HOME CARE SAFETY
Improvement Collaborative

WAVE 2
Final Symposium - February 21, 2018

Objectives of Wave 2

- Learn measurement techniques to evaluate your current state and how to track and report on success
- Develop effective strategies to engage patients and carers in improvement initiatives
- Build effective teams, and using communication techniques
- Advance safety as a strategic priority and engage senior leadership
- Apply quality improvement methodology to a unique challenge

Dementia Collaborative Client Centered Care

Aim and Measures

Aim

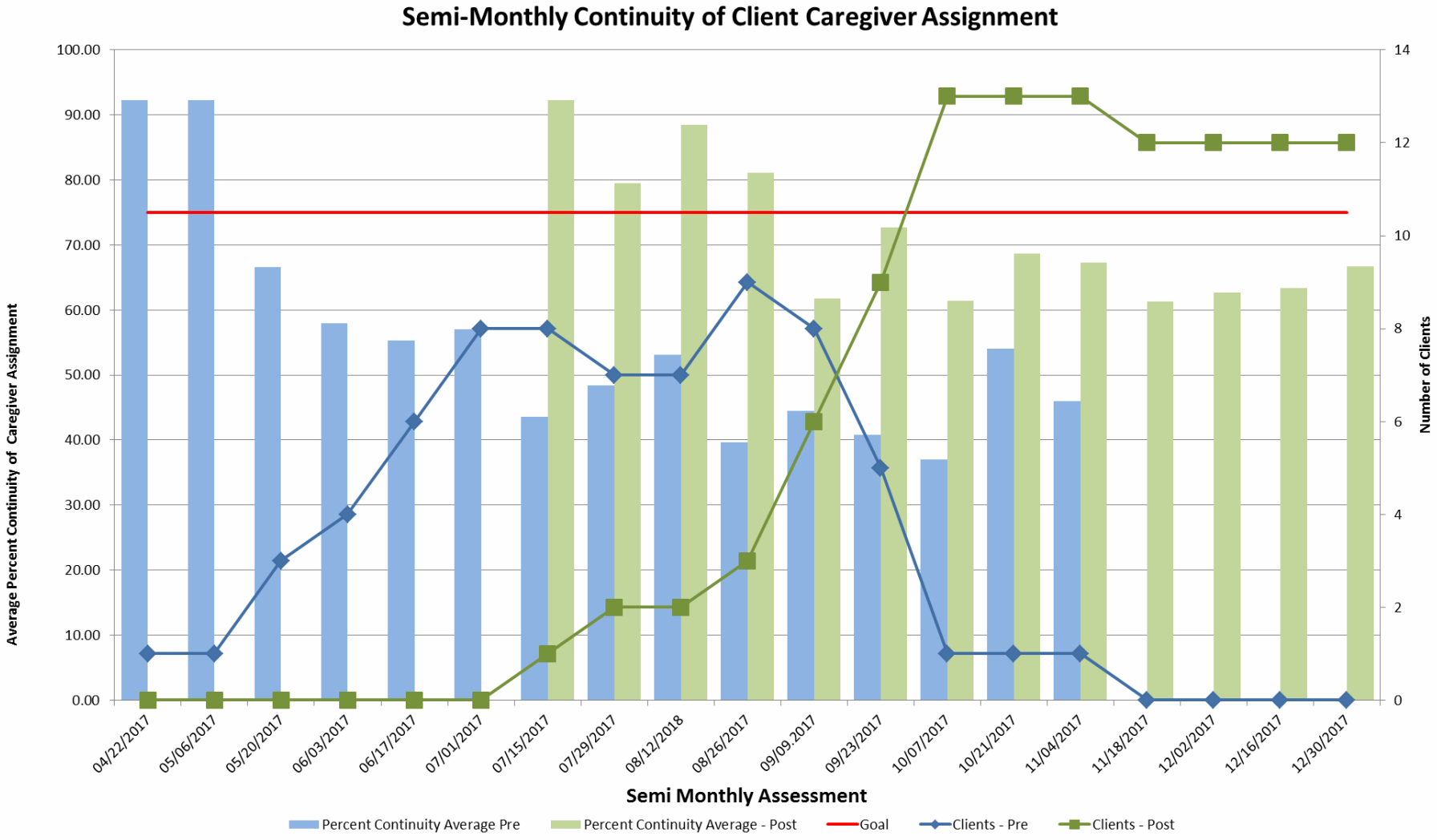
To improve the overall satisfaction of clients with dementia and their families receiving care in the community by February 2018 while providing staff with the tools to be successful and confident in providing care. Our target was to improve continuity to 75% on a bi-monthly basis.

Measures

- Track continuity on a bi-weekly basis
- Direct feedback from clients and care conferencing with Island Health
- Survey of clients at regular intervals

Change concepts

- To enhance information sharing through the utilization of a personal history form.
- To provide training to Community Health Workers that is specific to client needs.
- Monitor and evaluate continuity on a bi-monthly basis.
- Staff education (scheduling, nursing and management)
- Revised intake form to include key client specific information.


Semi-Monthly Continuity of Client Caregiver Assignment
Average Percent Continuity of Caregiver Assignment
Number of Clients
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
14
12
10
8
6
4
2
0
04/22/2017
05/06/2017
05/20/2017
06/03/2017
06/17/2017
07/01/2017
07/15/2017
07/29/2017
08/12/2018
08/26/2017
09/09.2017
09/23/2017
10/07/2017
10/21/2017
11/04/2017
11/18/2017
12/02/2017
12/16/2017
12/30/2017
Semi Monthly Assessment
Percent Continuity Average Pre
Percent Continuity Average - Post
Goal
Clients - Pre
Clients - Post

Results/Impact

Results

- We were not successful at meeting our challenging goal of 75%, however when comparing the client's involved in the collaborative vs those who are not, you can see a dramatic improvement in overall continuity on the basis of the added support and monitoring.
- The overall results can appear skewed when comparing a client who has one or two visits per week versus three visits per day/seven days a week as seen in the initial phase pre collaborative.

Impact

- Increased satisfaction to clients, families and CHWs providing the care.
- Focused understanding of importance of continuity.
- Increase of home care conferences this clients and their families.
- Therapeutic experience of sharing the challenges of being a family caregiver.

Overall Challenges

- Care giver burnout of existing client family members / interest in participating in Collaborative
- Loss of clients ie: deaths/admission to residential care
- Communication with scheduling and nursing departments
- Time constraints – care conferencing / disrupting CHW schedules
- Maintaining continuity once established (book offs/vacations)
- Length of time to establish client base

Overall Learning

- The importance and impact of improved continuity for all of our complex clients.
- CHW education (dementia training for initial clients)
- Personal History Form – works for new client
- We have learnt the importance of providing continuity to our clients and families who are struggling in private to some degree. Being able to support and facilitate communication and assessment that provides the care necessary to meet the client's progression in their disease process.
- Coaching calls were a valuable resource which validated process and provide meaningful support

Next Steps

- Continue to monitor dementia intakes and establish initial continuity for new clients.
- Recognition of existing clients requiring attention to schedule and care needs.
- Monitor continuity and maintain open communication with client, families and Island Health.

Infection Surveillance & Management of Central/Peripheral Line Sites in Home Care

Aim and Measures

Aim:

To reduce the time between the onset of central/peripheral line site infection identification and intervention within the Central Nursing Team.

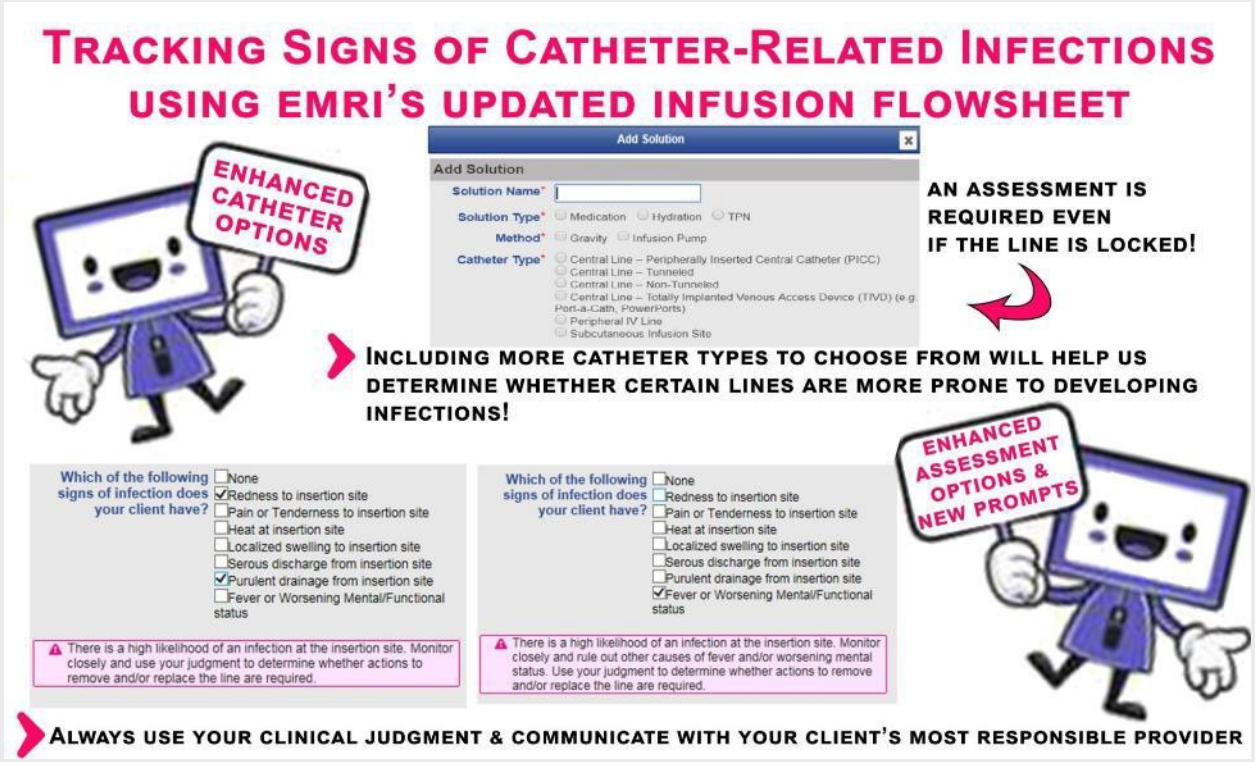
Measures:

# of symptoms associated with infection documented on the nursing "infusion flowsheet" in the electronic medical record.

# of clinical decision support aids displayed; evidence of intervention (date/time/action); intervention(s) utilized

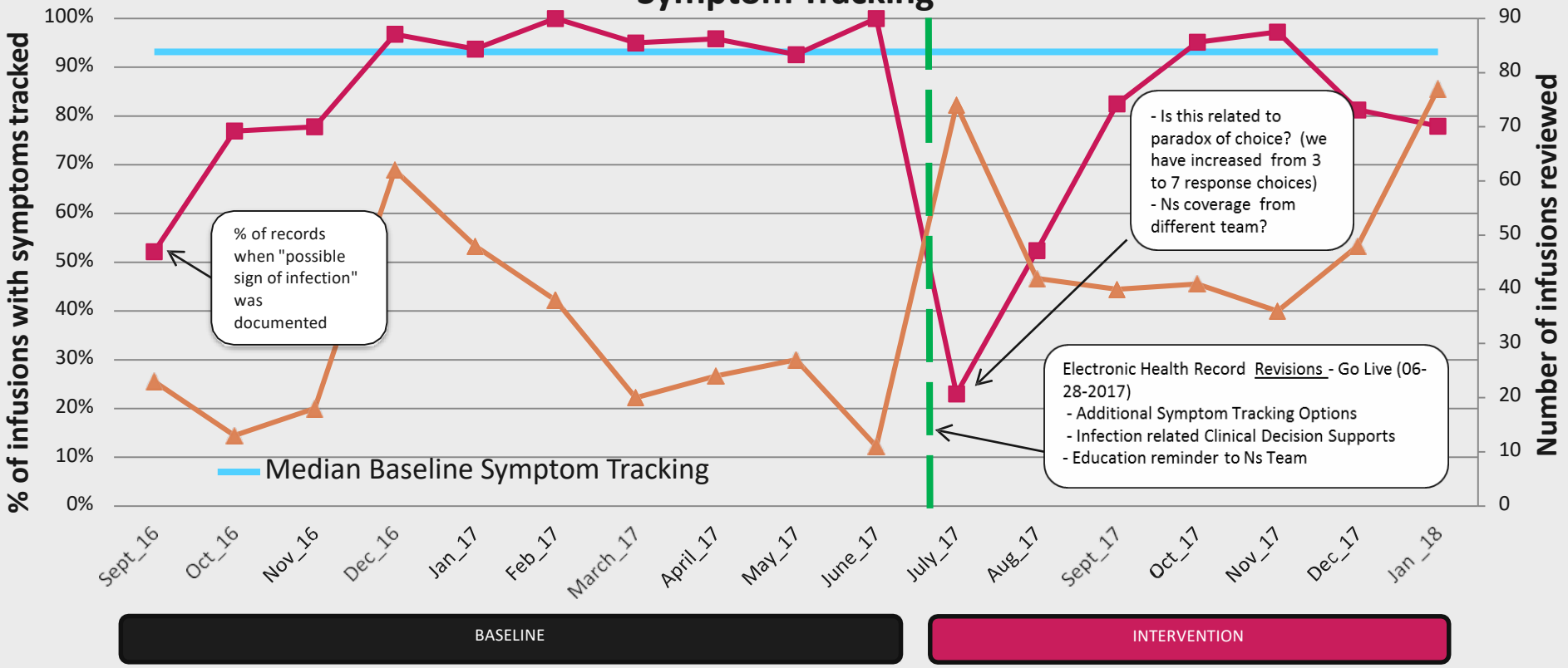
Negative clinical outcomes associated with infection.

