Canadian Patient Safety Week

Safer Care for Older Adults

Welcome

Statement of Acknowledgement of Indigenous Ancestral and Territorial Lands

Health services across Manitoba are provided in facilities located on the original lands of First Nations, Inuit, and on the homeland of the Métis Nation. Manitoba's health authorities respect that First Nations treaties were made on these territories, acknowledge harms and mistakes, and we dedicate ourselves to collaborate in partnership with First Nations, Inuit, and Métis peoples in the spirit of reconciliation.

Land Acknowledgement - Shared Health (sharedhealthmb.ca)

Canadian Patient Safety Week

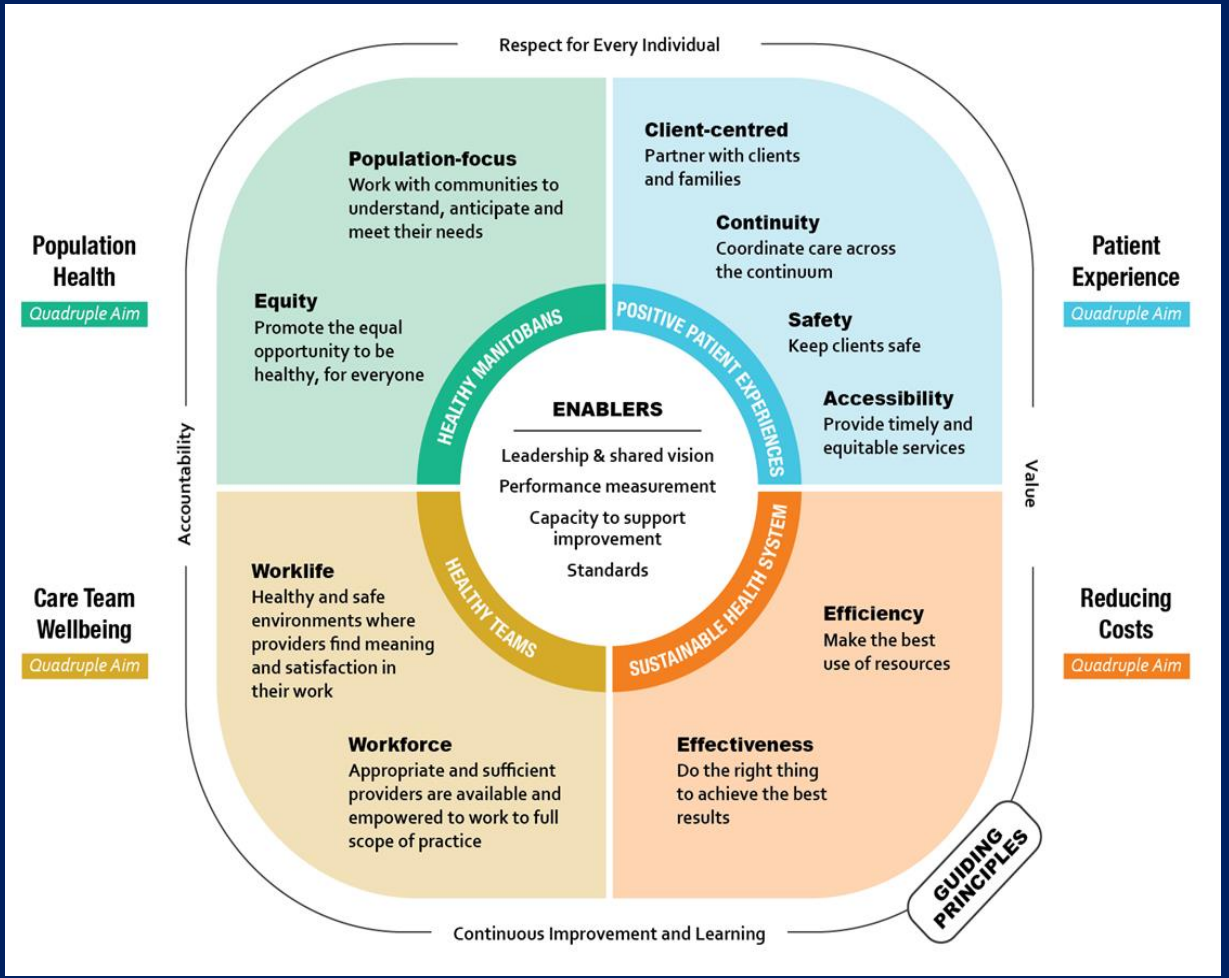
Canadian Patient Safety Week is an opportunity to hear about patient safety improvements across Manitoba and Canada and share resources to improve patient safety and the quality of care provided in Manitoba.

