PHASE I MID-POINT EVALUATION OF THE IMPLEMENTATION PROCESS COLLABORATIVE MODEL OF CARE

PREPARED BY PLANNING & EVALUATION

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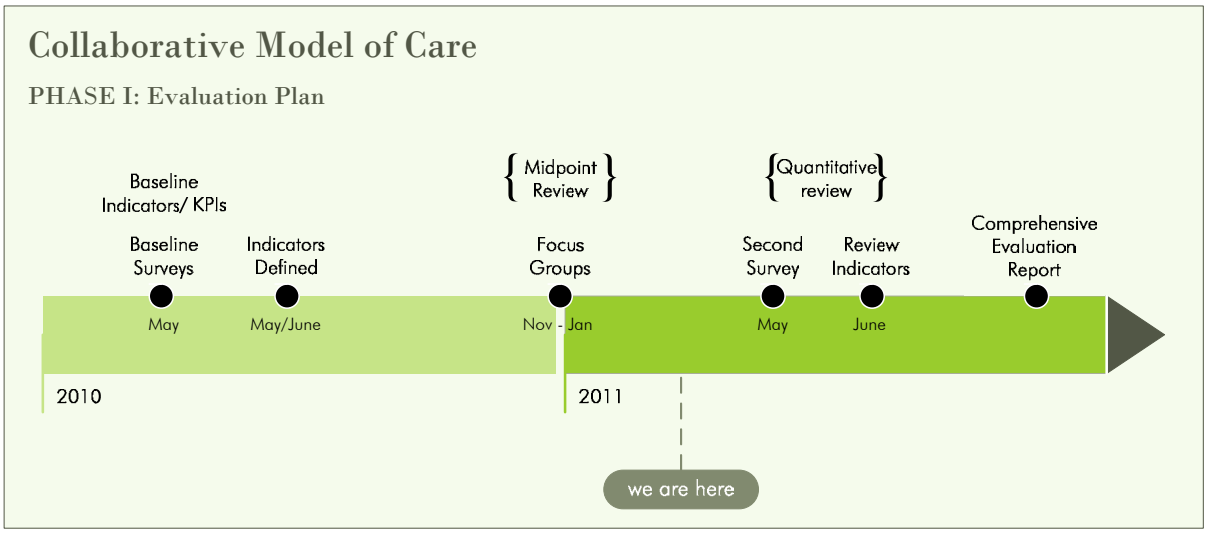
Contents

INTRODUCTION

Building towards a single integrated health care delivery system for Prince Edward Islanders, in response to the Corpus Sanchez report (2008), a Collaborative Model of Care (CMoC) for delivery of health services was developed in consultation with stakeholders. In phase one, a series of showcase units was chosen to implement the CMoC across the continuum spanning acute, home, and long-term care areas. In order to inform future implementation phases and ensure the uptake of "learnings" throughout the roll-out of CMoC, an evaluation plan was developed to review the implementation of phase one. This evaluation plan is outlined below in Figure 1. It should be noted here that this evaluation does not review or evaluate the model itself. Evaluations of the model in other jurisdictions have already confirmed several benefits of this model including better patient care, increased patient satisfaction, and improved job satisfaction of caregivers.



This report outlines focus group findings from the Mid-Point Evaluation of phase one that explored front line staff's implementation process, their successes and challenges. A qualitative method and iterative group process was preferred as an interim review step to capitalize on front line staff's experiential learning through phase one implementation. Contained is a synthesis of the core messages from focus groups that included participation of front line nurses, managers, site leads, and teams from the five showcase units. Findings promote organizational learning, support the ongoing evolution of phase one, and inform direction of the spread plan for future implementation phases. Opportunities for course correction were identified by exploring strengths and weaknesses to optimize implementation of this integrated health care delivery system on the front lines and across the Island. This report highlights the main messages of phase one, provides an executive summary, outlines how the information was collected, and details the synthesis under each

care delivery setting; namely acute care, long-term care, and home care. This review closes with recommendations for consideration and concluding comments.

Main Messages

Communication

- Stakeholders requested broad and consistent messaging in all related communications and direction on CMoC.
- Suggested definitive communications on staff impact and role clarity.

Education

- Recommended a coordinated and collaborative approach to educational support for each site.
- Identified the value of Mentorships and Preceptorships and potential for structure around the process.
- Attention to learning capacity, time for knowledge transfer, and sharing resources across the system may be beneficial.

Collaboration & Teamwork

- More positive experiences were evident where people felt supported by management and their co-workers.
- Identified RCW's role and support for patients and team as very helpful.

