SAFETY at HOME
A Pan-Canadian HOME CARE SAFETY Study

POLICY BRIEF

CASE MANAGEMENT IN HOME CARE

KEY MESSAGE

THE SAFETY AT HOME STUDY DETERMINED THAT THE RATE OF ADVERSE EVENTS (AE) IN CANADIAN HOME CARE CLIENTS WAS 10 – 13%, OVER A PERIOD OF ONE YEAR. OF THESE, OVER HALF WERE DEEMED PREVENTABLE. THE STUDY DETERMINED THAT THE MOST FREQUENT CAUSE OF ADVERSE EVENTS IN HOME CARE WAS INCONSISTENT PLANNING AND DELIVERY OF CARE.

Other gaps that contributed to these adverse events were: the lack of an integrated interdisciplinary health care team; poor standardization of processes; packaging of medication and equipment; and client choice and independent decision making.

A common case management role may mitigate some of these contributing factors. Indicators to identify home care clients requiring case management should be developed and standardized nationally and clients requiring this should be identified early in the referral process.

Organizations such as the National Case Management Network of Canada and the Canadian Home Care Association could play an important role in standardizing core competencies, standards of practice and role functions and education of home care case managers.

BACKGROUND

The National Case Management Network of Canada defines case management as a collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. It supports client safety within a complex health, social and fiscal environment.[1]

The quality and efficiency of any process is dependant on the successful coordination of its variously skilled participants.[2] This can be a challenge within the Canadian home care system where there is significant variation in the structure and policies related to home care across the country. Furthermore, many provinces and territories contract out a portion of their home care services to a variety of private agencies,[3] so that a number of different care providers from different agencies can be present in the home. This creates enormous coordination and communication challenges.

Across Canada, case managers are primarily used to assess eligibility and order services. Case management is not generally well understood or defined, leading to significant variation in the role occuring across regions and provinces.[4] In practice, it is often left up to the client or caregiver to relay communications between care providers or seek out services and make arrangements themselves.[5]

As a result, when problems arise there can be ambiguity regarding which health care provider has the responsibility and authority to act.

A 2008 Ontario study of front-line home care providers reported that more than one quarter (27%) of respondents were not satisfied with the information provided to them before their first encounter with a client. In particular, there was a persistent lack of information about a patient's medical history. Almost two-thirds (65%) of regulated health professionals reported having to ask clients to repeat some or all of their health histories, and a quarter (25%) had to repeat an assessment or test. More than one third (34%) reported relying on clients to relay information to other providers.[6]

The Safety at Home Study interviews with clients and caregivers revealed that many of the safety issues identified were related to home care system design, slow administrative processes, shortages of staff and equipment, and poor communication that led to a lack of continuity and coordination of care.

RECOMMENDATIONS

1 *Support organizations such as The National Case Management Network of Canada and Canadian*

Home Care Association in developing common case management competencies, standards of practice and educational requirements for case managers in home care.

A common understanding of the case manager role and function can enhance coordination of care, communication and effective use of resources. Enhanced coordination and communication could reduce adverse events experienced by home care clients. The Safety at Home Study results suggest the role of the case manager should be highly visible and hands-on with standardized, clearly defined role functions and accountabilities. Case managers should have the authority to act as "quarterbacks" within the system. They would be responsible for interdisciplinary and inter-sector liaising and ensuring that all new information at the interface of care is delivered to all decision-makers as required. They would also be accountable for monitoring care continuity and establishing reliable communication pathways including expanded mobile access to a case-manager 24/7. They could also facilitate frank and open dialogue between clients, families and their cross-sector care providers to determine and clarify care expectations.

2 *Identify clients who would benefit from case management early in the home care referral process.*

Not all home care clients require case management. The adverse event risk factors identified in the Safety at Home Study could be used in a pilot to assess their usefulness in identifying clients who could benefit most from case management. Once this population of home care clients is better understood, case management eligibility criteria and caseload benchmarks could be created.

3 *Assign to home care clients a designated case manager with the authority and responsibility required to ensure the planning and delivery of a consistent quality of care.*

In Canadian home care, there is an assumption that case management is a strategy used by all home care providers. In reality, clients are surrounded by a variety of service specific care managers, case managers, care coordinators, nurse managers, supervisors etc. Without a single designated individual to assume responsibility, the potential for error (or to miss error prevention opportunities) is high. A single member of the client's team should be identified based on the client's needs, who would then formally agree to take on this critical role. Structures and processes should be put in place to support the designated case manager.

4 *Implement reliable, standardized, closed loop communication processes, especially at transition points between acute care, home care, primary care and community pharmacy.*

Electronic health platforms and smart technology that can enable communication between systems would support more effective communication through the use of transition checklists based on best practices and trigger requirements for various assessments or other interventions to be done at certain intervals or after certain events (and be tailored to local requirements). This use of automated alerts and electronic tools has been shown to minimizing the potential for human error.[7]

REFERENCES

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