Mississauga Halton **LHIN**
RLISS de Mississauga Halton

Special Behavioural Support Unit at Sheridan Villa Mississauga Halton LHIN

July 10, 2014

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Introduction and rationale

- Recognizing the challenges associated with managing individuals with responsive behaviours in a normalized LTC setting and the increasing number of individuals who are awaiting LTC placement with behaviours the MH LHIN decided to pull together a Steering Committee that was made up of system partners from across the LHIN to consider opportunities to address gap, by pulling together existing resources and identifying where additional resources may be required in the system.

Sheridan Villa: Special Behaviour Support Unit (SBSU)

- A 19 bed transitional treatment unit located at Sheridan Villa
- Serves clients who have a primary diagnosis dementia and significant behavioural disturbances that cannot be managed in the community or a regular long term care home

Goals of the SBSU

- To reduce hospital ALC days by assisting with flow of hospital patients who are eligible for LTC home placement but who have not been accepted as a result of their unpredictable/unmanageable behaviours
- To prevent unnecessary and avoidable emergency room visits and potential hospitalizations of current LTC home residents
- To send or return residents of the SBSU to a normalized LTC home setting after successful treatment
- To enhance the knowledge and expertise of LTC homes

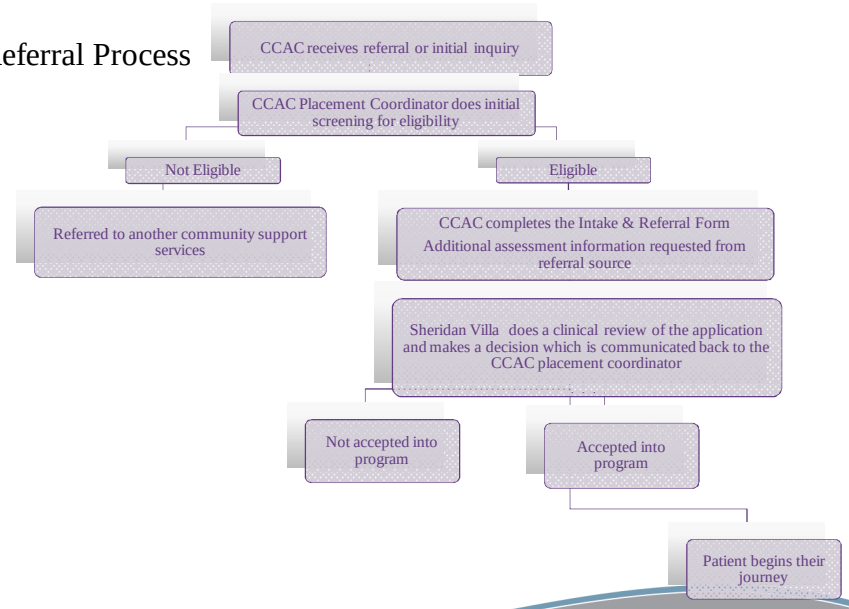
Admission Criteria

- Eligible for Long Term Care placement
- Primary diagnosis of progressive Dementia with significant behavioral disturbance
- Medically stable with medical needs that can be managed on the unit
- Ambulatory (self mobile) or ambulatory with aide or requires one to two person transfer
- Behaviours that cannot be managed in the current environment and require specialized resources outside of those offered in a normal setting.
- Unsuccessful with available community and or hospital based specialized geriatric services

Exclusion Criteria

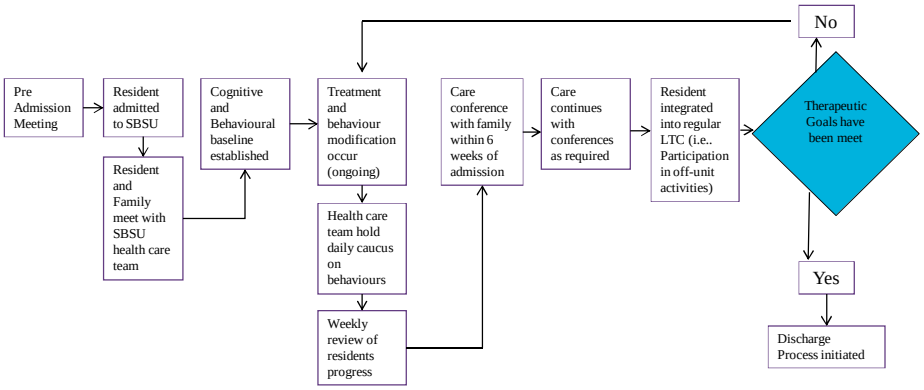
- Individuals requiring inpatient medical and or mental health services
- Individuals with behavioural disturbances that are not associated with a progressive dementia
- Individuals with behavioural disturbances that are associated with a progressive dementia but also have unstable medical illness or complex co-morbidities that cannot be managed on the unit
- Individuals with cognitive impairment as a result of: major psychiatric disorder or traumatic brain injury

Referral Process



Patient Journey

Those residents who have not met their therapeutic goals and following assessments and treatment are not expected to meet their therapeutic goals remain on the SBSU until they are accepted into another behavioural unit for refractory patients(i.e.. Toronto Rehab Institute, CAMH, Baycrest)

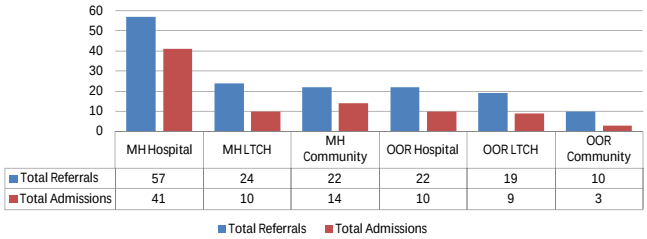


Discharge Criteria

- The resident has met the goals of their individualized care plan
- The resident develops a complex medical problem which the unit cannot manage.
- The resident no longer requires the services of the specialized unit
- The resident can safely be discharged to an appropriate environment

