HOME CARE SAFETY
Improvement Collaborative

Value of Safety Improvement Collaboratives for Home Care: Strategies and Outcomes

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Agenda

- Home Care Safety Improvement Collaborative
- Quality Improvement Journey
- Impact, Benefits and Lessons Learned
- Questions and Answers

Home Care Safety Improvement Collaborative

The Collaborative Approach

Designed to improve quality of care and reduce cost

How is this Achieved

- Organizations come together to facilitate learning and process improvement
- Organizations share a commitment to making significant & rapid changes

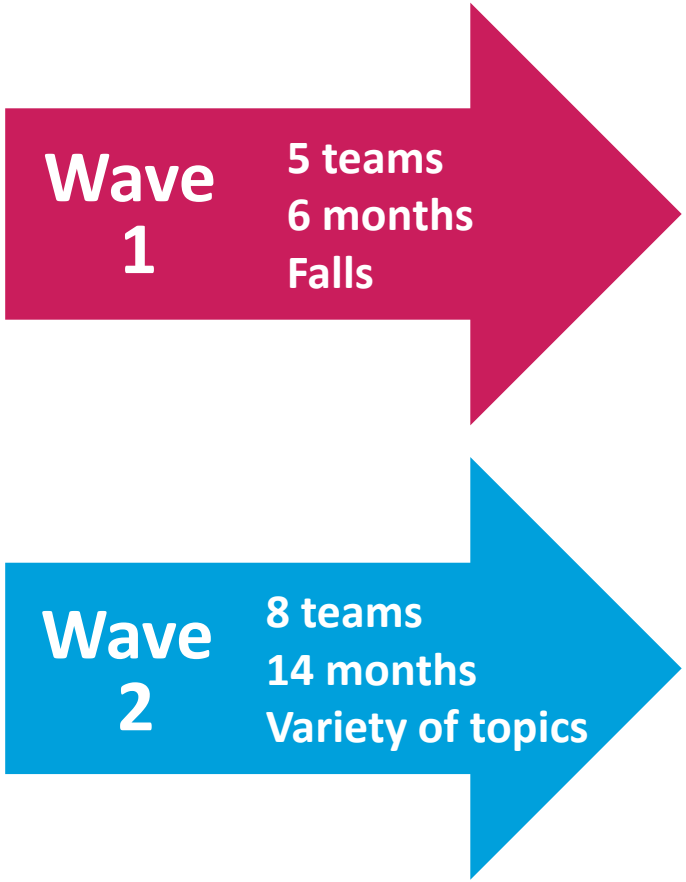
The Method

Spread and **adaptation** of **existing knowledge** to **multiple settings** to accomplish a **common purpose**

(1) The Breakthrough Series IHI's Collaborative Model for Achieving Breakthrough Improvement (2003)
http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

Applying Improvement Collaborative to Home Care

- Modeled after Institute for Healthcare Improvement (IHI) Breakthrough series
- Sponsored by Canadian Patient Safety Institute (CPSI) Canadian Home Care Association (CHCA)& CFHI (Wave 1)
- Involves participating teams representing health authorities and home care providers from across the country
- **Goal: collaboration and knowledge application to reduce preventable harm in the home**



Solving Common Challenges in a Complex System

Reducing preventable harm in the home is a complex challenge

- Solutions must involve active involvement of health care providers, clients and carers
- Change and improvement happens in a dynamic environment
- Safety Improvement Collaborative aims to support organizations to rapidly **plan, test, measure** and **make targeted changes** to improve quality and patient safety in the home

Elements of the Collaborative

1. Featured Speakers Sessions

- Content
  - Initial content related to QI topics
  - Subsequent sessions on home care harm reduction and improvement methodology
  - Tools and resources on Teamwork and Communication
- Presenters – Topic experts
- Frequency – 1-2 x / month
- Duration – 90 minutes
- Participation – all team members

Elements of the Collaborative

2. Coaching Sessions

- Each team was assigned a coach
- Between the learning sessions coaches connect by phone or Webinar
- Frequent coaching at the outset of collaborative
- As teams develop skills coaching was as requested
- Anticipated number of QI Coaching Calls - 12 to 20