Change Concepts

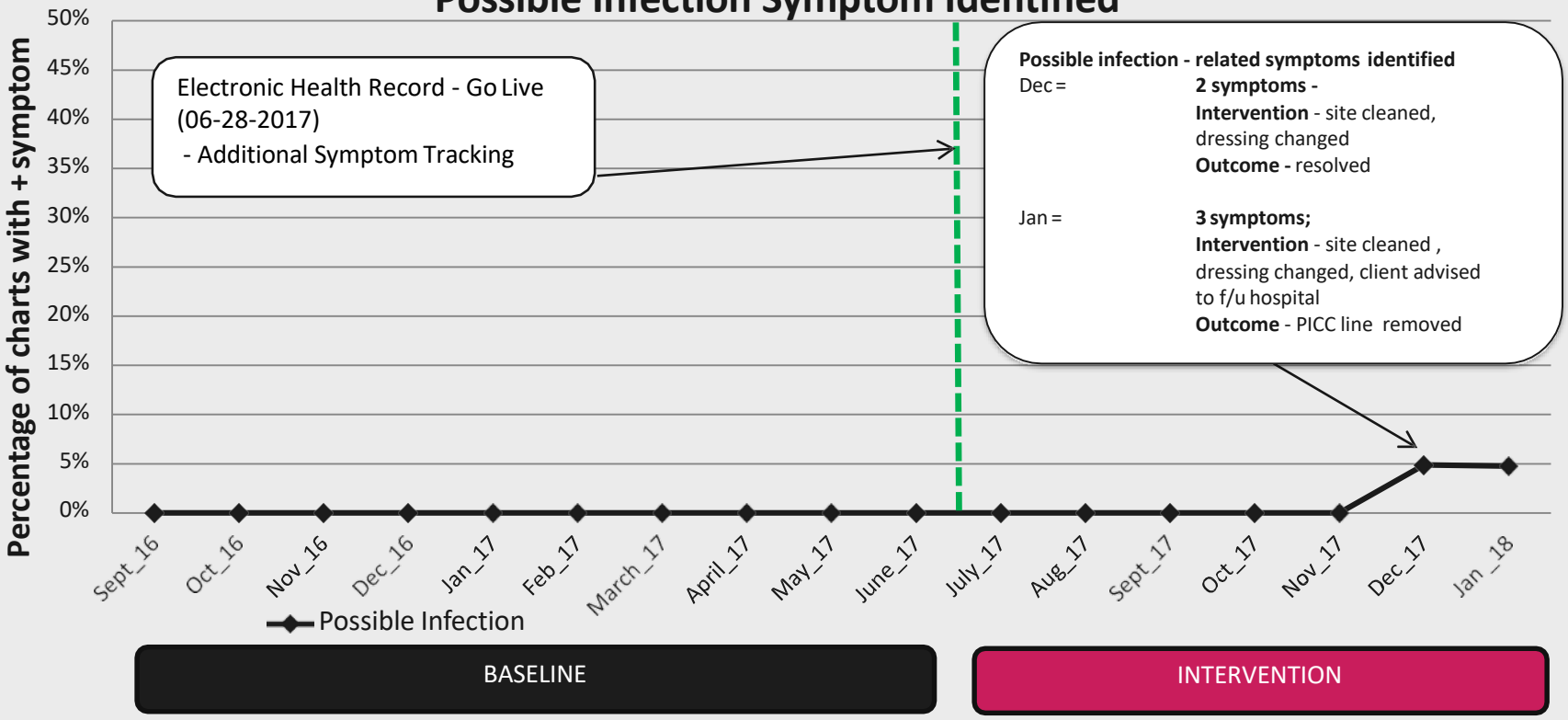


- Documentation Location
- Catheter Type
- Symptom Options
- Clinical Decision Prompts

HealthCare Associated Infection Project
Central IV Lines
Symptom Tracking



HealthCare Associated Infection Project
Central IV Lines
Possible Infection Symptom Identified



Impact

Standardized approach to infection surveillance.

Understanding of clinical incidence & action.

Overall Challenges

Development time in the EMR

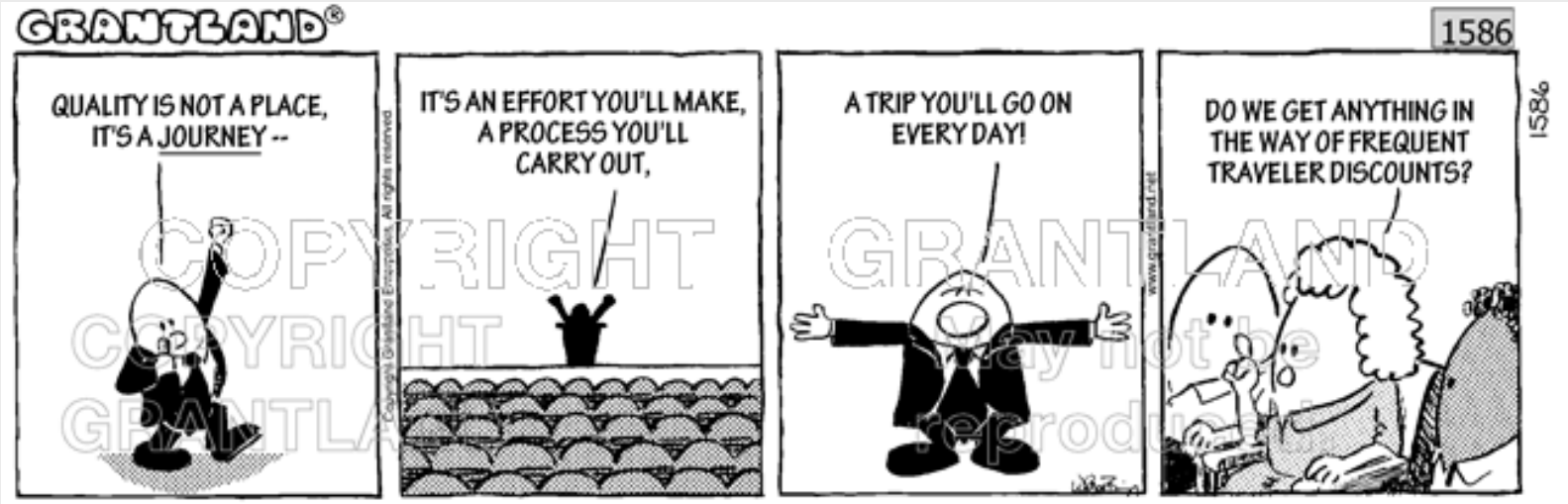
Integrity of data reports from the EMR

Overall Learning

New discoveries in this area.

Ability to learn from others & expert coaching!

Next Steps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IT'S AN EFFORT YOU'LL MAKE, A PROCESS YOU'LL CARRY OUT,
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Central West LHIN

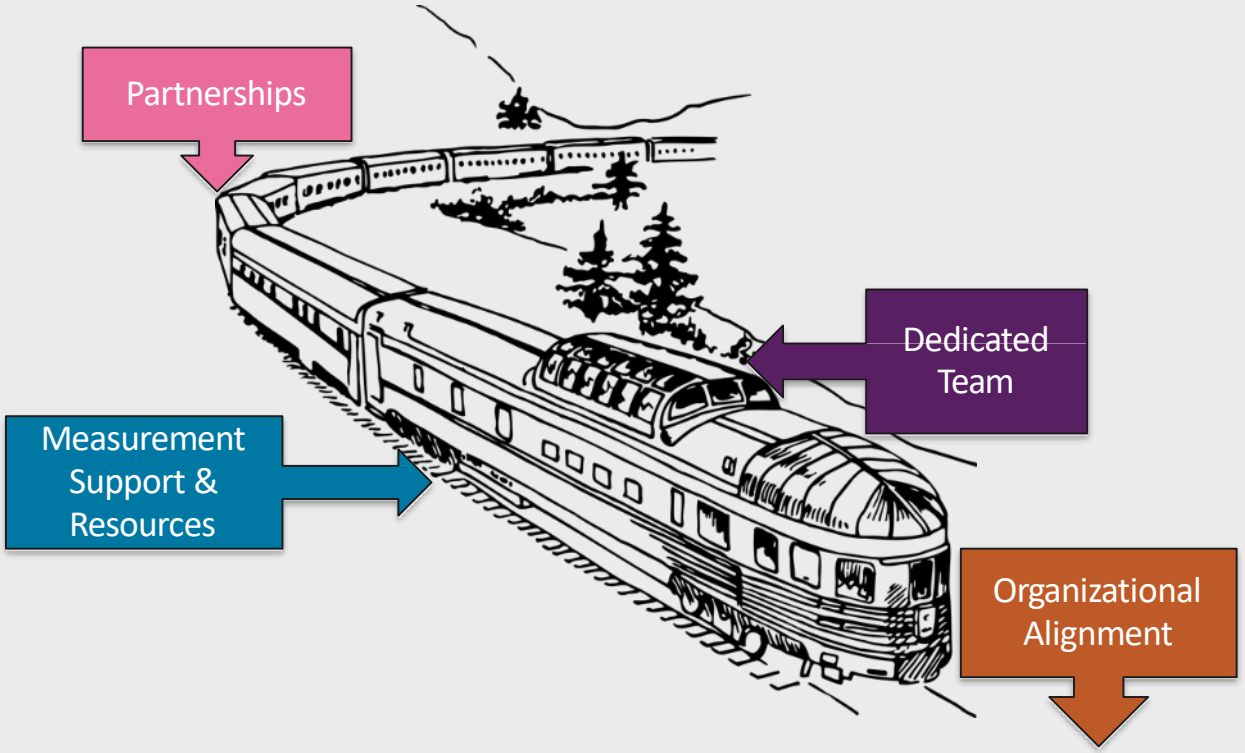
Reducing Negative Impacts from Repeat Patient Falls in the Community:

Implementing "Simple" Quality Improvement in a Complex & Dynamic System

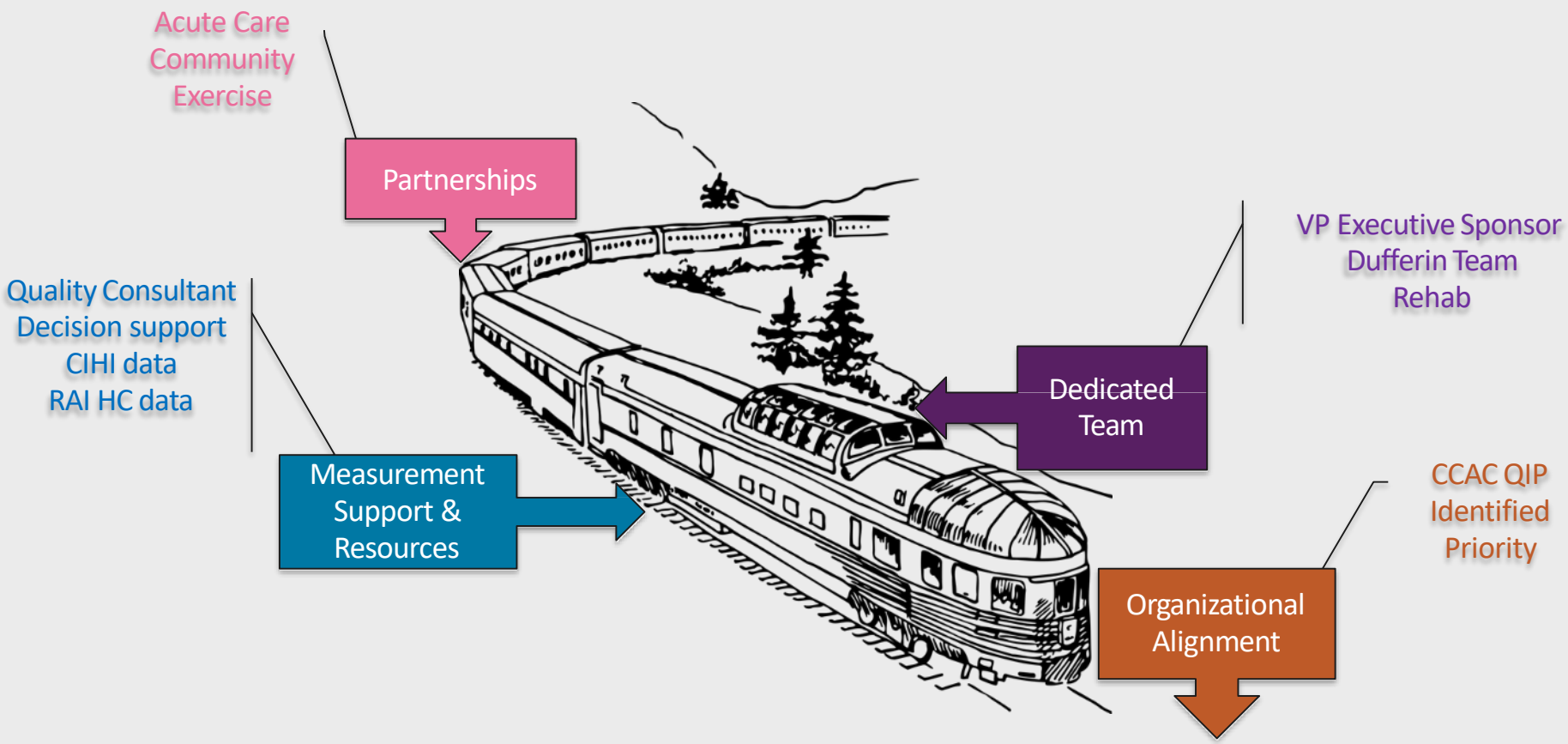
The Central West Improvement Team

- Adrian Christofides, Quality Associate
- Vijeetha Raviraj, Patient care Manager (Rehab)
- Aruna Mitra, Director Home & Community Care
- Patricia McKernan, Director Quality
- Candace Skinner, Patient Care Manager (Dufferin)
- Liam Flewelling, Project support

The Quality Improvement Journey



Our Assumptions: We were Ready!



