



The Patient Safety
Education Program™
CANADA

Module 18: Patient / Client Safety in Home Care

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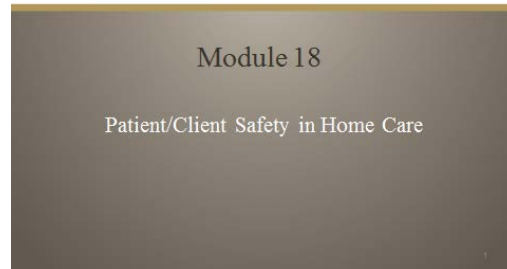
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[Revised 2017]

Abstract

Slide 1



This module explores how patient safety themes, such as safety culture, teamwork and communication can be applied to the Home Care context, beginning with the organizational culture found in those agencies providing care. An open and transparent culture requires honest reporting and rewards for those who implement patient safety principles within their workplace. The module focuses on how to recognize and create a positive safety culture and practices in the delivery of home care.

Keywords

Safety culture, Home Care, clients/patients, caregivers, providers, adverse events, incidents, preventability, case management

(Note: While the term client is used commonly within the Home Care sector, this module uses the term patient to ensure consistency across CPSI materials. Another nuance is the term ‘family caregivers’ which when used, includes not only family members but also friends and other individuals from patients’ social circles that provide ‘unpaid’ care. Users of this module are invited to choose and use these terms according to their preference and practice context.

Teaching methods

Interactive lecture, case studies with open ended discussions, role play.

Learning objectives

Slide 2

Knowledge requirements

- Safety culture within the Home Care context
- Features of positive safety practices for Home Care patients
- The incidence and types of patient safety incidents in Home Care
- Risk factors & other elements associated with patient safety incidents in the Home Care population
- The burden of patient/ client safety concerns & risks from the perspectives of patients & family caregivers

The learning objectives of this module are to understand safety culture, risks, and patient safety incidents within the Home Care setting and to know how to create a Home Care organization and system in which patient safety is an essential component.

Knowledge requirements

The knowledge elements include an understanding of:

- Safety culture within the Home Care delivery context
- Features of positive safety practices for Home Care patients
- The incidence and types of patient safety incidents in Home Care in Canada
- Risk factors and other contributing elements associated with patient safety incidents in the Home Care population
- The burden of patient/client safety concerns & risks from the perspectives of patients and family caregivers

Slide 3

Performance requirements

- Identify policies, practices & tools that enhance patient safety
- Evaluate safety factors within patient care delivery systems and environments
- Identify barriers to safety in Home Care
- Design and implement safety improvement strategies

Performance requirements

The performance elements include the ability to:

1. Identify policies, practices & tools that enhance patient safety (reduce avoidable patient safety incidence that cause harm)
2. Evaluate safety factors within patient systems and environments
 1. assess, track, monitor patient safety risks and outcomes
 - Identify barriers to safety in Home Care
 - Design and implement safety improvement strategies

Clinical Case

Slide 4

Case study

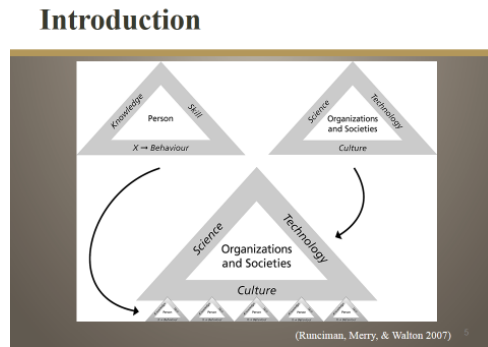


A Home Care nurse describes a harmful patient safety incident that occurred during the intravenous administration of a narcotic analgesic which resulted in the patient going into respiratory distress followed by cardiac arrest. As is the nature of Home Care, there is no fully staffed 'Code Blue' team close by. The nurse phones 911 and requests immediate Emergency Medical Technician (EMT) response, administers naloxone following existing medical orders, moves the patient to the bedroom floor and begins unassisted CPR. The EMT team responds within 10 minutes and assumes care and transport of the patient. The patient is transported to a rural hospital emergency department and his death is declared following a further 30 minutes of clinical intervention. The nurse explains how he wanted to go and speak to the family and say that he was sorry for their loss, but was advised to stay away from the family. The nurse describes what he feels is a lack of support from his colleagues and organization, and that the culture made it difficult for him to discuss the issue. Eventually he phoned the family and met with them. The family recognized the risks inherent in the provision of health care at home and places no blame for the event. The nurse now works to change the culture to make it acceptable to discuss patient safety incidents and to support Home Care workers involved in patient safety incidents.

OPEN ENDED DISCUSSION – What elements of patient safety and organizational culture are at play in this scenario?

Introduction

Slide 5



Despite overwhelming agreement among health leaders that a lack of a patient safety culture is a common and significant problem in health care, we have yet to replace all the old ways with policies and programs that support a culture of safety. We acknowledge the role of systems in patient safety incidents yet we still blame individuals when bad things happen. Mistrust is still prevalent - mistrust of managers, of bureaucracy, of government, of the media, of profession regulators, of colleagues and of other health professions.

Organizations are made up of individuals who collectively reflect the culture. In the above diagram (slide 5), the attributes of an individual healthcare provider (top left) and of an organization (top right), are each depicted as three sides of a safety triangle. The culture of an organization reflects the collective behavioural attributes of the individuals within it (the large triangle).

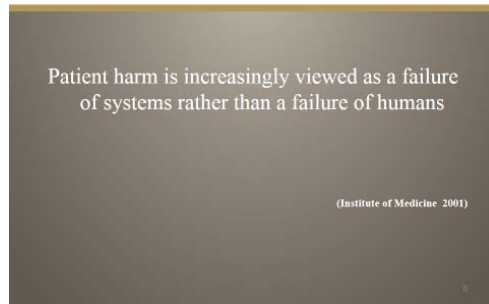
Individual awareness of the potential for and consequences of harm is an important first step in understanding the multiple factors associated with patient safety incidents, however, to improve the safety and quality of healthcare we need to also understand the organization and the cultural milieu in which care is delivered.

Providing safe care that is patient-centered requires two conditions:

- All healthcare professionals understand the need for delivering healthcare from the perspective of the patient, meeting their needs and expectations, and
- The healthcare system needs to support those in need of care to access services and to have care delivered in a context where the workforce and the design of systems recognize the inherent risks in healthcare.

Refer to PSEP – Canada Module 5: Organization and Culture for further information on patient safety culture.

Slide 6

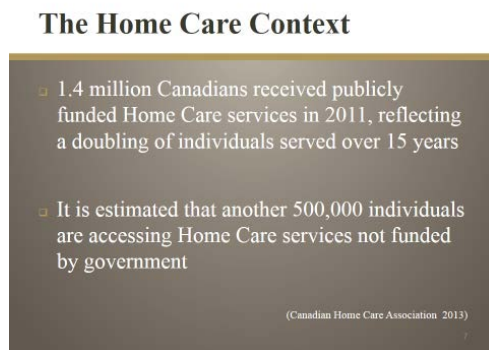


KEY MESSAGE

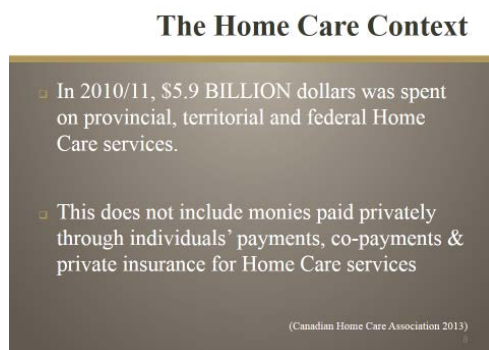
Patient harm is increasingly viewed as a failure of systems rather than a failure of humans
(Institute of Medicine 2001)

The Home Care Context

Slide 7



Slide 8



1.4 million Canadians received publicly funded Home Care services in 2011, reflecting a doubling of individuals served over 15 years and an increase of 55% since 2008.

It is estimated that another 500,000 individuals are accessing Home Care services not funded by government. In 2010/11, \$5.9 BILLION dollars was spent on provincial, territorial and federal Home Care services. This does not include monies paid privately through individuals' payments, co-payments, and private insurance for Home Care services.

(Canadian Home Care Association 2013)

One of the reasons for the increased demand for Home Care is the rise in acute care hospital discharges of patients who require ongoing acute and longer-term care. Approximately 73.4% of Home Care patients are reported to have been discharged from an acute care hospital setting. (Madigan 2007)

Patient safety is accepted as a core tenet of health service delivery. Factors related to patient safety have been well documented in hospitals and systematic examination in Canada began with the seminal study by Ross Baker & Peter Norton et al. (2004).

