

**Moving to a Culture of Safety
In Community Home Health Care**

August 4, 2006

R. L. Stevenson, RN, PhD, CHE

CCHSE Fellowship Project

Table of Contents

Key Implications for Decision Makers/Leaders.....	ii
Executive Summary	iii
Context	1
Implications.....	5
Approach	8
Results	13
Next Steps.....	21
Further Research.....	24
References	26
Appendix I - Modified Safety Climate Survey	30
Appendix II – Chart Review Tool.....	31
Appendix III – Job Observation Tool.....	33
Appendix IV – Risk Identification Form.....	35
Appendix V – Information/Communication Map.....	37

Key Implications for Decision Makers/Leaders

- The emphasis on institutional responses to the ‘patient safety’ agenda derive from and are embedded in assumptions exclusive to acute care hospital settings.
- Within the Community Home Health Care Context ‘patient safety’ and ‘provider safety’ should not be treated as anything other than completely intertwined concerns.
- Employers should examine their current policies/procedures related to safety in community home health care and ensure that they reflect the reality of the day-to-day work of providers. This is best done through regular substantive two-way communication between home care workers and management such that management understands the conditions and issues faced by the home care workers.
- Workplace health programs should be specifically designed for the unique features of the home setting.
- Any changes to practice must be pragmatic and provider-friendly to increase the likelihood of uptake, hence a participatory approach to development, implementation and evaluation is strongly recommended.
- Risk identification is a fundamental ‘triage’ step required prior to the first home visit.
- Incident reporting systems, processes and forms should reflect risks that are specific to the community sector rather than those of acute care. Underreporting may be a reflection of inappropriate tools rather than a sign of ‘safe’ conditions.
- Discharge information processes and content should reflect the safety information needs of community home health care rather than those of acute care.
- An electronic health record in home health care is essential to:
 - capturing magnitude of safety concerns in the community.
 - capturing care plans to mitigate risk.
 - evaluating care plan strategies.
 - mitigating potential for errors in information exchange between individuals and agencies.
 - developing community best practices in relation to risk.
 - enhancing communication regarding safety issues.

Executive Summary

The Intervention Project (IP) conducted as part of the CHSRF EXTRA program focused on exploring the concept of safety in community home health care in one health care authority in British Columbia. The exploration was conducted in four phases and focused on answering the following questions:

1. *What constitutes safety in community home health care in Fraser Health Authority (FHA)? What are the priority areas for action in relation to safety?*
2. *What is the current culture of safety in community home health care in Fraser East?*
3. *What information contributes (positively and negatively) to the safety of clients and providers when clients are discharged on Fridays?*
4. *What type of risk identification would be most helpful to community health workers to prepare them adequately to meet their clients' and their own safety needs?*

Interrelationship between client and provider safety:

Typically studies related to safety in acute care have focused on medical errors and strategies for recognizing and ‘catching’ them before harm to patient occurs. The evidence gathered in this IP strongly suggests that safety in the context of community home health care must take into consideration both providers and clients. Considerations include home environment, family, socioeconomic status, type of worker (nurse, physiotherapist, home care worker) and so on. The staff who participated in focus groups, interviews, work groups and the pilot study all confirmed the inter-relationship of their own experiences of safety and those of their clients. In the words of one, “If I don’t feel safe, then I can’t

attend to the safety of my clients.” The staff illustrated this strong inter-relationship by providing many examples such as:

- Home environmental issues that put clients at risk for falling also put providers at risk for musculo-skeletal injuries.
- Absence of access to a telephone in the home puts both provider and client at risk.
- Neighborhoods where staff felt uneasy due to high crime rates, drug trafficking etc., posed risks also to clients many of who were vulnerable due to illness and/or age.

Therefore strategies to mitigate risk for providers also have the strong potential to positively impact client risk/safety.

Risk Tolerance amongst Care Providers

Home health care providers were well able to identify the safety or risk issues in community home health care. The safety climate survey showed that the participants in this project felt well supported by the organization and that there were mechanisms in place for them to bring concerns forward and have them dealt with. The staff had many examples of risky situations for both themselves and their clients but provided very few examples where they had made the decision not to make a visit. Seldom during the focus groups or interviews or work groups did the staff identify under which circumstances that the risk or safety issue would be considered too high to make a home visit. The examples cited were very dramatic such as guns in the house, or known grow op houses, and even then these were off-set by many other examples when they had decided to visit as ‘if we didn’t visit who would look after them?’

Staff tended to rely on the ‘way things are done’ in a particular office rather than on the health authority wide policies/procedures that were available to guide practice. This high tolerance for risk and lack of clarity of what an acceptable range of risk might be, places both providers and staff in a vulnerable and potentially unsafe situation. Leaving the identification of risk up to each individual’s personal perspective does not provide the safe guards that are required to ensure that staff are not unwittingly putting themselves in harms way in the name of providing care.

Information Requirements

The IP illustrated the gap in information flow/processes that occurred from the acute to the community sector. Referral information was not completed and was not sensitive to the safety issues that are home-centric. Chart reviews revealed inconsistencies in the way in which risk was identified, planned for and evaluated. Many types of assessment tools had been developed but were not being used. The Community Health Workers (CHW) frequently visited clients with minimal information to indicate the presence or absence of risk/safety concerns.

A short ‘provider-friendly’ tool developed by a working group of staff and managers proved useful in the identification of risks and provided a ‘cue’ or ‘trigger’ to staff, supervisors and case managers that a more in-depth assessment was necessary. The process also provided a mechanism for the CHW to provide feedback to their supervisors when situations in the home change from safe to unsafe. The tool also provided a first step to identifying the types and magnitude of safety/risk in the home health care sector.

Key Implications for Decision Makers/Leaders

The unique features of home health care must be considered in the development, implementation and evaluation of any quality and safety initiatives in this sector. The traditional acute care approaches to safety are not well aligned with the realities of community practice. Leaders must be cognizant of the challenges facing staff that deliver care in clients' homes and ensure that there are mechanisms in place to mitigate risk to both providers and their clients. Involving staff in creating mitigation strategies is one method of ensuring that practices will change and be sustained after initial implementation has occurred.

Context

Safety is very topical in health care today. Many studies, activities and initiatives are focused on improving the safety of patients/clients/residents. The Canadian Council of Health Services Accreditation (CCHSA) indicates in their new safety standards that creating a culture of safety in organizations is one of their priorities.¹ A culture of safety is considered an important determinant of caregiver and client safety.^{2,3,4,5,6,7,8,9} Much of the attention and the majority of studies in the field of patient safety have been focused in the acute care sector.^{10,11,12, 13} There is ample evidence from both a quantitative and qualitative perspective that safety concerns contribute a significant monetary and human burden to the system. The safety issues most commonly identified in the literature in acute care are those related to medication errors, noscomial infections and errors occurring during surgical and obstetrical practices.

At the time of the initiation of this project, in British Columbia (BC), there was a Provincial Patient Safety Task Force (BCPSTF), with representatives from all of the health regions and the Ministry of Health (MOH), responsible for setting strategic priorities in relation to safety activities. The vast majority of the activities/strategies undertaken by the regions are focused on the acute care sector. For example all of the health regions are active participants in the “Safer Healthcare Now” activities, designed to save lives, and primarily focused in the acute care sector. Given that in BC the health regions have responsibility for the full continuum of health care services from pre-hospital to complex continuing care, we also have responsibility for ‘safety’ across these sectors.

At the time of this project, community home health care was organized across three health service areas in FHA: the North, South and East areas. Within each of the three service areas there are several office

locations, which are locally managed. Professional staff are guided by myriad policies/procedures and care guidelines, which are currently not consistent across FHA. For example, orientation programs for new staff are specific to each office, although they do share some common features.

