Responsibility for Canada’s Healthcare Quality Agenda: The Home and Community Sector

COMMENTARY

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ABSTRACT

In their study on the current state of the quality agenda in the Canadian healthcare system, Sullivan and colleagues interviewed healthcare leaders across Canada who predominantly represent the hospital care sector. The home and community sector is under-represented in research and discussions about quality and patient safety, despite the fact that it is the fastest-growing sector in healthcare. Patient safety research in home care has been spearheaded by VON Canada and the Canadian Patient Safety Institute since 2005. Quality and safety are not just parallel imperatives; rather, they are inextricably linked concepts that rely on each other to function effectively. Safety for clients or patients is complex when multiple organizations, regulated and unregulated paid providers and unpaid family caregivers make up the team providing care in an uncontrolled home environment. Add to this the pres-
The home and community sector is growing in importance as hospital stays grow shorter, as people live longer with chronic diseases and as the focus shifts from acute, episodic care to care across the lifespan. People live, get sick and get better in communities. Hospitals, physicians and health providers are part of a system that exists within communities. In community care, professionals quickly become aware that the client is the centre of care and that, as providers, they are simply passing through someone’s life. In institutional care clients are the guests, whereas in the community the paid care providers are guests in the clients’ life and home. The term patient is not used in the community; instead client is used, denoting a customer orientation.

In their study on the current state of the quality agenda in the Canadian healthcare system, Sullivan et al. (2011) interviewed healthcare leaders across Canada who predominantly represent the hospital care sector. The home and community sector is a smaller part of the Canadian healthcare system from a government-funding perspective. As a result, it receives less attention and notice from governments, quality councils and researchers. The purpose of this paper is to provide a response from the home and community care sector to the research on leadership viewpoints regarding the quality agenda, completed by Sullivan et al.

Sullivan et al. reported that provincial quality councils are a positive step, that patient safety is now viewed as a necessary part of a quality system and that efficiency improvements are being pursued in many provinces and institutions. Quality and efficiency emerged as the parallel imperatives in all provinces and internationally. Who is responsible and accountable for quality is an area of concern for many at local, provincial and national levels. Increased pressure for quality is being driven by three factors, namely: “(1) a move to person-centred models of care delivery in which individual needs and expectations for participation in health are given primacy; (2) the need to contain and reduce costs in healthcare delivery, duplication of services and process inefficiencies; and (3) the need to improve patient safety.”

Quality and Patient Safety in the Home and Community Sector

Quality and safety are not parallel imperatives; rather, they are inextricably linked and rely on each other for success. National and international literature have identified patient safety as a healthcare issue requiring immediate attention. Home care is the most rapidly growing segment of the Canadian healthcare system; yet, overwhelmingly, research on patient safety has been conducted within institutional settings, resulting in a significant knowledge gap about safety in home care.

VON Canada recognized this gap and in collaboration with the Canadian Patient Safety Institute (CPSI) spearheaded a number of initiatives. Together, in 2005, these organizations commissioned the development of a background paper that initiated a national roundtable dialogue on systematically identifying the key issues in home care safety and developing a research program to fill in significant gaps in our understanding. The report, titled “Safety in Home Care: Broadening the Patient Safety Agenda to Include Home Care Services,” highlighted the need to view
safety through a new lens in order to attend to the complexity, multi-dimensionality and distinctness of home care safety compared with institutional care safety, while addressing the importance of continuity across the continuum of care (Lang and Edwards 2006). This foundational portrait formed the basis for the work that CPSI is doing in home care safety. It prompted the establishment of a CPSI Core Safety in Home Care Team to investigate and increase understanding of home care safety. This core team conducted an environmental scan of the state of knowledge regarding safety in home care in Canada, and most recently secured an unprecedented number of partners to fund Safety at Home: A Pan-Canadian Home Care Safety Study.

