Transitions, Transitions, Transitions: The Smoother, The Better! (Part 3)

Working together to meet the challenge of transitions in care.

Hosted by The Ottawa Hospital & The Royal Ottawa Hospital

Monday February 27th, 2017
Villa Marconi Centre
Ottawa, ON

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

The Ottawa Hospital | L'Hôpital d'Ottawa

The Ottawa Hospital Nurse Led Outreach Team (NLOT)

Kathryn May NP
February 2017

Team Members:
Kelly Lumley-Leger APN Manager
Julie Ann Airth NP
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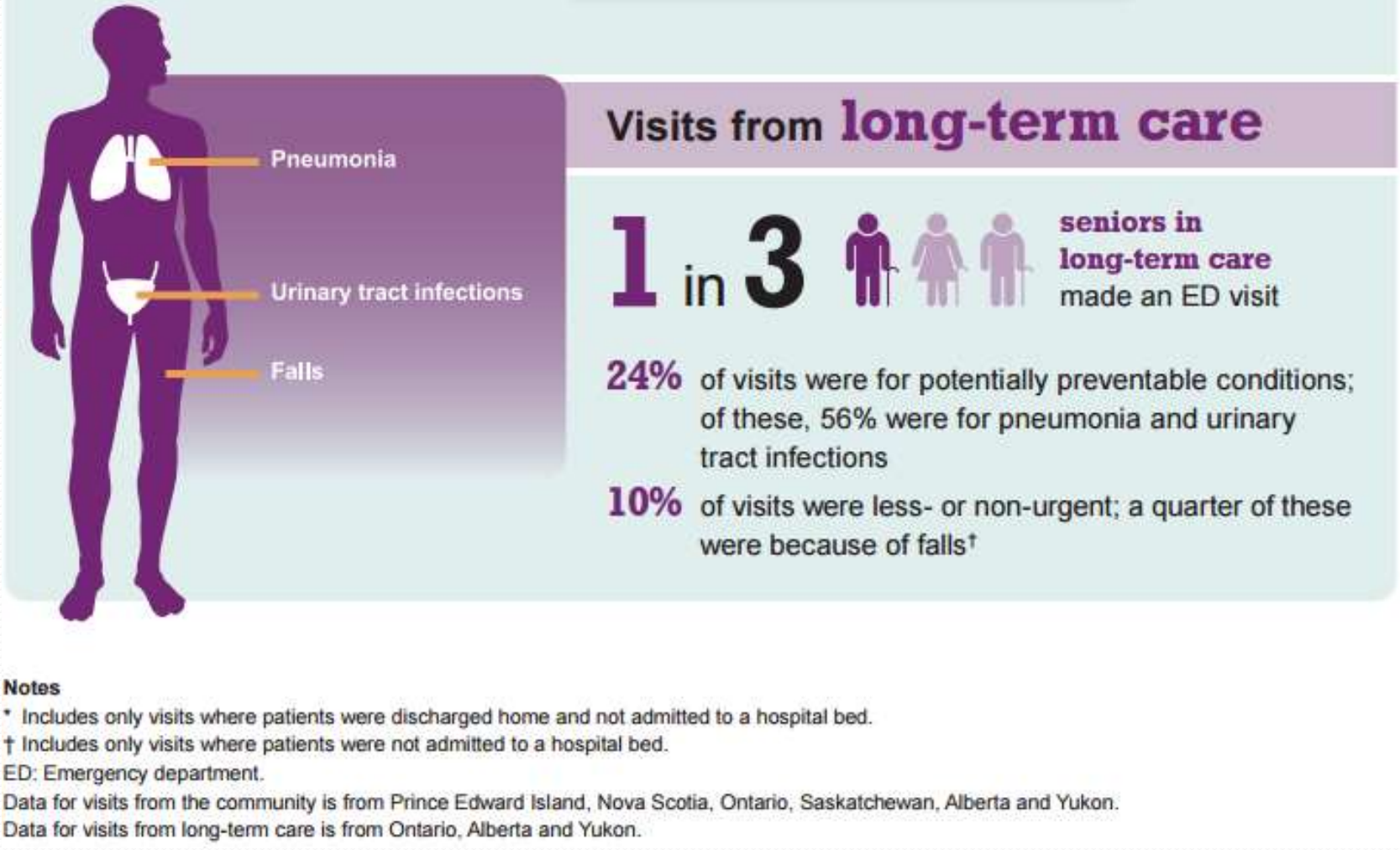

Notes

* Includes only visits where patients were discharged home and not admitted to a hospital bed.