Safety considerations are part of the 'usual' orientation for new staff; however, staff indicates that the current orientation is not adequate to address the issues they currently face in the field. They often rely on after-the-fact debriefings with colleagues to learn how to address safety concerns. "If something happens that I am not sure what do, and I feel uneasy I ask someone when I return to the office what I should have done" (Focus group participant, 2004). Safety (provider and client) issues and concerns were dealt with on a case-by-case basis in the local area rather than by system-wide approaches. Many of the existing processes, policies and procedures are specific to each office and there was very little cross regional sharing of information and/or effort to adopt a best practices approach to safety. Rochlin, conceptualized safety as a social construct viewed from a systems perspective.¹⁴ He indicates that changing a culture of safety requires interventions that go beyond sets of observable policies, procedures and established behavioral scripts. In other words many of the practices of the staff have little to do with formal processes and much to do with how they have constructed their safety culture in a somewhat reactive and incremental manner.

There is a risk to provider and client safety in FHA due to a lack of information related to quality in home health care and the lack of available information (evidence) upon which one could judge safety of existing services. In the absence of consistent information it is difficult to make informed decisions related to where improvement opportunities might exist or where resources might be required. The intervention project (IP) focused on moving towards a culture of 'safety' in community home health care. Home health care is a growing segment of the health care continuum in British Columbia, in part

due to hospital downsizing, decrease in the number of acute care beds resulting in increasing numbers of clients in need of care in their homes. As acuity and complexity of care has increased in the acute care sector the same is reflected in the growing demand in the community sector.

Initially, client safety was the central theme of the project, however, focus group participants were persuasive in their accounts of practice and strongly suggested in the words of one “If I don’t feel safe, then I can’t attend to the safety concerns of my client” (Focus group participant, 2004). Given the increased demand for care in the home it is predicted that home health care workers will be the fastest growing employment sector in health care.¹⁵ Therefore increasing an understanding of safety in home health care has the potential to not only positively impact clients but also their care providers.

15,16,17,18,19,20,21,22,23,25,26,27,28,29,30

Research shows that nurses expect a level of threat in their day-to-day work and unlike police officers who prepare for the risk, nurses tend to ‘just do it.’³¹ Community health workers (CHW) feel they have little say regarding safety and tend to believe that saying something may jeopardize their job.^{31, 22} The result is that they will underreport because they are concerned that the employer will believe the CHW is negligent in their performance. Often, CHW’s feel trapped and they can’t say no in relation to requests for providing care.²³ This trend has also been seen in registered nurses because they can also feel devalued and powerless.²³ In one study, Ore found that assaults were underreported by 41.2% as staff did not believe that reporting would result in any changes.²² Staff perceptions of risk add to the complexity of risk assessment. Evidence suggests that health care providers vary in their assessment of risk and that this impacts their decision-making for both themselves and their clients.¹⁸

There are a wide array of risks identified in the literature for both providers and clients. Risks that impact both include: lifts and home environment, attacks by animals or individuals, geographic location, lack of personal resources (lack of educational preparation), sharps injuries, underreporting of risks and interpersonal skills.^{16,24,28,32,33} In addition to those that impact providers and clients, there have also been several that are specific to clients. These include: medication errors, infections and falls.^{34,35,36}

As the majority of safety research and effort has occurred in acute care, there was not a clear articulation of what constituted ‘safety’ in community home health care in FHA. The focus in acute care has been in relation to safety issues that arise as a result of ‘medical errors.’ Many activities have been undertaken in acute care to ensure that there are systems and processes in place to ensure that care providers do not make mistakes and commit errors that cause harm to patients. In this IP, I am suggesting that the community and home environment pose many of the same risks and safety issues for both the provider and client. Therefore the development of strategies to mitigate and minimize these risks will need to be much different than those in acute care and take into consideration a much broader concept of ‘safety’ that encompasses both the provider and client. It is important to bring clarity to this broader notion of safety in the community and to begin to quantify the safety concerns and the risk to clients, providers and ultimately the organization. Currently many of the tracking tools for safety originate in the acute care sector and are not easily applied in the community home care context .

The administrative databases in FHA that are used for tracking safety information such as incident reports are not strongly aligned with the actual work done in home health care and it is questionable that they are reflective of the magnitude of safety issues. FHA Protection Services compiled data but it was limited, “there won’t be many reports, folks don’t report” (Protection Services, Fraser Health 2005).

The Nurse's Union Professional Responsibility Process and Form that are frequently used in the acute care sector to report safety concerns are seldom utilized in the home health care sector. Occupational health and safety reports capture actual injuries and are not used to capture 'near misses' or potential safety concerns in home health care. The underreporting of safety concerns has been shown in studies in acute care and shouldn't be surprising that it is similar in this sector, however, many of the staff indicated that the current tools (designed for acute care) do not reflect their work reality.

The key objective of the IP project was to explore the practices related to safety in community home health care which included both client and provider safety and to identify potential indicators for tracking safety concerns. Several questions framed each phase of the IP.

1. *What constitutes safety in community home health care in FHA? What are the priority areas for action in relation to safety?*
2. *What is the current culture of safety in community home health care in Fraser East?*
3. *What information contributes (positively and negatively) to the safety of clients and providers when clients are discharged on Fridays?*
4. *What type of risk identification would be most helpful to community health workers to prepare them adequately to meet their clients' and their own safety needs?*

Implications

There are implications of this IP for health care administrators, providers, professional associations, unions, educators and researchers and ultimately the health authority.

Healthcare Administrators and Providers

The findings of this project have applicability to healthcare administrators in particular those who have responsibility for community home health care. Safety and quality in the health care sector have been defined primarily by acute care standards and have focused on mitigation of errors. Many of the current systems and processes were designed for acute care and are either not sensitive enough to capture the uniqueness of community care or are not easily translatable to community circumstances. The increasing acuity and complexity of acute care is mirrored in the community, therefore it stands to reason that risk in the community would at the very least be similar in terms of magnitude as acute care.

This project points out that underreporting of safety issues/risk is in part due to misaligned systems and processes and in part due to the high tolerance of risk that providers have developed over time as just “the way things are in the community” (Focus group participant, 2005). This in part may be explained in relation to the incremental increase to care delivery in the home, which historically started out quite slowly, and in the past several years has increased dramatically without being particularly well planned out. Although policies/procedures/processes had been developed to address aspects of safety, usage was inconsistent as was monitoring of usage. Health care administrators need to ensure that they have mechanisms in place to report and address risk to both clients and providers and that implementation of any new practice should be followed up and evaluated to ensure that practice has changed and that the intended effect was realized. Any changes to practice must be pragmatic and provider-friendly to increase the likelihood of uptake, hence a participatory approach to development and implementation is strongly recommended.

Health care providers have a responsibility to identify risks to themselves and their clients. Although many of the participants in this study appeared to have a high tolerance for risk to themselves they need

to be aware that there is a strong relationship between provider and client safety. In other words, it may not be in their client's best interest to put themselves at risk as evidence would suggest that when providers feel unsafe they shorten their visit which may negatively impact care and client outcomes. It is important for administrators and providers to explore the reasons for the high tolerance of risk and to create a culture that encourages the questioning of risk or safety concerns and the development of mitigation strategies.

Professional Associations and Unions

The project findings point out the need for professional associations and unions to broaden their advocacy for quality and safe practice environments beyond the walls of acute care hospitals. Firstly, these groups in partnership with healthcare administrators should set clear and consistent standards for reporting and documenting the safety/risk concerns in the community sector. In the absence of consistent reporting of safety concerns, the issues for both providers and clients in this sector will remain in the background, just as the focus to date has been on issues in acute care. Secondly, these groups can influence the workplace health agenda to expand their typical mandates to include the development and implementation of safety standards in this sector. And finally, these groups should use their spheres of influence to broaden the current national acute care focus on patient safety to include the community sector.