Elements of the Collaborative

3. Action Periods

- Content
  - Simple homework assignments
  - Project focussed activities
- Team activities
- Private online work space on CHCA Knowledge Network – access to resources and tools
- Communication within organization
- Data collection
- Development of change ideas
- Participation – all team members

What We Learned from Wave 1

- **Focus: reducing harm from falls**
- **Results:**
  - Total falls in the target sites for VHA, Red Cross and Saint Elizabeth were reduced from 21 to 7 over a 4 mo. period
  - Successful in helping organizations to identify areas for improvement, scoping of goals, identifying measures, and choosing change strategies
  - Short duration allowed for some patient and family engagement and showed that this would require sustained effort to enhance this engagement on ongoing basis
  - Being part of Collaborative allowed teams to initiate work on this key safety issue and was valuable endeavour overall

Objectives for Wave 2

- Develop basic knowledge of quality improvement
- Learn measurement techniques to evaluate current state and how to track and report on success
- Develop effective strategies to engage patients and carers in improvement initiatives
- Build effective teams, and effective communication techniques
- Advance safety as a strategic priority and engage senior leadership
- Apply quality improvement methodology to a unique challenge

HOME CARE SAFETY
Improvement Collaborative

Stories for Wave 2

Aim – to increase satisfaction of clients with dementia and improve continuity of care. They introduced a new personal history form and training for staff

Aim – Advanced Care Planning. They developed curriculum, introduced tools, and trained staff to conduct and document difficult end-of-life conversations

Aim – Improve interventions for reported falls with a consistent process. They updated Falls Guideline and training and plan to implement new falls audit process

Stories for Wave 2 continued

Aim – Improved infection surveillance and management of central and peripheral lines. They updated infusion flowsheet in EMR

Aim – Reduce distress for clients with cognitive impairment. They implemented case management stds and protocols

Aim – Improve the identification and documentation of responsive behaviours and care for persons with dementia. They developed a new Cue Card for Compassionate Care

Aim – Improve work flow to capture actionable data on patients who have had a previous fall.

Wave 2: Impacts and Learnings

CROSS CUTTING IMPACTS:
- Learning & knowledge of QI and tools
- Collaboration across teams and within teams
- Process changes & development of tools – frontline impacts

LEARNINGS:
- Complexity of projects presented challenges
- Data challenges
- Importance of communications and sustaining change
- Value of patient and staff engagement & partners

NEXT STEPS:
- Evaluation
- Share results
- Implementation and spread by organizations

Take Home Messages

- Accessing and managing data is challenging
- Being part of the Collaborative provides a framework and impetus for organizations to start improvement work
- Coaching is very helpful in supporting teams to do QI work
- Patient and family engagement in improvement work is valuable and meaningful
- ***You don't know what you don't know***—the process of joining and participating in the collaborative provides a great window into how an organization is functioning
- Even the best ideas don't implement and spread themselves
- Change of any size takes time, capacity and dedicated resources
- Leadership, dedicated staffing time, and resources are critical

The Partner Perspective

- Builds on CPSI's landmark research "Safety at Home" and CHCA priorities
- Partnership between CPSI and CHCA
- Access to expert resources for home care sector
- Sharing of best practices and potential solutions in home care sector
- Development of tailored resources on teamwork and communication by CHCA
- Advancing culture of safety and QI in home care sector
- Value add for CHCA members – building capacity and improvement at the front line

QI Safety Collaborative Journey

Project Team Selection

PLAN

- Commitment to best practices
- Project management experience
- Understanding of Lean methodologies
- Diverse healthcare experience

Project Selection Criteria

PLAN

- Improve client care
- Find efficiencies and improve effectiveness in current practices
- Team driven—what's important to the staff?
- Scalable and spreadable
- Innovative—potential to have a significant impact beyond our organization

What is Advance Care Planning?

PLAN

- A tool to help individuals reflect and share their values, hopes, and fears for their healthcare with their family, friends and healthcare providers
- To make informed decisions about current and future medical and personal care
- To designate a substitute decision maker (SDM)

Facts About Advance Care Planning

Only **7%** of Canadians have had an end-of-life planning discussion with their doctor

Only **48%** of hospitalized patients in Canada have started an Advance Care Plan

Only **18%** of CAHS' patients have an Advance Care Plan

What Is The Surprise Question?

