Team Name: Home Care Nursing Team Lead: Director - Home Care, Palliative Care & Seniors Approved by: Regional Lead – Community & Continuing Care	Reference Number: CLI.5412.SG.001 Program Area: Home Care Nursing Policy Section: Nursing
Issue Date: June 12, 2022 Review Date: Revision Date:	Subject: Home Care Client Collaborative Care Model and Client Collaborative Review Meetings

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STANDARD GUIDELINE SUBJECT:

Home Care Client Collaborative Care Model and Client Collaborative Review Meetings

PURPOSE:

To provide direction on the process for the client collaborative care model and review meetings to ensure clients receive the most appropriate, evidence informed care. The Collaborative Care model aims to:

- increase continuity and consistency of client-nurse assignments;
- enable nurses to work to their full scope of practice;
- promote enhanced teamwork and inter-professional collaborative care;
- include input and clinical guidance from nurses on the care team; and
- be client centered and based on client needs.

DEFINITIONS:

Collaborative Care Model – Health Care Providers working together with clients, families, caregivers and the community to provide high quality care. It involves engaging any health provider whose expertise can help improve the client's health. When health providers collaborate, new possibilities exist that were not there before.

Complex Client – A client who has multiple comorbidities, multiple detrimental social determinants of health, or a combination of both which have the potential to place the client at risk and may negatively impact the individual's overall health status. These factors include but are not limited to:

- Acute and/or chronic medical conditions:
  - Spinal cord injury;

    - Cancer;
    - Diabetes; and
    - Uncontrolled pain.
- Social Vulnerability factors that impact the ability to support client:
    - Limited family supports;
    - Complex family dynamics;
    - Limited financial means; and
    - Reside in a remote location.
- Braden Scale risk level is high.
- Client has had history of poor health outcomes.

IMPORTANT POINTS TO CONSIDER:

- Collaborative Care creates better health outcomes for clients and positively impacts experience and satisfaction with care. Health providers also benefit through healthier work environments and increased job satisfaction.
- The new nursing care delivery model consists of teams of five or less nurses assigned to clients living within a defined geographical area.
- There are times when the same group of nurses cannot be assigned to the same clients if the schedules cannot accommodate this. Schedule shifting will be avoided for complex cases that have been identified.
- Members of the collaborative care team include Direct Service Nurses and Nursing Supervisor. Other members may include Case Coordinator, Manager – Home Care Nursing & Palliative Care, Nurse Educator, Health Care Provider, Pharmacist, Dietitian, Respiratory Therapist, Occupational Therapist, Physiotherapist, Palliative Care Team, and Nurse Scheduler.
- Clients and families are partners in care - ask “what matters to you”.
- Nursing care teams work in collaboration with other health and social care providers across the care continuum. Communication is essential in promoting collaboration.
- The Collaborative Care model presents the opportunity for health care providers to understand the services Home Care provides and to share this knowledge with clients, families and allied health professionals.
- The Collaborative Care model aims to improve client, family and staff satisfaction.
- The Collaborative Care Model enables nurses to work to full scope of practice according to their College’s Standards of Practice. The role of the nurse must include a focus on health prevention, health promotion and early identification of health issues.

PROCEDURE:

1. **Case Coordinator**
    - Determines whether client is complex based on complex client definition and communicates with Nursing Supervisor.

2. **Nursing Supervisor:**
    - Initiates collaborative care team meeting for complex clients on admission to Home Care.

- Prioritizes assignment of a complex client to a Collaborative Care Team.
- Develops a binder for each care team. Each binder includes:
  - Client Collaborative Care Model and Client Collaborative Review Meetings Guideline;
  - Home Care Collaborative Care Team Action Log;
  - Team Ground Rules; and
  - Supporting documents/reference materials.
- Ensures team meeting locations/rooms are booked and are communicated to the Nurse Scheduler for entry of the attendance types.
- Reviews action logs of each Collaborative Care Team Meeting.
- Prints out a list of active nursing clients prior to the collaborative team meeting.
- Attends each team meeting.
- Develops an action plan for follow up with identified Collaborative Care Teams where outstanding action items are not completed within identified completion date(s).
- Communicates and develops education plan to address education needs of the team.
- Articulates the expectations of both the care team and of individual nurses working in the care team for client follow-up.
- Sends an email to Nurse Scheduler with scheduling changes and provides updates from the action log.
- Ensures regular and ongoing communication with each care team.
- Acts as a resource.

3. Nurse Scheduler Responsibilities:

- Ensures attendance type of "Meeting" with start /stop time and duration of meeting for each collaborative care team nurse is entered in Procura.
- Inputs scheduling changes from the Nursing Supervisor email into Procura client schedules (e.g. increase visit time from 30 to 45 minutes, changes to client comments).

4. The Collaborative Care Team Responsibilities:

- Client collaborative care team meetings are held every six (6) to eight (8) weeks (or more frequently if required) for up to two (2) hours per meeting. Additional time can be requested from the Nursing Supervisor.
- Follow team ground rules for meetings.
- Discuss team functioning and identify options to improve collaboration and effectiveness as needed.
- Identify nursing diagnoses.
- Evaluate client care plans to determine:
  - Nursing care plan.
  - Appropriate service delivery options such as self-care, assignment or delegation to Home Care Attendant, nursing clinics.
  - Appropriate frequency of nursing visits. For complex clients, decreasing nursing visits should be done in consultation with the case coordinator/nursing supervisor.
  - Nursing interventions and care align with evidence informed practice, home care protocols, regional guidelines, etc.

    - Further consultations required such as Clinical Nurse Specialist, Mental Health, Hospital to Home Team, Community Therapy Services, etc.
- Ensure all actions items stemming from each meeting are:
    - Recorded on an action log that outlines nurse(s) assigned to each item, timeline for completion;
    - Documented in the identified client's in-home chart on the Nursing Care Plan and Interdisciplinary Progress Notes; and
    - Reviewed at subsequent meetings until the action items identified are resolved/completed.
- Ensure participation and communication regarding the care plan and service delivery occur amongst the team members including client, client's primary contact (if needed), Nursing Supervisor, nursing team members, Case Coordinator(s) and Prescriber(s).
- Identify education needs of the members and communicate needs to the Nursing Supervisor.

SUPPORTING DOCUMENTS:

CLI.5412.SG.011.FORM.01	Home Care Collaborative Care Team Action Log
CLI.5412.SG.011.SD.01	Home Care Collaborative Care Team Meeting Ground Rules

REFERENCES:

http://wrha.mb.ca/professionals/collaborativecare/index.php
WRHA Home Care Program Nursing Care Delivery Model Implementation Toolkit December 2015.