Supportive Leadership

- Leadership presence and availability to adopt and make quick decisions assisted staff in coping with change.
- The LPN Association site visits and message viewed as a positive support.

Capacity

- Increased scope for LPN's viewed with personal sense of achievement and job satisfaction.
- Expressed wish for Optimizing all Roles within teams and extending to allied health teams

EXECUTIVE SUMMARY

From the synthesis of the focus group information this section highlights over arching strategic priorities, a summary of key emergent themes, and lessons learned through front line staff during implementation. Key lessons and opportunities that surfaced during this process were similar across the three care areas, suggesting that change management requires similar support across the system. Participants' comments demonstrate three core areas of learning including communication, education, and collaboration. There was high value placed on more timely communication and consistent messaging, educational support for role clarity and role optimization, and support in the workplace to build collaborative teams.

Change management holds an integral role for open communication in support of the change process. Significant communication took place in order to reorganize roles within teams for care delivery: changes in nursing scope of practice and staffing mix. Value was placed on transparency and timing of communications, the need for broader knowledge of the plan, and a clear process for making decisions as change unfolds. Availability of managers and site leads for aid in decision making had a supportive impact on staff. Communication challenges surfaced in all care settings as well as challenges with delays in educational progress for team members to work at full scope. When given enough time to build competencies and strive for full scope participants felt positive about their new skills and expanded roles.

Positive changes in communication flow in home care was attributed to the implementation of a single intake phone line where patients were assessed, client groupings coordinated, and teams' assignments managed all in one phone call. The one call access for the client management process was noted as a positive for both clients and staff. Findings identified value in streamlined communications as caregivers were enabled to focus efforts on delivery of client care services.

The need and value in further education and communication to optimize care giver's roles was a common theme. Nurses report uncertainty of what the evolving role of team members are within CMoC moving forward. There were reports of feeling "stuck" and "unable to move forward" without additional training in care planning and coordination of discharges. A suggestion that the RCW's role could be expanded to optimize work within teams with further training in skin care suggests a need for further educational support. Allied health integration was highly valued in balancing teamwork in a care setting and balance within teams and sharing the care may be fostered with educational initiatives that

promote role optimization. This has upside capacity within teams and can promote coordination and collaboration of resources for improved efficiencies in care delivery.

In clinical areas where teams did not self-organize and where roles were described as "grey, rather than, black and white" and especially where LPN's were not yet at full scope; ability to see the merits of implementing CMoC seemed low. A marked difference was noted in teams who had respect training in advance as those teams were viewed as having "a more positive experience". Reports of educational training sessions being "full and not able to accommodate" indicates that coordinated and collaborative educational forums with greater capacity for participation may enhance availability of education and contribute to shared resources between facilities.

Leaders, who provided support on the front lines, had a positive impact on participants, especially during the initial stages of implementation. In areas where leaders worked alongside staff, it was reported that even though stress was high during the process, there was strong support for team members. Participants confirmed their sense of achievement with the additional education, and their feelings of personal growth and job satisfaction in their new roles. Support for the change felt strongest where leaders communicated firm direction to their staff about the change, adopted a 'no turning back' philosophy, and worked through the new decisions and processes together.

Collaborative Model of Care is a model being used and evaluations have confirmed it is making a difference in other jurisdictions with positive outcomes. For example, Dalhousie University in Nova Scotia recently completed a comprehensive and rigorous evaluation of Collaborative model of care. The results there have shown implementation of the model has led to better patient care, improved patient satisfaction, and improved job satisfaction for health care providers. As the CMoC strategic initiative continues within Health PEI, this review confirms success of the transition and that it has fundamentally impacted and may be enhanced by clarity in communication, support for education, and strength in leadership.

METHODOLOGY & APPROACH

Using an open ended question format, a series of six focus groups were conducted and qualitative experiences collected over a two month period (November 2010 – January 2011).

The questions asked of each group were as follows:

1. What did we do well?
2. What did we do not so well?
3. What could we improve the next time we are implementing a new model of care?

The profile and participation response of the show case groups are summarized in Table 1.

TABLE 1: FOCUS GROUP OVERVIEW

FOCUS GROUP	LOCATION	SHOWCASE UNIT	NUMBER PARTICIPANTS	DATE
1	PCH	Acute Care Hospital	10+	Nov/23/2010
2	QEH Unit 3	Acute Care Hospital	12+	Dec/1/2010
3		Site Leads & Nurse Managers	7	Dec/13/2010
4	Summerside	Home Care	18	Jan/5/20111
5	Wedgewood Manor	Long-term Care	14+	Jan/17/2011
6	KCMH	Acute Care Hospital	11	Jan/25/2011

Each focus group was conducted by a facilitator who scribed participants' comments on flip charts, and an observer who took detailed notes. The notes from both sources were subsequently transcribed to word documents, themed, and analyzed. A synthesis of the participants' comments and shared experiences are outlined in this report.