PLAN

Clinical tool to identify patients in need of a palliative approach

"Would I be surprised if this patient died within a year?"

If the response is:

"No, it would not surprise me"

patient is assigned to the pilot population

What Is The Surprise Question?

PLAN

Identify

Ask the 'Surprise Question"

Would I be surprised if the patient were to die in the next year?

No

Discuss Advance Care Planning (ACP) visit

Schedule ACP visit

Assess and Plan

Current and future clinical and personal needs

Yes

Reassess regularly

Discuss

-Patient values, wishes, and preferences
-SDM
-Goals of care
-Advanced Directives (MOST)
-Coordinate community resources (health authorities)

Complete

-Serious Illness Conversation
-Coordinate MOST with GP
-Document ACP in E H R
-Update CAHS' care plan to reflect values, wishes, and preferences

Aim Statement

PLAN

CAHS will increase the rate of

Advance Care Plans

in the home and the EHR by

60% for those patients where the

Surprise Question screener tool

response was **"No"**

by February 1, 2018

Objectives

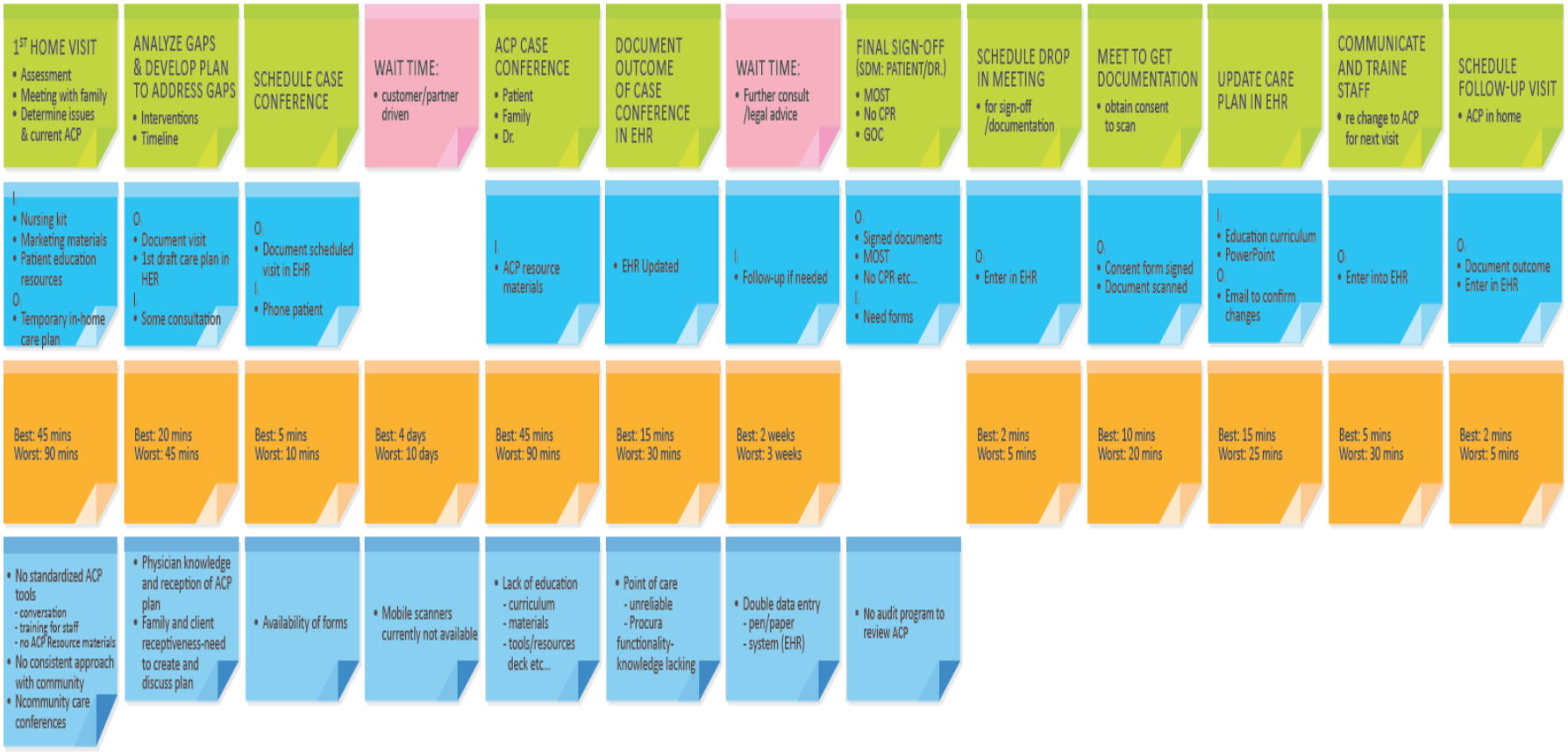
1. Increase clients and families understanding of ACPs
2. Identify clients who would benefit from a palliative approach to care
3. Improve staff effectiveness and confidence at facilitating end-of-life care conversations
4. Ensure the ACP is documented in the EHR and the home