Educators

This project identified many areas where education is needed at the undergraduate and continuing education levels. At both the undergraduate and continuing education levels, curriculum related to the principles of safety in the broadest context and the principles of risk and risk mitigation should be explored. Furthermore, students and providers need to be educated to understand their responsibility in

identifying safety/risk issues and to advocate for conditions that facilitate the provision of safe care to their clients. There needs to be education in relation to the risky nature of the home setting and the features of the risks which are different than one might encounter in a facility setting.

Approach

The IP was carried out in four phases designed to support decision making in relation to making changes to policies/procedures to improve safety in community home health care. The methodology was informed by a participatory action research (PAR) framework.³⁷ Participatory action research was chosen, as we were committed to involve managers and staff in identifying, prioritizing, developing, implementing and evaluating the action plans that formed the basis of the intervention project. We used this approach, as we believed that those who are part of the culture or context of a particular practice are those who ultimately have created the current reality and thus are those who can change it. The focus was on developing a mutual understanding of what constituted safety practices and the identification of strategies to enhance safety.

In the IP we were interested in focusing on how and what constitutes day-to-day practice in home health care through the accounts of managers/staff and how this impacts their understanding and construction of safety practices. Staff members have an understanding of ‘range of risk’ that they perceive of as part of the context or environment in which they work. The IP was not intended to disrupt those practices but to reveal how they know when they are at the outer edges of the range of risk and how this knowledge can be utilized to make changes to practice and the system to reduce risk and improve safety. Given that the IP was concerned with both client and provider

safety a member of the Professional Practice Office (PPO) and a member of the Occupational Health and Safety Office (OHS) joined me as part of the official 'IP' team.

Phase I answered the question: *What constitutes safety in community home health care in FHA? What are the priority areas for action in relation to safety?* In Step 1 we held three focus groups, using opened-ended questions, one in each of the health services areas (North, South, East). Participants included community health workers (CHW), RNs, managers, case managers, home support managers, occupational therapists, physiotherapists and educators. A Clinical Nurse Specialist in each community facilitated the focus group and two of us were in attendance to introduce the IP and take field notes. At the end of the focus group session participants were asked if they would be willing to review the transcripts and identified themes to validate what had been 'heard' and the interpretation of their words. In addition, they were asked if they would be willing to become a network of project advisors for the IP project. Many agreed to continue with the IP and indicated that by providing their contact information. These participants were integral to the ongoing progress of the IP. Additionally a 'formal' discussion was also held with a group of 12 public health nurses who had heard about the IP and were interested in sharing their perspectives in relation to provider/client safety. Their perspectives were included in the focus group information prior to analysis.

To analyze the data, the transcripts and field notes were reviewed and questions were categorized. Each time a word or phrase or concept was repeated a note was made. Once key words, phrases and concepts were highlighted, themes were identified at a high level that would be shared with participants.

In Step 2, we held a ‘validation’ focus group with staff made up of the same individuals (identified in Step 1). We met to review and validate the findings and themes from the initial sessions. The themes were clarified and revised as per input from the group and priorities for action were identified. We also included document reviews as we collected policies/procedures and forms from across the region that were designed or intended to address ‘safety’.

Phase II answered the question: *What is the current culture of safety in community home health care in Fraser East?* A modified Institute for Health Improvement (IHI) Safety Climate Survey was distributed to every CHW in FE (N= 450) in the spring of 2005 (Appendix I). A total of 174 were returned, a response rate of approximately 40%. The results were examined across all questions to identify any themes within the responses. Safety Climate Mean scores were calculated, as described by the IHI accompanying documentation, and were analyzed across occupations, work experience and age groups.

Phase III answered the question: *What information contributes (positively and negatively) to the safety of clients and providers when clients are discharged on Fridays?*

In Step 1, a series of focused interviews were led by the OHS team member and made up of CHWs, home support coordinators, home care nurses, case managers, and rehabilitation therapists held in two different communities in Fraser East (FE). These sessions followed a series of structured interview questions focused on Friday discharges as that had been identified as a priority by the staff and the IP team. Data collection in this step also included document reviews (assessment forms and referral forms) and a review of the process for communication/information flow from acute care (discharge) to the providers who would ultimately be visiting the client in the

home. Analysis of the information gathered followed a similar process as in Phase I and themes were validated by participants.

In Step 2, chart reviews were conducted at each of the two FE offices. A chart review tool was developed with safety indicators derived from initial analysis of the focus groups, and interactions with staff through validation processes and interviews (Appendix II). The intent was to audit a minimum of 20 charts at each of the FE community home health offices. At both offices the home care nursing team leader assisted with the pulling of charts. In both cases, there was great difficulty in pulling charts that met the following criteria – ‘the clients needed to be discharged from the acute care facility in that community and referred to Home Health (HH) in the same community and have been in receipt of active care from HH during the last week of May 2005.’ The frequency statistics were requested for the month of May, i.e., numbers of referrals to HH by date which met the above criteria. In both communities, it was not possible to obtain the types of charts that met the original criteria. An explanation is provided by one Home Health Nurse:

“Let me start by saying this is not totally accurate. Let me explain why. These referrals are only the patients that may require help with discharge planning. We may have other patients in hospital but don’t necessarily have to intervene to get them home. The hospital case managers also get asked by hospital staff to look in on patients without a referral. I don’t always get a request to generate a referral at my end. You may also want to talk to these case managers to see if they keep some sort of record over there.”

Forty-three charts were reviewed from the two communities. The charts were randomly pulled from those identified as clients who had been referred to home health care in the previous month

and were reviewed by one member of the IP team and two BSN students who were completing an undergraduate research course. Analysis consisted of frequency of completion of assessment forms, care plans, intervention strategies, outcomes of interventions with a particular emphasis on safety indicators.

In Step 3, observations and job shadowing occurred. One member of the IP team shadowed three different community health workers from two offices during their day shift. Field notes were taken and information was gathered in relation to risk on a form similar to the chart review form (Appendix III). Analysis of the data gathered was compared against the information gathered from the focus groups, the interview information and chart reviews. Similarities and differences between what was 'said' and what was 'seen' were identified and used to inform the fourth phase of the project.

Phase IV answered the question: *What type of risk identification would be most helpful to community health workers to prepare them adequately to meet their client's and their own safety needs?* In Step 1 of this phase an interdisciplinary working group comprised of home care nurses, community health workers, case managers, home support supervisors, an intake nurse and home care manager, occupational health and safety officer and protection services reviewed several existing assessment tools and from these developed a 'Risk Identification Tool/Form'.

The purpose of the tool was to provide a quick and easy way for all community care providers to identify risks for both provider and client when they visited a client and to communicate that risk to other care providers. A second group of care providers was assembled to evaluate the usability

of the form through the exploration of several ‘typical case’ scenarios. Further revisions were made and the working group approved the final draft (Appendix IV).

Step 2 entailed piloting the tool in the two offices in Fraser East. The pilot involved 22 workers for four days and the tool was to be completed for all client interactions. The purpose of the pilot was to explore the usability of the form and to identify whether ease of use would increase the likelihood of identifying risks. Pilot participants completed three hundred and thirty-six forms. Analysis of the data included the percentage of form completion, and comparison of risk identification among different care providers and between offices. Following the analysis, the usability group was reconvened to provide feed-back on the usage of the tool and revisions were made accordingly.