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ED: Emergency department.

Data for visits from the community is from Prince Edward Island, Nova Scotia, Ontario, Saskatchewan, Alberta and Yukon.

Data for visits from long-term care is from Ontario, Alberta and Yukon.

2014, CIHI

Why avoid ED Transfer?

- Transitions from hospital are broadly problematic for the vulnerable and frail elderly
  - Acute care transfers are not without risk
- Reducing avoidable use of acute care is being addressed world wide
- LTC population is identified as a high cost health system user who may be better served outside of the acute care sector
- Literature highlights opportunities on many levels to address “avoidable” transfers such as staffing, chronic disease management, to early detection of acute changes in condition

NLOT: Background

2007: Reported ED pressures

- TOH responds by designing an ED NP Outreach service to aid in addressing the urgent care needs of the LTC population

2008: As part of an ED-ALC strategy the MOH establishes a NLOT in each LHIN

2012: Dr. Sinha highlights NLOT programs

- His comment…….
- My Translation……

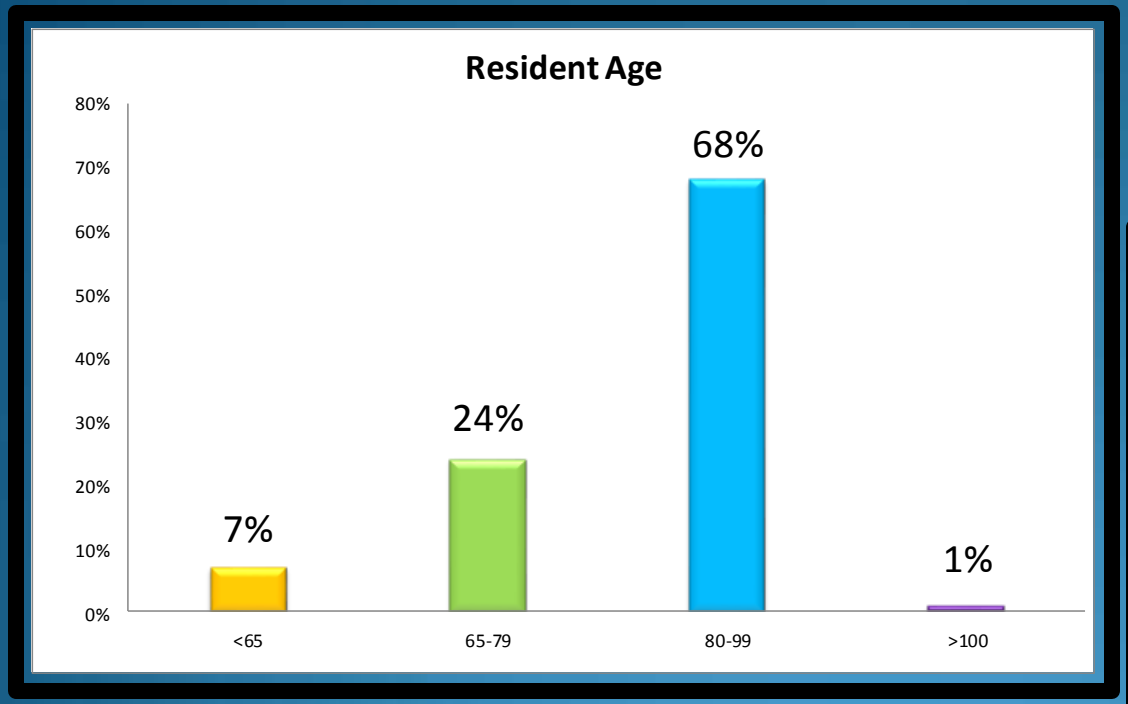
Who are we?