Utilization of QI Tools: GANTT Chart

24 to 28 July Weekly Accountabilities				July				
	Task	Sub-Task	Status	24	25	26	27	28
	Complete Development of QI Tools	Process mapping	60%					
		Fish bone	60%					
		Driver diagram	30%					
		Pareto	0%					
		Run diagram	40%					
	Develop Project Communication Plan	Engage key stakeholders	80%					
		Monthly project newsletter (21st of every month)	100%					
	Review ACP Documents and CPG's	Benchmark with best practices with local, provincial, national, and international community agencies	50%					
		Liaise with local health authorities (VCH, FHA) to ensure compliance with goal of project	30%					
	Compile Best Practice Document Samples	To create a library of resources, i.e., bibliography	30%					

QI Tools: Process Mapping

PLAN



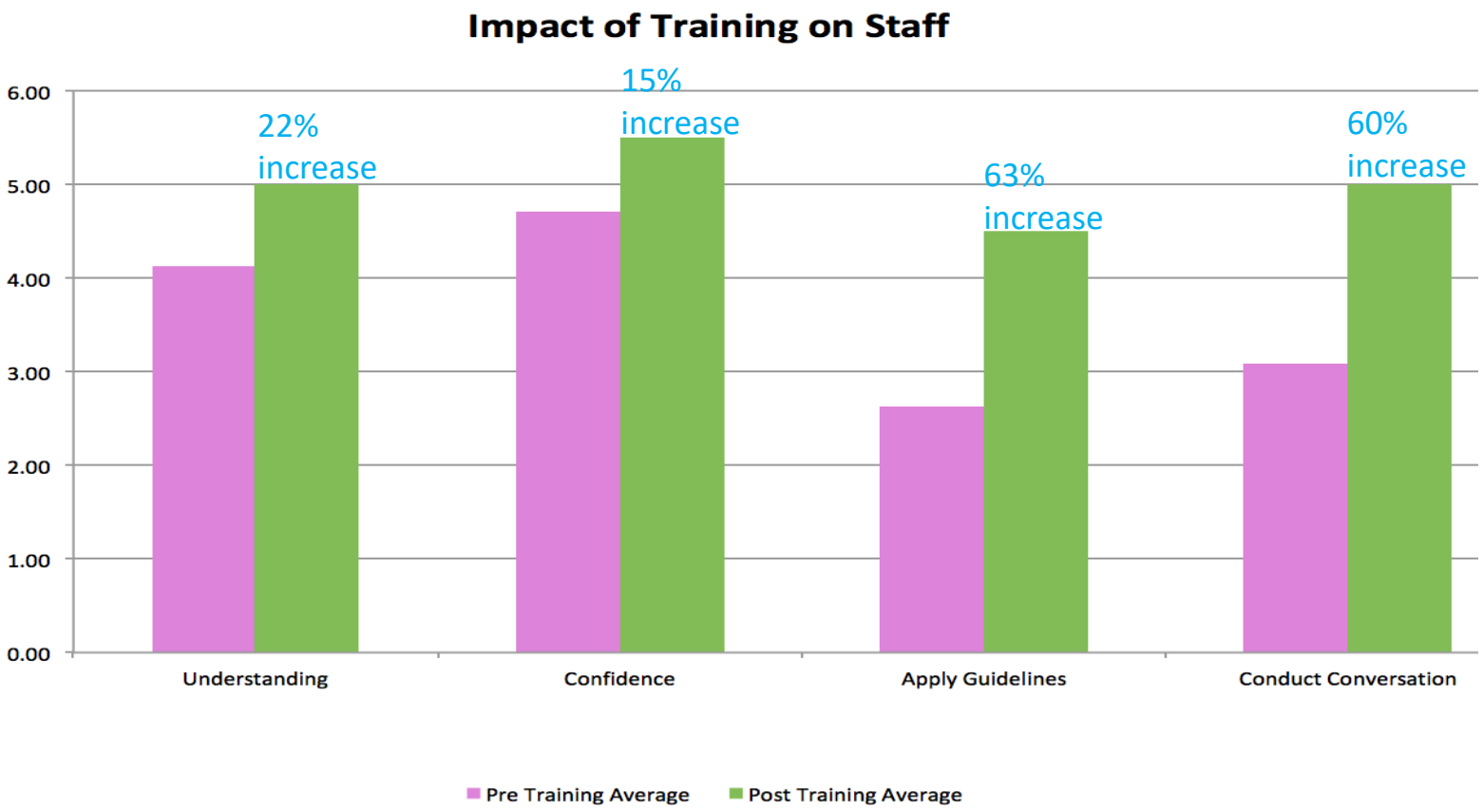
Deliverables

IMPLEMENTATION

- Curriculum for staff development
  - Classroom training
  - Shadowing in the home
- Clinical practice guidelines
- Communication tools
  - Brochures and newsletters
- Staff, client, family satisfaction surveys

Staff Confidence Survey Results

MEASURE



Client Satisfaction Survey Results

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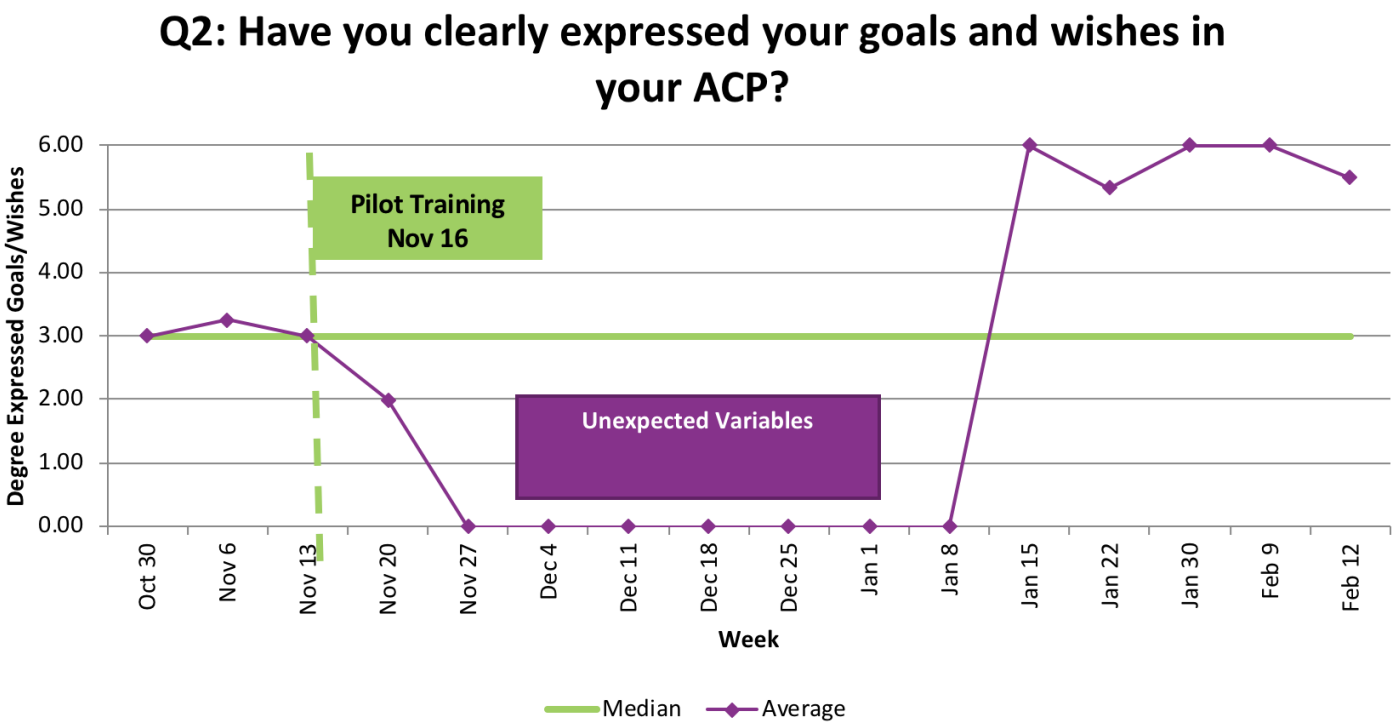

