

Under Pressure: Engaging with Patients and Caregivers in Pressure Injury Prevention



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BACKGROUND

Pressure Injuries

- A pressure injury (PI) is a localized injury to the skin and/or underlying soft tissue that is usually located over a bony prominence or under a medical device
- Risk factors include difficulty moving, not changing your position often, not eating well, wearing medical equipment
- PIs cause severe pain, discomfort, infection, extended hospital stays, and even death
- The total net adjusted hospitalization cost ranges from CA\$44,000-90,000 for stage 2-4 PIs respectively
- However, PIs are preventable!



Common Prevention Strategies

- Risk-assessment tools, support surfaces, repositioning and mobilization, nutritional support, prophylactic dressings, skincare, and education

The Importance of Engaging with Patients and Caregivers

- Patients that actively participate in their care have higher levels of confidence, satisfaction, and better clinical outcomes
- Patient education enhances health and encourages participation in ongoing care and treatment decisions
- Education empowers patients to incorporate knowledge, skills, behaviours, and attitudes related to specialized or general medical themes, preventative services, healthy lifestyle adoption, proper medication usage, and disease and injury treatment



AIM STATEMENT

- Our goal is to increase patient and caregiver knowledge, skills and attitudes related to PIP to decrease the incidence of hospital acquired pressure injuries at Niagara Health



PURPOSE

- Currently, Niagara Health (NH) does not have an approach for engaging with patients or caregivers to prevent HAIs
- We created interactive videos to educate patients on PIs and a tool for nurses to engage in meaningful conversations with patients about PI prevention

NEXT STEPS

- Due to COVID-19, these interventions were not able to be implemented
- Next steps would be to evaluate the effectiveness of these tools by measuring patient satisfaction and knowledge and nurse compliance
- Once it is established that these interventions are effective, they can be spread organization-wide



REFERENCES

Available upon request

ACKNOWLEDGEMENTS

We would like to thank our community partners and Dr. Law for supporting us through this project

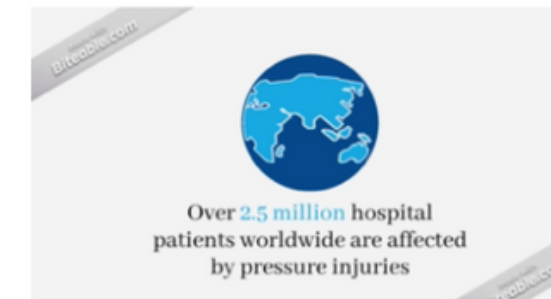
KNOWLEDGE TRANSLATION TOOLS

Video 1: Website Content



- Niagara Health does not have a section on their website dedicated to PI prevention
- Provides an in-depth overview of PI prevention by defining PIs, providing risk factors and outcomes, and preventative strategies
- There is both a voice-over and text on the screen for patients to follow along

Video 2: Waiting Room Content



- This video is designed to be played in patient waiting rooms throughout the hospital
- Provide a very brief overview of PIs to catch patient's attention and direct them to various resources in the hospital

Nurse Checklist

Every 24 hours, nurses should inform and remind patients to:

- Get up and move or ask for help to get up safely (if the patient is immobile: change their position in bed or chair often or ask for help)
- Have all meals, snacks, and drinks that are provided
- Keep their skin clean and dry
- Report any new pain, discomfort, or loss of feeling
- Ask the healthcare team to check their skin under any medical equipment
- If you have any questions or would like more information about your skin or your risk for pressure injuries, please speak with your healthcare team during We Round or at any point during your stay



- The nurse checklist is designed to promote interactions about PIs and preventative strategies between nurses and patients
- Previous literature suggests that patients want to have conversations with health professionals about PI prevention



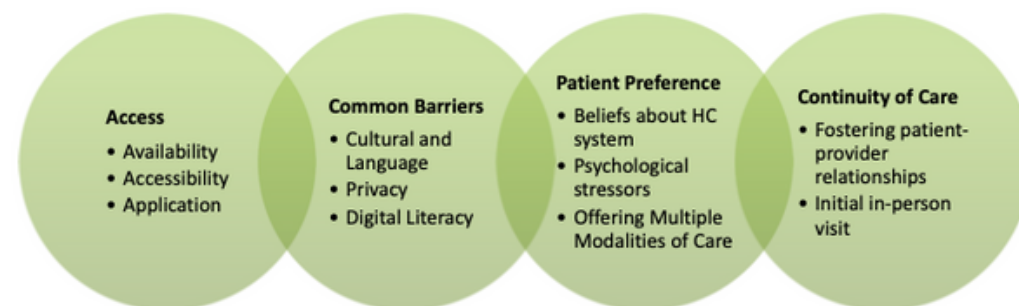
Integrating Virtual Care Beyond the Pandemic: Considering Health Equity & Digital Literacy

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BACKGROUND/OVERVIEW

- Virtual Care describes the use of communication or information technologies for healthcare providers to interact with patients remotely with the goal of maximizing the quality and effectiveness of patient care.¹
- Virtual care technologies often enhance existing inequities including lack of access and barriers to digital literacy skills, defined as the ability to use technology to find, evaluate and communicate information.^{1,2}
- Equitable care must ensure equal outcomes from virtual care irrespective of age, gender, ethnicity and income.³
- Key considerations relating to digital health equity include the following interrelated themes and sub-topics:



