THE CHANGE FOUNDATION

HEALTHCARE DESERVES
OUR FINEST THOUGHT

The Change Foundation's Summary & Reflections Safety at Home: A Pan-Canadian Home Care Safety Study (June, 2013)

INTRODUCTION

The Change Foundation, along with the Canadian Patient Safety Institute, the Canadian Institutes of Health Research and the Canadian Foundation for Healthcare Improvement, funded a two-year pan-Canadian study of patient safety in the home (2010–2012).

Over one million Canadians receive healthcare services in the home, and as the demand for home care increases with our aging population, there is a pressing need to ensure its safe delivery.

While much was known about adverse events in institutional healthcare settings, little was known about healthcare safety in the home. Nearly a decade ago, landmark Canadian research (Baker/Norton, 2004), documented "adverse events" in hospitals and quantified preventable ones. This new, first-of-its-kind study shines a similar spotlight on safety issues in home care.

The study builds on The Change Foundation's previous cautionary call to governments to plan ahead and not simply transfer care from hospital (and other institutional settings) to home without adequate support (see the Foundation's related resources).

WHY DOES THIS WORK MATTER?

All jurisdictions in Canada have recognized the growing need for expanded, quality home care as we shift resources out of acute care hospitals and into the home. In general, people prefer to be at home (provided they have one) as long as the environment is safe. We wanted to know—is the environment safe?

In Ontario, given the province's current *Action Plan for Health Care* mandated shift to providing care—where possible—at home or in the community, this study offers timely research insight to make the road ahead safer for both patients and caregivers.

The study pulls back the curtain to reveal how the provision of healthcare services in people's homes is a private and often complicated affair. There is often only one healthcare worker on site at a time, and family members are not always present. In most parts of the country the agencies that provide the services are not required to publicly report their adverse event records. In contrast, hospitals have a number of quality indicators they must report publicly.

WHAT DID THEY FIND?

A large research team led by Dr. Diane Doran, University of Toronto, and Dr. Régis Blais, Université de Montréal, looked at the research literature and designed a way of calculating the incident rates of adverse events in the home. They reviewed administrative data and undertook a chart review. In general, an adverse event was defined as an injury or consequence suffered by a patient and caused by healthcare.

The study found that the main types of events were falls, infections and medication-related incidents. A key finding is that more than half of these events could have been prevented (56%).

Canada

The overall incidence rate for adverse events in the home was between 10 and 13%. Approximately one mil-

lion Canadians receive home care services annually, so this means that between 100,000 and 130,000 people experienced an adverse event.

Ontario

Ontario was a focus for the study as its population is large and all the administrative databases needed were available. The team looked at data for 2008 and 2009 and was able to determine that the 2008 rate was 12.7%, or 48,461 people, and the 2009 rate was 13.3%, or 51,631 people.

WHAT WAS THE IMPACT OF THE ADVERSE EVENTS?

Outcomes ranged from increased use of healthcare resources, admission to a long-term care facility, disability and death.

CONCERNS RAISED IN INTERVIEWS

The team undertook one-on-one interviews with clients, unpaid caregivers and family members as well as home care providers for a deeper look into the issues.

A series of concerns was identified:

- The home environment is not always conducive to the safe provision of care: it can be cluttered, poorly maintained or cramped. Trying to use wheelchairs and walkers, IV pumps or oxygen tanks can be difficult. (See the study's photos to get a visual sense of the clutter and chaos impacting patient safety.)
- Care coordination can be difficult with multiple staff members coming in and out of the home on different days at different times. Staff training, client communication and equipment coordination can be disconnected, with poor hand-offs.
- The changing roles of family members—and the expectations placed on them—are often not acknowledged or accommodated. There is little support for informal caregivers who are prepared to take on the challenge of providing care, and not all clients have family members who are available.
- A specific focus in two provinces revealed that people with respiratory disease were limited to two portable oxygen cylinders a month. This limit diminishes a patient's quality of life by making travel outside the home difficult or by forcing people to go without oxygen support for periods of time.
- Clients state they sometimes under-report their support needs out of fear that they may have to give up living independently. Some see the receipt of home care services as an admission that they can't cope, rather than as a positive step towards maintaining their independence.
- Caregivers' health often declines as well. Many are elderly spouses or retired children who experience increased physical and emotional demands associated with the stress and isolation that can occur.

WHAT NEEDS TO BE DONE?

The research team offers a series of detailed recommendations (not all of which will relate to all of the varied provincial home care programs that exist across Canada).

1. Improve care planning through multidisciplinary teams
   Most of the fall-related incidents occurred with clients who had a well-established history of falls and, in most cases, medication was a contributing factor.
2. Give case managers some flexibility in determining needs
   Many of the clients experiencing problems had reached their maximum service allocations, and their case managers did not have the ability to increase the care provided to them.
3. Clarify roles and responsibilities and designate a "quarterback"
   Ambiguity over who had responsibility for what and under what circumstances, combined with poor documentation about what was being provided in the home, led to a failure to identify client deterioration.

4. **Standardize processes and procedures**
   Assessments are done differently at different points in time even within the same provider agency. Different agencies use different forms and records. Medication and equipment packaging is all over the map and confuses both the worker and the client.
5. **Find the balance between client and family autonomy and appropriate levels of support**
   Additional supports were sometimes rejected if they would mean a change in environment or additional people coming into the home. We need to find a way to have these delicate discussions, to ensure that the patient is still living in a safe environment.

NEXT STEPS?

The research team, in collaboration with the Canadian Patient Safety Institute and national partners, is developing tools and resources for clients, caregivers, home care organizations and policy makers, with the aim of informing change in policy, practice and behaviour in the home care setting. These tools will be developed and distributed over the next several months and can be found by visiting www.patientsafety.ca.

SEE RELATED CHANGE FOUNDATION WORK:

Winning Conditions to Improve Patient Care
Integrated Healthcare in Ontario. November 2011.

Because This Is the Rainy Day
A Discussion Paper on Home Care And Informal Caregiving for Seniors with Chronic Health Conditions
Health. February 2011.

Loud and Clear
Seniors and caregivers speak out about navigating Ontario's healthcare system. April 2012.

Further information about the study and its findings: www.patientsafety.ca.