Creating a Culture of Safety – National Improvement Collaboratives

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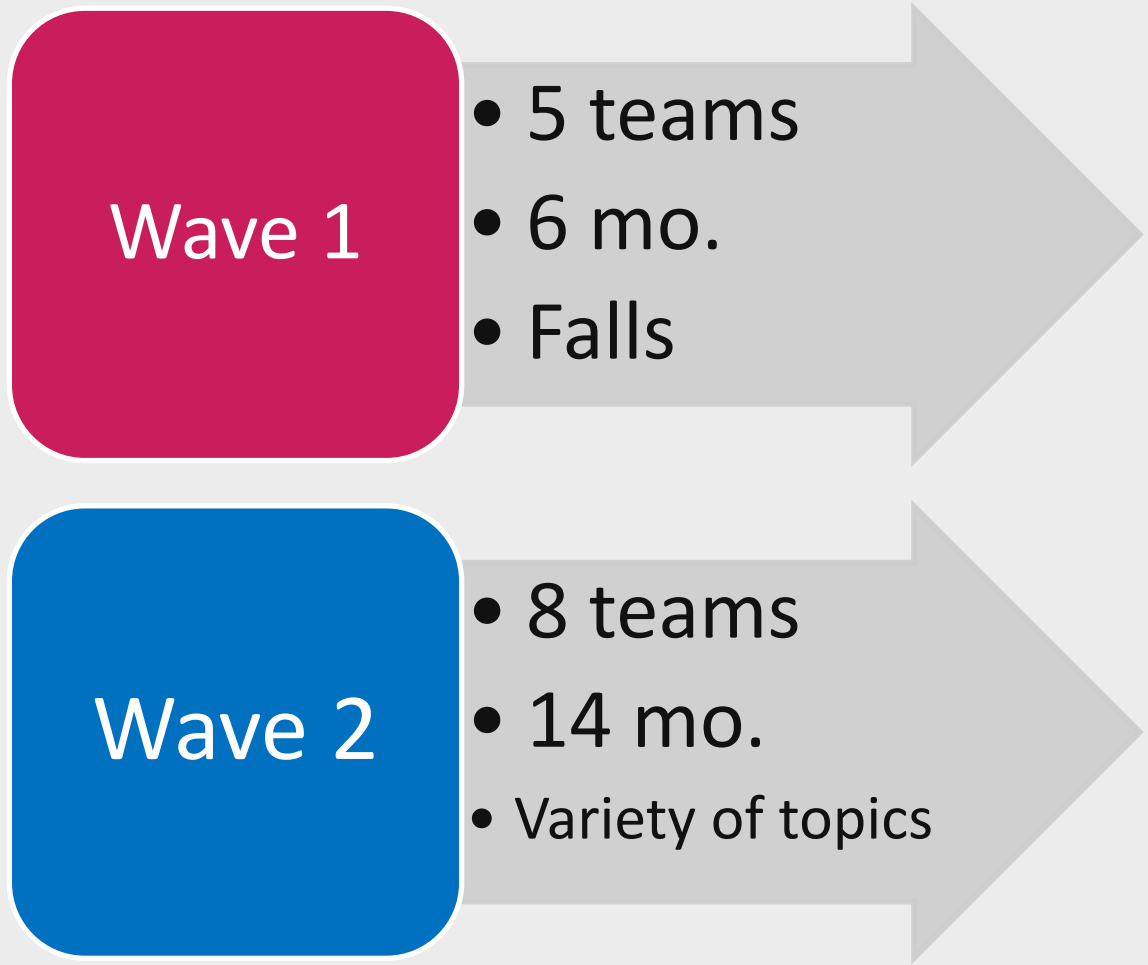
Applying Improvement Collaborative Model to Home Care

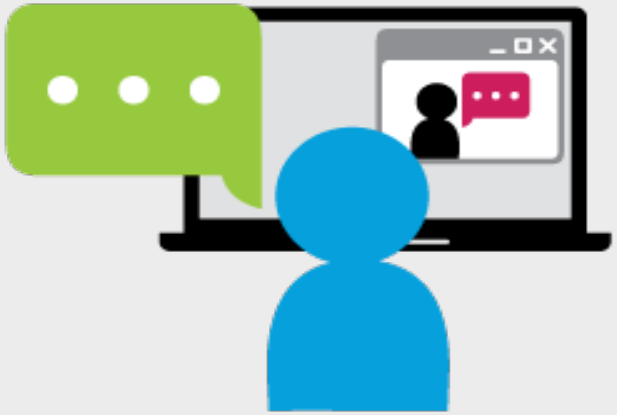
- Modeled after Institute for Healthcare Improvement (IHI) Breakthrough series
- Sponsored by Canadian Patient Safety Institute (CPSI) Canadian Home Care Association (CHCA)& CFHI (Wave 1)
- Involves participating teams representing health authorities and home care providers from across the country
-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



Wave 2 Home Care Safety Collaborative

Key Elements of Program

Learning Sessions



Coaching Sessions

Action Periods

Dialogue Session # 1

Questions:

1. *Thinking about quality improvement initiatives or similar processes that you have been involved with, what one thing was key to the success of the initiative?*

2. *What was the biggest challenge ? How did you address this?*

Home Care Safety Improvement Collaborative

Implementing and developing case management protocols which help identify and support clients with complex needs in the community

November 14, 2017

Canadian Home Care Association
canadienne de soins et services à domicile

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cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