Themes & Key Findings By Care Setting

Acute Care

Background

The findings from groups 1, 2, 3, and 6 were considered for analysis in this section of the review. As outlined in Table 1, they include front line staff perspective from mainly inpatient hospital based nursing units at PCH, QEH, and KCMH as well as a blend of site leads and managers comments from each of the three sites. These units reflect a delivery of nursing services to general surgery or internal medicine inpatients. Each of the three hospitals are progressing with model implementation at varying speeds depending mainly on if their LPN's have completed their training and are operating at full scope. Though this study did not seek to measure this aspect, where there were significant mentions of variance, the unit's progress with implementation was reportedly slower. Review of the study information captured for acute care identified findings within the following themes: communication, education, collaboration, capacity, change readiness, and patient safety.

Communication

Strong communication, specifically transparency and honesty, were mentioned multiple times. The feedback confirms that strong communication promotes team work. In response to what went well, frequent meetings, good communication, and keeping the teams forward focused were reportedly helpful. The comments suggested intentional team meetings hosted by Managers to bring staff together and assisted them in handling and coping with implementation processes. The information highlighted that meetings provide opportunities to share information and to identify what works well and what does not, and this allowed them to make changes because shared decision making could happen 'on the fly'. One group suggested the focus group was the first time they had come together as a team to provide feedback and talk openly about the process. In this case participants found the focus group process of meeting and talking openly helpful. This group requested "more meetings like this in the future".

Access via email, site visits, and communication with leadership were identified as supportive to front line staff. Value was found in connecting the showcase sites through face to face updates, newsletters, and project management office. Loss of the Project Manager had some sites expressing they felt disconnected and they felt the need for this connection to keep the momentum going. Many focus group participants asked why feedback had been given and in turn why they were not heard. They suggested feeling "like nothing ever came of it". This may be attributable to the baseline surveys that were collected early in the process and as per the plan outlined in Figure 1, page 3 there are plans to follow up with a second survey. This indicated there is a need for stronger and more consistent interactive communication between all stakeholders especially with site leads, managers, and front line staff.

A need for improvement in communication was expressed by many groups. Announcements leading to implementation were requested up to 2 months in advance as well as attention given to timing in regards to summer holidays. Participants indicated broad messaging on CMoC was not enough and there was an expressed need for a plan on when and how it would unfold. Participants used terms like "there were too many grey areas and they would like to see things more in black and white and even written would be ideal", suggesting a variety of communication methods may be beneficial.

EDUCATION

Within the education theme, there were a number of initial challenges some of which have been addressed since the phase one process began. Some key issues were with respect to timing and the lack of availability of courses for LPNs. There was a lack of information about courses, especially in the early phases when the implementation was first launched. Some participants felt stressed when they couldn't find courses available while others felt they needed hard and fast answers from stakeholders and the information was not coming fast enough. Other issues identified include the significant variance in each individual's capacity to learn, availability of time and costs associated with taking courses (work-life-balance), and volume of learners simultaneously mentoring and orientating within the same nursing units. The generational issue was also mentioned as a key influence on education especially for those who noted – this was the first time they had been in school in 27 years. Issues were identified around role clarity and many participants felt they could benefit from communication and educational support to further enhance and define their position and roles. For example, one group suggested LPN's understood their new role; however RN's did not have anything concrete to help them define their role. Lack of clarity in the role of an RN versus a LPN may have contributed to imbalances in workloads and conflicts between team members. Although RN's assumed the role of mentoring LPN's as they transitioned, "now they are unclear where they fit". RN's have expressed a need for role clarity in order to move forward and be successful in their positions. Another group suggested the need for clearly outlined roles for nurses to be written down on paper so assignments can be more balanced. LPN's suggested that while they felt the education process was very stressful at times, they found the overall experience of the educational process good and feels they have grown both personally and professionally.

At the time of information gathering, financial resources for LPN education were a potential barrier to fulfilling expanded scope requirements. Participants who had the financial support in the initial roll out said they appreciated how good this was for their ability to get the training they needed. On the other hand some suggested the education was rushed and they would have benefited from having more time to learn the new information. Staffing support for learning on the front lines was identified as something that worked well for teams so LPN's could study together in groups. These participants also acknowledged that this accommodation may have put pressure on their team as it made it challenging for staff that were left to cover patients.