AIM STATEMENT

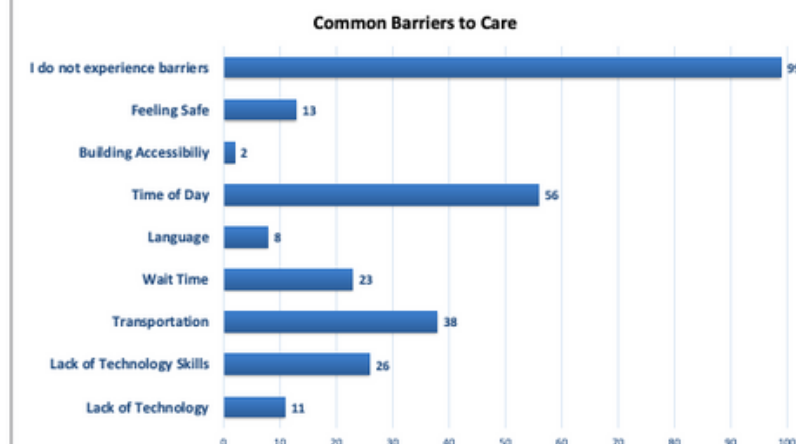
Our goal was to assess the virtual primary care program at the Niagara Falls Community Health Center from a patient-centered lens. Supported by digital health equity considerations from the literature, we aimed to develop a toolkit to aid assignment to virtual care in a mixed-care delivery model, post-pandemic.

METHODS

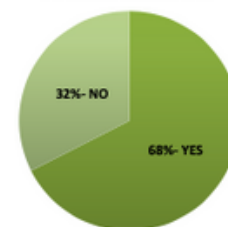


SUMMARY OF SURVEY RESULTS

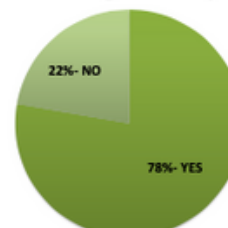
- Providers indicated that virtual care led to decreased patient 'no-shows' by resolving transportation barriers. Patient responses suggested an overall increase in access and most felt comfortable using virtual services.
- Providers confirmed language, access to technology and digital literacy are barriers in some situations. Patients identified the following factors as barriers to care:



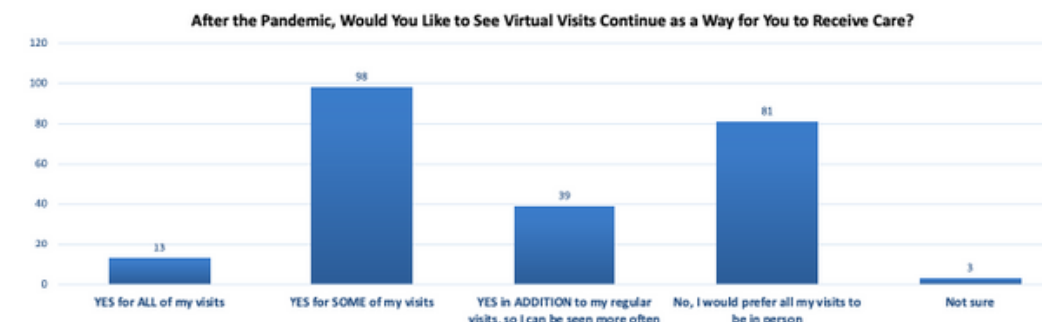
Did Having A Virtual Visit Improve Your Access to Virtual Care?



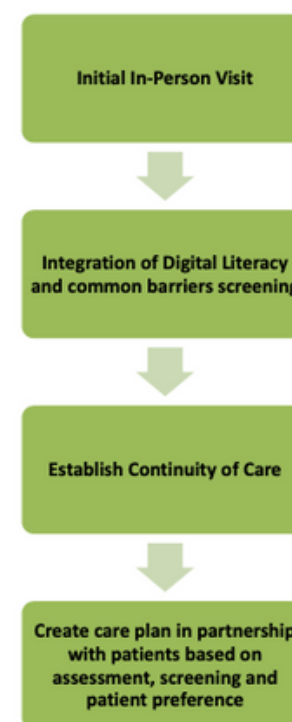
Did you Feel Comfortable Communicating with Staff Using the Virtual System?



- Providers recommended initial-visits remain in-person to allow for patient assessment. Assignment to virtual care should be provider-driven and honor patient preference, while continuing to offer a blended-care model. Patient responses to a blended-care model are as follows:



PROCESS MAP



Sample Questionnaire- Note: for questions #1-3 &5, check all that apply

- What type(s) of devices do you have access to?
 - Smartphone
 - Tablet
 - Computer
 - None of the above
- Where do you go to use the internet most of the time?
 - At home
 - At school or a learning center
 - At work
 - At the library
 - At a coffee shop
 - A cell phone or tablet using a cellular data plan
 - Other _____
- What types of technology do you use to communicate with friends and family?
 - WhatsApp
 - Facebook
 - Texting
 - Phone Call
 - Other _____
- How comfortable are you using technology for the following activities? (1= not comfortable 2= a bit nervous 3= very comfortable)
 - Using a computer/laptop for:
 - Voice calls
 - Video calls
 - Messaging apps (Facebook, WhatsApp...)
 - Searching the Internet
 - Using Apps (games, translation...)
 - Using a smartphone/tablet for:
 - Voice calls
 - Video calls
 - Texting
 - Messaging apps (Facebook, WhatsApp...)
 - Searching the internet (Chrome, Safari, Internet Explorer)
 - Using Apps (games, translation...)
- Do any of the following make it challenging for you to have an in-person appointment?
 - Transportation
 - Wait-times
 - Language differences
 - Scheduling with family members or caregiver
 - Building accessibility
 - None of the above
 - Other _____
- Would you feel comfortable having a virtual appointment with your provider in the future? Circle the answer: YES/NO
- How often do you have access to a quiet space with internet where you could have a virtual appointment? Circle the answer: Most of the Time/Sometimes/Never
- In general, how often would you like to have virtual visits as part of your care?
 - I would like all my appointments to be virtual visits
 - I would like some of my appointments to be virtual visits
 - I would prefer all my appointments to be in-person

CONCLUSIONS/NEXT STEPS

- Survey data suggests that by addressing gaps in digital literacy and access to technology, virtual care may reduce barriers, thus increasing overall access for some patient populations. Next Steps include: 1) finalizing and implementing the proposed assessment tool in practice and 2) testing and evaluating its effectiveness in different primary care settings

ACKNOWLEDGEMENTS

- This quality improvement project was conducted in partnership with Brock University and the Niagara Falls Community Health Centre.

