

EVALUATION OF THE KENORA WOUND CARE PILOT PROJECT



**Centre for Rural and Northern Health Research
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**Prepared for
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The interpretations and conclusions expressed in this study, however, are the authors' alone and do not necessarily reflect those of the Sunset Country Family Health Team and its project partners, Health Force Ontario or the Ministry of Health and Long-Term Care; no official endorsement is intended or should be inferred.



THE WOUND CARE PILOT PROJECT

Prior to the implementation of the Wound Care Pilot Project, Kenora area patients requiring care for wounds had limited options. Because the community had no outpatient wound service, most people were attending the Lake of the Woods District Hospital Emergency Department for all types of care, including assessments, treatments, routine dressings and follow-up care. Clients with chronic wounds related to diabetes were also seeking specialized care through from Kenora's three primary care clinics, which the clinics were unable to provide, due to limited staffing and a lack of specialized supplies. Some people with chronic wounds also received care through the Community Care Access Centre (CACC) and its network of home care agencies; most patients, however, were ineligible for home-based services because the CACC only had a mandate to deliver care to non-ambulatory individuals.

The Wound Care Pilot Project was created to address these service issues, creating an integrated wound care model that responded to the needs of Kenora area patients. The overall goal of the project was expand the scope of wound care services provided throughout the community by optimizing Kenora health care providers' competencies. Towards this end, best practice guidelines and specialized wound care education were disseminated to staff in acute care, primary care, community care and long-term care settings, with a view to improving the level of care provided.

Across the community, organizations worked collaboratively to ensure that patients received appropriate care for their wounds, while having the ability to access specialized care and follow-up services, as needed. The project also encouraged the

development of client self-management strategies, by developing a range of client and caregiver educational supports. Each client was given an individualized care plan, which fostered patient confidence in their health care providers and encouraged the client to take an active role in his or her wound care. Clients and family caregivers were instructed on the importance of proper wound care (ie., changing dressings regularly with the goal of healing the wound and reducing the chance of infection) and advised to contact their health care providers if they were concerned about any aspect of their wound care.

Long-term goals for the Wound Care Pilot Project included the development of a collaborative Wound Care Management Model which could be transferred and applied to other communities. Organizational policies and procedures regarding wound care also were examined to support the development of common approaches to care. As noted in the following report, however, some barriers arose during the implementation of the project, around referral processes, communications and flows of client information between agencies. As demands for the service grew, locations providing ongoing wound care experienced challenges in accommodating the additional number of clients requiring assessments and procedures.

This evaluation reports on the successes and challenges experienced during the implementation of the Wound Care Pilot Project. As described on the following pages, administrators, front-line providers, and clients give insight on how wound care issues were identified and rectified resulting in a much more streamlined and efficient wound care system.

THE EVALUATION

This study responds to Health Force Ontario's interest in conducting an evaluation of the Kenora Wound Care Pilot Project. The overall goal of the evaluation was to document the implementation of the project and assess evidence around program successes and challenges. Specifically, the research focussed on the objectives of documenting:

- i. Perceived effects on health care providers' confidence in their abilities to deliver competent wound care using best practice guidelines;
- ii. Health care provider and client experiences, with a focus on the implementation of an integrated wound care model;
- iii. Perceived outcomes of the project, in terms of client services, education and support;
- iv. Interface between wound care services provided by the Sunset Country Family Health Team (SCFHT) and those provided through Lake of the Woods District Hospital Ambulatory Day Clinic and the Northwest Community Care Access Centre;
- v. Perceived costs and cost savings of maintaining the Wound Care Pilot Project, including costs associated with maintaining the program within the SCFHT; and
- vi. Perceptions of program successes and challenges, including evidence around the transferability of the model to other Interdisciplinary Care Teams and other Family Health Teams.

Approaches

The evaluation employed both quantitative and qualitative methods to analyse the Kenora Wound Care Pilot Project implementation.¹ Available material, including descriptive reports, assessments, administrative data and consumer surveys, was analysed to document program development. Additional information was gathered through interviews with a purposive sample of respondents identified by project partners. Separate questionnaires were developed for health care providers (Appendix A) or for clients (Appendix B). Each respondent also was given a covering letter (Appendix C or D) and consent form (Appendix E). During November 2009, interviews were completed with 13 administrators and front-line personnel involved in delivering wound care and 9 client-caregiver dyads. These numbers were sufficient to meet the threshold for identification of major themes² and sub-themes.³

Deliverables

Information from all sources has been synthesized into this report, which was presented to the Wound Care Pilot Project partners for review and approval. In its final form, the report will be included as an appendix to the Wound Care Pilot Project Final Report to Health Force Ontario. At the discretion of project partners, results from the study also may be shared in the form of summaries, presentations or web-postings.

¹ All research procedures were approved by the Lakehead University Research Ethics Board.

² Jackson, W. (2003). *Methods: Doing Social Research*. (3rd ed). Toronto, ON: Pearson Education.

³ Guest, B., Bunce, A. & Johnson, L. How many interviews are enough? An experiment with data saturation and variability. *Field Methods*. 2006; 18(1): 59-82.

UTILIZATION OF WOUND CARE SERVICES

Quantitative data contribute significantly to evaluations of innovative health care delivery initiatives by providing concrete evidence that a new program is being used and valued, and that the program is making a clear and measurable difference in the functioning of previously existing systems. The data presented here on the utilization of the Kenora Wound Care Pilot Project offers a summary of the nature of client usage of wound care assessment and services, as well as the array of client conditions and services that were provided.

Statistics gathered in this study were collected from a variety of sources, namely the health care organizations who participated in the pilot project: Lake of the Woods District Hospital, Sunset Country Family Health Team, and North West Community Care Access Centre. Each group created and kept an independent system of tracking patients and visits throughout the nine-month period during which the Kenora Wound Care Pilot Project was active.

Attempts have been made, therefore, not to compare, but to utilize each dataset for the most useful information it presents. Taken together, these statistics confirm that the Kenora Wound Care Pilot Project served a diverse group of clients, providing both acute and continuing wound care services throughout the duration of the project. As noted on the following pages, four sets of data were available, documenting the number of wound care clients served by: (i) Lake of the Woods District Hospital Weekly Wound Assessment Team; (ii) Sunset Country Family Health Team; (iii) Community Care Access Centre; and (iv) Lake of the Woods District Hospital Emergency Room.

i. Lake of the Woods District Hospital Weekly Wound Assessment Team Clinic

On a weekly basis, the Lake of the Woods District Hospital Wound Assessment Team held a one-half day clinic for assessment of complicated, acute and chronic wounds. Patients were usually referred to the Wound Assessment Team Clinics by family physicians or emergency room physicians; however, referrals also were made by nurse practitioners, home care nurses and other health care professionals. Clinics were staffed by a multidisciplinary team including Wound Care Nurses, Surgeon, Chiropodist, Dietitian, Diabetes Nurse Educator, Pharmacist, Physiotherapist and Occupational Therapist, who were affiliated either with Lake of the Woods Hospital or the Sunset Country Family Health Team. With an emphasis on complex wounds (e.g., non-healing after several months), the team provided wound assessment and care management recommendations. Each client received an individualized care plan, including educational materials and referrals to partner organizations for routine dressing changes and various types of wound care.

A total of 578 visits to the Weekly Wound Assessment Team Clinic were made between April 2009 to end of October 2009, with 99 clients receiving care from the team during that period. The average age of clients was 59 years of age, with the youngest client being 15 and the oldest 96. As shown in Figure 1, the Wound Assessment Team assessed and treated clients with a variety of acute and chronic wounds, including: diabetic feet and neuropathy (20), post-operative complications (15), venous stasis ulcers (13), pressure ulcers (11), arterial ulcers (6), mixed venous arterial ulcers (5), trauma (9) and amputations (5).