In terms of educational resources, a team of participants declared they took the initiative to build an education binder and viewed it as a good resource that they updated with

information they found helpful through the process. Another team suggested they require more education and when they requested to attend educational forums offered at other sites they were advised "the course was full". This example suggested coordination and sharing of educational support may be something to consider. Front line staff declared "there is a clear role for an educator in the process" and one that would "be available to all teams" as they implement Model of Care.

COLLABORATION

The value of keeping all stakeholders connected throughout this dynamic change process resonated with a number of participants. There were reports of nurse managers hosting meetings to intentionally discuss the process and this led to shared problem solving and positive changes that helped to ensure everyone was following a similar direction through the process. Some identified how they creatively fit the meetings into their busy working environments by "holding team huddles to share how things were going and support each other".

The value of stakeholder communication and collaboration on CMoC was also deemed a positive resource in the broader system as noted in the following example. The LPN Association came in to speak to LPN's and RN's on the front line after changes were underway and there was a significant amount of support gleaned from this. This was such a positive experience participants recommended that this be expanded to include that the LPN Association do a speaking tour in support of other sites as implementation continues.

Some participants noted the variety of LPN progress through their learning made patient assignments challenging because even though the LPN was considered full scope by virtue of their assignment, some had not completed their training and/or mentorships. This example was suggested to have a negative impact on their teams. This also supports the notion that when communication, role clarity, and team responsibilities are clearly stated there is potential for positive impact. There was also some general discussion amongst participants suggesting the value in talking to each other and working together because the CMoC has "completely changed the way we care for patients" and some are "challenged with feeling good about it".

There was favorable mention from many acute care participants that the addition of RCW's and the role they took on in addressing patients needs freed up nurses to do other things. Nurses suggested there was a significant change in work load with this assistance in doing basic patient care and answering call bells and this addition to their teams assisted in their workload. The Home Care liaison nurse was reportedly working well from the acute care nurse's perspective. There was also indication that the participants valued the collaborative team approach as there was an expressed desire for additional team resources including Occupational Therapy, Physiotherapy, Pharmacy, and other allied health. One team offered an example of collaboration working well in that they noted the recognition of 8 patients needing to be up in the dining room and ready for breakfast by 0800. In this case the OT assistant team was supportive to the process and offered flexible scheduling and adjusted to 0730-1530 to assist.

Capacity

The staffing mix was cited as a key issue in supporting capacity for nursing teams to accommodate LPN's in their transition. Initially when a team of LPN's were trained it was a little more clear where all the LPN's were in their learning pathway, however now some areas report a strong variance on the LPN's scope depending on their learning progress. One group suggested the staffing mix is not fully operational and yet patient assignments and patient care loads are being set assuming LPN's are at full capacity. There were also indications that from time to time there was an imbalance in senior tenured staff to compliment new staff and fulfill the need for preceptors and mentors.

Participants suggested the addition of RCW's contributed to patient centered care, as call bells were being answered quicker and patients' needs were being met in a timely manner. In contrast, the need for RN role clarity was also suggested to have a negative impact as RN's "don't know where they fit". The forums also identified that through the expanded scope of practice process; LPN's have a greater sense of confidence when they are working to their new scope. Many also suggested that LPN's are doing a fine job and now have the opportunity to improve their practice.

Change Readiness

A consistent message from the comments within this theme included time. Timing of messages, time to prepare, time for education, and work-life-balance in terms of making time in life for the additional education required. The information suggested the timing to launch phase one implementation, especially before summer vacations, was not ideal. Some noted more time for knowledge transfer is needed. The comparison was made that "new grads get a full preceptorship while LPN's get only four days" indicating some LPN's felt the need for additional time to transition into their new role. LPN's on the front lines reported that what worked best was being able to self-gauge readiness to take on patient load, and this process offered them the opportunity to slowly build, take on additional responsibilities and feel comfortable in their new role. It was suggested that this positive slow build experience was achieved through preceptors facilitating patient loads with LPN's at a pace that was comfortable to the learner.

The focus group participants also observed that those who participated in the course on respect seemed to have a more positive experience with the implementation phase. A second group suggested the roll out unit at their facility had a more positive experience second time around compared to the first. The same group suggested although change is challenging from an emotional point of view, it did strengthen their team's relationships. One site declared "phase one has prepared for the spread to the broader system".

Patient Safety

Patient safety had two mentions, namely medication carts and incident reports. These showcase units suggested they identified logistics for improving patient safety by adding one medication cart per LPN and suggested this decreased the propensity for medication errors, although it is unclear if this was actually measured or staff opinion. There was also an intentional move to carefully monitor and liberally use incident reporting as learning tools.

