Tri-organization Community of Practice

Tertiary Geriatric Psychiatry

Friday September 25, 2015
Ontario Best Practice Exchange

St. Joseph's Healthcare Hamilton

St Joseph's Health Care London

Providence Care
Aging, Mental Health and Rehabilitative Care

McMaster University

Western University · Canada

Queen's University

Workshop Agenda

- Welcome and introductions
- Background to the Tri-Org Community of Practice
- Exchange experience of Point of Care Group
- Tapping into Lived Experience – patient/family
- Description and Measurement – population
- Large Group Discussion
- Report Back

Welcome and Introductions

St. Joseph's Healthcare Hamilton	St Joseph's Health Care London	Providence Care Aging, Mental Health and Rehabilitative Care
Dr. Maxine Lewis Julia Baxter Shelley Wright Dr. Carrie McAiney Dr. Peter Bieling Sheri Burns Eric VanRaay Sandra Forster Dr. Karen Saperson	Dr. Lisa Van Bussell Jennifer Speziale Dr. Iris Gutmanis Dr. Ed Black Kayley Perfetto Sukhi Brar Krista Harloff	Dr. Dallas Seitz Kelly Garrett Jack Henson Dr. Ken Le Clair

What is Tertiary Geriatric Psychiatry?

- Specialized care for people with complex mental health needs
- Unique, small numbers, high intensity needs
- Focus on inpatient units for persons with:

  - Moderate- Severe dementia with BPSD
  - Unable to be cared for in another setting

Background

- Innovation and Scholarship Award Jan 2014
- SJH, Hamilton; SJH, London; Providence Care
- **Objectives**:

  - Share assessment and treatment approaches
  - Improvement in direct patient care
  - Generate quality improvement strategies
  - Opportunities for research

Tri organisation CoP

- Meet via teleconference and OTN
- CoP meeting, Hamilton, November 2014
- **Four key areas identified**:

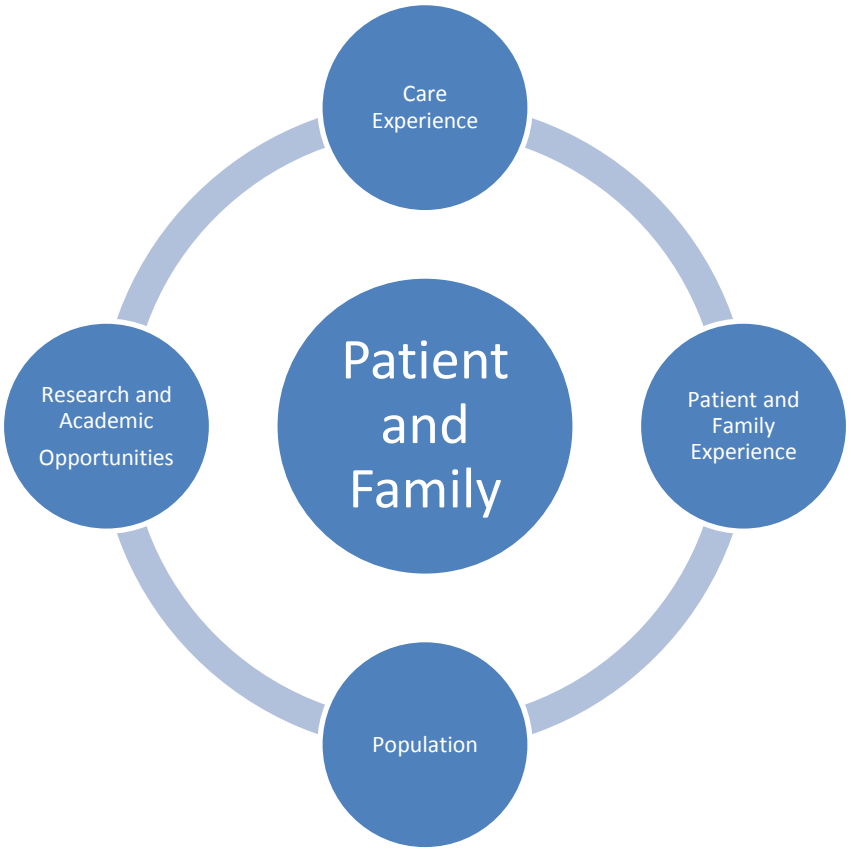
 - Person and Family
 - Services/ Skills required
 - Risks
 - Role and Function of Units in the System

CoP Working Groups

- Point of Care
- Lived Experience
- Measurement

Our Approach and Exchange

- Build on the knowledge and experience of three
- What are we doing? (care and function)
- What is the experience for patients/family?
- Needs and description of the population?
- Future opportunities?