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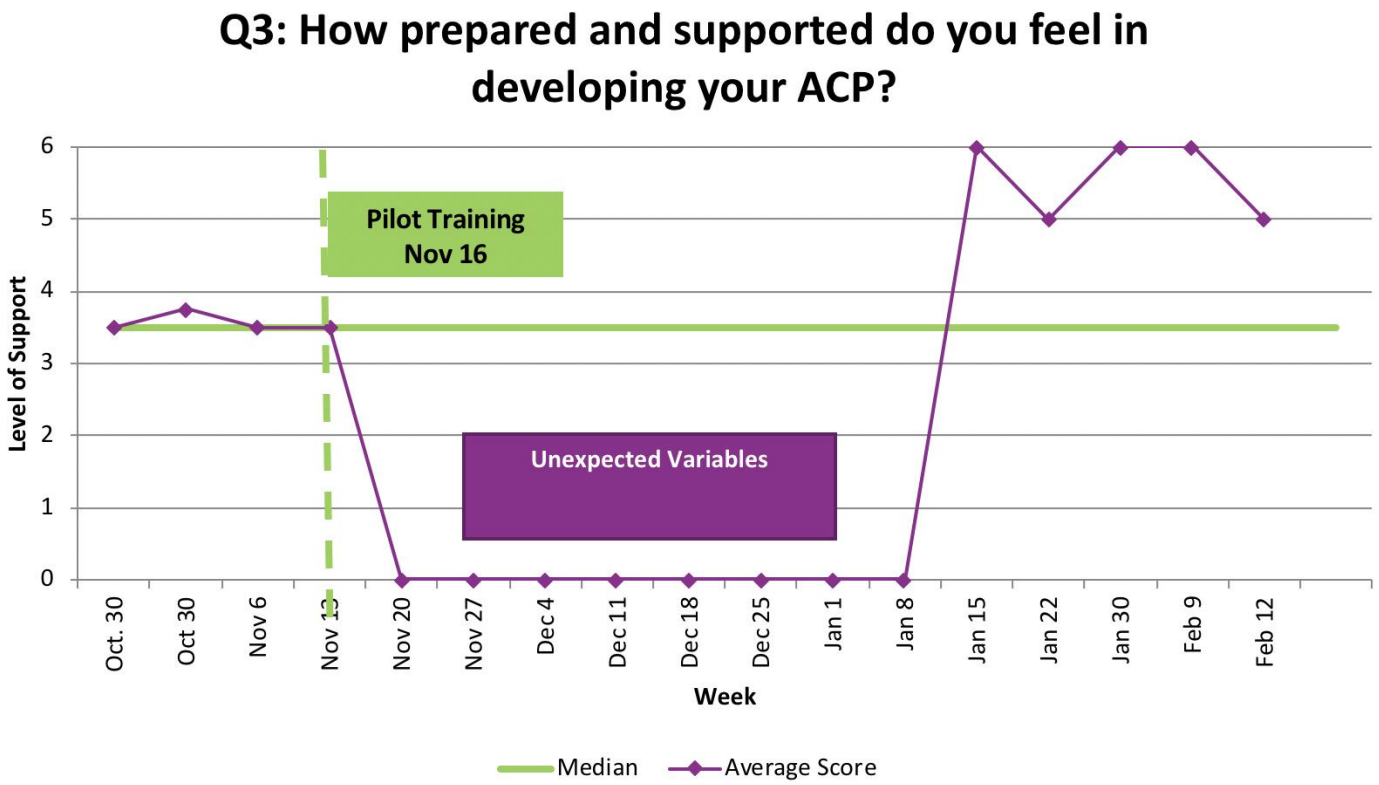