Importantly, although this may have led to patient safety implications, it was couched as a learning opportunity to ensure competencies and learning. These teams adopted the philosophy that they were leading the rest of the province who could learn from their process.

Home Care Key Themes & Findings

Background

Home care's implementation of CMoC was in many ways viewed through a different lens as their work previously used a collaborative work approach and service delivery is naturally integrated into their client focused work setting. However, when the Island delivery system was five regions provincially, each home care setting was described as a system that had "morphed regionally with independent care delivery processes". For these reasons through the course of moving to a single region and one Island health system their spread challenges may be viewed and impacted differently.

Also of significance, prior to the implementation of CMoC, it was noted that there were a number of demonstration projects stemming from the Home Care Renewal strategic initiative that were already underway. This potentially readied the home care team for some of the changes CMoC required. These were described as capital investment projects including introducing LPN's into the home care setting, increasing the number and expanding the reach of home care liaisons provincially (from 1 to 4), and initiating planning for a new strategic direction for home care. With this investment considerable work was also being done on integration of business processes including streamlining client intake, new documentation processes, and sharing workloads. It was suggested by participants that, on the whole, markers for successful implementation of CMoC within home care fall within three key theme areas including business processes, staffing, and collaboration. This section of the report outlines key findings and themes stemming from the home care formative review. Many are consistent with lessons learned within the other care delivery settings including communication, collaboration, teamwork, leadership, education, and change readiness.

Business Process

Home care participants described a new intake process - the way patients come into their care- as "fabulous". That is having a single phone number with a single point of contact streamlined clients, assisted with the intake assessment and the screening process, and decreased duplication of services. This process was said to be highly beneficial also for clients and families as they had one place to call to sort out what services were appropriate to meet their needs. Prior to this process being implemented, the information suggests there were up to 15 calls on any one case just to determine what the clients' needs were and what services were required. Home care participants reported clients have mentioned how they appreciate being able to call one number. It was also reported that previously clients were to call nurses directly leaving nurses spending time doing clerical work rather than delivering nursing care services.

The home care team noted significant increases in efficiency for planning client care with the integration of systems management. When nursing receives the client their file is already set up and they are further along the care continuum. They did however suggest it would be beneficial to be integrated with the acute care Cerner system. Access to this information system was said to be valuable so that home care could access what transpired with the client in the acute care setting. The team also spoke to the need for remote (in the home) access to the information/client information system (ISM).

Communication & Preparation

Similar to the acute care information, the home care situation indicates that site leads held regular meetings and this was a great way to stay abreast of the changes as they unfolded and share process in terms of what was working. In those meetings updates were given on new process implementation plans for the coming week and front line staff would report back the following week to evaluate the changes. Participants suggested this communication process helped because it gave people a heads up throughout the process. They also reported using the Staples button "that was easy" as a great addition to meetings as it kept the communication fun. Integration of information sharing as part of the home care intake process allowed the team time for advanced planning on behalf of clients rather than the time crunch felt when clients came direct from the hospital for example. This team described their implementation process as incremental so they changed as they went along.

Prior to implementing the new intake process the home care team mode of communication was described as informal. Now they suggest communication is efficient, more focused and one connection can make things happen. Participants also found their old ways of doing things no longer worked. Communication is described as more streamlined, client centered and the care coordinators facilitate workload by doing all the initial records and intake through contact with the clients.

The information strongly suggested that home care have access to the acute care information management system (Cerner). Participants also expressed that it would be beneficial if the two systems were somehow integrated so that home care nurses can have access to what medications the client was on and more detailed download of the client's care during hospital stay.

Communication of client status and updates of the care plans was highlighted by home care participants as valuable. Home support and nurses working extended hours is thought to be beneficial to clients however lack of remote access to their clients' files continues to be a significant issue.

Collaboration & Teamwork

Initially a group of provincial home care staff worked collaboratively to create the role of the LPN within home care teams. It was also noted that there is an increasing complexity of client care needed with the assistance of LPN's, the RN's can focus on the client's plan of care and this role in coordinating care is said to work very well. In contrast to other settings where role definitions and clarity were an issue, in home care the integration of the LPN's to the team was said to have been positive. Intake coordinators and home care liaisons were complimented by participants for their job well done in coordinating client care and creating

effective client groupings, which in turn makes delivery of care easier and therefore more efficiencies on the front line.

The information suggests there was a team centered approach within the home care implementation processes, this may have deterred any issues within teams and improved integration. In terms of team building, frequency of meetings, information sharing and use of humor at meetings was mentioned a number of times. For example at a team function they held a *Models of Care* fashion show as a team building exercise and this was a positive way to share information said the participants. They suggested they also tried to identify who was on their teams and play to their strengths (examples included a spirit committee, researchers, and organizers).