Figure 1: Kenora Weekly Wound Care Team Assessment Clinic - Conditions Assessed (N = 99)

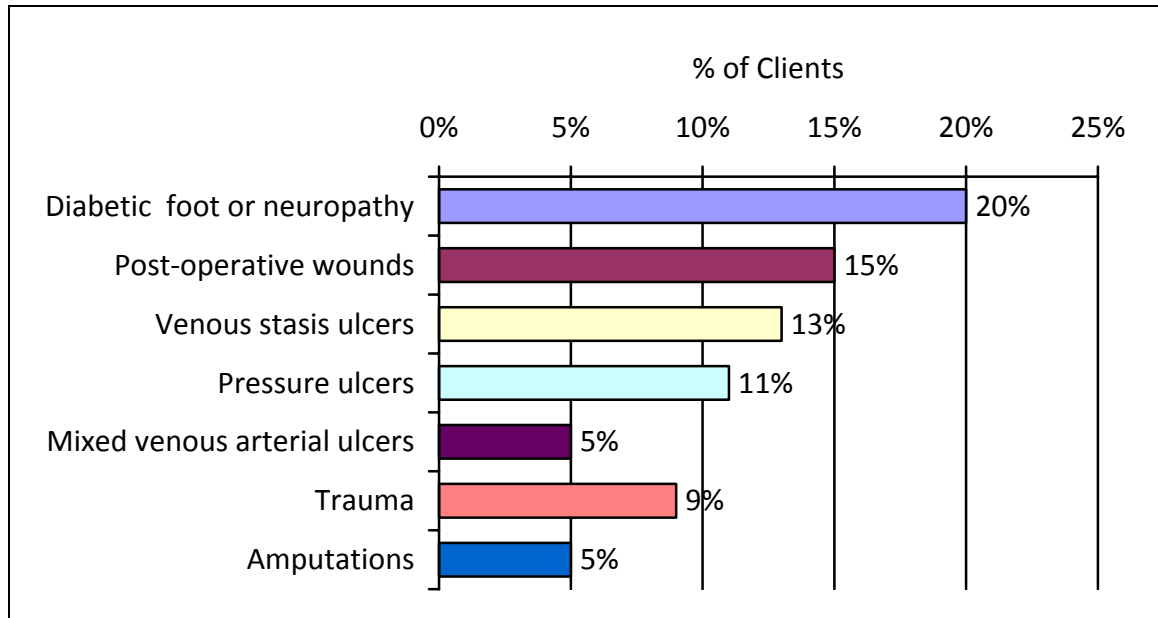
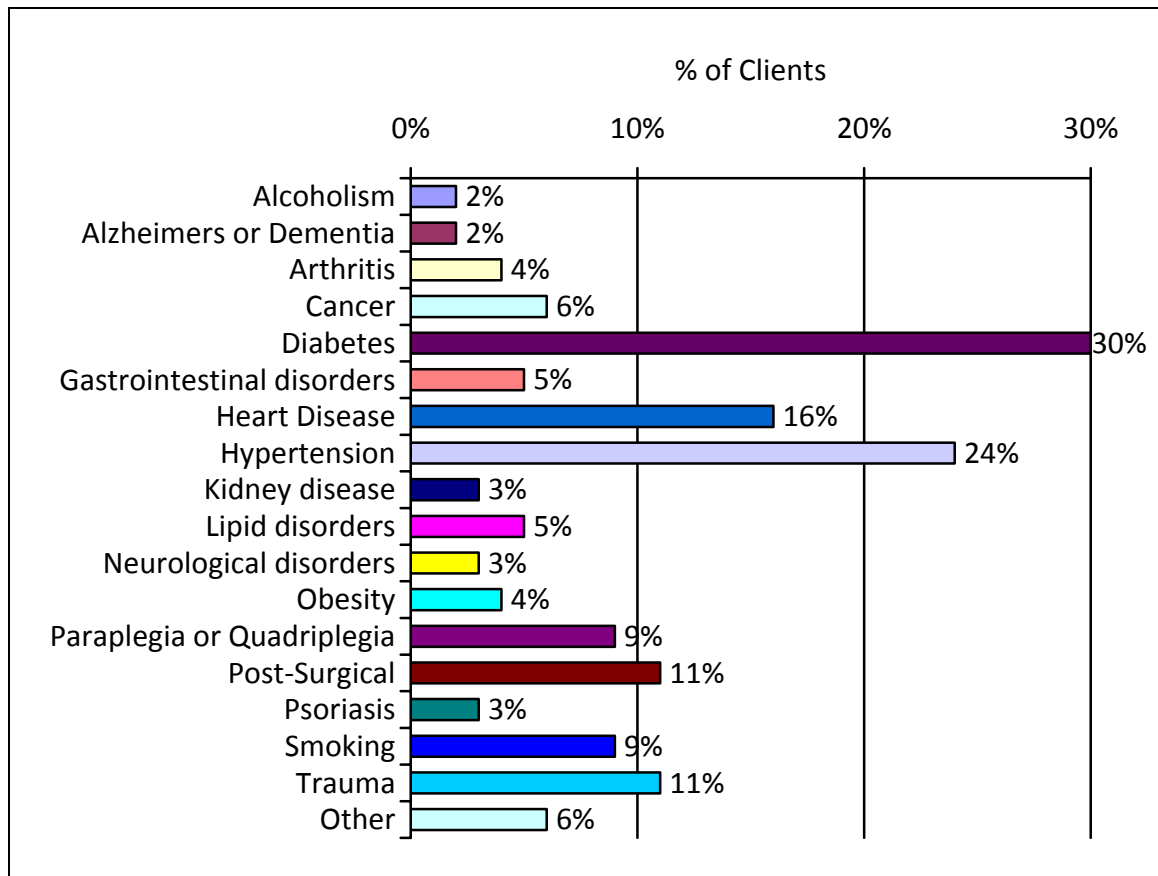


Figure 2 on the following page presents a snapshot of the general health of the patients treated at the Weekly Wound Care Assessment Team Clinic, along with a description of the frequency with which underlying health conditions were seen. As shown on the chart, clients with diabetes accounted for almost one-third of the clients seen; about one-quarter presented with hypertension. Additional risk factors which contribute to poor wound healing, such as smoking and obesity, also were identified. Significantly, more than 70 per cent of the clients visiting the clinic had one or more chronic conditions, which complicated their wound care and necessitated more complex types of treatment.

Figure 2: Kenora Weekly Wound Care Assessment Team Clinic -- Clients' Underlying Health Conditions (N = 99)



As summarized in Figure 3 shown on the following page, close to one-half of the clients attended the Wound Care Assessment Team Clinic only once; after assessment, they were referred to other organizations for follow-up care. An equivalent number, who required continuing care, made between 2 to 9 visits to the weekly clinic. Ten individuals, who had experienced wound complications or wound reoccurrences, each made more than 10 visits for care.

Figure 3: Kenora Weekly Wound Assessment Team Clinic - Number of Visits per Client (n = 99)

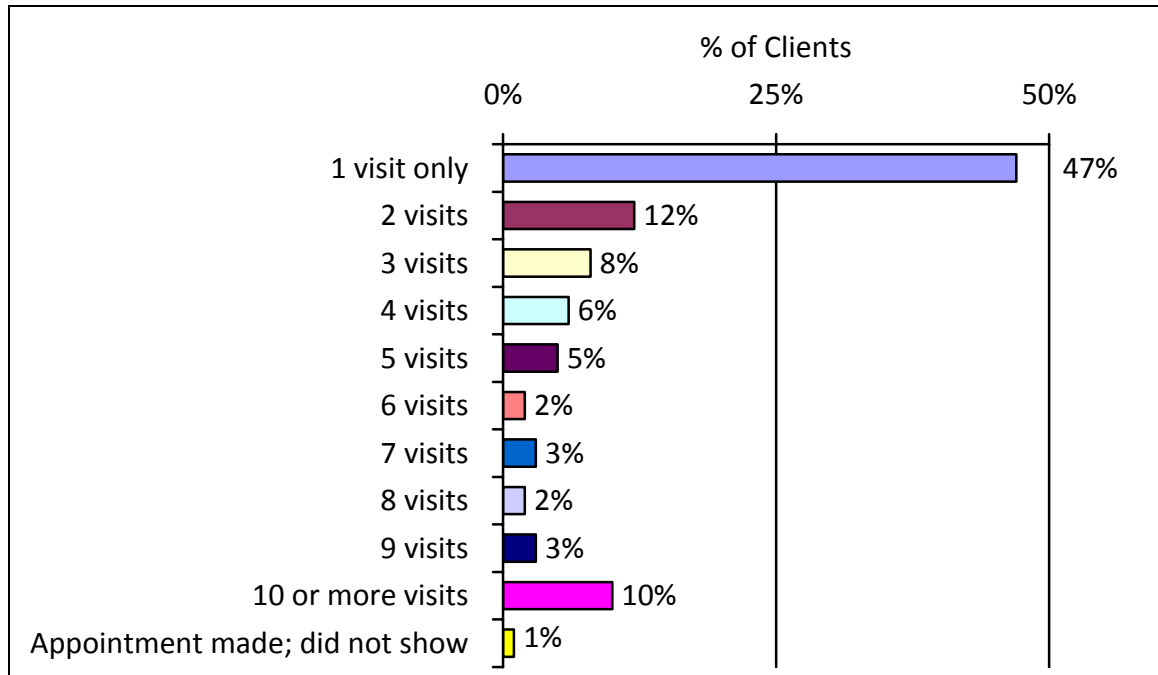


Table A, on the following pages, contains a detailed case-based summary of client care given at the Weekly Wound Assessment Team Clinics. Information is provided on the specific types of wounds assessed, consultations with members of the wound assessment team, as well as referrals for follow-up care through partner organizations, including the Sunset Country Family Health Team, the Community Care Access Centre and, for clients without access to a family physician or nurse practitioner, the Lake of the Woods Hospital Ambulatory Day Clinic. As illustrated, the Weekly Wound Assessment Team Clinics served as a focal point for managing complex wound care and facilitating client access to dressing changes, IV treatments, nutrition counselling, physiotherapy, occupational therapy, and other specialty services.