Results

The results of each phase of the project are presented below:

Phase I

Findings from steps 1 and 2 are reported together as there is considerable overlap in the findings. In this phase there were three interactions with staff and managers in home health care, including focus groups, staff meetings and focused interviews. In total approximately 125 staff were involved. The participants were somewhat ‘matter of fact’ in articulating the safety concerns. When probed whether they felt that they were expected to put themselves at risk or their clients, the staff indicated that they are not expected to do so, but then indicated that ‘things have always been this way’. The high tolerance of risk for themselves was taken for granted by the staff that participated in the focus groups and they did not seem alarmed by the situations that they

described for us. We found this a somewhat puzzling finding as the work on quality practice environments and safe workplaces is quite entrenched in the acute care sector. This was another indication that the typical notions of safety and risk in acute care do not readily transfer to the community sector, nor have the health care providers made the connection.

The first focus groups identified the following concerns/themes related to safety in the community: communication, acute care not understanding the community, working alone, neighborhood issues, knowledge around safety, environmental concerns at home, falls and medications. These findings were validated and added to by a second set of interactions with home health care staff.

The second interaction of validation identified additional concerns regarding: lack of continuity between acute care and community resulting in a need for a process and understanding between community and hospital; lack of pre-screening of client's home therefore staff may be exposed to risks due to unknown and undocumented factors regarding the home environment, - often there was no history on the client; that CHW were often responsible for doing the first assessment; identification that there were significant problems with Friday discharges because support services were closed and equipment was not available; lack of standards and process around safety; and finally that the providers appeared to have accepted a high degree of risk. This risk has been accepted for such a long time that it has come to be assumed that such risk acceptance is the norm for both themselves and their clients.

The documentation review revealed a large number of policies, procedures, forms and guidelines all directly related to 'safety' in community home health care, which conflicts with the focus

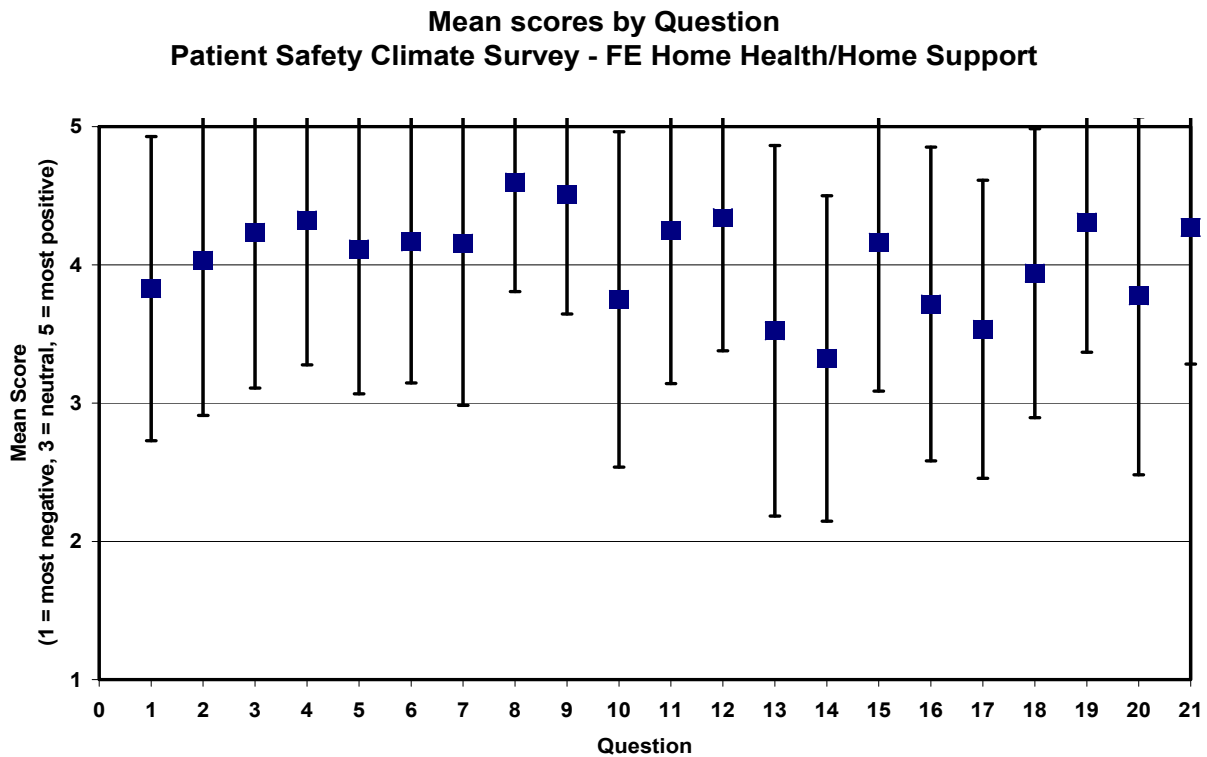
group findings. Either these were unknown to the focus group participants or they weren't seen as useful.

It was difficult to explain the apparent paradox of the staff feeling unsafe and yet not utilizing the mechanisms that had been developed to mitigate risk. The IP team questioned whether this was a consequence of the lack of staff involvement in the various policies/procedures or if the staff did not find them useful.

Phase II- The Safety Climate Survey

Grand mean scores were calculated for each question and examined for trends. Mean scores for each question, while having a good degree of variance, were all in the positive range of the scales. When the Safety Climate Mean scores were compared across occupations, work experience and age groups, no significant differences were identified; see Figure 1.

Figure 1



Phase III

In Step 1, the third interaction with staff, (through focused interviews), Friday discharges and related information needs were discussed, as that had been identified and subsequently selected by previous groups as a priority due to the perceived frequency of problems and the wide array of risks that it represented. Staff believed that the lack of information they received prevented them from completing a risk assessment prior to making a home visit. Several times nurses stated “... lots of detective work – can be very time consuming to try and hunt down the right information”...and also indicated that communication is a concern, that often the CHW was the first assessor, that mobility and dementia were major problems. Following this input, and given that it was similar throughout FHA, and for ease of implementation, the IP focused on one

geographical health services area, Fraser East (FE). The information/communication process was mapped (Appendix V).

In Step 2, a chart review (n = 43) was undertaken in two home health care offices in FE to examine concerns identified by staff related to client/staff safety and discharge planning. The chart reviews were completed by one of the professional practice staff and two BSN students. The review revealed gaps in: information related to discharge and home environment; whether there was a delay in discharge or not; information passed on was not always complete; and revealed very little documentation about safety on the chart. Reviewers were unable to compare and determine gaps regarding the discharge date and referral date because often the discharge date was not on the chart, 70% had no discharge date; however, of the known referrals and discharge dates, same day hospital discharge and referral to home health was 16%, which may have lead to delays. The reviewers found that clients may have multiple charts, i.e., each profession has a separate chart for the same client, however, were unable to locate information on the chart to indicate that multiple charts were in use, and if known, were unable to readily find all charts.

No obvious pattern/relationship was apparent regarding the use of forms, except that many different forms were used, and none were used routinely. It was noted that the patient profile was not always complete. It was noted that 63% had pre-visit information completed, however, in many cases this information was collected in hospital and did not reflect an assessment of known home environmental risk factors. Of interest, is the finding that 50% of clients who had pre-visit documentation completed and had a risk identified; of those, only 19% had some planning for that risk documented. It is difficult to explain this apparent mismatch. The IP team questioned

whether it was a consequence of passing on the risks verbally rather than on the care plan as the phone was frequently used to give report to the home care workers.

The average age of the client in the chart review was 74. There was only one adverse event noted on one chart. Neighborhood risk was reported 2% of the time. No dangerous animals were noted. No aggressive client/family noted. Medication concerns were identified at 16% or 7 of 43 charts and of those 12% ,or 1 of the 7 charts had some form of planning recorded.

Step 3 – Observations during the job shadowing sessions revealed a number of related issues.

