Home Care Safety Virtual Collaborative Falls Prevention

- Seize the Opportunity
- Plan for Success

ABOUT THE SPONSORS

The **Canadian Home Care Association** (CHCA), incorporated in 1990, is a national not-for-profit membership association that advances excellence in home care and continuing care through leadership, awareness, advocacy and knowledge. www.cdnhomecare.ca

The **Canadian Foundation for Healthcare Improvement** (CFHI) identifies proven innovations and accelerates their spread across Canada by supporting healthcare organizations to adapt, implement and measure improvements.
www.cfhi-fcass.ca

Established by Health Canada in 2003, the **Canadian Patient Safety Institute** (CPSI) works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality.
www.patientsafetyinstitute.ca

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FALLS IN THE HOME IS A PRIORITY

- **Leading** adverse event among home care clients
  (Doran & Blais, 2013)
- **20 – 30 %** of seniors fall at least once in a year
- **43%** rise in injuries related to falls
- **Most preventable** health risk for seniors
- **Half of falls** in the home result in hospitalization
- **$2 BILLION** in healthcare costs due to fall-related injuries

*Public Health Agency of Canada, 2014

http://www.phac-aspc.gc.ca/seniors-aines/publications/public/injury-blessure/seniors_falls-chutes_aines/index-eng.php

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DESIGNING IMPROVEMENT

- Modelled after the IHI Breakthrough learning series
- Structured approach to teaching and applying improvement methodologies
- Opportunity to evaluate current state
- Implement and test change ideas that lead to sustained improvement

DESIGNING IMPROVEMENT

- Specific goals of the Collaborative were to:
  - Identify outcomes for home care clients at high risk for falls
  - Adapt a quality improvement approach for the home environment
  - Increase quality improvement capacity with an emphasis on meaningful measurement.
  - Identify evidence/tools/resources
  - Engage patients and families in falls risk assessment and prevention

DESIGNING IMPROVEMENT

- Learning sessions introduced improvement science and measurement skills, subject experts, best practice and sharing of experience
- Action Periods to implement, test and measure change
- Key component was individualized coaching on measurement and QI

DESIGNING IMPROVEMENT

- Feature webinars on Patient and Family Advisor and Executive Sponsor
- Access to subject experts on relevant topics
- Online Share Hub provided access to Collaborative resources, learning sessions and opportunity for collaboration

ENGAGING ORGANIZATIONS

- National call for participation
- Selection of organizations who are ready for change
- Active competition to attract the best and brightest
- Diverse participants from Manitoba, Ontario and Newfoundland

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RECOGNIZING INNOVATORS

- Recognized as pioneers
- Formal acknowledgement of Wave 1 teams
- Quality Congress opportunity to profile journeys, actions and outcomes
- Teams instrumental in shaping the experience of those to follow
- Opportunity for mentoring Wave 2

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Collaborative goals - Lessons learned

1. Implementing quality improvement in the home care environment is challenging

2. Engaging patients and families in fall risk assessment and prevention can be challenging from many levels but necessary in order to influence and understand current state.

Collaborative process - Lessons learned

1. Inter- and intra-team collaboration is challenging in a virtual environment
   -requires commitment and support of executive sponsor
2. Accessing data and measurement and using for care planning may be difficult
   -may need new processes to help get data into the right hands in timely manner.

Collaborative process-Lessons learned

1. Being part of the Collaborative provides a framework and impetus for organizations to do quality improvement work.
2. Coaching is very helpful in supporting teams to do improvement work.
3. ***You don't know what you don't know***

- And that is ok, no one does!
- Joining Wave 2 will help

Home Care Safety
Virtual Collaborative -Falls

Meet the Teams

CATCH THE Wave

Falls Collaborative
Eastern Health's Experience

Presenter: Alice Kennedy BN, RN, MBA, FCCHL, FCHSRF
Vice President

Eastern Health

- Regional Integrated Health Authority.
- Provides full continuum of health services to a population of more than 300,000.
- Acute, long term care and community services offered throughout the region.
- 13,000 employees.

Eastern Health

CATCH THE Wave 1

Falls Challenge

- Falls Prevention is an area of focus of acute, long term care and community services within Eastern Health.
- Regional ROP Committee for Falls.
- Well established data and initiatives in Acute Care/Long Term Care.
- Falls in community/home not well understood or documented.
- Data from Community Rapid Response Team at Eastern Health showed high percentage of visits to Emergency due to falls.

Falls Collaborative Approach

- Established a interprofessional Falls Collaborative project team.
- Recruited Patient/Family Advocate.
- Conducted consultations with staff to identify areas for quality improvement as well possible solutions.
- Involved ‘end user’ in QI Project focused on Audit.

Falls Collaborative Approach

- The Falls Collaborative focused on clients within two community based programs: **Home and Community Care** (HCC) and **Community and Supportive Services** (CSS).

- Phase I: Identified Areas for Improvement

- Phase II: Conducted small scale QI project: Audit

Phase 1: Identified Areas for Improvement

- Policy
- Screening Tool
- Data
- Audits
- Interventions
- Staff Education and Training

Phase 1: Additional Findings/Observations

- Falls screening part of RAI-HC.
- No program data on falls.
- Variations in educational materials used with clients/families.
- OT/PT referrals from HCC and CSS completed and prioritized but long wait times.
- No formal feedback loop between referring HCC and CSS Programs and OT/PT referrals.
- Inconsistencies in reported use of client risk alerts.

Phase II: QI Project-Audit

Project Aim:

By March 31, 2016, 100% of clients in receipt of Home Support services from the Bay Roberts Office, who meet the criteria for falls risk assessment have been screened, and if they scored 3 or higher, have a falls prevention plan.

QI Project: Findings

- HCC
  - 10 clients files audited
  - 1 out of 10 clients scored > 3 for 'at risk' for fall
    - Had fall risk assessment performed
    - RAI-HC completed
    - Falls Prevention Plan documented
  - 7 out of 10 clients had RAI-HC completed
  - 6 out of 10 clients had been re-assessed for falls

  100% of clients in receipt of Home Support services from the Bay Roberts Office, who meet the criteria for falls risk assessment have been screened, and if they scored 3 or higher, have a falls prevention plan.

- CSS
  - 10 clients files audited
  - 3 out of 10 clients scored > 3 for 'at risk' for fall
    - Had fall risk assessment performed
    - RAI-HC completed
    - Falls Prevention Plan documented
  - 6 out of 10 clients had RAI-HC completed
  - 6 out of 10 clients had been re-assessed for falls
- 100% of clients in receipt of Home Support services from the Bay Roberts Office, who meet the criteria for falls risk assessment have been screened, and if they scored 3 or higher, have a falls prevention plan.