Our Initial Project Aim

- The purpose of this project is to **reduce the rate of ED visits and hospital admissions to Headwaters Health Care Centre**, for any ICD10 coded “falls” reason for visit/admission **by 20% by March, 30, 2018**.
- This will be achieved through developing and implement a comprehensive falls prevention framework based on the Safer Healthcare Now Reducing Falls and Injuries from Falls framework.

Project Scope & Boundaries

- This is a **pilot project** that will be designed and tested in Dufferin Neighbourhood sub-region. Will focus on patients identified as SRC 93 and 94, our long-stay patients. Once implemented, tested and evaluated, the framework will be spread (in a subsequent project) to all neighbourhoods

Improvement Objectives

1. Develop report to better understand why patients are admitted at rate higher than provincial average to HHCC (Dufferin)
2. Develop universal falls prevention education flyer
3. Develop an intake falls screener for CC
4. Develop Multifactorial Risk Assessment tool for SPOs
5. Develop care pathways for falls (interventions available for level of falls risk identified)
6. Develop ongoing reporting/monitoring of falls program

Scoping the Problem

Sum of visits to Emergency	HL- CW Neighbourhoods					
ICD10_CA	Bolton	Bramalea	Brampton	Dufferin	NEW_WW	Grand Total
(W00) FALL ON SAME LEVEL INV ICE AND SNOW	13	30	36	37	37	153
(W01) FALL SAME LVL FROM SLIP TRIP & STUMBLE	78	535	681	161	666	2121
(W0200) FALL INVOLVING ICE SKATES	1	2	2	6	1	12
(W0201) FALL INVOLVING SKIS			4	3	1	8
(W0202) FALL INVOLVING ROLLER/INLINE SKATES		1	2			3
(W0204) FALL INVOLVING SNOWBOARD				1		1
(W0208) FALL INVOLVING OTHER SPEC SPORTS EQUIP	1	1	1			3
(W03) OTH FALL SAME LVL DT COL/PUSH BY PERSON			1		1	2
(W04) FALL BEING CARRIED/SUPPORTED OTH PERSON		1	3			4
(W0500) FALL INVOLVING WHEELCHAIR	1	7	6	1	15	30
(W0501) FALL INVOLVING ADULT WALKER	5	10	18	14	15	62
(W0508) FALL INV OTHER SPECIFIED WALKING DEVICES			2	1	2	5
(W06) FALL INVOLVING BED	7	52	53	21	61	194
(W07) FALL INVOLVING CHAIR	6	23	36	10	29	104
(W08) FALL INVOLVING OTHER FURNITURE	1	8	6	3	8	26
(W0901) FALL INVOLVING SWING	1					1
(W0905) FALL INVOLVING TRAMPOLINE		1			1	2
(W10) FALL ON AND FROM STAIRS AND STEPS	44	162	244	99	178	727
(W11) FALL ON AND FROM LADDER	8	27	36	19	39	129
(W12) FALL ON AND FROM SCAFFOLDING		2				2
(W13) FALL OUT OF/THROUGH BUILDING STRUCTURE		2	6	4	2	14
(W14) FALL FROM TREE	1				3	4
(W17) OTHER FALL FROM ONE LEVEL TO ANOTHER	6	18	36	19	17	96
(W1800) FALL SAME LEVEL BATHTUB	4	18	24	9	23	78
(W1801) FALL SAME LEVEL SHOWER	2	2	18	4	3	29
(W1802) FALL SAME LEVEL TOILET	4	7	15	6	9	41
(W1809) OTHER UNSPEC FALL SAME LEVEL	18	148	215	48	152	581
(W19) UNSPECIFIED FALL	78	264	331	146	519	1338
Grand Total	279	1321	1776	612	1782	5770

Dufferin

- TOTAL ED visits due to falls 612
- Smaller population & number of providers
- Plan was to design and implement change idea in smaller more manageable population
- Perception fewer variables
- Good relationship with primary care (Family Heath team)

Un-anticipated Challenges

Executive Sponsor departed

Difficulty in access to timely fall reporting

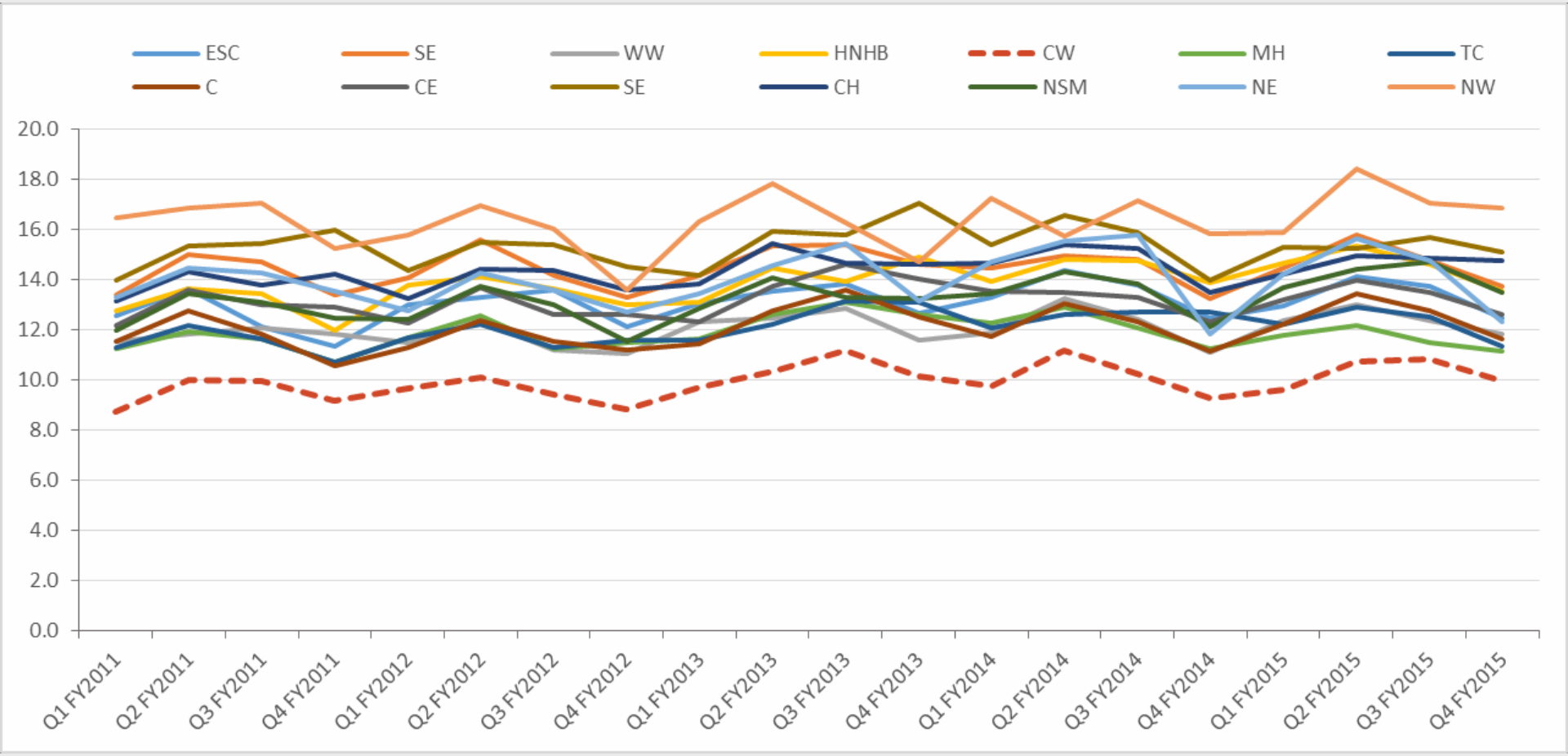
Organizational Restructuring (CCAC to CW LHIN)

Unanticipated Change & Impact on Momentum

	Difficulty in access to timely falls reporting	Executive Sponsor departed	Organizational Restructuring (CW CCAC to CW LHIN)
IMPACT	• Lack of clarity about what intervention would make a difference at the client level • Direct care providers track falls but are not required to report back to Care Coordinator	• Leadership in Transition • Lack of clarity regarding organizational Support for project participation	• Project members pulled into transformation activities • Limited time to dedicate to falls project
OPPORTUNITY 	• Upcoming roll out of incident tracking system to service providers (ETMS) • Is this an opportunity to piggy back on initiative to get falls data	• Revisit purpose of project • What do we really need to do? • What do we really want to do?	• Potential access to legacy LHIN staff who have access to system wide data (e.g. ED utilization)

New Data

ED Visits for a type of Fall (per 1000 patients)



Ministry of Health Data Analytics Branch

Time to re-visit the aim statement!

New Data

- 2014-2017, there were ~12,000 RAI-HC completed, ~48% (n=5791) reported a fall and **~64% (n=3695) of these reported >1 fall**

Revised Project Aim

- The aim is to have 100% of patient reported falls (RAI-HC, Q.K9) from the Home and Community Care Long-Stay (SRC 93, 94) active patient population, have a corresponding Falls eForm completed by the Care Coordinator. The goal is to achieve 100% compliance by June 30, 2018.

Revising the project aim assisted us take a more focussed approach to a more manageable project

Aim and Measures

- **Process Measure:**
  - % of Falls eForms completed with a falls care plan in place

- **Outcome Measures:**
  - 100% of reported patient falls (RAI-HC, Q.K9) have a corresponding Falls eForm completed
  - Decrease in the % of patients that report a negative impact (using World Health Organization's degrees of harm) from a repeat fall

- **Balancing Measure:**
  - Monitor potential increase in the use of restraints as a recommended intervention
  - ADL measures from the interRAI Home Care Assessment (TBD)

- **Compliance Reports:**
  - Managers: to receive a staff report that shows completed RAI-HC's with "Yes" to the falls question and no Falls eForm created
  - Care Coordinators: to receive caseload report showing # of Falls eForms completed with no corresponding falls care plan in CHRIS

Change Concept

- Improve Workflow (reporting, capturing, documenting falls)
- Focus on the Services (fall interventions)
- Manage Variation (fall assessment in standardized fashion)

What did We Learn (Re-learn)?