Tri-organization Community of Practice

Point of Care Experience

St. Joseph's Healthcare Hamilton: Dr. Maxine Lewis, Shelley Wright, Sandra Forrestor
St. Joseph's Healthcare, London: Dr. Lisa Van Bussell
Providence Care Centre, Kingston: Kelly Garrett

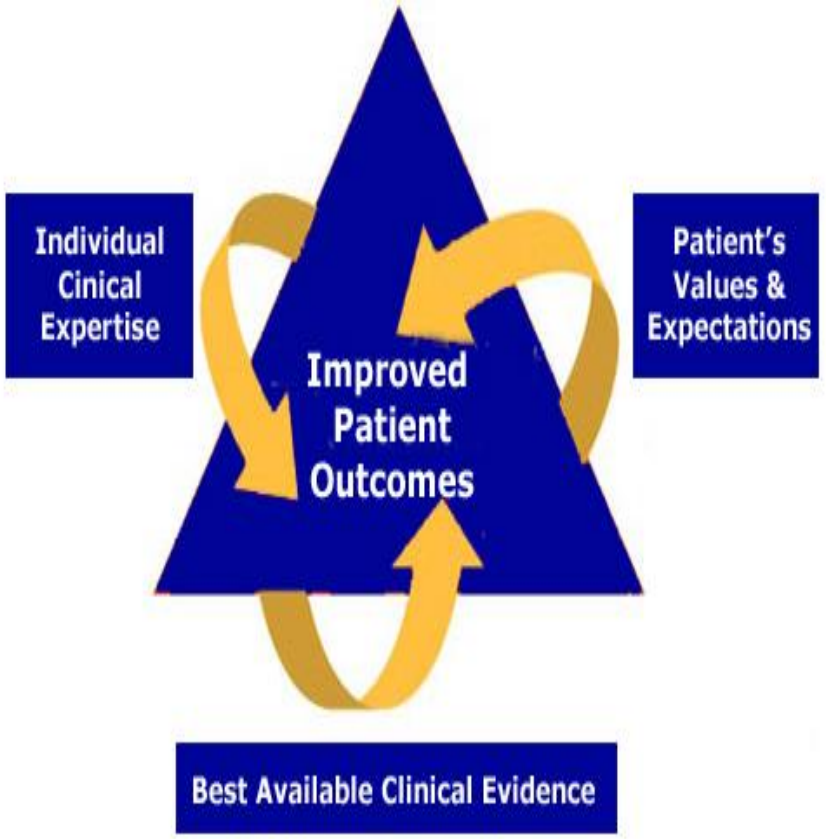
Point of Care
Who are we?

- Three tertiary inpatient mental health programs in Ontario.
  - Collectively 66 beds serving potentially 1 million seniors
- Each serves a large geographical area
- Persons with * BPSD with high risk behaviours that could not be managed in a lower level of care in the system.
- Highest level of behavioural care for this population

* BPSD = behavioural and psychological symptoms associated with dementia

Challenges to serve BPSD population

- Lack of evidence to guide care for this population
- Follow best practice
- Often find we are in unexplored territory and need to be creative to find care strategies to meet needs



Benefits of Discussion

- Few peers that specialize in this area
- Validating to share similarity of care experiences in this very specialized area
- Opportunity to learn what is possible from each other's different approaches and improve
- Power of collaboration – understanding need for service across Province
- Importance of advocating for services for this population and awareness of the needs

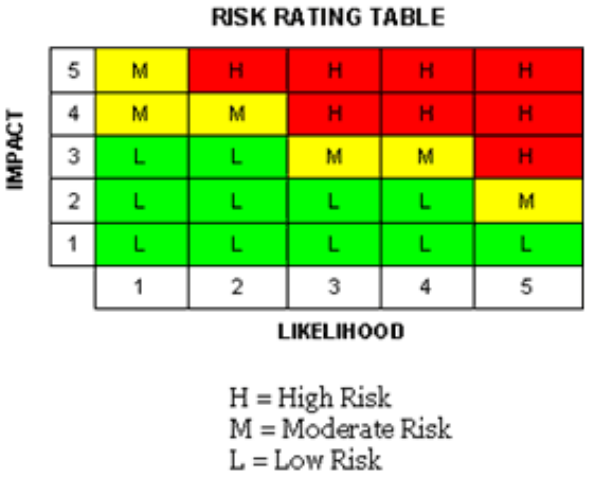
Our Collaboration & Exchange
Point of Care Experience