QI Project: Audit-Recommendations

- Work with QI Department to develop an audit protocol outlining a measurement/reporting protocol.
- Review the audit tool and make changes as necessary.
- Implement another small scale QI project; 1 rural;1 urban; using PDSA.
- Complete monthly audits of client files.
- Determine feasibility to collect and report data on falls.
- Explore options to partner with Home Care Agencies to collect data on falls; and plan to prevent falls among clients.

Patient/Family Engagement

- Initial challenges in engaging patients and families in this initiative.
- A family advisor had been identified to participate in the Collaborative however due to scheduling conflicts and work commitments she was unable to assist.
- We have identified a possible role in the future; in particular in the review of education/ information for patients/families related to falls.

Overall Recommendations
Falls Prevention

- Increase profile of importance of falls prevention in the home/community.
- Designate leader(s)/resources for falls prevention.
- Re-establish a Community Falls prevention Committee.
- Develop a comprehensive community falls prevention plan based on identified areas for improvement e.g. recommendations from Audit QI project.
- Implement and evaluate plan.
- Deliver ongoing training on quality improvement and falls prevention.
- Gather data to assess performance and impact.
- Work with key stakeholders e.g. health care agencies, to prevent falls.

Current Status

- Community Falls Prevention Committee re-established.
- Gaps noted in the screening tools changed.
- Policy related to falls for Home & Community Care and Community Supports have been standardized.
- Finding Balance material adopted.
- Staff education sessions planned.
- Exploring stakeholder engagement – Home Care Agencies.
- Engaged data analyst to use electronic documentation to flag client at risk of falls.

CANADIAN RED CROSS

Home Care Safety
Virtual Improvement Collaborative

Presenter: Jody Hales
Director, Quality Assurance and Risk
Community Health & Wellness

CANADIAN RED CROSS

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MISSION: The Canadian Red Cross mission is to improve the lives of vulnerable people by mobilizing the power of humanity in Canada and around the world.

1. **Disaster & Emergencies**
2. **Prevention & Safety**
3. **Community Health & Wellness**

SNAP SHOT – CHW Programs

HEALTH EQUIPMENT LOAN PROGRAM

HOME SUPPORT SERVICES

Over one million client encounters **<u>"Opportunities"</u>**

COMMUNITY SUPPORT SERVICES

Why Focus on Falls...

Falls are the most frequently reported client safety event affiliated with our Ontario Community Health & Wellness programs

**36% of our Ontario Home Support clients experienced a fall in 2015*

Falls VLC

- *Assisted Living program*
- *Attendant Care program*
- *189 clients*
- *14 team members (Client Advisor)*

CANADIAN RED CROSS

AIM Statement

- By March 1, 2016 we will reduce the incidence of falls to zero (0) and reduce the number of interRAI fall-related triggered CAPs by 10% for a target population of five (5) high risk fallers

Secondary Objective

- Exploration of client/caregiver engagement associated with the broader client population

Change Ideas Tested

- ❑ interRAI Assessor **education** and **training** refresh
- ❑ **Service planning tool** to help frontline staff, clients and families collaboratively address modifiable fall risk factors (interRAI *triggered CAPs*)
- ❑ ***Analysis** of the interRAI assessment process
- ❑ **Engagement** exploration via survey (in-person)
- ❑ **Client involvement** in care process design and delivery

Engagement

Client Advisor

*Meetings

interRAI education

Review of fall prevention processes

Five high risk fallers

interRAI Assessments

Service planning tool

Teach back method

Engagement survey

Broader Client Population

Engagement Survey

Service planning tool

CANADIAN RED CROSS

CATCH THE Wave 1

AIM Outcome: *Targeted 5 high risk clients*

Reduction in falls

Reduced number of interRAI triggered CAPs (fall risks) by more than 10%

***Point of care empowerment:** PSW, Client, Caregiver through the use of the Service Planning Tool

Other Findings

❶ Relationship/trust is <u>vital to process</u>

- Client fear/reluctance to discuss needs or reveal/acknowledge falls

❷ It is not just what you do, it is how you do it

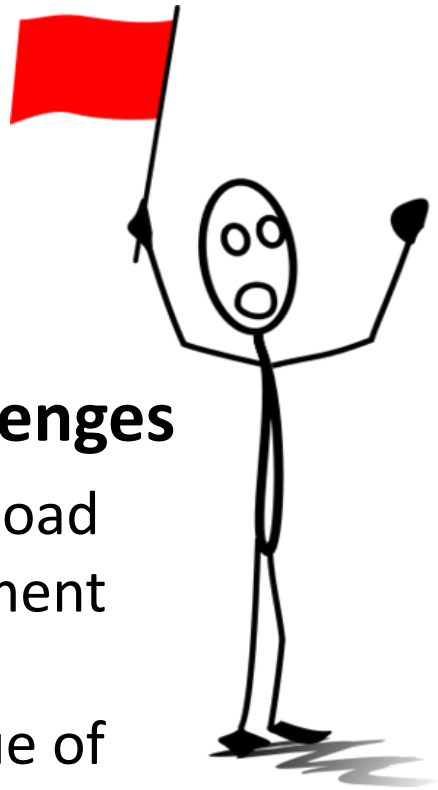
- Small changes can have a BIG impact

❸ Engagement (in-person)

- 92% of clients engaged in change processes, however limitations in cognition/ability to recall is a reality
- 37% caregiver/family engaged (work schedule or geographical distance from client location were recurrent factors)

❹ Staff Education & Training Needs

- Strategies that influence client/caregiver conversation and behavior change



❺ Point of Care Wi-Fi Connectivity Challenges

- *Significant Assessor administrative workload
- Ineffective completion of interRAI assessment
- Complicates the care planning process
- Substantial impact on the quality and value of interRAI data
- Perceived use and value of assessment process is diminished

What's next...