Assessment of risks prior to first visit by a CHW was not always performed, nor was there always documentation present in the care plan binder to reflect such an assessment had been performed.

Changes to the client's condition were documented in the care plan binder, however, the location and format in which this information was recorded varied depending on the perceived level of severity of the problem and the communication style of the staff involved. This variation in communication methods and processes may present risk to the workers and hence the client if information is missed by those providing care.

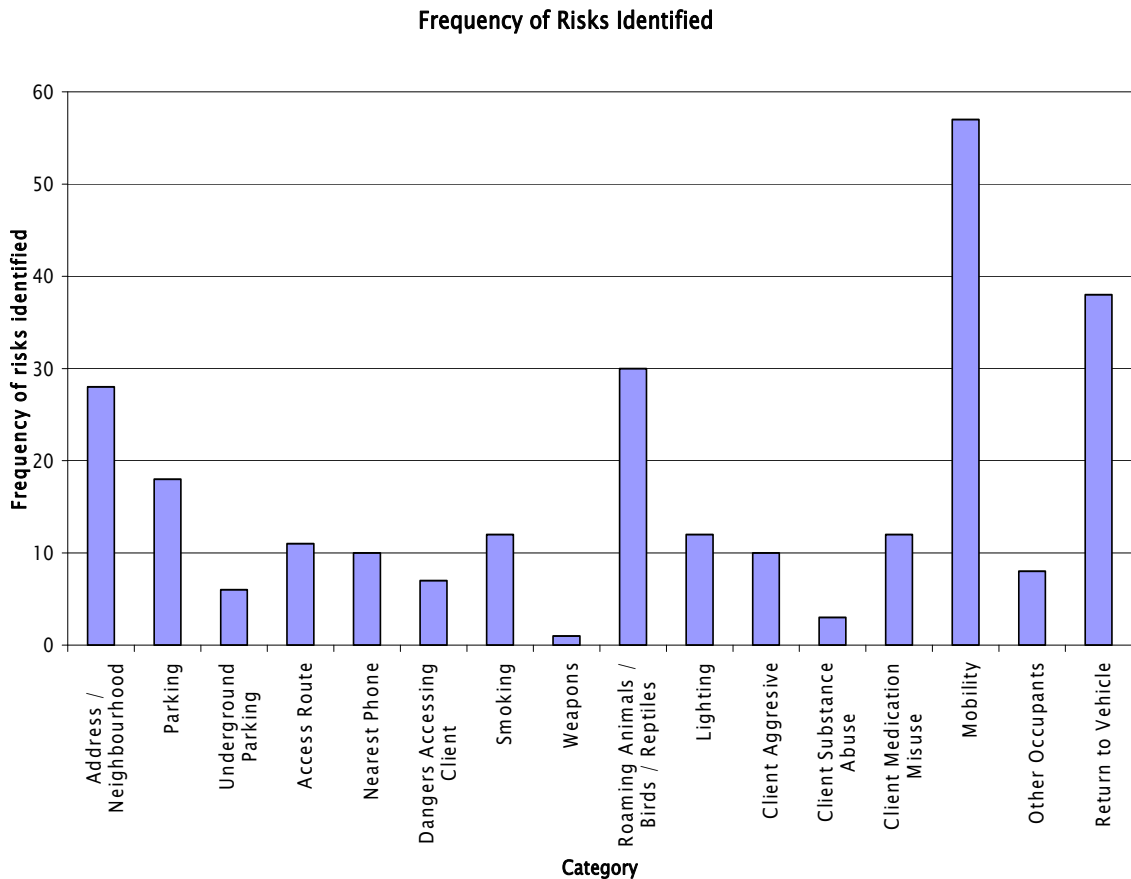
Communication between the office and the CHW in the client's homes was consistent, if not directly interactive in that the majority of communication from the office to the CHW was completed by voicemail. If the situation required immediate contact with the CHW, their location could be identified by their schedule that day, or the CHW could be called on their cell phone. It should be noted that the majority CHWs pay for connection with the office by cell phone themselves, that is, this is not a charge costed back to the health authority. The challenges with this system of communication are the

uni-directional style of communication, the inconsistent cell phone coverage in the area as well as potential for inequities in the ability/willingness to provide this service for oneself.

Phase IV

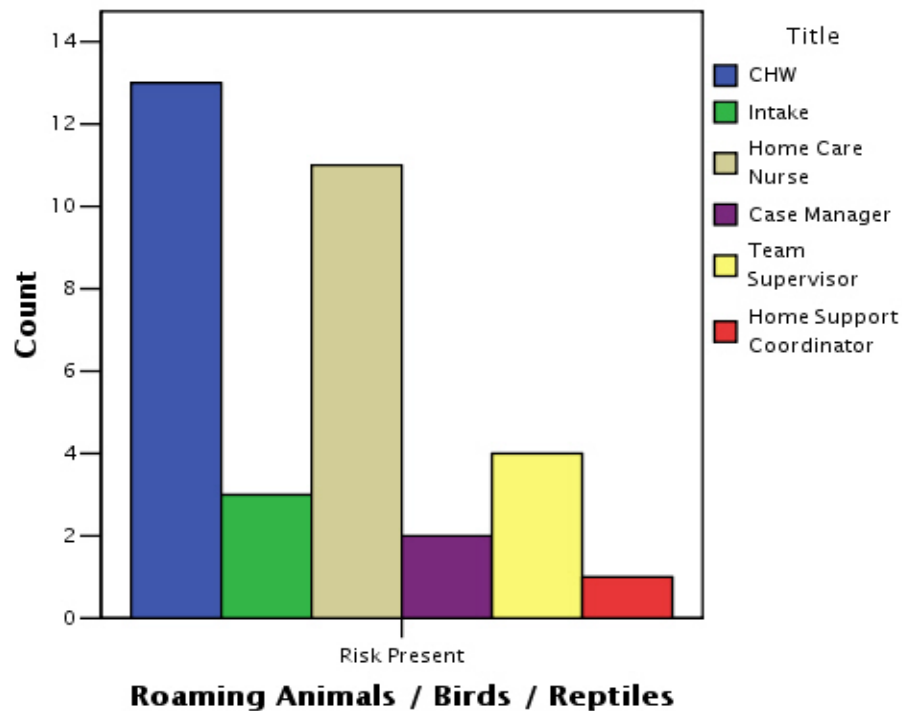
Steps 1& 2 will be reported together as there is overlap in both the process and findings. Three hundred and thirty-six surveys were returned from 22 workers over the four-day pilot. A number of risks were identified more frequently than others, as shown in Figure 2

Figure 2



These data revealed no differences in frequency in risk identification when all the occupations were compared. However, close inspection of the data indicate that those workers who spent the majority of their time in the client homes (CHWs, HCNs) tended to identify risks more frequently than those that spend most of their day in the offices (Intake, CMs, TSs, HSCs). This is illustrated in Figure 3.

Figure 3



Feedback from the focus group session after the pilot revealed a clear understanding of the information on the form by all occupations that used it during the pilot. Additionally, there were no recommendations to modify the criteria, either by collapsing the groups or providing more detail. There were concerns expressed, however, by those in supervisory roles as to the workload that would result from the regular use of these forms. The frequency of use was also discussed, staff indicating that it

would likely be completed when changes were identified. The inability to use it as a ‘recording’ form to document risks over the phone between the CHW and the office was mentioned.