- Tertiary care programs
- Population of BPSD severe behavioural disturbances usually late stage of dementia
- Recent trend toward younger, physically robust population
- Require intensive resources to assess, treat & manage
- Very little research to support practice in this population
- Need for risk assessment to include rating of harm behaviours including lethality of behaviours. May help person return home if we can show a validated method of evaluation versus clinician assessment.

Risk Assessment

- High frequency behaviours during ADL care and toward others in milieu.
- No identified specialized Assessment tool to predict harm for this population
- Use of CMAI, DOS, Custom behavioural Charting to assess and evaluate behaviour patterns
- Daily behaviours with low harm outcomes.
  - Predictable during ADL care
  - Predictably unpredictable – responsive in milieu

- Opportunity to develop tool to evaluate possibility to harm - not just prediction but need to evaluate if harm is low or high/lethal.
- Interest in Ontario Ministry of Labour Risk Matrix, DASA, AIM



Risk Management & Measurement

Risk Management

- Need high numbers of nurses to provide safe care
- Need weekly case conferences and daily team huddles to alert care team of risk issues
- Need highly qualified staff to assess risks, plan care and determine actions to manage imminent risks.

Risk Measurement

- High number of Employee Incident Reports
  - Phenomenon that nurses are under-reporting due to normalization of behaviours
  - Nurses only report when injury occurs
- RAI definition of aggression indicates intent to harm
  - Potentially not being selected as nurses do not identify intent as part of the disease manifestations – rather see behaviours as expression of needs without intent to harm
- High number of Safety Incident Reports for
  - Falls
  - Aggression
    - Under reporting – especially during provision of care due to normalization of behaviours and time to report high frequency of behaviours.

Family perception/meaning of risk

Perception

- Varied emotions: embarrassed for person, anger, denial, acceptance, gracious
- Some expectations to manage risk without treatment – puts care givers and others at risk
- Expected behaviours would stop in this care setting

Meaning

- Far from home
  - Cost of travel
  - Access to visit
- Stigma of mental health facility
  - May die in mental health setting
- Need to develop trusting relationships with care team
- Need Care team collaboration & support
  - Emotionally taxing for family
  - Absolute need to be part of the decision making process

Balance with awareness and risk

HOW DO WE FOSTER FAMILY INVOLVEMENT?

Tri-Organization Community of Practice: Tertiary Geriatric Psychiatry Units

Patient and Family

Lived Experience Subcommittee

Understanding Experience: **Critical**

"It so important for health providers to understand the patient /family experience and to have a shared understanding of this. When we have a full understanding of the patient/family experience we will have the necessary knowledge to:

- Better anticipate common sources of anxiety, misunderstanding, confusion, etc. and take steps to mitigate
- Understand the importance of treating patients and families as unique whole persons, and to take steps to treat them as whole persons not just their conditions
- Consistently approach all aspects of care with compassion and sincerity"

Patient Experience Toolkit (2102): Advisory Board Company – Nursing Resource Centre

Our Exchange

- How are we currently tapping into the experience?
  - Satisfaction surveys
  - Scheduled and ad hoc contact
- How could we do it better?
  - Resources – what's important/valued?
  - Story, conversation
- How about the individual patient experience?
  - Family as proxy
  - Still unsure

Starting the Process

- Who – families
- When
  - On the waiting list
  - On the unit 30 days
  - Discharged from the unit 2-4 weeks
- How – telephone
- What – developed conversation/interview guide

- Recruitment
  - Some reluctance
  - Purpose?
  - “scared to speak up”
  - Bias in our selection?
- Staff
  - Hesitant – what will others say?
  - Need preparation to receive information