- To be successful we must implement and **sustain** effective improvement

- Any change requires a significant investment of time, financial resource and leadership effort. There is evidence that up to 70% of all organisational change fails to survive and that is just not acceptable when undertaking health care improvement[1]

[1]Daft and Noe, 2000. Beer and Nohria, 2001

Next Steps: Adapt Our Approach

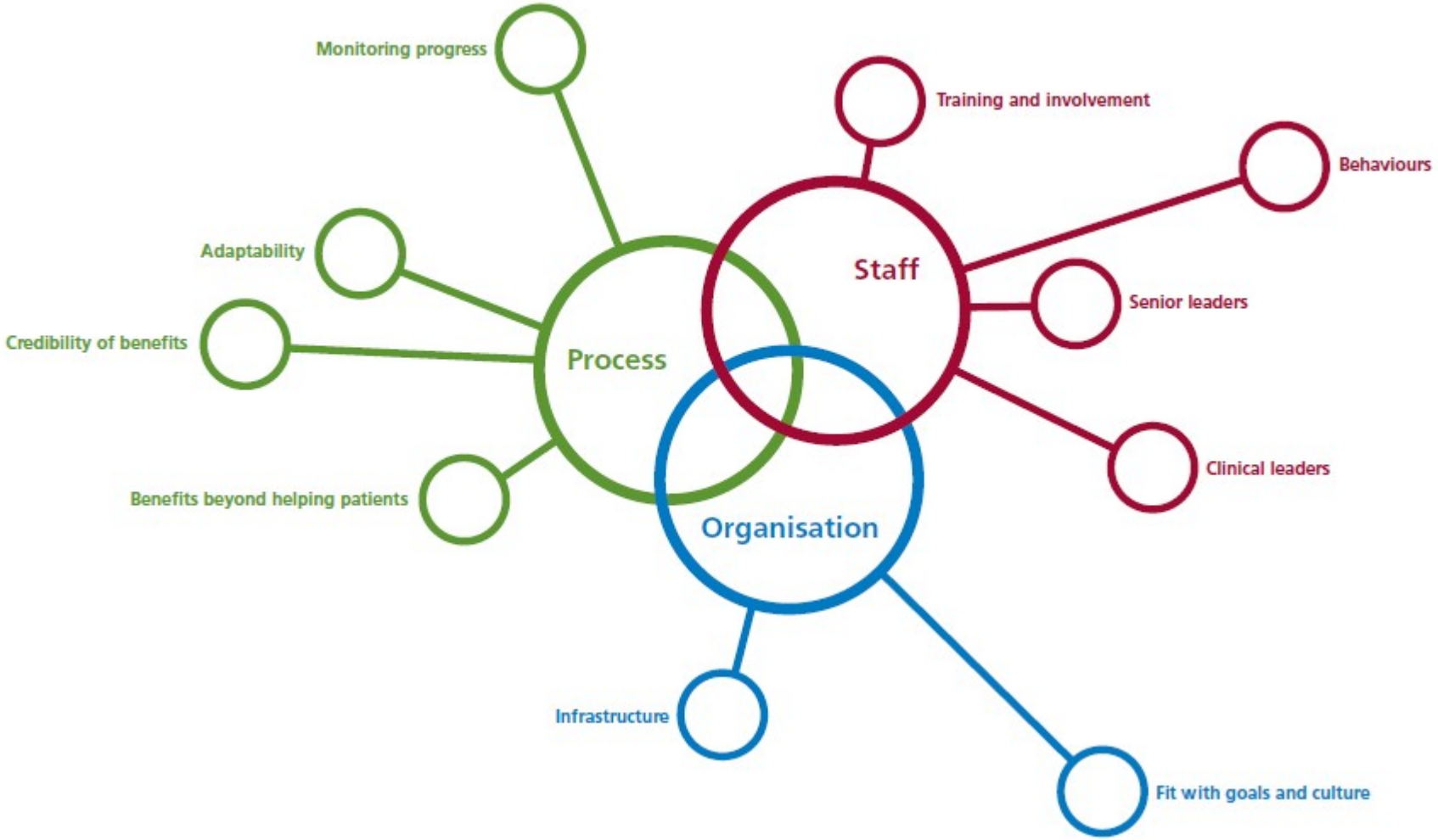
- Complete the NHS Sustainability Model and Guide[2] **before** improvement work begins
- The Sustainability Model is a diagnostic tool that will identify strengths and weaknesses in your implementation plan and predict the likelihood of sustainability for your improvement initiative
- The Model has **not** been designed to assess whether a department, whole organisation or health community is likely to sustain change in general
- Its use needs to be linked to a specific improvement initiative

[2] NHS Institute for Innovation and Improvement, NHS Sustainability Model, Lynne Maher, Professor David Gustafson, Alyson Evans

Next Steps

- The NHS Sustainability Model was to developed to be an easy-to-use tool to help teams:
  - plan for sustainability of improvement efforts
  - recognise and understand key barriers for sustainability, relating to their specific local context
  - self-assess against a number of key criteria for sustaining change
  - identify strengths in sustaining improvement
  - monitor progress over time

NHS Sustainability Model



[2] NHS Institute for Innovation and Improvement, NHS Sustainability Model, Lynne Maher, Professor David Gustafson, Alyson Evans

'The challenge is not starting,
but continuing after the initial enthusiasm has gone'

Ovretveit (2003) Making temporary quality improvement continuous:
A review of the research relevant to the sustainability of quality improvement in healthcare

island health

IMPROVING DOCUMENTED INTERVENTIONS FOR REPORTED FALLS FOR LONG-TERM HOME SUPPORT CLIENTS IN COMMUNITY HEALTH SERVICES


Queen Charlotte Sound
Queen Charlotte Strait
British Columbia
Pacific Ocean
1
2
3
4
Campbell River
Port Alberni
Nanaimo
Victoria
Strait of Georgia
Juan de Fuca Strait
Canada
United States
0 15 30 Miles
0 15 30 KM

Aim and Measures

AIM

To improve documented interventions for reported falls for long term home support clients in Community Health Services (CHS) from 32% to 100% by March 2018 through a consistent regional process and improved monthly data review.

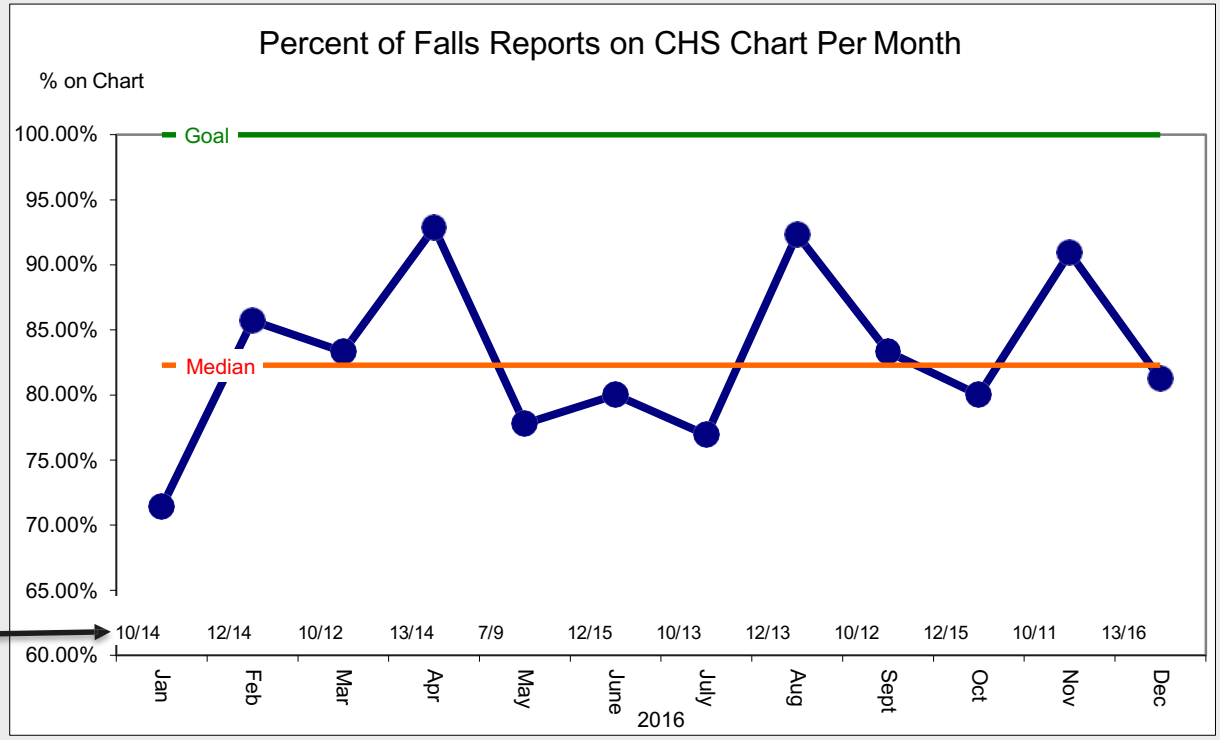
MEASURES

% of CHS clients with fall report on the chart

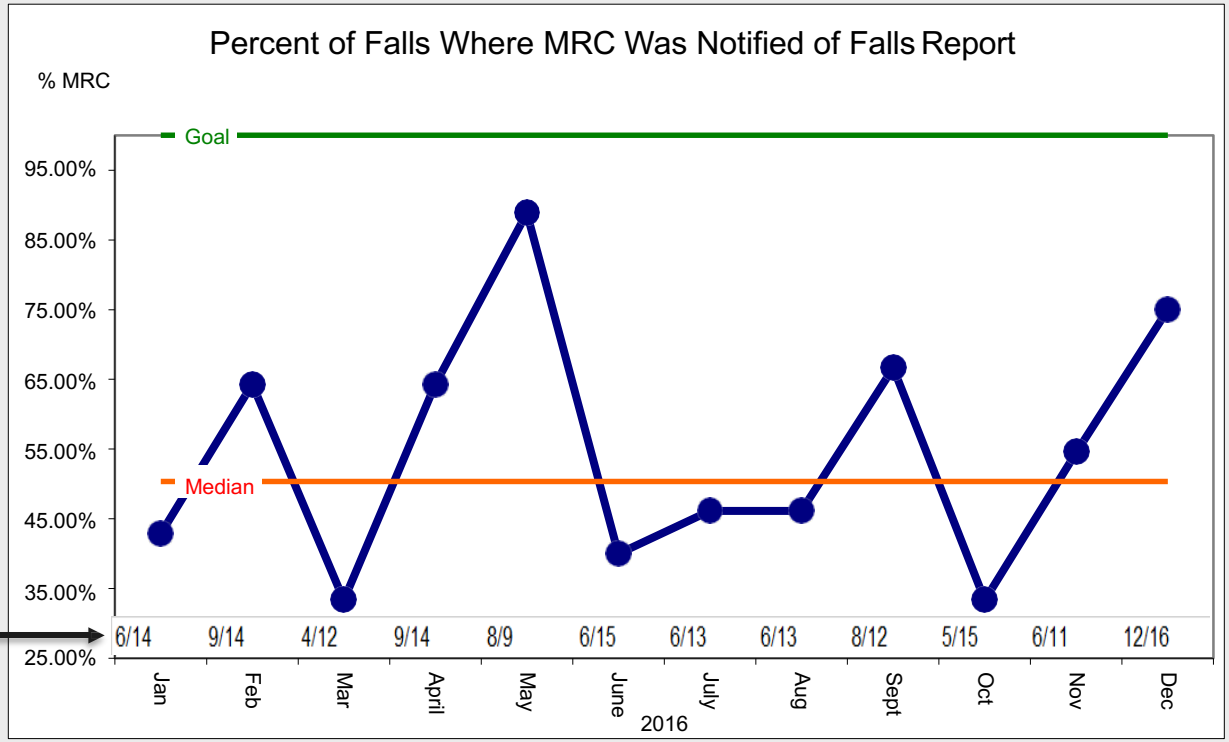
% of falls where the Most Responsible Clinician was notified of the fall report