Next Steps: Moving from IP to Program Priorities

In order to imbed the work of the IP in the organization and ensure sustainability a formal hand-over occurred from the EXTRA Fellow to the Executive Vice-President responsible for home and community care. The IP provided the organization with much needed information about the safety needs of providers and clients in home health care. With the participation of staff in all phases, there is ample locally identified evidence to indicate the need for ongoing development of strategies and mechanisms to mitigate the risk in this sector. The organization has recently undergone a re-organization that provides a structure to continue this work. For example an executive director for home and community care has been appointed and the following priorities have been identified for implementation:

Risk Identification Tool

The evaluation of the pilot indicated high acceptance by the staff in relation to usability, alignment with risks identified during their home visits and the perception that the tool would assist them to not only identify risks but also communicate those with the variety of providers who serve clients in their homes. Given the issues identified during the chart review phase, the organization understands the importance of implementing this tool as the current documentation in relation to risk, and care planning for mitigation is not acceptable.

This is a critical first step in the consistent identification of risk that will provide the organization with an initial set of indicators to track in relation to safety in community home health care. The risks

identified in the tool are readily translated to indicators and include both provider and client risks. In order for the organization to report on safety in community home health care, documentation must be standardized across the authority. This tool provides a vehicle to begin that process of both standardization by using a tool that has been developed for this sector.

Safety Climate Survey

As indicated in Phase II, the results of the initial survey conducted compared mean scores across occupations, work experience and age groups. Although no significant differences were identified, there were areas for improvement in particular in relation to the ability of staff to influence changes that will have a positive impact on safety. Staff need to be listened to and empowered to provide suggestions as to how to make things work better for them and their clients. Given the participation of staff in the development of the Risk Identification Tool, one would expect to see higher scores in the areas of staff participation and increased satisfaction in their ability to influence. The survey is due to be repeated June 2006.

In addition to repeating the Safety Climate Survey, work has been undertaken by the Occupational Health IP team member to explore the relationship between the staff perception of safety (climate survey), worker safety and particularly the dynamics of risk tolerance. Using similar variables as measured in the Climate survey, age, years of work experience in the occupation and years of work experience in the community a tool was developed to assess the worker's perceptions of the working culture and risk tolerance behaviors with respect to safe client handling practices. This is a natural next step in attempting to ascertain and measure the relationship between provider and client safety. At the time of this writing the findings are pending.

Working Alone

Throughout the IP project phases, staff identified risks associated with working alone. The risk themes were similar to those articulated in the literature. However, wide variations in practice were also identified and there was a lack of clarity and hence the wide variability amongst the staff regarding what would be considered ‘too risky.’ The apparent high tolerance for risk and inconsistency in practices amongst care providers is considered a priority by the health authority.

A working group comprised of staff who participated in the IP, protection services, occupational health and safety and the Health Benefit Trust organization are utilizing the information and data from the IP to develop the necessary structures/processes/policies/procedures to improve the safety conditions for providers. The Risk Identification Tool will provide the initial data that staff will utilize to determine if risk exists and the working group will develop the decision making algorithms to guide staff in determining what would be considered an ‘acceptable level of risk’ in order to make a home visit.

Injury prevention in the home

Utilizing the information gathered in the IP, another working group has been struck to explore equipment needs to prevent injuries to both clients and providers. The results of the pilot of the risk identification tool identified mobility to be the most prevalent risk. Of the recorded injuries to providers in the health authority, the highest number was in the area of musculo-skeletal injuries e.g. lifting issues. The working group includes occupational health and safety staff involved in the IP, home health care and home support providers and supervisors, also many of whom were involved in the IP. The purpose of this group is to develop strategies for identifying potential mobility issues in the home and making appropriate equipment available and accessible to mitigate injuries.

As there is information related to numbers of musculo-skeletal injuries, this is one concrete indicator, which can be tracked by the home and community program. It is possible for the authority to determine if identification of this risk using the risk tool and implementation of a mitigation plan using equipment or other strategies has a positive effect on provider injury.

With regard to client mobility, the working group will also ensure that their efforts are aligned and integrated with the authority Falls Prevention initiative. Similar to the ability to positively impact provider injuries utilizing the risk tool, the ability to identify fall risks in home health clients and put in preventative mechanisms has the potential to positively reduce the number of home based falls.

Further Research

Additional research needs to be done. As the acuity and complexity of care needs in the community sector increases, the need to have a better understanding of safety and risk will also increase. Currently ‘best practices’ in relation to community home health care appears to be based on evidence gathered through a trial and error methodology and is primarily qualitative. While this is helpful to inform our understanding of safety, it is necessary to begin to quantify the espoused safety concerns to expose the magnitude of the issue and to increase our understanding of the inter-relationship between provider and client safety. Specifically, research is necessary to determine what type of evidence-based practices result in positively impacting the safety of providers and clients in home health care. Important features of such research would:

Determine the usefulness of risk identification tools to identify safety issues.

Identify the most important influences on providers to identify and report safety issues and how to ensure that staff feels safe in reporting risks and adverse events to management staff without fear of reprisal or job threat.

Identify the relationship between perceptions of safety culture and risk identification (does underreporting correlate with safety culture reports).

Evaluate inter-rater reliability of the forms (controlling for client and environment), allowing for specific identification of differences in perceptions across occupations.

Estimate the number of home visits that would not be made if staff refused to go because of perceived risk based on a less extreme definition of risk than is currently used by the staff.

References

- ¹CCHSA Patient Safety Goals and Required Organizational Practices. (Communiqué # 2)
(December 2004)
- ²Berwick, Donald. Worker Safety – Patient Safety: Fortifying Partnerships to Promote Well-being in the Healthcare Sector. Unpublished. References – Yassi, A. CIHR Team Application (2004) Grant
- ³Carthey, J., de Laval, M.R. & Reason, J.T. (2001). Institutional resilience in healthcare systems. *Quality in Health Care*, 10, 29-32.
- ⁴Firth-Cozens, J. (2003). Evaluating the culture of safety. *Quality and Safety in Health Care*, 12(6), 401
- ⁵Meyer, J.A., Silow-Carroll, S., Kutyla, T., Stepnick, L.S. & Rybowski, L.S. (2004). *Hospital quality: ingredients for success – overview and lessons learned*. New York, NY: The Commonwealth Fund.
- ⁶Morris, R. (2004). Better safe than sorry: one agency's successful safety and security strategies. *Home Healthcare Nurse*, 22(6), 417-422.
- ⁷Nieva, V.F. & Sorra, J. (2003). Safety culture assessment: a tool for improving patient safety in healthcare organizations. *Quality and Safety in Health Care*, 12, 17-23.
- ⁸Singer, S.J., Gaba, D.M., Geppert, J.J., Sinaiko, A.D., Howard, S.K. & Park, K.C. (2003). The culture of safety: results of an organization wide survey in 15 California Hospitals. *Quality and Safety in Health Care*, 12, 112-118.
- ⁹Pronovost, P.J., Weast, B., Holzmueller, C.G., Rosenstein, B.J., Kidwell, R.P., Haller, K.B., Feroli, E.R., Sexton, J.B. & Rubin, H.R. (2003). Evaluation of the culture of safety: survey of