NSHA Project Team

Wave 2 Coaches

Leadership

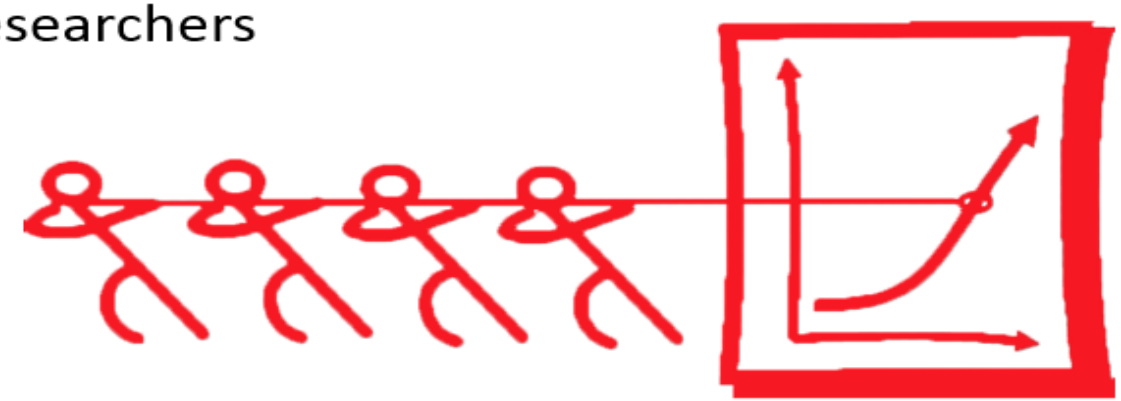
Client Advisor

Care Coordinator

Data Analysts

Project Manager

Researchers



Challenging Behavior
Resource Consultants

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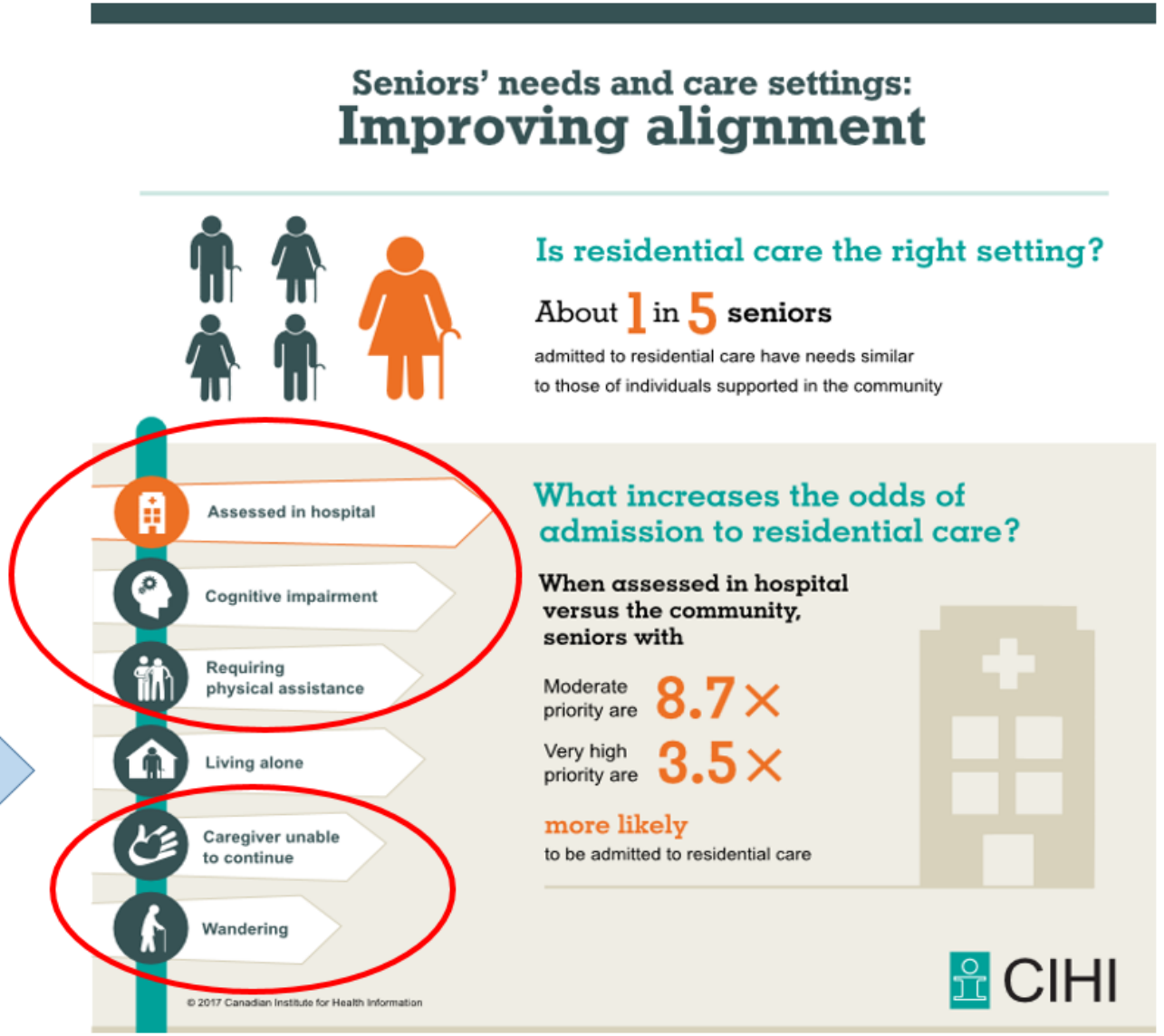
Cognitively Impaired Clients (RUG)



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Problem Identification

- Approximately 16% of clients receiving home care services were classified under the Cognitive Impairment (CI) RUG

- 33% of the primary caregivers of clients in the CI RUG category who were discharged last year expressed feelings of distress, anger or depression (36% in Central zone)

- From the research – we understand that caregiver distress can lead to:
  - Poorer health outcomes for caregiver (physical, psychological)
  - Poorer health outcomes for clients
  - Shorter length of stay at home
  - Premature entry into LTC
  - Preventable admissions to hospital
  - Quality of life impact for both client & caregiver

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Project Aim

Reduce % of caregivers of clients within the Cognitive Impairment RUGs category in Central Zone experiencing feelings of distress, anger or depression from 36% to 18% by June 2018.

