a safe model for HOME CARE

designing a hospital without walls

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INTRODUCTION

More than 1.8 million Canadians receive publicly funded home care services;[1] the majority of these individuals are seniors.[2] The seniors' population in Canada has grown exponentially, with the proportion of seniors now surpassing that for children for the first time ever. The seniors' cohort is expected to continue to grow. And yet, we only spend a meagre 5% of total public health care spending on home care.[3]

In 2013, the results of a pan-Canadian home care safety study[4] were published, which involved five simultaneous studies, including one examining the experiences of home care recipients and providers in British Columbia, Manitoba and New Brunswick. The results from B.C., Manitoba and New Brunswick highlighted many commonalities between provinces. For example, everyone who was interviewed spoke to the value of home care and expressed their desire to remain in their homes. Among the three provinces, B.C. and Manitoba clients expressed a lack of confidence in home care's commitment to supporting them to remain in their home for as long as possible, and dissatisfaction with the lack of continuity of care providers. With no primary health care provider who would have a true sense of their needs, conditions and context, and a different person arriving each day, with scarce knowledge of their medical history, clients in B.C. and Manitoba expressed reluctance to disclose their actual needs out of fear of having to leave their home. In contrast, the New Brunswick model of home care comprised of an integrated multidisciplinary team of professionals stood out because patients and families repeatedly explained they were assigned one 'primary' care provider (usually a nurse) who worked with them for all home care coordination. They believed the goal of home care was to help them remain at home. Given the success of this model, it is important to identify the elements that contributed to New Brunswick's positive reports. As all provinces consider the best way forward, it is important to consider best practices in home care that exist in Canada and internationally and fund home care models that are proven to provide the best economic and health returns.

SAFETY AT HOME: A PAN-CANADIAN HOME CARE SAFETY STUDY, 2013[5]

Purpose: To determine the nature and incidence of adverse events/safety problems in the home care setting

Methods: involved five simultaneous studies, including a systematic review, database study, chart review, sentinel event audit, and interviews with home care clients, family members and health care providers

Description of adverse events

- Main types – falls, medication-related incidents and infections
- Main subjects of incidents - most vulnerable clients with several debilitating conditions and high levels of dependence
- Direct association with an increase in the odds of death - delirium, sepsis and medication-related incidents

Assessment of home care services

- Inconsistencies in care planning and delivery
- Lack of integration of home care teams, lack of coordination across sectors and communication failures

RESULTS

Adverse events – by the numbers:

- Incidence rate – 10%
- Preventable – 56%
- Increased use of health care resources – 91.4%
- Led to disability – 68.8%
- Led to death – 7.5%

THE NEW BRUNSWICK MODEL: OPTIMIZING NURSING, OPTIMIZING INTEGRATION OF CARE

Elements

- Interprofessional team – nurses, respiratory therapists, physiotherapists, occupational therapists, dieticians, socials workers;
- Nurse assigned as primary care provider for most new clients and families and providing on-call services 24/7; other professionals may serve as a primary care provider based on assessed need;
- 24-hour contact information for home care service with 'primary' available as 'go to' person in case of questions or concerns;
- Stated goal of service: to help clients remain in their homes

"I have one regular person who visits, every six months they change over, but I know the new ones because they have come in when my regular (PCP) has vacation and days off. They have it all written down. They know exactly what I'm taking for medication, when I started and when I stopped, and when I got the first antibiotic. They've got my whole history. And they're talking between each other."

CONCLUSION

Nursing and home care are synonymous. Nursing has a 120-year history of home care delivery in Canada. Last year, 10,716 nurses, or 3.0% of the regulated nursing workforce engaged in direct care, worked in home care.[6] However, unregulated health care workers still deliver the majority of paid home care services (70-80%)[7] involving instrumental activities of daily living such as bathing, dressing, ambulating and housekeeping. There are also 8 million Canadians, or over one quarter of the population (28%), providing unpaid home care services[8] estimated to be worth over 25 billion annually.[9]

The health care system's demand for home care has risen year over year,[10] requiring the care of clients with increasingly debilitating and chronic conditions, taking multiple medications and requiring skilled assessment, coordination and delivery of care. The integration and coordination of services is foundational to an efficient and effective delivery of services. Further, the millions of unpaid caregivers in Canada are a valuable asset that requires the support and education of skilled professionals. Nurses are best positioned to provide education and support in a primary care provider role to caregivers. The increasingly essential role of managing, planning, integrating, coordinating and employing one's

clinical judgement required in direct home care can only be provided by nurses with the formal education, skills and expertise to meet the needs of an increasingly complex home care client population. We need to maximize the role of nursing in the home care sector, not introduce additional ancillary personnel.

The evidence is clear that, in hospital settings, increases in nurse staffing (RN & LPN) lead to improved patient outcomes, decreased adverse events, and reduced lengths of stay, without an increase in patient care costs.[11] The same argument could readily be made for clients in the home care sector. Although studies examining the optimal nurse-to-client ratio in home care delivery have not been conducted, it is likely that parallels can be drawn with the work completed in the hospital setting. Increasing the ratio of nurses to home care clients – thus providing for the appropriate assessment of home care clients – would reduce the presence of adverse events, including delirium, sepsis and medication-related events, known to contribute directly to client death.

Continuity of care is known to reduce the risk of adverse events and contribute to the delivery of safe care in the home, as well as enhancing the comfort and confidence of home care recipients.[12, 13, 14, 15, 16] To ensure continuity in home care, clients should be assigned a nurse – as in the New Brunswick model – to act as cross-sector case manager with the authority and responsibility to ensure the planning and delivery of a consistent quality of safe care. Further, as noted in New Brunswick, interdisciplinary health care teams, involving both clients and caregivers, ensure that clients have seamless access to required health care services. Communication between sectors and across disciplines is a priority to ensure the client's medical needs are understood and a collaborative response is undertaken.

The economic rationale for nurse-led models of community care in home care settings is supported by a systematic review of nursing intervention literature. The review found that nurse-led models of care are most effective and equally or less costly than usual physician-led care. The review authors point to the need for care that is "nurse-led, proactive, team-based and comprehensive, as well as based on a supplemental managerial model of continuity of care,"[17] where the nurse enlists all the health and social services to augment the client's health. This nurse-led model would provide all the criteria for a high-quality primary care system: "accessibility; continuity; coordination; comprehensiveness; health promotion; secondary disease prevention; and chronic disease management, while allowing for greater patient impact and controlling system costs."[18]

Research, and New Brunswick's experience with home care, support the case for investments in nurse-led home and community care models that provide the best economic, social and health returns, while safeguarding patient safety.

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