% of falls with a documented intervention on the CHS chart

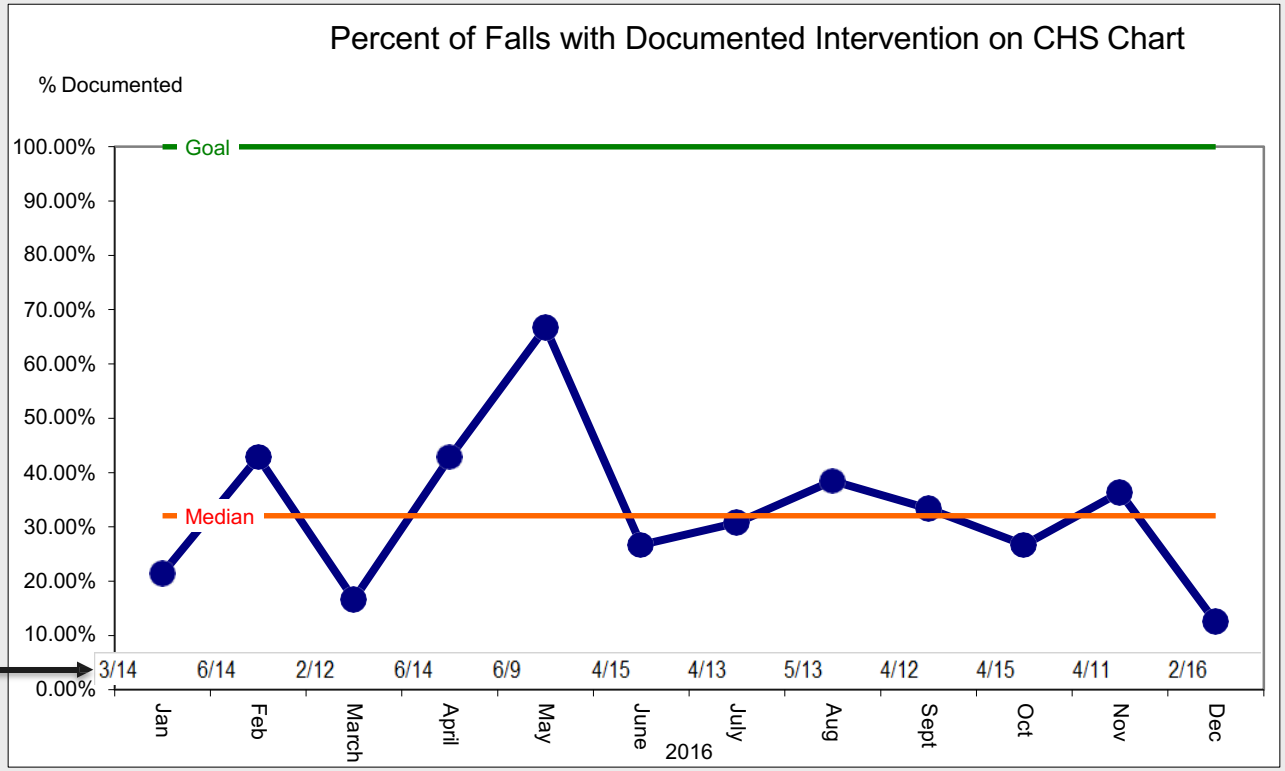
BASELINE DATA



BASELINE DATA



BASELINE DATA



CHANGE CONCEPTS

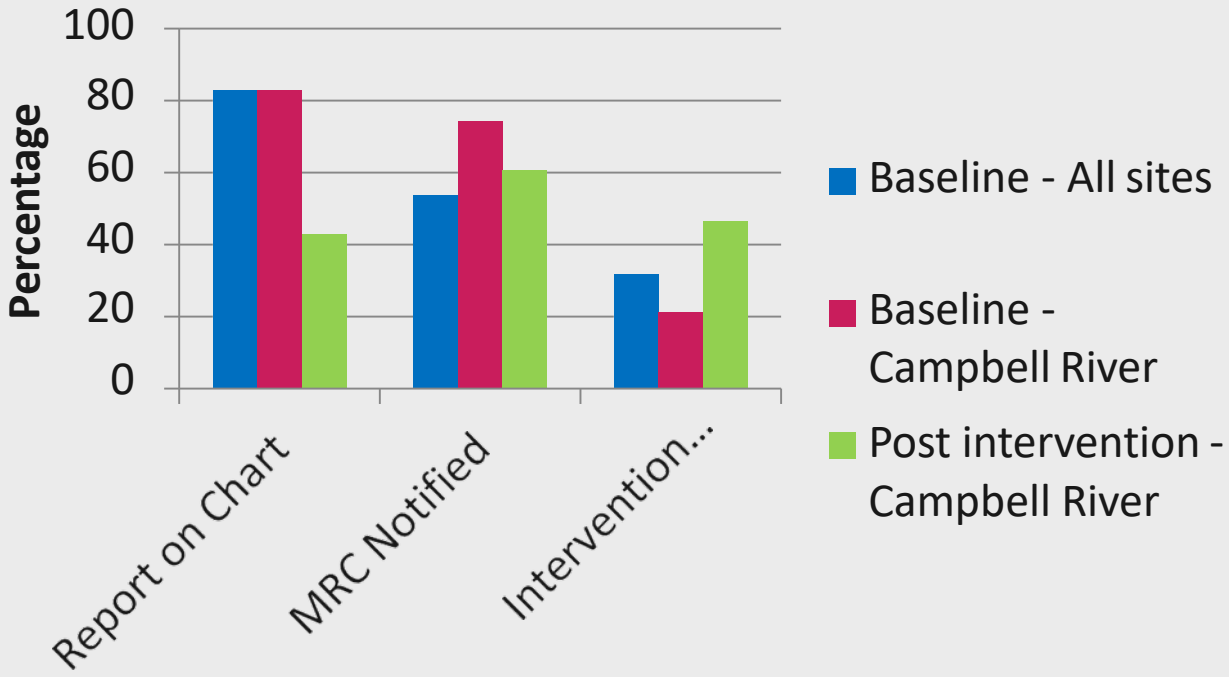
Revision of the current CHS Falls Guideline

Revision and development of online learning support tools and resources

Development and delivery of education

Review and revision of fall audit tools

RESULTS


100
80
60
40
20
0
Percentage
Report on Chart
MRC Notified
Intervention...
Baseline - All sites
Baseline - Campbell River
Post intervention - Campbell River

OVERALL CHALLENGES

Staff participation in education webinars

Number of stakeholders involved

Complexities of fall reporting structures

OVERALL LEARNING

Importance of using data to inform practice.

Engaging all involved stakeholders is necessary for implementation of any large scale change

Clear next steps have been identified, for ongoing improvement

NEXT STEPS

1. Complete fall chart audits to allow for comparison of pre and post data
2. Initiate new quarterly local fall audits
3. Shift focus to specific interventions and performance supports available for front line clinicians
4. Incorporate client perspective

CBI HEALTH GROUP

Ensuring Safe, Effective and Quality Care To Persons With Dementia: A Balanced Approach To Person-centered Care, Personnel and Patient Safety

Presenters: Célynne Pilon, Melissa Hill, Rosanna Dolinki, Caroline Gill

Aim and Measures

Aim:
By February 2018, improve the identification and documentation of responsive behaviours and associated care needs in home care tool by Unregulated Care Providers (UCPs) for 75% of patients with dementia in Havelock, Ontario.

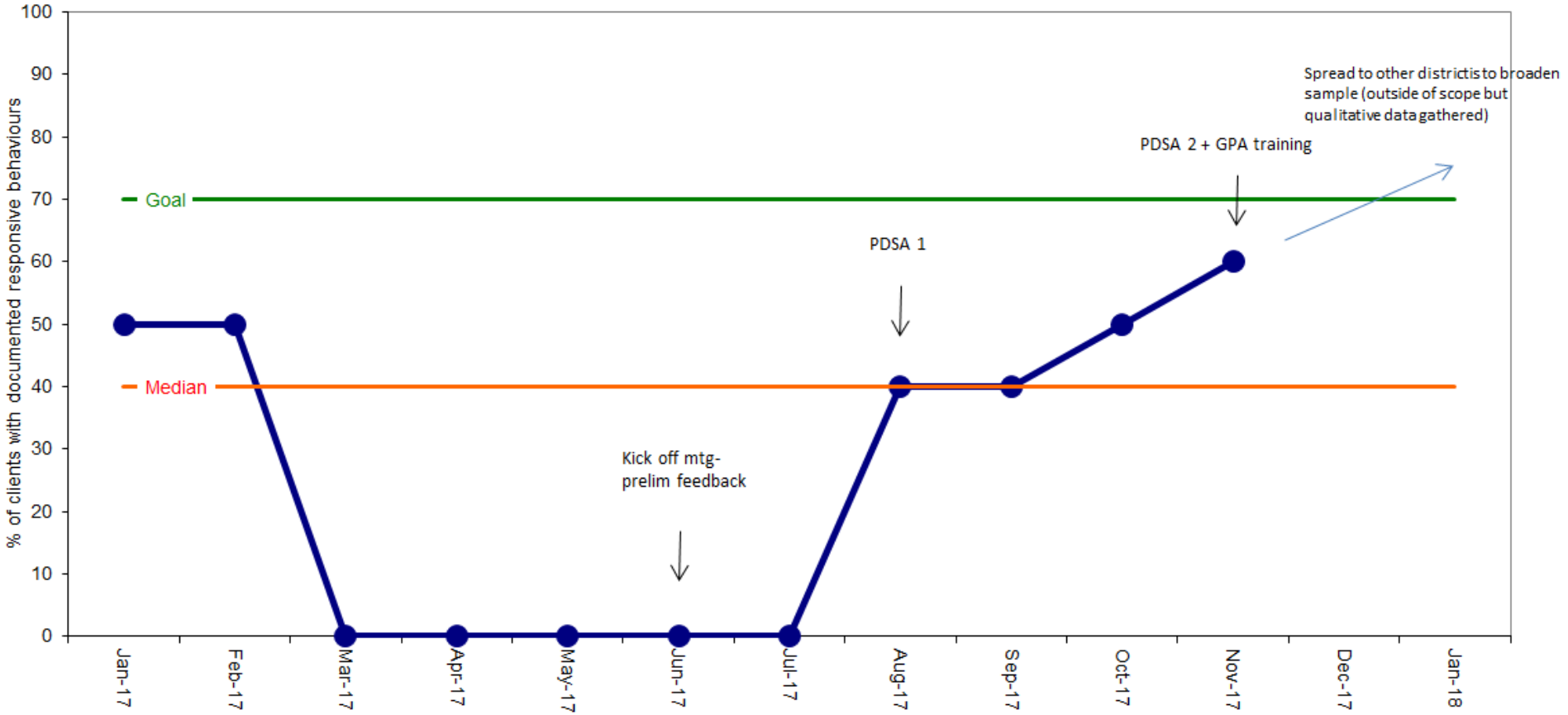
Measures:
1. Documentation of responsive behaviours and associated care needs
    - Documentation of responsive behaviours and associated care needs is defined as in the use of a “Cue Card for Compassionate Care”
2. Personnel Survey

Chart Audits will also be completed to understand demographics and baseline/current state.

Change concepts

- Individualized identification and communication tool for use by the unregulated care providers (UCPs) e.g. Personal Support Workers
- Customize education and training based on known scenarios
- Focus group conducted with UCPs and Personal Support Services (PSS) Supervisors from the region to better understand current state and explored needs and possible change ideas to test.

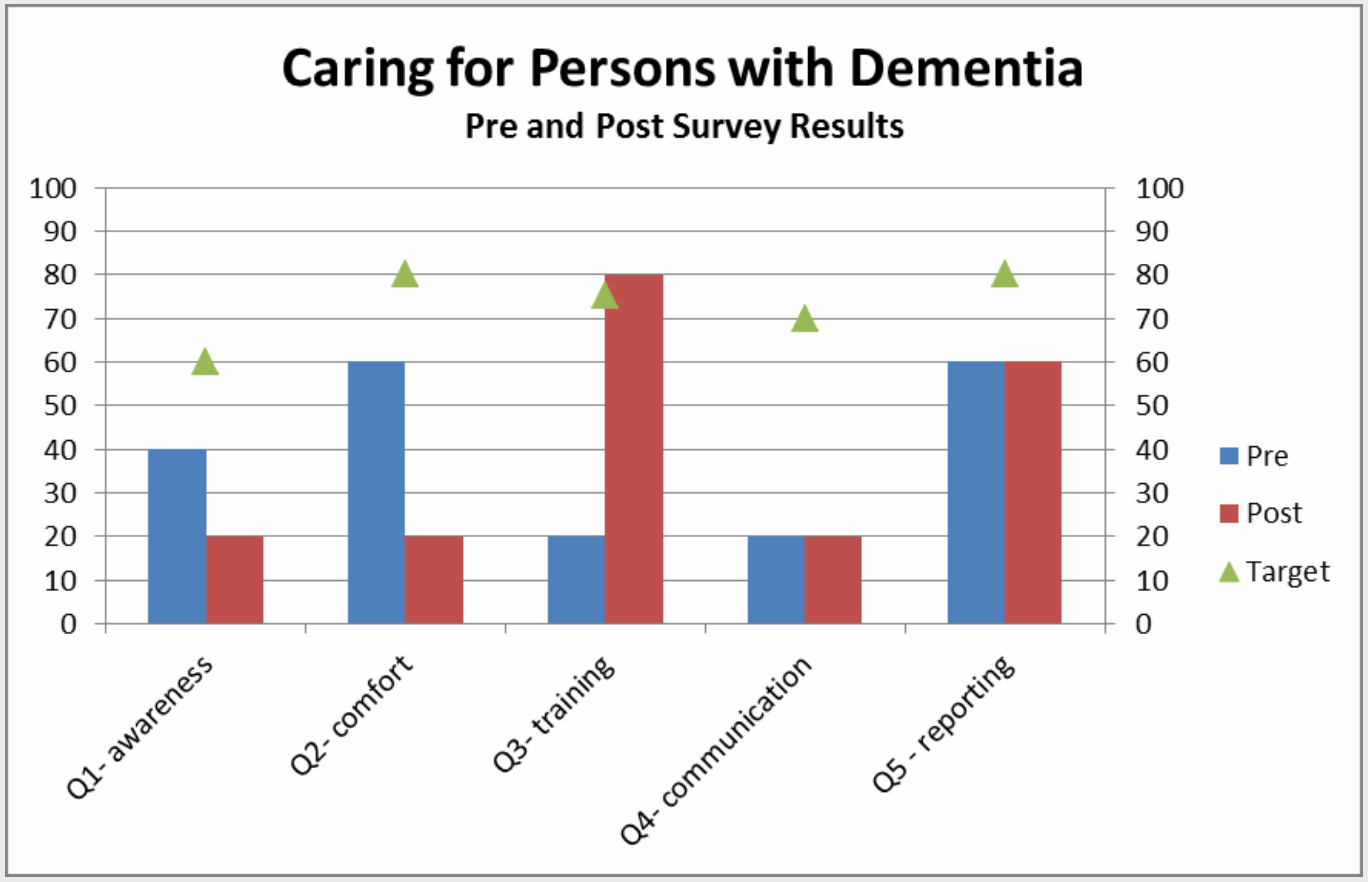
Caring for Persons with Dementia



Survey (Baseline – Pre)

HOW WILL WE KNOW A CHANGE IS AN IMPROVEMENT?