- ❑ **Address Technological Challenges**
  - ✓ Provincial connectivity survey
  - ✓ National IS team analysis of survey results
- ❑ **Service planning tool SPREAD**
  - ✓ Atlantic Quality rep
  - ✓ Home Support CQI Team
  - • National Standardization team
- ❑ **Engagement training for frontline workforce**
- ❑ **Revision to client-focused safety materials**

Saint Elizabeth
Well beyond health care

Decreasing Falls in Home Care Clients by Increasing Falls Prevention Knowledge in Personal Support Workers

Presenter: Christopher Mis
Regional Director

Saint Elizabeth
Well beyond health care

CATCH THE Wave 1

8,000 staff
National
100+ Years of Experience

Canada's Largest
Social Enterprise

Saint Elizabeth

Well beyond health care

Lifetime Care Experts

- Nursing
- Personal Support
- Rehabilitation
- Mental Health
- vHealth
- Caregiving
- End of Life Care

Client Diversity

- Long Term Care Facilities – Management and Staffing
- Hospital Staffing
- Rehab Clinics
- Medical Centres
- HomeCare
- Consulting Contracts
- Training Contracts

Knowledge & Training in Action

- Virtual and Face to Face Learning Programs
- Clinical Practice and Training
- End of life Thought Leadership
- Consulting
- SE Health Career College

Innovation Trailblazers

- Strategic Alliances & Investments
- Leader in Frontline Digital Technology
- Living Lab
- Soapbox
- TYZE

www.saintelizabeth.com

Local Falls Challenge

North Simcoe Muskoka Team:

- Saint Elizabeth is focused on falls prevention and understanding impact of falls prevention initiatives
- North Simcoe Muskoka highly engaged team, **high number of falls reported in personal support team visiting community patients**

Strategy:

- Detailed understanding of the impact of falls prevention education strategies on patients and the number of patient falls
- Opportunity to spread this strategy in a cost effective manner that has been proven to be effective

Title: Decreasing Falls in Home Care Clients by Increasing Falls Prevention Knowledge in Personal Support Workers	**Scope Boundaries:** Administrative, management and front line staff in our NSM office. Clients at home on either PSW or Nursing services in the NSM catchment area that are at risk for falls.
Team: Saint Elizabeth **Executive Sponsor**: Helene Lacroix **Team Leads/Process Owner**: Kristen Parise **Measurement Lead** – Robin Hurst **Team Members**: Colleen Turner **Pt/Family Advisor -** Marilyn Hollander, Dorothy McDonald	**Problem Statement:** Falls in the home are too common and our staff need to be able to quickly identify who is at risk and understand preventative strategies to decrease the fall risk for clients. Baseline Quarterly Fall rate (overall clients): Q2= 21 Q3=22
Aim Statement: **Reduce incidence of falls by 25% from current baseline by March 2016.**	**Root Causes of Problem:** We have many excellent resources, processes, plans but we need to continue to work on creating cohesive and sustainable plans
Measures: **Outcome**: Incidence of falls (Goal=17 falls in Q4) **Process**: • Number of staff that complete the module (Goal=100%) • Compliance with preventative strategies (Goal 80%) • Time from fall report to reassessment • Development of a Fall Prevention plan in at risk patients Compliance with Fall Prevention Plan	**Change Ideas:** Falls program needs to be clear, easy and accessible to all staff. Each staff need to understand their role in fall prevention and work as a team. Teaching the preventative strategies to all SE staff – Develop Compliance Checklist for Falls Prevention Plan **Patients/Families/Carers – inclusion**

Patient and Family Advisor Role

Consultant

Patient's Learning:

- Better understanding of all the training health care workers have with respect to falls
- The number of falls that happen at home and the impact

Contribution

- Sharing my perspective and the sensitivity older people have when it comes to talking about falls.
- Patient are asked multiple times about falls by doctor's, pharmacists and home health workers

