Editorial

There’s no place like home: research, practice and policy perspectives regarding safety in homecare

Since 1997, the number of homecare clients in Canada has increased by 51% [1]. As suggested by Masotti et al. in this issue of the International Journal of Quality in Health Care, this dramatic increase in the amount, acuity and complexity of healthcare being provided in peoples’ homes has grown at a much faster pace than has the body of research on patient safety, which to date has focused predominantly on institutional settings [2]. Nonetheless, emergent shifts in thinking evident in recent patient safety literature are also pertinent to homecare. These include the views that patient safety is mostly perceived as a systems’ failure rather than a human failure [3–4], that organizational culture and workplace factors influence patient safety [5], that multiple change processes are necessary to create safe environments [6] and that patients play a key role in their care and thus must be included in the patient safety dialogue [7]. In this editorial, I describe some of the recent Canadian initiatives and reflect on existing gaps in knowledge and the complexity of advancing our understanding of the issues and challenges around homecare safety.

Homecare safety is about mitigating the risks in diverse environments that are: uncontrolled and unregulated [8]. Risks exist in all health-care settings; however, private homes lack the uniformity that exists in institutional/hospital environments. Homes are not designed for providing or receiving health-care services rather they are designed for living. Homecare is superimposed on the ‘everyday’ circumstances of peoples’ lives. Consequently, in contrast to institutions of care, there are no national standards in place regarding the physical environment in which homecare services are provided. Indeed, the notion of standards for homecare safety needs to undergo a re-visioning process in light of consistent and persistent concerns among clients (physical, emotional, social, functional) and the challenges of scarce human resources and maintenance of competence by caregivers and paid providers [8, 10]. For example, in the caregiver literature, it has been discussed extensively that family members or friends are often untrained, elderly, and are contending with their own health challenges. In stark contrast to the institutional setting where there are two or three shifts of professionals who provide care, family/friends/caregivers are frequently sleep deprived as they provide around-the-clock care.

Care at home embodies a complex socio-ecological challenge with regards to safety. Although providers can engage clients, family members and caregivers in conversations and collaborate with them to reduce risk, these homecare recipients often make decisions about managing medications and treatments while clearly recognizing that these decisions are not always congruent with or endorsed by their provider. This is a particularly unique aspect, given that care happens on ‘home turf,’ and that the autonomy and choice of the client, family and caregiver are at the forefront. This means that the provider can offer health education, recommend strategies and suggestions for care, but ultimately the clients decide. Thus, ethical care must be closely aligned with the values, needs and decision-making of clients and those around them.

A substantial body of literature exists about the myriad of conditions, situations and events (i.e. falls, end-of-life, HIV/ AIDS, etc.) that affect the safety of patients. Additional literature addresses the risks to family, caregivers and providers of homecare services. While existing literature could generate significant insights into challenges and successful strategies for mitigating the risks for homecare recipients and providers, this literature seldom explicitly identifies the topic of safety in titles, keywords, or abstracts [8]. As the review by Masotti et al. confirms, research in homecare has rarely been reflected into the larger portrait of patient safety.

In 2008 CPSI convened an interdisciplinary pan-Canadian Core Safety in Homecare Team of researchers and homecare decision-makers charged with identifying areas of inquiry and to advance and build capacity. Research is needed to identify: the types and patterns of safety concerns for clients, family members, caregivers and providers; how family/caregiver
involvement in care delivery affects safety; how to attend to safety given that many variables are more difficult to regulate or control in private homes; the impact of advances in treatments, assistive devices, medications and technology and the challenges of transitions, communication and continuity of care among an array of recipients and providers. Leading edge research in this field requires inter-disciplinary teams of researchers, practitioners and decision- and policy-makers using a wide array of research and knowledge translation/ exchange methods. It is encouraging that funding agencies are becoming sensitized and increasingly providing opportunities and resources to conduct multimethod, cross-jurisdictional collaborative studies in homecare safety.

We need to view safety in homecare with a different set of glasses than those used for institutional settings [8, 10]. Collaboration to increase our understanding of how to mitigate the risks while optimizing the health and quality of life for those involved in receiving and providing homecare may yield benefits with economic and socio-political impact. To this end, some of the recommendations set forth in the most recent CPSI report [11] may be relevant not just in Canada, but also in other nations.

Recommendations for researchers

(i) Involve clients, family members, caregivers and providers in order to understand their respective vulnerabilities, needs and strengths.
(ii) Elicit the elements of a definition of homecare safety from stakeholders in order to develop a framework for understanding this concept.
(iii) Identify and explore study designs and methodologies along with various sources of visual and textual data to capture the multidimensionality of homecare safety.

Recommendations for decision-makers

(i) Consider a model of practice that enables the provider and the client(s) to co-create a health-promoting environment conducive to risk-mitigation for all involved in response to the emerging homecare safety landscape.
(ii) Focus on staff education to build the knowledge and competencies required to work in a different way with clients that is directly linked to the new model of practice.
(iii) Prioritize technology enabled documentation to facilitate the transfer of information within the home and across the health-care continuum.

Recommendations for policy-makers

(i) Acknowledge that homecare safety has fundamental differences than in institutional settings requiring different approaches and policies for developing, implementing, evaluating and sustaining strategies and interventions to mitigate risks.
(ii) Prioritize the development and implementation of an electronic health record system that links across health-care system sectors.
(iii) Embed opportunities in service authorization and funding for caregivers to be the recipients of services, and to be able to access respite care that will enable them to continue to fulfill the critical role that they play.

Much can be done in homes and communities to keep people healthy and out of hospitals and emergency rooms. However, current health-care systems often fail to offer the supports and care that individuals and families require to remain healthy and safe in their homes. The safety perspectives of homecare recipients diverge from those of providers. One homecare recipient captures the issue by the following statement: ‘Sometimes they [homecare providers] agree with what I am doing and sometimes they don’t agree.’ [9] Ongoing research and safety-related interventions need to be sensitive to these divergent perspectives and work in collaboration with all involved. Although standards can be set for instruments, equipment and supplies used in homecare delivery as well as for the credentials of paid providers, where and how the client and their family/caregiver choose to live cannot nor should it be standardized. A tailored approach to client/family centered care that embraces varied client perspectives along with their respective vulnerabilities, needs and strengths is the way to address the existing tensions while mitigating the risk for all involved. Together clients, family members, caregivers and paid providers can build consensus on what ‘a safe haven’ means for each household.

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References


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