*note :very small sample size n= ≤ 10; ambitious targets!	Baseline	Target	Post
When providing care to a person with dementia for the first time, are you aware that they have dementia?	60% sometimes 40% always	60% always	*Not achieved* 80% sometimes 20% always
How comfortable do you feel working with persons with dementia who express responsive behavior(s)?	40% moderately comfortable 60% extremely comfortable	80% extremely comfortable	*Not achieved* 20% moderately comfortable 60% very 20% extremely
Have you received any training fully focused on caring for a person with Dementia?	80% no 20% yes	75% yes	*Exceeded* 80% yes
How well do you feel you communicate with persons with dementia?	20% moderately well 60% very well 20% extremely well	70% extremely well	*Not achieved* 40% moderately well 40% very well 20% extremely well
How confident are you that when you report information to your supervisor that other members of your team learn about the information you have shared?	20% not at all confident 20% somewhat confident 20% very confident 40% extremely confident	80% very/extremely confident	*Not achieved* 40% not at all 20% somewhat 40% very confident


Caring for Persons with Dementia
Pre and Post Survey Results
100
90
80
70
60
50
40
30
20
10
0
Q1- awareness
Q2- comfort
Q3- training
Q4- communication
Q5 - reporting
Pre
Post
Target

Results/Impact

- Development of a ‘tangible’ tool to assist personnel with patients with dementia (or high complexity)
- **Cue Card for Compassionate Care;** new tool; compliments other PFCC internal resources already in place
- Empowerment and engagement of UCPs and Peterborough team members; opportunity to participate in initiative; valuable insight
- Built awareness regarding principles of person centered care and gained a front-line perspective on challenges and opportunities
- Perceived opportunities to spread successes and resources
- Opportunity to spread capacity in continuous quality improvement methodologies

Overall Challenges

- Personnel turnover; changes in composition of team members
- Conflicting priorities at the pilot site; day to day operational expectations of patient care (e.g., the focus on meeting funder KPIs) v. QI initiative
- Even when the project is seen as valuable and aligned with other strategic directions ensuring adequate time/resources can be difficult
- Communication; time it takes to connect with remote teams; i.e. often limited to meeting larger group at planned quarterly team meetings
- Sample and population from the selected area was much smaller than expected, impacting data and overall project scope and impact
- Data accessibility due to project scope and resource constraints
- Incorporating the Patient Voice into projects

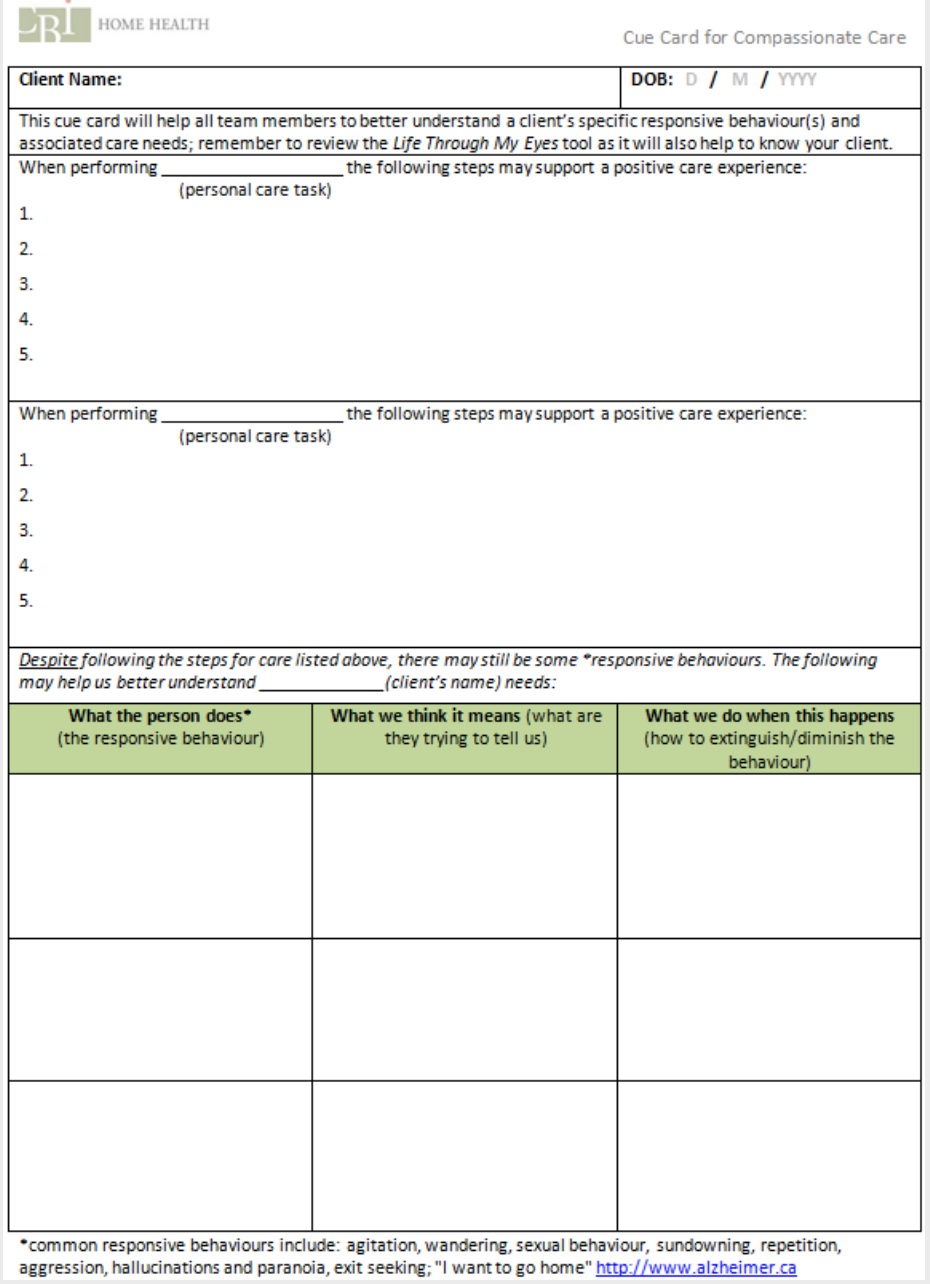
Overall Learning

- QI building capacity is important and takes time; involvement in Collaborative facilitated QI capacity in our team(s) e.g. ensuring QI tools (PDSA, run charts etc.) were used
- Clarity in terms of having an aim statement that truly guides the project; open to evolving aim overtime
- Importance of finding a balance between a large enough project scope and realistic aim
- It requires commitment to devote the time to incorporate QI tools and learnings and keep the project moving over 12 months with competing priorities
- We focused on the UCPs (i.e. user's) voice in lieu of the patient voice due to challenges as outlined in earlier slides
- Ongoing communication with all levels of organization is important

Next Steps

- Transitioning from pilot site to multiple sites (spread) using an approach similar to a previous launch (webinar with key stakeholders, ongoing evaluation etc.)
- Strategic and gradual spread across sites
- Continue building and leveraging data collection to inform spread
- Leverage use of Tool while enhancing delivery of relevant training (e.g. GPA)
- Ensure patient voice is captured
- Share successes of processes used, engagement of personnel, and the development of the product (C4) across organization.

Cue Card for Compassionate Care (C4)



HOME HEALTH

Cue Card for Compassionate Care

Client Name:	**DOB:** D / M / YYYY

This cue card will help all team members to better understand a client's specific responsive behaviour(s) and associated care needs; remember to review the *Life Through My Eyes* tool as it will also help to know your client.

When performing _____ the following steps may support a positive care experience:
(personal care task)

1.
2.
3.
4.
5.

When performing _____ the following steps may support a positive care experience:
(personal care task)

1.
2.
3.
4.
5.

*Despite following the steps for care listed above, there may still be some *responsive behaviours. The following may help us better understand _____(client's name) needs:*

What the person does* (the responsive behaviour)	**What we think it means** (what are they trying to tell us)	**What we do when this happens** (how to extinguish/diminish the behaviour)

*common responsive behaviours include: agitation, wandering, sexual behaviour, sundowning, repetition, aggression, hallucinations and paranoia, exit seeking; "I want to go home" http://www.alzheimer.ca

Improving Assessment & Case Management of Clients with Cognitive Impairment

Aim

Reduce distress among caregivers of clients within the Cognitive Impairment RUGs category in Central Zone from 36% to 30% by March 2018 (start with a few caseloads, then spread).

Measures

Outcome Measures
% of caregivers expressing feelings of distress, anger or depression
% of caregivers expressing that they are unable to continue in caring activities

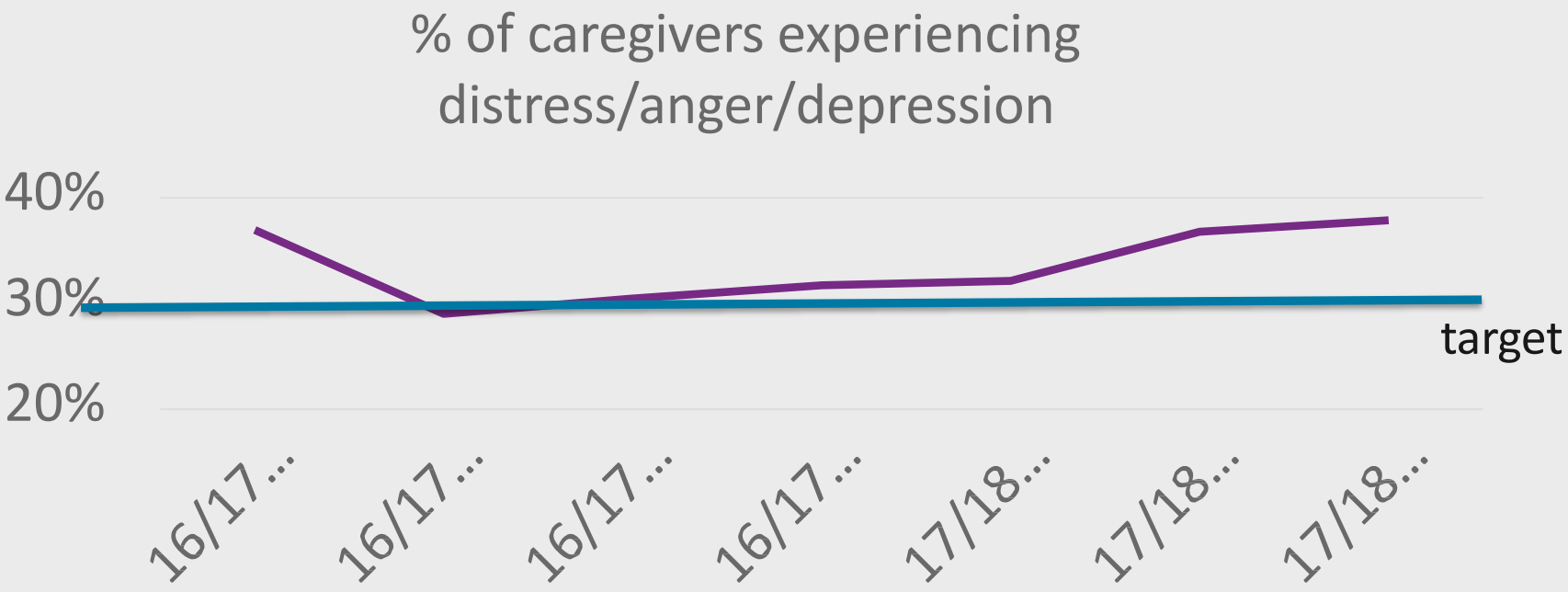
Balancing Measures
Perceived value by staff
Impact to work load
# of referrals for services outside Continuing Care
Amount of authorized continuing care services

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
% of clients and caregivers satisfied with the case management service they received

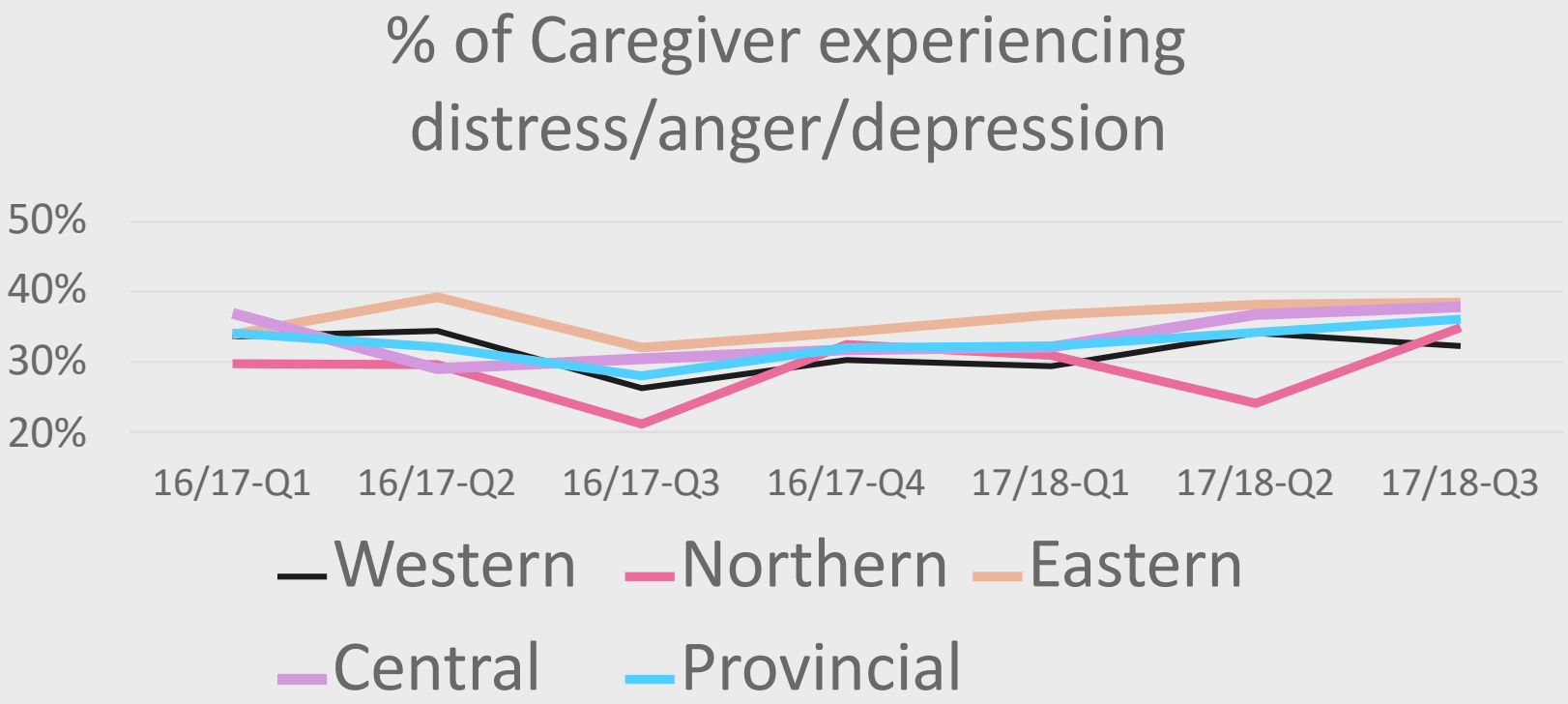
Change concepts

- Implementing an evidence informed, standardized person-centred approach to support case management for clients with cognitive impairment and their caregivers
- Develop & validate guidelines to support the usage of interRAI Clinical Assessment Protocols (CAPs) in care planning