The systematic study of patient safety in the Home Care Sector is more recent. Home Care patient safety studies, by the very nature of Home Care, differ from those in the hospital setting as they take into consideration the nature of service provision, the role of family members, the context of care and the characteristics of the individuals receiving care.

(Hirdes 2004)

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The Home Care Context

- Patients and families are singularly and jointly the units of care, inextricably linking the safety of the patient and family caregivers
- Home environments are unregulated and uncontrolled in contrast to the hospital setting; homes are designed for living, not for providing and receiving health care

(Lang 2006)

The Home Care Context

- Safety in Home Care includes physical, emotional, social, and functional safety dimensions;
- There is greater autonomy and choice for patients, families, and caregivers than what is experienced in hospital settings; and
- A large proportion of Home Care patients are elderly and live alone.

(Lang 2006)

It has been estimated that about 80% of Home Care is provided by family members, and other individuals sometimes referred to as informal caregivers. The amount of daily contact between home-care staff and a patient is substantively less frequent than in the hospital setting. In fact, there is often no daily contact between patients and staff or other caregivers in Home Care.

Hospitals and other institutional settings control safety risks by assigning the performance of health care tasks to regulated health providers and directly supervised trained health care workers such as personal support workers (PSWs).

In Home Care, while some complex or invasive health care activities are provided by regulated health care providers, many of the care tasks are assigned to unregulated workers under indirect supervision, family caregivers and the patient themselves. These approaches to care introduce risks arising from potential breakdowns in communication, lack of immediate assistance when treatment issues arise, and variations in the levels of knowledge that support the performance of patient care tasks.

An environmental scan of patient-safety issues among Canadian Home Care patients identified unique challenges associated with safety in Home Care:

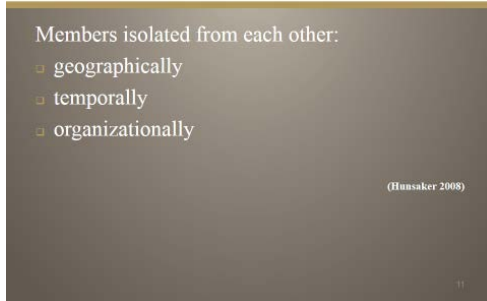
- The patient and their family are singularly and jointly the units of care and as a result, the safety of the patient and family caregivers are inextricably linked;
- The setting of individual homes is unregulated and uncontrolled in contrast to the hospital setting; homes are designed for living, not for providing and receiving health care;
- There are multiple dimensions of safety in Home Care, including physical, emotional, social, and functional safety;
- There is greater autonomy and choice for patients, families, and Home Care staff than what is experienced in hospital settings; and
- A large percentage of patients receiving Home Care supports are elderly and live alone.

(Lang 2006)

Virtual Teams

Slide 11

The Virtual Team



Virtual teams, sometimes known as geographically distributed teams, of regulated health care professionals and trained but unregulated workers, often from a number of organizations, make up the paid team of Home Care providers. Most work in physical and temporal isolation from each other, communicating by electronic and hand-written notes and telephone messages, or not at all.

Sometimes members of the virtual team, while all focused on the same patient, report to different supervisors and function as empowered professionals who are expected to use their initiative and resources to contribute to accomplishment of team goals.

(Hunsaker 2008).

Virtual teams in Home Care do not have ‘stable’ membership, as the team players change for each patient.

In addition, the ‘virtual team’ is augmented by family caregivers and the patient themselves.

Additional services (beyond those of health care) are often needed to support the living environment and these impact on, or expand membership in, the virtual team

Potential Risk Factors arising from Virtual Team

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Virtual Team Risk Factors

- Breakdowns in communication
 - Potential for differences in ‘plans of care’
 - Various charts and charting standards (if any)
- Challenges in Role Clarity
 - Lack of immediate professional assistance when treatment issues arise
 - Different interpretations of ‘*who does what*’
- Variations in levels of knowledge that supports the performance of tasks

Members of virtual teams rarely or potentially never meet. They may not know each other. This provides an environment ripe for breakdowns in communication with different individuals having different values and opinions about what the ‘right’ plan of care is.

Their isolation from each other means they may problem solve independently and that they cannot depend on getting help or a second opinion immediately or easily.

They will undoubtedly have differences in the type, breadth and depth of the knowledge that they use and they may be so unfamiliar with the other members of the team that they don’t know who to ask for help, or even if they can ask for help.

The separation and isolation of members of virtual teams introduces factors that may influence patient safety:

- Communication is often reliant on written and electronic messages and files as the team members do not meet regularly or at all for face-to-face discussions
- Diverse opinions about and actions to resolve problems introduce diverse actions, some of which are compatible, and some of which may be incompatible with each other;
- Role clarity, especially responsibility for tasks, and location of the authority and responsibility to act, may need explicit definition

(Shachaf 2005)

Responses to Risks arising from Virtual Teams

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Response to Virtual Team Risk Factors

- Team leader
 - Focuses the team on the patient's needs
 - Listens to all inputs
 - Clarifies ambiguities
 - Assigns roles
 - Has final authority to decide and direct action while not encumbering on professionals' responsibilities and accountabilities

Studies of virtual teams suggest that benefits of these teams can be gained, and the risks mitigated, if an assigned and acknowledged team leader engages in regular and prompt communication, provides continuous feedback, consolidates patient needs, clarifies tasks, and assigns responsibly – all in a way that remains primarily focused on patient needs while being respectful of each team member.

(Shachaf 2005)

Example of Home Care 'virtual team':

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Case Study - Rosalie

- A retired nurse in her early 80s
- Lives alone with her dog
- Diagnosis - moderately advanced Alzheimer's disease
- Physically active, confused about date/time but knows daughters and neighbours

Slide 15

Case Study - Rosalie

- Does not know or recognise health care workers by name or role
- Most she likes; some she finds annoying
- Expressed wishes - no new medical care; that she stays in her home until death
- Her daughter, a nurse, is POA for both personal care and finances

Rosalie is a retired nurse in her early 80s who lives alone (with her faithful, old golden retriever) and was diagnosed with moderately advanced Alzheimer’s disease. She is physically active, confused about date and time of day but knows her daughters and neighbours. She does not know or recognise health care workers by name or role but knew that they come to ‘do something’. Most she likes; some she finds annoying. Her directions to her power of attorney for personal care are that she is to have no new, invasive medical care and that she is to stay in her home, where she has lived for about 50 years, until death. Her daughter, another nurse, is her Power of Attorney (POA) for both personal care and finances.

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Case Study – Virtual Team



Case Study - Plan of Services:

2. Patient is physically well and able to dress, bathe, eat independently; likes to sit on swing chair in back yard, watch the weather station on TV, ‘go out’ with anyone who offers to take her; go for walks with her dog (who almost always directs her home)
3. Monday through Friday – personal support worker (PSW) from Agency A for one hour (9 a.m. to 10 a.m.) to make sure she is out of bed, has breakfast (always coffee and toast), dog is put out ‘to pee’, and everything is basically safe and secure
4. Monday through Friday – Meals-on-Wheels from Agency B (with 2 meals delivered on Friday so that one is available for dinner on Saturday)
5. Sunday – Dinner chosen and delivered by small, Chinese restaurant in the neighbourhood
6. Tuesday & Thursday – Respite care program worker from Agency C for 3 1/2 hours (12:30 p.m. – 4 p.m.) to supervise, provide companionship, take on outings; cue to take medications from dosette (kept in locked box)
7. Monday, Wednesday & Friday – Home Care Program personal support worker from Agency A for 1 hour just after lunch to ‘cue’ medication administration from dosette (kept in locked box) and to assist with activities of daily living and anything that was ‘out of sorts’

8. Monday, Wednesday & Friday – Privately paid PSW from Agency A for 2 hours early each evening to prompt eating, feed dog, do laundry, take Rosalie to grocery store, pharmacy etc. as needed
9. Local pharmacist – Prepared weekly medication dosettes (dosette picked up during a ‘walk’ by Rosalie, dog, & the respite care program worker)
10. Home Care Program case manager (RN) – on-call for advice and trouble-shooting
11. Daughter 1 (nurse) – visits or checks-in by telephone daily to do ‘whatever was needed’
12. Granddaughters (2 young teenagers) visit Monday through Friday for 2 hours after school to socialize and provide activities such as playing cards
13. Daughter 2 (veterinary assistant) – visits weekly and manages overall care of golden retriever (buying and setting out food in baggies for workers to feed to dog; veterinary appointments; etc.)
14. Neighbour 1 – keeps ‘an eye on the house’ to watch for anything unusual; visits frequently; available to ‘drop in’ if something seems out of sorts and on request of daughter 1
15. Neighbour 2 – sons shovel snow from driveway and steps to house during winter
16. Lawn care service – cut grass weekly in spring/summer/fall
17. Cleaning service – comes in every 2 weeks to provide housecleaning

This multiplicity of ‘players’ and the uniqueness of every home care situation complicates our ability to study and understand the full picture of what it is to provide and receive safe health care at home.