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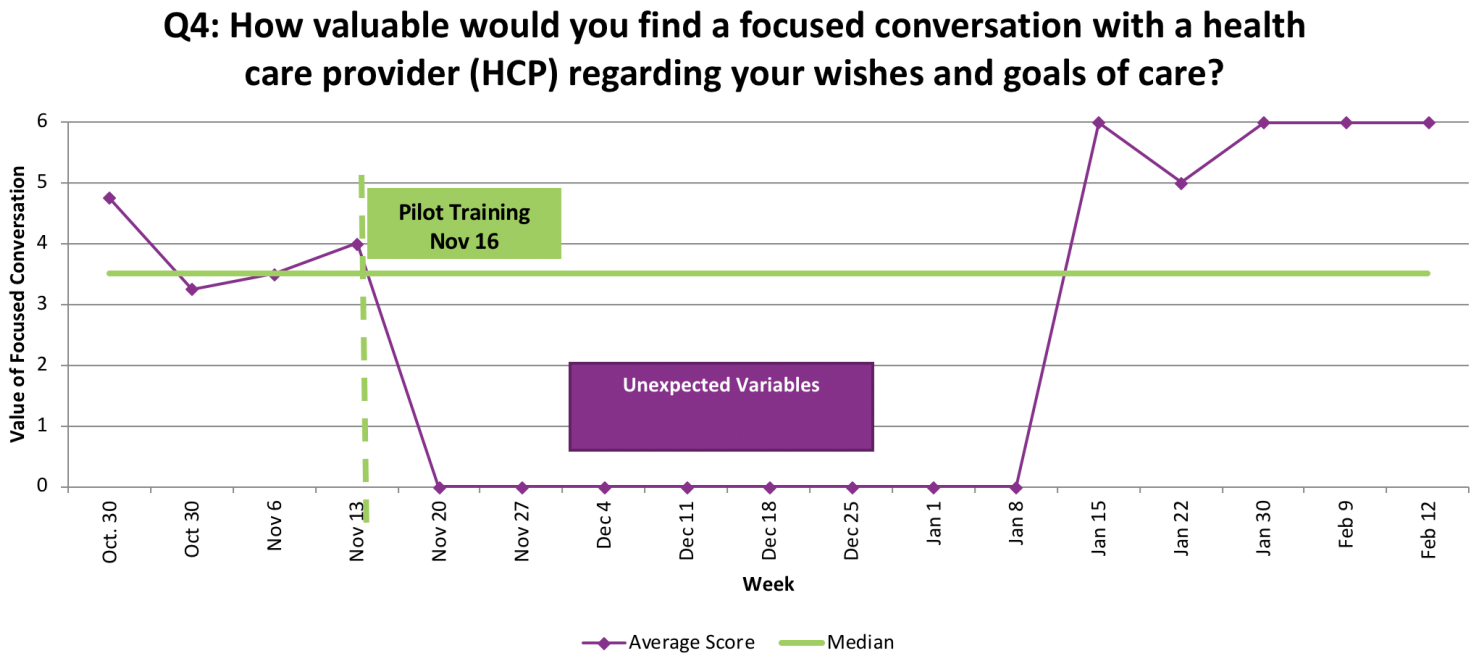


Impact, Benefits and Lessons Learned

Impact

Client/Family Impact

- Increase in Advance Care Planning conversations with high-risk clients
- Clients had the opportunity to express their wishes and felt more prepared and supported in developing their Advance Care Plans
- Clients expressed their satisfaction regarding the value of having Advance Care Planning conversations with their health care professionals