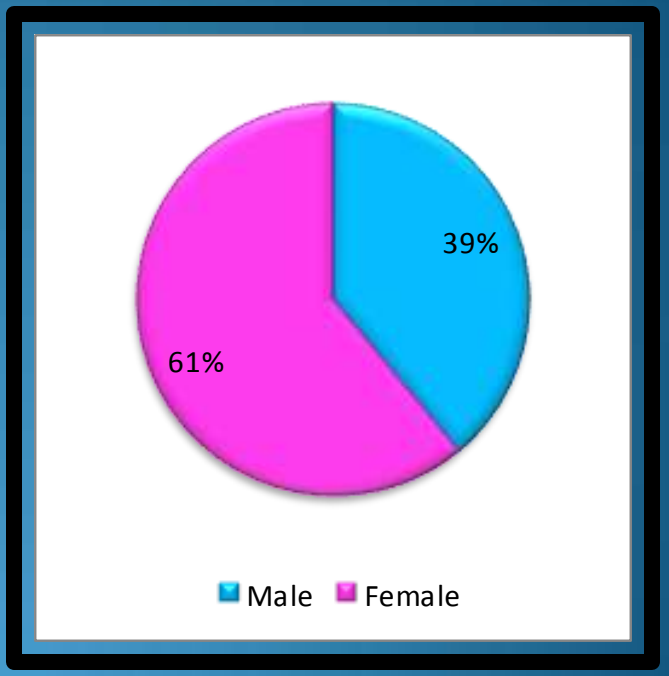
- LHIN funded program hosted by TOH with a mandate to reduce avoidable ED transfers
- Extension of TOH: providing outreach to LTC
- 4 FTE NPs working in 8 LTC Homes in Ottawa
- Monday to Friday coverage (0830 – 1630)
- Work in collaboration with LTC staff and MDs
- Supported by TOH ED MDs for clinical oversight

LTC Homes

- Carlingview Manor
- Glebe Centre
- Granite Ridge
- Laurier Manor
- Medex
- Perley Rideau
- Villa Marconi
- Westend Villa

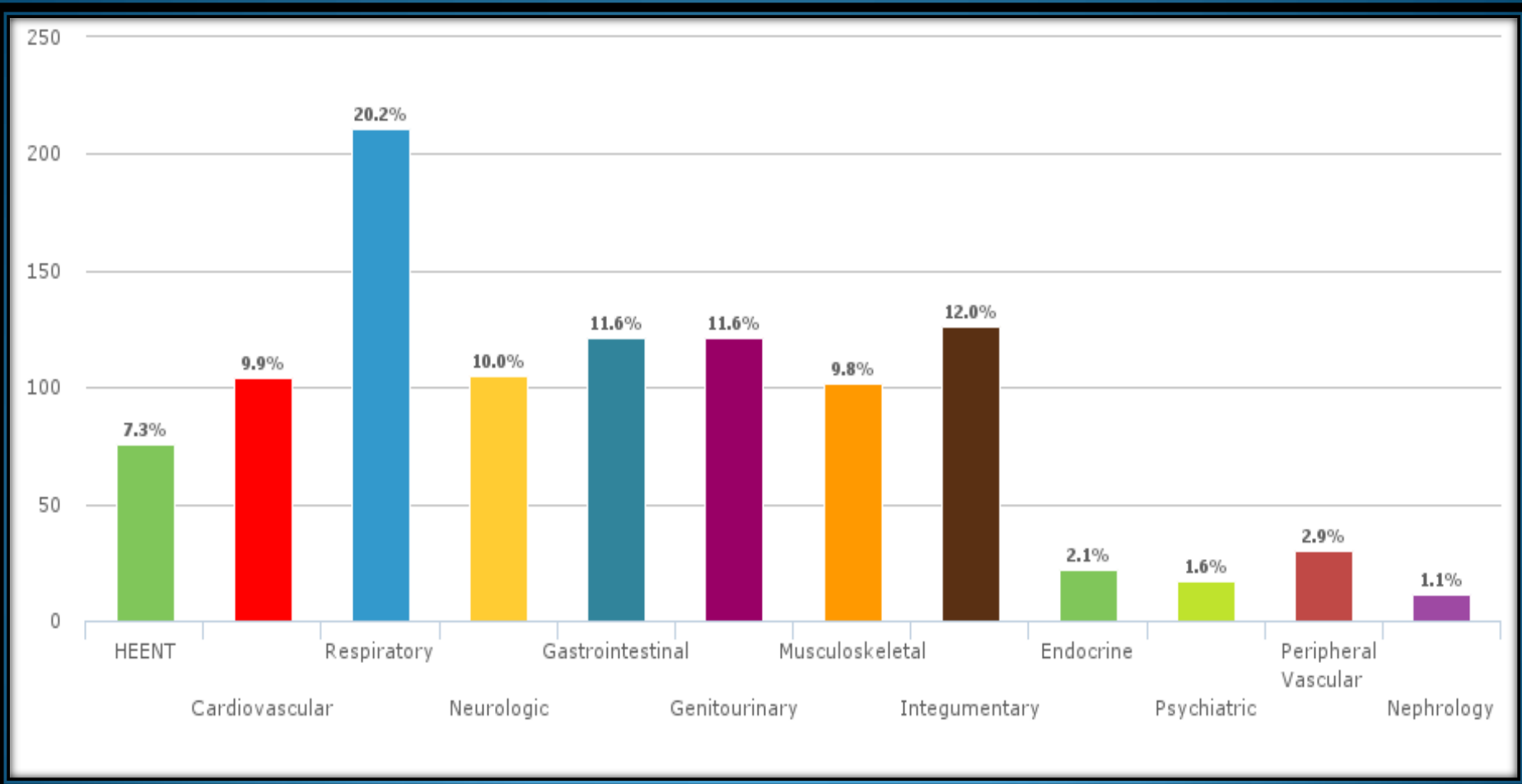
Who did we see in 2016?



