



How Are We Doing? A Home Health Agency Self Assessment Survey on Patient Transitions and Family Caregivers

Well-planned and managed transitions are essential for high quality care and patient safety. Transitions occur when patients are admitted and discharged, when they move from one care setting to another (for example, from rehab or hospital to home with home care). Transitions also occur when home care ends. When family caregivers are informed about what is going to happen and prepared for their roles and responsibilities, transitions are smoother and more effective. Yet home care agencies do not always focus on communication with family caregivers in a systematic and integrated way. For instance, does your agency know how well it manages transitions? Does it involve caregivers in discharge planning? Does it assess a caregiver's ability and willingness to assist their family member after the end of home care?

As part of its *Next Step in Care* campaign (www.nextstepincare.org), the United Hospital Fund, a nonprofit research and health policy organization, designed a home health agency self-assessment survey to help home care agency staff evaluate how well they work with family caregivers in planning transitions. A companion survey for family caregivers is also available.

Self-assessments are important because they give you a realistic view of what is happening in the day-to-day practice of your agency. They help you sort out problems that need considerable work from issues that appear to be working reasonably well and perhaps need only staff reminders to be on track. Unlike surveys in which you try to put your best foot forward, this is a survey that requires you to look at both feet honestly and constructively.

If the issues that arise through the survey process then become part of a multidisciplinary approach to fix the problems, your staff's day-to-day work should become more manageable and more satisfying. Utilizing the surveys at your agency can provide you with the feedback necessary to improve quality of care, increase patient and family satisfaction, as well as provide staff the tools needed to better manage patient transitions.

These self-assessment surveys were piloted at a number of hospitals, rehab units in nursing homes, and home care agencies in New York City. The results guided Fund staff and consultants in creating the guides and checklists available on the *Next Step in Care* website.

The surveys are presented here in PDF format. If you want to add questions (for example, about a specific patient population), please contact us at 212-494-0760 or nextstepincare@uhfnyc.org. We will be pleased to work with you to make necessary adaptations.

How to Use the Self-Assessment Surveys

These surveys are the initial steps in identifying areas of strengths and weaknesses around which an action plan can be developed to improve the quality of transitional care. Here are some suggested steps in the process:

1. Designate someone to coordinate and monitor the process.
2. Determine whether you want to distribute the staff survey broadly throughout the agency or target it to a specific unit or patient population. If you distribute the surveys broadly, you will need to assign different codes so that you know which unit is responding.
3. Make sure that there is broad representation among the staff taking the survey. Each person who completes the survey will have a different perspective, depending on whether he or she works in administration, finance, nursing, social work, or therapy.
4. All replies should be anonymous and surveys should be distributed in ways that allow staff to complete and return them without being identified. Stress that you are looking for what actually goes on, not what is supposed to happen.
5. You can print the survey for distribution and collate responses, or you can use an online survey service such as Survey Monkey, Polldaddy, or Zoomerang, which are easy to use and summarize the results for you.
6. Set reasonable deadlines for returning the survey.
7. Develop a plan for sampling family caregivers with the companion survey.
8. Compare family caregiver results with the staff findings to determine areas of agreement and disagreement.
9. Report findings back to all relevant staff members. Congratulate them on the strengths that you found.
10. Use the results to develop a plan to tackle the problems you identified.
11. If your plan involves integrating Next Step of Care materials into your practice, you may want to repeat the survey after a period of using the material to evaluate impact.

In addition to the surveys, you may want to consider other sources of information:

- Review of agency's admission and discharge packet (What information is provided specifically for family caregivers?)
- Focus groups with family caregivers, staff, community agency personnel who serve your patients
- Review of patient satisfaction surveys to identify areas that are related to family caregivers

Home Health Agency Performance Self-Assessment Survey Instructions for Completing the Survey

The _____ is working to improve communication with caregivers in planning and managing transitions in care. Transitions occur when patients are admitted and discharged, or move from one setting to another (for example, from hospital, rehabilitation facility, or nursing home to home and vice versa). Improvements in this area can impact quality of care and patient safety. To help us evaluate our work with family caregivers, we ask that you complete the attached anonymous survey by _____. *The survey should take about 20 minutes to complete.*

Developed by the United Hospital Fund, a nonprofit research and health policy organization, the survey asks questions about your experience with family caregivers of patients who are admitted to the homecare. The typical patient to think about is an adult who has a chronic illness or serious disability. Some likely diagnoses are stroke, congestive heart failure, and hip fracture or other trauma. This list is not comprehensive; it is only intended to be suggestive.

Family caregiver is a broad category including people who are related by blood, marriage, or adoption, as well as partners, neighbors, or friends. A family caregiver is the person who is going to be responsible for providing or managing the care and communicating with professionals if the patient is too ill, frail, or otherwise unable to participate fully or needs assistance in essential aspects of daily care. The family caregiver may or may not live with the patient.

Some Suggestions

1. As you think about your responses, remember that the survey is about family caregivers of patients who are unable to manage their care on their own, not all patients.
2. In answering the questions think about your experiences with family caregivers within the past month.
3. There are no right or wrong responses. The survey headings give you a wide range of responses ranging from "Always" to "Never," with an additional category of "Don't know/not relevant." Choose the heading that best describes your overall experience.
4. If you want to clarify or add something, there is a space after each section for that purpose. For example, you might say, "this always happens, but there isn't a lot of consistency in the way it's done," or "some other department handles this."

