South East Regional Behavioural Supports Transition Unit (BSTU) at Quinte Health Care

March 2015

Agenda

- BSTU Mandate
- BSTU Project History and Approach
- About BSTU
- Access and Flow
- Transitions Support – Providence Care

BSTU Mandate

- To help those with a dementia or other age-related cognitive impairment with behavioural needs exceeding what can be managed with available resources in their current setting
- To work with and build upon the knowledge of those who know the person the best – their family, care givers, care providers in LTCH/community/hospital
- To develop a behavioural care plan that is transferrable to a new setting (chosen destination upon discharge)

History of the BSTU

- Impact of Behavioural and Psychological Symptoms of Dementia (BPSD)
  - Safety, quality of outcomes, experience, access
  - Person, family, care teams, others, system
  - Prevalence of dementia and BPSD (9,000 with Dementia in SE LHIN, 90% of dementia will experience "problematic" BPSD)
- Proposal originated by Providence Care and SELHIN as part of the Behavioural Support Services model
- No current capacity to implement in LTCH

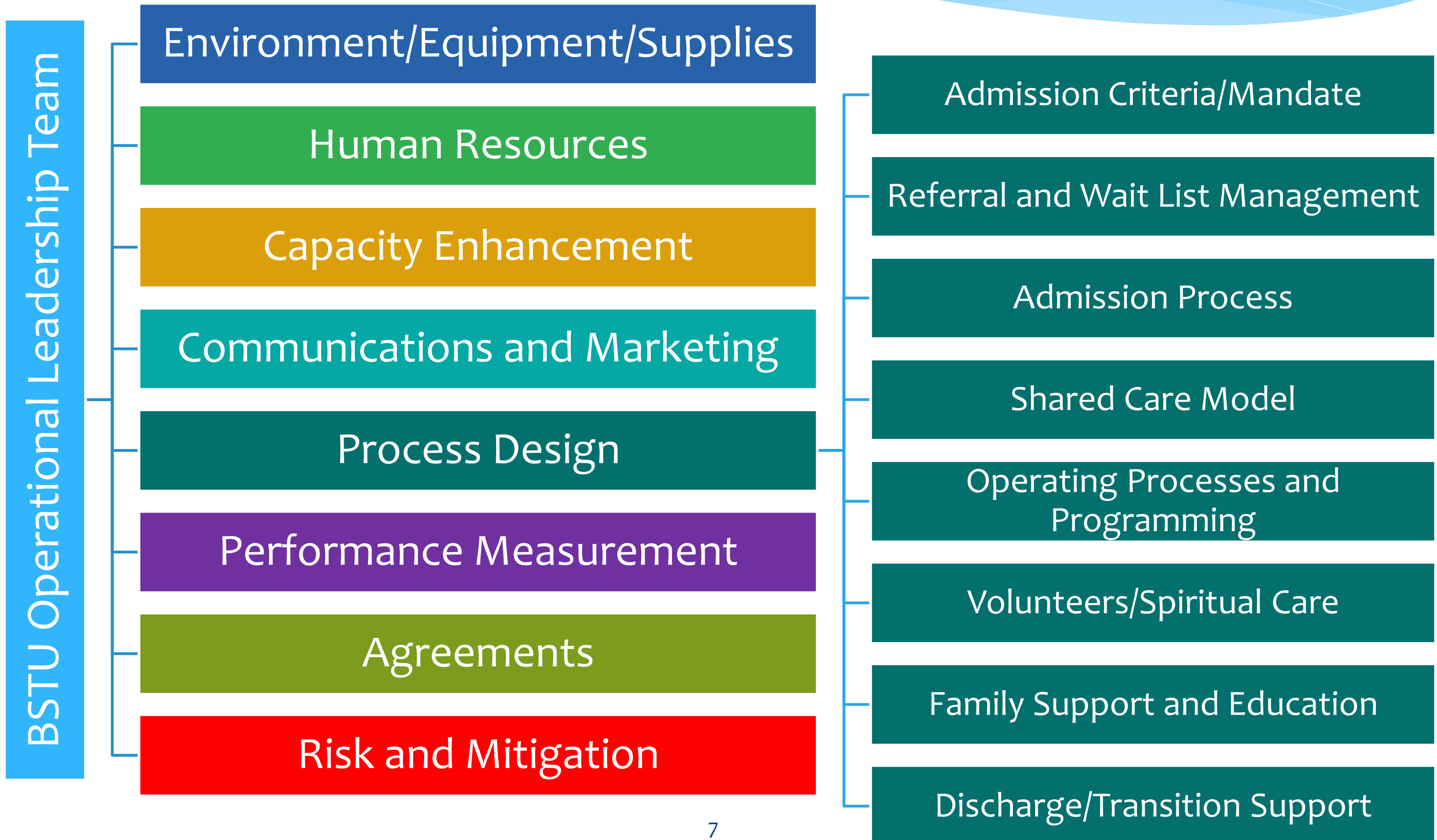
Sequence of events …

Jun 2013	SELHIN earmarks funding for a BSTU at recommendation of Providence Care
Feb 2014	QHC undertakes feasibility study
Jun 2014	QHC Business Case Approved by SELHIN – Project Planning begins
Oct 2014	Funding letter received by QHC
Sep 2014-Jan 2015	Operational Planning, Recruitment
Feb 2015	Operational approval by SELHIN
Feb 23 2015	BSTU Staff Training begins
March 30 2015	Target opening week

BSTU Operational Leadership Team

1. Adrienne Bell-Smith, QHC, Project Lead
2. Mitch Birken, QHC, Director of HR
3. Lisa Callahan, QHC, Communications Consultant
4. Mary Grattan-Gielen, SECCAC, Snr. Mgr. Access
5. Terry Holland, QHC, Professional Practice Coordinator
6. Charmaine Jordan, Stirling Manor, Administrator
7. Tracy Kent-Hillis, LACGH, CNO