Linking Safety with the Client, Family, Caregiver and Provider

Caring for individuals with chronic illness in their home is inherently complex. There has been an augmentation in the medicalization of private homes, resulting not only from the escalating threshold for hospitalizations but the increasing acuity of patients at the time of discharge. This transition has been facilitated by an explosion in “hospital at home” services and the increasing availability of mobile technology (i.e., peritoneal dialysis and hemodialysis, long-term intravenous catheters and oxygen/inhalation therapy; Williams 2002). Furthermore, the physical environment, family dynamics and the cognitive and physical abilities of the client and caregivers are other essential factors to be considered when delivering services. Caregivers are often elderly and contending with their own health challenges. They often lack sufficient sleep as they provide around-the-clock care. This is in stark contrast to the institutional scenario, where two or three shifts of professionals provide care. Family and caregivers often make promises out of love and a sense of responsibility to keep loved ones at home, without being aware that this objective may be beyond their capacity (Stajduhar 2003; Stajduhar and Davies 1998). Thus, the quality of care and safety of clients cannot be attended to without including the family members, unpaid caregivers and paid providers in the equation (Canada Health Council 2008; Harrison and Verhoef 2002; Lehoux 2004).

Healthcare providers vary greatly in their abilities. Lay people, who increasingly represent a growing proportion of caregivers, demonstrate even more variability. Their performance and the safety profile of the care they provide are often compromised by noise, poor lighting, heat, dirt, improper cleaning products and moisture. Stress and fatigue, in addition to their lack of preparation and education to manage an array of medications and treatments, can also degrade performance over time. Caregivers’ performance is directly influenced by the operating characteristics of the equipment or medication involved (Macdonald et al. 2011).

The unique nature of private homes and communities as well as the multiple interrelationships among clients, family, unpaid caregivers and home care staff constitute a complex socio-ecological phenomenon. Providers can engage clients and families in conversations and collaborate with them to mitigate risks; but the nature of the home setting requires clients and caregivers to regularly exercise autonomous decisions in the context of minimal professional supervision as well as frequently strained or absent home and community supports (Lang and Edwards 2006).

Family caregivers provide more than 80% of the care needed in the home, causing them physical, emotional, social and financial challenges. When the needs of caregivers are not clearly understood and supported, home care clients end up institutionalized at an earlier point in their illness trajectory (Canadian
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Home Care Association 2008). Quality and safety in home and community care cannot be addressed or improved without recognizing and attending to the family and caregivers who provide the lion’s share of the care. The issues of accountability and responsibility for healthcare outcomes become complex when much of the team is composed of unpaid family members.

People-Centred Care
Consistent with the increased pressure for high-quality care is a growing desire for people-centred care (Sullivan et al. 2011), strongly driven by the delivery of care in people’s homes. Client-centred care is an approach that actively involves the clients in decision-making about their care; this client empowerment is in contrast to the power imbalance seen in provider-centred models of care. Family-centred care is the purposeful inclusion of family members in decision-making related to client care (Kyler 2008).

Client participation is increasingly recognized and advocated as a key component in the redesign of healthcare processes to improve patient safety (Harrison and Verhoef 2002; Longtin et al. 2010). Entwistle (2007) noted that certain interventions to support patient involvement in patient safety are not only justified but ethically required. The meaningful engagement of patients and their families/caregivers in patient safety supports the development of respectful relationships, open communication and empowered patients and family members (Hovey and Paul 2007).

To date, efforts have not focused much on the client experience, and certainly not on the family/caregiver experience, beyond asking what was good and what was not. Questions have not been asked to find out details of what their experience was or should be (experience being different from attitudes); this information could systematically be used to co-design services with clients. Clients are the experts on the experience of being a client, on how it feels to be ill and on what they need. Family members and unpaid caregivers who provide the majority of care at home are the experts on caring for their patient as well as their own needs to remain healthy and productive.

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Many organizations would report that they are doing well in family- and client-centred care. In reality, however, clients are rarely consulted about program design, few organizations have client advisory committees and fewer still have client advisors for every change they make in care services. The concepts of client- and family-centred care are in sharp contrast to how healthcare organizations have traditionally operated and require a significant culture shift. The concepts are “soft” and are mistaken as easy to achieve. A growing body of evidence is linking improved patient- and client-centred care with better health outcomes. The Institute for Healthcare Improvement identifies five drivers of an exceptional client experience; leadership, engagement of staff hearts and minds, respectful partnership, reliable care and evidence-based care (Balik et al. 2011).