Run Chart – Central Zone



Provincial Picture



Results/Impact

- Concentration has been on:
  - Understanding best practices
  - Understanding the population we serve through the RUGs lens
  - Exploring leading practices as it relates to CAP areas
  - Applying a Nova Scotia context and resource availability to CAPs
- Implementation of changes initiatives – Winter/Spring 2018
  - Providing provincial education session for staff on person centred case management
  - Applying CAPs to target population among 4-5 Care Coordinators in Spring 2018

Overall Challenges

- Starting with the solution as opposed to defining the actual problem
- Scoping the project appropriately and aligning our aim with patient safety focus
- Dedicated resources & time, changes in team members
- Important to identify & engage all key stakeholders
- Assessment software not current with interRAI CAPs, nor CIHI compliant
- Data Limitations

Overall Learning

- Tackling a non-traditional patient safety project is complex!
- Acquired new knowledge and skills related to patient safety and quality improvement
- Raised awareness and understanding among front line staff about quality improvement methodologies
- Resulted in broader case management work being prioritized and moved forward
- Resulted in government initiating work to update software and become CIHI compliant (interRAI-HC)

Next Steps

- See this project through to implementation and apply PDSA fully.
- Build on the work undertaken in this project to further enhance our understanding and application of leading practices in person-centred care.
- Incorporating Quality Improvement as part of Learning & Development Plan for Continuing Care Team.
- Identify other key issues that may benefit from applying the quality improvement process & tools we learned about through the Improvement Collaborative.

Advance Care Planning

Aim Statement and Measures

AIM STATMENT

Aim Statement

By February 28, 2018 Care At Home Services will increase the rate of Advance Care Planning conversations by 60% for those patients where the **Surprise Question** (SQ) screener tool response was " no".

* Surprise Question screener tool: " Would you be surprised if this client died within the next twelve (12) months".

MEASURES

Measures

1. Increase the rate of Advance Care Planning conversations by 60% for those patients where the **Surprise Question** screener tool response was " no"

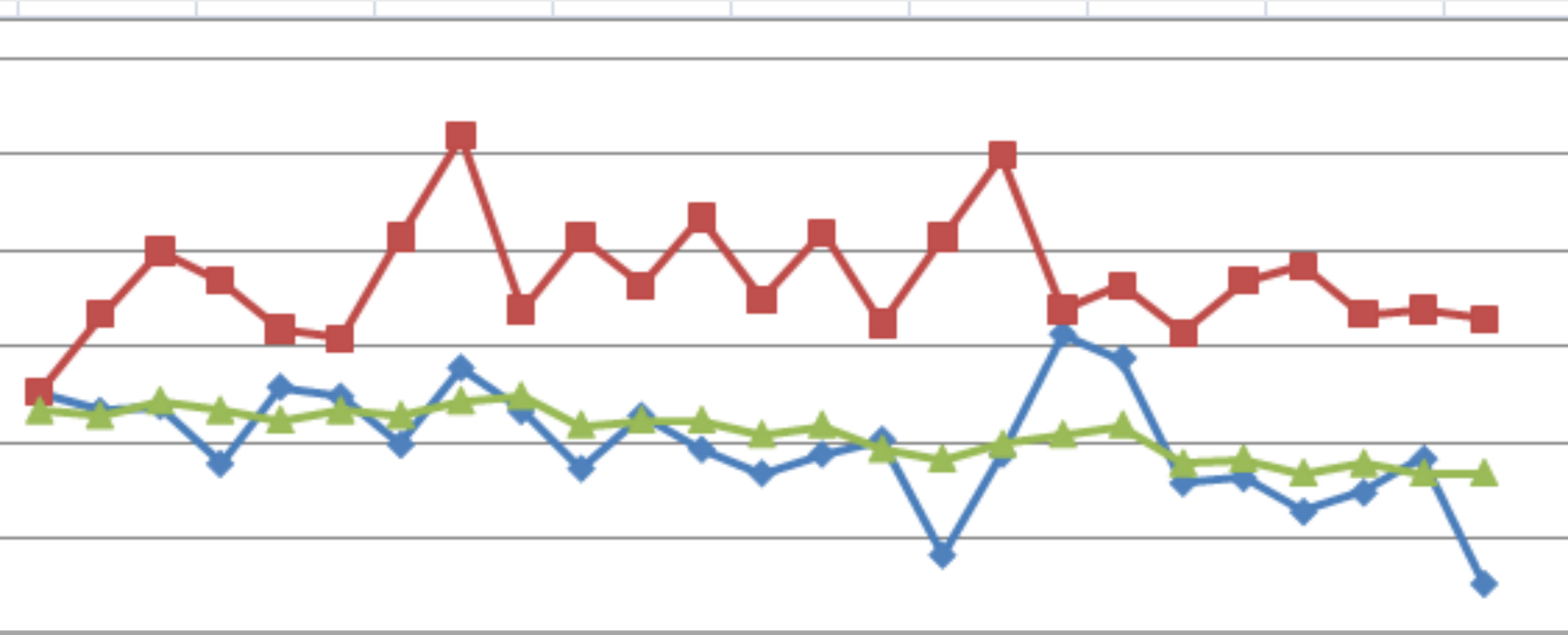
2. All full-time nurse case managers are trained to use the Guideline Tool and family brochure Speak Up "My Voice" to facilitate ACP conversations

3. Improve by 20% client and family satisfaction with ACP conversations

4. Improve by 30% staff confidence with ACP conversations

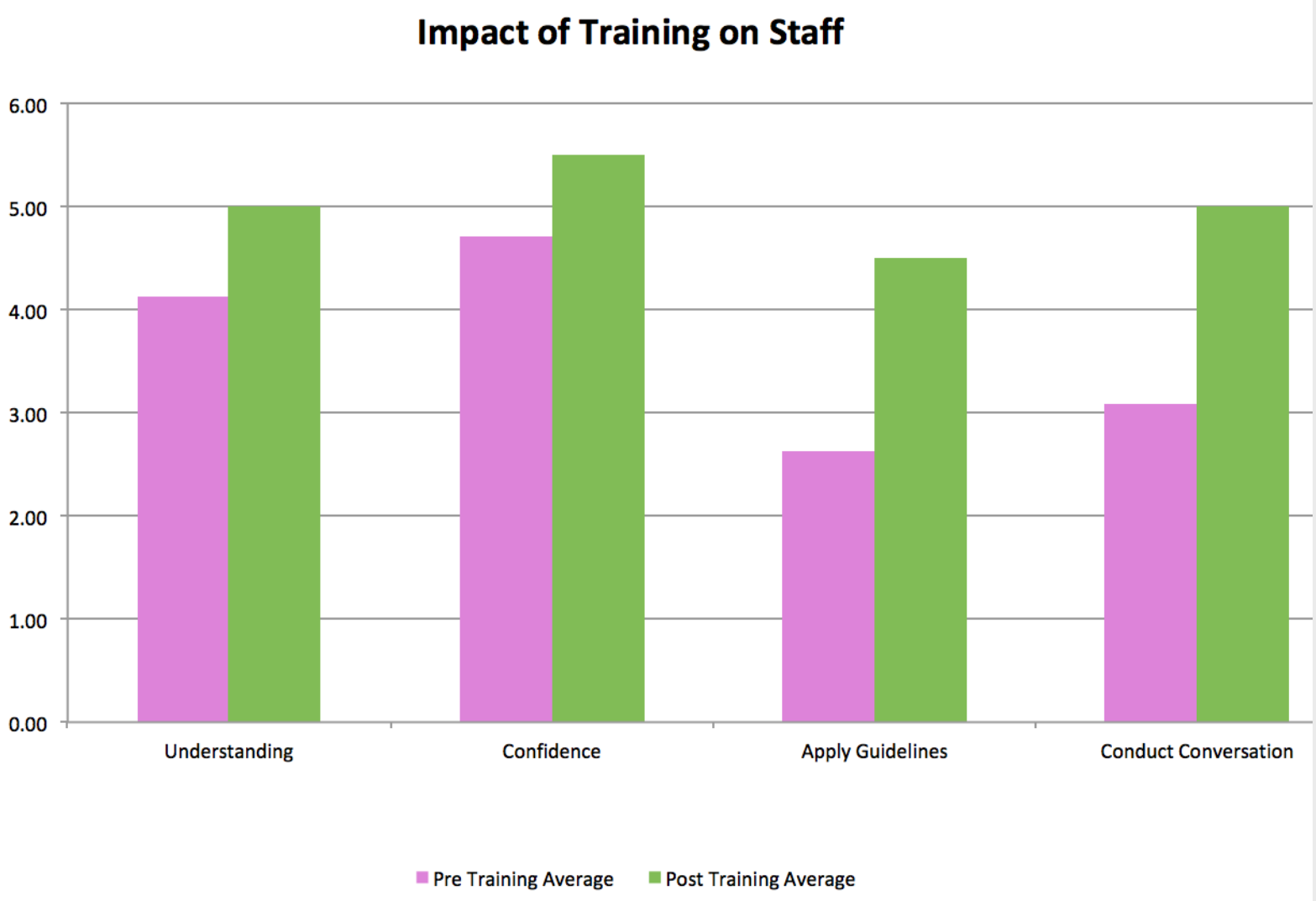
Change Concepts

	Clinical Issue	Change Concept
CHANGE CONCEPTS	Care At Home Services has a high number of complex and palliative care clients, with no formal ACP process or no way of identifying clearly those with a high need for ACP conversations	• Use the 'surprise question' to triage those with a high need for ACP conversation and to allow staff to prioritize based on client needs
	Staff often feel unprepared to broach ACP conversations with clients	• Develop a broad range of teaching materials to educate staff • Offer staff mentorship in acquiring new skill set