8. Dr. Nadia Knarr, QHC, Family Physician Co-Lead
9. Paul McAuley, QHC, Director Strategic Planning & Projects
10. Catherine Nicol, Providence Care, BSTU Project Manager
11. Michael O'Keeffe, Moira Place, Administrator
12. Deborah Pidgeon, Lanark Lodge, Administrator
13. Dr. Robert Pincock, QHC, Family Physician
14. Christine Sellery, Arbour Heights, Administrator
15. Brian Smith, The John M. Parrott Centre, Administrator
16. Katherine Stansfield, QHC, VP and CNO
17. Darcy Woods-Fournier, Providence Care, Administrative Director, Seniors' Mental Health
18. Christine Wilkinson, QHC, Director, Medicine, Critical Care, ICU, CCC, Rehab

BSTU Planning Structure



BSO Framework Principles

Overarching principle of Person and Caregiver Directed Care

- The principle of person and caregiver directed/centred care is a key, overarching principle that must be reflected strategically as well as in day-to-day practice
- All persons must be treated with respect and accepted – "as one is", the older person and caregiver/family/social supports have a central voice and are the driving partners in the care and life goals and decisions
- Respect and trust should characterize the relationships between staff and clients and between providers across the continuum

1. **Behaviours are communication**
2. **Respect**
3. **Diversity**
4. **Collaborative Care**
5. **Safety**
6. **System coordination and integration**
7. **Accountability and sustainability.**

BSTU Planning and Development

- Broad stakeholder representation (over 50 participants with many more informants)
  - Cross SE Region
  - Cross "sector" (LTCH, Hospital, CCAC, Alzheimer's Society)
  - Variety of perspectives (Persons with Lived Experience, Administrative, Front-Line, InterProfessional)
- Use of best-practices, literature, standards of care
- Inspiration from across sectors, regions and other Behavioural Support Units
- Small working group format with broader stakeholder vetting