Home care participants suggest collaboration and communication has improved not only internally but with other stakeholders. By example, Physician communication has improved (especially with the addition of the Liaison role). They suggested that now they have doctors who are asking the Liaison how to work with them to help people discharge in a few days, whereas before, they would just be discharged with little to no warning. There was also expressed recognition for the value of the newly created leadership role within their operational framework and the value in association with the client groupings. The lead relieves the burden on the front line staff because so much of the care is coordinated, making delivery of services smoother and easier.

EDUCATION

For this group, a change workshop conducted by Joan MacDonald was said to be very valuable. In contrast there was suggestion that the provincial CMoC education was more acute care focused and did not meet the educational needs of the home care team.

These focus group participants identified the evolving need to further educate and define the RN role in home care. There was an expressed feeling that they had been given new roles within their work but they would have liked more education in support of knowing what to do in their new roles. Home care focus group participants recommend leadership come from within and advise that the RN's be involved in the planning, defining and clarifying of their roles in this process as the spread continues.

There was some expressed frustration about what their service definitions and limitations are. How do they balance client demands with what their service limitations are? Home care participants confirmed they enjoy the scope of flexibility they are allowed as service providers, but are requesting clarity and direction on service limits to know where they can offer clear and consistent responses to clients especially in regards to who gets what service.

LEADERSHIP

Home care participants suggested strength in leadership was fundamental to their success. Their two co-leads were described as "phenomenal", "provided excellent leadership and guidance" and "kept the team well informed". They also suggested their leaders "did not allow them to stagnate or go back to their old ways". Their site leads were complimented for

providing lots of one on one time and mentoring. There was a great deal of expressed pride and sense of achievement for what front line home care participants had accomplished. There was an expressed sense of empowerment being change leaders and they did not want to go back. There was recognition of how far they had come and what they had achieved. They noted that as a team they benefitted from their leaders strong sense of direction and clear vision that supported this change initiative.

Change Management

Some participants expressed feeling challenged by a pull to regressing back to old ways. How do we avoid falling back? As suggested above, others in this group offered appreciation for their leaders who they said held them accountable to the change and did not allow them to regress through the process.

Participants spoke about how they had a process in place for dealing with conflict. They talked openly about the real approach and how to deal with it "sometimes we will fight – how will we deal with it". Home care participants valued the accessibility of their leadership especially to address issues immediately. They managed the changes by spending a lot of time planning and going over things, however they did not track the time spent (but wish they had).

Measurement

The home care group strongly recommended more feedback loops be built into the future roll out and spread plan. For example, participants identified that it would be useful to track some results that were not built into their processes, the home care liaison for example. It was suggested that this could be measured from the acute care perspective but not from home care. There was some suggestion too, that they need a road map with a beginning and an end or a pathway with milestones that would allow for the team to know where they are at in the process.

Long Term Care Themes & Key Findings

Background

Wedgewood Manor is a public long term care facility in which 76 residents reside. Planning for CMoC implementation began in September 2009. A focus group was conducted post implementation on January 18, 2011. LPNs required additional training and education in order to work to their full scope of practice. The LPNs at Wedgewood had approximately ten days notice prior to beginning their studies. They studied health assessment, followed by pharmacology and medication administration. Courses in anatomy and mathematics were also taken. The majority of LPN's completed their studies in March 2010. RCW's were already an integral part of Wedgewood Manor as well as all public long term care facilities prior to CMoC implementation.

The learnings within this care sector are captured under the themes of communication, preparation, education, collaboration, teamwork, and leadership.

COMMUNICATION & PREPARATION

This team reported that there were no formalized processes in place, they learned as they went along, and now they express feeling a sense of achievement and pride proclaiming "we paved the way for others in long term care". Biweekly meetings were scheduled to keep track of how nurses were doing, define problems, find solutions, and follow up was sent by written memos to share the learning. The leadership team at the facility conveyed the message 'we are in this together – doing it together - and anything we can do to support you through the change will be done'. There were concerted efforts to balance the learning with support in the form of mentoring teaming RN's with LPN's and making the space for the learning through staffing support. There were educational days off and shifts covered so LPN's could attend their studies. Leadership worked flexibly to cover staffing on evenings, work alongside staff as necessary in support of their learning within the workplace and to guide and mentor LPN's and RN's applying their new scope of practice.