TABLE A: Summary Of Client Care Given At the Wound Assessment Team Clinic Throughout Kenora Wound Care Pilot Project. Listed by client, including wound description, health professionals consulted, follow-up and additional education. (n = 99)

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
1	PostOp	Surgeon	1	Home Care Nutrition follow up with Dietitian as needed
2	PostOp	Surgeon	1	Family Physician Nutrition review post surgery
3	Burns	Physiotherapy	1	Ambulatory Day Clinic Nutrition and wound healing
4	Diabetic neuropathic	Chiropody	1	Home Care Regular follow up with Chiropodist and Diabetes Educator
5	PostOp	Dietitian, Diabetic nurse educator	1	Home Care Nutrition, glycemic control, diabetes education follow up
6	Trauma	Chiropody, Physiotherapy	6	Education Off-loading techniques, footcare
7	Exposure		1	Education Nutrition, wound healing, exposure
8	Small vessel disease	Chiropody, surgeon	2	Family Health Team Smoking cessation, limb protection, footwear

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
9	PostOp	Physiotherapy, Dietitian	1	Family Health Team Nutrition and wound healing, chronic disease management, post cardiac surgery exercise
10	Charcot	Physiotherapy, Chiropody	2	Referral to Thunder Bay Fracture Clinic Off-loading techniques, footcare, Diabetes management
11	Pressure ulcer	Physiotherapy, Occupational therapy, surgeon	10+	Family Health Team Nutrition and wound healing, chronic disease management, post-surgery exercise
12	Abscess	Surgeon	1	Family Health Team Off-loading techniques, footcare, Diabetes management
13	Diabetic neuropathic	Physiotherapy, Surgeon	7	Debridement and hospitalization
14	Diabetic neuropathic	Physiotherapy, Chiropody, Orthotics	8	Home Care Family Health Team Chiropodist Regularly followed (q6 wk) footcare.
15	Arterial ulcer	Chiropody	1	Family Health Team Dressing changes taught to client Follow up with nurse practitioner

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
16	Pressure ulcer	Physiotherapy, Occupational therapy, Chiropody	10+	Home Care Off-loading techniques, footcare and footwear
17	Cellulitis	Physiotherapy, Occupational therapy	1	Follow up visits with Physiotherapist for lymphedema management
18	Sebaceous cyst		1	
19	Venous stasis ulcer		3	Family Health Team Non-compliant
20	Pressure ulcer		5	Home Care Arrangements made for long-term care placement
21	Diabetic foot	Surgeon	1	Home Care Referral to Winnipeg Diabetic Clinic re grafting
22	PostOp	Surgeon	30+	Home Care Repeated explorations under anaesthetic of small draining sinus
23	PostOp	Surgeon	2	Family Health Team Nutrition and wound healing
24	Pressure ulcer	Occupational Therapy	16+	Home Care Developed additional pressure ulcers, hospitalized for wound and nutrition management
25	Non-diabetic neuropathy	Chiropody, Surgeon	4	Home Care Refer to Winnipeg for further assessment

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
26	Venous stasis ulcer	Surgeon, Physiotherapy	9	Home Care Low compression stocking
27	Diabetic	Chiropody	2	Home Care Footwear, Diabetes Education
28	Mixed stump ulcer		1	Long-Term Care bilateral above knee amputations
29	PostOp	Surgeon	11	Home Care Hardware removed from arm following infection
30	PostOp	Surgeon	1	Home Care Vacuum assisted closure
31	Venous stasis ulcer	Chiropody	2	Had been fitted for stockings but was not wearing them until wounds healed
32	Diabetic foot	Chiropody	12	No other service provider Chart closed
33	Venous stasis ulcer		1	Did not return to clinic
34	Pressure ulcer	Chiropody	6	Home Care Physiotherapy
35	Diabetic foot	Surgeon, Physiotherapy	1	Client was to have x-rays , did not return
36	Trauma	Surgeon	1	Ambulatory Day Clinic Consultation Chart closed
37	Diabetic foot		1	Did not show
38	Trauma		7	No other health care provider
39	Trauma	Surgeon	1	Ambulatory Day Clinic Consultation

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
40	Trauma		1	Follow up with surgeon re infected granulation tissue
41	Diabetic foot	Dietitian, Diabetic nurse educator	12	Ongoing care
42	Pressure ulcer	Occupational therapy, Physiotherapy	3	Home Care Required hospitalization and debridement, then follow up in Winnipeg
43	Cellulitis	Surgeon	1	Referral to Winnipeg for lymphedema management. Could do here; however , Physiotherapist with training no longer works at LWDH
44	Venous stasis ulcer	Dietitian, Diabetic nurse educator	1	Further tests and vascular consultation
45	Diabetic toe	Chiropody	1	Chiropody Orthotics
46	Perineal rash		1	Family Health Team Infection control
47	Incisional dehisced wound		1	Follow up with Surgeon
48	Pressure ulcer	Occupational therapy, Surgeon	14	Community Nursing Ongoing Care Chart closed
49	Venous stasis ulcer		5	Low compression stocking

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
50	Sebaceous cyst	Surgeon	1	Ambulatory Day Clinic Follow up with surgeon Nutrition and wound healing education
51	Venous arterial disease	Physiotherapy	1	Medication compliance
52	Pressure ulcer	Occupational therapy, Physiotherapy	4	Ongoing care Nutrition education
53	Finger ulcer	Surgeon	1	Follow up with family physician Ambulatory Day Clinic
54	Venous stasis ulcer	Dietitian	5	Low compression stockings Nutrition education Ambulatory Day Clinic
55	Abdominal nodule	Surgeon	1	Assessment only
56	Post Surgical hernia repair	Dietitian, Surgeon	13	Community Nursing Continuing care Nutrition Assessment
57	PostOp	Surgeon	4	Synder drain placed Home Care Nutrition and wound healing education
58	PostOp	Dietitian, Surgeon	15	Referral to Winnipeg Ostomy Clinic
59	Diabetic foot	Chiropody, Physiotherapy	3	Assessment and treatment Chart closed
60	Diabetic toe	Surgeon	1	Referred for amputation Chart closed
61	Venous stasis ulcer		1	Long-Term Care

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
62	Venous stasis ulcer	Diabetic nurse educator	2	Home Care Non-adherence to care plan
63	Sebaceous cyst	Surgeon	1	Surgical excision Ambulatory Day Clinic Chart Closed
64	Pressure ulcer		2	Home Care Chart Closed
65	Fungal foot infection	Chiropody	1	Family Health Team Chirpodist follow-up
66	Unknown		0	Did not show
67	Diabetic with knee infection	Physiotherapy	7	Home Care Chart Closed
68	Arterial ulcer		4	Family Health Team Ambulatory Day Clinic Referral to Vascular clinic
69	Diabetic foot	Chiropody	2	No family doctor, no other health care provider Chart closed
70	PostOp abdominal wound		9	Home Care Nutrition and wound healing education
71	Diabetic venous stasis		1	Home Care Chart closed
72	Diabetic feet	Chiropody, Physiotherapy	4	Seen by Vascular Surgeon no concerns Case closed
73	Pressure ulcer	Occupational therapy	1	Seen in Emergency Discussed off-loading techniques
74	PostOp Ostomy	Dietitian	8	Home Care Nutrition Education Chart closed

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
75	Venous stasis		4	Home Care Chart closed
76	Arterial ulcer	Surgeon	2	Long-Term Care Will probably require amputation
77	PostOp Hernia	Surgeon	9	Home Care Taken off home care, so required more clinic visits Nutrition education Chart closed
78	Mixed venous arterial ulcer	Chiropody	1	Home Care Footcare, skincare education
79	Below knee amputation	Chiropody	3	Chiropodist follow up
80	Arterial ulcer	Surgeon	3	Home Care Chart closed
81	Traumatic cellulitis	Surgeon	1	No recurrence Chart closed
82	Venous stasis ulcer	Chiropody	5	Home Care Chart closed
83	Mixed venous arterial ulcer	Surgeon	1	Chronic disease management education Chart closed
84	Pressure ulcers	Occupational therapy, Physiotherapy	1	Admitted to Thunder Bay Regional Health Sciences Centre
85	Mixed venous arterial ulcer		1	Assessment only
86	Fungal foot infection and venous disease	Chiropody	3	Footcare, nailcare education Chart closed
87	Diabetic foot with amputation	Surgeon, Chiropody	5	Footcare education Chart closed

