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Impact of the Shift to Ambulatory Care: Responsibilities and Supervision for Delivering Homecare

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Impact of the Shift to Ambulatory Care : Responsibility and Supervision in Delivering Homecare

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Key Implications for Decision Makers

Reorganization of Quebec's healthcare and social services system has transferred responsibilities from government to other social players, especially patients, their families, and community organizations. This study examines the impact of the shift to ambulatory care on the quality of care delivered, patient safety, and the ability of users and workers to take on this responsibility.

The study reveals the following.

- Hospital officials lack consistent standards or criteria to determine what can be transferred, and to whom. There is a presumption that anyone can deliver care, although some care is difficult for lay people to understand and deliver.
- Hospital officials do not always consider the human and financial aspects for patients and their families before approving homecare.
- Concerted action and co-operation between the hospital, CLSC, patients and their families are essential to the success of homecare.
- Some conditions must be in place for patients to feel safe and comfortable providing or receiving homecare:
 - the patient must be in agreement and motivated
 - assistance and specialized equipment must be available
 - patient monitoring must be planned
 - training must be adequate
 - qualified resources must be available to handle difficulties
- Transferring care to the home is not always a realistic solution. Hospital officials should provide alternatives such as temporary accommodation in nursing homes or in long-term care hospitals.

Executive Summary

Background

Transformation of Quebec's healthcare and social services system has transferred responsibilities from government to other social players, especially patients, their family and the community organizations. As an integral part of this transfer, the shift to ambulatory care has reduced the length of hospital stays for many clients leading to an increase in homecare delivered by workers with CLSCs, community groups, private companies, or patients or their families.

The research was designed to describe and achieve a better understanding of the impact of the ambulatory shift in Quebec. It also sought to determine how responsibilities are currently shared, what difficulties are faced by workers and patients, the solutions found, as well as the necessary conditions for effective sharing acceptable to everyone involved.

The research also strived to determine the guidance that families need, as well as what is currently available. It was intended to shed light on the conditions for success and the limits to transfer of knowledge and responsibilities from healthcare professionals to family. Finally, it sought to provide indications on how to meet the expectations of people requiring homecare.

Consequences

The findings of this study are of interest to ambulatory care program officials in Ministries of Health as well as hospital and CLSC managers, and homecare officials and workers in these institutions' programs.

In this study, quality of care, and the safety or needs of families and patients, are not considered from a clinical perspective. They instead are examined in terms of the potential for people to obtain assistance or answers to their questions or requests. They are also studied in light of the perception by workers and families of the conditions for a safe transfer of responsibilities. The research focuses on assessment of the ability of patients and their next of kin to take on delivery of some care. It seeks to determine whether they find a response to their requests, concerns or questions about the responsibilities they must take on, as well as the source of any such response.

Results

The study shows that the ambulatory shift is based on and simultaneously reinforces a dumbing-down of care. There is a presumption that anyone can deliver a range of care that authorities claim is easy for lay people to understand and deliver. In fact, care is often more complex for patients and their families than for professional workers. This situation is specifically linked to:

- the complexity of patients' health problems, and
- the complexity of the home situation in which care is delivered — a physical, social, private and non-specialized environment.

Transfer of responsibility for care from hospitals to patients and their families affects their personal, social, family and work life as well as their physical and mental health. Homecare also entails financial costs that can prove substantial in some cases for patients and their families. Moreover, while patients may want to return home quickly, the same cannot necessarily be said of their families.

The study highlights a series of ideal conditions for people to feel safe and comfortable providing or receiving care at home.

- Transfer is easier when people are willing and motivated, and have assistance from a relative at home.
- Preparation and follow-up must be given special attention—patients and their families must be given time to assimilate the information, procedures and techniques, to build their confidence.
- Time must be taken to inform patients and their families (about the disease, care and side effects), to listen to them and consult with them.
- Support must be ongoing. Safety at home must be assured by providing easy access at all times to qualified resources should problems arise. These resources, which are also “ambulatory,” must be able to travel in order to handle emergencies and conduct home visits.

Patients with financial resources or some level of comfort have a head start, but homecare cannot be solely dependent on patients and their families. When most of these conditions have been met, the ambulatory shift proceeds smoothly. When several are missing, problems — sometimes major — can arise.

Approach

The research focused on five client groups: intravenous antibiotic therapy, hip fracture, palliative care, chronic obstructive lung disease, and strokes. The research was conducted in five Quebec regions: the Lower St. Lawrence, Montreal, the Outaouais, Quebec City and the Saguenay.

Between January 1999 and November 2000, the research team interviewed workers in hospital settings (bedside nurses and link nurses, physicians, social workers, physiotherapists and occupational therapists), CLSC workers (nurses, visiting homemakers, physiotherapists, social workers, occupational therapists or managers) and patients and their families. The interviews conducted in the five regions were divided as follows:

- Hospitals: 17 group interviews, plus 7 individual interviews;
- CLSC: 9 group interviews, plus 2 individual interviews;
- Patients and their families: 120 individual interviews.

The research did not cover the frequency of situations or the respective weight of each variable. The sample was not intended to be statistically representative. The objective

instead was to identify a wide variety of situations and obtain an overview of the difficulties encountered and the solutions found. The research therefore did not attempt to make a systematic comparison of the five client groups and five regions for a series of variables, which is impossible given the size of the sample and the many factors involved. Standard situations were identified to see how patients and their families react, and to describe the assistance and report received.