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Assessing multidimensional complexity in home care: Congruencies and discrepancies between patients and nurses

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Complexity in home care requires collaboration and participation

Over the last decade in Switzerland, the shift from inpatient to ambulatory/home care has led to a surge in complex care situations in home care settings (Baumann & Wyss, 2021). Complexity can be defined as a multidimensional concept involving interactions with health determinants, including biological, socioeconomic, cultural, environmental and behavioural factors (Bonzoni et al., 2018). This view was operationalized when developing the COMID (Busnel et al., 2021), a 30-item check list to be used by professionals in homecare settings for complexity screening. The COMID goes beyond the factual elements given in the interRAI-HC (the Resident Assessment Instrument Home Care used to scaffold comprehensive geriatric assessment). It requires that nurses ➡

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position themselves and judge a given situation based on their global evaluation and knowledge.

Complex situations require reinforced joint and collaborative interventions from different actors (e.g., patients, nurses, doctors and social workers) (Karam et al., 2021), who must together determine the specific care plan for a given patient. This process begins by sharing their individual evaluations of the situation.

Mobilising tools common to patients and professionals could help operationalise the person-centred philosophy by considering both professionals and patients' assessment of a given situation.

COMID-P offers a vital patient perspective on complexity in home care

In terms of complexity assessment, the COMID questionnaire is not sufficient on its own to guarantee the promotion of a person-centred approach. While measures of complexity in home care evaluate numerous aspects of patients' situations that are essential to propose individualised care plans, they must also take into account patients' perceptions to indeed involve them in care decisions. Patients' evaluations of their own s ituations provide essential and unique information about their personal situations and health needs, thereby providing a complementary tool to traditional clinical indicators in defining care plans in a consensual manner. This is precisely to fill this gap and to empower patients in actively contributing to care decisions that the COMID-P was developed. Just like the COMID, the COMID-P is short, accessible, easy-to-score, self-reported measure; it demonstrates the characteristics required for very practical patient-reported outcome measures (PROMS). (Kroenke et al., 2015)

The two instruments – the COMID for professionals and the COMPID-P for patients should work together to help assess home care complexity in a patient-centered perspective. Further, the joint use of the two checklists helps pointing out similarities and differences in assessments, offering a platform for discussion of care plans between all concerned actors. COMID and COMID-P assists nurses, and ultimately patients, in identifying and analysing the contributing elements that render a situation complex. This assessment of complexity, which includes several bio-psycho-social, contextual and care aspects of a person's situation, contributes to a more all-encompassing consideration of a person, which consequently aids in establishing a personalised care plan.

COMID and COMID-P tackle the complexity in home-care practice

The study was part of the larger "fraXity" project associated to the Swiss Centre of Expertise in Life Course Research LIVES (Ludwig & Busnel, 2019). It was designed to compare complexity assessment by nurses (COMID) and patients (COMID-P) in homecare settings. The participants, or "patients", were people aged 65 and older, without major cognitive impairment, living at home who volunteered to take part to the fraXity study. After a nurse-led comprehensive interview on care needs guided with the interRAI-HC, the COMID and COMID-P questionnaires were completed independently by the professional and the patients. The nurses who collected the data included four middle-aged men and women, all registered nurses with bachelor's degrees in nursing and substantial experience in home and/or intensive care.

The nurses carried out assessments at the patients' homes. The COMID-P was systematically introduced after the COMID questionnaire to avoid patients' answers influencing those of the nurses.

On a general level, the results reveal that the complexity rating is comparable between patients and nurses, thus representing global agreement. It is interesting to note that the complexity score for patients was significantly lower than for nurses. Overall, patients rated their situations less complex than nurses, yet with an extremely modest difference and questionable clinical relevance.

On an item level, comparisons between patients and nurses revealed that low agreement resulted in areas related to care (i.e., resistance or opposition to care, partnership between the different actors, therapeutic incoherence, health insurance problems, and emotional and/or physical burden) or to cognition (i.e., cognitive deficits and acute change in cognitive abilities).

Patients reported significantly higher complexity on items related to the partnership between actors, while nurses reported notably higher complexity around chronic disease and pain, poly-medication, inadequate housing and emotional and/or physical burden.

COMID and COMID-P contribute to future care-related decisions

Despite an overall high agreement, the COMID and COMID-P results illustrate that patients and nurses have divergent views on certain components of complexity. Moving forward, it will be important to identify and address each reason for the discrepancy to reach shared and informed care-related decisions.

On the whole, COMID-P prompts patients to consider their individual health status and raise issues with nurses, thus potentially developing a template for a home care routine that could help nurses quickly identify points of agreement and disagreement. Joint health information can enrich and contribute to the collection of data that professionals might not detect on their own.

Our results clearly show that COMID and COMID-P can be administered in parallel by employing a feasible process with clinically informative patient-reported outcomes. This multidimensional approach of complexity reflects the ➡

accumulation of embedded health conditions and issues, with a potential solution being a collaboration between different actors, in this case, between patients and nurses, to reach a discussion that ultimately leads to a more enhanced patient-centred home care resolution.

Conclusion

The joint use of COMID and COMID-P could foster the patient/healthcare professional partnership, allowing patients to take part to the assessment of their own condition and actively contribute to informed care decisions. The COMID and COMID-P evaluations lend themselves to fostering patient adherence and nurse awareness, improving communication through active patient participation and, consequently, optimising quality home care through a therapeutic link that can be reinforced in the understanding of the shared situation.

Including patients in their own care decisions leads to changes in the culture of care among both professionals and patients. Looking at it from a culture of care perspective, the patients can actively share perceptions of their individual situations, all with varying degrees of complexity.

Providing quality care in complex situations requires skilful collaboration among all health professionals, informal caregivers and patients, who are thus considered full partners. Measurement is necessary to assess, promote and disseminate individualised care to align with patients' priorities.The joint use of the COMID and the COMID-P is an innovative opportunity for a committed partnership between the patient and the nurse and for the implementation of the patient-centered care model into homecare practices. ■

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