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
88	Sebaceous cyst excision		3	Ambulatory Day Clinic Follow-up as needed Chart closed
89	Traumatic arm wound		1	Ambulatory Day Clinic Follow-up as needed Chart closed
90	Arterial disease	Dietitian, Diabetes Educator	1	Nutrition education, Glucose control Follow-up as needed Chart closed
91	Diabetic ulcer and toe amputation	Footcare, Physiotherapy	3	Follow-up as needed Chart closed
92	Mixed venous arterial ulcer	Physiotherapy, Chiropody	1	Home Care Follow-up as needed Chart closed
93	Impetigo and eczematous lesions		1	Ambulatory Day Clinic Follow-up as needed Chart closed
94	Puncture wounds to arm and hand		1	Follow-up as needed Chart closed
95	Arterial ulcers post-traumatic injury	Surgeon	1	Follow-up as needed Referral to Winnipeg for vascular assessment Chart closed
96	Venous stasis ulcer	Physiotherapy	2	Home Care Nutrition and medication education Noncompliant Chart closed
97	Diabetic below knee amputation non-healing	Physiotherapy, Surgeon	1	Home Care Referral to Vascular Clinic in Winnipeg Follow-up as needed Chart closed

Client #	Initial Assessment Type of Wound	Team Member Consults	# of Visits to Clinic	Follow-up Referrals, Health Education
98	Traumatic wound to arm	Surgeon	2	Ambulatory Day Clinic Follow-up as needed Chart closed
99	Psoratic wound toe	Chiropody	2	Medication education Noncompliant Follow-up as needed Chart closed

ii. Community Care Access Centre

As a partner agency, the Northwest Community Care Access Centre (CCAC) utilized the weekly Wound Assessment Team Clinic for their wound care clients. Table B on the following page shows that 31 CCAC clients visited the weekly Wound Assessment Team treatment between January 2009 and September 2009; 24 clients returned to the clinic more than once for follow-up assessment or treatment; five Community Care Access Centre clients required more than 10 return visits. CCAC clients received a variety of in-home wound care services from the CCAC's contracted nursing agencies, including dressings, other treatment and IV therapy.⁴ Patients requiring wound care, however, only were eligible for in-home services through the CCACC if they were non-ambulatory and would experience undue hardship to go outside the home for their treatment.

⁴ IV therapy was provided in the home only after an initial dose of IV therapy was done in Lake of the Woods Hospital Emergency Department.

TABLE B: Frequency Of Community Care Access Centre Clients Utilizing the Wound Assessment Team Clinic at Lake Of The Woods District Hospital Between January and September 2009 (n = 31)

Client ID#	January-June	July-September	Total Visits Clinic
1	3		3
2	5		5
3	7	2	9
4	8		8
5	3	5	8
6	2		2
7	1		1
8	5	7	12
9	3	6	9
10	6		6
11	5	2	7
12	12	4	16
13	4		4
14	2		2
15	8		8
16	3		3
17	2	4	6
18	4		4
19	1		1
20	4		4
21	12	6	18
23	10	4	14
24	6	9	15
25	2		2
26	1		1
27	5		5
28		7	7
29		1	1
30		1	1
31		1	1
<i>Total</i>	124	59	183

iii. Sunset Country Family Health Team Clinic

As summarized in Table C, the Sunset Country Family Health Team (FHT) delivered a range of wound care services and supports to clients who were rostered with Family Health Team physicians, as part of its commitment to the Kenora Wound Care Pilot Project. Data regarding numbers of patient encounters, referrals, type of treatment received, education given to patients, stocking and ordering of supplies, and training, as well as development events for staff are shown. Wound care, including daily dressing changes, suture and staple removal and other procedures, as well as referrals to other services, were provided on an appointment basis, five days a week, by physicians and wound care nurses. In addition to direct wound care, a significant component of project effort on the part of the Sunset Country Family Health Team was allotted toward enhancing provider competencies, through professional development and education activities (not shown).

TABLE C Summary of Patient Visits for Wound Care with Sunset Country Family Health Team Between March and September 2009. (Note: A patient visit may have included more than one activity).

Summary of Patient Visits								
Month	Mar	Apr	May	June	July	Aug	Sept	Total
Total # Visits	8	125	101	99	97	131	127	688
Reasons for Visits								
Suture removal		26	27	25	42	17	20	157
Staple removal		3	1	5	2	2	5	18
Initial assessments		65	37	9	10	11	16	148
Simple dry dressings	8	22	12	27	54	22	45	190
Complex dressings		18	39	53	47	84	70	311
Patient and family education	2	3	10	4	2	6	16	70
Referrals to other providers		3	7	15	21	22	33	101

iv. Emergency Room Visits

One of the secondary goals of the Kenora Wound Care Pilot Project was to alleviate the pressure and congestion associated with the prior pattern of clients accessing wound care through the Lake of the Woods District Hospital Emergency Department. Table D presents a comparison of Emergency Room visits during the three busiest months of the year (June, July and August) between 2007-08 and 2009-10, which clearly shows an obvious reduction in the number of visits per month. Considering these three months during 2009, when the Wound Care Pilot Project was operational, the total number of individuals visiting the Emergency Room was reduced to 76.4% of what it was in 2007-08. It is reasonable to suggest that the patients seen by the Wound Care Assessment Team Clinic were a large part of that previously existing emergency room traffic.

TABLE D: Lake of the Woods District Hospital Emergency Department Visits, 2007/08 through 2009/10 (June, July and August)

Year	June	July	August	Total
2009-10	1894	2025	1939	5858
2008-09	2197	2397	2439	7033
2007-08	2258	2728	2678	7664

PRIOR TO IMPLEMENTATION

Health care administrators, front-line providers and clients were asked to reflect on the way that wound care was delivered prior to the implementation of the Kenora Wound Care Pilot Project. Their views confirm that care was largely fragmented, with clients often receiving care from multiple sources. Systemic gaps, associated with discontinuities in care, contributed to both provider and client frustrations and, in some instances, were believed to have been associated with poor client outcomes.

Systemic Gaps

Among Kenora's key health service organizations, there was no specific program dedicated to outpatient wound care, which resulted in inconsistencies in service and patient dissatisfaction. With the exception of non-ambulatory patients who received wound care treatment through the Community Care Access Centre's home care organizations and some who sought wound care from family physicians, all other clients went to the Lake of the Woods Hospital Emergency Department for care. Summing up the situation, an interviewee said: "There were definite gaps in the system ... if you didn't qualify for Community Care Access Centre [home care services], you had nowhere else to go but to Emergency."

Another provider mentioned a deficiency in collaboration and communication between health care agencies around wound care, which resulted in lack of flow and no continuity of care, because there were "many different entities, each doing their own thing with different guidelines." The net result was that referrals were problematic;

sometimes “people were getting lost in the shuffle before they were actually able to be seen.”

Client Frustration

Because Kenora had previously not had any comprehensive outpatient wound care services, both health care professionals and their clients reported that patients had experienced considerable frustration in accessing appropriate care. Clients who had been forced to use the Emergency Department for wound care, for example, often had to wait from “four to six hours” for non-urgent care, such as a “routine dressing changes.” Furthermore, the Emergency Department was “so fast paced” that clients would sometimes feel that they had been “just left with a dressing” and not given any detailed instructions about follow-up care.

One of the clients who had a complex wound that required frequent treatment, for example, reported that she was only given “instructions just the first time” about caring for her wound at home. People who needed continuing wound care on a daily or weekly basis often became so frustrated with accessing care through the Emergency Department that they gave up on this source of care entirely. As a health professional stated:

There were long wait times in Emergency, so often people would leave because they would get frustrated and they felt like their needs weren't being met and so they wouldn't bother coming back.

Discontinuities in Care

Given the “massive disconnects and gaps” in the wound care services available to clients in the Kenora area prior to the implementation of the Wound Care Pilot

Project, clients had great difficulty accessing continuing “consultation or ongoing basic care.” Limited collaboration and communication also meant that referrals sometimes were not made effectively, so “people were getting lost in the shuffle before they were actually able to be seen.” Poor communication and collaboration, also contributed to discontinuities in care. As a manager reported, clients who had been referred for follow-up care sometimes arrived “without any kind of documentation as to what had been happening.”

