Environmental Scan of Ontario's Behavioural Support Transition Units (BSTUs)

Report Created by the Behavioural Support Transition Unit (BSTU) Collaborative

Part of Ontario's Best Practice Exchange

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What is Behavioural Support Transition Unit (BSTU)?

In this document, Behavioural Support Transition Units (BSTUs) refer to specialized units in Ontario, Canada caring for individuals expressing responsive behaviours associated with dementia, mental illness and/or other neurological conditions.

Since 2010, Long-term Care (LTC) homes in Ontario can seek to have one of their units, or a portion of a unit, designated as a 'Specialized Unit', which expands the home's ability to serve residents within the continuum of care (Bruyère, 2016). These specialized units provide higher intensity, specialized care for individuals compared to that which is offered in regular LTC home units (Bruyère, 2016). Click here for the legislation governing Ontario's LTC homes. Today, in addition to BSTUs, there are designated units that serve residents who need dialysis (Orosz et al., 2016).

After a period of assessment, care planning and treatment, BSTUs work to support individuals' transitions to LTC homes or to the community. If higher levels of care are required, specialized Complex Continuing Care units and/or Tertiary Mental Health programs may be considered.

What is the Behavioural Support Transition Unit (BSTU) Collaborative?

The Behavioural Support Transition Unit (BSTU) Collaborative is a group of health care professionals and individuals with lived experience that meet on a monthly basis with the following shared objectives:

- To learn about and to share existing successes, challenges and person-centred approaches within BSTUs.

- To identify, understand and share the critical elements in providing person- & family-centred care within BTSUs.

For more Information, click here to visit the BSTU Collaborative web page.

This collaborative is part of Ontario's Best Practice Exchange which is supported by Behavioural Supports Ontario (BSO) and brainXchange

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Environmental Scan Background

In the **fall of 2016**, the Behavioural Support Transition Unit (BSTU) Collaborative designed and facilitated an environmental scan of existing BSTUs in Ontario.

The **objective** was to gather general information about the BSTUs for the purpose of learning and establishing an overall understanding of existing units so these experiences could be compared for knowledge sharing and quality improvement.*

The environmental scan was not intended to be an evaluation or a comparison of the units' work; rather, it was designed to be a snapshot of the BSTUs at a specific moment in time.

Participation in the environmental scan was voluntary. The survey was completed by unit staff or managers who were very familiar with the work of their own unit. Respondents held different positions and thus could have different perspectives and levels of understanding of the details of the work of the unit. This was identified by the collaborative as a limitation to the scan data. An additional limitation was that residents and care partners were not surveyed.

Nonetheless, the scan is a good example of how BSTUs can work together and exchange information regarding the benefits of the BSTU model and possible quality improvement activities.

* This scan included recall data that was self-reported. No verification of the data was completed. Each unit submits regular operational and quality information to their Local Health Integration Network (LHIN) in accordance with their service accountability agreements.

Behavioural Supports Transition Unit (BSTU) Participation

The following Ontario BSTUs participated in the Environmental Scan:

- Baycrest (Toronto Central - LHIN)
- Cummer Lodge (Central LHIN)
- Hogarth Riverview Manor (North West LHIN)
- Peter D. Clark (Champlain LHIN)
- Quinte (South East LHIN)
- Sheridan Villa (Mississauga Halton LHIN)
- T. Roy Adams Regional Centre for Dementia Care/ Linhaven (HNHB LHIN)

At the time of the scan, five BSTUs were located in Long-term care (LTC) homes and designated as a specialized unit under the Long-term Care Homes Act (2007). A fifth BSTU was also located in LTC however, was not formally BSTU-designated and the sixth was located in a hospital setting.

SNAPSHOT OF UNITS (Fall 2016)

Number of Beds

- Range of the Number of Beds: 12 - 32

- Average: 19.3

- Median: 17

BSTUs have a mixture of accommodation types: private (7 units), semi-private (4 units), and basic (2 units); 3 units have exclusively private accommodations.

Each LTC home-based unit represents a fraction of the host LTC home's bed complement.

The maximum number of beds in each unit is dependent on a number of elements: anticipated demand, the environmental layout of the host home/hospital (e.g. whether a section of an existing unit could be separated), front line/direct care staffing requirements, and/or available funding.

Most Common Referral Sources

- Hospital/acute care (noted as the number one referral source for 3 BSTUs)

- Long-term care (noted as the number one referral source for 2 BSTUs)
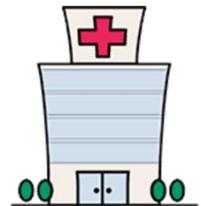
A weighted referral source ranking confirms that the majority of BSTU residents come from acute care, followed by LTC.

Other referral sources include community and tertiary care.

