care at home
services

QI Safety Collaborative

Lessons Learned

Presented by
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Care At Home Services (CAHS)

Agenda

- Safety Collaborative Highlights
- Lessons Learned
- Q&A

Declaration

- No conflicts of interest
- Gratitude to the Indigenous Communities

Safety Collaborative: Background

Participants Wave 2 Home Care Safety Improvement Collaborative

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CBI HEALTH GROUP

island health

Central West CCAC CASC Community Care Access Centre

Beacon Community Services

nova scotia health authority

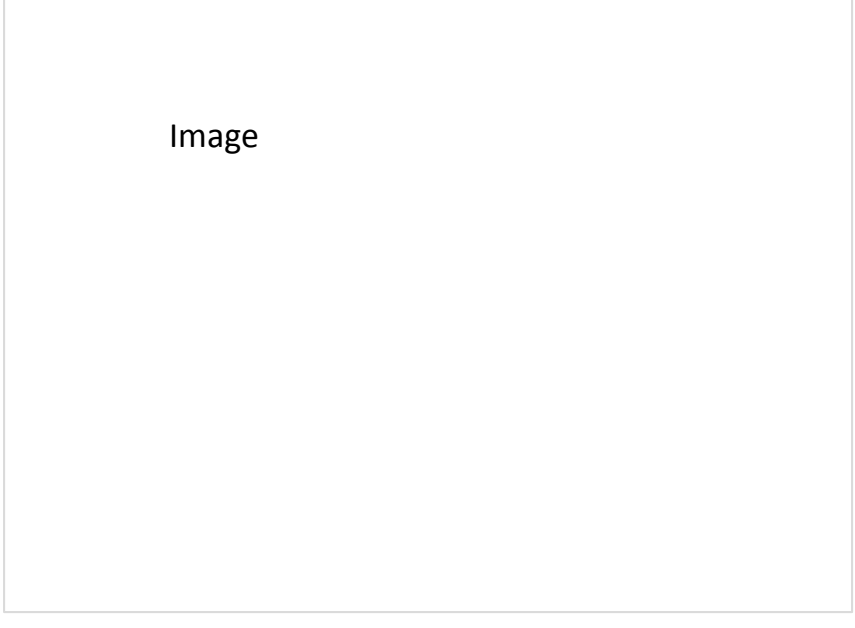
Spectrum HEALTH CARE Always with you.

VHA Home HealthCare Creating More Independence

QI Safety Collaborative Highlights

Project Team Selection

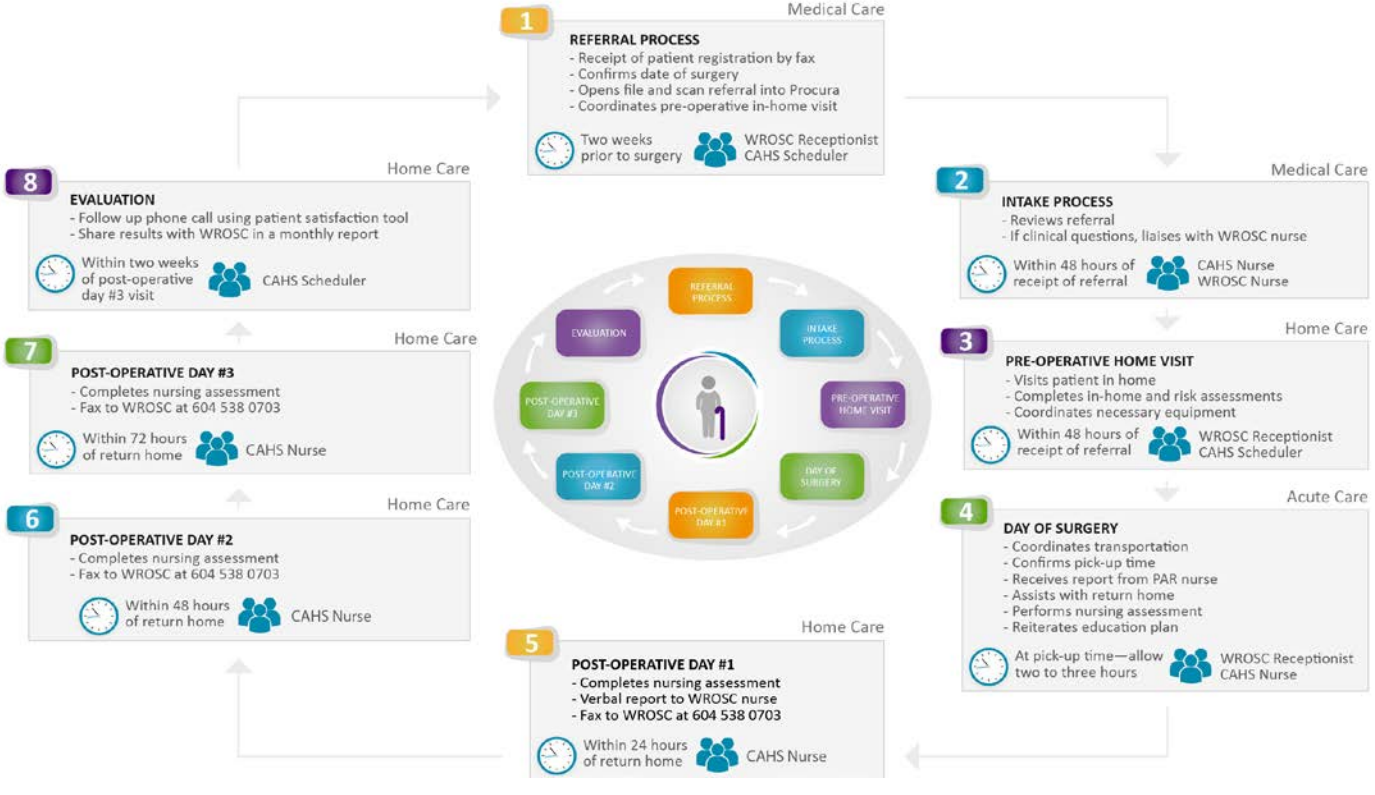
- Commitment to best practices
- Project management experience
- Understanding of Lean methodologies
- Diverse healthcare experience