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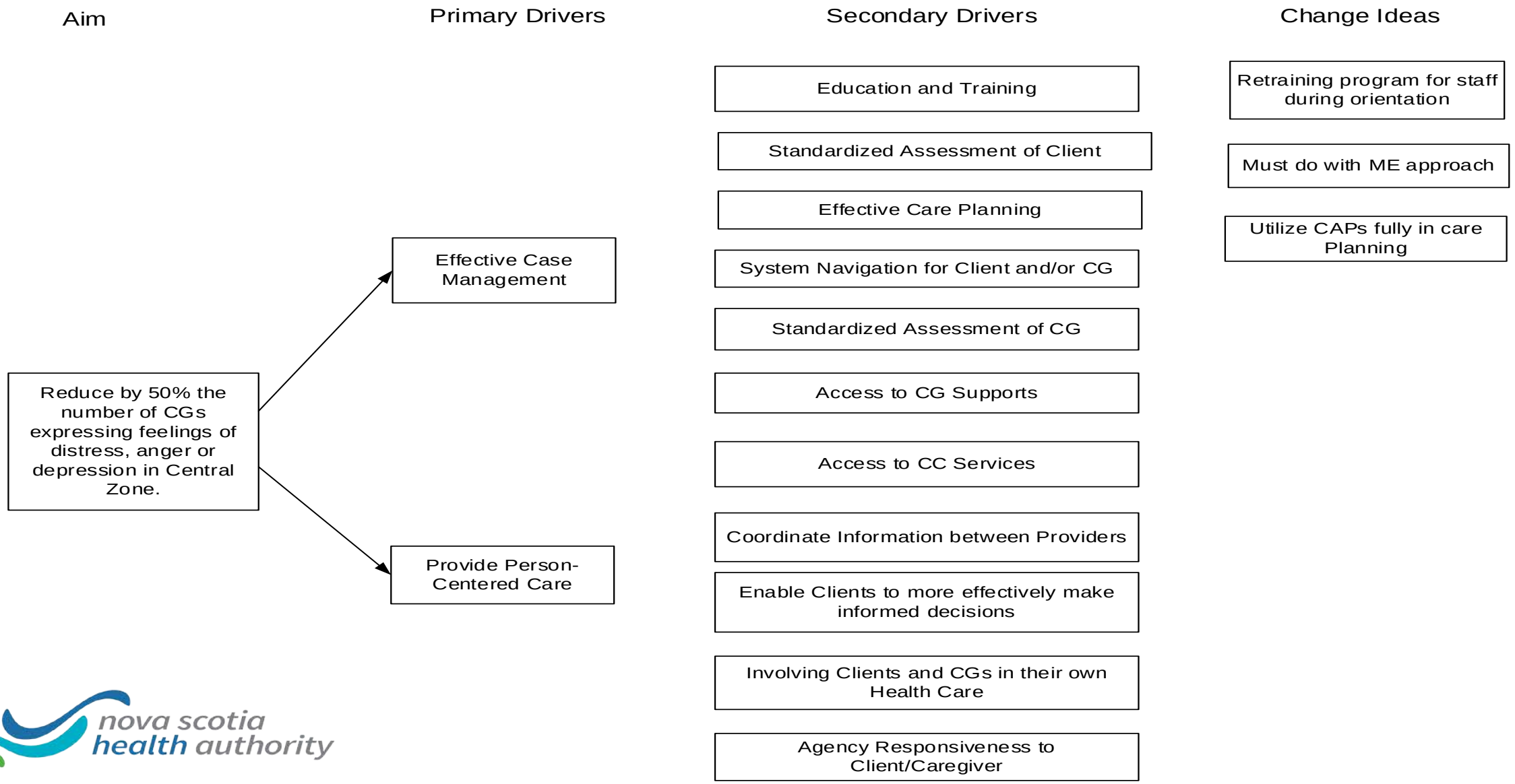
Draft Driver Diagram



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Focus on CAPs

CAPs identify opportunities to influence health outcomes

Triggers within broad areas such as:

- Functional Performance
- Cognition and Mental Health
- Social Life
- Clinical Issues

CAPs Structure:

- Problem statement
- Goals of care
- Triggers
- Guidelines

InterRAI's Clinical Assessment Protocols (CAPs) are clinical algorithms that identify the need for care plans to address factors that may lead to adverse outcomes that are amenable to clinical intervention.

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Healthcare Improvement Scotland

Must do with Me

- *What matters to you?*
  - *Your personal goals and the things that are important to you have been discussed and form the basis of your care.*
- *Who matters to you?*
  - *We have asked you about the people that matter most in your life and we have given you the opportunity to involve them in a way that you choose.*
- *What information do you need?*
  - *We have provided you with understandable full information and supported you to make decisions that take account of your personal goals and the things that are important to you.*
- *Nothing about me without me*
  - *You will always be given the opportunity to be involved in discussions. All information exchanges and communication between professionals or between different services or supports are transparent and always provide you with the opportunity either to be present or to contribute to the process.*
- *Personalized contact*
  - *As much as possible, the timing and methods by which you contact and use services or supports are flexible and can be adapted to your personal needs.*

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Key Indicators

Outcome Measures
% of CGs expressing feelings of distress, anger or depression
% of CGs expressing that they are unable to continuing in caring activities
% of clients and caregivers satisfied with the case management service they received

Balancing Measures
Perceived value by staff
Impact to work load
# of referrals for services outside Continuing Care
Amount of authorized continuing care services

Process Measures
Number of clients who receive case management services using enhanced CAPS training & proposed person centered approach
% of Care Coordinators satisfied with training content/approach

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Key Pieces of Work

Indicators:
- Finalize Measurement Worksheet
- Development of Qualitative Outcome Survey & Methodology

Development of Change Initiatives:
- Analysis of Current State
- Literature Review on Leading Practices
- Development of Case Management Protocols

Implementation of Change Initiatives:
- Recruitment & Training of Care Coordinators

Collection, Monitoring and Tracking of Indicators

Refine Change Initiatives based on Results

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Lessons Learned

- Don’t mistake the solution for the problem
- Dedicated resources & time
- Capacity development
- Be realistic when scoping the project
- Important to identify & engage all key stakeholders
- Data limitations

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Dialogue Session # 2

1. *Having heard about the experience of the Nova Scotia Health Authority with the Collaborative, what would be some of the challenges you might face in establishing an effective team to participate in a quality improvement initiative?*

2. *In your organization, what are some of the key safety-related problems that you would like to address?*

CHAC Summit Halifax 2017

Creating a culture of safety-National Improvement Collaboratives.