Eligibility

For all beds in Ontario LTC homes (including those in BSTUs), eligibility is determined by the Community Care Access Centres (CCACs). For BSTUs specially, the important admission question is 'of those eligible for LTC, who would benefit from the specialized services offered by the unit?'

Units use different processes to determine whether an application is appropriate with some having set up a unit-specific review process/team while others continue to use the host home's regular admission review channels.

Admission Criteria

Each unit has a set of criteria to identify individuals who would most benefit from the care model their unit offers.

Common Admission Criteria:

- Units located in LTC homes follow the general LTC admission criteria, as set out by the regulations.

- All units require that applicants have responsive behaviours that cannot be managed in their current environment.

- Six units also require a diagnosis of dementia.

Some of the units also identify sub-groups of clients whose specific needs they cannot meet:

- Individuals with behavioural expressions not associated with progressive dementia (2 units specifically refer to exclusion of individuals with Acquired Brain Injury)

- Individuals with a major psychiatric disorder(s) (5 units)

- Individuals who are medically unstable (2 units)

Primary Discharge Destination

- 'In home' Long-term Care (meaning discharged to a general unit within the same LTC home that includes the BSTU) (5 units)
- 'Other' Long-term Care homes (most common destination for 2 units and 2nd most common for 5 units)

Using a weighted discharge destination ranking, in-home discharge and other LTC home are equally important.

None of the residents have returned to the community.

Number of People on the Waitlist at the End of 2015/2016 Fiscal Year

The CCACs where the unit is located keep a separate waitlist for the BSTU beds, as outlined in the regulations.

- The number of individuals waiting for a bed in a BSTU ranged from 0 to 11.

- One unit had no one waitlisted and 2 units did not submit their waitlist numbers.

Average Clinical Length Of Stay (CLOS) – 2015/2016 Fiscal Year

• Minimum average unit CLOS: 90 days

• Maximum average unit CLOS: 387 days

• Average for all units: 200.6 days; Median: 165.8 days

Collaborative members noted that Clinical Length of Stay (CLOS) can be influenced by the care model of each unit, by the availability of other services in the region, and by the small total number of residents.
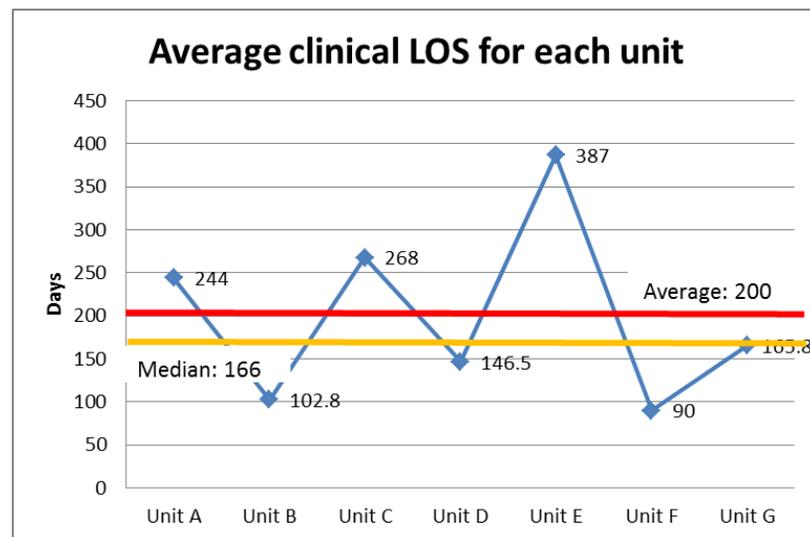

Note: In order to present the data anonymously, BSTU names are not included in the graphs/tables. Units A-G do not coincide with the participating units listed at the beginning of the document.

Average Number of Days Spent on a BSTU after Clinical Goals Reached – 2015/2016 Fiscal Year

The BSTUs' experience shows that not all residents could be discharged from the unit as soon as they reached their clinical goals. Since the units offer time-limited care, these extra days could be considered similar to the 'Alternate Level of Care' (ALC) days that Ontario's acute care hospitals track.