Such difficulties were widely seen as contributing to delays in care and, potentially, leading to poorer client outcomes. Clients who became frustrated in accessing care, who were unsure where to go for follow-up, or who were unable to access timely care all were at greater risk of developing wound care complications. Several providers noted that prior to the implementation of the Wound Care Project, there were people who couldn’t access wound care services when they first needed them and, as a consequence, their conditions became more serious. As an administrator pointed out, such clients “wouldn't have gotten worse had there been an earlier intervention.” Often, delays in care were such that client’s “wound had deteriorated to the point where they required hospitalization because they developed something very significant.”

WHAT THE PROJECT WAS DESIGNED TO DO

The overall objectives of the Wound Care Project could be summed up, in the words of a manager, as improving wound care for Kenora area residents through “communication, common tools, education, developing confidence in the providers, and the funding to have people to do the work.” Towards these objectives, one of the things that the Wound Care Project sought to do develop comprehensive approaches to care that would give clients the possibility of having regular treatment, including assessments and referrals for specialist consultations and education, when needed.

Multidisciplinary Care

All partners in the Kenora Wound Care Project worked towards establishing a collaborative model of care that would allow clients to access the expertise of a wide variety of health care professionals, including Wound Care Nurses, Physicians and Nurse Practitioners, as well as a Surgeon, Chiropodist, Dietitian, Diabetes Educator, Pharmacist, Physiotherapist, and Occupational Therapist. Working collaboratively, the project partners created a collaborative care model to expedite client’s access to appropriate and timely wound care from any point in the system. At the Lake of the Woods District Hospital Weekly Wound Assessment Care Team Clinic, for example, clients could have their wounds assessed by, obtain treatments for complex conditions, and if needed, additional specialist consultations and referrals, as well as client and family caregiver education. At the Family Health Team, clients could have their wounds assessed, obtain both simple dry dressings and complex dressings, have sutures or staples removed, obtain referrals to other health care providers, and access

client and family education. Non-ambulatory clients also could access follow-up wound care, including dressing changes and referrals, through the Northwest Community Care Access Centre's home care agencies.

Continuity of Care

Collectively, the services provided by the Wound Care Pilot Project partners were designed to improve continuity of care by giving clients a level of specialized supports which otherwise had been unavailable. As a provider emphasized, there was a need to alleviate the "huge gaps" that had previously existed in the delivery of services: "We had people calling us all the time, 'I have got a wound I am trying to get help and there is nobody. Where do I go?' and we would say 'I don't know, there is nobody.'" In this respect, the Pilot Project would improve continuity of care by fostering effective partnerships and interdisciplinary collaboration.

Improving Provider and Client Competencies

The Wound Care Project's educational initiatives also had potential to improve health care provider and client competencies. One of the reasons that "patients kept returning and returning" was because there was "no care based on best practices" and no systematic education for clients around "what they needed to do" to prevent complications. Prior to the implementation of the Pilot Project, "there was no consistency in practice or methods, education was far and in between, so we realized that it was a significant deficiency within our community."

EFFECTS ON HEALTH HUMAN RESOURCES

While the Kenora Area Wound Care Project funding covered the costs of hiring a Clinical Nurse Specialist, full-time Registered Practical nurse and part-time administrative support staff, supplies, and educational initiatives, it was pointed out that the delivery of services could only be accomplished through the in-kind services of a multidisciplinary team of health care professionals. The one-day a week operations of the Wound Assessment Team Clinic, for example, required the services of a Surgeon, Nurses, Chiropodist, Dietitian, Diabetic Nurse Educator, Pharmacist, Physiotherapist and Occupational Therapist, all of whom were affiliated with either the Sunset Country Family Health Team or the Lake of the Woods District Hospital. In this respect, the health human resource capacity of Kenora Wound Care Pilot Project was enhanced significantly because participating organizations donated a considerable amount of staffing support to make the project succeed.

Resource Constraints

Given the increasing demand for wound care services which were experienced during the year that the Wound Care Pilot Project was operational, however, administrators acknowledged that the resources devoted to the Wound Care Project, including funding and in-kind contributions, were severely tested. As a manager commented: “We didn’t realize the scope, we knew that there was a need, but didn’t recognize how demanding it was going to be on our time for sure.” Another said: “I don't think we had any idea going into it how many clients we would have.”

Workload

In terms of staffing, the greatest impact seemed to be experienced by front-line providers, who found it difficult to fit the delivery of wound care services into their regular responsibilities. Both the wound care nurses and administrative support staff who booked appointments found it challenging to accommodate the increasing number of clients that were using the services. The extra workload was significant: “we didn’t have enough staff... there were too many people.” Another health care professional emphasized that clinics could have been “extended to full day or two days because there are a lot more people we need to see.” In this situation, “having nurses that only have to do wound care” was seen as the ideal.

There was also awareness that the operations of the Wound Care Pilot Project, to some extent, were limited by the number of health professionals who had the expertise required to provide more care for clients with wound complications. Needs were identified, for example, for physiotherapists trained in “lymphedema management.” Additional nursing staff, with “specialization in wound care,” was viewed as equally advantageous, given the number of clients requiring care.

While unable comment on the resources required for the Wound Care Pilot Project, clients observed that the nurses who staffed the program were increasingly busy, considering the number of people who were using the services and the level of care provided. When prompted, one client remarked that the wound care nurses were “a little overworked.” He added that “they could probably [use] one more to take the overload, maybe two ... it is not only looking after the people, they have to follow up ... multitasking is what it is.”

EFFECTS ON COORDINATION OF CARE & COMMUNICATIONS

One of the widely appreciated outcomes of the Wound Care Pilot Project was the improvement in communications, with significant impacts on the coordination of care and referrals. The development of a standardized referral process between organization, charting flowsheets, and agreement around referral processes gave everyone involved a better of understanding of where patients would receive care. As a manager said, the process improved both provider and patients' understanding of where patients "were going to go and what services they were going to get." He added, "it suddenly gave us some structure to provide to patients."

Standardized Referral Processes

The establishment of common referral processes also enabled "community wide coordination of care." While patients were the primary beneficiaries, health care organizations also found that they could "run a bit more efficiently with the program" in place. The establishment of the Wound Care Project increased coordination of care and provided structure for health care providers. Unlike previously, health care providers "now speak a common language" because of the use of generic forms. Organizations also reported that they now more often received referrals suitable to the services offered and did not have to turn clients down. Even when providers received referrals in error, they were able to direct clients to appropriate departments for care:

Now when we get a referral, usually the referral is appropriate for our services so we are not always on the phone telling clients 'sorry, we can't take you on the program you are going to have to go to Emergency.' ...

Even if we get a referral in error ... we can refer them to the Family Health Team or up to the Hospital so people are happier ... they get directions and they know exactly where to go. So it is better for everybody, families patients, even the morale of the staff here because now they are not getting [criticized] all the time because we are not taking on clients.

Enhanced Coordination of Care

Overall, it is clear that providers felt patient care was much more successful since the implementation of the Wound Care Pilot Project. Comparing the coordination of care through the Wound Care Pilot Project with what had gone before, a health care professional said: “We know now what kind of care they are getting; before we didn’t know; they were just discharged from our program and we didn’t even know what happened to them.” As a front-line provider emphasized, the greatest impact of the project was seen in the improved coordination of patient care:

It is coordination of care for services for the patient. And you have to look at who in the end is the beneficiary of the project. It has to be the community; it has to be the patient. And I think the biggest impact is for the patient ... it’s been able to increase not only their access but their satisfaction with the services regardless of what facility is providing it.

From a patient perspective, improved coordination of care was evidenced by more timely referrals and shorter wait-times for appointments. Most patients were referred to the Wound Care Program through a physician at the Lake of the Woods District Hospital Emergency Department. In one instance, a family caregiver reported that the Wound Care Assessment Team “actually came to the Emergency ... and assessed him for everything right then and there.” Although one of the interviewees said it took some time for him to be referred to the Wound Care Program, most patients were referred relatively quickly to the Wound Assessment Team Clinic. They spoke

positively about the level of ease of making an appointment through the Wound Care Program. Clients and caregivers also confirmed they did not have to wait very much beyond the scheduled time for their appointment. Comparing her experience of appointments with the Wound Care Program to accessing care in the Emergency Department, a client said:

They would give you appointments at a certain time and you could figure that you were going to get it; whereas if you are going to Emergency for something non-immediate you could sit there for five or six hours.

Another patient responded, when asked about wait times: "Waits? Is ten minutes too long?" Another patient recalled the ease of attending: "I would just go in and sign in and *boom* they were right there." Clients also received prompt follow-up appointments when needed. As a family caregiver said about a relative's care, "as soon as she makes one appointment, they give her another one; it's all in a week."

