

Welcome to the Road to Recovery project





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A little history...

- This project was a PhD thesis about reducing hospital readmission costs by providing home care intervention
- Printed material was included as part of "the intervention"



Who was involved?

- Over 20 groups...
- From TEGH
 - Cardiologists and family doctors
 - CardioRespiratory health services
 - Pharmacists, Emergency staff
- CCACs
- Toronto Public Health
- Home care service providers



How did we start?

- The team had already met for several months before CWA got involved.
- We were invited in to help with some forms because the research study needed consistent collection "devices".





What did we start with?

- The pathway...this was the document used by nursing staff to define the criteria for recovery.
- Assorted brochures from food manufacturers.



The materials

- Various documents were available to heart attack patients.
- Total weight was over 5 lbs –
 more than you were
 supposed to carry after a
 heart attack!



The process

- When we studied the paperwork process of how information travelled (the communication loop), we saw a few problems...
- Let's call them issues...



Issues in the process

- Information wasn't getting to GP (Family Physician) and heart attack patients were being released before their GP knew they were in hospital.
- Follow up appointments were not happening.





More on the process

- Different nursing agencies were using different forms.
- There was no contact between home care nurses and GPs.
- Caregivers needed contact information.



And more on the process

- Patients and caregivers were overwhelmed by the volume of material available to them.
- Patients needed something to make it easy to keep track of their recovery.



Our approach

- Determine who needs to know what.
- Determine how they want to read that information.
- Determine how to make the presentation of that information usable.



We defined the documents in the "new" process

- Patient Booklet
- Discharge Form
- Nursing Checklist
- Visit Report

Consent Forms...





The booklet

- Our target audience was a multi-cultural audience, average age 65.
- The goal was to use the existing source material, consolidate and simplify it.
- We wanted to have a positive tone in the booklet.



The booklet

continued

 And we wanted to create a document that nurses could use in the hospital to talk to patients about going home.



The booklet

continued

- We created several sections in the booklet:
 - Going home
 - Getting better
 - Preventing another heart attack
 - Their Recovery Diary
 - Patient Notes
 - Community Resources information





The booklet

continued

- We treated the topics in a very "matter-of-fact" manner.
- We talked about lifestyle changes, nutrition, sexual relations.



The Recovery Diary

- This was the second half of the booklet. It was designed to be helpful and easy to complete.
- It was a way for home care nurses to see progress between visits.



Discharge Form

- The biggest change here
 was giving the patient a copy
 of this form. We put a pocket
 in the back of the booklet.
- It was also faxed to the GP when the patient was discharged.



Discharge Form

continued

- There were 3 sections:
 - In-hospital Notes
 - Discharge Planning
 - Notes to Family Doctor
- All appointments were set up before the patient left the hospital.



Discharge Form

continued

- Medical terms were used on the form because they were conditions or names of tests.
 The language used was based on audience level.
- Plain language instructions were used for the appointment section.





Nursing Checklist

- There were several agencies involved in the project and each one had their own forms.
- We needed "consistent" data collection devices.
- There was a lot of material, so the form became a booklet.





Nursing Checklist

continued

 The patient may not get the same nurse on each home visit...the booklet became a way to ensure continuity of care, regardless of the provider.



Nursing Checklist

continued

- There were 4 parts to the booklet:
 - A chart listing conditions and what the patient should be able to accomplish over time.
 - Visit Record
 - Nurses's Notes
 - Referral Record



Visit Report

- One page document to be faxed to the GP after a home care visit.
- If an emergency arose, nurses would of course phone the doctor or hospital...



Nurses were trained

 Both hospital and home care nurses were trained on the "new system" by the project leader.



Nurses were asked about the new system

- They said it took a little longer but they felt it was easy to do and allowed them to provide better care to their patients.
- Patients liked having the information "all in one place".



Did the materials make a difference?

- The project leader has submitted papers for publication in nurses journals about the study.
- She recommended that as a best practice, professional writers should be used as it makes a positive impact on the materials.



Did plain language make a difference?

- YES!
- To the patients
- To the GPs
- To the nurses in the hospital and home care
- To the CCACs





Thank You

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