*References available upon request.



PATIENT RELATIONS: USING UPSTREAM APPROACHES TO PURSUE COMPASSIONATE AND PATIENT-CENTERED CARE AT NIAGARA HEALTH

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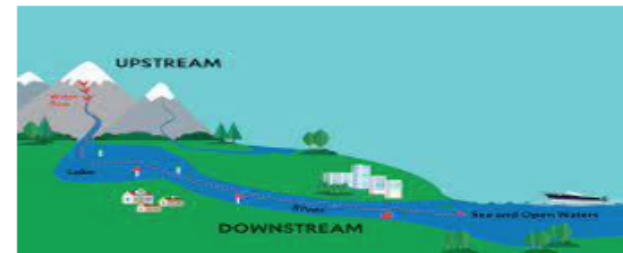
BACKGROUND

- Patient Relations (PR) departments within hospitals and healthcare organizations have a long-standing history of being considered exclusively as an outlet for patient complaints.
- To that end, there is a growing body of literature that advocates for the movement of healthcare to a more patient-centered approach.
- NH noticing uptick of patient and family complaints and did not have a model that allowed them to address these concerns in a preventive way.



AIM STATEMENT

To establish a framework that facilitates an organizational culture of patient-centered care in order to help Niagara Health (NH) create a PR model that is more preventive and upstream, rather than relying on a patient complaints process.



METHODS

Data from the following sources was evaluated:

- ✓ Peer-reviewed journal articles on patient-centered care and other related concepts
- ✓ Best practices in PR in the top ten healthcare organizations internationally
- ✓ Patient complaint data from NH
- ✓ NH Patient Declaration of Values

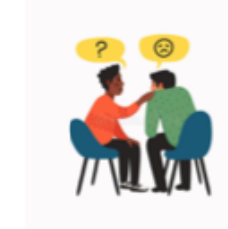


- This information was then used to create a short-list of values which constitute an organizational culture of patient-centered care.
- List of values was shared in a short survey to specific departments within NH to seek their input.

RESULTS

Common values included:

- 1. Communication:** communicating treatment information clearly and in a way that is tailored to patient as demonstrated by behaviours such as active listening and asking open-ended questions.
- 2. Empathy/compassion/respect:** understanding each patient's personal experiences and ensuring patient feels safe enough to share their concerns and health issues.
- 3. Shared decision making:** incorporate patient and family perspectives in treatment plan and involve families in healthcare decisions.
- 4. Teamwork:** communication and collaboration between members on the care team as well as with patients and families. Creating a safe environment where each team member's ideas are valued and encouraged.
- 5. Accountability/responsibility:** ensuring that patients' best interests are priority by taking the opportunity to follow-up on patient concerns in order to learn from them and make meaningful change



NEXT STEPS

- Analyze survey results and revise framework accordingly using PDSA cycles.
- Connect values with associated behaviours/actions that can be implemented.
- Establish best practices that pioneer innovation both regionally and provincially.

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- Newell, S., & Jordan, Z. (2015). The patient experience of patient-centered communication with nurses in the hospital setting: a qualitative systematic review protocol. *Journal of Clinical Pharmacy and Therapeutics*, 40(1), 76-87. doi: 10.1111/jcph.12072

A REVIEW OF POST-INTUBATION ANALGESIA AND SEDATION WITHIN EMERGENCY DEPARTMENTS IN A MULTI-SITE COMMUNITY-BASED HOSPITAL SYSTEM

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AFFILIATIONS: Brock University, Department of Applied Health Sciences¹; Niagara Health²



BACKGROUND & AIM

There is great variability of practice in regards to post-intubation care in the emergency department (ED), specifically in the provision of analgesia and sedation. Given the current demand on our healthcare system, intubated patients are remaining under the care of the emergency physician for longer periods of time. Furthermore, the ED setting is lacking clear guidelines regarding post-intubation care to guide clinicians in their management. Previous literature has suggested that provision of analgesia and sedation is often delayed or inadequate following endotracheal intubation in the ED which can lead to negative outcomes. Sedation protocols in other settings have been suggestive of reducing ICU length of stay, mechanical ventilation, resource utilization and mortality. The objective of this study was to review practice patterns in the provision of post-intubation analgesia and sedation in a multi-site community hospital emergency department (ED).

METHODS

A retrospective chart review was conducted to identify all ED intubations from April 2015 until December 2019. Inclusion criteria consisted of all patients intubated by means of rapid sequence intubation (RSI) in the ED, patients remaining in the ED for at least 30 minutes post-intubation and surviving to hospital admission. Data analysis was performed by frequency to determine general trends in specified variables. These variables included patient demographic information, indication for intubation, choice of induction agents, choice of post-intubation analgesic, sedative and paralytic if applicable, timing of initiation of post-intubation sedation, post-intubation destination (ICU, transfer etc.) and ED length of stay post-intubation.