OPEN ENDED DISCUSSION – What elements of care planning and delivery that affect patient safety might be at play in this scenario?

Dimensions of Safety in Home Care

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Dimensions of Safety in Home Care



The physical safety of patients has been one of the most thoroughly studied dimensions, starting with hospital care and moving into Home Care. Most of our measures of risk, such as the occurrence of harmful patient safety incidents, reside in the physical safety domain.

The introduction of the ‘home’ into health care delivery introduces a range of physical environments in which health care is delivered, and broad diversity within the group of people receiving and providing care and the relationships between these people. For these reasons, Home Care patient safety needs to also include emotional, social and functional safety.

Emotional safety in Home Care addresses the psychological impact of receiving health care at home.

It may be distressing or anxiety-provoking for the patient and/or family to manage medications, treatments, and/or sudden or extended changes in patient health status. The effect for the patient and the family caregiver may be very different; never assume that the effect is the same for both ‘parts’ of the Home Care patient unit.

Social safety addresses where and with whom the patient lives, their interactions with friends and their community, and the nature of the patient’s social support network.

Abuse (e.g., financial abuse) is an important consideration with regards to the social safety of Home Care patients.

Functional safety is about how people carry out activities of daily living and instrumental activities of daily living.

Home Care disrupts patients’ and the families’ ‘normal’ activities. They may stop some activities or change how they attend to their daily functioning. Unexpected changes have the potential to introduce new safety risks.

(Lang et al., 2006)

Which risks are acceptable and which are not?

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What risks are acceptable and which are not ?

- Home Care professionals cannot determine the standard of safety independently from patients and families
- Each situation differs and requires initial and ongoing discussions

(Lang 2009)

Home Care patients' perspectives of 'acceptable risk' differ from those of Home Care professionals. Both can describe situations of unsafe or risky experiences related to Home Care, but generally, patients and families view their home as a safe haven. Being at home means being in control. **Interpretation:** Home Care professionals cannot determine the standard of safety independently from patients and families. Each situation differs and requires initial and ongoing discussions.

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What risks are acceptable and which are not ?

“Although clinical standards are essential to Home Care, a single set of standards for Home Care safety that encompass the multidimensionality and personal preferences involved is not reasonable or desirable. Rather, evidence-informed guidelines that mitigate risks associated with decision-making within this complex Home Care context are preferable.”

(Lang 2009)

“Although clinical standards are essential to Home Care, a single set of standards for Home Care safety that encompass the multidimensionality and personal preferences involved is not reasonable or desirable. Rather, evidence-informed guidelines that mitigate risks associated with decision-making within this complex Home Care context are preferable.”

(Lang 2009a; Lang 2009b)

Injuries from living at home

Slide 20

Injuries at Home

| | AGE | | | | | | SEX | | | |
|---------------------------------|---------|------------|---------|--------------|------|--------------|-------|--------------|---------|--------------|
| | 12 - 19 | | 20 - 64 | | 65+ | | Males | | Females | |
| | % | CI 95% | % | CI 95% | % | CI 95% | % | CI 95% | % | CI 95% |
| House work | 3.5 | 2.6 4.4 | 16.6 | 15.4 17.8 | 27.1 | 24.5 29.7 | 14.4 | 13.2 15.6 | 15.6 | 14.4 16.8 |
| Walking | 5.9 | 4.7 7.0 | 11.0 | 10.1 12.0 | 28.2 | 25.0 31.4 | 7.0 | 6.1 7.9 | 17.7 | 16.4 19.0 |
| Stairs | 2.5 | 1.8 3.2 | 3.9 | 3.3 4.5 | 7.3 | 5.9 8.7 | 2.2 | 1.7 2.8 | 6.2 | 5.4 7.0 |
| Sleeping, eating, personal care | 14 | 1.0 1.9 | 2.9 | 2.4 3.4 | 6.4 | 5.0 | 2.3 | 1.8 2.8 | 3.8 | 3.1 4.4 |

Statistics Canada. Canadian Community Health Survey 2009–2010 combined

People not receiving health care services at home also experience ‘harm’ e.g., fractures and soft tissue injuries from slips and falls through the experiences of ‘normal’ living. These are separate from and in addition to the patient-safety (e.g., care related) risks and harmful patient safety incidents experienced by Home Care patients.

Activity when the most serious injury occurred, among people who sustained at least one activity-limiting injury Canada, 2009–2010

| | AGE | | | | | | SEX | | | |
|---------------------------------|---------|------------|---------|--------------|------|--------------|-------|--------------|---------|--------------|
| | 12 - 19 | | 20 - 64 | | 65+ | | Males | | Females | |
| | % | CI 95% | % | CI 95% | % | CI 95% | % | CI 95% | % | CI 95% |
| House work | 3.5 | 2.6 4.4 | 16.6 | 15.4 17.8 | 27.1 | 24.5 29.7 | 14.4 | 13.2 15.6 | 15.6 | 14.4 16.8 |
| Walking | 5.9 | 4.7 7.0 | 11.0 | 10.1 12.0 | 28.2 | 25.0 31.4 | 7.0 | 6.1 7.9 | 17.7 | 16.4 19.0 |
| Stairs | 2.5 | 1.8 3.2 | 3.9 | 3.3 4.5 | 7.3 | 5.9 8.7 | 2.2 | 1.7 2.8 | 6.2 | 5.4 7.0 |
| Sleeping, eating, personal care | 14 | 1.0 1.9 | 2.9 | 2.4 3.4 | 6.4 | 5.0 | 2.3 | 1.8 2.8 | 3.8 | 3.1 4.4 |

Statistics Canada. Canadian Community Health Survey 2009–2010

An estimated 4.27 million Canadians aged 12 or older suffered an injury severe enough to limit their usual activities in 2009–2010. This represents 15% of the population.

Overall, falls were the leading cause of injury. About 63% of seniors are injured in falls each year. Falls in seniors, are most often the result of tripping or stumbling while walking or doing household chores. Over half (55%) of seniors' injuries occurred while walking or doing household chores.

Scrapes, bruises and blisters represent 14% of all activity limiting injuries among seniors. Fractures occurred in about 26% of seniors who sustain an activity limiting injury.

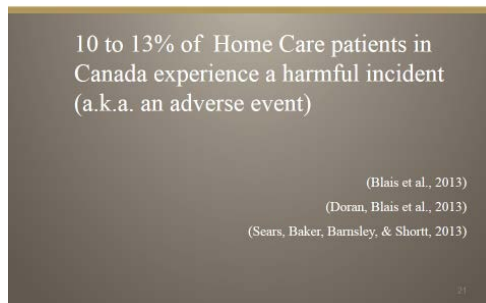
(Statistics Canada June 2011)

Discerning what ‘harm’ is from Home Care and what ‘harm’ is simply from daily life is challenging but important when assessing and addressing Home Care risk and is a complicating and confounding feature that is not found within the context of assessing or managing patient safety in hospitals.

So what are the Canadian statistics and measures for Home Care?

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Canadian Statistics and Measures



Canadian Statistics and Measures

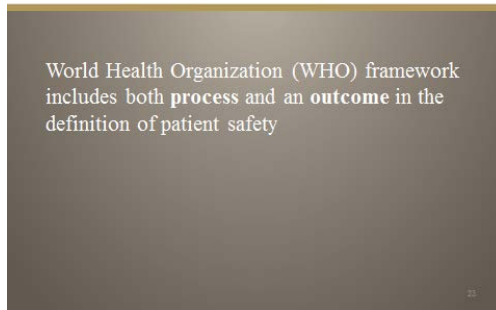
We are growing our understanding of patient safety problems amongst Home Care patients. Canada is a leader in studying Home Care patient safety. The most recent research results indicate that each year, 10 to 13% (i.e., about 1 in 10) of homecare patients in Canada experience an adverse event as a result of the care they are receiving.

(Blais et al., 2013; Doran, Blais et al., 2013; Sears, Baker, Barnsley, & Shortt, 2013)⁷

Rates differ across regions of the country, with some provinces demonstrating harmful patient safety incident rates that are a bit higher and some that are a bit lower. This may be the result of differences in the types of patients provincial Home Care programs care for, differences in how the services are delivered, or differences in how case management is practiced. It is likely also related to the difference in patient safety culture between organizations.