Improved Communication with Clients

The Wound Care Pilot Project, in developing educational materials for clients and caregivers, also ensured that health care providers in the partner organizations were better equipped with information for clients. As well, individualized care plans were seen as an important communication tool, ensuring that clients were fully informed about where they would receive follow-up care. Improved client knowledge along with better communications between health care providers and clients, therefore, emerged as an significant outcome of the project:

We know chronic wounds in particular become very frustrating over time they are time consuming and costly and its frustrating...it is important to

sit down with them right at the beginning and talk about the goals of care and what the treatment is, what best practice recommends.

All of the patients reported that the health care providers who participated in the Wound Care Pilot Project were very open to questions, took time to listen to concerns, encouraged questions and explained medical procedures in detail. Patients reported that wound care nurses, for example, made sure they were fully informed. Family caregivers who were involved in changing dressings for wounds and other care for their relatives also felt comfortable enough with health care professionals to ask questions about their relative's care:

They made sure we knew what was happening, what they were doing, they were all very good about explaining just what was going on. They always were quite sure to mention you know if anything happens in between [appointments], just to give them a call and [they'd] be able to work out some kind of an appointment.

The combination of having services accessible, appropriate providers addressing concerns and improving access to client and caregiver educational supports resulted in higher patient satisfaction. A physician reported that "patients are happier, they see results, they know they are healing and they're not bothering with Emergency, and there's an actual plan, a dedicated plan." A nurse had received similar responses:

They were so thankful to have this service available to them. Some people needed daily dressing changes and they really liked the accessibility in coming into the clinic and seeing someone right away as opposed to waiting hours in Emergency.

EFFECTS OF PROVIDER & CLIENT EDUCATION

There was consensus among administrators and providers that the Wound Care Pilot Project had been very successful in achieving the objective of improving provider knowledge about wound care best practices. Towards this end, the project team leaders held meetings with stakeholders to document current wound care practices across the community, in acute care, community and long-term care settings. The focus was on identifying areas in which discrepancies in practice occurred and identifying ways of improving efficiencies and effectiveness of care through introducing common approaches and practices. As a manager remarked: "That was a great benefit being able to provide that community wide."

Provider Education Initiatives

Provider education was delivered through dissemination of materials around best practice guidelines and workshops. Care guidelines, covering basic wound assessment, wound cleansing, wound swabbing policies, procedures and medical directives, were made available to all health care organizations in the Kenora area. Care models also were developed for specific types of wounds, i.e., diabetic foot wounds, arterial leg wounds, and venous leg wounds, specifying realistic outcomes, expectations and enhanced client education. Kenora area providers also had the opportunity to attend wound care education sessions, including locally delivered workshops and presentations by Dr. David Keast, MSc, MD, FCFP, an internationally recognized expert on outpatient wound care.

Front-line providers confirmed that education and training proved to be an important piece of the Wound Care Project. Having access to this type of expertise

made providers “more confident” in the delivery of care, which in turn contributed to “cohesiveness in wound care delivery” across the community. There was also evidence that participation in the Wound Care Project educational sessions encouraged physicians, nurses and other health care professionals on the Wound Care Assessment Team to share their knowledge with colleagues, creating a “positive environment” in which best practices were reinforced. As a manager remarked:

Anytime you have any kind of question in regards to wounds [they] would get back to you ... It is so encouraging to work at such a positive atmosphere here and I really, really enjoy that the physicians have been very approachable ... in discussing things that are going on with patients' wounds. In the past, I don't think that would have happened, it is now . . . with the education they've had sessions too which they attended and they're more aware of what they can use in regards to ordering for the patient. It's a very positive thing.

Client Education Materials

There was strong appreciation for the wide variety of patient education materials that were developed as part of the Wound Care Pilot Project. Several interviewees saw the patient education component of the project was extremely helpful because in the past, clients had nowhere to go for information and education regarding wound care. With the patient education materials in hand, front-line providers now “will go in and teach the client's family on how to do proper [wound] care.” Clients were also given resources about where they should go for follow-up care:

Now when we provide education and information we can provide them with [specific instructions]: ‘this you can do at home, this you need to follow up with somebody and there is somebody who can follow you.’

Effects of Client Education Initiatives

Patient and family education was reported to have improved during the wound care project, which resulted in some individuals being able to manage their wounds at home with help from family members. According to providers, client and caregiver education sessions also had an impact on patient compliance, for example, around the use of compression stockings: “Nobody had ever explained why stockings were important for them ... patients got to be more compliant with treatment because we took the time to explain it to them.”

From a patient perspective, both clients and their family caregivers reported that they have been given extensive information in regards to treatment plans and the nature of their wounds. As one client said, “every time ... they explained what they were doing and changed my bandage and they did other things, like checking my blood pressure.” Some patients recalled they had been unaware as to the seriousness of their condition and the necessity of ongoing care until providers informed them “if you don’t come back you are going to get infected.” Family caregivers also were more confident that the explanations given improved their ability to manage care at home. Relating her family’s experiences, a client said: “We can just ask questions and it’s a load off my mind ... to know that it's going right or something's not doing what it's supposed to be ... and it’s less stress at home [for my relative], too.”

PROJECT SUCCESSES & CHALLENGES

Access to Services

There was strong agreement that the Kenora Wound Care Project was successful in improving the care provided, as evidenced by a reduction in repeat visits for wound care and fewer complications. As a professional said, the services provided by the Wound Care Assessment Team and partner organizations largely eliminated “the revolving door syndrome” that occurred when patients received inadequate care for their wounds by providing more timely care and more comprehensive treatment. More timely care also was viewed as successful care, which prevented the development of fewer complications:

We have seen huge successes for a lot of our patients. To see they have not come back with reoccurring wounds or their wounds are a lot less than they were before. To me, that’s a success story, when I see people walking around town that normally would be wheelchair bound, because of the pain in their leg, because of the wound.

The Wound Care Pilot Project, moreover, was especially beneficial for clients who did not have family physicians: “So many of the patients who have really challenging wounds are people who don’t have family physicians ... so from that aspect, certainly the access has improved.” All around, participants thought that clients now had better healing and control over wounds that were previously challenging:

People are getting better care, it’s more structured, the patients are happier because they know where they’re going and who they're going to see, we have a multidisciplinary team looking at it now, it’s not just that one person changing the dressing, there’s other people involved, it’s just better care, patients are happier, wounds are healing faster.

Supporting Collaborative Care

Communication and collaboration between health agencies and providers was identified as being a key factor for the success of the Wound Care Pilot Project in Kenora. Multiple providers recognized the benefits of interdisciplinary collaboration and partnership and were able to relate this to patient satisfaction and treatment success: “Now it is the same information, the same courses, the same products so that we are more aware of what the others are talking about.” This provider went on to say, “by meeting with partners and getting to know more about their programs which we never had the opportunity to do before, we know ... who can respond to the patients needs.”

The Wound Care Program, through strengthening partnerships, also had given health care providers’ more confidence in team-based care. As a community-based provider reported, ““you can now pick up the phone and talk to each other [about client care] because when you are on a team with people ... you are working for the same goal.” Providers also liked the fact that the Wound Care Project’s emphasis on multidisciplinary care gave them additional resources, because “they could call anyone in the team and get feedback.” In this respect, the phrase “one stop shopping” was used repeatedly to describe the ease of accessing services through the Wound Care Program. The advantage was that:

Now everything is in one place. The patient comes in, they'd see [the wound care nurse] and the chiropodist, they could see [the surgeon], we'd have a plan in a matter of minutes and order the appropriate x-rays, bind the wound, do the pressure if we need to, [and] make a recommendation to the family doctor.

Applying Best Practice Guidelines

Both managers and front-line providers reported that prior to the Wound Care Pilot Project, their organizations had not had uniform guidelines in place. Given this situation, there had been considerable differences in the way that wound care was approached; practices were generally used in wound care differed greatly, depending on which organization delivered the services. As a provider commented,

A lot was depending on where the patient was . . . more location rather than the patient condition and the wound. If they were in the hospital, it gets treated at the hospital . . . if home care was seeing the patient, they would send them in to see the doctor, they would send them in with their supplies . . . and you might not always have the same supplies at that time as the hospital or whatever program would be seeing the patient. So . . . it was very confusing for us.

Following best practice implementation, tools were developed to assist practitioners in maintaining consistency in following guidelines and standards. After much deliberation, the Bates Jenson Assessment Tool and Canadian Association of Wound Care guidelines were adopted by the project and disseminated widely. Organizations also made sure that the information was readily at hand. Citing an example, a nurse reported that her organization had:

[Wound care] algorithms up in all of the examining rooms now in terms of treatment... the doctors are using the algorithms . . . and in each major treatment room we have a huge poster board from the Canadian Association of Wound Care about the products to pick for what kind of wound.