• Minimum 'ALC' days: 0 days

• Maximum 'ALC' days: 294 days

• Average: 155 days; Median: 158 days
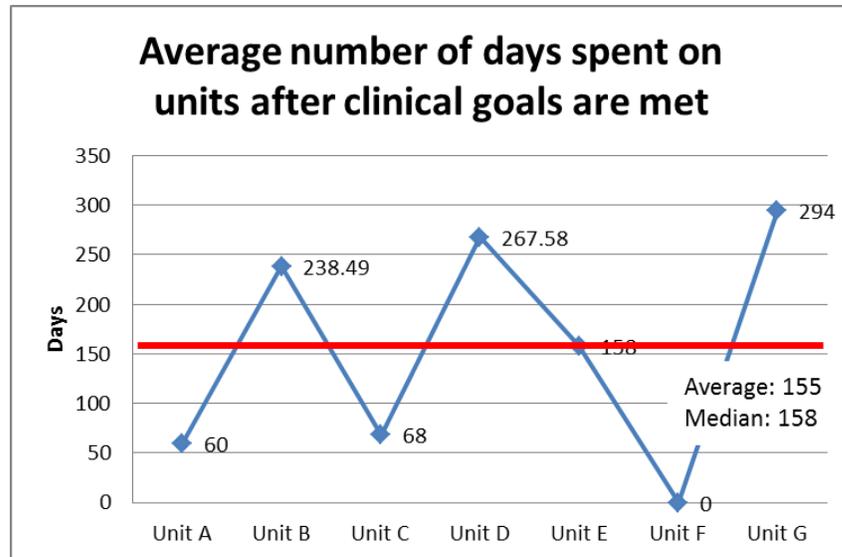
Average number of days spent on units after clinical goals are met

Note: Units A-G do not coincide with the participating units listed at the beginning of the document.

There is a large variation among BSTUs' Clinical Length of Stay (CLOS) (90 – 387 days) and total Length of Stay (LOS). This can be partly explained by the difference in the sub-population targeted and that the total number of BSTU residents remains small (i.e. a few clients' experiences can greatly impact the average).

Still, the practices of the units that have significantly lower average 'ALC' days could be further explored to find useful processes. These might relate to practices within the unit, within the host home and/or within the sub-region in which the host home is located, and could be considered for replication elsewhere, if appropriate.

Unit-Specific Data:

	Unit A	Unit B	Unit C	Unit D	Unit E	Unit F	Unit G
Expected LOS	120	Not reported	Not reported	270 – 547.5	Not reported	90	Not reported
Average Clinical LOS	244	102.8	268.0	146.5	387	7 to 90	165.8
Average 'ALC'	60	238.49	68.0	267.58	158	0	294
Total LOS	304	341.29	336.0	414.08	545	7 to 90	459.8

Note: Units A-G do not coincide with the participating units listed at the beginning of the document.

Staffing

Staffing levels and staff mix varied from unit to unit.

In addition to front-line nursing staff (e.g. Registered Nurses, Registered Practical Nurses and/or Personal Support Workers), staff from the following disciplines are reported to be associated with the units:

- Activation/ Recreation staff (5 units)
- Social Work (4 units)
- Occupational Therapists (2 units)
- Nurse Practitioner (1 unit)

There are varying levels of support from Medical Physicians and Geriatric Psychiatry.

The chart below details the total FTE (full time equivalent) staff per bed during day shifts (including nursing, allied health professionals and unit supervisor staff).
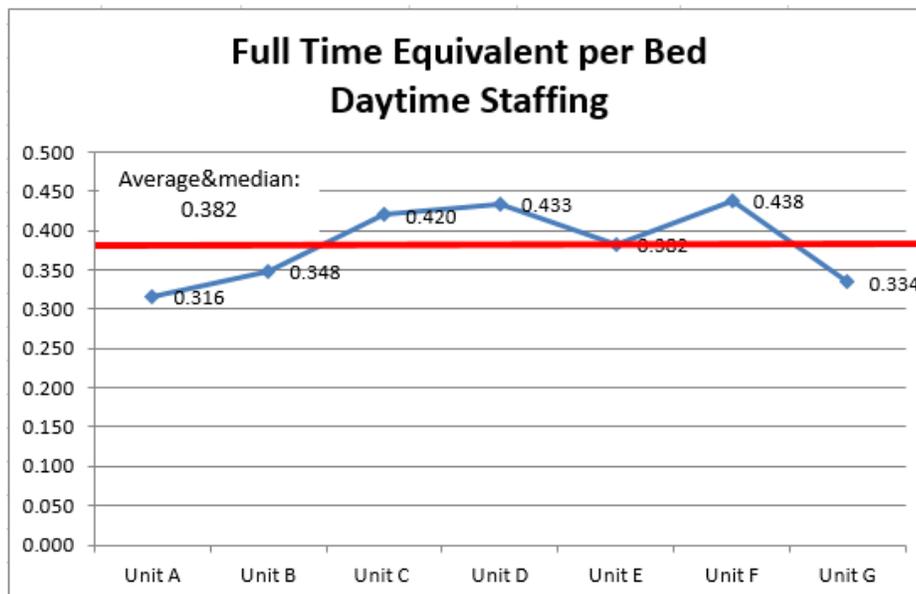
Full Time Equivalent per Bed Daytime Staffing

Average&median: 0.382

Unit A: 0.316
Unit B: 0.348
Unit C: 0.420
Unit D: 0.433
Unit E: 0.382
Unit F: 0.438
Unit G: 0.334

Note: Units A-G do not coincide with the participating units listed at the beginning of the document.