RESULTS/FINDINGS

750 charts were reviewed, with 487 included in the analysis due to insufficient data in the remaining charts. Wide variability was seen in the choice of sedative used for induction, the most common being propofol in 23% of intubations. A post-intubation sedative was given in 85% of patients at a median time of 12 minutes after induction with 52% of total patients receiving propofol. Only 40% of patients received a type of analgesic post-intubation administered at a median time of 26 minutes following induction, the most common agent being fentanyl. Rocuronium was administered as a paralytic agent in 55% of cases, succinylcholine in 27%, a combination in 1% and no paralytic in 16% of cases. 47% of those who received post-intubation sedation had hypotension documented at some point. ED length of stay post-intubation was a median time of 153 minutes.

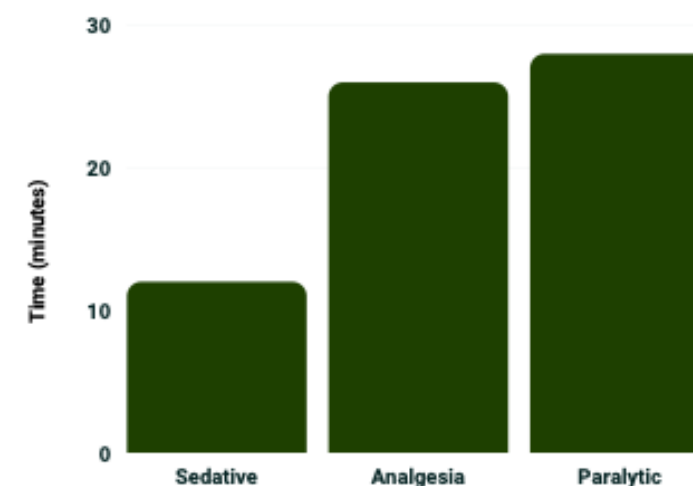


Figure 1: Comparison of drug administration timing post-intubation in the provision of RSI in the ED.

CONCLUSION

Current literature and best practice point to the benefits of an analgesia-first model of post-intubation care. The current review was a first step in understanding current practice and adherence to these standards, with a goal to facilitate a quality improvement approach that enhances care for ED intubated patients. This study signals that post-intubation analgesia is insufficient and delayed in most cases which warrants further review and discussion to improve patient care.

NEXT STEPS

The next steps from this review are to revisit the clinical practice patterns in regard to sedative and analgesia administration. More investigation is needed into these practices in the ED and evaluation of patient outcomes is needed for comparison. Further, there is potential for a quality improvement project where implementation of an analgesia-first model of intubation can be evaluated.

REFERENCES

Available upon request

Authors: Lidia Mateus¹, Evelin Melekh¹, Vani Sharma¹, Sophia Nikitin¹, Madelyn P. Law¹, Anna Boric², Megan Brown², Brandon Batey², Fred Cipryk²

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Background

The Covid-19 pandemic has put an immense strain on hospitals globally, requiring rapid responses in order to maintain quality of care. Majority of patients receive their care in community hospitals; however, most research on how hospitals are adapting and responding to the pandemic originates from academic medical centres. Due to differences in resource availability, approaches to maintaining quality of care that are used within academic medical centers may not be applicable or feasible within community hospitals. Prompted by collaboration with Niagara Health (NH), a local community hospital team, the authors investigated approaches taken in community hospitals to maintain quality of care in response to the pandemic.

Aim Statement

This scoping review seeks to explore the impact of Covid-19 on the six domains of health care quality within community hospitals, through the investigation of pandemic response strategies.

Methods

Articles were collected using Medline and CINAHL databases, resulting in 95 articles. Two levels of screening were performed by four independent reviewers, and this resulted in 17 articles that were included for data extraction.