A. Information						
1. On admission our agency provides information to the family caregiver that includes:						
	Always	Usually	About half the time	Seldom	Never	Don't know/not Relevant
a) a number to call with questions 24 hours, 7 days a week.	<input type="checkbox"/>					
b) a list of supplies and/or equipment that the patient needs and how to get them	<input type="checkbox"/>					
c) an estimate of how long the patient will receive home care services	<input type="checkbox"/>					
d) what services insurance will cover	<input type="checkbox"/>					
e) an explanation about personnel delivering services and their roles	<input type="checkbox"/>					
f) a copy of the privacy statement that makes clear that staff members are allowed to provide medical information to family caregivers unless the patient objects.	<input type="checkbox"/>					
g) an explanation of the role of the designated family caregiver in the plan of care	<input type="checkbox"/>					
h) a statement recognizing the importance of the family caregiver to the patient's care and well-being	<input type="checkbox"/>					
i) the resources available to the family caregiver, such as support services, respite, transportation etc.)	<input type="checkbox"/>					
Comments:						

B. Assessment

2. Our home care agency routinely assesses the ability and willingness of family caregivers to provide care.

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
	<input type="checkbox"/>					

This assessment is done by (please select YES or NO) :

	Yes	No
a) written caregiver-specific assessment tool	<input type="checkbox"/>	<input type="checkbox"/>
b) interview	<input type="checkbox"/>	<input type="checkbox"/>
c) direct observation	<input type="checkbox"/>	<input type="checkbox"/>
d) other (please describe):	_____	

Comments:

C. Services

3. To carry out the doctor's orders and care plan, clinical staff ensure that family caregivers are:

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
a) informed about the patient's condition and prognosis	<input type="checkbox"/>					
b) told what services will be provided	<input type="checkbox"/>					
c) told when visits will be scheduled	<input type="checkbox"/>					
d) given instructions about medications, use of equipment, etc.	<input type="checkbox"/>					
e) given the telephone number of a person to contact in the event of an emergency	<input type="checkbox"/>					

Comments:

D. Communication

4. In communicating with family caregivers our agency staff:

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
a) ensures that they are given timely, understandable information about the patient's condition and prognosis	<input type="checkbox"/>					
b) make sure that they are actively involved in decision making	<input type="checkbox"/>					
c) encourage them to discuss and ask questions about treatment goals	<input type="checkbox"/>					
d) demonstrate respect for religious and cultural practices	<input type="checkbox"/>					
e) provide printed materials in different languages, when needed	<input type="checkbox"/>					
f) use professional interpreters (e.g. Language Line, staff who speak the language), when needed	<input type="checkbox"/>					

Comments

E. Training

5. Our home care agency prepares family caregivers to:

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
a) accurately administer medications	<input type="checkbox"/>					
b) observe and report symptoms and side effects of medication	<input type="checkbox"/>					
c) monitor and operate medical equipment, if needed	<input type="checkbox"/>					
d) manage diet and activity	<input type="checkbox"/>					
e) recognize if the patient's condition begins to worsen	<input type="checkbox"/>					
f) know what to bring to the doctor's appointment and what to discuss with the doctor	<input type="checkbox"/>					
g) know what to communicate to the agency after a doctor visit	<input type="checkbox"/>					

Comments:

F. Changes in Care Plan

6. When the plan of care changes, family caregivers are given:

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
a) information as to why the plan has changed	<input type="checkbox"/>					
b) advance notice on when the new plan will take effect	<input type="checkbox"/>					

Comments:

G. When Home Care Ends

7. When home care ends, family caregivers are:

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
a) given timely notice as to when discharge will occur	<input type="checkbox"/>					
b) given information to assist them in obtaining additional care, if needed	<input type="checkbox"/>					
c) provided with clear instructions about medication, diet, activity, and symptom management moving forward	<input type="checkbox"/>					

G. When Home Care Ends (continued)						
	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
d) given the a telephone number of a person to contact with questions or concerns following discharge	<input type="checkbox"/>					
e) given information on when to schedule post-discharge medical visit(s)	<input type="checkbox"/>					
Comments						
H. Communication with Other Providers						
8. In transitions between care settings, our agency shares information with new providers about family caregivers and their involvement.						
	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
	<input type="checkbox"/>					
Comments:						

I. Quality Improvement

9. Overall, I think our agency pays attention to family caregivers' needs.

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
	<input type="checkbox"/>					

10. Overall, I think patients and family caregivers are satisfied with the services, support, and information they receive.

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
	<input type="checkbox"/>					

11. Our agency evaluates family caregivers' experiences and uses that information to improve quality.

	Always	Usually	About half the time	Seldom	Never	Don't know/Not Relevant
	<input type="checkbox"/>					

Comments

J. Optional

12. I am a/an (choose best fit)

- Administrator
- Nurse
- Therapist
- Social Worker
- Other (please indicate): _____

13. What do you find most difficult to explain to family caregiver when opening and closing a case?

14. What would make it easier to support family caregivers during the transition home or from home to another care setting?