Optimizing Provider Competencies

There was general consensus among administrators, front-line providers and clients interviewed that the Wound Care Project had boosted both health care providers' and clients knowledge and confidence. First and foremost, the implementation of the Wound Care Project had brought about consistency in the coordination of care. As one of the participants commented: "We have got common tools which is huge [advantage]; everybody is given the same tool, common referral patterns and an understanding of who provides what." The introduction of a common referral form, for example, was believed to have contributed significantly to improved confidence in the care delivery process across the entire spectrum of care:

Doctors . . . are extremely confident now that when they refer . . . all they have to do is decide which area to tick off, whether it is the Community Care Access Centre, the Family Health Team, or the Hospital so it works very well that way . . . So the level of confidence from everybody ... their confidence has increased.

Although there were differences in the way that partner organizations choose to enhance competencies of health care providers, there was evidence that overall competencies of providers had increased. While the Family Health Team placed emphasis on enhancing wound care knowledge and skills of Registered Practical Nurses, the Lake of the Woods District Hospital and the Community Care Access Centre and Home Care largely worked with Registered Nurses. In this respect, the use of RPN's to deliver wound care within the Family Health Team was a significant innovation in care. As an administrator emphasized: "We clearly illustrated that we did optimize competencies of who we felt was the most appropriate provider."

Creating Effective Partnerships

Recognized as a success was the acceptance of the Wound Care Project by the different stakeholders, in particular physicians. “The way the program was embraced by all the sectors and all the providers was a gigantic success.” More importantly, the Project “showed that partnerships work ... that this was the first time that there was a real collaboration between all of the groups, but once it started to roll it was fantastic and [a] huge successes.” What made the Wound Care Pilot Project successful, in the opinion of a manager, was the collaborative care model employed:

[The success of the project was] not only the interprofessional collaboration that we have developed, it is partnerships ... our success has been partnerships with all of our community partners and being able to identify ... key people within those groups and organizations, who to call. The confidence and the trustworthiness of all the groups, the sharing and partnership is built in, [which gives] that basis in which to work from.

Front-line providers also applauded the efforts of all practitioners to communicate with each other and develop more effective ways of referring patients through the system, so they received assessments, treatment, education and follow-up care in a timely and efficient manner. In this respect, better communications were acknowledged as a key in developing trust and partnerships between agencies.

An administrator noted that the meetings, consultations and communication around the implementation of the Wound Care Project also produced more effective care because these contacts improved providers’ knowledge of the services and programs which were available in the community: “By meeting with the partners and getting to know more about their programs ...we now know who kind of goes where . . . who can respond to the patient needs.”

Improving Client Outcomes

Another success story was seen in the evidence that “the severity and the frequency of the really severe wounds have reduced.” Health care professionals also observed that clients and their family caregivers were more satisfied with the wound care services provided: “I know a lot of people were happy with it, a lot of the clients were happy with it.” The fact that clients were given individualized care plans and education also was viewed as contributing to better outcomes:

We know chronic wounds in particular become very frustrating over time they are time consuming and costly and its frustrating...it is important to sit down with them right at the beginning and talk about the goals of care and what the treatment is, what best practice recommends.

Both patients and family caregivers reported increased confidence in the care provided and were pleased with the consistency that occurred over the time they were treated. Comments reveal that they thought the level of care provided to them or their loved ones was “exceptionally good,” “amazing,” and “seamless.” They confirmed that they now experienced significantly reduced wait times for treatment and other essential services, such as chiropody, dietetics, and rehabilitation therapy. Clients also felt comfortable in the care provided, as evidenced by their ease in asking questions of care providers. Many patients credited the Wound Care Project with their successful recoveries: “I’m mobile again, what else do I need?” Another client said: “I don’t know what I’d do without them.”

Challenges

From an operational perspective, the increasing volume of clients requiring wound care represented one of the greatest challenges associated with the implementation of the Kenora Wound Care Pilot Project. Some providers noted that larger numbers of clients could have been accommodated more easily if there had been “another day of the week dedicated to wound care” or “another full time nurse dedicated to front line wound care.” Additional administrative supports also would have been helpful; as the situation existed “many times charting and paperwork was completed in a rush or pushed aside for completion in the evening or the next day.”

Although physicians who worked on the Wound Care Pilot Project realized the value and capabilities of the wound care nurses and other providers and welcomed their assistance, it was acknowledged that at times patients had difficulty accepting care from alternate providers, which resulted in some resistance. There were also challenges around eligibility for services, as each organization had different criteria; the solution which emerged was to “move that person to the appropriate agency” to access care.

While there was sufficient funding allocated by Health Force Ontario for the Kenora Wound Care Pilot Project for its first year of operations, the lack of resources to sustain the wound care model in its entirety beyond September 2009 was identified by the providers as the biggest challenge for the project itself. The inability of some partner organizations to find resources for specialized staffing, education, supplies and administrative supports also meant that Kenora area patients no longer have access to a seamless system of collaborative wound care delivery. As a provider said: “The biggest challenge again is, when the money runs out, how do you sustain something that you have put in place?”

Transferring the Model to Other Settings

Looking back over the successes and challenges experienced during the implementation of the Kenora Wound Care Pilot Project, health care administrators and providers were of the opinion that that the Wound Care Model could be transferred to other health care organizations and settings. They suggested, however, there were a number of things which could be addressed to enhance both the model and its transferability.

Based on their experience, a key challenge in transferring the model to other care settings was the development of partnerships. They recommended that project partners should devote a considerable amount of time to consultations with health care organizations who would be involved with delivering wound care services, with a view to “really breaking down the barriers and getting everybody working along the same page.”

An additional factor affecting the implementation of the Kenora Wound Care Pilot Project and, by extension, its transferability to other settings, was the need for accurate assessments of the demand for wound care. As a manager noted, “good data” on the number of clients requiring wound care, for example, would have better prepared the Kenora partner organizations for the influx of clients requiring care. As it was, resources were strained because partners “didn’t realize there was a lot more people than we knew who had wounds.”

There also were challenges in assessing project implementation because of the lack of a common mechanism for collecting client-level “data from partner organizations.” To address these issues it was recommended that any organization considering implementation of the Kenora Wound Care model should “keep good data

and have good observations.” Ongoing client tracking would also ensure that all partner organizations could be strategic about the progression of the project, the staffing which was required, and other resources, such as provider and client education, which had to be put in place to ensure effective implementation. As an interviewee recollected, looking back on the implementation of the Kenora Pilot Project:

All of those pieces that we struggled with . . . if I could help another team along, I would say stop and think about your process first and the data you want to collect and how you want to collect it before you open your doors because once you let those people in there is not a lot of time to change or to add or to [the program] . . . luckily we were able to get the process going.

In addition to these two main recommendations, health care providers emphasized the importance of the educational components of the Kenora Wound Care Model, with education of providers and clients identified as key measures important to the model’s success. In terms of best practices and enhancing provider competencies, it was recommended that any organization implementing the Kenora collaborative care model should investing time and resources to ensure that professionals were “all on the same level in terms of wound care.” Client and caregiver education was also seen as contributing to the success of the model, because clients and their caregivers could realize the importance of self care and take greater responsibility for their own health:

It brings together the goal of treating the patient holistically as a whole person rather than just treating the wound ...It makes the patient feel very important so they see so many different things and they do the learning. It really empowers them for their own health.

SUMMARY

The current report responds to Sunset Country Family Health Team's interest in evaluating the Kenora Wound Care Pilot Project that was implemented across acute care, community care and long-term care settings during 2009. Prior to this implementation, wound care delivery in Kenora was seen by both administrators and health care providers as somewhat disorganized and uncoordinated. Designed with the intention of delivering seamless wound care to patients, the collaborative wound care model which was developed was viewed as being successful, because it created effective partnerships between diverse health care agencies, fostered interdisciplinary collaboration and implemented care methods that reflected best practice interventions.

Although the implementation of the Wound Care Pilot Project was not without challenges, it was widely viewed as being a success. Participants believed that the project had improved clients' access to services, as evidenced by significantly reduced wait times for treatment and other essential services, such as chiropody, dietetics, and rehabilitation therapy. Health care professionals had improved their wound care competencies, as shown by their knowledge of best practices and use of care guidelines. Both patients and family caregivers also reported increased confidence and satisfaction with the care provided. More timely care, higher quality care, and fewer complications were seen as evidence of success. Concern was expressed, however, around the inability to continue the Kenora Wound Care Project in its entirety past the pilot phase and serious worry expressed over the consequences of ending the wound care clinics on patients in the community.