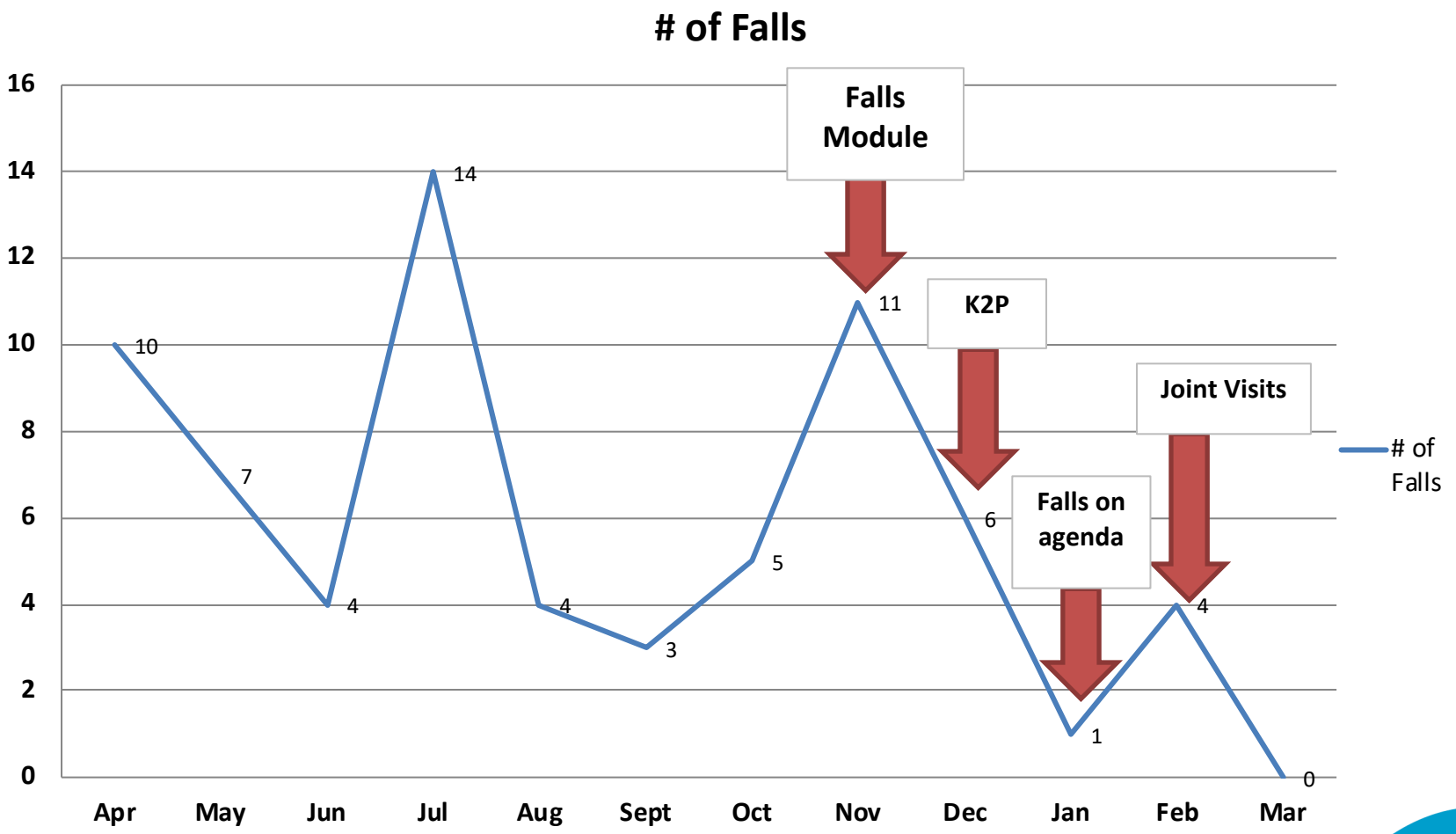
Changes Tested

- Use of Knowledge to Practice (K2P) lead in Personal Support Worker (PSW) team with a focus on Seniors and falls
- Focus on falls prevention education:
  - Online falls prevention module
  - Falls education in meetings
  - Ongoing Falls focus on every agenda

Staff feedback:

- Focus group to understand falls reporting, processes, level of knowledge
- Joint Visits, see falls prevention education in action

Outcomes



Saint Elizabeth
Well beyond health care

CATCH THE Wave 1

Key Learning

1. Major keys to success
   - Multiple approaches to falls prevention
   - Structural supports, supporting staff, data collection, learning
2. Barriers
   - Competing priorities
   - Multiple sources of information
   - Patient advisors discomfort with technology
3. Aha moments
   - Team focus on falls achieved desired impact

Lessons Learned

1. Key indicators need to be monitored frequently
2. We have more opportunities to integrate the care we provide within the patient centred care framework
3. Lost key champion part way through this project, still able to sustain, current model is effective, important for spread and sustainability
4. Focus on falls resulted in desired effect
5. RAI data and early identification of fallers and integration of data into plan

What's Next

What are the organization's plans for sustaining and spreading this initiative?

- Working to understand the most critical elements of our interventions
- Understanding time and effort required to help plan for resources needed
- Continue with our existing falls reporting and data
- Look to how we can better use interRAI data at the time of admission
- Falls and Incontinence consensus

Creating More Independence

Home Care Safety
Virtual Improvement Collaborative

Presenter: Kathy Sidhu
Manager Professional Practice Rehab




- Established in **1925** as a charity
- Founding member of the United Way Toronto
- A not-for-profit charitable organization with over **2,000** staff and service providers
- Provides nursing, rehab and personal support services as well as community support programming (extreme cleaning, caregiver relief, volunteer support)

VHA is:

ACCREDITATION AGRÉMENT CANADA

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA

United Way

VHA Home HealthCare
Creating More Independence

Local Falls Challenge

2011 - Rehab

2014 - Nursing

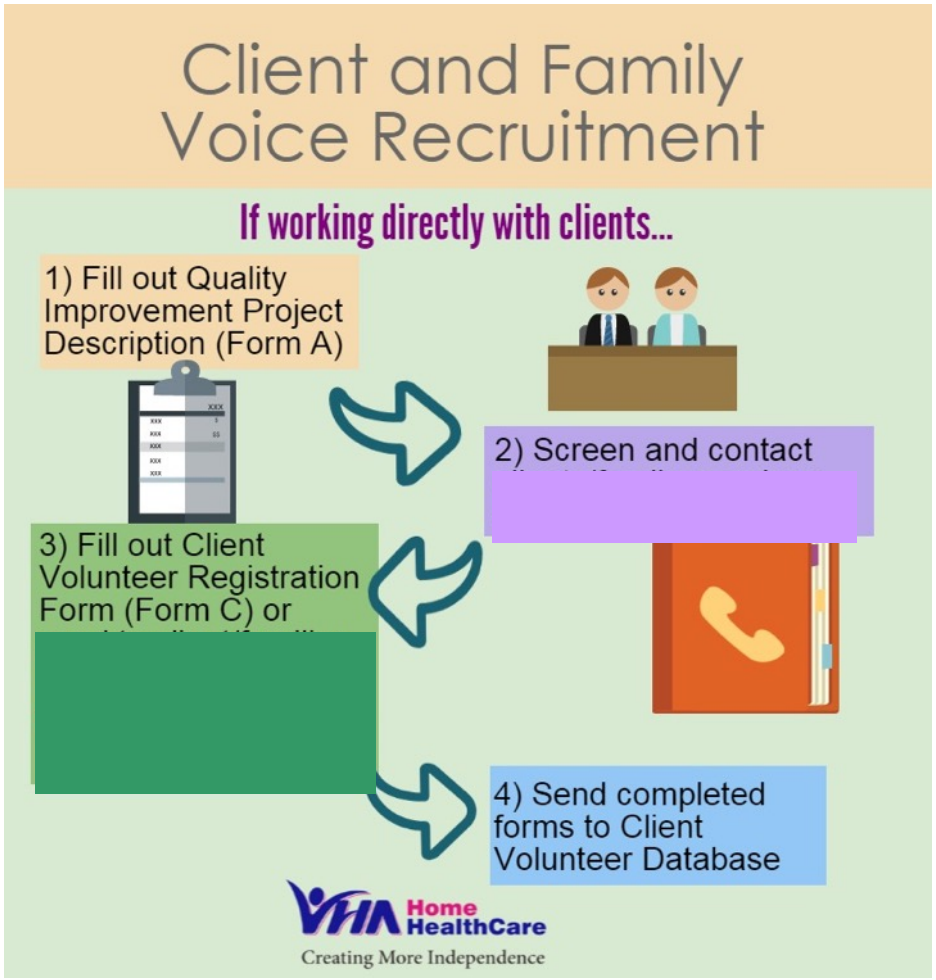
2016 – Care Team Supervisors

Home HealthCare
Creating More Independence

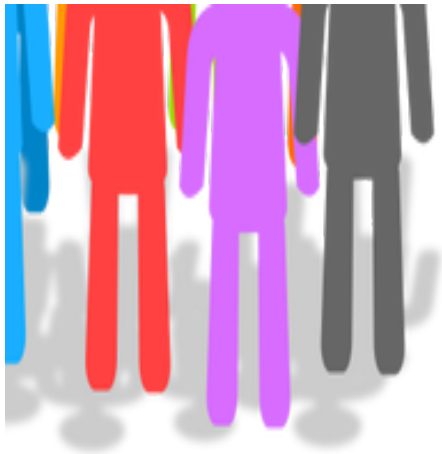
Aim Statement

Reduce the incidence of falls by 25% in all adult patients newly admitted to personal support services in the Central CCAC region by March 2016.