- BSO Guiding Values and Principles
- Define attributes of the "ideal"
- Process maps
- Metrics
- Evaluation
- Continuous Improvement

About the BSTU

BSTU Program Description

- 20-bed in-patient unit located at Belleville General Hospital Sills Wing Level 4
  - Secure unit
  - "LTCH" environment with dining, lounge and activity
  - Supportive dementia friendly design elements
- Available to those living within south east Ontario and to those who meet the criteria
- Referrals will be accepted through the SECCAC
- Operating as a "Special Rehabilitation" unit under the Public Hospital's Act
- Planned admissions – not Crisis beds

BSTU Admission Criteria

- People with age-related cognitive impairment with responsive behaviours
- People with behavioural health needs exceeding available resources (for example, CCAC, community-based Behavioural Support Services) in current setting
- People with medical co-morbidities that can typically be managed in home or other community settings
- Consent for admission from the patient/Substitute Decision Maker

BSTU Admission Criteria

People not typically serviced by the BSTU:

- People requiring initial workup and treatment of acute delirium
- People with responsive behaviours NOT due to age-related cognitive impairment
- People who have been stabilized in other units
- People requiring dialysis may be considered on a case-by-case basis
- People experiencing psychiatric issues *, such as:
  - Severe and/or frequent behaviours requiring high-intensity support
  - Admission under the Mental Health Act
  - Severe mental illness
  - Requiring on-going ECT treatments

  * These people are served by the in-patient Seniors’ Mental Health program at Providence Care

BSTU Referral Process

- To make a referral, contact CCAC Care Coordinator or call SECCAC Central Intake 310-2222 (no area code required)
  - Determine eligibility, including engagement with Behavioural Support Services to ensure person meets the criteria of having exhausted available resources
  - Provide SDM information about BSTU and obtain consent
  - Complete referral package:

Capacity assessment	RAI-HC or RAI from LTCH
Health assessment	Smoking assessment
Behavioural assessment	SDM Letter of Understanding and Consent
POA documents	Medication records
Health care professional reports	LTCH/Care team documentation

- BSTU Interprofessional Team review all referrals at weekly rounds, contact point person from care team to obtain any additional information and make admission decisions based on wait time/need/ability to accommodate

Referral and Admission Planning

- If referral not accepted or appropriate, CCAC/BSTU will support patient/family/care team in connecting with appropriate resources and BSTU will discuss rationale directly with referring care team
- Bed offers will be made as far in advance as possible, based on planned discharge dates of BSTU patients, to allow for admission transition planning
- Social Worker will connect with family upon acceptance of referral to provide information, support and development of patient profile
- Advance Practice Nurse begins consolidation clinical/behavioural profile prior to admission
- Shared Vision of Success meeting

BSTU Interprofessional Team

- Patients admitted under Family Medicine: Subset of department to provide MRP and after-hours call service
- Advance Practice Nurse M-F
- Geriatric Psychiatry consultation service
- Social Work M-W-F
- Recreation Therapy 6 days a week including Saturday and evening programming
- Access to pharmacist, occupational therapy, physiotherapy
- Days: 2 RPNs (1 RN/1RPN on weekends), 3 PSWs
- Nights: 2 RPNs, 2 PSWs

- Specialized training for staff:
  - PIECES/U-FIRST
  - Gentle Persuasive Approaches (GPA)
  - Non-Violent Crisis Intervention (NVCI)
  - Priming-Timing-Miming
  - Pain and Symptom Management
  - Sexual Expression
  - Pharmacology
  - Hearing from those with Lived Experience
  - Shadowing in LTCHs

BSTU Model of Care

Discharge Criteria

Any of the following:

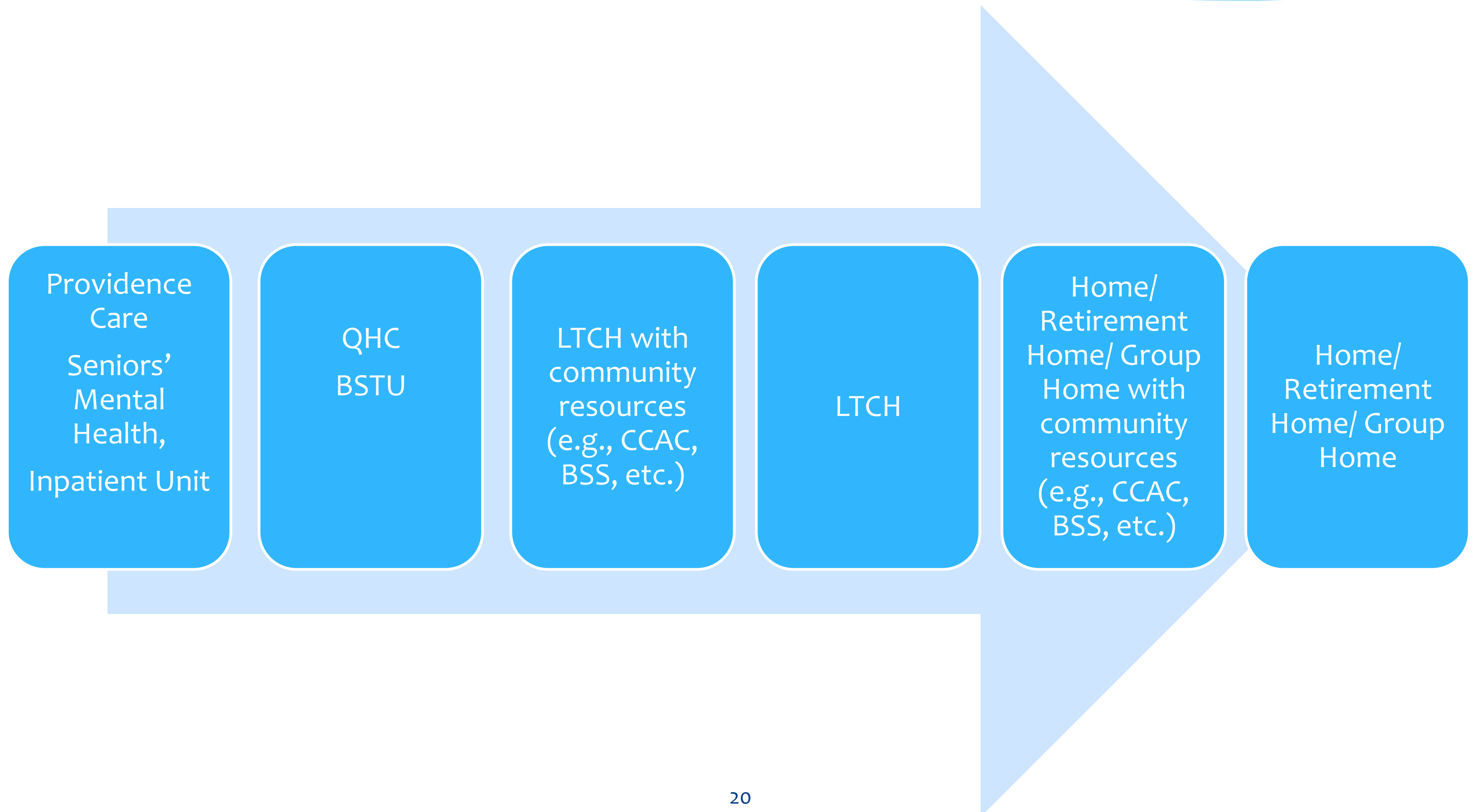
- Patient has met the goals of their individualized care plan
- Patient develops an acute/complex medical program which the unit cannot manage
- Patient no longer requires the services of the BSTU (e.g. change in physical abilities limits impact of behaviours)
- Patient can safety be discharged to an appropriate environment