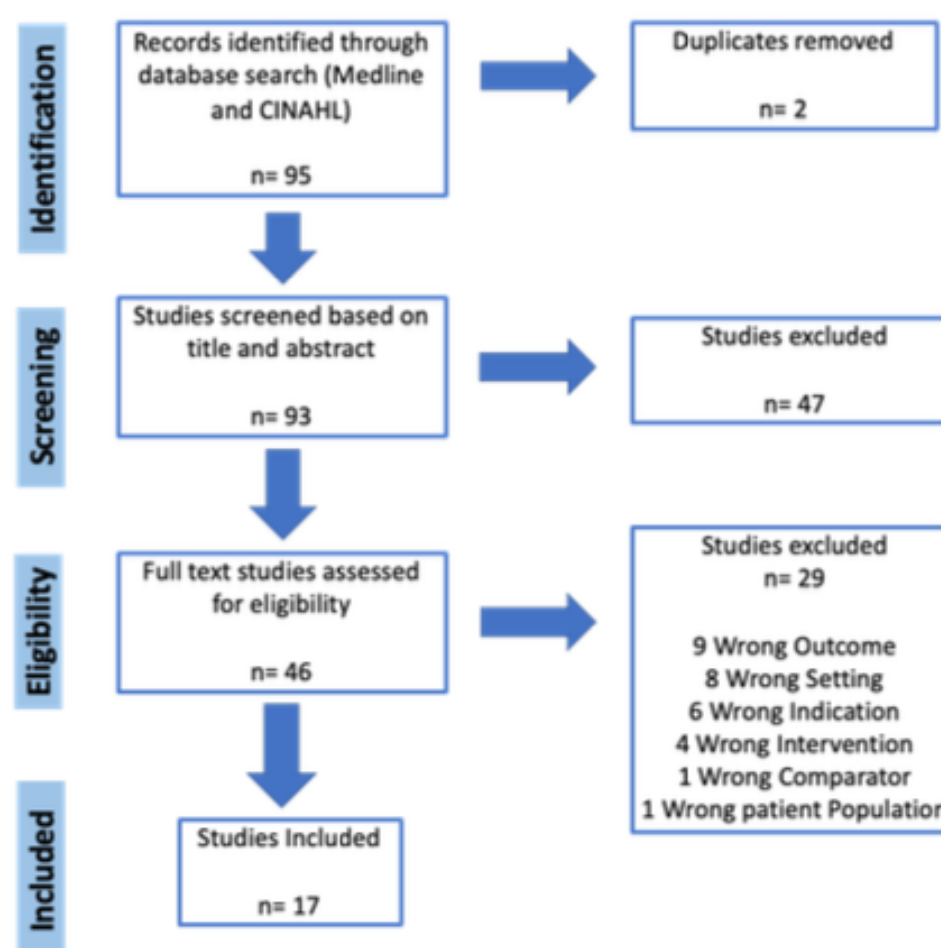


Figure 1. Flow Diagram of Included Articles

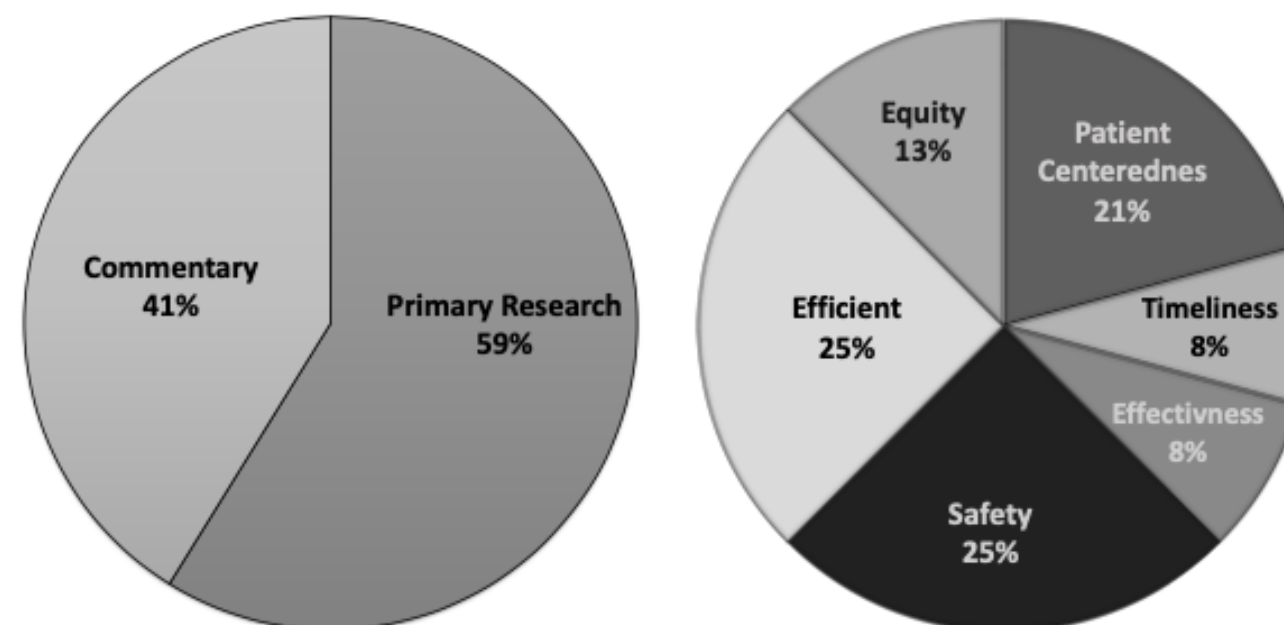


Figure 2. Article Characteristics

Results

Three primary pandemic responses that addressed each of the domains of quality were evident. Community hospitals responded to the pandemic by restructuring workflow, restructuring physical space, and implementing virtual care. Many of the responses described in the literature were also applied within NH, demonstrating feasibility as well as the potential barriers. Through the implementation of these responses, the domains of health quality such as: timeliness, effectiveness, and equity were addressed less frequently than safety, efficiency, or patient centeredness. Rapidly shifting priorities and limited resources may explain the uneven distribution across the dimensions of health care quality.

Conclusion

Community hospitals-maintained quality of care during the Covid-19 pandemic by implementing small- and large-scale responses. Through adaptive thinking, sharing of information, and creative use of available resources, community hospitals were able to address each dimension of health care quality. Further research is needed to understand why certain dimensions of quality were prioritized over others and the effects of the deprioritized dimensions on patient care and experience.

Transitioning Patients on Long-Acting Injectable Antipsychotic Medication

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All authors involved contributed equally to the project at hand

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What is Schizophrenia?

Schizophrenia is a very serious mental disorder that alters the way people interpret and perceive reality. Some common symptoms of schizophrenia include, disordered thinking, delusions, hallucinations, disorganized speech as well as altered personality. Many people have genetic predisposition to get the disorder, however, the symptoms are typically initiated by experiencing a traumatic event such as abuse or extreme change in one's life. Most patients with this disorder get diagnosed in their 20s after which they are prescribed life-long treatment. Implementing treatment early can help with ensuring that serious complications are avoided.

Long-Acting Injectable Antipsychotics

Long-acting injectable antipsychotics (LAIs) are commonly prescribed to patients who have schizophrenia. There can be many reasons why someone with schizophrenia would be prescribed with an LAI as apposed to daily medication with the most common being issues with dosage adherence. The introduction of these medications can be very beneficial as LAIs ensure that patients are receiving their appropriate dose at a frequency that continues to provide the desired benefits.

Purpose of the Project

The purpose of this project is to develop a care transition process to connect individuals receiving LAIs in Niagara Health to primary care settings.

This presentation provides an overview of the developmental stages of this project from the development of a Readiness Scale, Transition Process Map and Evaluation of the Transition process.

What are Community Health Centers?

Community health centers (CHCs) are non-profit organizations which deliver primary health care services, illness prevention services and run health promotion campaigns.