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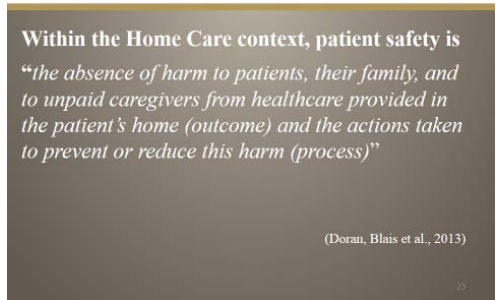
What is Patient Safety?



The World Health Organization (WHO) framework defines patient safety both as a process (the reduction and mitigation of unsafe acts within the healthcare system and use of best practices) and as an outcome (“freedom for a patient from unnecessary harm or potential harm associated with healthcare”)

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What is Patient Safety?

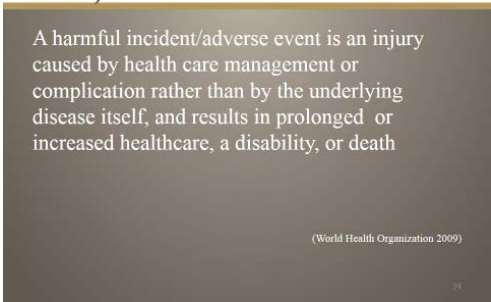


Within the Home Care context, this definition of patient safety is adapted to include the patient ‘unit’ which includes family caregivers -- *the absence of harm to patients, their family, and to unpaid caregivers from healthcare provided in the patient’s home (outcome) and the actions taken to prevent or reduce this harm (process).*

(Doran, Blais et al., 2013)

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What is a harmful incident (adverse event)?

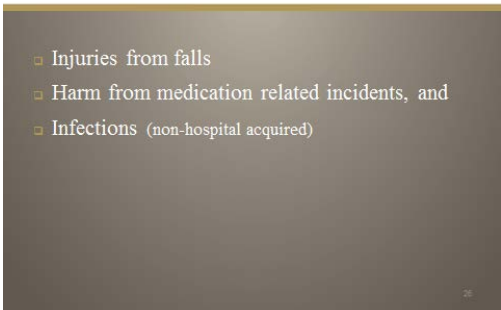


To get reliable quantitative measures, patient safety is commonly assessed by measuring the incidence of adverse events. The WHO defines an adverse event as *an injury caused by medical management or complication rather than by the underlying disease itself, and one that results in an adverse outcome. An adverse outcome precipitates prolonged healthcare, temporary or permanent disability, or death.*

(World Health Organization 2009)

Slide 25

Most Prevalent Incidents in Home Care



The main types of harmful patient incidents/adverse event in Home Care, identified from both chart reviews and secondary databases, are injurious falls, harm from medication related incidents and infections. Infections were the most common of the adverse events that occurred during the first 30 days of referral to Home Care.

Specifically:

2. Injuries from falls
3. Harm from medication related incidents, and
4. Infections (non-hospital acquired)
 - Ventilator-associated pneumonia
 - Catheter-associated UTI
 - Peripheral IV infection
 - Localized skin infection
 - Central line IV infection

- Sepsis / bacteremia
- Surgical and non-surgical wound infection

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Less Frequent Incidents

| | |
|--|---------------------------|
| Injury from incidents other than falls | Delayed wound healing |
| Delirium | Shortness of breath |
| Deep vein thrombosis | Skin tear or laceration |
| Diabetic foot ulcer | Hypo/Hyperglycemia |
| Pressure ulcer (stage 2+) | Gastro-intestinal problem |
| Pulmonary embolus | IV site problem |
| Venus leg ulcer | Fracture |
| Psychosocial, behavioral, mental problem | Bleeding |
| | Syncope or seizure |

Other types and consequences of adverse events that have been identified in Home Care are:

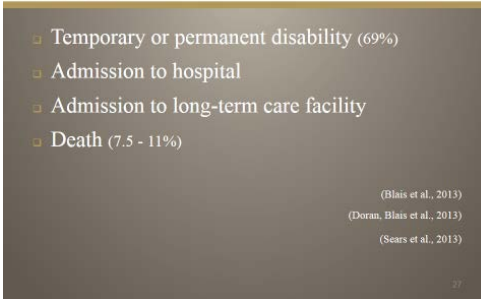
- Injury from incidents other than falls
- Delirium
- Deep vein thrombosis
- Diabetic Foot ulcer
- Pressure ulcer (stage 2+)
- Pulmonary embolus
- Venus leg ulcer
- Psychosocial, behavioral, mental problem
- Delayed wound healing
- Shortness of breath
- Skin tear or laceration
- Hypo/Hyperglycemia
- Gastro-intestinal problem
- IV site problem
- Fracture
- Bleeding
- Syncope or seizure

(Blais et al., 2013; Doran, Blais et al., 2013; Sears et al., 2013)

Consequences of Home Care Harmful Patient Incidents

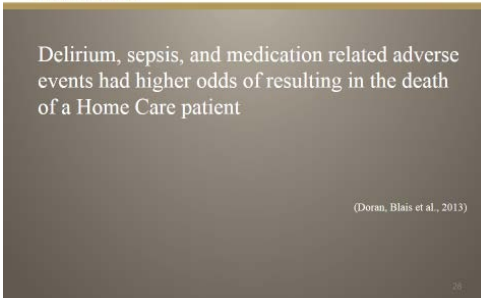
Slide 27

Consequences of Home Care Harmful Incidents



Slide 28

Consequences of Home Care Harmful Incidents



Injurious falls, injuries from incidents other than falls, and medication-related incidents were the harmful patient incidents that most frequently required hospitalization.

Consequences of harmful patient safety incidents in Home Care include:

- Temporary or permanent disability (69%)
- Admission to hospital
- Admission to LTC
- Death (7.5% - 11%)

Three types of events namely, delirium, sepsis, and medication related incidents were associated directly with an increase in the odds of patient death occurring.

(Blais et al., 2013; Sears et al., 2013)

Source Contributions

Slide 29

Sources of Contribution to Harmful Incidents

- Health care provided by family and friends - 20 – 28% of incidents
- Patient provided health care (self-care) - 48 – 53% of incidents
- Paid health care team members - 30 – 46% of incidents

(Blais et al., 2013)
(Sears et al., 2013)

In homecare it can be difficult to determine causal relationships to harmful patient incidents because much of the care provision is not observed.

Based on case analyses by physicians trained to analyze charts of home care patients 30 - 46% of harmful patient safety incidents were caused by the actions (or lack of actions), judgement, knowledge and/or skill of healthcare personnel/ system, 20 – 28% by unpaid caregivers, and 48 – 53% by patients themselves. More than one ‘source’ contributed to about 14% of adverse events experienced by Home Care patients.

(Blais 2013; Sears 2013)

Preventability

Slide 30

Preventability

33 to 56% of Home Care harmful incidents are preventable and due to:

- errors in judgement or task completion
- lack of knowledge that ought to be known

(Blais et al., 2013)
(Doran, Blais et al., 2013)
(Sears et al., 2013)

Some harm is preventable; some is not. In Home Care, between 33 and 56 percent of all harmful patient incidents are preventable as they are due to preventable errors.

Harm which is not preventable is that which cannot be reasonably predicted. For example, harm from the administration of a drug that triggers a first-time allergic reaction in a patient is NOT preventable harm.

Preventable harm is related to errors in judgement or task completion or lack of knowledge that ‘ought to be known’. For example, administration of a drug to a patient with a documented allergy to that drug, but by a person who did not know of the allergy, is preventable.

Preventability of harmful patient incidents, both in Home Care and elsewhere, can be judged using a 6-point scale:

- 1 - virtually unpreventable
- 2 - slight to modest preventability;
- 3 - preventability not likely (less than 50/50, but “close call”);
- 4 - preventability more than likely (more than 50/50, but “close call”);
- 5 - strongly preventable;
- 6 - virtually certain for preventability.

(Blais et al., 2013; Doran, Blais et al., 2013; Sears, Baker, Barnsley, & Shortt, 2013)

Which Home Care Patients are most at risk?

Slide 31

Which Home Care patients are most at risk ?

Patients with:

- Higher numbers of co-morbid conditions
- Higher levels of dependence for Instrumental Activities of Daily Living and Activities of Daily Living.
- Unstable conditions,
- Peripheral vascular disease,
- Parkinson’s Disease,
- Renal failure,
- Polypharmacy, or
- Hospital discharge 30 days or less ago

(Blais et al., 2013)
(Doran, Blais et al., 2013)

Patients with more co-morbid conditions, unstable conditions, peripheral vascular disease, Parkinson’s Disease, renal failure, polypharmacy, those requiring a higher than average number of Home Care days of service, those recently (within 30 days) discharged from hospital and those who were more dependent for completion of instrumental activities of daily living (IADLs) and activities of daily living (ADLs) are all at higher risk of experiencing harmful patient incidents.