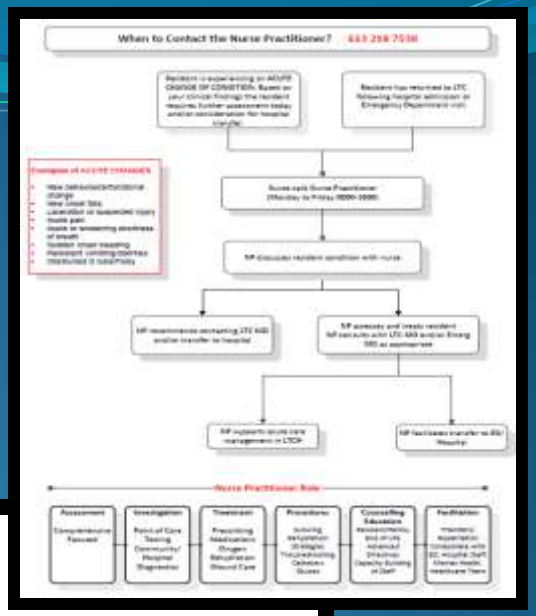


N = 1497 resident encounters

Diagnostic Category



NLOT Algorithm



Resident is experiencing an ACUTE CHANGE OF CONDITION and your assessment reveals that your resident needs further assessment today or you are considering a transfer to hospital

Resident has returned from a hospital admission or Emergency Department visit

Nurse calls Nurse Practitioner
Monday – Friday 8:30-4:30

What can I expect from the NP?

Assessment
- Comprehensive advanced health assessment and diagnosis

Diagnostic
- POCT
- Ordering XR, U/S, Lab testing
- Facilitating CT

Treatment
- Pharmacotherapy
- Oxygen
- Wound care
- Rehydration

Procedures
- Support of PEGs, PICCs, Foleys
- IV therapy
- Suturing

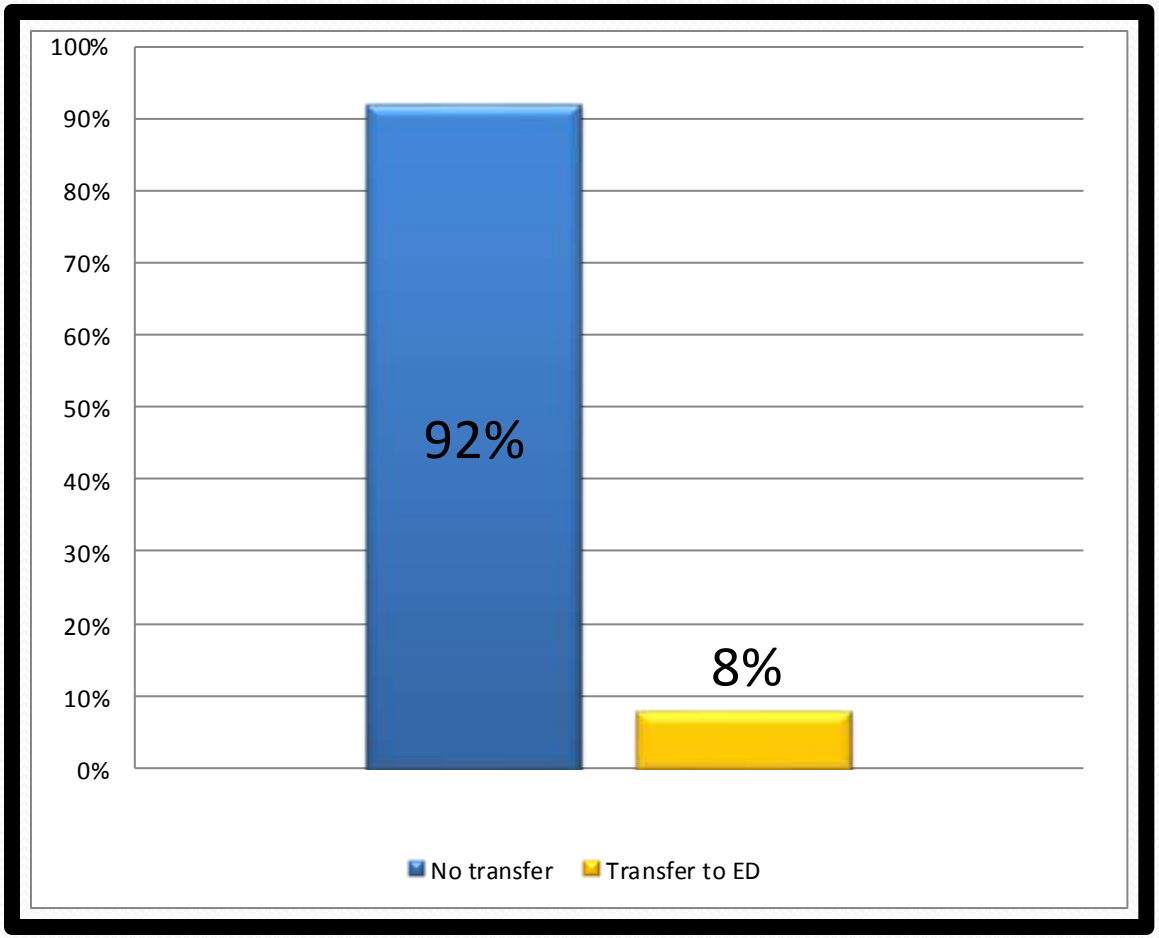
Counselling/Education
- Resident & Family
- End of Life
- Advanced Directives
- Capacity building

