovery concepts.

How Does the Person-centered Care Pathway Developed?
Based on Extensive Consultations

1. Patients
2. Carers
3. Nurses
4. Supported information
Process of Redesigning Care Around Needs

Through community meetings, carer forum & nurse panel discussion

Consolidate patients’, carers’ and nurses’ views on the most salient needs during hospitalization

Through an information/evidences reviews

Define the good practice for mental health care

Determine key elements of care for the care pathway

A needs-led care pathway was developed based on person-centered care/recovery concepts as well as generated from patients’ and carers perceptions of service requirements.

Collaborative partnership & share decision making for change
A Person-centered Care Pathway for In-patients

Jointly Developed by Patients, Carers and Nurses (Jan 2013)

Rapport & Exploration

1. Support and orientation
2. Identification of patients’ concerns
3. Patient empowerment on personal rights
4. Family engagement
5. Provision of information on services available in the hospital
6. Comprehensive Assessment on:
   - Mental health
   - Physical health
   - Risks
   - Strengths and potential
   - Family system
   - Understanding and Communicating
   - Getting around
   - Self-care
   - Getting along with others
   - Life activities: household & work/school
   - Participation in society

Goal Setting & Gap Identification

1. Sharing of feelings on diagnosis
2. Sense of identity reestablishment
3. Reinforcement on the possibility of changing
4. Personal goals Identification and prioritization
5. Gap/Barrier identification

Exploring Options & Possibilities

1. Provision of a range of options for achieve life goals, including:
   - Family nursing
   - Psycho-educational activities
   - Self-management training
   - Career counseling
   - Support system
   - Leisure activities
   - Community resources
   - Spiritual care
2. Empowerment on decision making
3. Roles and responsibilities discussion
4. Determining actions for a meaningful life
5. Person-centered care plan development
6. Patients’ involvement in treatment decisions

Looking Ahead & Moving into Advocacy

1. Maintenance plan establishment
2. Handling mental illness labeling
3. Linking patients and their carers to community services
4. Summary on gains from hospitalization
5. Care coordination
6. Follow up services after discharge

Partnership

Disease Specific Interventions
2 Levels of Application

1. Ward Operation Level
   • Provides a framework for the integration of recovery and person-centered concepts into daily routine of care

2. Primary Nurse Level
   • Develops a person-centered care plan template for facilitating patients’/carers’ participation in their own care planning
What Have Been Done to Support the Implementation of Person-centered Care Pathway?
1. Staff Training

- A series of recovery trainings have conducted to promote cultural change

- Included recovery training in the curriculums of the Induction and orientation program for newly recruited or transferred-in nursing staff

- 252 (81%) supporting staff and 267 (56%) nursing staff in in-patient setting were trained

2. Person-centered Care Plan

Base on the patient’s own goals

Work with patient to explore all possible options and empower them to take actions

A share decision making tool that incorporates coaching
3. Production of Manuals for Nurses

As an engagement for the implementation of Person-centered Care Pathway among frontline colleagues
4. Maintenance Plan

(自在自主、居安手記)

• A personalized relapse prevention plan

• Promote continuity of care among helping professionals and carer(s) after patient discharge
5. An Electronic Pull Down Menus

Derived from recovery/person-centered concepts, which outlined options for achieving patient’s goal.
How to Address Language Differences?

Person-centered Care Plan + Maintenance Plan + Pull-down menu are with

English, Traditional Chinese and Simplified Chinese Versions
What Have been Done to Ensure Adequate Respect and Responses to Patients’ Needs?

A patient panel was established for reviewing the suitability of pull-down menu
Effectiveness of Satisfaction

**Study Design**

**Sampling**
- Nurses, patients, and carers with specific inclusion/exclusion criteria

**Instrument**
- The Perception of Care Chinese Translation Questionnaire (Modified) + a self-developed questionnaire

**Procedure**
- Prospective: compare the changes in the level of satisfaction before and after the implementation of the pathway

- Baseline Survey: 2 months before intervention
- Phase 1: 6-month pilot in 7 specialties wards
- Midpoint Survey: after phase 1 pilot
- Phase 2: 6-month full implementation in all wards
- Post-intervention Survey: after phase 2 full implementation

Patients and carers complete the questionnaire before discharge.
Nurses complete the questionnaire after the pilot and full implementation.
## Pilot Findings (1)