Staff Impact

- There was a marginal improvement in staffs' understanding of ACP conversations and a significant improvement in clinical practice relating to ACP conversations
- Staff had a better understanding of how to apply ACP conversations with clients and families
- Staff felt significantly more confident in their ability to conduct ACP conversations with their clients and families

Applications and Benefits

Learning Application	
QI Tools	• Learn how to apply the Pareto, fish bone, run charts, process mapping, etc.
Measurement and Analysis	• Learn how to establish measures and analyze results and tweak for improvements i.e. run charts
Benefits of the Project	
Best Practices	• Align care with best practice standards
Leadership and Team Development	• 1st opportunity for management, clinical services and scheduling teams to work together on a project • Gained a vast amount of knowledge with respect to ACP and participating in a national project
Network of Experts	• Developed a network of experts across Canada to help elevate the standards of our services

Lesson Learned: Planning

Emphasis on getting “it right” ***versus*** wanting to “get the job done”

Lessons Learned

Test small pilots and apply lessons learned earlier in the project cycle

Lesson Learned: Role Clarity

- Who's on first?
- Roles were well defined in the project charter
- In practice there was confusion re roles and accountabilities

Lesson Learned

- Commit to weekly project huddle of accountabilities

Lesson Learned: Communications

- Weekly webinars
- Online newsletter (MailChimp)
- Staff meetings
- Bi-monthly coaching sessions

Lessons Learned

- Webinars cannot replace face-to-face meetings
- Key team members needed to attend coaching sessions

Lesson Learned: Leadership

ADJUST

- Defined roles within the charter
- Diverse experience and learning needs within the team
- Created opportunities to rotate chairs and attend and speak at provincial and national conferences

Lessons Learned

- Know team member interests
- Provide leadership development opportunities

Lesson Learned: Staff Development

- Methods of training:
  - Traditional classroom and role playing
  - Training “at the bedside”
  - Shadowing with expert clinicians

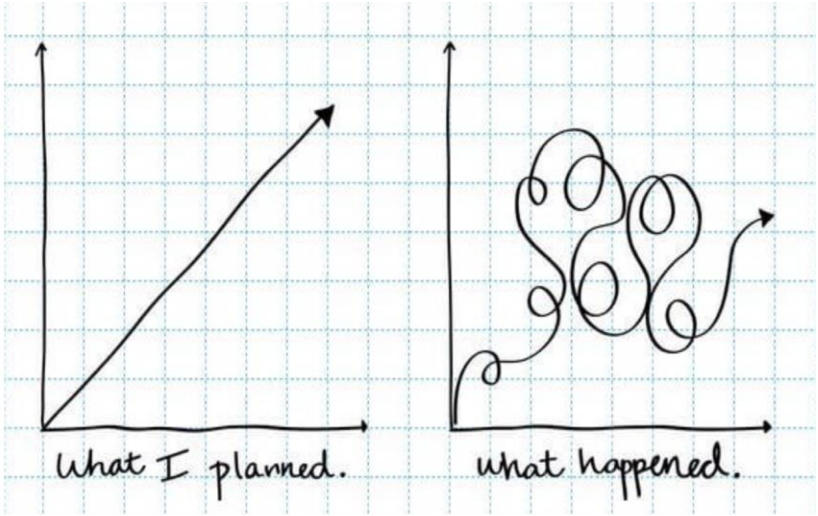
Lessons Learned

- Team members need different methods of training

Lesson Learned: Time and Resources

ADJUST

- Underestimated time required to deliver quality product
- Competing priorities
- Unexpected absences from key team members
- Over committed and under delivered i.e., weekly newsletters



Lessons Learned

- Need more resources and time than expected

Next Steps: Improving Practice

ADJUST

- Expanded our Advanced Care Planning conversions beyond those within the high-risk cohort
- Included curriculum on Advanced Care Planning in staff orientation
- Shared our successes with palliative care organizations
- Applied what we learned in this collaborative to other improvement projects

Questions and Comments