> **"I was there every day and witnessed what the staff went through.**
> **Their genuine care and kindness to residents and family members was above and beyond"**
>
> *~ Family Member of a BSTU resident*

Most-Used Staff Education

- Gentle Persuasive Approaches (GPA)
- P.I.E.C.E.S.
- Montessori
- U-First!

Assessment Tools

Most Frequently Used Assessment Tools:

- Dementia Observation System (DOS) (8 units)
- Cohen Mansfield Agitation Inventory (CMAI) (5 units)
- Mini Mental State Examination (MMSE) (4 units)
- Resident Assessment Instrument - Minimum Data Set (RAI-MDS) (mandatory for LTC homes)

Other Assessment Tools Used:

- Pain Assessment In Advanced Dementia (PAIN AD) (3 units)
- Antecedent-Behavior-Consequence (ABC) (2 units)
- Confusion Assessment Method (CAM) (2 units)
- P.I.E.C.E.S. (2 units)
- Abbey Pain Scale (1 unit)
- Cornell Depression Scale (1 unit)
- Geriatric Depression Scale (GDS) (1 unit)
- Montreal Cognitive Assessment (MoCA) (1 unit)
- Palliative Performance Scale (1 unit)
- Side effects of Antipsychotics Checklist (1 unit)

Most Important External Partners

- Community Care Access Centre (CCAC)
- Behavioural Supports Ontario (BSO)
- Alzheimer Society

Lessons Learned

- A mixed population of residents with significant behavioural expressions (combining residents with psychiatric diagnoses, brain injury and/or developmental disability along with residents with a primary diagnosis of dementia) presents challenges in BSTUs. It is for this reason that most units focus on a specific segment of the population (i.e. individuals living with dementia). The drawback to such an approach is that gaps may remain in the behaviour support services available in Ontario.

- Unit applicants' needs are increasing: more complex co-morbidities are evident on admission, which mirrors trends observed in the general LTC population.

- The beds within a BSTU are considered provincial resources, as such, most units receive referrals from outside of their LHIN. It would be interesting to know whether the BSTU beds serve more out-of-LHIN residents, or whether these residents come from further away than those in the host LTC homes' regular units. Data on this is not collected consistently.

- There are challenges for BSTUs in complying with MOHLTC regulations due to the transitional nature of these units and the high needs of their residents (e.g. environmental modifications and creative, relationship-oriented interventions).

- BSTUs in LTC homes are a new service model as they offer time-limited, transitional care in long-stay beds. This makes it is even more important for host homes to build different types of partnerships with community-based healthcare providers. In this sense, BSTUs are more akin to convalescent care LTC beds.

- BSTUs in larger homes may be better able to "absorb" the BSTU residents who opt for an in-home discharge/move when they have reached their clinical goals.

Key Elements For Success

- Building strong relationships with families and care partners throughout the process is key; this includes effective communication.

- Enhanced staff complement in terms of staff to resident ratio, staff skill mix and flexible staff hours. Flexible staffing ensures "elasticity" in resources and moves the unit beyond '9-5 planning' to better suit the needs of the residents.

- Building and supporting an inter-professional team environment.

- Investing in start-up and ongoing staff education, both for professional development and as part of addressing staff turnover.

- Clear criteria needs to be shared with referring organizations so that they can quickly identify people who would benefit from the services of the BSTU.

- A modified unit environment, including easy access to outdoors, and an appropriate mix of basic and preferred accommodation to support the requirements of the chosen clinical approach.

Next Steps

Using the environmental scan as a basis to understand the current BSTU context, the BSTU Collaborative is working to identify critical elements in providing person and family centred care within this specialized setting. Essential to this work is understanding the lived experience of BSTU residents and their care partners. As such, the collaborative actively engages those with lived experience as key informants. This work will ultimately lead to identifying emerging and promising practices that have shown to positively influence the care provided by and operations of BSTUs.

Acknowledgements

References

Porteous, A., Donskov, M., Luciani T., & Orosz, Z. (2016, May 5). *Understanding the designation process for specialized units in long-term care homes: a multi-stakeholder toolkit.* Retrieved from: http://clri-ltc.ca/files/2016/03/BruyereCLRI_SpecializedUnits_Toolkit.pdf

Orosz, Z., Porteous, A., Donskov, M., Luciani, T., & Walker, P. (2016). Designated specialized units: How Ontario's long-term care homes fill a gap in care. *Healthcare Management Forum*, Vol. 29 (6).

We welcome your thoughts and feedback.

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