CPSW webpage

Safer Care for Older Adult Provincial Contest

Evaluation Criteria

- The initiative enhanced patient safety by improving safer care for older adults
- Demonstrated intended results (measurement)
- Input from patients and families was utilized
- Innovative
- Connected to the Manitoba Quality & Learning Framework



Canadian Patient Safety Week: Safer Care for Older Adults Provincial Contest Winners

- **WRHA** – Norwest Dental Care Partnership
- **PMH** – Functional Independence Program
- **IERHA** – Silos to Solutions
- **Shared Health** – I've Got 99 Problems But Age Ain't One
- **Cancer Care Manitoba** – Fall Risk Reduction Associated with Weigh-in Procedures
- **SH-SS** – Formal Huddle Implemented with Multidisciplinary Team for Carmen and Starbuck Home Care Offices

Congratulations!

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Safer Care for Older Adults

NorWest Dental Care Partnership

Presented by:

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg

NorWest Co-op COMMUNITY HEALTH

Initiative Details

- NorWest Co-op Community Health Centre partnered with 3 local dental offices to offer free dental screening, hygiene, and restorative care
- Priority care was provided to community members with limited or no dental coverage
- First-time not-for-profit partnered with private practice dental clinics to offer service to clients and community
- Collaborative effort:
  - Dental offices (Sturgeon Creek Dental/Pearl Family Dental/Polo Park Dental)
  - University of Manitoba (volunteer hygiene and dentistry students)
  - International College of Dentists
  - MB Dental Foundation (small grant funding)


ICD
INTERNATIONAL COLLEGE OF DENTISTS


ICD
INTERNATIONAL COLLEGE OF DENTISTS

Patient and Family Engagement

- Community partners and our collaborative, integrated team promoted the service
- Attended resource fairs and community events within higher needs neighborhoods
- Dental screening that had been offered onsite at NorWest Co-op indicated need for follow up care
- Clients and families helped us understand what barriers they encounter regarding accessing dental care

Measuring and Monitoring

- Screening Appointments:
  - 140
- Hygiene Appointments:
  - 46
- Restorative Appointments (extractions, fillings, etc.):
  - 56 (a total of 85 were completed)
- 15 people received partial dentures/complete dentures or reline
- Children’s Dental World Referrals:
  - 5
- U of M Referrals:
  - 2 (not counting those who may have been previously referred from the Spring 2022 screening)

What was Learned?

- Many clients had not visited a dentist in several years or longer
- First-time denture work was offered at no cost
- Many clients would not have had restorative care (extractions, fillings) if not for this initiative
- Some clients were provided more care than expected
- Transportation and childcare were provided for clients requiring that support
- Clients reporting feeling more confidence
- Some clients attending had benefits (through EIA, NIHB), however, were not accessing or did not know how to access/what was covered
  - ** Could be an opportunity area in the future to provide education to the community regarding benefits, etc.
- Some clients who were anxious prior to treatment felt at ease and more comfortable with the dental teams

Q & A and Reflections

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Functional Independence Program

Presented by:

PRAIRIE MOUNTAIN HEALTH

Initiative Details

- The program takes a multi-disciplinary approach to functional independence; including Physiotherapists, Occupational Therapists, and Rehabilitation Assistants.
- Referral sources include Physicians, Home Care, and Primary Care providers.
- Sites offered: Virden, Brandon, Swan River, Minnedosa, Neepawa. (Russell and Dauphin's programs are currently on hold)
- The program is delivered in client homes making it accessible to a wider range of clients. 81% of participants were 70 and older.
- Following assessment, Rehabilitation Assistants provide exercise and education for 8-12 weeks.

- This preventative approach has decreased falls, ER, and Physician visits.

