"why am I here, for whom am I here?"

Leadership is one of the most important cruiser stones. Not just the leadership of the manager, but also "my own" leadership as a member of the care team, guided by the answers to the questions "why am I here" and "for whom am I here". It is important that the manager ensures adherence to stipulated goals and has good knowledge and understanding of the reality "on the floor".

What is going on now?

The PCC –model has today spread to many County Councils in Sweden (around 50 hospitals), and PCC gain ground even in Out Patient Care units as well as within Psychiatric Clinics.

Presenter

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In 2006 I published a book about PCC "Framtidens Vårdmodell. Patientnärmre vård. Hur gör man?" (translated, The Care Model of the Future. Patient Closer Care. How Do You Do It?)

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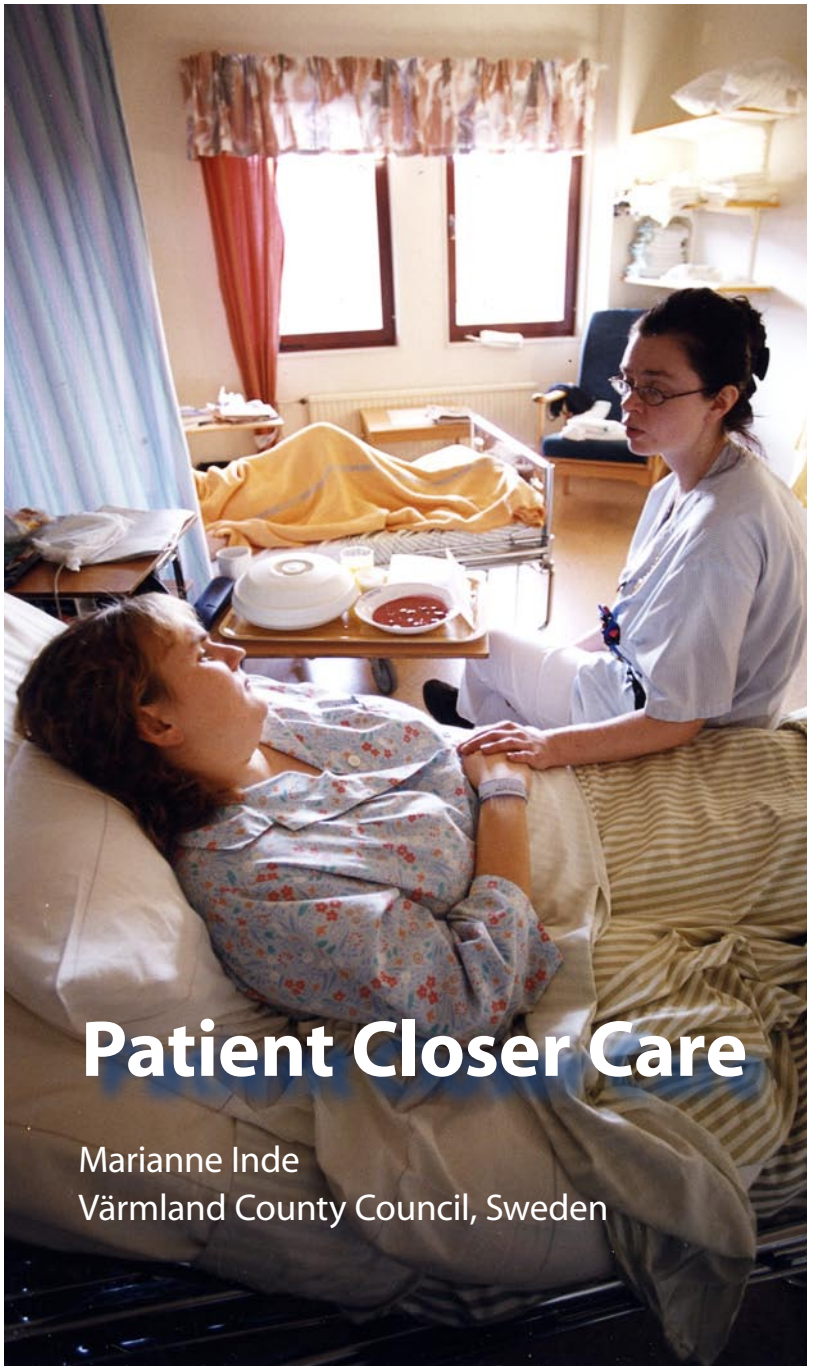

Patient Closer Care

Marianne Inde
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Background

"the rush and tear of everyday life"

My career started in early ´70s, as a nurse anaesthetist during about 15 years at operating theatre and intensive care ward. As trained teacher in nursing for about 5 years I returned to healthcare again in the middle of ´90s, now as a headnurse for a surgical ward.

The improvement journey began when I, now as the headnurse, experienced "the rush and tear of everyday life" at the ward. In my earlier career, I was used to staying close to and nursing one patient at the time. Here, nurses were responsible for more than 10-12 patients, and nurses were located too far away from patients, administrating telephone calls and other inquiries that interrupted them from patient encounters. The focus of health care appeared ambiguous and overly task oriented. Patients lacked participation and access to staff, and staff felt unsatisfied.

An article about Patient Focused Care, PFC, 1998, inspired me to visit Henry Ford Hospital in Detroit, USA. Back home, together with team members, we adapted the PFC model to a Swedish context. We called this new model Patient Closer Care, PCC.

Strategy for change

" it depends on us"

An assistant nurse was trained to manage administrative duties. Smaller nurses' stations were located in close proximity to subsets of patients. Each nurse, together with a team of caregivers, had responsibility for one subset of patients and participated fully in daily patient care. Administrative duties were minimal. With patients' priorities in focus, patient care was carefully planned and evaluated each day. Using balanced scorecards, patient-care was monitored over time. Team members communication changed to be more equal with a shared responsibility for daily work – "it depends on us".

Measurement of improvement

Basic measurements guided early stages of the change process: number of patient signals and number of phone calls to nurses. Further on, validated instruments were repeatedly administrated: The "Creative Climate Questionnaire" (CCQ) (staff), the "Quality from the Patients Perspective" (QPP) (staff and patients), and, the "Health Index" (HI) (patients, subjective health).

Effects of changes

"the patients cry more now"

The number of patient signals decreased with two-thirds. Patients experienced increased participation (QPP). Nurses received on average two-three calls per day, whereas the receptionist handled on average 80 calls. Team members had more time available, which was invested in time with patients and strategies to further improve care processes. Nurses expressed "the patients cry more now", a result of more time spent with breast cancer patients, talking about feelings. Staff experienced a stronger sense of closeness with patients and a stronger connection with team members (QPP). The work environment was creative (CCQ). There was also a relationship between patients' perceptions of quality of care and their subjective health status (QPP+HI).

In 2007, based on QPP data, the team understood that patients preferred more structured conversations with staff. Therefore we started a process for making pre-booked appointments between staff and patients. The team also learned that patients wanted more information about self-care upon discharge. Recently team members decided therefore to collaborate with health and fitness specialists, receiving training to better equip patients to make necessary lifestyle changes.

Over the years, a large number of learning cycles have addressed and clarified important associations between values, work climate, physical organization, team work and leadership in the Swedish context. While describing the model, these crucial cornerstones of care have frequently been pictured in the form of a house; the essential building blocks of PCC.

Lessons learnt

The promotion of patient safety required both structural changes and ongoing evaluation of personal incentives and values related to serving as a health professional.