RISK REFERENCE SHEET

Inadequate Care Coordination

Sector: LHIN/Home Health Funder, Homecare

Effective care coordination can reduce service and care interruptions and offer patients/clients a single point of access, information, and referral thereby improving the care for those requiring services at home. Inadequate care coordination is a high-ranked risk for home care service provider and coordinating organizations. When service provision and coordination falls short with inadequate communication, scheduling issues or unanticipated gaps in the plan of service, the impact to patients/clients and their families can be significant.

COMMON CLAIM THEMES

- Complaints from patients/clients and families regarding lack of information about the care coordination process, in particular, ineligibility, disengagement and discharge from services.
- Poor process for same day/urgent referrals.
- Patient/client care plans and services not updated/revised as patient/client needs change.
- Poor patient/client handoffs (communication) between hospitals, care coordinators, placement organizations and/or patients/clients and families during periods of transition and discharge.
- Failure to follow standard notification protocols when adverse events occur.
- Changes to patient/client and family contact information (new and temporary) not kept up to date, resulting in missed appointments.
- Failure to provide adequate oversight of service providers to ensure safe and consistent care is delivered.
- Failure to recognize deteriorating patient/client condition.

CASE STUDY 1

A 75 year old patient underwent triple cardiac by-pass and valve replacement surgery. Arrangements were made for homecare wound management. Planning on staying at his son's house over the holiday season, the patient notified his nurses and care coordinator of his temporary change in address. Despite numerous calls from the patient to the nursing agency, the patient did not receive nursing services for nine days. The patient was experiencing severe chest pain, lethargy and had developed a deep wound infection requiring a four-month hospital admission.

Canadian Case Example

RISK
REFERENCE SHEET

Inadequate Care Coordination

REFERENCES

- HIROC claims files.
- Accreditation Canada. (2015). Health care without home care puts Canadians at risk.
- Canadian Home Care Association. (2012). Health systems integration synthesis report.
- Canadian Patient Safety Institute. (2013). Safety at home. A pan-Canadian home care safety study.
- Harrison A, Verhoef M. (2002). Understanding coordination of care from the consumer's perspective in a regional health system. Health Services Research, 37(4): 1031–1054.
- Hollander M, Prince M. (2008). Organizing healthcare delivery systems for persons with ongoing care needs and their families: a best practices framework. *Healthcare Quarterly*, 11: 44-54.
- National Case Management Network of Canada. (2009). Canadian standards of practice for case management.

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MITIGATION STRATEGIES

Note: The Mitigation Strategies are general risk management strategies, not a mandatory checklist.

Reliable Care Processes

- ☐ Adopt a structured and standardized patient/client intake tool to enable effective screening, prioritizing, and eligibility.
- ☐ Adopt a standardized and validated patient/client assessment tool to identify patient/client goals, priorities, and plans of care.
- ☐ Implement a mechanism to ensure patient/client goals, priorities and plans of care are reassessed and updated frequently (or as clinically required).
- ☐ Provide a consistent care coordinator to support continuity of care and integration of service delivery.
- ☐ Adopt streamlined and standardized processes for:
  - Same day/urgent referrals; (consider the use of an electronic referral service);
  - Prescriptions (particularly high-risk or concerning medications);
  - Supplies and laboratory services.
- ☐ Ensure that patient/client receives and continues to receive the required on-going care when needed.
- ☐ Provide adequate oversight/supervision of service providers to ensure consistent quality care is delivered.
- ☐ Ensure service providers appropriately notify their organization and coordinating organization when a patient's/client's condition deteriorates and/or for adverse events (i.e. falls, not seen not heard visits etc.).
- ☐ Ensure timely interdisciplinary case conferences (including key service providers) take place when working with patients/clients/families with complex care, socio-economic and social situations.
- ☐ Ensure patient/client handoff communication includes review of critical and pending test results, ongoing laboratory test and monitoring, and pharmacy prescription, including medication reconciliation processes.
- ☐ For high-risk medications such as anticoagulants, provide the patient/client with documented instructions citing the dose must be received by a given time and if not received to contact (e.g. the service provider's emergency number).

Patient/Client & Family-Centred Care

- ☐ Ensure patients/clients/families are provided with contact information for the care coordinator or service provider organization; ensure patient/client/family contact information is updated in a timely manner and shared with service providers.
- ☐ Implement standardized mechanisms to ensure patients/clients and families are advised and understand:
  - Their rights and responsibilities;
  - Code of conduct for staff, patients/clients and families;
  - The care coordination process for eligibility;
  - Assessments as it pertains to patient/client care;
  - Their options in the event of ineligibility, premature disengagement or discharge from service.
- ☐ Ensure patient/client/family materials regarding the care coordination process are available in the most common languages spoken in the area with consideration for appropriate health literacy levels.

Documentation

- ☐ Ensure referral forms/templates are completed appropriately and in full; implement mechanisms to ensure critical/time-sensitive patient/client information is highly visible on the referral.
- ☐ Document all attempts to remove/resolve service and support gaps, 'not seen not heard visits', missed and cancelled appointments.

Monitoring and Measurement

- ☐ Implement formal strategies to ensure consistent adherence to the referral procedures through scheduled health records review.
- ☐ Track and review incidents involving inadequate care coordination.
- ☐ Conduct random audits to ensure supplies and medications are included in the appropriate order forms and arrive when required.