Now that things have evolved and LPN's are integrated, this team expressed the need for further communication and clarity on the role of the RN in the staffing mix. The role of the RN is not clear. RN's expressed a sense of loss over no longer administering medications, this was deemed a defining role and now they are no longer aware of how to define their work. Participants expressed they no longer felt purposeful or intentional in their work. Administering medications defined their purpose with the patient and now they suggest there is a genuine need to create something to fill that gap. Focus group participants suggested more communication is needed with residents of long term care facilities with the spread so that residents realize roles are changing. For example it was suggested some residents expressed feeling odd about not knowing about the change.

EDUCATION

This group suggested all education should come first before any implementation begins. The LPN's suggested the courses were intense and too short, scope of information was too much to cover, and there was too much information to comprehend given the short time period. The same group of participants suggested instructors seemed too rushed, the courses were put together too quickly, and things were done on short notice. There was also an expressed need for preceptors to have more training and for the preceptor role to be extended to include more RN's as there was only a select number of RNs that were preceptors.

There was a recommendation that RN's prior to implementation be given more insight into their new working role as it seemed the majority of the focus was on the LPN role. Specifically it was suggested that RNs have training in leadership and conflict management. This team suggested that RN's may benefit from education prior to the LPNs so they have clear expectations in how to mentor or what to expect of the LPN's. There was no clear starting point, although the LPN role did evolve as the changes were implemented. Moving forward, the RN role needs clarity and it was recommended that a process of shift and staff to staff reporting be built in to their education.

Though there was a high value placed on the expanded role of RCWs to the team collectively, participants felt there was a high need for this group to have additional education on basics, such as skin care and product applications. This group of participants suggested if RCWs had more training before the LPNs and RNs changed their role it may have been a smoother integration. It was difficult when all nursing staff were changing their respective roles all at the same time. Having a mentorship program for RCW's to give strength and scope to their orientation would be valuable to both those doing the mentoring and being mentored. Another suggestion from long term care participants was to gauge the number of RCWs hired at once. In phase one, they went forth with 18 new hires at the same time and in retrospect felt that the number of RCWs that needed to be simultaneously oriented and mentored was too intense. For future hire processes it is recommended that a maximum of four RCWs be orientating at one time.

Collaboration & Teamwork

This team seemed to garner some strength from the fact that their leaders were on the provincial collaborative model of care committee. From the start, and as a team, they adopted the philosophy of "we are in it together". Everyone wanted the model of care implementation to work and be successful. From the start there was an effort to balance and ensure that the time needed off for studies and coverage needed on the floor to care for residents was balanced. This was said to take the pressure off during the education phase. Increased support from team mates was positively regarded. Though they suggested the change was intense and stressful, in reflection they realized teams bonded and the process surfaced each other's strengths. Participants reported they were very team-oriented, worked well together and there was both personal and team growth achieved.

The process of medication administration itself was described metaphorically as a 'mother who overprotected her child'. However, the LPNs confirmed they needed the mentoring and supervision as they built on their experience and skills. Wedgewood Manor established a mentoring process for in depth supervision and guidance of the LPN administering medications with the RN shadowing. RNs shared their experience and it created chances for team members to bond through this process. This process evolved to include the use of incident reports as educational opportunities. The process was recognized as a positive learning process. It created a safe learning environment and mechanisms for feedback. The LPNs have been passing meds since May 2010 and it has taken up to six months for the team to gain comfort in process.

This group of participants identified the need to revisit 24 hour scheduling especially the night shift. The RN declared that not having a LPN to consult with as there are only RCW's on the night shift. This was felt to be too much for one RN without the expertise of another nurse or a LPN, as was suggested. There was an expressed need to have this opportunity to collaborate on resident care especially if a resident deteriorates.

LEADERSHIP

In this showcase unit, it is reported that the Director of Nursing and Nurse Coordinator worked closely during the CMoC implementation and transition. They identified a transparent communication chain and the staff knew who to go to resolve issues or answer their questions. The leaders worked flexibly and were available to support staff as needed. It is also of note that there was no educator or project lead in this facility. The leaders noted that they implemented the model of care process in addition to their other operational duties. Many additional hours, as well as flexible working hours, were provided to the facility by both leaders to ensure model of care was successfully implemented. The leaders in this regard go further to suggest that an educator or clinical resource nurse position be established prior to implementation of CMoC in order to ensure future successful implementation.

RECOMMENDATIONS

In reflecting on the findings, there are some key factors arising from the phase one implementation formative review for consideration, especially as the planning for spread continues. The main considerations include communication, education, collaboration, and leadership. Potential strategies for each consideration are outlined below.