A bit of what we heard – waiting list

- Husband of a 59 year old wife/mother
- Suffered head injury/++strokes, "**everything changed – out of control**", very physically fit but, above the shoulders there is "**chaos**"; moved into LTC and moving and touching everyone – a real problem and now she and home receiving outreach geriatric psychiatry support "**I think we have hit the nail on the head**" (hopeful)
- Communication: Kept me up-to-date and inquired how things are going, wanted and valued my perspective
- Want: Improve her quality of life, have her respond a bit better, "**see it in her eyes**"
- If a bed came up – "**don't know what her reaction will be, she is a totally different person now; preferably would like her to stay where she is**"

A bit of what we heard – on the unit

- Daughter of a 58 year old wife/mother, Pick's Disease, living in community, 5 days in ED, 5 weeks in acute care, "**very difficult experience**", transferred to geriatric psychiatry unit with 2 hours notice, "**Chaotic, rushed, hurried, pushed out of one bed and into another**"; theme of poor/ lack of communication came out in every question; wanted/needed > involvement and > decision making
- Wife of an 80 year old very modest and private man, AD, moved to LTC but soon "**they decided, he was having behavioural problems and needed to be moved**"; highlighted some personal care issues on the unit; on the unit wife shared "**he has an *aura* that says he is happy**"; in community wife was "**trying to help the system**" (e.g. 8 choices for LTC) but now … "**this disease has taken its toll on me and my husband, I won't/can't help the system anymore. The end is coming and I want him in a good place**."

A bit of what we heard -discharge

- Daughter sharing about her father with AD – experience started in community to acute care (months) to LTC (one day) "**violent tendencies**" and then with police back to acute care and then transferred to geriatric psychiatry; on the unit they were able to discover all his "**quirks and quarks; he will always have his temperament**"; "**a real process of discovery**; "**they would be in regular touch with us, every time they tried something**"
- Discharge to LTC with use of a transition team /prepped him for LTC, good communication, included in decisions and informed – very pleased!
- "**felt very lucky**" – a swap in the system
- Dad said " **I think I'll stay, I like it here**."

Reflections

- Conversations and allowing a story = > rich and meaningful
- Prepare and support families/patients and staff to share and receive
  - Trust, relationship, no retribution, transparency, shared goal
- Communication and involvement were key themes for improvement
- Emotional experiences
  - "scared out of my mind", uninformed, confused, angry, litigious, grieving
- Movement across the system
- Stigma - "an insane asylum" , perceptions of psychiatry
- Value balanced with time
- Use and application of the information
- **Families want to help improve care and want opportunity to be contribute**

Discussion

1. From your experience, can you share ideas of how to develop strong and meaningful partnerships with family ?
2. How can we/should we further tap into the experiences of families and of the persons with moderate to severe dementia, severe mental illness, behavioural disturbance?

Tri-Organization Community of Practice: Tertiary Geriatric Psychiatry Units

Measurement Subcommittee

Case example

- 74 yr old female with moderate dementia
- Emigrated to Canada at age 20; has lost ability to speak English & now only speaks Armenian
- Lives with spouse in rural community
- Wanders - has been found outside in cold weather
- Does not want to take her medications
- Several incidents of abusive behaviours toward husband during meal preparation (throwing pots, dishes)
- Incontinent but refuses assistance with bathing/hygiene
- Enjoys husband’s homemade wine; this and her arthritis have led to an increasing number of falls

Focus of Our Work

- There are many possible aspects of measurement we could focus on regarding tertiary geriatric psychiatry units
- Our focus:
    - Responsive behaviours
    - Resident Assessment Instrument for Mental Health (RAI-MH)
    - System of Classification of In-patient Psychiatry (SCIPP)

RAI-MH

- RAI-MH:
  - A standardized tool used to assess individuals in inpatient psychiatric settings
  - Required to complete at admission and discharge as well as every 90 days or when a significant clinical event occurs