Mike Cass
Patient Safety Improvement Lead
CPSI

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 will support your organizations to rapidly **plan, test, measure** and **make targeted changes** to improve quality and patient safety in the home.

The National Safety Improvement Collaborative

What is involved

1. Create a team with QI, measurement, and front line experience
2. Engage patient and family advisors
3. Learn and implement QI methodology

- Develop an AIM statement
- Identify and Test change concepts
- Measure the effect of the changes tested
- Study the results
- Repeat
- When ready spread the successful changes

Team Roles and Responsibilities

- Not be completed off the side of your desk
- Plan in advance for
  - Team meetings
  - Coaching calls
- Minute your meetings including assigned responsibilities
- Don’t leave things to the last minute
- Work with Executive Sponsor to *‘release time to reduce harm’*
- ***Expect the unexpected***

The TEAM

Who does the patient/client see?

Who is needed for Implementation?

Who supports the changes?

Who is needs to know about the changes?

Each member is a champion

The TEAM

Executive Sponsor:
Approve time and other resources
Establish an accountability mechanism
Support the team

Patient and Family advisor:
Member of core team
May attend learning sessions
Role is determined by Individual skills and
Needs of project

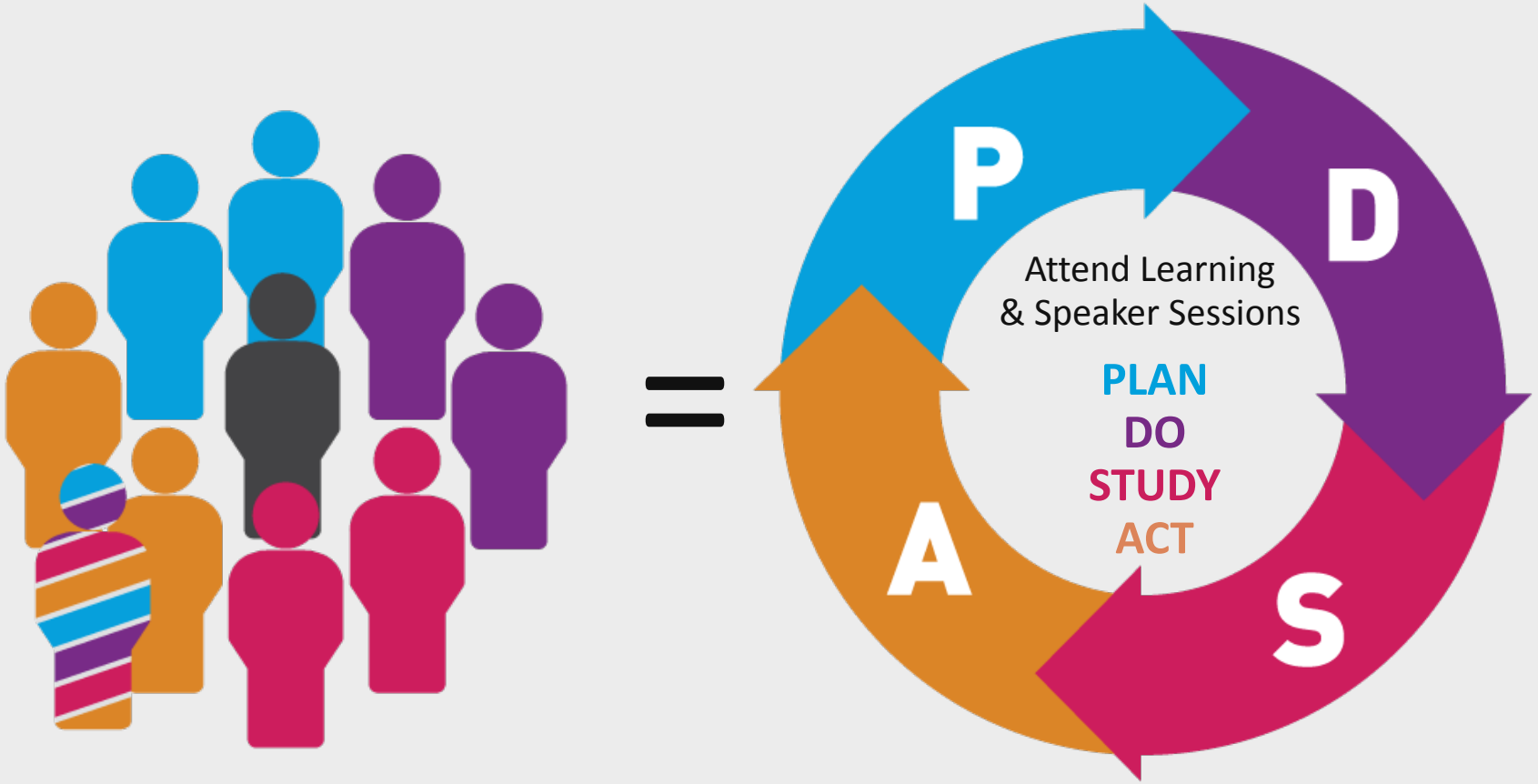
Team leader:

Complete the project charter
Organize meetings
Facilitate work
Communicate with team and coach
Ensures involvement of patients and families
Schedules calls

Measurement lead:

Access/interpret/share data
Identify baseline and ongoing performance
Plot data pre and post testing change concepts
Measure, interpret and report impact of the test of change

Collective Team Roles & Responsibilities



If a team member has a unique skill required at a specific point in the project that individual becomes "**Leader**" for that skill.