Client & Family Involvement



Falls Collaborative Team

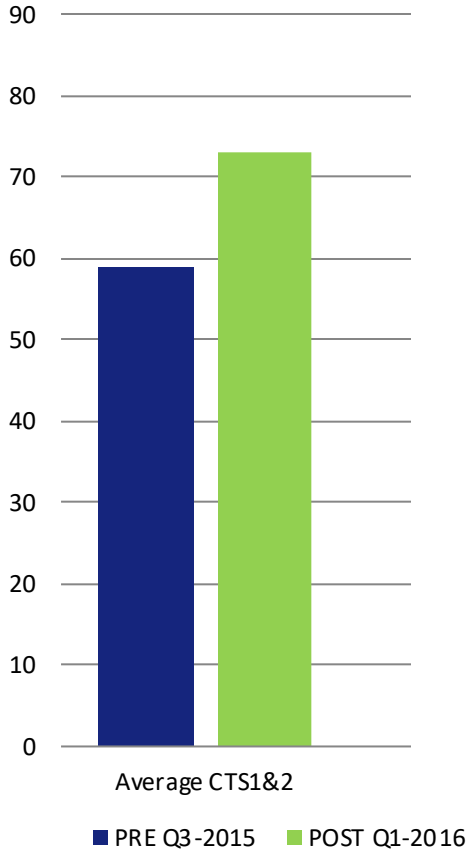


Client Education Handout

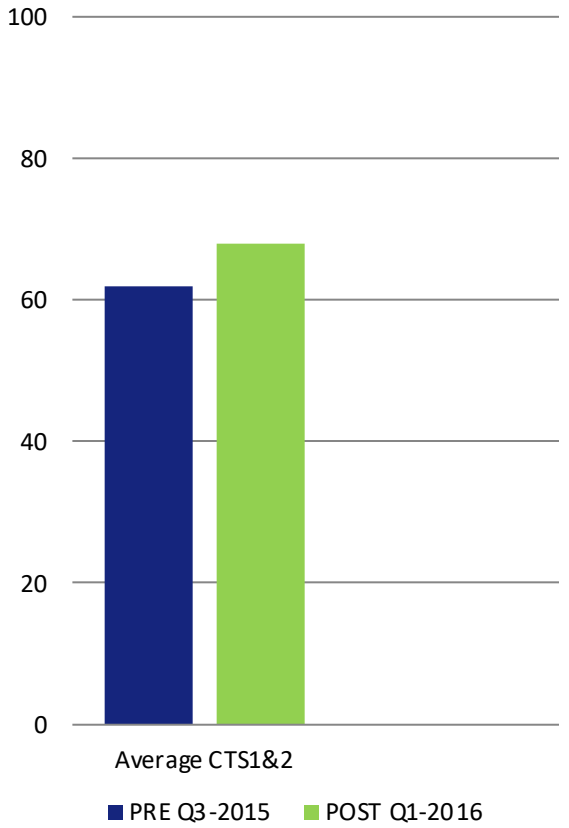
VHA Home HealthCare
Creating More Independence

Findings & Outcomes

Percentage of Fall Risk Assessments Complete



Percentage of Fall Risk Plans Complete



CTS1

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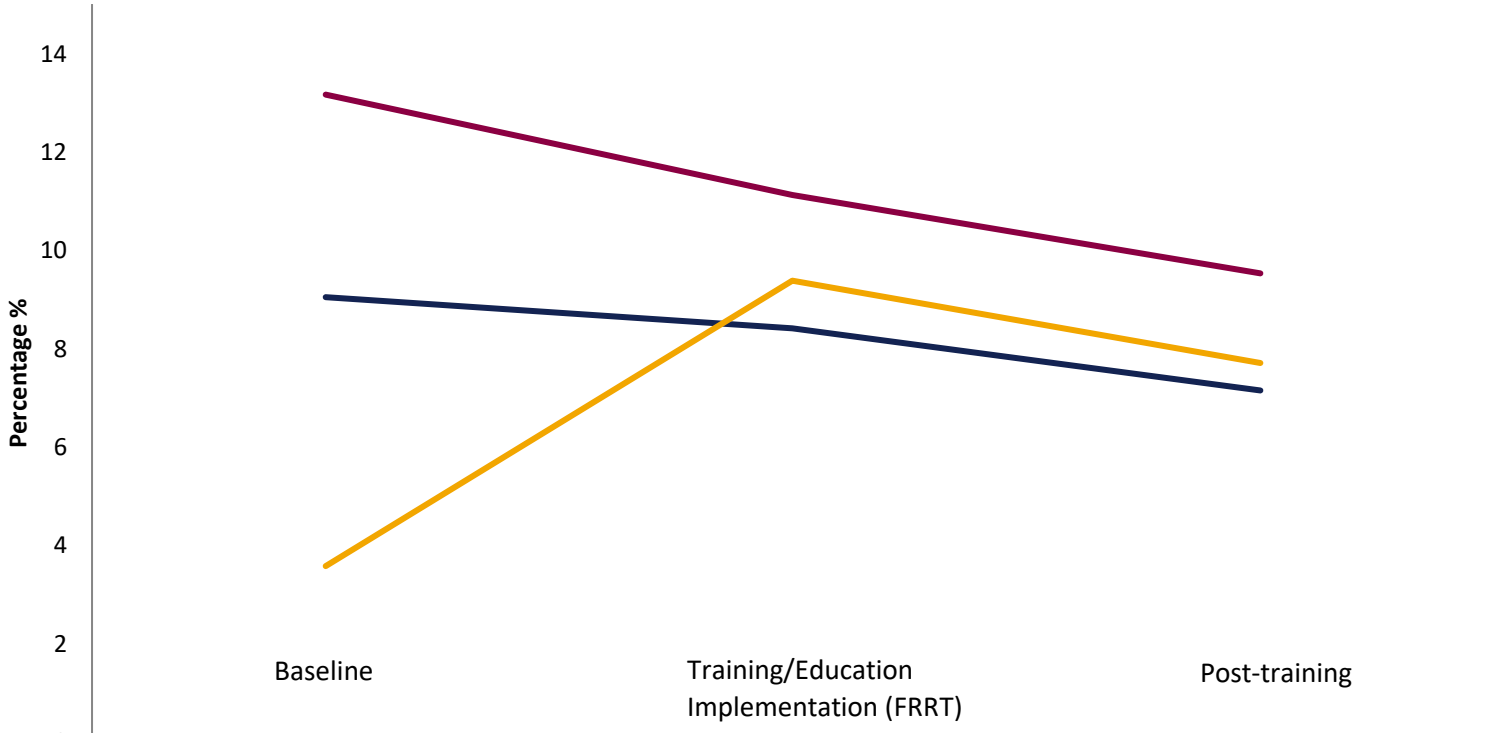
Findings & Outcomes

