ACPF Quality Improvement Project:

PERSON AND FAMILY-CENTRED CARE WITHIN A COPD INTEGRATED CARE PATHWAY

About the Project

To determine the perceptions of the clients with Chronic obstructive pulmonary disease (COPD) related to Person and Family-Centered Care (PFCC) as they navigate the integrated care pathway and transition services within the North-Western Toronto-Ontario Health Teams (NWT-OHT).

Project Questions

1. What are the **experiences** of **persons with COPD** who access **services for COPD** and are placed on **a care pathway**?

2. How do **persons with COPD experience PFCC** in their care journey across a **care pathway** for **COPD**?

Organizations Involved

Black Creek CHC

Humber River Family Health Team

Humber River Hospital

Runnymede Healthcare Centre

West Park Healthcare Centre

Project Fellows

Laleine Pontigon, BScN, RN
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- Certified Diabetes Educator

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- West Park Healthcare Centre
- Respiratory Rehabilitation

Methods

Semi-structured Interviews
Conversational interviews conducted with participants, caregivers, and healthcare providers.

Group Qualitative Analysis
Interview transcripts were analyzed to identify themes and finding.

Project Participants

Who Participated?
- 18 years old or older
- Receive services from BPSO-OHTs
- Have been diagnosed with COPD
- Experienced a transition between at least two health sectors within the project period.
- Participants had the capacity to consent and participate in semi-structured interviews

Interviews with Participants

Participant with COPD
- Initial, transition, and final interviews

Caregiver
- Initial interview

Healthcare Provider
- Transition interview

Number of Participants

- Participant with COPD = **4**
- Caregiver= **2**
- Healthcare Provider= **1**

16 Interviews over 6 Months

For More Information Contact

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Recommendations and Findings on Next Pages

Findings: Barriers and Challenges

Interpersonal Relationships in Healthcare Settings

When participants were asked about their experiences with their healthcare providers, they tended to focus on whether they felt *heard*, *respected*, or *seen*.

"A lot of the times no one seems to listen to the things I said or asked or you know and ... it's glossed over. My GP isn't...I don't care for him at all. It's hard to get a doctor and the doctor I had before him retired. So, I basically had to stick with this guy ... , he's very inattentive, completely inattentive. Half the time doesn't even look at me." (Participant with COPD)

Activity of Daily Life

COPD impacts an individual's ability to complete tasks; some participants had caregivers to provide support, and others did not. The participants that did not have caregivers indicated that their quality of life was impacted, such as having an unclean home or inability to run errands.

Access to Resources and Support

Most participants stated that they were unaware of specific resources and support before coming to BCCHC and WPHC, such as rehab. Some felt that their requests for additional resources and supports were not heard or taken seriously by certain healthcare professionals.

Continuity of Care

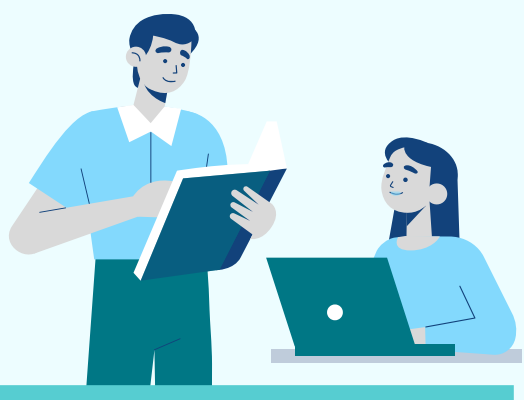
All of the participants with COPD reported multiple transitions in care. This was necessary to treat their COPD but also their other comorbidities such as musculoskeletal disorders and mental health conditions.

- **The participants highlighted their negative experiences during care transitions, such as losing information, complicated processes, miscommunication, and lack of support at home.**
- **The healthcare provider discussed the difficulty of sharing information within community-based care.**

Findings: Facilitators that Improve Health

Education

Once patients understand their condition, they can be active participants and are more satisfied with their care. They are empowered to make their own decisions. Education removes the uncertainty and the unknowns of the condition.



"A big difference, cause no I never had any, in all the time, the years that I've been coping with the illness, I've never had any type of help in that respect, or teaching, or explanation, or anything about the illness. ... [They] say all you got [is] COPD, see around. Here's your oxygen tank. You know, kind of thing, you fall through the cracks" (Participant with COPD)

Healthy Clinical Interactions

In these clinical health interactions, patients are active participants that have agency. This is encouraged when the healthcare provider *listens*, *communicates*, *educates*, and is *attentive* to the patient. Additionally, the clinical setting should *feel safe*, *secure*, *and comfortable* to encourage and promote *trust*.

Present and Consistent Caregiver

Participants with present and consistent caregivers indicated a robust support system. These participants have other individual/individuals to support them with tasks they could no longer complete. This results in a better quality of life and standard of living for the individual with COPD.

Recommendations

1 One Location for Healthcare Services

- Convenient
- Improve accessibility
- Encourage patients to attend their appointments

2 Supports to Counteract Isolation

- Such as support group and exercise groups
- Encourage connection with others with similar health experiences

3 Increased Access and Funding for Home Care

- Increase access to support to all individuals
  - Insured and non-insured
- Support integrated care
- Lobbying strategy that would support policy changes

4 Caregiver Support

- Addition homecare and mental health support for caregivers
- Support with added responsibilities

Glossary

Advanced Clinical Practice Fellowship (ACPF): an opportunity for the Registered Nurse or Nurse Practitioner(RN/NP) to create an experience to meet goals that are focused on skills,
implementations, leadership, knowledge and evidence-based practices. These learning needs will be supported by RNAO and the organization.

BPSO-OHT (Best Practice Spotlight Organization-Ontario Health Team): to support OHT partners across the continuum of care to achieve the quadruple aim, RNAO created BPSO model for an integrated system of care, as a part of the implementation of best practice guidelines.

Care Transitions: When a person experiences a change in health status, care needs, health-care providers, or location, within, between, or across settings (RNAO, 2014a).

Intergrated Care Pathway: Implements a set of actions designed to ensure the safe and effective coordination and continuity of care as individuals experience a care transition.

Chronic obstructive pulmonary disease (COPD): is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, mucus (sputum) production and wheezing.

Ontario Health Teams (OHTs): “groups of health care providers and organizations that are clinically and fiscally accountable for
delivering a full and coordinated continuum of care to a defined geographic population” (Queen’s Printer for Ontario, 2020)

Person- and family-centred care (PFCC): A person- and family- centred approach to care demonstrates certain practices that put
the person and their family members at the centre of health care
and services.

Registered Nurses’ Association of Ontario (RNAO): is the professional association representing registered nurses, nurse practitioners and nursing students in the province of Ontario, Canada. RNAO provides a strong and credible voice for the nursing profession to influence and promote healthy public policy.

ACPF Project Co-Leads

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