- clinicians and managers in an academic medical center. *Quality and Safety in Health Care*, 12(6), 405-410
- ¹⁰ Avery, A.J. (2003) Classifying and identifying errors. *Quality and Safety in Health Care*, 12 (6), 404.
- ¹¹ Frankell, A., Gandhi, T.K. & Bates, D.W. (2003). Improving patient safety across a large integrated health care delivery system. *International Journal for Quality in Health Care*, 15(Suppl 1), 31-40.
- ¹² Gallagher, R.M. & Rowell, P. A. (2003). Claiming the future of nursing through nursing sensitive quality indicators. *Journal of Administration Quarterly*, 27(4), 273-284.
- ¹³ Rogers, A.E., Hwang, Wei-Ting, Scott, L.D., Aiken, L.H. & Dinges, D.F. (2004), The working hours of hospital staff nurses and patient safety. *Health Affairs*, 23(4), 202-212.
- ¹⁴ Rochlin, G.I. (1999). Safe operations as a social construct. *Ergonomics*, 42(11), 1549-1560.
- ¹⁵ Forst, L., Nickels, L. & Zanoni, J. (2003). Occupational safety of home health workers. *Journal of the American Medical Association*, 290(23), 3069-3070.
- ¹⁶ de Savorgnani, A.A., Haring, R.C. & Davis, H. (1992). A survey of home care aides – a personal and professional profile. *Caring*, Apr.11(4), 28-32.
- ¹⁷ Fazzone, P.A., Barloon, L.F., McConnell, S.J. & Chitty J.A. (2000) Personal safety, violence and home health. *Public Health Nursing*, 17(1), 43-52.
- ¹⁸ Kendra, M.A. (2002). Perception of risk by administrators and home health aides. *Public Health Nursing*, 19(2), 86-93.
- ¹⁹ Kendra, M.A., George, V.D. (2001). Defining risk in home visiting. *Public Health Nursing*, 18(2), 128-137.
- ²⁰ Kendra, M.A., Weiker, A., Simon, S., Grant, A. & Shullick, D. (1996). Safety concerns affecting delivery of home health care. *Public Health Nursing*, 13(2), 83-89.

- ²¹ Feldman, P.H., Peterson, L.E., Reische, L., Bruno, L. & Clark, A. (2004). Charting the course for home health care quality: action steps for achieving sustainable improvement. *Home Healthcare Nurse*, 22(12), 841-850.
- ²² Ore, T. (2002). Occupational assault among community care workers. *Journal of Healthcare Protection Management*, 18(1), 72-89.
- ²³ George, V.D. (1996). Field workers' sense of coherence and perception of risk when making home visits. *Journal of Public Health Nursing*, 13(4), 244-252.
- ²⁴ Grindlay, A., Santamaria, N. & Kitt, S. (2000) Hospital in the home: nurse safety – exposure to risk and evaluation of organizational policy. *Australian Journal of Advanced Nursing*, 17(3), 6-12.
- ²⁵ Haiduven, D. & Ferrol, S. (2004). Sharps injuries in the home health care setting – risks for home health care workers. *Journal of the American Association of Occupational Health Nurses*, 52(3), 102-108.
- ²⁶ Hall, R., Yassi, A., Robinson, D., Rekart, J., Mackey D., Lee, E.J., & Hatter, B. (2002). *The development of an ergonomic risk assessment tool, education and training module, and reporting tools to reduce the risk of musculoskeletal injury in community healthcare workers.* Proceedings of the 33rd Annual Conference of the Association of Canadian Ergonomists, Held in Banff, Alberta, Canada, 2002. Toronto Ontario: Association of Canadian Ergonomists.
- ²⁷ Hunter, E. (1997). Violence prevention in the home health setting. *Home Healthcare Nurse*, 15(6), 403-409.
- ²⁸ Janiszewski, A.L & Caley, L. (1995). Preventing back injury in home care. *Caring*, Jan.14(1), 54-58.
- ²⁹ Nadwairski, J.A. (1992). Inner-city safety for home care providers. *The Journal of Nursing Administration*, 22(9), 42-47.

- ³⁰ Nicholson, P. (2005) Tool measures home care quality. *Medical Post*, 41(5), Retrieved October 4, 2005 from http://www.medicalpost.com/mpcontent/article.jsp?content=20050131_192415_6084
- ³¹ Henderson, A.D. (2003). Nurses and workplace violence: nurses' experiences of verbal and physical abuse at work. *Journal of Nursing Leadership*, 16(4), 82-98.
- ³² Caley, L.M. & Janiszewski, A. (1995). Personal factors contributing to back injury in home care. *Caring*, Feb. 14(2), 50-53.
- ³³ Galinsky, T., Waters, & Malit, B. (2001) Overexertion injuries in home health care workers and the need for ergonomics. *Home Health Care Services Quarterly*, 20(3), 57-73.
- ³⁴ Hirdes, J. P., Fries, B.E., Morris, J.N., Ikegami, N., Zimmerman, D., Dalby, D.M., Aliaga, P., Hammer, S. & Jones, R. (2004). Home care quality indicators (HICQIs) based on the MDS-HC. *The Gerontologist*, 44, 665-679.
- ³⁵ Long, L. (2003). Fall prevention and intervention in home care. *Caring*, Jan. 22 (1), 8-10.
- ³⁶ Rubenstein, L.Z., Powers, C.M., MacLean & C.H. (2001). Quality indicators for the management and prevention of falls and mobility problems in vulnerable adults. *Annals of Internal Medicine*, 135 (8), 686-693.
- ³⁷ Denzin, N. K., & Lincoln, Y. S. (1998). The landscape of qualitative research; Theories and issues. *Thousand Oaks: Sage*.

Appendix I – Modified Safety Climate Survey



Safety Climate Survey*

Please answer the following items with respect to the specific office/area you work in/from. Choose your responses using the scale below.

	A	B	C	D	E	X
	Disagree Strongly	Disagree Slightly	Neutral	Agree Slightly	Agree Strongly	Not Applicable
1. The culture of this area makes it easy to learn from the mistakes of others.						
2. Errors are handled appropriately in this area.						
3. The senior leaders in my area listen to me and care about my concerns.						
4. The management in my area listens to me and cares about my concerns.						
5. Leadership is driving us to be a safety-centred health authority.						
6. My suggestions about safety would be acted upon if I expressed them to management.						
7. Management/Leadership does not knowingly compromise safety concerns for productivity.						
8. I am encouraged by my colleagues to report any safety concerns I may have.						
9. I know the proper channels to direct questions regarding patient/client safety.						
10. I receive appropriate feedback about my performance.						
11. I would feel safe being treated by this area as a patient/client.						
12. Briefing personnel before the start of a shift (i.e., to plan for possible contingencies) is an important part of safety.						
13. Briefings are common in this area.						
14. I am satisfied with the availability of clinical leadership (please respond to all three):						
Physician						
Nursing						
Pharmacy						
15. This health authority is doing more for patient/client safety now, than it did one year ago.						
16. I believe that most adverse events occur as a result of multiple system failures, and are not attributable to one individual's actions.						
17. The personnel in this area take responsibility for patient/client safety.						
18. Personnel frequently disregard rules or guidelines that are established for this area.						
19. Patient/client safety is constantly reinforced as the priority in this area.						

Have you every completed this survey before?
 Yes No Don't know

Experience in Position:
 < 6 months 6 to 11 months 1 to 2 yrs 3 to 7 yrs
 9 to 12 yrs 13 to 20 yrs 21 yrs or over

Job Position: (mark only one)

- Home Care Nurse
- Home Support Worker / Community Healthcare Worker
- Physiotherapist, Occupational Therapist, Speech Therapist
- Manager
- Case Manager
- Intake Nurse
- Team Leader
- Educator
- Home Support Supervisor/Coordinator
- Social Worker
- Other: _____

Experience in Community:
 < 6 months 6 to 11 months 1 to 2 yrs 3 to 7 yrs
 9 to 12 yrs 13 to 20 yrs 21 yrs or over

Experience in the Health Authority:
 < 6 months 6 to 11 months 1 to 2 yrs 3 to 7 yrs
 9 to 12 yrs 13 to 20 yrs 21 yrs or over

Age:
 < 30 30 to 34 35 to 39 40 to 44 45 or over

Unit (please write in title and or location): _____

*Thank you for completing the survey. Your time and participation are greatly appreciated.
 If you have any questions regarding this survey, please contact Cora McRae (phone: 1-604-702-4721; email: cora.mcr@fraserhealth.ca) or
 Waqar Mughal (phone: 604-520-4742; email: waqar.mughal@fraserhealth.ca)*

Appendix II – Chart Review Tool

UNIQUE IDENTIFIER _____

Intervention Project – Chart Review Tool June 8, 2005

Context:

Problem Statement: Currently, in FH there is no consistent way of tracking (and therefore addressing) safety concerns in community home health. Safety in this context includes both provider and client safety.

