Safety and Medication Management in Home Care: Preliminary Findings

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Canadian Association for
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HEALTH STARTS AT HOME
LA SANTÉ COMMENCE CHEZ SOI

Background

- Patient safety is an ongoing health system priority globally, with medication safety revealed as a prevalent, high-risk area of concern.[1-4]

- Roughly 1.5 million preventable adverse drug events occur per year, resulting in a total cost of $3.5 billion (US).[5]

- As many as 1 in 5 Canadian patients admitted to hospital suffered adverse events within 3 weeks after being discharged home.

  - 66% of these were medication related events[6-8]

Background on Safety in Home Care

- Since 1997, the number of home care clients in Canada has increased by 51%.[9]

- However, patient safety research is predominantly focused within institutional settings.

- Little is currently understood regarding the experiences of clients, caregivers and providers managing medication safety in a home care setting.

- VON Canada recognized this gap and in collaboration with Canadian Patient Safety Institute spear-headed a number of initiatives.

Broadening the Patient Agenda to Include Home Care Services [10]

- Six themes for home care safety:
    1. Safety of the client, family, caregiver, and provider are inextricably linked
    2. Unregulated and uncontrolled settings, autonomy, and isolation
    3. Challenges of communication on many levels
    4. Safety is multidimensional (physical, emotional, social, functional)
    5. Diminishing focus on prevention, health promotion, and chronic care
    6. Quandaries of human resources (revolving door) and maintenance of competence

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Safety in Home Care: Focus on Medication Management

- This study addresses a critical gap in our current understanding of medication safety for seniors (>65) within the Canadian home care sector.

- Purpose:
  - To understand medication management within the socio-ecological complexity of the Canadian home care environment

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Research Questions

1. What medication management issues do seniors with chronic illness, their family members, caregivers, and paid providers identify within publicly funded home care programs in four Canadian provinces (AB, ON, QC, NS)?

2. What socio-ecological factors contribute to or reduce the risks of medication management in the home for seniors with chronic illness, their family members, caregivers, and providers in these four Canadian provinces?

3. What strategies do seniors with chronic illness, their family members, caregivers, and paid providers employ to mitigate the risks of medication management at home in the these four Canadian provinces?

4. How do the medication management issues, relevant socio-ecological factors, and mitigation strategies that are identified compare across these four provincial home care programs?

Methods – Phase 1

- Audio-taped, in-depth, semi-structured interviews were conducted with clients, family members and/or caregivers and providers.
    - To capture the experiences, challenges, and insights of participants in relation to managing medication safety in the home.
- Audio-taped, photo-narrated environmental walkabouts with clients, family members and/or caregivers.
    - To capture relevant measures taken in the home for medication management.
- Transcripts and photos were analyzed using Interpretive Description[11] and Human Factors Analysis.

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Methods – Phase 2

- After analyzing and integrating data from Phase 1, we used photo elicitation and photo narration to conduct audio-recorded kitchen-table talks with clients, family members, caregivers and providers.

  ○ Focusing on selected photos and emerging patterns, we have asked participants to share further perspectives and stories on managing medication safety in the home.

Methods – Phase 3

- Following our analyses and re-integration of Phases 1 & 2 data, we will conduct focus groups with 6-8 home care providers from a variety of disciplines (i.e., nursing, medicine, occupational therapy, social work, etc.) to obtain practitioners' perspectives on managing risks and improving medication safety in home care.

- The final analysis will synthesize findings from all 3 phases.

Preliminary ON Findings

- **Having a system in place**
  - Clients and caregivers often have two systems to manage medications; the clients and the caregivers.
  - "Disorganized but organized" system
  - Routines and rituals to manage and remember to take medications

Preliminary ON Findings

- **Medication Concerns**
  - Client adherence
  - Frequent changes in medications
  - Multiple physicians prescribing
  - Client /Caregiver varying knowledge of medications

Preliminary ON Findings

- **Taking on a job**
  - Caregiver roles
  - Client / Caregiver dealing with losses
  - Assumptions of the caregiver's ability
    - "it is not rocket science"

Current State of Project

- AB:
  - 8 HH's complete, 1 KTT's complete
  - 1 KTT remains
- NS:
  - 7 HH's complete, 2 KTT's complete
  - 1 HH remains
- ON:
  - 8 HH's complete, 2 KTT's complete
- QC:
  - 8 HH's complete
  - 2 KTT's remain
- Face-to-face team analysis meeting Sept 2012
- Focus groups estimated to take place Fall 2012 – Winter 2013.

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Emerging Themes and Questions Across Provinces

- **Systems in Place, Routines and Rituals**
  - At what point do we advise (are we allowed to advise) what is safe and what is not?

- **Health and Medication Literacy**
  - How is client / caregiver health and medication literacy assessed? Who assesses?
  - What triggers re-assessment? Are we expecting too much of providers and caregivers?
  - A whole multi-part medication learning module for home care? (one size fits none)

- **Goal Orientated Care**
  - Is the care that's going on explicitly goal oriented? And whose goals are they (client / system)? Are they shared goals? Are goals disparate? How are they evaluated?
  - Does shared assessment reduce a client's autonomy – or does it support it by actively engaging them to look at evidence-informed strategies to support their care?

- **Red Flags Indicating Caregiver Burden**
  - Who assesses competency of the caregiver?
  - Decision to care – when and how does this happen? Are there expected obligations to care or is there distrust of providers coming into the home?

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