Facilitation
- Coordinates Econsult outpatient clinics
- Supports transitions
- Collaborates with health care team

"Setting an example is not the main means of influencing others; it is the only means"

~ Albert Einstein

Encounter Outcome



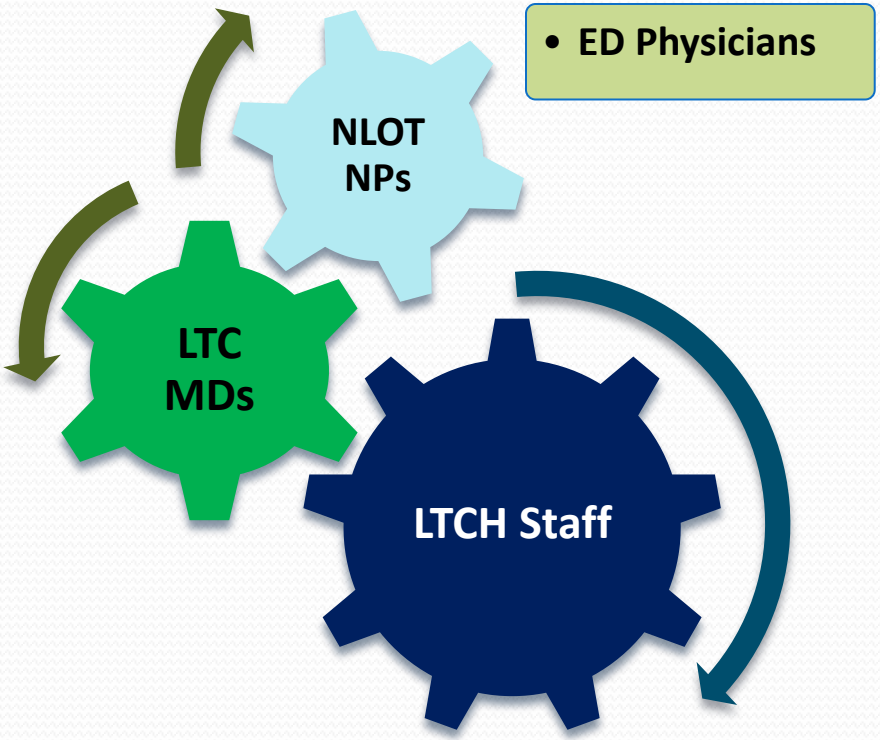
50% of ED transfers were admitted to hospital

N = 1497 resident encounters

Key Factors for Success

- Collaborative LTC environment: NP is a team member
- Strong leadership and nursing buy-in
- Trust
- Early identification of acute changes in condition
- Timely response to clinical demands
- Evidence based care and enhanced clinical expertise
- ED/LTC physician support
- Memorandum of Understanding
- Monthly tracking and review of ED transfer data