Purpose Chart Review:

- To establish a baseline on discharge planning specific to discharge being problematic
- To determine frequency (ratio/proportion) of discharges and safety concerns
- To determine whether discharge delayed and reason for delay
- To determine status of planning or not specific to safety concerns
- To understand the context and seriousness of the issue by looking at the evidence in the chart

Tool: Note Timeframe for chart review is first chart entry up to maximum of 14 days

Demographic Indicators	Data				
Date of birth	Date: (State)				
Community	Chilliwack Abbotsford				
HH Service Referred To:	Rehab	HCN	Home Support	Other (State)	
Date of Discharge	Date: (State)				
Day of Discharge	Sun	Mon	Tues	Wed	Thurs Fri Sat
Safety Indicators	Data				
Date HH first notified of referral	Date: (State)		Unknown		
Discharge delayed	Yes	No	Unknown		
Reason for delay	Communication HH		Communication Acute Care		
	No Home Support		No Equipment	Other (State)	
Equipment required:					
Cane	Yes	No	Unknown	Present	Not Present
Walker	Yes	No	Unknown	Present	Not Present
Wheelchair	Yes	No	Unknown	Present	Not Present
Lifting Equipment	Yes	No	Unknown	Present	Not Present
Adjustable Hospital Bed	Yes	No	Unknown	Present	Not Present
Other	(State)				
Any evidence re:					
Pre-visit assessment completed	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Risk identified at any home visit	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Address/neighborhood risk	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Actual/potential threats	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Pets that pose a risk	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Aggressive client/family	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Medication concerns	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				

Appendix III – Job Observation Tool

Intervention Project – Observational Day *August 19, 2005*
Home Support Worker/ Community Healthcare Worker (CHCW)

FH Office Area _____

Context:

- Evidence/Literature suggests CHCW most vulnerable
- Findings/Interview suggests CHCW due frequent triage

Purpose Observation Days:

- To be open to take in the ‘whole context’ of the ‘typical day’ in the life of the CHCW by office area

Timeframe:

Shortly after each ‘manager group meeting’, scheduled for Sept 6; 7; and 19

Length of actual observational day is approximately 7 hours

Total number of observation days is 3

General Observations: Before Visit

General Observations: During Visit

General Observations: After Visit

Equipment required:					
Cane	Yes	No	Unknown	Present	Not Present
Walker	Yes	No	Unknown	Present	Not Present
Wheelchair	Yes	No	Unknown	Present	Not Present
Lifting Equipment	Yes	No	Unknown	Present	Not Present
Adjustable Hospital Bed	Yes	No	Unknown	Present	Not Present
Other	(State)				
Any evidence re:					
Pre-visit assessment completed	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Risk identified at any home visit	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Address/neighborhood risk	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Actual/potential threats	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Pets that pose a risk	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Aggressive client/family	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Medication concerns	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Impaired mobility	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Falls (actual/potential)	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Assistance/guidance to informal caregivers	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Impaired mental status of client	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Lack of communication	Yes	No	Any planning/action completed?		Yes No
Type of planning/action documented	(State)				
Have any adverse events occurred?	Worker:	Yes	No		
Have any adverse events occurred?	Client:	Yes	No		
Have any near misses occurred?	Worker:	Yes	No		
Have any near misses occurred?	Client:	Yes	No		

Appendix IV- Risk Identification Form



RISK IDENTIFICATION CHECKLIST

Client Name _____

Client Number _____

PILOT DATE: _____
 TIME OF VISIT: _____

Circle Title: CHW IN HCN CM TS
 (see back page) HSC _____

INSTRUCTIONS: FOR EACH RISK FACTOR CHECK EITHER “RISK PRESENT” OR “RISK ABSENT”

<i>RISK FACTORS</i>	<i>RISK PRESENT</i>	<i>RISK ABSENT</i>
ADDRESS/NEIGHBORHOOD - Safe neighborhood or not; suspicious people, inability to see home after dark		
PARKING - Feel safe or not; light for parking; parking distance from address		
UNDERGROUND PARKING - Feel safe; distance from address; lighting; suspicious people		
ACCESS ROUTE - Distance to entrance; entrance in rear of building		
NEAREST PHONE - Location of phone in event of emergency		
DANGERS ACCESSING CLIENT - Broken steps		
SMOKING		
WEAPONS - Firearms		
ROAMING ANIMALS / BIRDS/ REPTILES		
LIGHTING - Entrance well lit versus poorly lit		
CLIENT AGGRESSIVE		
CLIENT SUBSTANCE ABUSE		
CLIENT MEDICATION MISUSE		
MOBILITY - Falls, lifts and transfers		
OTHER OCCUPANTS - Feel safe or not		
RETURN TO VEHICLE - Feel safe or not		

Pilot Feedback:

HEALTH CARE PROVIDER TITLES: IN (Intake Nurse); CM (Case Manager); HCN (Home Care Nurse); CHW (Community Health Worker); TS (Team Supervisor); HSC (Home Support Coordinator)

RISK IDENTIFICATION CHECKLIST DEFINITIONS

- **ADDRESS/NEIGHBOURHOOD:** Isolated. Address located in unsafe neighborhood as per Police advice or area map. Additional staff and special procedures may be required.
- **PARKING/UNDERGROUND PARKING:** Parking isolated or unsecured. Not available close to home.
- **ACCESS ROUTE INCLUDES RETURN TO VEHICLE:** Poor area lighting around home access. Lengthy walk to reach home. Long driveway. Entrance rear of building instead of front. Home not visible from road. Isolated entry. Limited exit routes.
- **PHONE:** No telephone or no staff access to telephone.
- **DANGERS ACCESSING CLIENT:** Steps or pavement in poor repair. Home in poor repair i.e. unsafe flooring; excessive dirt or debris in kitchen/bathroom surfaces; heavily soiled clothing and linen; space concerns i.e. not enough space to work safely with client; rodents i.e. rats or mice. Unsecured building i.e. no locks on doors.
- **SMOKING:** Evidence of smoking in home. For example odour without active smoking.
- **WEAPONS:** Client has guns or other weapons that are in view and not safely secured.
- **ROAMING ANIMALS/BIRDS/REPTILES:** Located and roaming freely in home or on the property.
- **LIGHTING:** Poor lighting on street, access to home, in home.
- **CLIENT AGGRESSIVE/OTHER OCCUPANTS:** Concerns or known aggressive behaviour. Actual or potential behaviours that cause difficulty to staff in providing care or make staff feel unsafe. May be verbal statements or physical actions. Persons in home whose lifestyle/behaviours/presence may impact safety of staff.
- **CLIENT SUBSTANCE ABUSE:** Legal or illegal substance use/abuse/activity in the home.
- **CLIENT MEDICATION MISUSE:** Evidence of medication errors or confusion around self-administration. For example, disorientated to time, person or place. Requires frequent direction.
- **MOBILITY:** Evidence of frequent falls i.e. generalized bruising, documented falls. Unsafe walking aids i.e. canes/walkers/crutches/wheelchair/lifting equipment in poor repair. Ergonomic concerns i.e. low beds, bed against wall, restricted spaces. Potential for awkward positions when providing care i.e. lifting, twisting, bending, kneeling, any prolonged position holding. Difficulty with the transfer or with bed-positioning.

Appendix V - Information/Communication Map