CHCs have a strong community development focus, rather than solely focusing on the health of individuals CHCs often run initiatives that target social, economic and environmental problems that negatively impact the health of individuals and their community. For these reasons, partnering with CHCs are the ideal setting to focus on the care transitions for the clients on LAIs.

Throughout this project we partnered with two CHCs, namely, Quest Community Health Center and The Niagara Falls Community Health Centre.

Community Health Center Benefits

In the CHC the clients will:

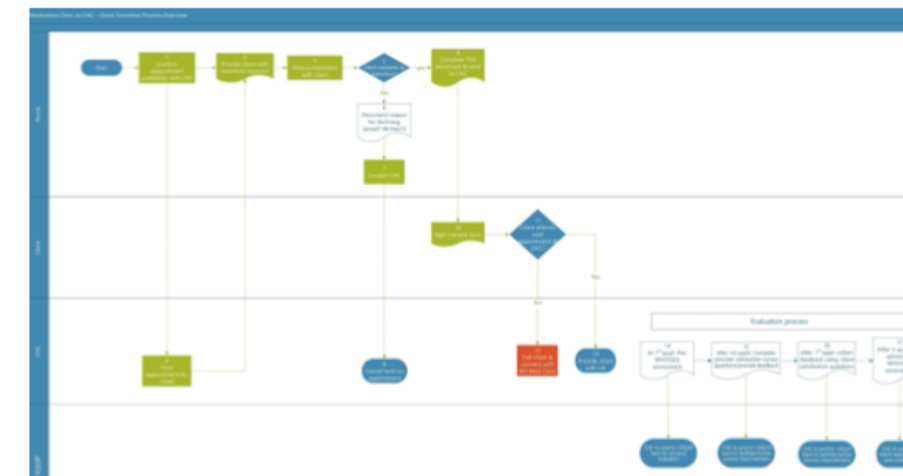
- ✓ receive primary care and LAI in one location
- ✓ have greater access to community and health resources
- ✓ build rapport with health care providers
- ✓ help to alleviate pressure on hospital clinics due to capacity limits in on site clients



1. Client Transition Process

Readiness Scale for Client Transition		
High-Risk Future Clients Transitioning	Moderate-Risk Clients Second Clients Transitioning	Low-Risk First Clients Transitioning
<ul style="list-style-type: none"> - Client has had high (11+) admissions to inpatient mental health in the past year - Client has been at NH Medication Clinic for less than one year - Client has no community primary care provider, just psychiatrist through NH Medication Clinic, not willing to accept from CHC - Client's current LAI being adjusted, not taking routinely - Client / substitute decision maker is aware of transition / disagrees with / struggles to transition - Primary care provider requires further knowledge & skills training to accept client to provide LAI - Client new to LAI medication 	<ul style="list-style-type: none"> - Client has had moderate (6-10) admissions to inpatient mental health in the past year - Client has been at NH Medication Clinic for one year plus - Client does not have community primary care provider, but is willing to accept from CHC - Client stable with current LAI, some side effects and /or inconsistently taking routinely - Client / substitute decision maker is aware of transition / agreeable to transition - Primary care provider is knowledgeable, skilled and able to accept client to provide LAI 	<ul style="list-style-type: none"> - Client has had low admissions to inpatient mental health in the past year - Client has been at NH Medication Clinic for one year plus - Client has NFCHC or QUEST as primary care - Client stable with current LAI, no side effects, taking routinely - Client / substitute decision maker is aware of transition / agreeable to transition - Primary care provider is knowledgeable, skilled and able to accept client to provide LAI

2. Transition Process Map



3. Evaluation of Transition Process

Provider Satisfaction Survey

- Completed after clients' first appointment
- As a healthcare provider did you feel like you had the knowledge, skills and capacity to accept this client and provide them with their Long Acting Injectable?

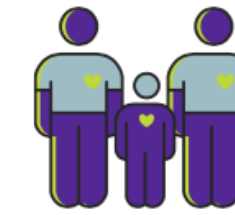
Client Satisfaction Survey

- Completed after clients' first appointment
- Prior to being transitioned, were you provided with enough information about the transition process to allow for an easy and comfortable transition of care

THE WORLD HEALTH ORGANIZATION QUALITY OF LIFE (WHOQOL)

- Pre and Post assessment of patient's quality of life
- Approximately 26 questions

Provider Perceptions of Virtual Care at Pathstone Mental Health



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PROJECT OVERVIEW

The goal of this research project was to utilize stakeholder experiences to maximize the effectiveness of virtual programming at Pathstone Mental Health, revealing areas of success and areas for improvement. A secondary aim was to create tools to aid, support and address gaps in virtual care services.

The research sought to understand the perspectives of three identified stakeholder groups; clients aged 12-18, parents/guardians of clients, and providers. Both questionnaires and focus groups were conducted to gain a comprehensive understanding of the

various perspectives involved. Within these questionnaires and focus groups, metrics related to experiences, feelings/opinions, concerns, barriers, supports, and satisfaction were collected.

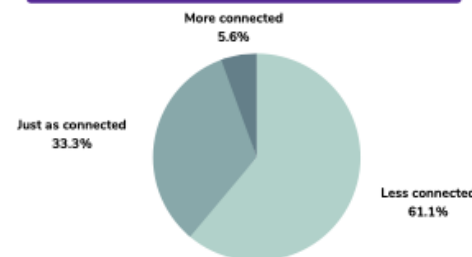
QUESTIONNAIRE

Due to low client and parent/guardian participation, only provider results can be disseminated as there are concerns of confidentiality and privacy. A total of 18 providers responded.