(Blais et al., 2013; Doran, Blais et al., 2013)

Slide 32

Ontario study found higher risk in patients . . .

- Taking psychotropic medications,
 - Being left alone for short or long periods,
 - With Parkinson’s disease
 - With a history of falling
 - Dependent for management of housework
 - Dependent for ambulation outside of the home
- (Sears et al., 2013)

An Ontario study found that the use of psychotropic medications, being left alone for short or long periods, dependency for ambulation outside of the home, a history of falling, dependency for management of housework and the presence of Parkinson’s disease were factors that were predicative of a harmful patient safety incident.

(Sears et al., 2013)

Note: The factors listed on the slide are those that are associated with the identification of Home Care patients who experience a harmful incident. We do not know if any of these factors contribute to the cause of the harmful incident. Those relationships still need to be investigated. What is interesting is that many of these factors are related to walking and moving, and that harmful falls are the most prevalent harmful incident that Home Care patients experience.

Risks to family and unpaid caregivers as part of the Home Care ‘patient’ unit

Slide 33

Risks to family caregivers as part of the Home Care ‘patient’ unit

- Family caregivers ‘decline’ occurs in about 3 - 11% of Home Care cases
 - Decline occurs in caregiver general and/or mental health, and as sleep disruption
- (Doran et al. 2009)
(Doran et al. 2014)

Remembering that the patient and the caregiver are the unit of care, consideration of caregiver safety is an issue within Home Care. Caregiving puts family caregivers at risk of ‘decline’ and has been found to occur in about 3 - 11% of Home Care cases. Decline is generally expressed in terms of general health, mental health, and/or sleep disruption.

(Doran et al. 2009; Doran et al. 2014)

Family members who assume caregiver roles ‘because there is no one else to do it’ may be reluctant or unwilling, or have a sense of being trapped and confined to caregiving tasks. Caregivers who experience anger and resentment tend to express caregiving as a burden.

Younger women experience more distress and find care harder to manage; older women tend to have existing health problems that make caregiving challenging.

Higher caregiver income and education do not mitigate strain and Caregivers who are employed experience more strain.

(Macdonald et al., 2010)

Slide 34

Risks to patient from caregiver decline

- Caregiver decline might place the direct Home Care patient at risk (or at higher risk) if that decline results in reductions or withdrawal of patient care by the affected caregiver
- Reducing caregiver burden may reduce safety risk of Home Care patient

Caregiver decline might place the direct Home Care patient at risk (or at higher risk) if that decline becomes a reason for reduction in what the caregiver is willing or able to do, or results in their withdrawal from patient care.

Reducing caregiver burden may reduce safety risks of Home Care patient.

Abuse

Slide 35

Abuse

- Psychological or physical abuse has been reported in up to 25% of caregiver-recipient relationships
- The abuse goes both ways

(Cooper et al., 2009)
(Selwood, Cooper, Owens, Blanchard & Livingston, 2009)
(Macdonald et al., 2010)

Psychological or physical abuse has been reported in up to 25% of caregiver-recipient relationships. The abuse goes both ways. Abuse may be directed from the caregiver to

the patient or from the patient to the caregiver. It may also go simultaneously in both directions in the same case.

Abuse occurs more often in husband/wife dyads – Psychological abuse in up to 25% of cases; physical abuse in 5-6%.

Caregivers who misuse alcohol are more likely to perpetrate abuse.

Patients with cognitive impairment/dementia and aggressive behaviours are more at risk for abuse by caregivers.

Abusive relationships may pre-date the initiation of Home Care.

(Cooper et al., 2009; Selwood, Cooper, Owens, Blanchard & Livingston, 2009; Macdonald et al., 2010)

Supporting Family Caregivers

Slide 36

Supporting family caregivers

- Formal instruction in caregiving
- Periods of respite from caregiving
- Adequate professional services

Slide 37

Supporting family caregivers

“Understanding the safety concerns associated with unpaid caregiving is essential to sustain the role. If the needs of caregivers are not clearly understood and supported ... Home Care patients will end up institutionalized at an earlier point in the illness trajectory.”

(Canadian Home Care Association 2008)

Prevention and management: Family caregivers will benefit from formal information and instruction about the knowledge and skills needed to provide safe care. Structured consultation and support is needed by those in caregiver roles. Respite, social support and adequate professional services integrated into the provision of Home Care can result in safer and sustainable caregiving by family members.

“Understanding the safety concerns associated with unpaid caregiving is essential to sustain the role. If the needs of caregivers are not clearly understood and supported ... Home Care patients will end up institutionalized at an earlier point in the illness trajectory.”

(Canadian Home Care Association 2008)

Themes in Home Care Patient Safety

Slide 38

6 Themes in Home Care patient safety

1. The unacknowledged challenge of taking healthcare into private homes which are not designed for the delivery or receipt of health care
2. System design issues that force patients and caregivers to deal with a patchwork of services, equipment & supplies
3. “Duty creep” - unpaid caregivers take on more and more

Slide 39

6 Themes in Home Care patient safety ...

4. Rationing of services and equipment may lead to *rationed living*
 5. Patients *do what it takes* to stay at home
 6. Declines in caregivers' health
- (Lang et al., 2014)

Qualitative evidence identifies 6 safety-related themes:

- The unacknowledged challenge of taking healthcare into private homes that are not designed for the delivery or receipt of health care;
- System design issues that force patients and caregivers to deal with a patchwork of services, equipment and supplies;
- “Duty creep” and changes: unpaid caregivers (e.g., family, friends) take on more and more responsibilities, while dealing with their role as a caregiver and the impacts this may have on their own health, and lifestyle;
- Rationing of services or equipment may lead to “rationed living”, (e.g., limiting the duration of provision of portable oxygen concentrators can lead to constraints in life activities for COPD patients or doing without oxygen);

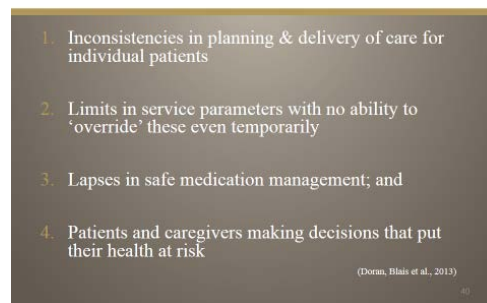
- Patients *do what it takes* to stay at home, sometimes hiding their needs for fear of being told they can no longer live independently; and
- Declines in caregivers' health.

(Lang et al., 2014)

4 systemic safety-related factors that contribute to the occurrence of harmful patient safety incidents

Slide 40

4 Systemic Safety-Related Weaknesses



Patient safety risks can be the unintended consequences of factors that are built into the design of Home Care programs, and by how Home Care services are implemented. Sometimes these factors are embedded in legislation and regulations related to Home Care, sometimes in policy, and sometimes as a result of service delivery processes. None are intended to create safety risks for Home Care patients. Some of the systemic safety-related factors that have been identified as contributing to the occurrence of harmful patient safety incidents are:

1. Inconsistencies in planning and delivery of care for individual patients
 - Lack of familiarity with and variation in understanding of the details and history of patients' care across Home Care workers
 - Unreliable communication processes at care transition points
 - Interdisciplinary healthcare team not integrated in communication and action
 - Variations in makes, models, and instructions for use of equipment
 - Lack of care management across healthcare sectors
 - Ambiguity regarding which team member had the responsibility and authority to make decisions and direct actions
 - Inadequate and infrequent reassessments of patient needs and evaluation of care outcomes
 - Slow response to new care needs
 - Delayed delivery of equipment and supplies

2. Limits in service parameters with no ability to ‘override’ these even temporarily
 - Legislated, regulatory, policy or budgetary limits in volumes, frequency and/or duration of the availability of services.

3. Lapses in safe medication management
 - Lack of medication reconciliation
 - Inconsistent or inappropriate medication packaging and storage

4. Patients and caregivers making decisions that put their health at risk
 - The ability of patients and their families to act as independent decision-makers, often viewed as a strength in Home Care, contributes to risk and is a very difficult element of the Home Care context to mediate

(Doran, Blais et al., 2013)

Actions that may enhance Home Care Patient Safety

Slide 41

Enhancing Home Care Patient Safety

Consider influences of the following:

- The magnitude of the responsibility for providing care that families feel
- Home care involves designing unique ‘work- arounds’ within the physical environment
- Patients decide what they are willing to ‘live with’

(Lang et al., 2006)

Slide 42

Enhancing Home Care Patient Safety

- The depth and breadth of family and self-care giving skills varies considerably, as does their capacity to learn new skills and willingness to abandon ‘old’ skills
- Distance from immediate health care help
- Communication challenges

(Lang et al., 2006)

Purposeful patient behaviour, family caregiver behaviour, health provider behaviour, and/or health system ‘rules’ can be used to mitigate patient safety risks.