NLOT: A Collaborative Partnership



Quality Improvement Project: Reducing Antipsychotic Medication Use in Long Term Care Homes

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Spreading an Approach from the Canadian Foundation for Healthcare Improvement (CFHI) and the Executive Training for Research Application Program (EXTRA)

Canadian Foundation for Healthcare Improvement

- Project at a Long Term Care Home in Winnipeg
- Plan to reduce the inappropriate use of antipsychotic medications
- Result 6 months following the initiative:
  - 27% of residents were taken off of their antipsychotic without any increase in behavioural symptoms or increases in the use of physical restraint
  - Residents and families lives were improved
  - Front line staff were empowered

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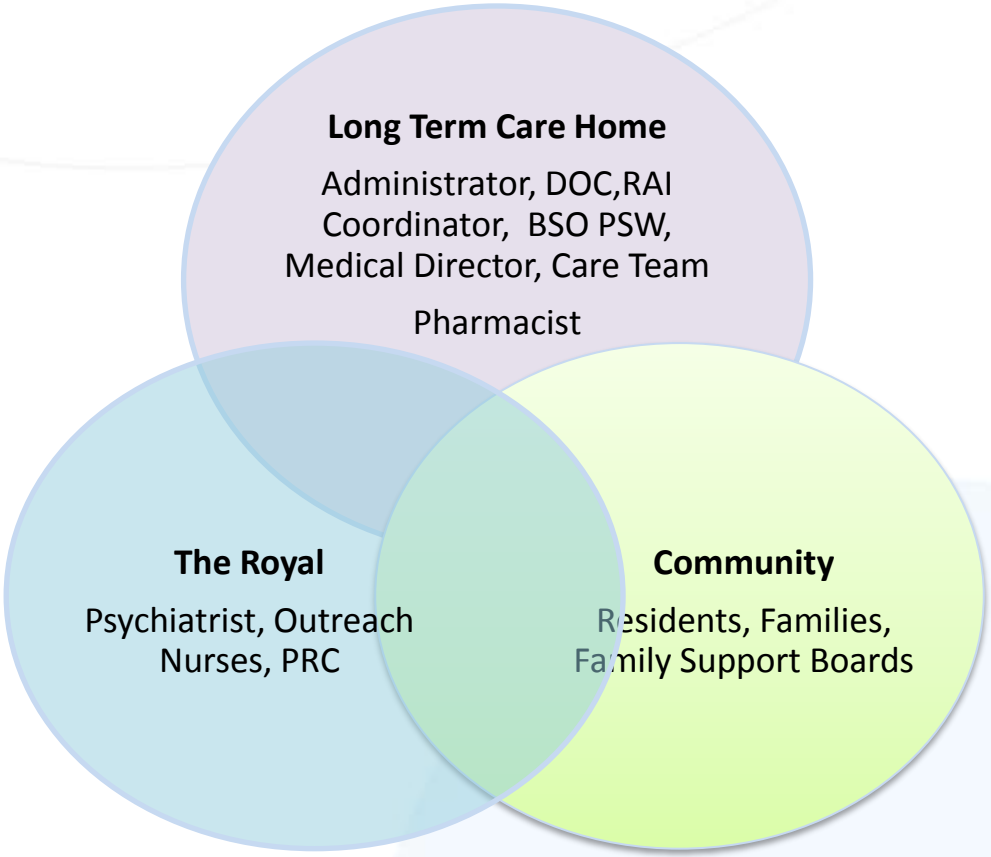
Project Team Members



Pilot Project

- Initially started at 35%
- Launch to introduce all partners to the project
- Binders were created to streamline the steps in the reduction process
- Education Sessions were given to all staff on topics related to Antipsychotics, and illnesses in which antipsychotics may be prescribed, as well as on the tools necessary to assess, and to establish non pharmacological approaches
- At Project completion was at 16%
- Currently at 11%

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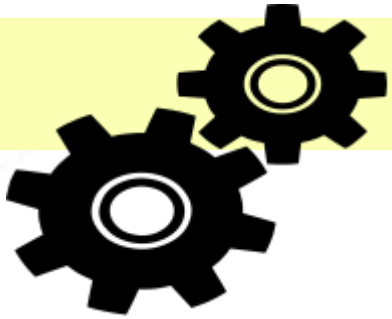
The Process



- Launch to inform stakeholders
- Inclusion of all staff
- Develop Binders with tools for project
- Education Sessions
- Identification of Participants
- Obtaining Consent
- The Huddle
- Reduction Process Initiated
- Midway Evaluation
- Sustainability

