Using comprehensive assessment data to support person-centred, goal-oriented care planning by Registered Practical Nurses in community-based transitional care

Standardized comprehensive home care assessments, such as the interRAI Home Care™, are used to collect information about clients' medical, functional, and psychosocial care needs.[1] It is key that providers are trained to collect this information effectively, but even more critical is their ability to interpret and use these data meaningfully in the care planning process. This project aims to harness Registered Practical Nurses' (RPNs) expertise working in transitional care programs to create user-friendly tools that assist point-of-care providers in person-centred care planning.

> "Creating tangible practice resources that can be used by the whole care team to more effectively link necessary holistic assessments with the goal setting and care planning process promotes dialogue-based, goal-oriented care and highlights the leadership role of RPNs in the delivery of interdisciplinary team-based care within transitional care programs."
> – Shelby Fisch, Vice President, Acute Care Operations and Rehabilitation Strategy

Project overview

Community-based transitional care programs are organized and delivered through partnerships between hospitals and home care service organizations. These programs provide services to support clients as they move from hospital to home.[2] Transitional care programs reduce unnecessary hospitalizations and premature admissions to facility-based long-term care, as well as improve clients' quality of life and care satisfaction.[2,3]

Research shows care plans, which are co-developed and aligned with clients' goals, support active engagement in care.[4] Providing goal-oriented care is particularly important for clients with more complex health and social care needs. The use of comprehensive assessment tools, such as the interRAI Home Care™ (interRAI HC), supports the detailed assessment and documentation of the full range of life care needs[5] and goals to allow for a shared understanding of client context.

In Ontario, Registered Practical Nurses (RPNs) make up close to half of the home care nursing workforce.[6] In transitional care programs, RPNs serve as the primary provider for many clients, working together with an interprofessional team to coordinate and deliver holistic health and social care. It is imperative to the success of transitional care programs that RPNs have the tools and resources necessary to lead the development of data-informed holistic care plans.

Leaders and care providers within transitional care programs have identified a need for RPNs and other interdisciplinary team members to more effectively use interRAI HC data for person-centred, goal-oriented care planning. To date, RPNs have not been intentionally engaged in research efforts to improve clinical use of standardized comprehensive home care assessments.

What have we done?

As part of our Models of Care Delivery portfolio, we partnered with RPNs and clinical and operational leaders within SE Health's Acute Care Transitions program to design a 1-year two phase participatory[7] project to iteratively develop a point-of-care tool that supports RPNs' use of interRAI HC assessment

data in person-centred care planning.

In Phase 1 we conducted virtual in-depth interviews with eight RPNs from six transitions programs with diverse experiences (e.g., age, geography, race). Through constructivist analysis, we generated knowledge about RPNs' success and challenges in four categories:

1. **Training RPNs to complete interRAI HC assessments in @Home Programs according to assessment standards**
   - **Success:** Having a culture of mentorship and continuous learning supports RPNs in conducting interRAI HC assessments.
   - **Challenge:** RPNs desire additional training in how to conduct interRAI HC assessments based on assessment standards.
2. **interRAI HC assessment processes within @Home Programs**
   - **Success:** RPNs follow assessment standards when completing interRAI HC assessments.
   - **Challenges*:*** Uncertainty about the priority of the interRAI assessment within existing care tasks; Individual and infrastructure barriers complicate the assessment process; and Practice-knowledge gaps in steps required to accurately capture assessment information.
3. **RPNs engage in data-informed care planning drawing on interRAI HC assessment data:**
   - **Successes:** interRAI assessment outputs support development of goal-oriented holistic care plans; and the interRAI HC assessment and outputs support dynamic care planning over the course of the @Home Program**.**
   - **Challenges:** Obstacles to engaging in conversational goal setting to drive care plan development; difficulty combining clinical judgement with interRAI assessment outputs in care planning process; and individual and system barriers can impede needs-based care planning.
4. **The integration of interRAI HC data supports interprofessional collaboration in @Home Programs:**
   - **Successes:** interRAI outputs support decision-making about interdisciplinary team member involvement to support deliver of holistic care; and frequent and consistent team communication supports better care planning and delivery
   - **Challenge:** Missed opportunities for team-based care planning limits team members' ability to meet client's needs

What will we do next?

Drawing on these findings, in Phase 2 we will facilitate two co-design workshops to develop a point-of-care tool, and associated processes that support transitional care providers to engage in conversational goal setting, which integrates interRAI HC data with clients' values and clinical judgment to plan holistic care. Participants will include RPNs, clients/caregivers, and transitions team members.

What are the implications of this work?

We expect this project will foster a greater understanding of how data from comprehensive home care assessments can support planning and delivery of holistic, person-centred care.

We also expect that outputs from this research will promote greater autonomy for RPNs working within transitional care programs and result in more efficient care processes, reducing assessment duplication and promoting care continuity. Finally, we anticipate that the point-of-care tool will enable other health and social care providers to more effectively guide conversational, data-informed, and person-centred care planning.

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To cite this work/ References