(Doran, 2009)

In planning risk mitigation, consider influences of the following factors:

- The home and family are the contexts in which Home Care services are mobilized around the patient. Paid providers are ‘guests in people’s homes’ and the health care is superimposed on the life of the patient and family. Home Care providers need to identify the magnitude of the responsibility for providing care that families feel. It will be different in each case. A ‘cost’ of caregiving can be declines in caregivers’ health and well-being. If caregiver well-being declines so may the quantity, quality and appropriateness of the care the caregiver provides to the patient.
- Safety in hospital care is often focused on providing a safe physical environment (e.g., adequate lighting, non-slip flooring, standardized supplies and equipment) in which care is delivered. In Home Care, the physical environment is that of the patient’s home, which was designed by personal preference and needs for ‘living’. Introducing health care technologies that are noisy, big, aesthetically unpleasant, complex to use etc. may not be acceptable by patients and families. They may overtly or covertly reject them or their use. Some living environments have architectural obstacles to providing care. Home Care often involves designing unique ‘work arounds’ that would be unheard of in hospital care.
- Autonomy and choice for patients and families is greater in the home as it is their ‘home turf’. Patients decide what they are willing to ‘live with’.
- Isolation (i.e., distance from immediate health care help) – introduces reductions in the potential for risk situations to be identified and responded to. A Home Care patient who lives alone and experiences a harmful incident may be incapable of calling for assistance; and if capable, assistance may be delayed for minutes or hours. Home Care professionals cannot ‘call’ a colleague down the hall for an immediate second opinion. A ‘second pair of hands’ is not available. Even the arrival of Home Care professionals depends on external factors unique to each situation (e.g., transportation and weather conditions).
- Communication is challenging. Information exchange is dependent on written and verbal exchanges. Interceding patient and family communication can confound communication attempts between Home Care professionals. Home Care professionals in the ‘circle of care’ for a patient may never meet to discuss and debate healthcare factors and considerations.

- Variations in makes, models and use instructions leads to client and caregiver confusion that results in harmful outcomes.
- Whenever possible, guidelines, protocols and checklists should support care regimes.
- Medication reconciliation should be conducted on admission, transfer and discharge as well as when new medication orders are received.
- Caregiver support
- Home Care patients are at increased risk for readmission to hospital or admission to long-term care facilities when the willingness or ability of family caregivers decline.
- Assess caregiver status when admitting a patient to home care and subsequently on a weekly basis using a valid caregiver assessment tool.

(Doran et al. 2014)

Slide 44

Recommendations to address safety issues

Policymakers:

- Standard competencies for unregulated home support workers
- Maximize opportunities for collaboration
- Common electronic chart
- Integrated, interdisciplinary healthcare teams
- Avoid arbitrary restrictions on the supply of services, equipment and supplies

(Doran, Blais et al., 2013)
(Doran et al., 2014)

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Specific considerations for policy makers include:

- Develop standard skill and knowledge competencies for unregulated home support workers;
- Maximize opportunities for collaboration between Home Care and institutional care;
- Build integrated, interdisciplinary, cross-sector healthcare teams to ensure continuity of care delivery across all healthcare sectors, with particular attention to patients recently discharged from hospital;
- Require a common electronic chart accessible by all caregivers from all sectors to standardize communication among disciplines and across sectors;
- Avoid arbitrary restrictions on the supply of services, equipment and supplies; and
- Standardize formulary for medication packaging and equipment.

Slide 45

Recommendations to address safety issues

Organizations:

- Offer unpaid caregivers training, ongoing support, counselling and health assessments
- Implement policies and procedures for safe medication management
- Include contingency plans for predictable events in each patients care plan

(Doran, Blais et al., 2013)
(Doran et al., 2014)

Specific considerations for organizations include:

- Offer unpaid caregivers training, ongoing support, counselling and health assessments;
- Implement policies and procedures to direct safe medication management for all involved;
- Include contingency plans for predictable events in each patients’ care plan
 - *What would you do if..... you fell, caregiver got sick, weather was bad and no-one could come, power went out ...*

(Doran, Blais et al., 2013; Doran et al., 2014)

Slide 46

Recommendations to address safety issues

CRITICAL SAFETY FACTOR

An umbrella recommendation that applies across most patient safety themes and factors in Home Care is the assignment to each case of a cross-sector case manager with the authority to act as “quarterback”

This ‘quarterback’ must have the clinical knowledge, authority and responsibility required to ensure the planning and delivery of consistent quality of safe care

(Doran, Blais et al., 2013)

A critical safety recommendation which has come out of patient safety research is to assign each Home Care patient a cross-sector case manager with the clinical knowledge, authority and responsibility required to ensure the planning and delivery of a consistent quality of safe care.

An umbrella recommendation is to assign a cross-sector case manager to each case with the authority to act as “quarterback”.

(Doran, Blais et al., 2013)

Slide 47

**Case Manager (Quarterback)
Essential Roles**

- Ensure people selected to deliver care have the appropriate skills and education required for the task
- Manage interdisciplinary and inter-sector liaison

(Doran, Blais et al., 2013)
(Sears 2002)

Slide 48

**Case Manager (Quarterback)
Essential Roles**

- Ensure all pertinent information about the patient is delivered to the appropriate decision-makers
- Ensure that frank and open dialogue is conducted between the patient, the patient’s family and the paid caregivers to determine and clarify expectations for care

(Doran, Blais et al., 2013)
(Sears 2002)

The case manager should be responsible for ensuring consistency of care delivery, for overseeing staff continuity, and for establishing processes and policies for a reliable communication pathway including expanded mobile access to the case manager 24/7. The “Case Quarterbacks” would be required to ensure people selected to deliver care have the appropriate skills and education required for the task. They would be responsible for interdisciplinary and inter-sector liaison and for ensuring that all pertinent information about the patient is delivered to the appropriate decision-makers. In addition, the “Case Quarterback” would ensure that frank and open dialogue is conducted between the patient, the patient’s family and the paid caregivers to determine and clarify expectations for care.

The case manager functions in a similar way to the attending physician in a teaching hospital. They assess patients’ needs and make admission and discharge decisions; they prescribe the plan of care, assign roles and activities to be undertaken by others involved in the care, and evaluate patient outcomes. They are actively involved in oversight of the circle of care, step in to perform care procedures when and if needed, and generally are the person most responsible for the case.

(Doran, Blais et al., 2013; Sears 2002)

Summary

Slide 49

Summary

A slide with a dark background and light text. It contains four bullet points, each preceded by a small square icon. The text is as follows:

- About 1 in 10 homecare patients in Canada experience harm from the care they receive
- Safety risks emerge from practices of health care staff, family caregivers and self-care by the patient
- Patient & family perspectives of what is 'risky' and what risks are acceptable differ from perspectives of home care staff
- Errors in home care can and do lead to temporary / permanent disabilities and to death

Small numbers '49' and '50' are visible in the bottom right corner of the slide.

- About 1 in 10 homecare patients in Canada experience harm from the care they receive; about a third to one half of adverse events in home care are preventable
- Safety risks emerge from practices of health care staff, family caregivers and self-care by the patient
- Patient & family perspectives of what is 'risky' and what risks are acceptable differ from perspectives of home care staff
- Errors in home care can and do lead to temporary / permanent disabilities and to death; home care is not 'safer' than hospital care

Potential Pitfalls

Slide 50

Potential pitfalls

A slide with a dark background and light text. It contains four bullet points, each preceded by a small square icon. The text is as follows:

- The geographically distributed teams needed for Home Care create substantial communication issues and breakdowns in 'teamwork'
- Patient homes are designed for 'living' not for health care – creating the need for novel problem solving in every case
- Injuries from falls, medication related incidents and infections are the most common patient safety incidents in Home Care
- Patients at highest risk include those with more co-morbid conditions, unstable conditions, and those more dependent for completion of (ADLs)

Small numbers '50' and '51' are visible in the bottom right corner of the slide.