Supportive Transition to Discharge

- Cross-organization Transition Planning Meeting approximately 2 weeks prior to discharge
- Physician to physician transfer of care phone call one week of discharge
- Proactive updating and sharing of information
- Discharge destination care team support and education
- Overlapping transition support services
- MRT, Family and/or other accompanying parties arrive in time for pre-discharge activities
- 6 week post discharge follow-up meeting/debrief, hosted by BSTU NP/SW
- Ability to reconvene discharge transition planning team

Continuum of Care Options

(demonstrates intensity of care – highest to lowest)



Access and Patient Flow

Access and Flow

Working Together with Regional Partners to maintain access to BSTU for those who need the service.

- Length of stay range: 60-120 days with target average length of stay 90 days (approx. 80 admissions per year)
- Target discharge destination identified upon referral
- Shared and consistent expectations among family, BSTU, care partners regarding the role and goals of BSTU for each patient
- Collaborative transition support and planning

Memorandum of Understanding

- Expectations of the BSTU, sending/receiving teams and supporting teams
- Content developed by cross-sector working group
- Endorsed by BSTU Operational Leadership Team, LTCHs (Qtly Meeting), SE LHIN, South East CCAC and Hospital Executives Forum (SECHEF)
- Goal to have hospital, LTCH and care partner executive sign off prior to opening

Access and Flow - Assumptions and Mitigation

Assumptions

- There will be high demand for BSTU
- BSTU patients will be highly sensitive to negative impacts of transfers and are high risk for ALC
- Patient flow is the number one challenge reported by other behavioural units in Ontario
- Unnecessary transfers are not ideal for the person, family or system

Mitigation

- Home First philosophy
- Enhanced access to LTCH beds
  - Bed hold for LTCH residents
  - Readmission priority (higher than crisis) for return to LTCH
  - Specialty Unit priority (level 2.1) for new LTCH applications
- Hospital Patriation/ Repatriation if necessary and where appropriate
  - For medical care
  - To wait for LTCH bed post-discharge
  - All transitions supports and will be applied

BSTU Transitions Support –

Providence Care Seniors Mental Health

Behavioural Support Services

- Outreach
- Psychogeriatric Resource Consultants
- Mobile Response Teams

"Honouring people, possibilities, and partnerships"

Behavioural Support Services Sept 2013

Providence Care

BSTU Transitions Support

Transition Pathways

1. Home to BSTU returning Home
2. LTCH to BSTU returning LTCH
3. Home to BSTU to LTCH

Transition Points

1. Pre-Admission
2. Admission
3. Discharge

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Memorandum of Understanding

Expectations of Behavioural Support Services teams of Providence Care

1. Provide all relevant documentation to the BSTU in a timely manner when a BSS client has been referred to the BSTU
2. Collaborate with CCAC Care Coordinator and BSTU team in determining ability to meet the needs of a potential BSTU patient and his/her care team in the current setting (admission prevention)
3. Provide integrated access to Behavioural Support Services and behavioural transition support to the patient, family and discharge destination care team through the BSS teams appropriate to the discharge setting, as planned during the pre-discharge planning conferences.

Providence Care

BSTU Transitions Support

Transition support provided by BSS will match the needs of the patient/family/care teams and will be dependent on the discharge setting. Transition supports may include:

- Ongoing Outreach consultation support
- Participation in pre-discharge planning and 6-week follow-up team conferences
- Collaboration with discharge destination care team to support implementation and refinement of the behavioural care plan
- Direct care for ADLs utilizing specialized physical contact, care delivery, and communication techniques

Providence Care

BSTU Transitions Support

- Communication liaison between patient/resident, family, and care team
- Side-by-side learning or peer mentoring of behavioural support strategies to all care providers in order to strengthen capacity for understanding and managing behaviours
- Meeting the person on the day of transition in the new setting
- A period of observation/coaching/demonstration in the new setting to support transfer of the behavioural care plan

Providence Care

Questions?