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Education Sessions

Antipsychotics	PIECES Refresher Psychosis	GPA Refreshers
Delirium	PIECES Refresher The Tools	Huddles
Compassion Fatigue	End of Life Medications	Personal Space and Safety

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Identify-Consent-Physician's Order

- Identify residents prescribed antipsychotic medications without a diagnosis of psychosis
- Obtain a consent for participation for those identified
- Physician's order for participation

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Getting Started

- Identify who will be first
- Getting to Know Me in Place
- Two per unit at one time
- Go Slowly
- Involve the Team
- Establish Non Pharmacological Interventions
- Evaluate and Adjust as needed

The Huddle

- Weekly brainstorming sessions with the whole team – including RN, RPN, PSWs, Recreation, OT, PT, RAI Coordinator, Food and Nutrition etc.

- Using the P.I.E.C.E.S. model to look at the whole situation – trying to figure out why they are displaying these behavioural symptoms. Look at the Physical, Intellectual, Emotional, Capabilities, Environmental and Social/Spiritual aspects to determine the possible causes.

"The staff feel more empowered by what they're doing because they can see results."

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Moving Forward Learning Process

Successes

- Reduction of EPS
- Improved Resident Quality of Life
- Staff satisfaction
- Staff empowerment
- Creativity of Caregivers
- Increased Teamwork

Challenges:

- Too Zealous Reducing too quickly or on people who have a diagnosis of Psychosis
- Staff worried
- Staffing numbers to implement non pharmacological interventions
- Not looking for alternative triggers such as a UTI for behaviours vs antipsychotic reductions
- Inconsistent Accountability

Sustainability

- RAI Co-Ordinator Involvement
- Admission Checklist Highlighting Antipsychotics and Reduction
- Accountability
- Established Re-evaluation Process
- Appropriate Diagnosis
- Continued Education Sessions
- Include all Partners

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Important Points to remember:

- Antipsychotics may be appropriate for residents with dementia if they are experiencing or have:

  - an underlying mental health condition that is being treated with antipsychotics
  - Delusions that are distressing to the resident
  - Hallucinations that are distressing to the resident
  - Defensive/Reactive behaviour (aggression) that is high risk
  - Other high risk behaviours that have not been managed successfully by other methods

Important Points to remember:

- Antipsychotic drug use shows little if any benefit for the following behaviours:
    - Insomnia
    - Wandering
    - Room-entering
    - Pacing
    - Inappropriate dressing/undressing
    - Vocally repetitious behaviour
    - Hiding/collecting items
    - Pushing wheelchair bound co-resident
    - Eating inappropriate items
    - Trying to remove restraints

Important Points to remember:

- "The goal is not to reduce antipsychotic medication to zero, but to use this method of therapy judiciously, with caution, and where appropriate."
- "There is still a small percentage of the dementia population that may benefit from these drugs (antipsychotics), especially for those exhibiting extreme aggression and anxiety."
- "When we're cutting down on antipsychotics, we're cutting down on reducing falls, injuries and illness, and in the end, residents have a better quality of life."

Schlesinger, J (2012). Formula for Success: Research project helps reduce need for medication at personal care home.

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Additional Information

- DE prescribing Tool – deprescribing.org

Antipsychotic (AP) Deprescribing Algorithm

Inspired by research. Inspiré par la recherche.
Driven by compassion. Guidé par la compassion.

CASE REVIEW

FEBRUARY 27TH, 2017

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CASE 1- MR. H

- 72 y/o old male from home; admitted to neurosurgery with a fractured C1-2 after sustaining an unwitnessed fall.
- PMHx: Mixed vascular dementia & Dementia with Lewy bodies (DLB), HTN, AFib, proteinuria, osteoporosis, compression #'s, obstructive sleep apnea & sleep walking.
- Lives with wife. Prior to admission (PTA): talking, independent with ambulation, required cueing for ADLs, no incontinence.

CASE 1- MR. H CONT'D

- Since admission: increasing confusion, fluctuating LOC, had not been out of bed.
- By day 4 of admission: received 28 mg Haldol.
- Referral made to the Geriatric Psychiatry Behavioural Support Team (GPBST).
- O/E: Pt was in a 4-point restraint, awake but difficult to understand, agitated - pulling at his Aspen collar.
- No bowel movement x 3 days. Very rigid. Foley catheter in situ.

KEY QUESTIONS

1. What are your concerns about this case?
2. What do you want to know from your assessment?
3. What are your *thoughts* about this the care of this patient?
4. What would you *suggest* as interventions in planning care for this patient?