Patient and Family Engagement

- SMART (**S**pecific, **M**easurable, **A**ttainable, **R**elevant and **T**ime Based) Goals are set collaboratively with the patient/client/family.
  - SMART Goals can include tasks of daily living or mobility they want to get better at to stay independent at home.
  - This gives families the opportunity to have a voice and to be part of their loved ones' programming.
  - Patients were also involved in program re-development through survey feedback and interviews.

Measuring and Monitoring

- BERG Balance Scale or FIST (Function in Sitting Test)
  - 57% showed significant improvement in the BERG
- Falls Efficacy Scale (FES)
- Other measures as appropriate such as: Timed Up and Go (TUG)
- Assessment occurs at the onset of the program
- Reassessment at the final session with results shared with the referral source

What was Learned?

- Fewer falls were reported during and after the intervention
  - (69% before, 21% during, and 37% 6 months later)
- Fewer Emergency Room visits were reported
  - (39 visits prior, 1 visit during, and 7 visits post)
- Following intervention, clients were more likely to safely maintain independent living at home.
  - 89% felt they achieved their goals
  - 73% felt they had improved their ability to look after themselves
- 98% of clients said they would recommend the program to others

Q & A and Reflections

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Silos to Solutions

Presented by:

Interlake-Eastern
Regional Health Authority

Initiative Details

- We are proud that we continued service delivery to our older adult population during the pandemic.
  - Due to the rapid increase in COVID-19 numbers, it was necessary to think outside of the box to provide important services in our region.
- Our team worked tirelessly with our funded agencies, providing them with additional funding for IP&C equipment.
- Extensive education was given to the board members and staff regarding contactless delivery methods; algorithms on how to manage symptomatic clients in their homes as well as in the office.
- In addition, education sessions were held regarding AGMPs, COVID-19 transmission, how to conduct a risk assessment, etc.

Patient and Family Engagement

- We received many positive comments from clients via our funding agencies.
  - Families were very appreciative to have received services during the pandemic

Measuring and Monitoring

- By educating our boards and their staff, we were able to bring all agencies back up and running and continue providing services.
- This supported the home care program and caused minimal impact across multiple levels of service delivery programs.
- Through our IP&C protocol education sessions, our funded agency staff were better prepared and informed on how to protect both themselves and their clients when providing services in the home and office environment.
- Education feedback forms were provided to our agency staff to complete, and overall the feedback was positive.

What was Learned?

- There is a need to share information widely and communicate effectively
- Freely sharing knowledge in the spirit of continual learning
- Sharing collective expertise with our funded agency partners and providing the necessary tools to be successful during the pandemic

This sharing of knowledge and information has continued, and we have further education sessions planned to empower our staff and maintain best practices.

Q & A and Reflections

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I’ve Got 99 Problems But Age Ain’t One

Presented by:

Shared health Soins communs Manitoba

Initiative Details

- At any given time, older adults make up the majority of patients in acute care.
- Recognizing there is limited education related to the older adult in acute care this day was organized to address the gap.
- We were able to connect with the site and regional experts who have an interest in, and passion for, the care of older adults.
- Not only would attendees learn about the care of the older adult but also experience what it would be like to be an older adult via a virtual reality exercise

Patient and Family Engagement

- The day was organized by those who have a wealth of experience in working with older adults.

- Patient/family experiences and our encounters with them during their hospitalization provided context to the education provided.

Measuring and Monitoring

- Formal evaluation forms
- Informal feedback from participants was used to determine the success of the education day

What was Learned?

- The day was open to clinicians (n=30) who wanted to know more about caring for older adults in the acute care setting
- Within days of registration opening, all spots were filled, and currently have a waiting list
- This led us to believe that there was a demonstrated demand for this knowledge, and a deficit in available knowledge
- This day filled a gap and served as a pilot for future endeavors

Q & A and Reflections

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Canadian Patient Safety Week

Safer Care for Older Adults

Fall Risk Reduction Associated with Weigh-in Procedures

Presented by:

CancerCare Manitoba
ActionCancerManitoba

Quality Patient Safety Walk Rounds

Keeping Clients Safe

Client: The recipient of care
(patient, consumer, individual, resident, family or support)

Patient Engagement: Building a Culture of Safety Through Quality Patient Safety and Efficiency

WHY:
Encouraging patients to be active partners in their care allows for patient participation in discussions and processes that can help to identify opportunities for improvement in patient safety and/or process efficiencies.