Provider Participant Demographics

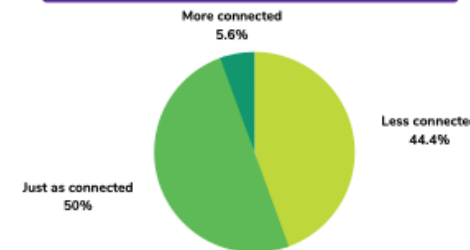


How emotionally connected do you feel to your clients during virtual services in comparison to in-person services at Pathstone Mental Health?

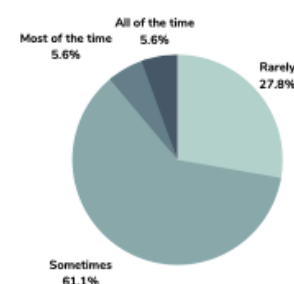


44% of providers felt **less impactful** conducting virtual services in comparison to traditional in-person sessions.

How emotionally connected do you feel to your clients' parents/guardians in comparison to in-person services at Pathstone Mental Health?



How often are you concerned that your clients do not have a private space to talk to you?



FOCUS GROUPS

Focus group interviews were held with providers in March 2022. Below are common themes discussed in the interviews along with a representative sample of quotes from provider participants.



"So I find kind of those those therapeutic relationship, active building activities - I don't get to do [them] as much virtually. Maybe even as an agency if there's an opportunity for increased training about how do you play a game online with a youth or these are some options [for relationship building activities]."

"...You might have a session planned with the client and they get on and they're sobbing about something. And that's when I feel like there's really this distance. You just wish you could be physically there with them. So, I I feel that even myself as the therapist sometimes that can be difficult"

"I do believe that I'm providing service to kids who if we didn't have virtual means, might not actually be receiving services in the first place."

"I've had a client that couldn't have complete privacy while they were talking to me. [People] walk into the room or they get interrupted in some way... the walls are just too thin in their home, and they didn't feel that they had quite the amount of privacy that they would have if they were to come to the office."

CONCLUSIONS

Below are the key findings from the questionnaire and focus groups that should be taken under consideration by Pathstone Mental Health.

- 1. Privacy**
 - Providers are often concerned about the level of privacy clients have during virtual sessions
- 2. Making Connections**
 - Providers want to be able to foster relations with their clients virtually
- 3. Management**
 - Emergency procedures should be clearly understood by all parties and updated regularly

Check out the full report here!



Pathstone Mental Health – Violence Threat Risk Assessment Service Pathway

Help Me, Help Myself: Effective Therapy for High Risk Youth

Authors: Anusha Chacko¹, Silvana Nguyen¹, Ryan Andres², Erin Clayton², & Madelyn P. Law¹

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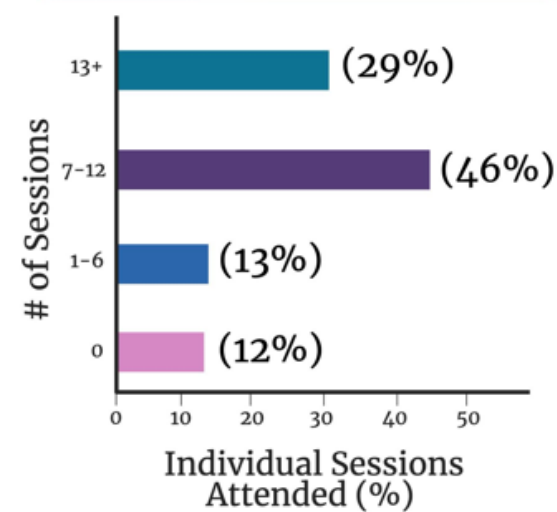
What is Violence Threat Risk Assessment (VTRA)?

The Violence Threat Risk Assessment (VTRA) is a community protocol used to promote the safety and well-being of children/youth, families, and communities by responding to incidents of high-risk threats and violence by children/youth.

High Risk Behaviours

- Threat is specific and plausible.
- There is an identified target.
- Student has a capacity to act on threat.
- Information suggests strong concern about the student's potential to act violently
- Receive increase in baseline behaviour
- Immediate intervention is required to prevent an act of violence from occurring.

Individual Sessions Attended



September Project Aim

80% of referrals through the VTRA pathway to the Pathstone Mental Health High Risk program meet program eligibility.

September - December Methods

Increase internal knowledge and awareness of VTRA service pathway, as well as external knowledge and awareness of High Risk program eligibility through:

- 1) Design of Pathstone VTRA Service Pathway Process Map
- 2) Design of VTRA information document for youth and families

Results

• VTRA service pathway referrals were audited by the High Risk therapist for appropriateness
 Identified potential internal and external knowledge gaps

January Project Aim

The Pathstone Mental Health VTRA team is collecting feedback on quality of the VTRA process and service pathway from different stakeholders

January - April Methods

- Creation of 3 surveys:
 - (1) Client/Youth Feedback
 - (2) Parent/Caregiver/Guardian Feedback
 - (3) Therapist Feedback
- Feedback surveys from each perspective to determine the effectiveness of the referral process and other factors for improvement.

Next Steps

- Presentation of Process Map and knowledge translation to all Pathstone staff
- Presentation of Feedback surveys to Niagara Community VTRA Team
- Begin collecting Therapist Feedback



Supporting the ECP Program at Niagara Health

Noah James¹, Jessica Mrezar¹, Evelin Melekh¹, Madelyn Law¹, Sonia Pagura², Phillip Valvasori², Fred Cipryk²

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BACKGROUND/OVERVIEW

In rapid response to the highly transmissible nature of SARS-CoV-2, many hospitals limited visitors with rare exceptions on a case-by-case basis. These restrictions were sweeping and immediate. A **scoping review** was conducted to identify published and unpublished literature that described the impact of pandemic-related hospital visitor restrictions (HVRs) on patients, care partners, and staff during the COVID-19 pandemic. This review found that these significant HVRs had deleterious effects on the quality-of-care patients received, their mental health, and physical health.