- The geographically distributed teams needed for Home Care create substantial communication issues and breakdowns in 'teamwork'
- Patient homes are designed for 'living' not for health care – creating the need for novel problem solving in every case
- Injuries from falls, medication related incidents and infections are the most common consequences of adverse events in Home Care

- Patients at highest risk include those with more co-morbid conditions, unstable conditions, and those more dependent for completion of Instrumental activities of daily living (IADLs).

Pearls

Slide 51

Pearls

- A cross-sector case manager with the authority to act as “quarterback” can reduce patient risks
- Patient safety improves when family caregivers receive formal information and instruction about the knowledge and skills they need to provide safe care
- Patient safety is enhanced when a common electronic chart, accessible by all caregivers from all sectors, is used

- i) A cross-sector case manager with the authority to act as “quarterback” can reduce patient risks and improve responses to new, emerging safety risks
- ii) Patient safety improves when family caregivers receive formal information and instruction about the knowledge and skills they need to provide safe care
- iii) Patient safety is enhanced when a common electronic chart, accessible by all caregivers from all sectors, is used\

Toolkits

CPSI Recommended Readings

<http://www.patientsafetyinstitute.ca/en/toolsResources/PatientSafetyIncidentManagementToolkit/Pages/Resources-and-Recommended-Readings.aspx>

This CPSI resource provides a compendium of evidence based patient safety resources and considerations for all health care sectors.

Patient Safety and Incident Management Toolkit

<http://www.patientsafetyinstitute.ca/en/toolsresources/patientsafetyincidentmanagementtoolkit/pages/default.aspx>

This toolkit provides an integrated set of practical strategies and resources related to patient safety and incident management. The needs and concerns of patients and families and how they can be engaged at each stage in the process were considered in the

development of the toolkit. The toolkit aims to help healthcare organizations prevent patient safety incidents and minimize harm when incidents do occur.

Drawn from the best available evidence and expert advice, and regularly updated, this toolkit is designed for those responsible for managing patient safety, quality improvement, risk management, and staff training in any healthcare setting.

With the main focus on patient safety and incident management, the broader aspects of quality improvement and risk management are not specifically discussed in the toolkit; however, ideas and resources for exploring these topics are offered.

There are three sections to the toolkit: incident management, patient safety management and system factors. Incident management is the foundation, where the focus is placed on the actions that follow patient safety incidents (including near misses.) The focus of the patient safety management section is broader and upstream, on the actions that help proactively anticipate and prevent patient safety incidents from occurring. Encompassing everything are the system factors, consisting of the forces that shape and are shaped by patient safety and incident management. These three toolkit sections include components which provide practical strategies and resources for specific focus areas.

Resources

Safety at Home – A Pan Canadian Home Care Study (Video)

<http://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/SafetyatHome/Pages/default.aspx>

Dr. Diane Doran, professor at the Faculty of Nursing at the University of Toronto, and Dr. Regis Blais, professor at the Department of Health Administration at the University of Montreal, co-led a team, supported by funding from CPSI, provincial governments and other organizations to identify the scope of the patient safety challenge in home care.

This video introduces and summarizes results from the Safety at Home: A Pan Canadian Home Care Study.

Home Care Safety

With the release of the Safety at Home: A Pan Canadian Home Care Study (2013), the Canadian Patient Safety Institute (CPSI) and the Canadian Home Care Association (CHCA) worked with the research team to translate the knowledge acquired from the study into tools, resources and programs for the field. Click on the following links to access resources available to home care providers, clients and families, and policy makers.

(A) [Resources for home care providers](#)

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Pages/Resources-for-home-care-providers.aspx>

The following resources are targeted to those who provide home care services, to help them improve safety in the home for their clients.

Resource guide on falls prevention

This resource guide is intended to help home care service providers find appropriate falls prevention resources that are available online from numerous national, provincial and regional organizations. Each resource has been assessed for currency, clarity, audience and credibility, and comes with a brief explanation of the material. Introduction

- General falls prevention best practice guidelines
- General falls prevention education
- Identifying falls risk
- Gait and balance assessments
- Home and environmental safety
- Medication safety
- Fall prevention interventions for specific client populations
- Post fall care
- Independent decision making

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Documents/Resources%20for%20home%20care%20providers%20-%20Resource%20guide%20on%20falls%20prevention.pdf>

Resource guide for supporting caregivers at home

This resource guide is intended to help home care service providers find appropriate resources to help support family caregivers. The resources are available online from numerous national, provincial and regional organizations, and have been assessed for currency, clarity, audience and credibility; each comes with a brief explanation of the material. Introduction

- General Caregiver Distress Prevention Best Practice Guidelines
- Caregiver Distress Screening
- General Caregiver Distress Prevention Education and Tools

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Documents/Resources%20for%20home%20care%20providers%20-%20Resource%20guide%20for%20supporting%20caregivers%20at%20home.pdf>

Webinars on safety at home

Medication Safety

Video [Click here](#) to watch the video

Presentation [Click here](#) to download

Falls Prevention

Video [Click here](#) to watch the video

Presentation [Click here](#) to download

Building a culture of safety: Lessons learned from high risk industries – The human factor

Video [Click here](#) to watch the video

Presentation [Click here](#) to download

(B) [Resources for family caregivers and clients](#)

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Pages/Resources-for-family-caregivers-and-clients.aspx>

The following resources are to help home care clients and their family caregivers improve safety at home.

Resource guide on falls prevention

This resource guide is intended to help clients and family caregivers find appropriate falls prevention resources that are available online from numerous national, provincial and regional organizations. Each resource has been assessed for currency, clarity, audience and credibility, and comes with a brief explanation of the material. Introduction

- Falls prevention education – Activity and exercise
- General falls prevention education
- Identifying falls risk
- Home and environmental safety
- Clothing and footwear
- Medication safety (46-48)
- Fall prevention interventions for specific client populations
- Post fall care

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Documents/Resources%20for%20family%20caregivers%20and%20clients%20-%20Resource%20guide%20on%20falls%20prevention.pdf>

Resource guide for supporting caregivers at home

This resource guide is intended to help family caregivers find resources that will support them in their role and with the stress that often accompanies this role. The resources are available online from numerous national, provincial and regional organizations, and have been assessed for currency, clarity, audience and credibility; each comes with a brief explanation of the material. General Caregiver Support Tools

- Identifying Risk
- Caregiver Information for Specific Client Populations (Children, Dementia, Stroke, Spinal Cord Injuries, Long Distance Caregiving, Mental Health, Heart, Cancer/Palliative Care, Parkinsons, Others)

<http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Documents/Resources%20for%20family%20caregivers%20and%20clients%20-%20Resource%20guide%20for%20supporting%20caregivers%20at%20home.pdf>

Medication safety brochure

http://www.patientsafetyinstitute.ca/en/toolsResources/HomeCareSafety/Documents/CPSI_safetyathome_medrec_brochure_Electronic%20copy%20EN_Feb10_2014_FINAL.pdf

(C) Resources for policy makers and academics

The following resources are intended to relevant information those who are in a position to make a positive change to improve safety in home care. Key learnings from the Safety at Home study have informed the content of the documents.

Safety at Home: A pan-Canadian home care safety study

<http://www.patientsafetyinstitute.ca/en/INCORRECT-Research/commissionedResearch/SafetyatHome/Pages/default.aspx>

Two page summary: [Click here](#) to download

Policy briefs

- [Adverse events and chronic illness in home care](#)
- [Screening for client safety risks in home care](#)
- [Case management in home care](#)
- [Cross sector collaboration in home care](#)

Reports

1. Foundations for a home care reporting system. Two page summary: [Click here](#) to download. Full report available upon request
2. [Safety at home expert roundtable proceedings](#) (September 11, 2013)

Webinars on safety at home

Medication Safety

Video [Click here](#) to watch the video

Presentation [Click here](#) to download

Falls Prevention

Video [Click here](#) to watch the video

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Building a culture of safety: Lessons learned from high risk industries – The human factor

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Principal message

The single most important message your audience should come away with is that *while patient safety incidents in Home Care do occur there are interventions to help mitigate risks*. Participants should understand that *individuals, organizations and legislators can take actions that reduce risks* by implementing patient safety principles into Home Care practices and workplaces.

Module overview

This module provides the audience with an overview of the importance of patient safety themes within the Home Care context. Evidence and patient safety theory provide ways to enhance Home Care patient safety. The material in this module presents evidence informed information on safety risk factors that Home Care patients are exposed to, the incidence and types of harm they experience, and family and patient perspectives with regard to patient safety risks.

Because advancements in Home Care patient safety are emerging following seminal patient safety work in hospitals and other institutional settings, the context of health care delivery at home and the need for this 'home' context to be incorporated into patient safety considerations is included in the material.