The Collaborative APPROACH

Designed to improve quality of care and reduce cost

How is this Achieved

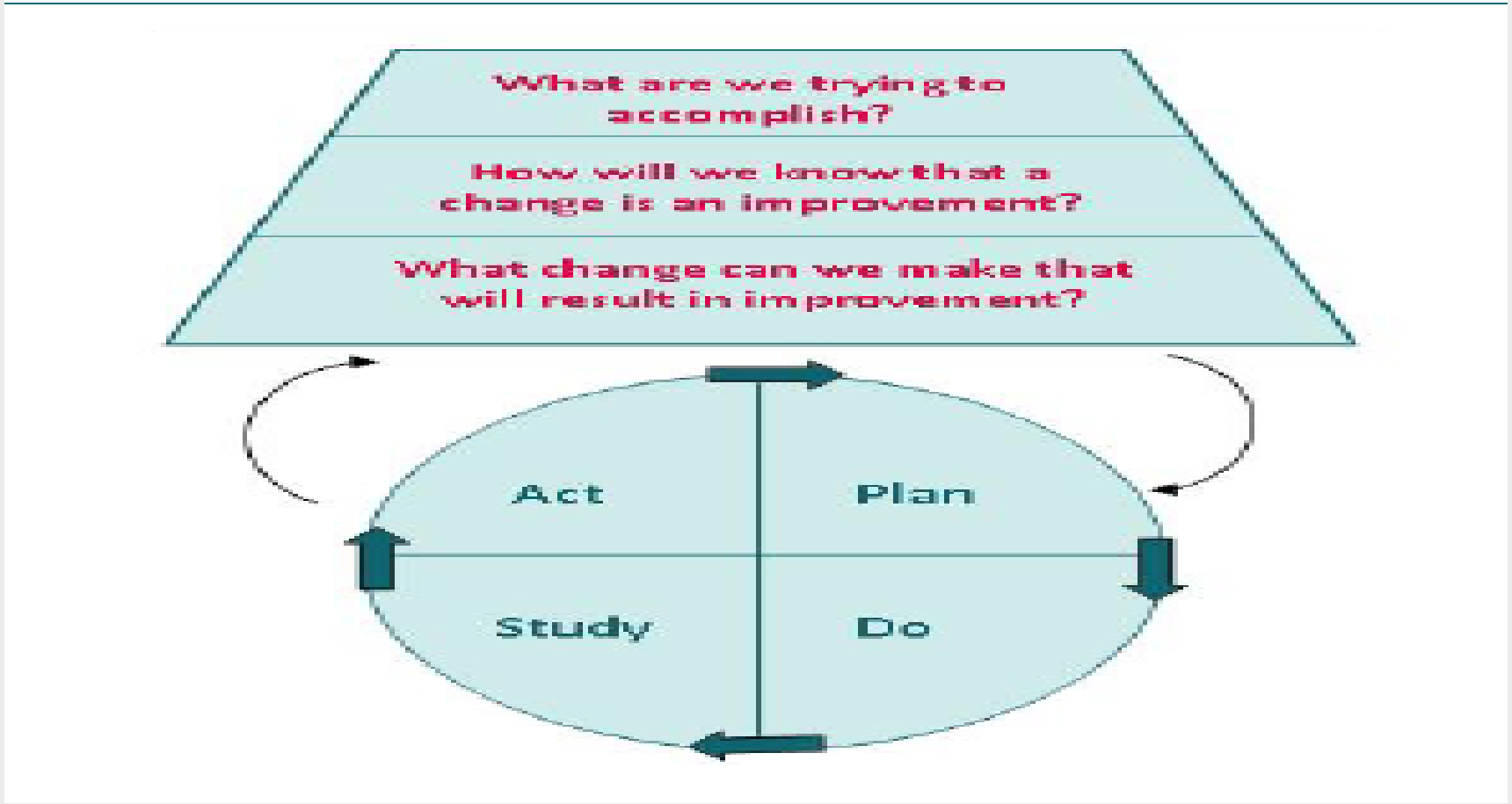
- Organizations come together to facilitate learning and process improvement
- Organizations share a commitment to making significant & rapid changes

The Method

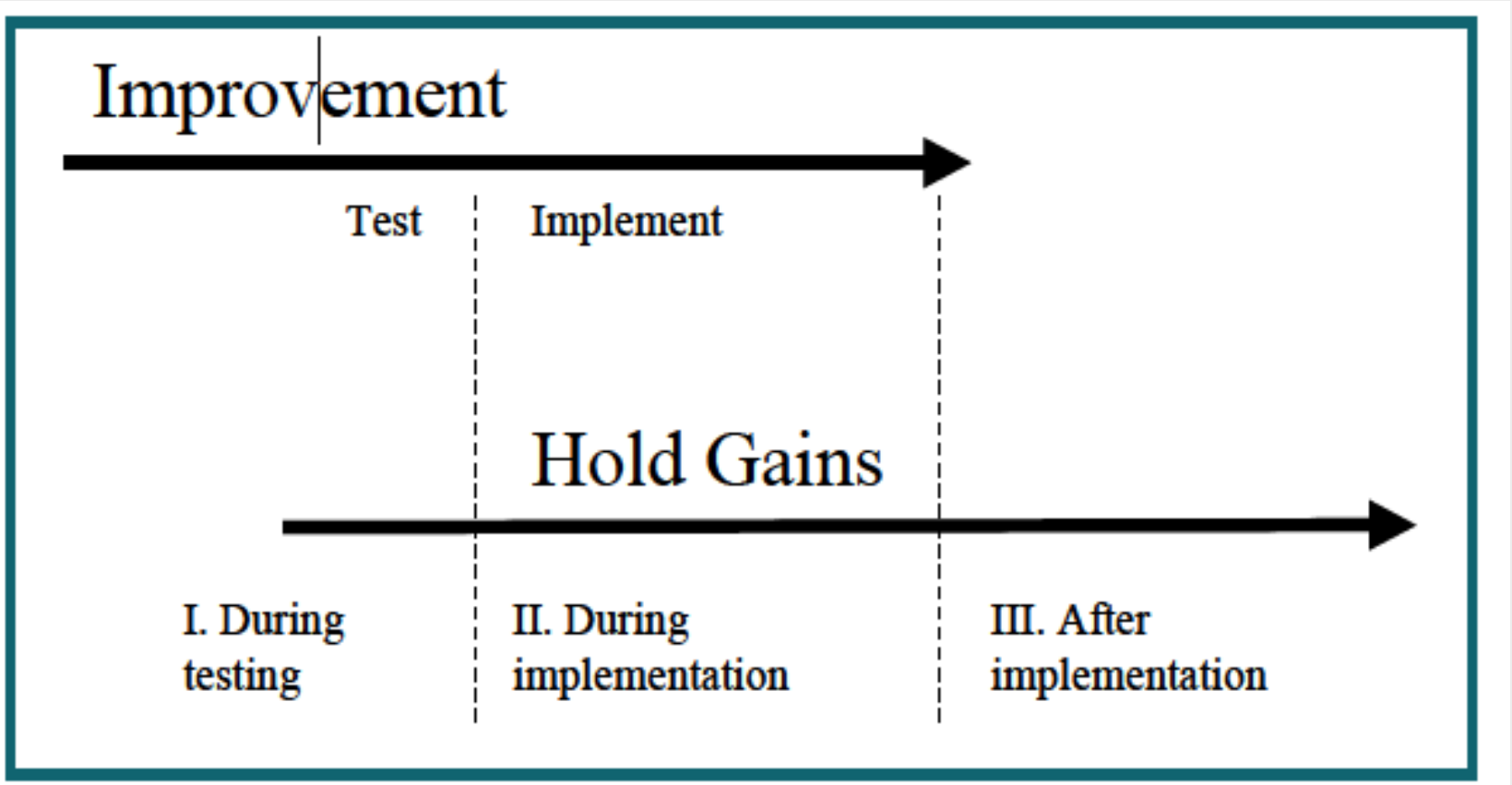
Spread and **adaptation** of **existing knowledge** to **multiple settings** to accomplish a **common purpose**

