One Patient, One Plan: *Coordinated, Communicated, and Accessible for Safe Patient Care*

Mary Stroble, MSN, RN, Sharon Sauer, MSN, RN, ACNS-BC, Kaye Steger, MSN, RN, and Chris Redford, PE, SSMBB

THE PERFECT STORM

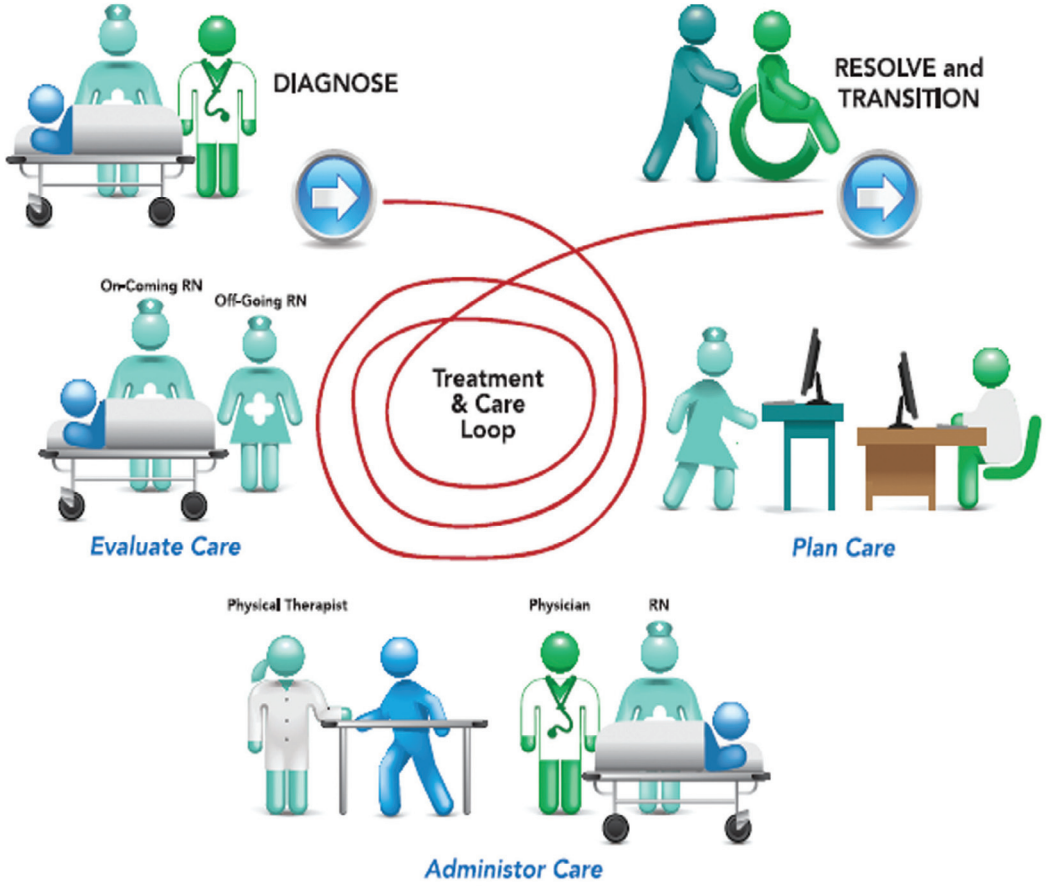
In 2007, 8 community hospitals that are part of a large health care system in regional St. Louis were in the process of standardizing their clinical documentation systems. The differences in clinical workflows became dramatically apparent as the design and build of a common technology platform became a high priority for the organization.

At the same time, there was a growing concern at these hospitals that the care planning models in place could not satisfactorily address deficiencies identified by key stakeholders. Patients and families complained that their care team did not communicate with each other and they were unaware of any plans created on their behalf. Care providers and other professionals believed they provided a focused approach, but found the plan was siloed and rarely coordinated across specialties. As efforts to standardize technology tools moved forward, it quickly became apparent that the hospitals needed to evaluate their current processes and look for ways to move from a *multidisciplinary* approach to care toward one that is more *interdisciplinary*.[1]

In late 2008, a project team was chartered to transform the model for planning and communication of care. Simply put, the purpose was to have a coordinated plan of care across disciplines with transparent planning and communication. Their goals included:

- One accessible and interdisciplinary plan for care

Figure 1. Care Loop



- Decreased steps in the care planning and communication process
- Involvement by the patient and family
- One access point to view patient goals and progress toward discharge
- Common communication processes

The team was led by group of master's-prepared nursing professionals, a Lean/Six Sigma black belt, and information technology application specialists. Clinical subject matter experts from each hospital participated in the design work and gathered feedback from peers at their respective hospitals.

CARE PLAN MODEL

The first step in developing the new Care Plan model was to evaluate current state processes. Based on qualitative data collected from nursing staff, collaborative disciplines (such as respiratory, physical, and occupational therapists), ancillary staff, patients and family, and physicians, the following key concepts emerged:

1. Interdisciplinary approach to patient care
2. Turning data into usable information
3. Identification of reason for admit (interdisciplinary problem[s])
4. Focused care planning to resolve identified active problem(s)
5. Proactive impression and plan
6. Transparent communication process (TRIO rounds, interdisciplinary care team rounds, and bedside shift report)

To validate our qualitative feedback, we looked to the published literature. In their book, *Health Care Teamwork: Interdisciplinary Practice and Teaching*, Drinka and Clark[2] described an "integrated health care team" (IHCT) as

> a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. In order to provide care as efficiently as possible, an IHCT creates formal and informal structures that encourage collaborative problem solving. Team members determine the team's mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalize on disciplinary differences, differential power, and overlapping roles.[2(p.6)]

Drinka and Clark go on to state that a functional unit (interdisciplinary team) "allows for a continuously evolving core operation for evaluation, feedback, and improvement." Our model uses a similar approach to understand the inpatient care experience which we call the "care loop" (*Figure 1*). This is a sequential process of planning care, administering care per the Plan of Care, and evaluating the patient's response to the treatments. The care loop represents a cycle of