ADVERSE EVENTS AND CHRONIC ILLNESS 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 per cent, over a period of one year. Of these adverse events, over half were deemed preventable.

Clients who have chronic or unstable diseases such as congestive heart failure (CHF), dementia and diabetes are at a higher risk of experiencing an adverse event. Home care clients with chronic or unstable disease are at the highest risk of experiencing an adverse event with significant consequences, and would benefit from enhanced and standardized screening, cross sector collaboration and enhanced case management.

BACKGROUND

There are several reasons for the increased risk of adverse events in chronically ill clients: they are complex clients, often with co-morbid conditions, and they often receive more services. In addition, the burden of illness can make it difficult or impossible for them to receive adequate primary care, either because they are homebound or because primary care providers will not accept clients with chronic disease.

Previous research also notes the following:

- Heart failure is a leading cause for hospital admissions for seniors in the US and Canada, with one million seeking emergency care annually in the US. These patients are known to have high rates of re-admission and other serious AE on discharge.
- 30% of COPD patients discharged from hospital relapse within 8 weeks requiring re-admission.
- 25% of patients discharged after hospitalization for depression were re-admitted or visited an emergency department within 30 days.
- A recent Health Quality Ontario report estimated that approximately 21% to 37% of patients with acute exacerbations of COPD who present to the ED may be eligible for home care.
- Cross-sector discharge coordination has been shown to improve discharge outcomes in patients hospitalized with acute exacerbations of COPD.

THE EVIDENCE

In interviews with clients and families the Safety at Home Study authors found that home care tends to be a patchwork of services offered by an ever-changing kaleidoscope of providers. This presents significant challenges to clients and families dealing with chronic illness. Barriers clients and families must overcome include: finding out about the programs that are available; understanding how to apply for service; and coping with wait times for equipment, therapists and various support workers.

Clients with COPD sometimes require home oxygen. In some provinces the home care program provided fully-funded oxygen concentrators to supply their needs at home; however, their supply of the portable oxygen cylinders they required to get out of their home for appointments was limited to two a month. That limitation left clients feeling trapped in their homes or forced them to go without the oxygen they required; this can lead to oxygen deficiency, dyspnea, and in extreme cases, loss of consciousness – and therefore falls.

Safety at Home Study also found:

- Home care clients with dementia and CHF had the highest rate of fall related injuries; falls in turn increase the risk of long term care placement.
• Rates of medication related adverse events were highest for diabetes, CHF and COPD clients.
• Dementia and CHF clients had the highest rates of caregiver distress.

RECOMMENDATIONS

1 Assign to home care clients with chronic illness a cross sector case manager with the authority and responsibility required to ensure the planning and delivery of a consistent quality of care.

Chronically ill clients and their families in particular would benefit the most from an enhanced case management role. The consequence of not effectively managing these clients’ needs in the home adds significant costs to the larger healthcare system.

2 Explore opportunities and incentives for collaboration between home care and institutional care including the establishment of integrated, interdisciplinary healthcare teams, which include clients and caregivers as integral parts of the team.

Regional outpatient clinics serving the needs of specific groups of clients (CHF, COPD, diabetes) would be an ideal place to begin to build expanded partnership models. Such initiatives need to be supported by a common electronic chart that is accessible to all caregivers in order to standardize communication and care-plans among disciplines and across sectors, and incorporate individual client “Transition Checklists” and electronic platforms with decision support tools.

3 Encourage the national use of the Resident Assessment Instrument (RAI) assessments to prospectively identify clients at risk (e.g., signs of decline) for adverse events and to provide a basis for ongoing monitoring and evaluation of outcomes.

Clients with chronic illness, and their caregivers, are at the greatest risk of adverse events related to lack of early and routine standardized assessments.

The RAI assessment tools and its MAPLe prioritization system (and the RAI-CHA) should be used to provide information on the level of clients’ needs. These tools evaluate factors such as the degree of physical limitations, cognitive impairment, and behavioural problems. The MAPLe can be used to prioritize clients’ needs and to appropriately allocate home care resources and placement in long-term care facilities.

4 Lift restrictions on the supply of portable oxygen tanks for clients with COPD

Home care systems should ensure an equitable and reasonable level of client independence. Mobility, through access to portable oxygen equipment, can assist COPD clients to stay fit and experience a higher quality of life.

REFERENCES