Project Selection Criteria

- Improve patient care
- Find efficiencies in current practices
- Team driven—what's important to the staff?
- Scalable
- Innovative—potential to have a significant impact

First Project: Same Day Discharge TKR



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Back to the Drawing Board

- CAHS has a high prevalence of patients with complex needs
- Advance care planning is an important tool for patients, families, and clinicians for EOL care
- Our staff is not currently trained to deal with advance care planning and serious illness conversations

Advance Care Planning

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

Facts About Advance Care Planning

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

Only **48%** of hospitalized patients in Canada have started an advance care plan

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

Aim Statement

CAHS will increase the rate of

Advance Care Plans

in the home and the EHR by

60%

for those patients where the

Surprise Question (SQ)

screener tool response was

“No”

What is the Surprise Question?

Clinical tool to identify patients in need of a palliative approach

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

If the response is:

"No, it would not surprise me"

patient is assigned to the pilot population

ACP Project Objectives

1. Increase patients and families understanding of the need for ACPs
2. Improve staff effectiveness at facilitating end-of-life care conversations with patients and families
3. Identify patients who would benefit from a palliative approach to care
4. Ensure the current ACP is documented in the patient EHR and the home
5. Deliver the right care, at the right time, in the right environment

Data Collection

Measures	Current Performance	Goals
% of pilot patients with ACPs	18%	60%
Average # of days to completion of ACP	NA	Within two (2) weeks of admission
% of patients with SDM	NA	60%
Family satisfaction with ACP	NA	80%
Nurse case managers trained to use Conversation Guideline Tool and patient education resources	NA	100%
Staff satisfaction with ACP training*	NA	80%

*Current staff satisfaction performance is 76% on curriculum

Utilization of QI Tools: Process Mapping

Utilization of QI Tools: GANTT Chart

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

Identify

Ask the 'Surprise Question"

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

No

Discuss Advance Care Planning (ACP) visit

Schedule ACP visit

Assess and Plan

Current and future clinical and personal needs

Discuss

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

Yes

Reassess regularly

Complete

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

Lessons Learned

Lesson Learned: Risk Analysis

- Conduct a risk analysis before proceeding with project
- Identify factors that may be outside of your team's control
- Ensure commitment of external partners

Lesson Learned: Planning

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

Lesson Learned: Role Clarity

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

Lesson Learned: Communication Strategy

- Online newsletter (MailChimp)
  - Challenging timeline (weekly)
  - Stakeholder engagement low
- Staff meetings
  - More effective than newsletter
- Limited patient and GP involvement

Lesson Learned: Leadership Development

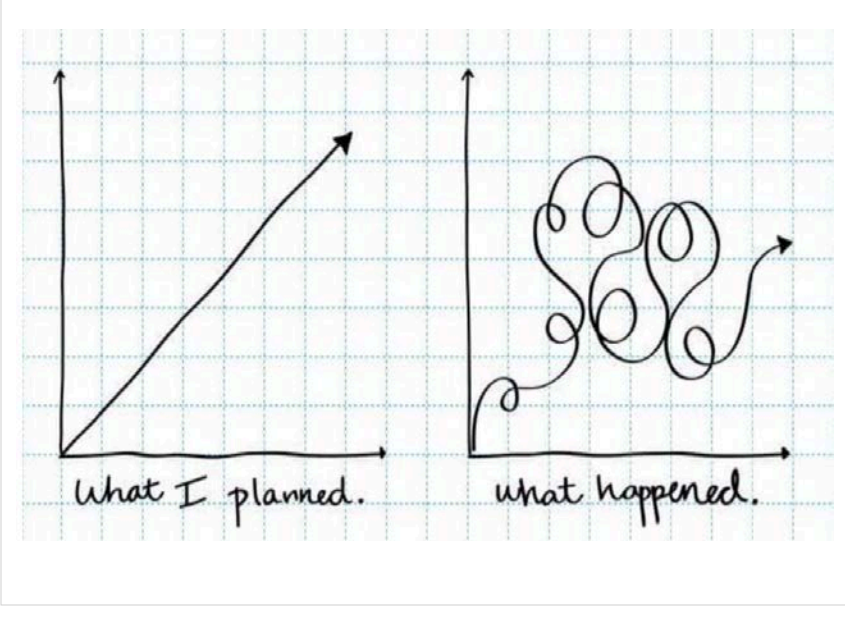
- Team development
- Coaching sessions
- Opportunities:
  - Rotate chairs
  - Attendance at provincial and national conferences

Lesson Learned: Staff Development

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

Lesson Learned: Time and Resources

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



Develop a Network of Experts

- Underutilization of local experts regarding ACP
- Develop a pan-Canadian network of experts for ACP

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Questions and Answers

www.careathomeservices.ca