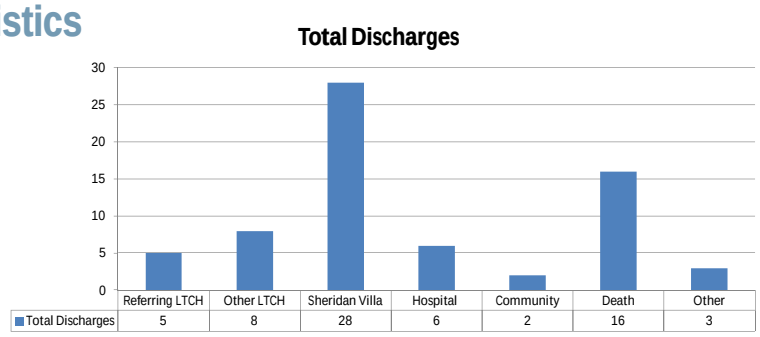
Statistics

SBSU Intake Stats
June 1, 2010 to January 31, 2014



As of January 31, 2014 there were 154 referrals made to the SBSU. Of those referrals 87 were admitted to the SBSU. 66% of the referrals and 74% of the admissions were from the Mississauga Halton LHIN region. For both in region and out of region the majority of the referrals came from the hospital 55% and 43% respectively. But when it comes to the acceptance rate for admission the LTC sector out of region had a greater proportion of admissions compared to referrals compared to within region where the greatest proportion lay with hospitals.

Statistics



To date there have been discharges 68 with 41% of the discharges going to Sheridan Villa. On average there are usually 7 residents that are ready for discharge every month but they remain on the unit unable to be discharged because no long term care bed is available at their destination of choice. Of those that have been discharged, to hospital it should be noted that these residents are transferred to hospital for a medical condition that is unrelated to their behaviours.

Key findings and recommendations

- The SBSU has established processes for data collection to track access and flow indicators. A robust data set can effectively inform policies and procedures related to access and flow. Baselines and targets should be considered for each metric.
- Inability to "fast track" the discharge of residents to a normalized LTC home, thereby impeding flow through the unit; high occupancy and limited flow impact referral decisions.
- Have the CCAC ensure that family/substitute decision maker identify at least one discharge destination prior to submitting to the SBSU.

Key Findings and recommendations

- The increased number of refractory patients coming from LTC homes where treatments have not worked. These residents are not transitional or stable
- Residents with other diagnosis that required stabilization prior to treating their behaviours
- Residents being admitted with advanced dementia, and as they progress through their journey new behaviours are emerging

Key findings and recommendations

- Residents that are just not suitable for the unit due to the complexity the case and our need to manage the safety of our other residents and staff
- The increase cost of the running the unit, without any increase in funding
- The waitlist may not be an accurate indication of demand. Previous experience with a wait list for the SBSU or extended wait times for admission can deter individuals from referring to the SBSU

Key findings and recommendations

- Formalized network of specialized behavioural care partners to assist with refractory residents
- Engage and communicate with SBSU families throughout the entire journey from time of referral through admission to resident stay and discharge
- Make the SBSU environment multigenerational/child friendly for families and visitors.
- Establish knowledge transfer protocols and procedures to support succession planning and ensure continuity of service

Key findings and recommendations

- Applications to the unit must demonstrate that available community and hospital based specialized geriatric resources have been tried unsuccessfully prior to admission to the SBSU. If this is done then it can be inferred that prior to admission to the SBSU, these other support services have been engaged and it provides a level of vetting to ensure that the admission to the SBSU is appropriate
- Initial criteria excluded individuals with reduced mobility, for example those that required the aid of at least two people to assist with transfer.

Key Findings and recommendations

Initial criteria excluded individuals with reduced mobility, for example those that required the aid of at least two people to assist with transfer. As the unit has evolved the ATD Committee recognized the need for flexibility with respect to this exclusion criteria and the decision was made to allow admission of a limited number of residents with reduced mobility. Based on the staffing model and physical environment there is a maximum of two residents with limited mobility that could reside in the unit at the same time.

Key findings and recommendations

- The number of treatment days for those who complete the program is range from a minimum of 44 days to a maximum of 629 days. Given that the 6 week conference serves as the first formal discussion regarding discharge it was decided that the CCAC Placement Coordinator should also be at the care conference to prepare families for discharge, and result in a more proactive approach to discharge planning.

Key findings and recommendations

- Residents admitted to the SBSU from hospital are experiencing challenges securing access to a normalized long term care bed following their stay in the SBSU
  - We have established agreements for conditional acceptances with the homes in the MHLHIN and are in the process of establishing such agreements with homes in the CW LHIN.
  - We provide support and a transition plan with the homes that are considering accepting these residents. We do site visits and encourage the homes to come and visit the residents while in the SBSU

Key findings and recommendations

- SBSU needs to continue working with health system partners to ensure that the goals of the SBSU are fully understood and supported by community partners
- SBSU should be considered a component of the healthcare system, and should leverage the strengths of existing behaviour support systems within the LHIN. This includes the Geriatric Mental Health Outreach Teams, BSO team members, Psychogeriatrician, LTC homes, Alzheimer's Society, hospitals, and the CCAC.
- Implement marketing and outreach activities to increase awareness of the unit, goals, eligibility criteria etc.