<table>
<thead>
<tr>
<th>Patients</th>
<th>Carers</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of cases recruited</strong></td>
<td>63</td>
<td>25</td>
</tr>
<tr>
<td><strong>Age range (yr)</strong></td>
<td>35-45yr (44.4%)</td>
<td>35-45yr (47.2%)</td>
</tr>
<tr>
<td><strong>Years in role</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gender (%)</strong></td>
<td>45(71.4%)</td>
<td>31(54.4%)</td>
</tr>
<tr>
<td>Male</td>
<td>18(28.6%)</td>
<td>26(45.6%)</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>7 (28%)</td>
</tr>
<tr>
<td><strong>Duration of Receiving Mental Health Service</strong></td>
<td>52.4%</td>
<td>48.3%</td>
</tr>
<tr>
<td>Less than 6 months</td>
<td>48.3%</td>
<td>72%</td>
</tr>
<tr>
<td>Less than 9 months</td>
<td></td>
<td>72%</td>
</tr>
</tbody>
</table>

## Pilot Findings (2)

### Patients Satisfaction

<table>
<thead>
<tr>
<th>The Satisfaction Score of Individual Subscale</th>
<th>Before implementation</th>
<th>After implementation</th>
<th>Independent pair t test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>1. Information Received</td>
<td>1.7407</td>
<td>.47432</td>
<td>2.0994</td>
</tr>
<tr>
<td>2. Interpersonal Aspect of Care</td>
<td>2.4825</td>
<td>.91110</td>
<td>3.0737</td>
</tr>
<tr>
<td>3. Continuity / Coordination of Care</td>
<td>1.8135</td>
<td>.66271</td>
<td>2.0132</td>
</tr>
</tbody>
</table>

- Significant improvement was found in the four Subscales
Pilot Findings (3)

Nurses Satisfaction

**Perceived the Implementation of the Care Pathway Increases their Workload**

- Strongly Disagree: 0%
- Disagree: 4.8%
- Not Sure: 25.4%
- Agree: 46.0%
- Strongly Agree: 23.8%

**Considered the Care Pathway Enhances the Quality of Care to Patient**

- Strongly Disagree: 0%
- Disagree: 3.2%
- Not Sure: 27.0%
- Agree: 49.2%
- Strongly Agree: 20.6%

**Believed the Implementation of the Care Pathway Promotes Nurse-patient Relationship**

- Strongly Disagree: 0%
- Disagree: 4.8%
- Not Sure: 28.6%
- Agree: 54.0%
- Strongly Agree: 12.7%

**Supported the Implementation of the Care Pathway In-patient Context**

- Strongly Disagree: 1.6%
- Disagree: 4.8%
- Not Sure: 22.2%
- Agree: 54.0%
- Strongly Agree: 17.5%
Carer Satisfaction

Did the nurses give you reassurance and support?

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEVER</td>
<td>24%</td>
<td>17.9%</td>
</tr>
<tr>
<td>SOME TIMES</td>
<td>52%</td>
<td>42.9%</td>
</tr>
<tr>
<td>OFTEN</td>
<td>16%</td>
<td>5.4%</td>
</tr>
<tr>
<td>ALWAYS</td>
<td>0%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Were you involved as much as you wanted in decision about patient’s care plan?

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</tr>
<tr>
<td>ALWAYS</td>
<td>0%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Did the nurses give you information as needed?

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>28%</td>
<td>7.1%</td>
</tr>
<tr>
<td>NOT SURE</td>
<td>8%</td>
<td>10.7%</td>
</tr>
<tr>
<td>YES</td>
<td>75%</td>
<td>76%</td>
</tr>
</tbody>
</table>

Did nurses review with you the plans for continuity of care after patient discharge?

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>4%</td>
<td>10.7%</td>
</tr>
<tr>
<td>NOT SURE</td>
<td>20%</td>
<td>14.3%</td>
</tr>
<tr>
<td>YES</td>
<td>76%</td>
<td>75%</td>
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</tbody>
</table>

Using any number from 1 to 10, what is your overall rating of the care you received?

<table>
<thead>
<tr>
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<th>Pre</th>
<th>Post</th>
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<tbody>
<tr>
<td>0-4</td>
<td>16%</td>
<td>14.2%</td>
</tr>
<tr>
<td>5-6</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>7-8</td>
<td>24%</td>
<td>14.3%</td>
</tr>
<tr>
<td>9-10</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

How much were your relative helped by the care he/she received?

<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOMETHING</td>
<td>20%</td>
<td>21.4%</td>
</tr>
<tr>
<td>QUITE</td>
<td>60%</td>
<td>57.1%</td>
</tr>
<tr>
<td>VERY</td>
<td>20%</td>
<td>25.0%</td>
</tr>
</tbody>
</table>

Pilot Findings (4)
Way Forward (1)

Full implementation of the Person-centered care pathway in all clinical wards with evaluation to be conducted with improvement made accordingly
Way Forward (2)

- Peer to Peer: Patient Newsletter
- Aim at promoting patient involvement, strengths sharing and peer support
Way Forward (3)

Authorizing public access to our educational materials and users’ booklet namely, information leaflet on carer support and stigmatization, maintenance plan and person-centered care pathway pamphlet