COMMUNICATIONS

It is important through communications on the CMoC strategic initiative to create a common understanding of CMoC, its purpose, what it means for staff, and to gain buy-in with all major stakeholders. This is especially true for the front line staff as they are essential to effectively implementing the change. The literature suggests when people share a common purpose their motivation for success comes from within. Generating this begins with having conversations at all levels of the organization on the CMoC and ensuring a common understanding of the process and especially the intent and logic behind it.

Because of the variety of learning styles amongst people generally, communication tools in a variety of formats may be beneficial. Some participants suggested the DVD produced by Corpus Sanchez offered great insight and could be made available -- “everyone should watch it”. Some Managers declared they did not have their questions answered and therefore found it challenging to answer questions from their staff. A clear line of communication and resources available to answer any and all questions around the spread implementation, with attention to transparency and priority of steps to take may be impactful.

Participants in this focus group noted “we have come a long way and there is a tendency to forget that because things are moving so quickly”. By the same token there was mention of the need for feedback from this review to be heard and to demonstrate this. Moving forward it will be critical to be honest, intentional and completely open in communications on the process, feedback that was given, actions taken, changes and adaptations made to address issues. Success with home care implementation was in part attributed to the new business processes which by and large were a means of streamlining communications on

client care. Moving forward, in other settings, communication tools such as the whiteboard help to clarify roles and streamline team orientation around care plans.

Through communications there is also an opportunity to recognize where we have come from and share success stories to further build trust in the process. This recommendation is rooted in keeping CMoC topical amongst key stakeholders, creating venues for telling success stories and conveying what worked so that the peers and the system may learn and grow from internal energy and experience.

Educational Considerations

The participants in phase one reflected on their highs and lows during the phase one implementation process. Front line staff and key managers noted an expressed need for a dedicated nurse educator to support staff CMoC implementation process. Home care suggested that although the education was interesting, it did not apply in their care giver setting. Senior leaders in long term care, who dedicated time around the clock and above and beyond their daily operational responsibilities, suggested there is a need for the support of an educator or site lead within each implementation site.

In view of this review process there is a demonstrated need to define the new role for RN's and the scope of practice of all front line staff. Across all showcase units there were clear examples of RN's who, even if they knew what to do early in the process, reported feeling they do not know how they fit in the care of the patient now that they do not give medications. "Giving the patient medication was my reason for being with the patient and now I do not know how to fill that gap" one participant declared.

The findings also indicated that from time to time there was an imbalance in new staff or lack of seniority for preceptors or mentoring. There was also some disparity noted in how LPN's were mentored and supported while they worked to demonstrate their new scope competencies. The responsibilities of identifying and training mentors, overseeing preceptors, implementing tools designed to assist in the implementation process, expanding the nursing role in care planning, and augmenting team competencies could fall within the educator's role. This may provide nurse managers more opportunity to deal with daily operations responsibilities.

Collaboration

The participants broadly suggested there is a great need to promote optimization of roles, and this may nurture professional integration and team building. The research identified that conflict in the workplace arose especially when there was lack of insight into how to implement CMoC and specifically in regards to role clarity and who should be doing what roles. Front line work is increasingly demanding as health care consumers are living longer, presenting with more complex co-morbid conditions, and they generally require more assistance and care. In referencing the addition of RCW's, it was clear the provision of services and the capacity to deliver care was stronger when all team mates were sharing in

the care. There was also a strong positive mention regarding the impact of the home care liaison in facilitating transition of patients from hospital to home more smoothly.

LEADERSHIP

The participants identified the importance of strength in supportive leadership citing amongst other successes the experience in long term care at Wedgewood Manor. In this case, leaders worked shifts together with their front line staff on evenings and nights to support and facilitate adapting to the new ways of doing things. From the outset they and the home care participants suggested the clear message "we are not turning back" helped lead them through the new process. The example given where Leaders front loaded their team with a respect workshop reportedly noted a positive difference in how staff managed the change. Given the natural trepidation and fear of the unknown that comes with change, supportive leadership styles are noted in literature as the most desirable in facilitating positive, successful transitions.

CONCLUSION

This formative experiential review confirms the CMoC strategic initiative has been successfully evolving across the showcase units, albeit at different paces, depending on the number of available LPN's to full scope in the workplace. The staff and leaders of these showcase units have effectively sown the seeds of change in how delivery of health care services for Islanders transpires within acute care, long term care, and home care settings. Successes and challenges of change have largely been influenced by communication, collaboration, education, and supportive leadership; all of which impact capacity for change within the system. Importantly, there is an expressed need for education and role clarity to optimize human resource potential within the new model. Moving forward with CMoC implementation will enable a more efficient use of resources in delivery of health services as the spread continues for phasing the CMoC integration across the continuum of care for One Island Health System.