Walk Rounds - We all have a role to play!

*Seeing the same thing differently

Goal:
To identify potential quality, safety and efficiency issues by having a TEAM walk through patient care areas.

Why:
- The tri-lens perspective provides patients, front line staff, and quality personnel different aspects from which issues are identified and acknowledged, and gives recommendations for improvements.
- Accreditation Canada requires partnering with clients and families in processes to improve patient safety and overall quality of care

The Patient Experience

"I think that patient involvement is beneficial to the safety walk rounds."

"It made me feel like I could be helpful to other people having to undergo a difficult process."

"I hope that through my own experience, I can make useful suggestions."

SAFETY TIP!

Providers and patients working together = safe patient and family centered care.

CCMB strives to embed accreditation and quality patient safety into its daily operations with a focus that includes clients and families as true partners in client-centered service delivery.

Delivering Excellence...Everyday

CancerCare Manitoba
ActionCancerManitoba

Client Centered Approach

Share the Story – Spread the Win

Measuring and Monitoring:

ONGOING

Prior to 2022:

- Falls related to chemotherapy foot plate = 5 (post intervention = 1)

Prior to 2022:

- Falls related to weight scale procedures = 2 (post intervention = 2)

What was Learned?

- Team work
- Communication (share/spread the win!)
- Standardization improves patient safety

Q & A and Reflections

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Safer Care for Older Adults

Formal Huddle Implemented with Multidisciplinary Team for Carman and Starbuck Home Care Offices

Presented by:

Background Information

- SH-SS is largely a rural Service Delivery Organization
- Home Care services: 3400 clients out of 19 offices across the region
- Three Regional Centers: Portage HC, BTHC, Steinbach HC have multiple Case and Resource Coordinators, Hospital Based CCs, and Discharge Coordinators
- Weekly huddles were implemented in these sites in 2018 to assist teams to identify the demand for services, prioritization of clients and services, and promoting a team approach to service delivery.
- Smaller communities like Carman and Starbuck have also experienced shortages of Home Care Attendants and Nurses

What We Do

- Throughout the week, CCs and RCs update a spreadsheet kept on a shared HC drive
  - For new referrals, we indicate the date of the referral and what the needs are
  - For existing clients, we note if significant additional care is required
- Weekly meeting via Teams on Thursday mornings for CCs, RCs, and Managers
  - The manager leads the review:
    - What are the priorities?
    - In which communities are the needs and where might we have resources available?

Initiative Details

- CCs/RCs give a short update of the clients on their caseloads
- Manager or designate updates the spreadsheet during the discussion
- As both the RC and CC are in attendance, information can be shared, discussed, and actioned as needed
- Clients that are appropriately resourced are removed from the spreadsheet to keep the spreadsheet up to date
- We seek to keep the huddle short and concise: 30 min or less as we recognize everyone on the team has a lot to do

Patient and Family Engagement

- Clients and families do not attend huddle however; concerns from clients may be shared as necessary by the coordinators if it impacts client care
- Complex client discharges from the hospital are a good example where the huddle is beneficial:
  - CC shares client care needs and proposed discharge date
  - RC shares whether there are potential resource challenges
  - Other items that might be shared are between offices if assistance is needed and the neighboring office is able to lend support

Measuring and Monitoring

This initiative for Carman and Starbuck was implemented in August 2022.

We monitor the following dates:

- The date the referral was received to the date the client was contacted
- The date the referral was received to the date of the assessment
- The date the referral was received to when the care plan was completed
- The date the referral was received to the date of the patient's first visit by HCA

While formal quantitative data has not been analyzed, we have received qualitative feedback from the other regional huddles indicating these weekly huddles have improved patient flow and resourcing times.

What was Learned?

- Importance of information sharing
- Collaboration between disciplines and neighboring offices
- Exploring options in order to coordinate care in a more timely manner
- Keeping management up to date on challenges in respective offices
- Ensuring documentation of requests for services that might be waitlisted
- Allocating resources based on risk and client need

Q & A and Reflections

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Congratulations SDO Initiatives!

If you have any questions, please contact
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