Involving clients, family members and caregivers in the design of care processes and in the development of care plans, and listening to their feedback as a way to boost improvement in organizations takes strong leadership – in healthcare organizations accustomed to a paternalistic approaches to knowing best what the clients need.
Community care access centres (CCACs) in Ontario have embarked on measurement of the client experience as a key performance indicator for care organizations providing services. In future, these results will be available to the public. When the healthcare consumer can shop for the best healthcare organizations, not only for the best clinical results but also for how they treat patients and families, organizations will be motivated to change. The CCAC survey tool provides comparable data by using standard questions, and the results can be compared with international data and other healthcare services (CCAC 2010). The new survey tool has allowed VON Canada to identify areas for change and to target training and service delivery improvements to address the areas of greatest impact to the client experience. An emerging body of research and best practice about client and family experience improvement is available to help organizations such as VON Canada to pave the way to better care. VON Canada is leading the way in establishing exceptional client experience as a key performance indicator in its strategic plan.

Although measurement of client experience by CCACs is an encouraging direction, it falls short of clients, family members and caregivers being involved in the design of care processes and it does not deal with the complexity of multiple providers working with unpaid caregivers in the delivery of home care. “Nothing about me, without me” as an underlying paradigm is still an emerging concept that is getting attention but is still far from being practiced routinely in home care (Balik 2010: 2). Future directions should involve all partners in the delivery of care, including clients and caregivers, redesigning processes together with a focus on the care delivered to the clients.

Reducing Costs and Increasing Efficiency

Ironically, while the healthcare system still has an unacceptable error rate, this industry has risings costs. The study by Baker et al. (2004) put patient safety on the agenda when it found that 7.5% of patients admitted to acute care hospitals experience one or more adverse events. The error rate in healthcare is at $10^{-2}$, whereas the aviation and nuclear industries achieve rates as low as $10^{-6}$. The healthcare error rates are not consistent with a high-reliability industry, and such errors increase costs (Evans et al. 2006). Trends show that healthcare costs are increasing at an unsustainable rate. Ontario has been growing the healthcare budget at a rate of 7.7% per year, from $21.2 billion in 1999 to $45.2 billion in 2009, while the tax base in the province is being eroded (Ontario Association of Community Care Access Centres et al. 2009). The situation is similar in every province in Canada, with the cost of healthcare taking up 42% of provincial budgets. Costs continue to rise, with an aging population, chronic diseases and the increasing use of new treatments and drugs (McKenna 2011, February 27). With little understanding of healthcare except the rising costs, politicians of all stripes ultimately cut budgets and tinker with payment systems, with little lasting effect and no real solution to the problem.

Few who work in healthcare would describe the industry as efficient or effective. Healthcare is behind in terms of computerization of the clinical record, making it difficult to quantify and manage clinical care. Healthcare is an information industry, and without the necessary tools to manage that information there is little hope of efficiency. Healthcare has relied on the individual practitioners’ competence and knowledge as the major quality control mechanisms. With the information revolution, individual practitioners cannot keep abreast of all changes in treatments, and every practitioner has a slightly different knowledge base to work from. As a
result, care delivery is not consistent or reliable, and the error rate in healthcare remains unacceptably high compared with other industries (Evans et al. 2006).

An emerging trend of looking to other industries for guidance on approaches is occurring in the United States, Great Britain and Canada. One organization in the United States, ThedaCare, has been on a remarkable journey using the knowledge of Lean methodology from Toyota. What it has discovered is that “a different kind of healthcare is possible – care that is patient focused, with less waste and cost and better medical outcomes” (Toussaint et al. 2010: 3). The outcomes ThedaCare has achieved speak for themselves: improved health outcomes and reduced costs. It has focused on the science of healthcare rather than the art, on the experience of care from the patients’ perspective and on the process of steps in healthcare delivery to reduce waste, increase ease of work and remove barriers. These changes require knowledge, leadership and a culture shift in order to succeed. VON Canada is taking initial steps to introduce Lean processes to the organization to address a specific challenge. Lean methodology is a new paradigm and tool set in healthcare. We believe learning can occur as people use the Lean methods to solve real problems and that capacity building can result.

Conclusion
At the heart of patient safety and efficiency in home care are the client and the family. What appears to link the concepts of quality, safety and efficiency is an exceptional client experience. Is it possible that by becoming truly client and family centred we can also achieve safer healthcare and lower costs for all involved? Leadership is critical for quality improvement and patient safety – leadership that truly engages and respects those who deliver and receive care. Leadership that puts the tools in their hands to solve the problems, address the challenges and create the efficiencies will lead the organizations that lead the way in quality and patient safety. Mitigating the risks and reducing error and waste while streamlining care delivery and improving safety for all are possible by involving the patients and clients, families, caregivers and front-line staff directly in the design of healthcare delivery.

References


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