To support the achievement of improved Home Care patient safety, the material moves beyond 'what is' to 'what could be', presenting a selection of conditions, practices and strategies that, if implemented, should reduce the occurrence of breaches of Home Care patient safety and result in fewer injuries and deaths.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the module according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

The suggested timing for each part of this module is:

| | |
|------------------------------------|--------------------------------|
| Introduction | 5 minutes |
| 2 case presentations & discussions | 20 minutes |
| Presentation | 60 minutes |
| (Role play | optional 15 minutes) |
| Debrief about teaching methods | 5 minutes |
| <u>Summary</u> | <u>5 minutes</u> |
| Total | 95 minutes (without role play) |

3. Number of slides: 51

4. Preparing your presentation

The text in the module was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all the content. Their use presumes that you have mastered the content. Source references are provided throughout the text so that you can refer to original sources whenever you feel the need to further understand or explain the text content further.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The module and slides were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include acknowledgment of the PSEP – Canada program in your handouts and slides.

6. Equipment needs

- Screen, computer and projector
- Flipchart or whiteboard and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- If the video fails, you can read the vignette of the trigger tape story;
- If the slides cannot be shown, you can refer to the hand out slides; and
- If flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of the topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Start with the case study

After reviewing the objectives for the session, describe the case study and engage the audience in a short, open-ended discussion about what elements of culture and organizational considerations might be at play in this scenario?

A teachable moment: discussion of the case study

Let the discussion emerge, without confirming or refuting any of the items raised. The intent is to engage the audience, to bring forward patient safety culture knowledge that,

hopefully, is review for them, and provide an appropriate clinical context for the session. It was not designed to demonstrate an ideal interaction, but to *trigger* interest, discussion and interaction. Use the discussion to set the stage for the material to follow. Do not let the discussion focus on a critique of how *real* or plausible the case seemed. If the participants do not like something that was said or described in the case study, acknowledge that there is always room for improvement and invite them to draft an alternate case study after the session.

Setting limits to discussion time

It is usually best to limit discussion of the case study to no more than ten minutes, then move on to the presentation. To help move on if the discussion is very engaged, try saying something like:

- let's hear two last points before we move on, and
- now that you have raised many of the tough questions, let's see how many practical answers we can find.

For the more advanced facilitator who is very confident of both the patient safety material and his or her pedagogic skills, it is possible to use the case study as a form of case-based teaching and to facilitate the discussion to draw out the teaching points of the module. The hazard of this approach is that the discussion will not yield the desired teaching points. Return to the slides if this happens. If this approach is used, it is essential to write up the points on a flip chart as they arise, to fill in any gaps and to summarize at the end. Again, use this method with caution and only if you are really ready.

There is a second case study embedded in the presentation. The intent of using another case and open-ended discussion is to help break-up the presentation and, if necessary, re-energize the audience. Moving even a couple of times between participatory and didactic activities is known to *wake-up* audiences and help them focus on internalizing the information being provided. Use the same teaching approach you selected for the first case study. Switching approaches mid-stream in the session is likely to introduce confusion and a sense of not knowing what the expectations for participation are.

5. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time.

From time-to-time throughout your presentation, ask the participants about their major concerns regarding the point under discussion, and invite them to give you a scenario from their organization or experience. Once you find a scenario that resonates with the group, you may choose to use that scenario, and aspects that flow from it to further discussion of other points further along in the presentation. Have a back-up scenario from

your own experience in case you there are reasons to not go into the ones from the audience. Choose the focus so that you can deliver specific content you have prepared.

Optional addition: Role play

After the presentation, if you choose, you can conduct a role play using the case description below. The goal is to:

- experience the challenges presented by a Home Care patient situation, and
- experience advocating for practices and strategies that mitigate patient safety risks.

The role play can be conducted as a fishbowl, where five participants perform the role play in front of everyone, or it can be conducted more privately within small groups. After completing the role play, facilitate discussion among the group. Possible questions include:

- To actors: What did you find difficult about your role?
- To group: What Home Care patient safety considerations were at play? How would you have handled a similar situation?

Case description

A 77 year old Home Care patient drove himself from home one evening to the Emergency Department (ED) with new abdominal pain. He was examined by the resident and presented to the attending physician; after full and appropriate assessment, no clear diagnosis could be made, so he was sent home and told to tell his Home Care nurse about what had happened. The patient returned home, felt much better the next day and decided not to mention the event to anyone. A week later a personal support worker (PSW) found the patient lying on the floor of his home, surrounded by a pool of urine. His walker, which he used due to an old back injury, was tipped over and beyond his reach. He was conscious, embarrassed by the situation, and once helped up, felt that he was fine. He asked that no-one be told of the incident as his son has stated that ‘the next time something happens’ an application for admission to long-term care would be made. The patient was determined not to go into long-term care as that was for ‘old people’. The PSW felt empathy for his patient and decided that he had to act in accordance with his patient’s instruction not to disclose the incident. Except for a bruised knee and some renewed back pain, which the patient hid from everyone but the PSW, no further incidents happened. However, during his annual performance appraisal when asked to talk about a ‘dilemma’ he had encountered in his work, the PSW related the situation to his supervisor. The supervisor completed an incident report, and notified the Home Care case manager who then held a case conference with the patient, the patient’s son (non-activated POA for personal care), the PSW and a representative from all the agencies involved in the patients care plan.

Role – Mr D, the Home Care patient

You are mentally competent and generally ‘*a nice guy*’ who simply wants to stay at home. You view health care help as a necessary evil and you don’t want to get anyone in trouble or ask for extra help, even though daily life is a struggle. You know that your son cares about you but is busy and cannot be around frequently. You have always prided yourself as being a ‘man’s man’ and view your many scars as badges of honour, each with a story to tell.

Role – Jonathon Alsalwi – the PSW

You are concerned that your patients like and trust you. You always want to do the right thing. You have a fundamental understanding about confidentiality and consent, but the nuances of complex, specific situations often overwhelm you. You have worked with this patient for several years and in your opinion, his fall was a one-time-thing and unlikely to happen again. You do not understand why this past event, in which the patient did not really get hurt, is such a big issue. You need this job and are afraid of being fired if the son and home care program feel that something needs to happen.

Role – Mr. JD – the son

You are aware that your dad is competent and that your POA for personal care really only comes into effect if and when your father cannot make decisions for himself. That said, you are the ‘*take charge*’ person in your family. You love your dad and want him to be safe. He is getting to be so old. For years you have thought that he should not be living alone, but should be somewhere healthcare professionals could make sure he was OK. You are upset that your father fell and that no-one intervened or called you. He could have been badly hurt or have died. You feel let-down by the Home Care program. You believe that he needs to move somewhere safe, where nurses can provide him with the protection and oversight that will keep him safe and prevent any future falls or events. You feel a great sense of responsibility.

Role – Barbara Jones, the PSW agency manager

You have never met Mr. D, Mr. JD or Ms Star before today. The contract your agency has with the Home Care program is very important. Your organization’s lawyer has confidentially advised you that there may be liability issues for your organization if injuries emerge that may be even remotely related to the lack of immediate reporting of the patient’s fall. The back pain that worsened is of significant concern as back pain and liability regarding cause is difficult to defend in civil law suits. Jonathon Alsalwi, the PSW has always been reliable and is one of the employees that you can depend upon to take a difficult or last minute assignment. You need him, but you feel that this time he has let you down.

Role – Ravi Star, RN, the Home Care case manager

You are following Home Care Program policy by holding a case conference within two weeks after a report of an incident with this patient was received. The last time you saw Mr. D was 5 months ago when, also following policy, you visited his home and reassessed him using the standardized assessment form (possibly the Inter-RAI-HC – if you are familiar with this). Prior to that, you visited him for reassessment every 6 months.

6. Key take-home points of the role play

1. The home support agency's and the home care program's patient safety culture are critical to improving quality and safety for patients.
2. A blame culture is motivating some of the concerns and behaviours.
3. The patient and the son have different perspectives about what is 'safe' and what risks are acceptable.
4. Communication lapses are contributing to safety risks.
5. Case management activity is distant and based on program policies driven by timeframes rather than patients' needs.

7. Summarize the role play

Briefly, review each part of the role play. Recap two or three of the most important points that were discussed.

8. Summarize the presentation

Use the *summary*, *potential pitfall* and *pearl* slides in the PowerPoint presentation to wrap-up the presentation and teaching session. Thank everyone for their attention and participation and acknowledge the role play actors for their contribution to the session.

9. Debrief about the teaching method

Tell the group that it is time to consider the teaching methods used, how they worked and what their limitations were. Ask them what other methods might work, and what methods would work best for this topic in their organizations. Ask them to consider what method would work best for themselves as facilitators and for their target audience.