Results

Staff Confidence Results

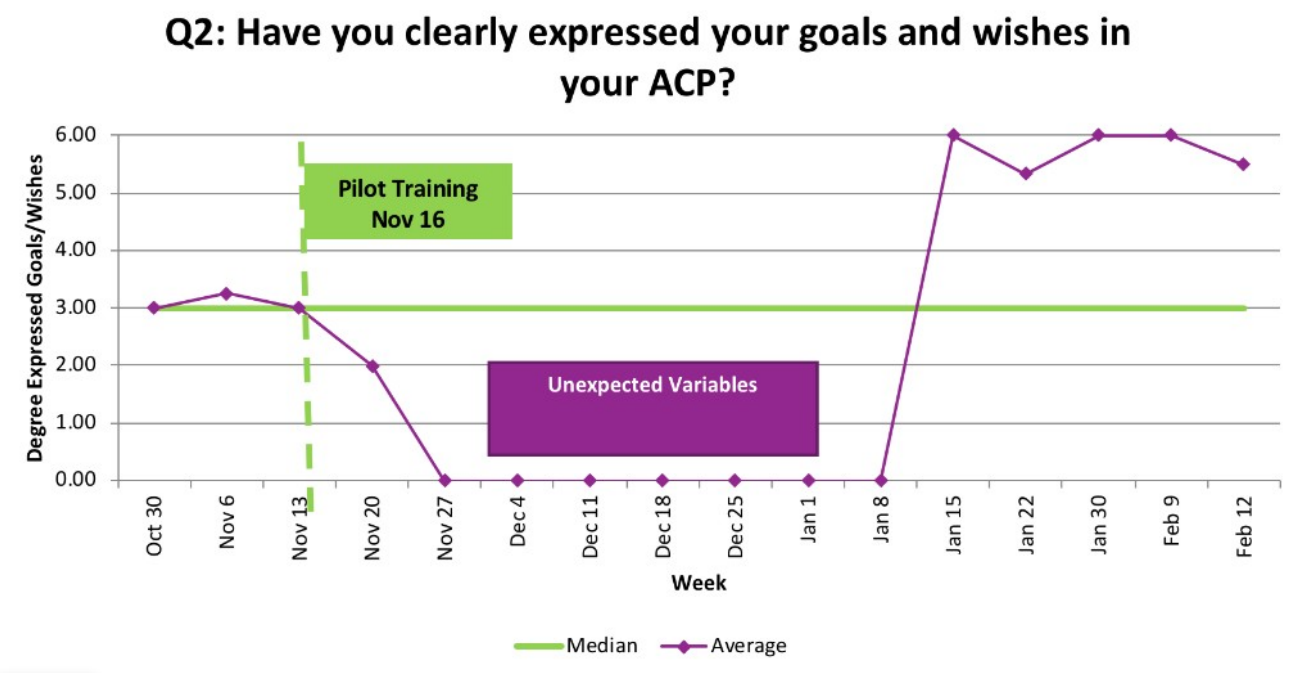


Client Satisfaction Results

Total Number of Patients		
Clients	**Proxy**	**Total**
21	7	21

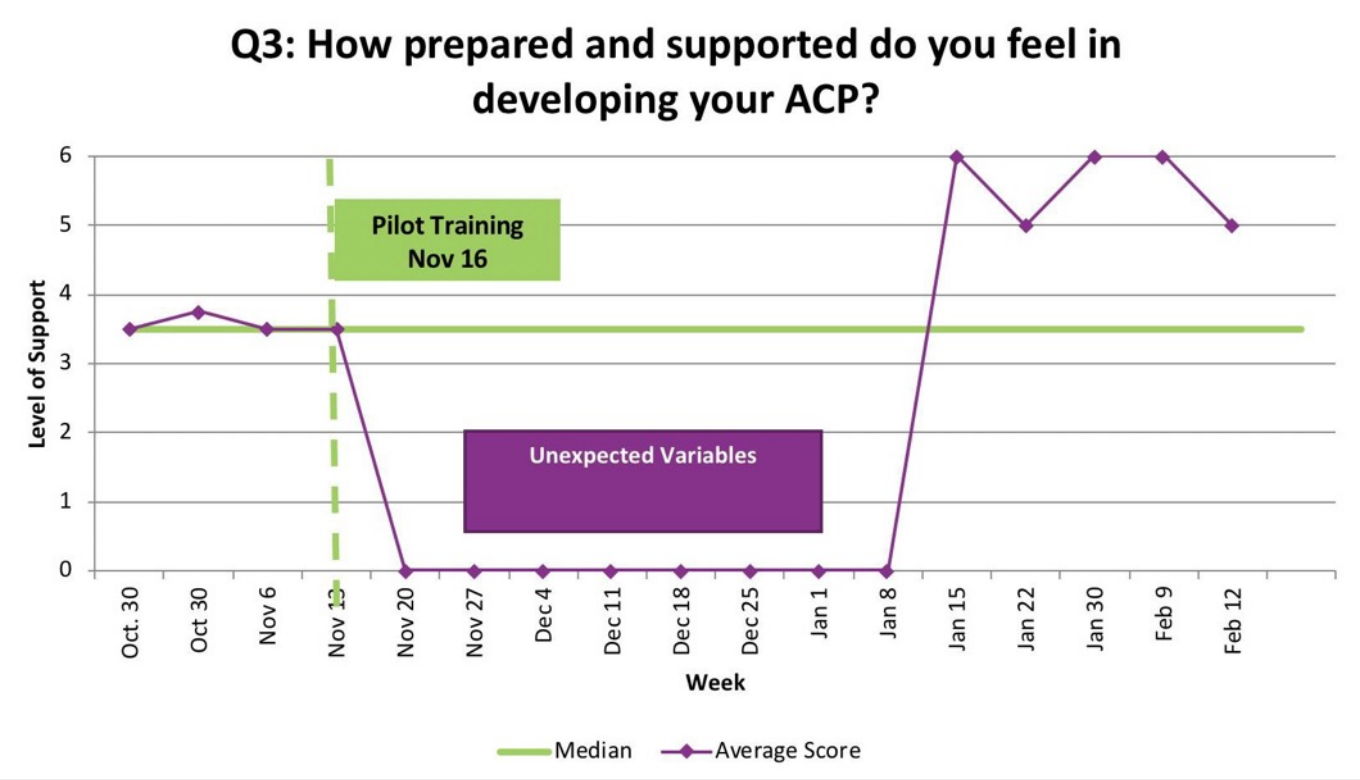
Q1. Discussion between HCP and Patient or Family regarding Advanced Care Planning			
Timing	**Patient/Proxy**	**Discussed with HCP**	**Percent Complete**
Pre-Training	10	5	50%
Post-Training	11	9	82%

Client Satisfaction Results



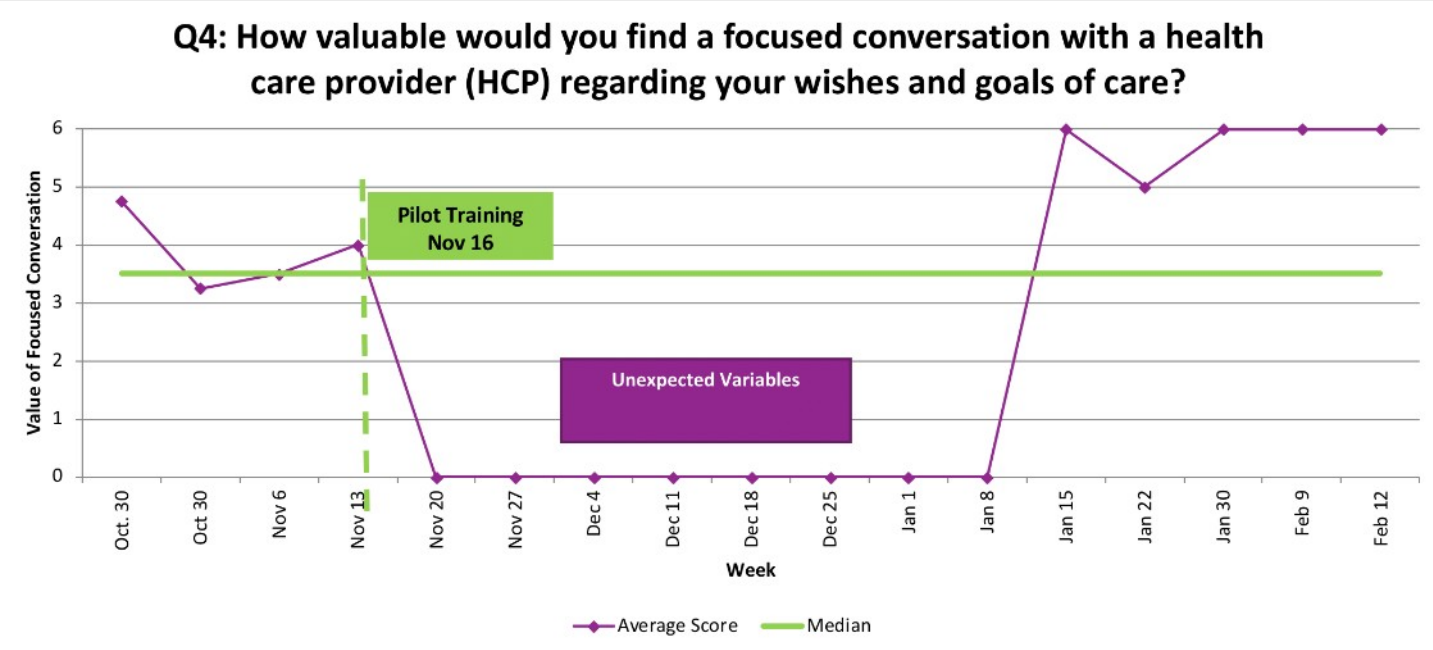
105% client satisfaction improvement

Client Satisfaction Results



57% client satisfaction improvement

Client Satisfaction Results



50% client satisfaction improvement

Impact

IMPACT

Client/Family Impact

- Increase in Advance Care Planning conversations with high-risk clients
- Clients had the opportunity to express their wishes and felt more prepared and supported in developing their Advance Care Plans
- Clients expressed their satisfaction regarding the value of having Advance Care Planning conversations with their health care professionals

Staff Impact

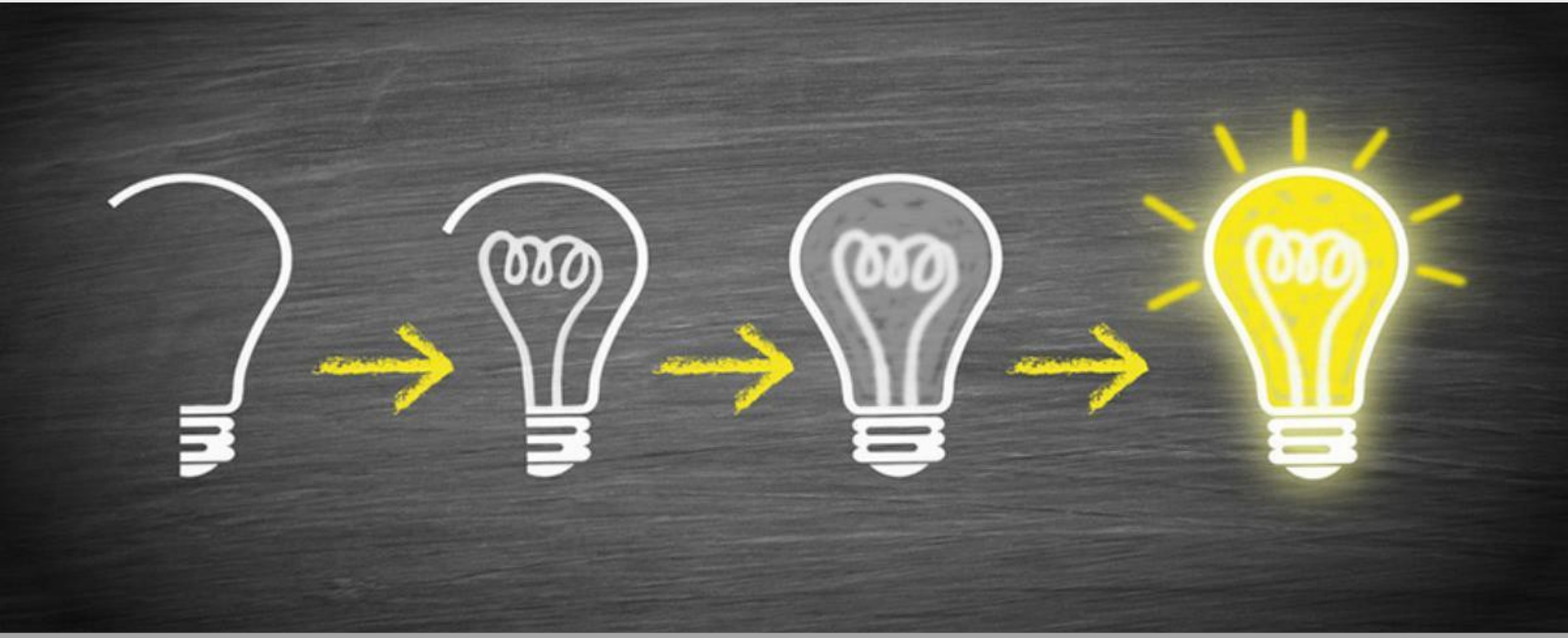
- There was a marginal improvement in staffs' understanding of ACP conversations and a significant improvement in clinical practice relating to ACP conversations
- Staff had a better understanding of how to apply ACP conversations with clients and families
- Staff felt significantly more confident in their ability to conduct ACP conversations with their clients and families

Challenges

CHALLENGES

Project Challenges

- Steep learning curve for the entire team
- Changed topic mid project due to lack of provincial approval for innovative joint replacement program
- Competing operational priorities
  - Awarded Vancouver Coastal Health Palliative contract during the "unexpected variable" period
  - Loss of key team members
- Sufficient internal resources
- # clients who were not able to participate in project and required a proxy



Lessons Learned

	Lessons Learned	
LESSONS 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
	Planning	• Emphasis on getting it right versus wanting to get the job done • Test small pilots and apply lessons learned earlier in the project
	Scope	• Don't bite off more than you can chew
	Communications Strategy	• Face-to-face staff meetings more effective than teleconferencing and online newsletter project updates
	Leadership and Staff Development	• Coaching sessions critical • Rotating chairs is beneficial • Best results when broad methods of training used (classroom, shadowing experts, and bedside)
	Time and Resources	• Under estimated the time required to deliver a quality product—allocate more time

APPLICATIONS AND BENEFITS

Learning Application	
QI Tools	• Learn how to apply the Pareto, fish bone, run charts, process mapping, etc.
Measurement and Analysis	• Learn how to establish measures and analyze results and tweak for improvements i.e. run charts
Benefits of the Project	
Best Practices	• Align care with best practice standards
Leadership and Team Development	• 1st opportunity for management, clinical services and scheduling teams to work together on a project • Gained a vast amount of knowledge with respect to ACP and participating in a national project
Network of Experts	• Developed a network of experts across Canada to help elevate the standards of our services

Next Steps

NEXT STEPS

Next Steps

1. Develop a standardized tool in the EHR that records clients' wishes, values, and beliefs
2. Continue to develop a framework with ACP to include Serious Illness Conversations and targeted Goals of Care
3. Incorporate ACP conversations with all complex clients who receive nursing services
4. Celebrate milestone!

Wave 2 Home Care Collaborative

Delivered in partnership and collaboration with:

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

Canadian Home Care Association
canadienne de soins et services à domicile

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Improving & Driving Excellence Across Sectors

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