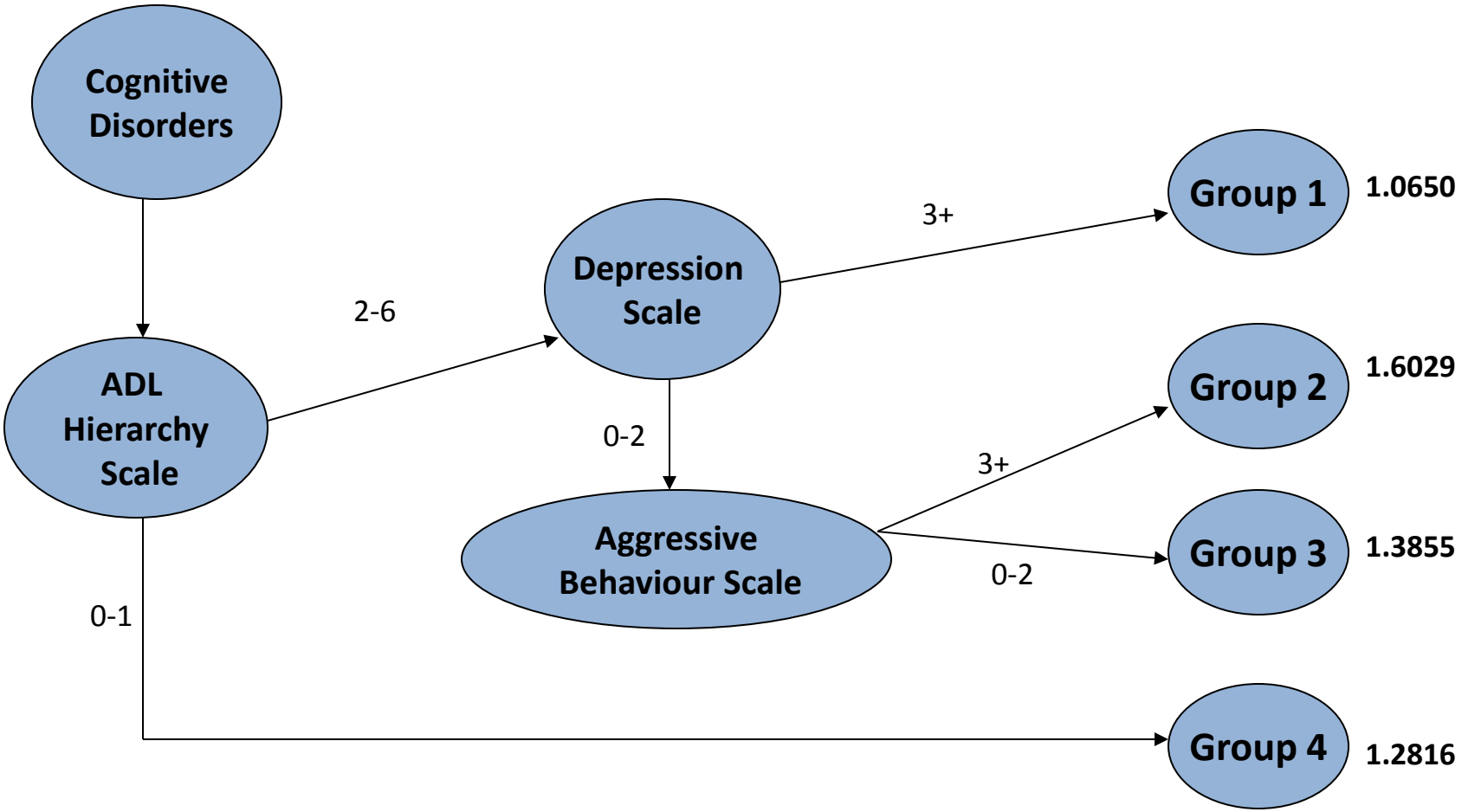
SCIPP

- SCIPP groupings are derived from items within the RAI-MH
- Used to group individuals who are similar in their clinical presentation and use of resources
- Used for planning and resource allocation

Cognitive Disorders SCIPP

- 7 SCIPP categories
- Cognitive Disorders SCIPP is most common in tertiary geriatric psychiatry units
- 3 factors contribute to the Cognitive Disorders SCIPP:
    - Activities of Daily Living (ADLs)
    - Depression
    - Aggression
- Only 4 resource categories within this SCIPP

Cognitive Disorders SCIPP



Reflection on the Cognitive Disorders SCIPP

- RAI-MH has many positive qualities
- However, Cognitive Disorders SCIPP groupings do not accurately reflect the population served on tertiary geriatric psychiatry units as many important items in the RAI-MH are not included in the SCIPP score

Case example

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- Emigrated to Canada at age 20; has lost ability to speak English & now only speaks Armenian
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Discussion

1. Based on your experience, what factors are important to the care of persons on tertiary geriatric psychiatry units but are not included in the Cognitive Disorders SCIPP?

2. How can we improve the way the complexity of our population is being captured ?