# Improving the use of Coordinate My Care using a Quality Improvement Approach for Medical Patients admitted to Barnet Hospital

K Goffe, J Wilson, T Gluck, J Brady, G Singh, A Burns, C Bergbaum, H Petra, M Stewart, E Wilson
Barnet Hospital, Royal Free London NHS Foundation Trust

## Introduction

Coordinate My Care (CMC) is a digital care plan for communicating person-centred urgent and advance care planning.

We are an acute hospital serving a large older population, and community work has led to a continual growth in the number of our patients with a CMC record. Although CMC is used in our hospital where we have worked to integrate it within the electronic patient record, we have not realised its full potential, as it is not consistently accessed on admission, nor updated on discharge.

This led to a risk of ignoring patient wishes or previously clinician-agreed care plans. We recognised an unmet need amongst patients who would value conversations about 'what matters to me' and would benefit from sharing their advance care planning discussions effectively across care settings.

We used a quality improvement approach to increase the use of CMC.

## Methods

We gathered baseline data on the number of users utilising their account, and explored current practice and barriers. We mapped the patient journey and developed a driver diagram. A Steering Group met regularly and interventions were tested using Plan, Do, Study, Act.

Outcome measures were defined as an increase in views, updates and creation of care plans, which was measured monthly. Process measures included the total number of users and the number of users actively using their account.

Interventions began in January 2021. These included electronic circulation of a guide to gain access to CMC, posters about CMC, departmental teaching, and drop-in training sessions.

A Core Group of clinicians was formed to carry out these interventions and to champion CMC across clinical areas. They repeatedly surveyed 12 medical ward areas regarding system access and confidence, and offered on-the-spot troubleshooting.

We considered how to embed CMC within routine processes and to mitigate the effects of staff turnover. A hospital-wide e-classroom training was developed for new starters, a standard operating procedure was developed and a process to curate users as the enter and leave the Trust is under development to maintain accurate reporting and measure progress in future.