Falls as a % of new admits

Falls = during service & found on floor



	Q3-2015	Q4-2015	Q1-2016
ALL CTS'	9.0	8.4	7.1
CTS 1	13.2	11.1	9.5
CTS 2	3.6	9.4	7.7

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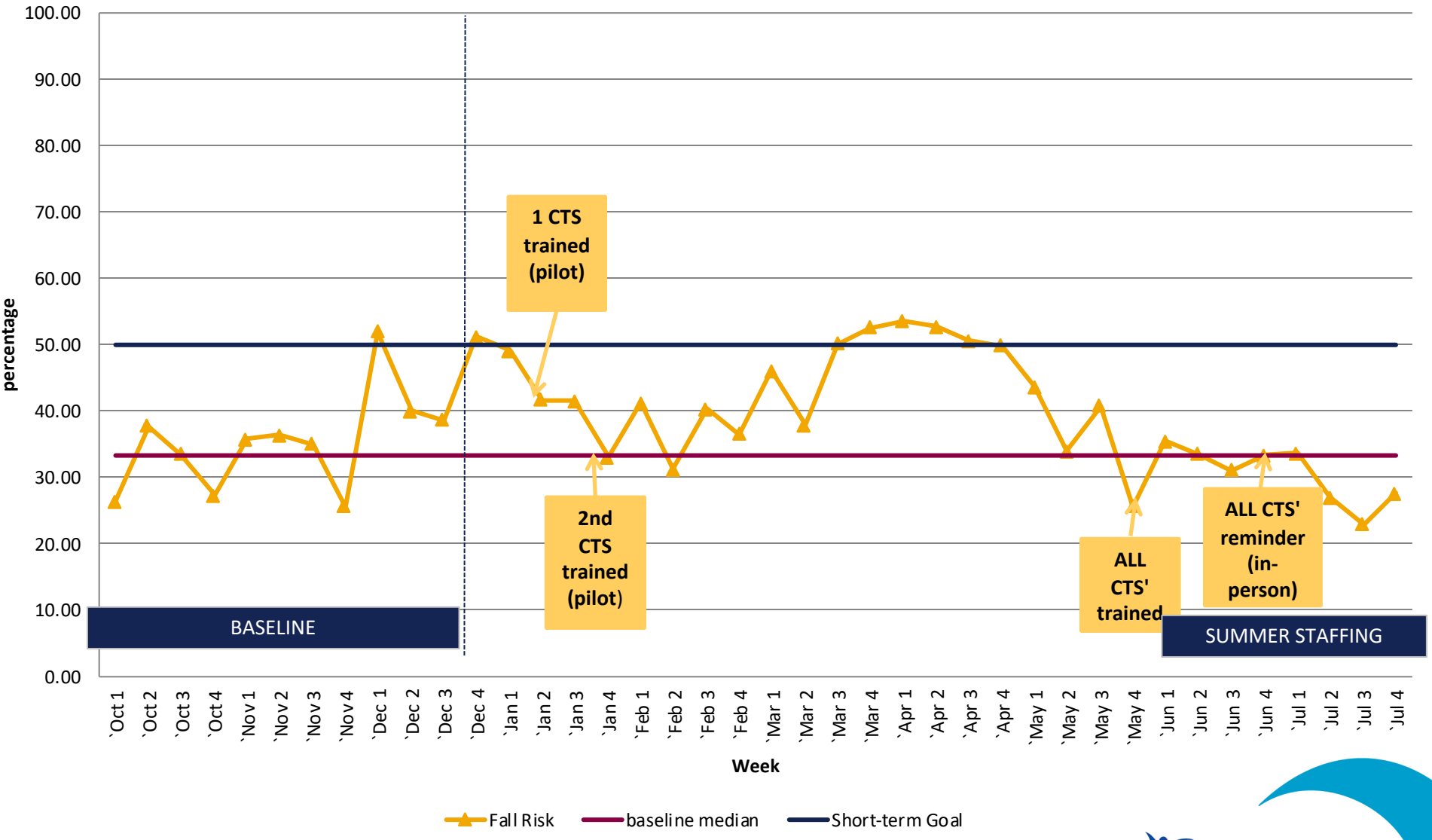
Percentage of Fall Risk Assessments Complete