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

The Model of Improvement



Holding the gains…Sustaining your Improvement



The importance of Measurement

Before we encourage sustaining or scaling up a new care practice, we must first know if it has improved care, or simply changed the way we provide care

What do we measure?

1. Outcome measures
2. Process measures
3. Balancing measures

Outcome measures

Capture what is important to the patient/client/user and reflect how the overall system is working.

Answer the question:
Are we fulfilling our aim?

Examples:
1. Responsive Behaviours rates
2. Pressure ulcer rates
3. Falls rates

Process measures

The voice of the process; they reflect how steps in the system are performing

Answer the question:
Are we doing the things we thought would result in an improvement?
Process measures are leading indicators

Examples:
Percentage of clients screened for falls risk

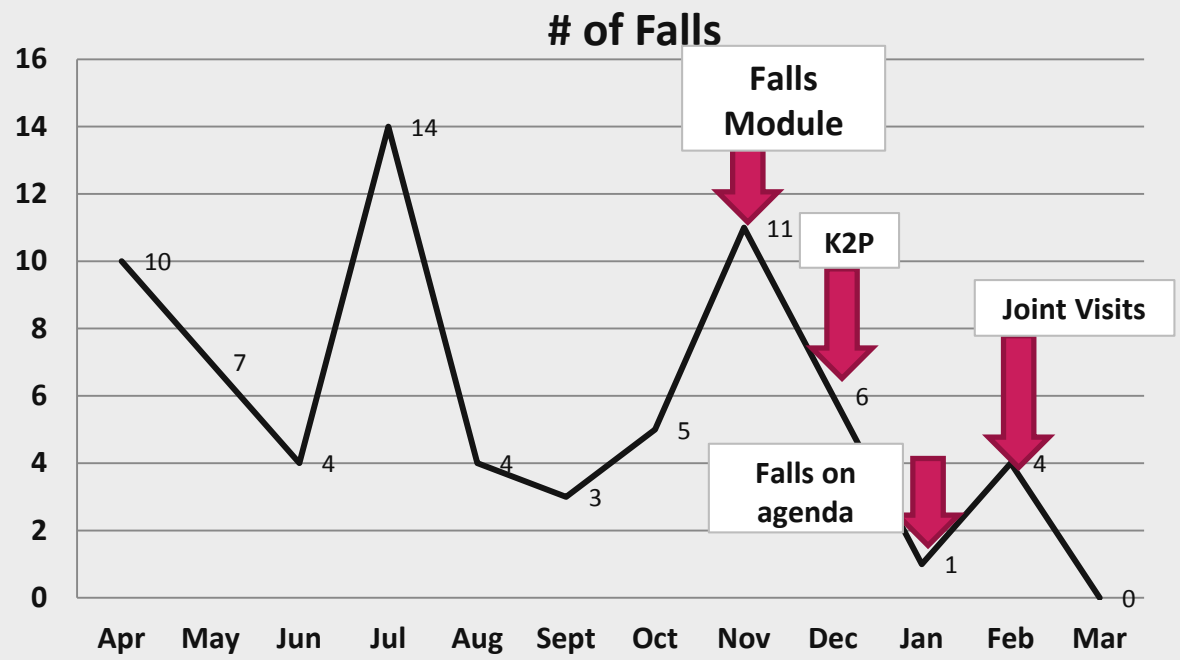
Balancing measures

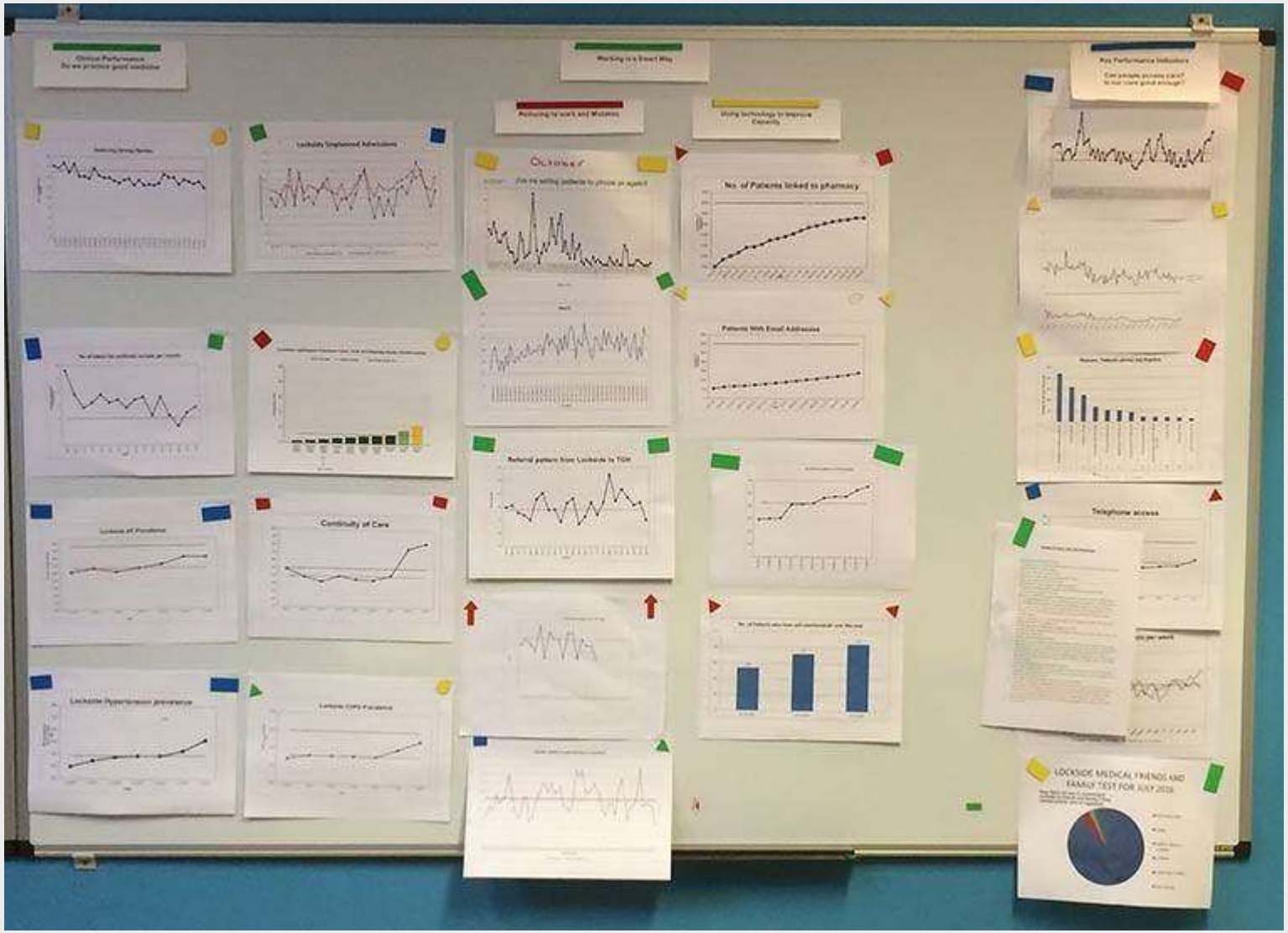
Looking at a system from different directions / dimensions.
What happened to the system as we improved process and outcome measures?

Answer the questions:
Are we inadvertently having a negative impact on other parts of the system through our actions?
What could go wrong if we do this?

Examples:
Use of Restraints

Run Charts


# of Falls
16
14
12
10
8
6
4
2
0
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
10
7
4
14
4
3
5
11
6
1
4
0
Falls Module
K2P
Joint Visits
Falls on agenda


Clinical Performance
Working in a Smart Way
Key Performance Indicators
Lockside Unplanned Admissions
No. of Patients linked to pharmacy
Patients With Email Addresses
Referral pattern from Lockside to TGH
Continuity of Care
Telephone access
LOCKSIDE MEDICAL FRIENDS AND FAMILY TEST FOR JULY 2018


HEALTHCARE QUALITY
.. MAYBE WE SHOULD ASK PATIENTS WHAT THEY THINK
? ? ?
DOLGHAN
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Patient Engagement:

Patient engagement is the involvement of patients and/or family members in decision-making and active participation in a range of activities (e.g. planning, evaluation, care, research and training).

Starting from the premise of expertise by experience, patient engagement involves collaboration and partnership with professionals.

Patient Engagement:

Why is patient engagement so important?