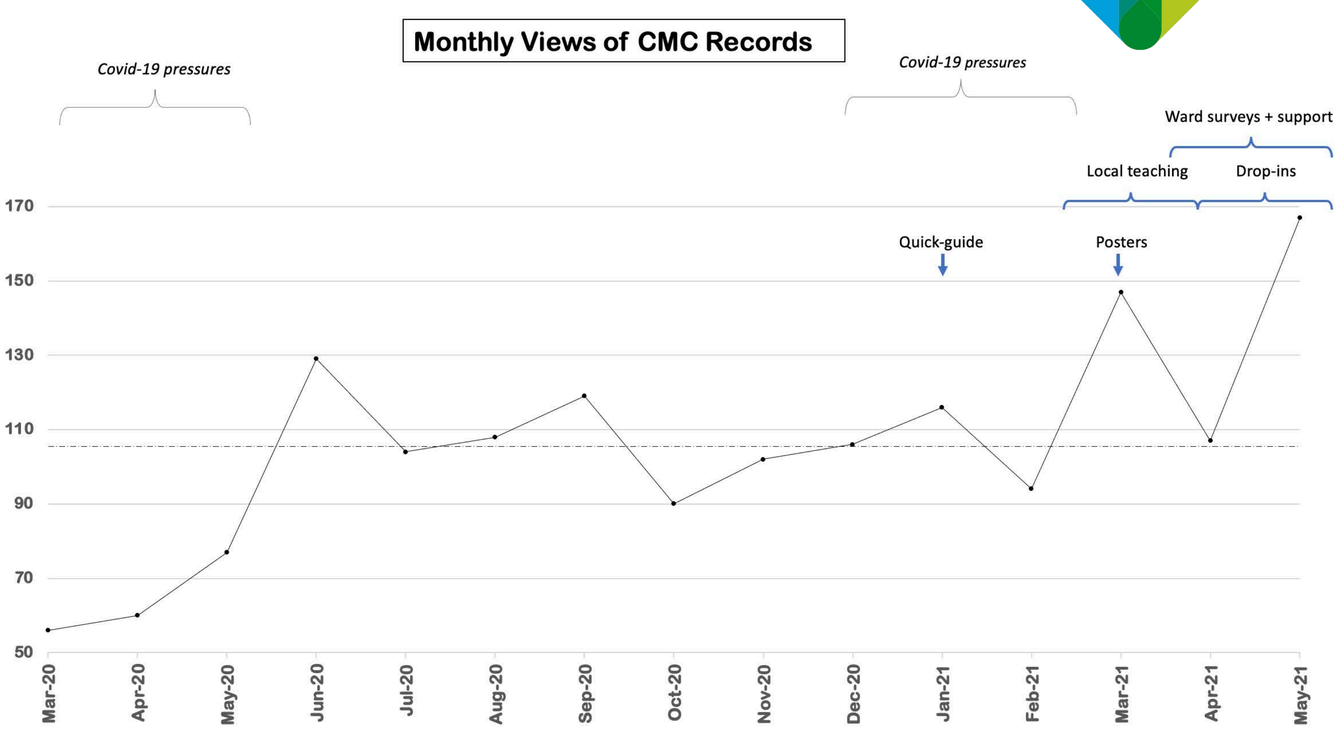
## Results

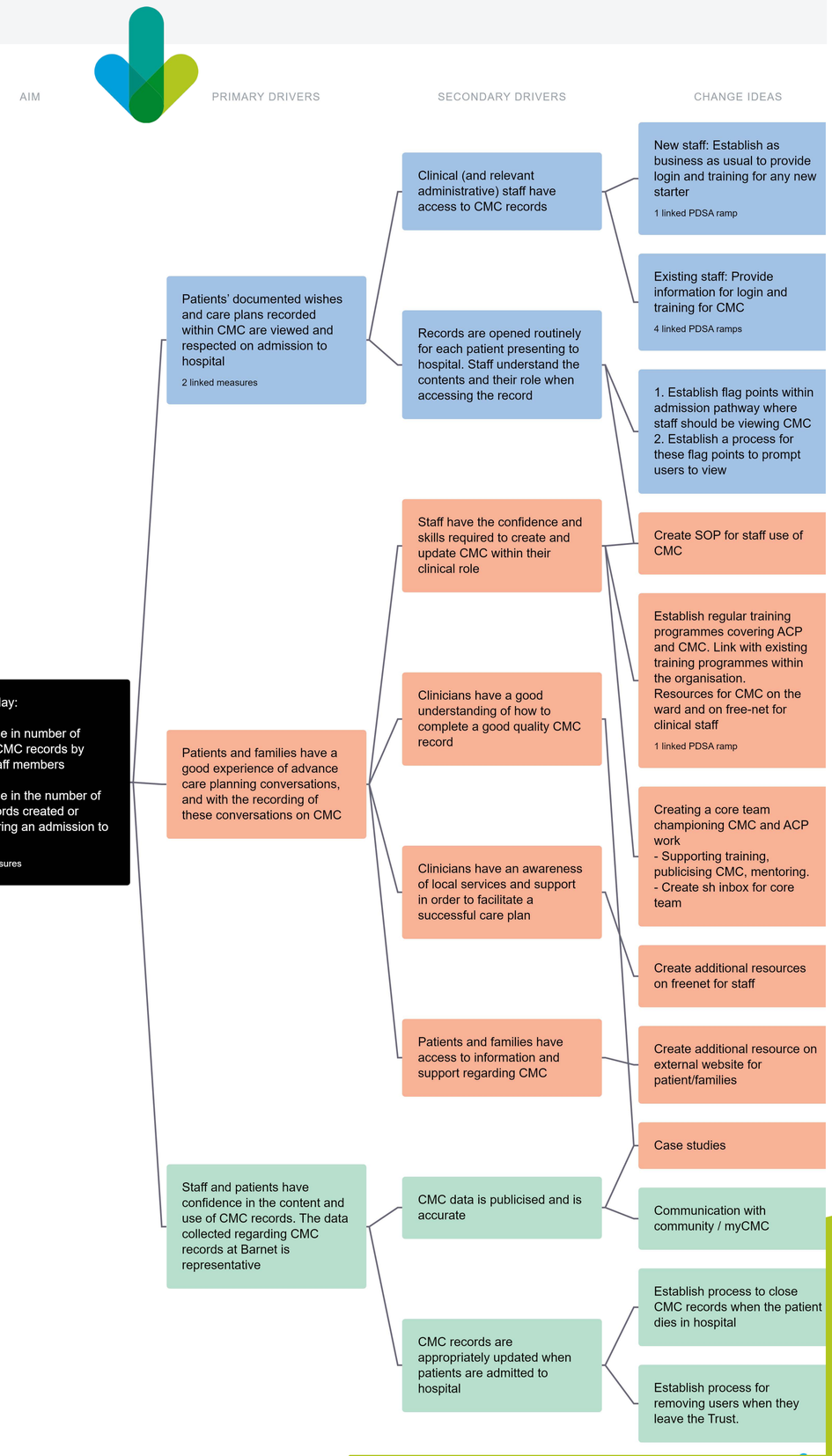
53 people attended departmental teaching and drop-ins.

The number of users actively utilising their accounts showed a steady increase, rising from 25 to 42 users per month (fig. 2). This represents between 10 and 15 per cent of the total number of registered users.

Monthly views of CMC records are increasing, with 167 in May 2021 compared to an average of 105 in the 5 months prior to the project (fig. 3)

Creation and edits to CMC care plans are yet to show a sustained improvement and remain a focus of further work.




## Conclusions

- Use of CMC is becoming more established.
- Reflecting on learning from this project, future actions will concentrate on face-to-face training and user support. Operations team involvement has been invaluable in starting to embed interventions into routine processes.
- We wish to further explore the barriers faced by users and examine patient feedback.
- Up-coming interventions include training (including in the emergency department and during junior doctor changeover), helping clinicians hold conversations and establishing mentoring.

In Autumn 2021, we will run eight simulation training courses in Advance Care Planning (ACP) for 120 healthcare professionals, aiming to increase skills and confidence in initiating ACP conversations, and hope that this will also be an opportunity for staff to build relationships and learning between specialties and disciplines.

Recording ACP on CMC is a final step in a complex process of identifying that a patient may be in the last year of their life, starting conversations and taking actions. It follows that varied and sustained actions are needed to improve this, in order to realise the benefits of person-centred planning for our patients and those caring for them.