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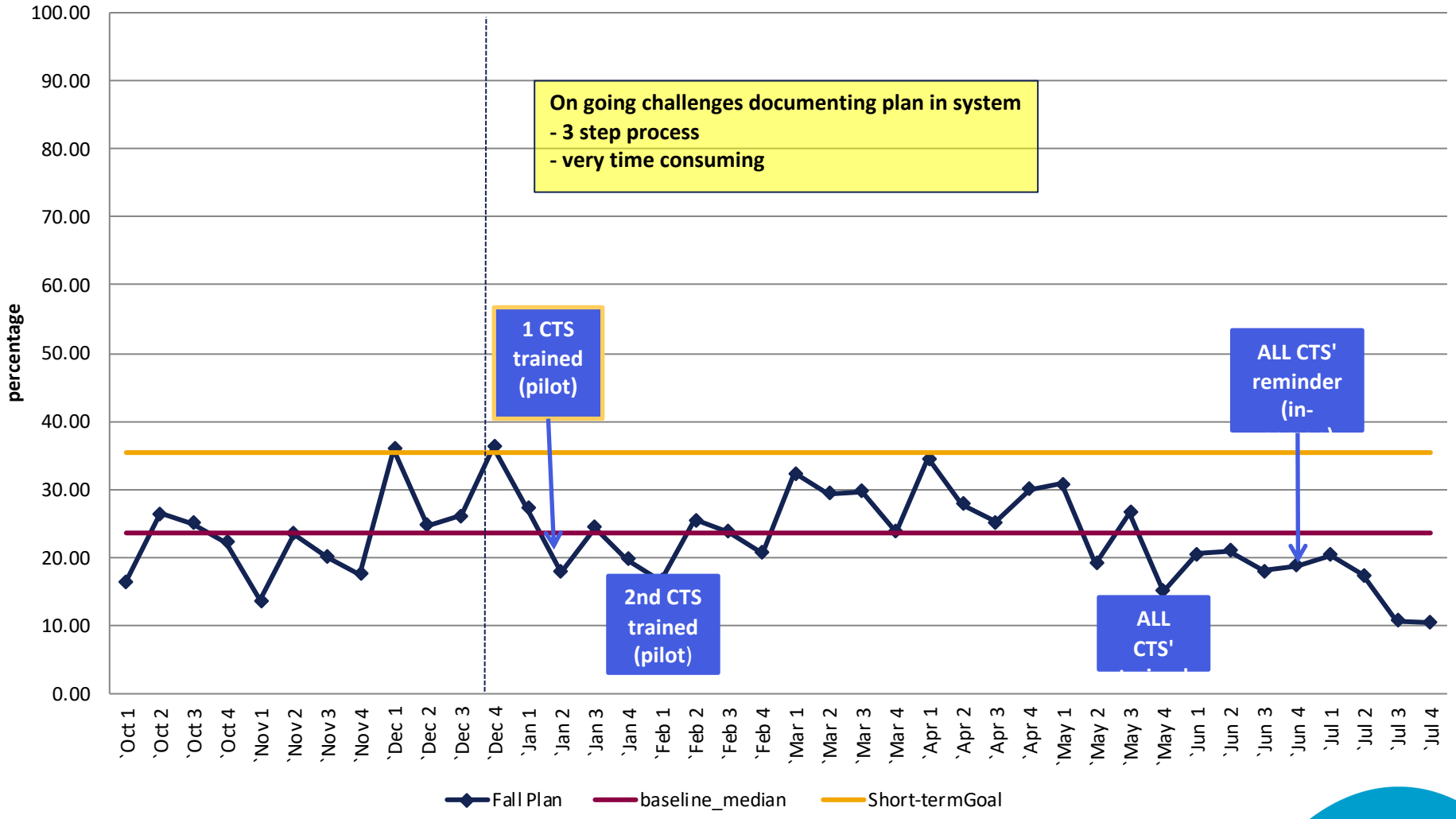
Percentage of Fall Plans Documented



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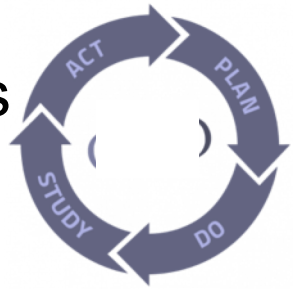
What's Next?

1. Complete recommendations for client education materials

2. Process improvement for Care Team Supervisors



3. Spread to Personal Support Coaches

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Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

Experience with Falls Prevention in the Winnipeg Regional Health Authority (WRHA) Home Care Program

Lori Mitchell, Ph.D., Researcher
WRHA Home Care Program

Winnipeg Regional Health Authority
Caring for Health
Office régional de la santé de Winnipeg
À l'écoute de notre santé

WRHA Home Care Program

- Serves Residents of Winnipeg Health Region
- Provides comprehensive services to those with assessed need free of charge
- About 4,000 employees
- Some contracted components as an extension to the core service
- Serves 15,000 clients at any one time
  - 78% of clients on the home care program are over 65 years of age
  - 43% of clients are between the ages of 75 – 84

WRHA Home Care Falls Challenge

- Data trends showed prevalence of falls increasing over time among long-stay clients in WRHA Home Care program
  - Prevalence steadily increased from 24% (2002) to 29% (2013)
- Clearly linked to increasing client complexity & need
- Monitor client status/profile and indicators with RAI-HC client assessment data

Collaborative Aim

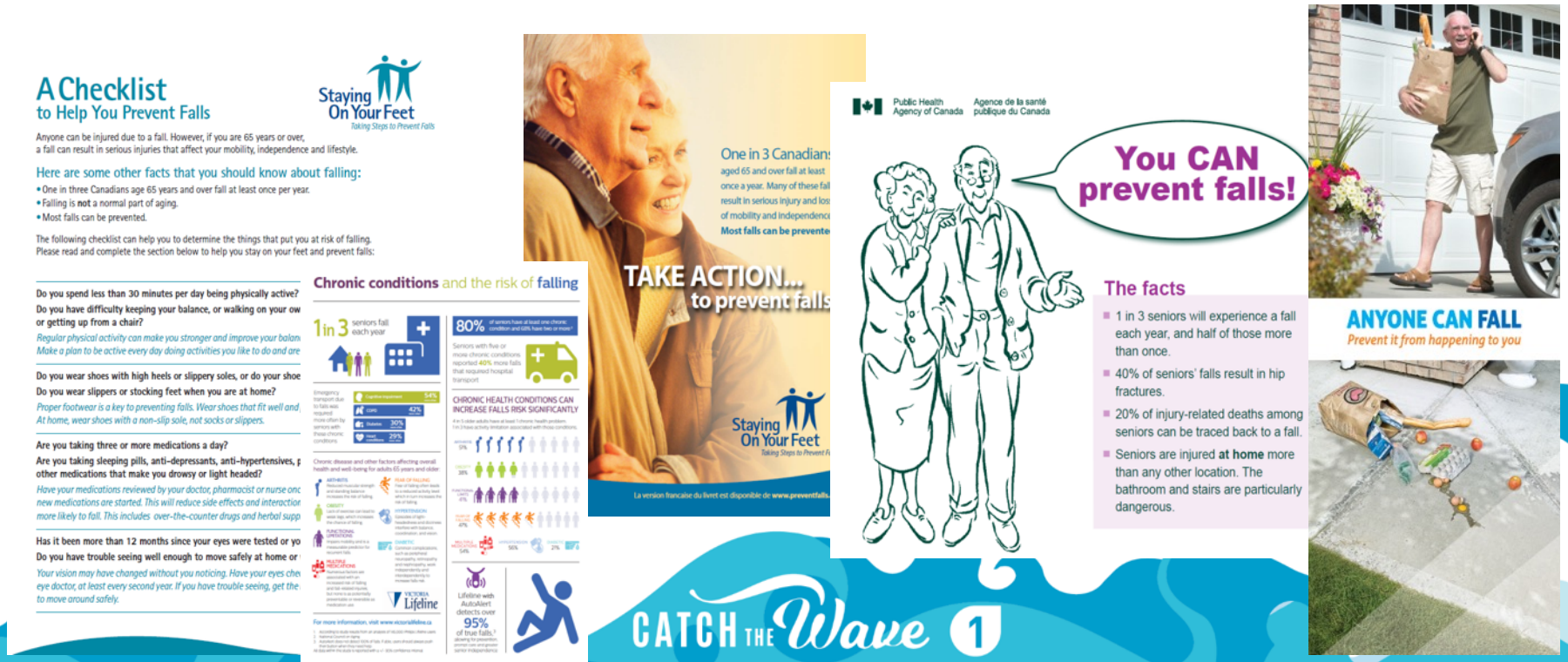
- By March, 2016 reduce the rate of falls in the one volunteer community Home Care area/office in WRHA by 5% (reduce falls from 1000 falls /quarter to 950 falls/quarter) through improved communication of the clients' fall risk and caregiver & staff education.