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“Evaluation for the Health Force Ontario – Optimizing Health Care Providers
Competencies Fund: Wound Care Project”

Appendix A: Interview Questions – Health Care Providers

1. Could you please describe your current role in this organization?
(Administration, Client Care, Supportive Services? What roles and responsibilities have you had in regard to the Wound Care Project?)
2. Thinking about the situation that existed before the implementation of the Wound Care Project, how was wound care delivered in your community?
(Family health teams? Ambulatory care? Community care?)
3. What impacts has the Wound Care Project had on your organization? (Changes in number of clients served? Health human resources? Coordination of care? Communication?)
4. Has the operations of the Wound Care Project had any budgetary impacts on your organization? (Staffing? Workload? Other resources?)
5. Has the Wound Care Project improved health care providers’ confidence in their ability to deliver wound care using best practice guidelines? (Why or why not?)
6. What effects has the project had on clients’ access to Wound Care services?
(Treatment? Education and information? Specialized services, such as nutrition, counselling, chiropody, physiotherapy, occupational therapy?)
7. Overall, how would you characterize the successes and challenges of the Wound Care Project? (What worked well? What was especially successful? What did not work so well? What challenges were experienced? What improvements are needed?)
8. In your opinion, could the Wound Care Project model be transferred to other Family Health Care Teams or other health care settings? (Why or why not? Lessons learned? Advice you would give to other health teams who were considering this type of integrated care model?)
9. So we can analyse our interviews, could you tell us something about yourself?
(Occupational background? Specialization? How long in this community?)
10. Are there any comments you would like to add?



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Appendix B: Interview Questions – Clients and Family Caregivers

1. Could you please tell us something about your experiences with the Wound Care Team? (When did you first hear about the team? Which health care staff did you see? Was most of your care received from SCFHT? Home care? Staff at hospital?)
2. What types of care have you received from the Wound Care Team? (Treatment? Information and education? Specialized services, such as nutrition, counselling, chiropody, physiotherapy, occupational therapy?)
3. Has getting care from the Wound Care Team made a difference in your knowledge about wound care? (What types of problems to look for? What you should do when problems occur? Where you should go if your condition suddenly gets worse?)
4. Has having the Wound Care Team made a difference in your ability to communicate with doctors, nurses and other providers? (Comfort around asking questions? Discussing problems and issues? Asking about other services?)
5. Has the Wound Care Team made a difference in your ability to get care when you need it? (How long do you have to wait for appointment? When referrals are made, do you get timely care? Do you sometimes have to explain things all over again?)
6. In your opinion, has the Wound Care Team made a difference in the quality of wound care you have received? (Treatment? Information and education? Nutrition, counselling or other special services?)
7. Overall, thinking about the care you have received from the Wound Care Team, what worked well? What did not work so well? (What was successful? What challenges occurred? How satisfied were you with the care you received?)
8. What improvements would you like to see in Wound Care Services locally? (Communication with health care providers? Coordination between Family Health Team, Hospital, and Community Care? Other services you would like to see?)
9. So we can analyse our interviews, could you tell us something about yourself and your family? (Age? Marital status? Your occupation? Your language? How long have you been in this community?)
10. Are there any comments you would like to add?



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Appendix C: Covering Letter – Health Care Providers

Dear Colleague:

We are writing to ask your assistance in this evaluation of the Wound Care Project which is being conducted by the Centre for Rural and Northern Health Research (CRaNHR) on behalf of the Sunset Country Family Health Team (SCFHT) and its project partners. The purpose is to explore the successes and challenges experienced during the implementation of the project. As you have been identified as a health professional who is knowledgeable about the issues around providing wound care, we are interested in hearing your opinions.

It is our hope that you would be willing to take part in an interview to be held in Kenora during the week of (date to be specified). The interview would be scheduled at a time and place that is convenient for you and would last approximately 20-30 minutes. Participation in this study is voluntary and you may answer the questions any way that you choose, decline to answer any question, or withdraw your participation at any stage. There are no apparent risks associated with the study and participation will not affect your employment or your organization’s access to services and supports.

With your permission, we will audiotape the interview to ensure that information is accurately recorded. Interview tapes will be secured in locked cabinets in the CRaHNR office at Lakehead University, for a period of five years after completion of the study, and then they will be destroyed. Data will be kept confidential and you will not be identified in any written reports or subsequent presentations. Results will be shared, at the discretion of the SCFHT and partners, at the end of the evaluation.

One of our research assistants will be contacting you within a few days to discuss your participation in this study. In the meantime, for your information, we are enclosing a copy of the interview questions and consent form for the study. If you have any questions, please contact Dr. Mary Ellen Hill at the Centre for Rural and Northern Health Research, by telephone (collect) at 807-766-7278 or email maryellen.hill@lakeheadu.ca. For further information about procedures for maintaining consent and confidentiality, you may contact the Lakehead University Research Ethics Board at (807) 343-8283. I hope that you will agree that such an evaluation is important and will be prepared to help us carry it out.

Sincerely,

Bruce Minore, PhD
Research Director

*Evaluation of the Kenora Wound Care Pilot Project
Centre for Rural and Northern Health Research
Lakehead University*



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Appendix D: Covering Letter – Clients and Family Caregivers

Dear Client:

We are writing to ask your assistance in this evaluation of the Wound Care Project in Kenora. The study is being conducted by the Centre for Rural and Northern Health Research (CRaNHR) on behalf of the Sunset Country Family Health Team (SCFHT) and its project partners. The purpose is to explore successes and challenges experienced in providing wound care to clients in Kenora.

As you have been identified by the SCFHT as a client who has received care from the team, we are interested in hearing about your experiences. We would also like you to choose a family member or friend who has provided help to you during your illness to take part. It is our hope that you and your caregiver would be willing to take part in an interview to be held in Kenora during the week of (date to be specified). The interview would be scheduled at a time and place that is convenient for you and would last about 20-30 minutes.

Please be assured that participation in this study is voluntary. You may answer the questions any way that you choose, decline to answer any question, or withdraw from the study at any stage. There are no apparent risks associated with the study and participation will not affect your access to services and supports. With your permission, we will audiotape the interview to ensure that information is accurately recorded. Interview tapes will be secured in locked cabinets in the CRaHNR office at Lakehead University, for a period of five years after completion of the study, and then they will be destroyed. Data will be kept confidential and you will not be identified in any written reports or subsequent presentations. Results will be shared, at the discretion of the SCFHT and partners, at the end of the evaluation.

One of our research assistants will be contacting you within a few days to discuss your participation in this study. In the meantime, for your information, we are enclosing a copy of the interview questions and consent form for the study. If you have any questions, please contact Dr. Mary Ellen Hill at the Centre for Rural and Northern Health Research, by telephone (collect) at 807-766-7278. For further information about procedures for maintaining consent and confidentiality, you may contact the Lakehead University Research Ethics Board at (807) 343-8283. I hope that you will agree that the evaluation is important and will help us carry it out.

Sincerely,

Bruce Minore, PhD
Research Director

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Centre for Rural and Northern Health Research
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Appendix E: Consent Form

- If you agree to participate in the interview, please read, sign and date the following consent form, which will be picked up by staff from the Centre for Rural and Northern Health Research at the time of the interview.
- The purpose of the study, being conducted by the Centre for Rural and Northern Health Research (CRaNHR) on behalf of the Sunset Country Family Health Team (SCFHT) and its project partners, is to explore the successes and challenges experienced during the implementation of the Kenora wound care project.
- Researchers ask that you assist in this study by taking part in an interview to be held in Kenora during the week of (date to be specified). The interview would be scheduled at a time and place that is convenient for you and would last approximately 20-30 minutes.
- Your participation in this study is voluntary and you may answer the questions any way that you choose, decline to answer any question, or withdraw your participation at any stage. There are no apparent risks associated with the study. Because we do not wish to cause discomfort to anyone, your participation is voluntary, you are free to answer the questions in any way that you choose, decline any questions you do not wish to answer, and to withdraw from the interview at any time.
- To ensure that information is gathered accurately, we also ask that you give consent to audiotaping of the interview. This will be done with the understanding that the tapes will be secured in locked cabinets in the CRaHNR office, for a period of five years after the completion of the study, after which time they will be destroyed. All data will be kept confidential and you will not be identified in any written reports or subsequent presentation of the results.

I, _____ agree to be interviewed as part of the Centre for Rural and Northern Health Research study entitled “Evaluation for the Health Force Ontario – Optimizing Health Care Providers Competencies Fund: Wound Care Project”

In addition please check one of the following:

- _____ I give permission to the researchers to audiotape the interview.
 _____ I do not give permission to the researchers to audiotape the interview.

 Signature

 Date

Evaluation of the Kenora Wound Care Pilot Project
Centre for Rural and Northern Health Research
Lakehead University