CASE 1 OUTCOME

Immediate Recommendations:

- D/C Haldol, reduce narcotics
- Reduce restraint use, implement 1:1sitter
- Start AChEI, Quetiapine, Trazodone, loxapine prn
- Initiate Bowel protocol, remove foley catheter

2 Days later:

- More bright & alert
- Improved intake of food & fluids
- Sitting up, commode for toileting, better pain management
- Reduce restraint use: family & sitters
- Staff note easier to care for

CASE 1 OUTCOME

Within 1 week:

- Sitter and restraint use d/c'd
- Weaned off Seroquel, use of prn trazodone
- Staff education re: sleep disorder in DLB patients, pain, hunger, positioning

Within 4-6 weeks:

- Developed urosepsis with delirium; needing additional Seroquel prn

CASE 1 OUTCOME

3 months later

- Discharged to LTC after 9 weeks
- Not aggressive
- Referral made to BSO team

September 2016:

- Return to ED with increased confusion
- BSO team notified acute care GPBST
- Avoided admission – d/c back to LTC

CASE 2: MR. R

- 71-year-old male from home admitted to psychiatry after being brought to the ED by police.
- PMHx: AFib, DM2, Vascular dementia dx1 year PTA with slow progression of irritability, paranoia, & aggression. + family hx dementia.
- Premorbid: Early Hx of suspiciousness, paranoia, aggressive behaviour.
- Lives at home with his wife who had to leave her job (Montessori teacher) to care for him. PTA: increasing resistance to care, suspicious behaviour, wandering, wanting to drive his car. 1 week PTA took his car and got lost. Was found by the police.
- 5 months on psychiatry then transferred to Transitional Care Unit to await LTC.

CASE 2: MR. R

- Referral to GPBST 6 months after admission for agitation, aggressive behaviour, & care resistance.
- O/E: Incoherent speech. Nonsensical answers & mumbling. Not oriented.
- Poor insight, poor judgment, + Parkinsonian.
- Care resistant ++, spontaneously aggressive, paranoid, + wandering, poor sleep, calling out.
- Requiring 3 people to assist with care
- Current medications: Metformin, low dose ASA, Simvistatin, Naproxen, Mirtatzipine, Loxapine prn, Seroquel prn but getting very regularly.

KEY QUESTIONS

1. What are your concerns about this case?
2. What do you want to know from your assessment?
3. What are your *thoughts* about this the care of this patient?
4. What would you *suggest* as interventions in planning care for this patient?

CASE 2 OUTCOME

- Biggest priority was care resistance
  - Supported GPA strategies: Distraction – one to talk, one to provide care
  - Meds adjusted: Regular Seroquel (overall decrease), added trazodone
- Much improved sleep, more awake during the day making it much easier to provide care.
- Met with family:
  - Interests: simple coloring, drawing, Lego, puzzles, happy singing
  - Discovered that he was the nurturer with babies when he was younger
- OT took GPA course: discovered doll as a substitute for interest in children
- Staff education & empowerment: Improved staff interaction
- D/C to LTC with BSO referral.

CASE 3 MRS. A

- 98 y/o female to the ED with c/o irregular heart rate & confusion. ED reports negative delirium work-up. Held for GEM assessment.
- PMHx: AFib, HTN, COPD, hypothyroidism.
- Patient is a widow & has no children. Polish speaking. Lives with niece & her husband (who are in their 70's) who provide all IADL support. Has some CCAC support for bathing & respite.
- Family report "fine until fall down stairs 3 months ago" when she was admitted with vertebral fractures. Since d/c has become more irritable & argumentative. Poor intake of food and fluids. X 3 days accusing them of changing her pills, yelling & screaming but does not remember episodes.
- Meds: Oxazepam, Citalopram, diltiazem, furosemide, levothyroxine, K+
- O/E: Anxious +++, tearful, distraught, passive SI, Able to provide reasonable hx, no obvious cognitive concerns

KEY QUESTIONS

1. What are your concerns about this case?
2. What do you want to know from your assessment?
3. What are your *thoughts* about this the care of this patient?
4. What would you *suggest* as interventions in planning care for this patient?

CASE 3 OUTCOME

- Support for family; reassurance for patient.
- Discovered error in oxazepam dosage from previous discharge.
- D/C oxazepam, start mirtazepine, trazodone.
- Patient settled & was d/c home from the ED.

2 months later:

- ED visit for unrelated concern.
- Still living with niece but with regularly scheduled respite care; improved mood, ambulating with 4 wheeled walker.
- Family reports great improvement in quality of life.