Client/Family Engagement

- Engaged family caregiver
  - In-depth knowledge of Home Care Program
- WRHA Home Care Advisory Council involvement
  - Review of falls-related resources

Falls Prevention Tools

- WRHA Resource Staying on Your Feet
- Alberta Finding Your Balance Pamphlet
- Victoria Lifeline One Pager
- Public Health Agency of Canada

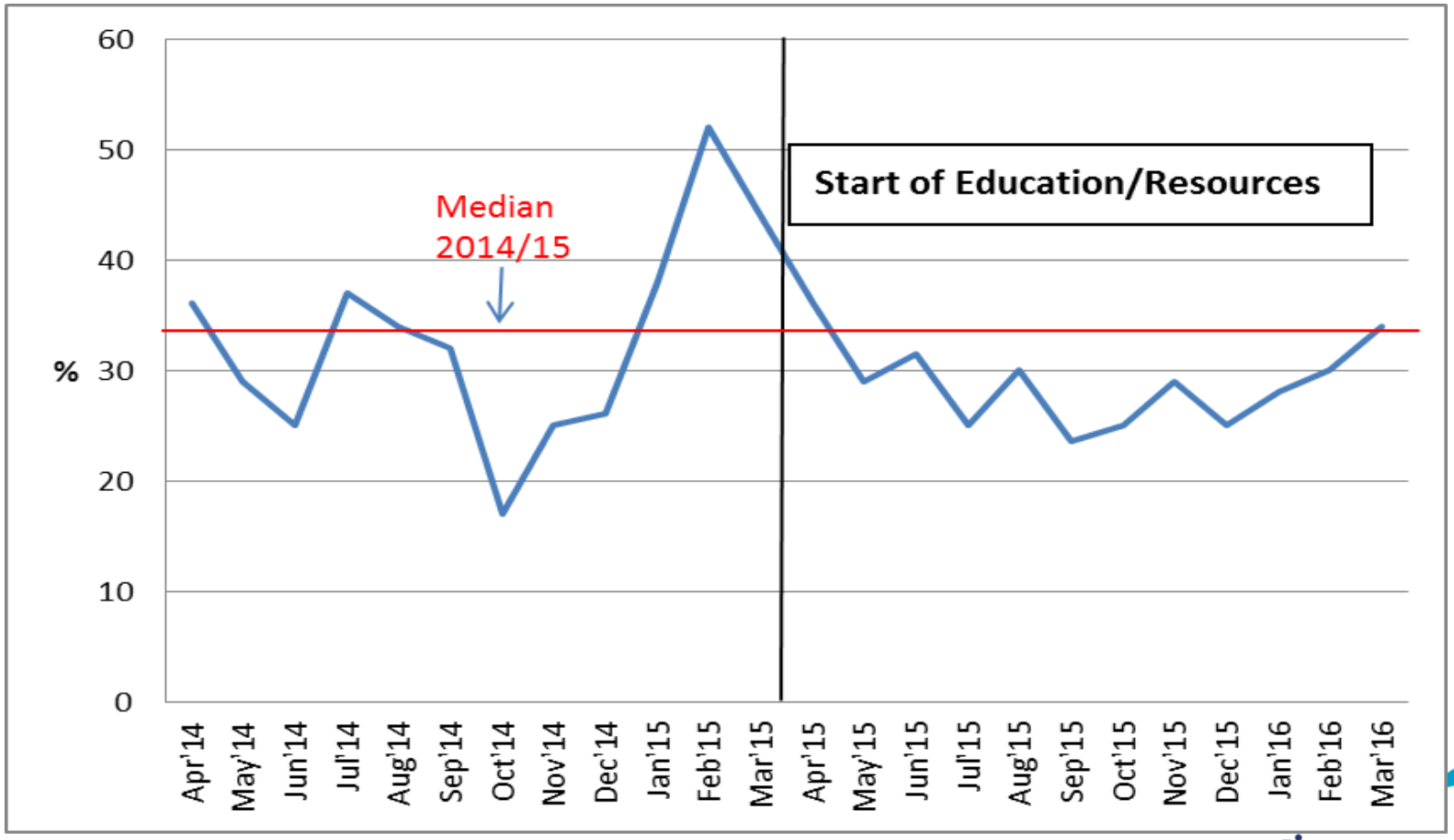


Changes Tested

- Electronic voice-over presentation for nurses
- Home Care Advisory Council feedback on client falls prevention/awareness resources
- Staff education resources (e.g., Drugs and Risk of Falling)
- Audit of client charts for adherence to falls prevention guidelines → education

❖ **Increased clients' falls risk communication among staff care teams**

Outcomes – Prevalence of Falls, Target Site Pre & Post



Lessons Learned

1. Major keys to success
   - Team effort
   - Sponsor support
   - Identified some really good resources moving forward
   - Engaging client/family advisors in improvement efforts/plans
2. Barriers
   - Competing priorities!!
   - Tight timelines
3. Aha moments
   - Always test your assumptions

What's Next?

- Continue to monitor falls through assessment and occurrence reports
- Incorporate falls audits in peer-review chart audit process
- Provide annual reminder of falls prevention algorithms (e.g., staff meetings, voice over presentations)
- Use client and caregiver feedback to develop falls prevention resources
- Collaborate with Public Health with falls information for the public
- Enhance communication of falls risk with visuals

Thank You

WRHA Home Care Falls Team

Executive Sponsor: Vikas Sethi, Regional Director, WRHA Home Care Program
Team Lead: Rachel Ganaden, Manager, Quality & Innovation
Measurement Lead: Lori Mitchell, Home Care Researcher
Team Members:

- Pat VanRysselt, Family Advisor
- Cheryl Peters, Staff Development Instructor
- Lynne Anderson, Case Management Specialist
- Donna Taplin, Resource Coordinator Specialist

- Tara Morden, Hospital Based Case Coordinator
- Louise Nichol, Team Manager, Community Stroke Services
- Pat Garbutt, Nurse Educator