To address the unintended effects of the sweeping HVRs, Niagara Health implemented the Essential Care Partner (ECP) Program in January 2021. The ECP program has been subject to continuous quality improvement since inception. An organization wide **Staff Survey** was sent distributed to evaluate staff awareness of, attitudes towards, and suggestions for the ECP program.

AIM STATEMENT

This project sought to support the Quality and Patient safety staff at Niagara Health to ensure their pandemic response was evidence informed and subject to continuous quality improvement.

The Impact of COVID-19 Hospital Visitor Restrictions on Patients, Caregivers, And Staff: A Scoping Review

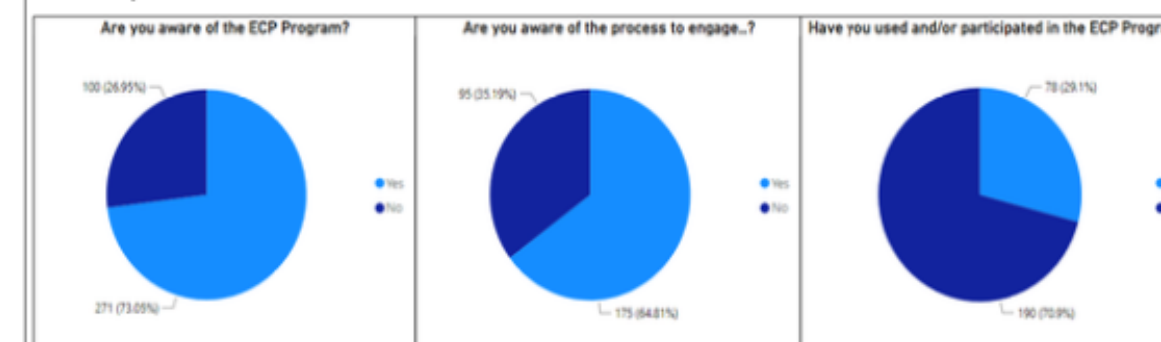
- 6 Databases were searched for published and pre-print literature (PubMed, Embase, EMCARE, Medline, CINAHL, and medRxiv)
- All 1904 citations returned were screened by three reviewers and 48 relevant citations were included in the final review

Four **Major Themes** were identified from the 48 articles:

1. Leveraging the use of technology
2. Impact on vulnerable populations
3. Quality of care considerations
4. Mental health concerns

The findings of this scoping review demonstrate that HVRs have negatively impacted the mental, and in some instances physical, wellbeing of patients, care partners, and staff. Future visitor restrictions must be carefully developed prior to implementation while considering the perspectives of all hospital stakeholders.

Survey Results



	Strongly Disagree	Strongly Agree	Mean	Standard Deviation	Variance	Count
The criteria to identify and recruit an ECP is clear.	1	5	3.55	1.18	1.39	75
The process for staff to identify and recruit an ECP is simple and easy to navigate.	1	5	3.43	1.11	1.23	75
The ECP is valued by staff and physicians as a way in which to improve the patient and family care experience at NH.	1	5	3.63	1.23	1.51	75

Of 414 responses, 374 were complete and included in the analysis. Responses were received from all NH sites with most respondents working days (49.8%) and from the St Catharines site (48.9%). The **majority (67%) of staff who were aware and knew the process agreed that the ECP program is valued at NH.** A total of 139 open-ended responses were reviewed, most indicated that the ECP program had a strong positive effect on patients emotional and cognitive wellbeing. **The concept of ECP Champions (mentors) was mentioned numerous times and is being investigated as an addition to the current program.** Other areas of improvement included further streamlining and clarification of information pathways; these improvements are currently underway.

CONCLUSIONS/NEXT STEPS

- The scoping review along with recommendations from Niagara Health on how to address some of the concerns raised in in preparation for publication
- **The evidence provided from the Scoping review and data from the survey provide evidence and improvements from which to base a program expansion on. A similar program is being developed for ambulatory care patients.**

REFERENCES

*available upon request

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Social Prescribing: Developing the Infrastructure at a Community Health Centre

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Background

According to the Social Prescribing Network, social prescribing is a means of enabling healthcare professionals to refer patients to a link worker, to co-design a nonclinical social prescription to improve their health and wellbeing [1]. Throughout 2020 and 2021, Quest Community Health Centre partnered with the Interprofessional Education for Quality Improvement Program (I-EQUIP) at Brock University to build the infrastructure for social prescribing.

Aim Statement

The aim of this work was to develop the infrastructure for social prescribing at Quest Community Health Centre.

Methods

Drawing on the Social Prescribing Guidebook that was released by the Alliance for Healthier Communities [2], which conducted Canada's first social prescribing pilot [3], team members worked together to create the infrastructure for social prescribing. They created a social prescribing process map, created a social prescription pad for health care providers, created a social prescribing menu for clients and link workers, developed an evaluation plan, worked with data experts to establish social prescribing documentation in the electronic medical record, conducted social prescribing training sessions for staff members, including separate sessions for health care providers and link workers, and held a social prescribing launch session for clients.

Results

Team members successfully created the infrastructure for social prescribing. The Social Prescribing Guidebook played a crucial role in guiding this work [2].

Conclusions and Next Steps

The time and effort that team members put into building the infrastructure for social prescribing was critical to the successful launch of social prescribing. Through PDSA cycles, improvements will be made to the social prescribing pathway over time. A convergent parallel mixed methods approach will be used to conduct a process and outcome evaluation of social prescribing. With social prescribing gaining momentum across Canada, it is anticipated that this work will help to advance the evidence base on social prescribing in Canada.

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