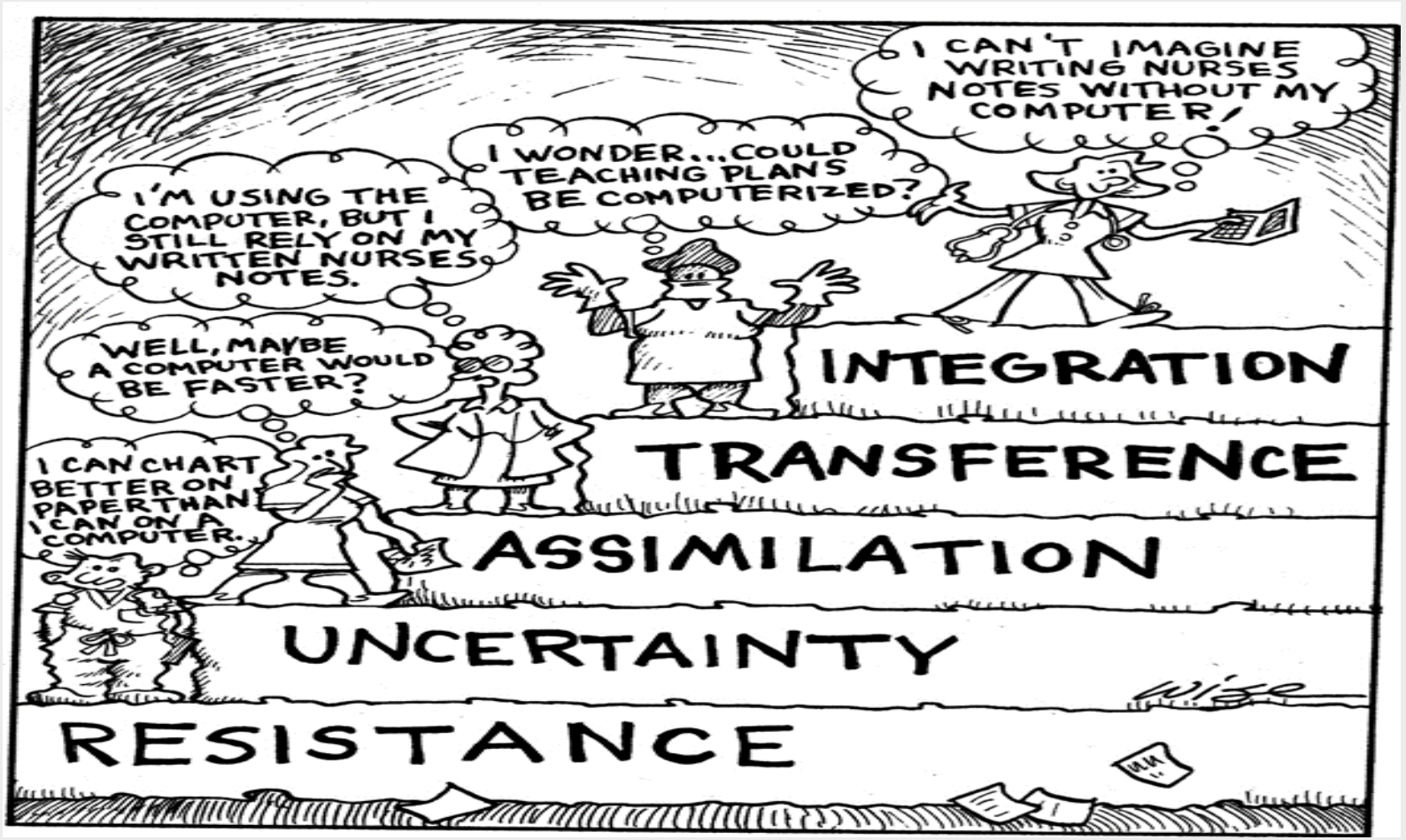
Engage early, engage often

Sustainability:

Locking in the progress that you already made during the implementation cycle and continually building upon it (IHI, 2008).

The process through which new working methods, performance enhancements, and continuous improvements are maintaianed **for a period appropriate to a given context** (Buchanan et al, 2013; Ilot, 2016).

Sustainability:



Key Components of Sustainability (Holding the Gains)

1. Supportive Management Structure
2. Structures to “Foolproof” Change
3. Robust, Transparent Feedback Systems
4. Shared Sense of the Systems to Be Improved
5. Culture of Improvement and a Deeply Engaged Staff
6. Formal Capacity-Building Programs

   (IHI, 2008)

Spread

Spread: Actively disseminating best practice and knowledge about every intervention and implementing each intervention in every available care setting (IHI, 2008)

The process through which new working methods developed in one setting are adopted, perhaps with appropriate modifications, **in other organizational contexts**" (Ploeg, 2014).

Are you ready to spread your work?

A team is ready to spread their ideas and successes to other parts of the system when:

- They have been successful at testing, implementing, and holding the gains in their own environment.
- They can demonstrate their results through their data and stories;
- There is ***commitment*** among senior leaders and sponsors to spread the changes
- The topic is an important priority for the organization and communicated in strategic and business plans;
- A senior leader has been assigned to spread the changes.

The faster we can spread good ideas, the better home care will be.

Successful Spread: Lessons Learned

Even the best ideas and practices don’t implement and spread themselves.

Patients and families are critical for system transformation.

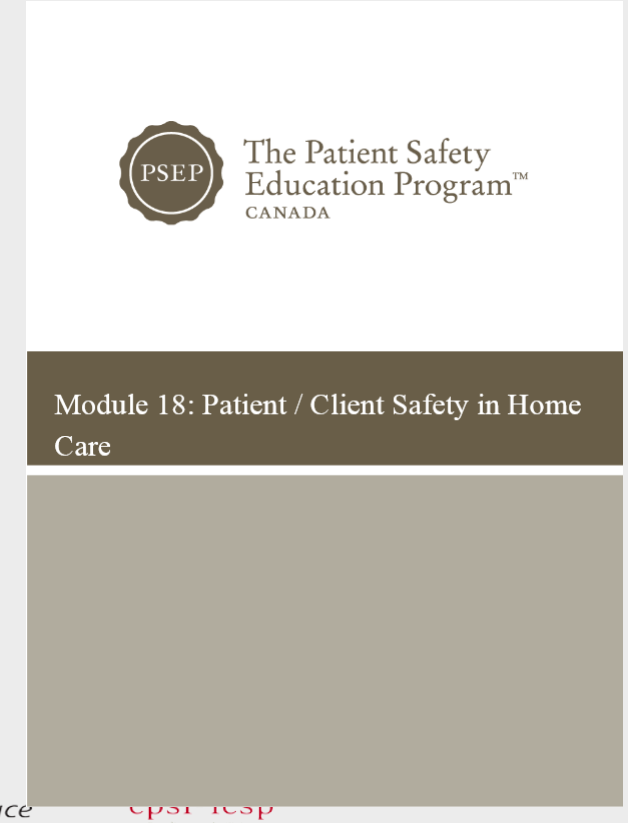
Change of any size takes time, capacity and dedicated resources.

Leadership, dedicated staffing time, and resources are critical.

Take Home Messages

1. Accessing and managing data is challenging.
2. Being part of the Collaborative provides a framework and impetus for organizations to do quality improvement work.
3. Coaching is very helpful in supporting teams to do improvement work.
4. Patient and family engagement in improvement work is valuable and meaningful
5. ***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.

Patient Safety in Home Care Curriculum



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Canadian Home Care Association
canadienne de soins et services à domicile
Advancing Excellence in Home Care

Working together to reduce preventable harm in the home

Dialogue Session # 3

1. *As Mike has explained, there are many tools and resources available to help organizations with QI initiatives. What tools have you found to be the most useful?*
2. *Accountable care is the theme of our Summit – how do you see QI Collaborative approaches helping organizations to provide more accountable care?*
3. *What else would you like to know about the Collaborative?*

Questions & Comments

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