Delivering Exemplary Care in Geriatrics: The Journey of One Organization

Mount Sinai Hospital
Toronto, Ontario Canada

Outline

• Our journey to a senior friendly hospital
• Key accomplishments highlighting nurse-led initiatives
• Program Outcomes
• Lessons Learned

Canadian Health Care System

• Single payer for hospital and some community care (Ontario Popl'n = 13.6 million)
• Medical Care - funded by the province
• Pharmacare by employer or for those on social benefits or >65 years of age
• Volumes increases are not always rewarded
Mount Sinai Hospital

- 442-bed acute care academic health sciences centre affiliated with the University of Toronto
- Located in downtown Toronto
- Founded in 1913 as a maternity hospital
- Amalgamation in 2015 to form the Sinai Health System

Geriatrics at MSH Prior to 2005

**Issues**
- Aging urban population
- Lack of priority for care of older adults (organizationally and provincially)
- Older adults as “the problem”
- Difficulty recruiting Geriatricians

**Resources**
- Robust Geriatric Psychiatry Program (inpatient consult, ambulatory, community)
- Clinical Nurse Specialist, Geriatrics

Geriatric Journey Timeline and Enablers

- Acute Care for Elders Research Grant
- Katz Gift to ACE Program
- SPSS™ Research Grant
- National 3M Innovation Award
- Magnet® Designation
- Southbridge Gift to SP/SS™
- National Safety Award
Where did we start...

- Big vision -
  - The very best care for older adults
  - Focus on transformation of care across the organization and continuum
- We knew couldn’t afford to fail
- Sought models to inform next steps

IHI - Execution of Strategic Improvements


Execution of Strategic Improvements
Key Organizational Capabilities

- Coordinate projects, human and capital and investments to deliver on system level aims
- Local leadership of activities to stabilize performance, support/sustain outcomes
- Employee development to lead process improvement and quality management

Nolan TW (2007)
Execution of Strategic Improvements
System Components

1. Set breakthrough performance goals
2. Develop a portfolio of projects to support the goals
3. Deploy resources to the projects that are appropriate to the aim
4. Establish oversight and a learning system to increase the chance of success!

Nolan TW (2007)

Execution of Strategic Improvements
System Components

1. Goal - “care of older people a priority”
   - Demonstrate how improved elder care contributes the MSH mission
   - Create a Senior Friendly Hospital
   - Focus on areas of strength (e.g., Emergency, Geriatric Psychiatry)
2. High Impact projects to support goals
   - Evidence based Strategic Plan
   - Build an improvement lab (ACE Unit)
   - Demonstrate organizational value

Execution of Strategic Improvements
System Components

3. Align supports and resources
   - Organizational, provincial and national priorities
   - Realign resources and selective investments
   - Journey to Magnet Excellence® as an enabler
   - NICHE - GRN, GIAP Data
   - Focus on education and development
   - Teams that can lead and deliver on change
   - Leadership development - direct care staff
Execution of Strategic Improvements
System Components

4. Oversight and Learning
   - Geriatric Steering Committee
   - Early on - incremental spread across early adopters
   - Patient and Family Centered with community support and partnerships
   - Garnering and sharing results aligned with priorities
   - Celebrate successes

The Mount Sinai Geriatrics Continuum

Why Establish an ACE Unit?

- Large % of older medical patients are medically and socially complex, benefitting from clinicians with expertise in geriatric care principles.
- Consultative Services have their limitations.
- Allows for patient needs to be matched to resources
- Could be used as a “laboratory” for best practice protocols and practices
- Supports internal and external profile development and fundraising initiatives.
Implementation Strategy
PEOPLE, PLACE AND PROCESSES
• Determine actual staffing needs
• Prepare and engage the staff
• Prepare the environment
• Develop evidence based policies and processes
• Standardize communication processes and practices
• Develop a monitoring and evaluation process
• Develop external and internal partnerships

Preparing The Staff
• Early engagement of RNs
  - The converted and the skeptics
• Make it inter-professional
  - Learn from each other
  - Build relationships
• Orientation days and education modules
  - Acknowledge attendance + participation

Opening Day on the ACE Unit
• Opened April 2011
  - Conversion from a General Medicine Unit
• Unit-Based Nursing and Allied Health Staff
• 4 Medical Teaching Teams
• Unit dedicated APN
• Geriatric Medicine and Psychiatry Services provide Consultative support
• Protocolized Order Sets
• Evidence-based Care Plans
• Dedicated Home Care Coordinator
Admission Criteria

65+ with an Acute Medical illness + any THREE or more of the following:

- A recent decline in functional abilities
- A recent change in cognition or behaviour
- Problems common to older adults (falls, incontinence, polypharmacy, adverse drug reactions, acute or chronic pain, delirium etc.)
- Complex Social Issues
- Risk Assessment score completed in ED ≥ 2

Process for ACE Unit Admission

- Influenced by ED RN/Geriatric Emergency Management (GEM) RN
- ACE designation placed by Internal Medicine MD
- Electronic admission orderset triggers various electronic flagging systems
- Admission to unit:
  - Interprofessional screen and assessment
  - RN developed “welcome” package
  - Review of risks and existing geriatric syndromes
- Daily review bed-spaced ACE patients

Unit Sustainability and Growth

- Driven by identified gaps and needs
  - Outcome measures
  - Staff reports
  - Patient + Staff Survey results
- Focus on Improving Discharge planning + Transitions of Care
- Advancement of Staff Empowerment and Leadership at the unit level
- Mentoring of staff across the hospital
What We Learned

- Communicate Early and Often...and Repeat
- Staff at all Levels Need to be Supported through change
- Frequent Leadership/Development Meetings
- Don’t Let Perfection be the Enemy of the Good
- Demonstrate + Share the ACE Unit’s Benefit
- Don’t forget about Processes and Care for Bed-spaced ACE Patients
- Leverage lessons learned and skills developed to support hospital-wide advancement

What We Learned

- The way we “thought” needed to transform
  - More holistic
  - Nursing role in discharge planning/transitions of care
- There is benefit to showcasing your work
  - Recognition builds confidence and motivates
- Share best practices with other areas
- Support capacity building of other inpatient units
- Never underestimate the power of collaboration, communication + interprofessional approach to care

ACE/Geriatrics Program Metrics
Geriatric Education Plan

**Issues:**
- All employees, not just clinicians interact with older patients and visitors
- Staff receive minimal to no education in geriatric principles in their formal training or organizationally

**Solution:**
- Develop an educational program that provides information to staff that is meaningful and relevant to their area of employment and interaction with older adults; utilize available resources to minimize “re-inventing the wheel”

**Goals of Education Plan**
- Increase staff capacity to provide the best care to older adults
  - Evidence informed practice
- Build in peer mentoring, teaching and collaboration
- Improve outcomes
  - ↓ length of stay and recidivism
  - ↓ incidence of hazards of hospitalization
  - ↑ patient satisfaction and patient experience
  - ↑ staff knowledge, attitudes and perceptions
- Support the strategic plan of a Senior Friendly Hospital
- Expand with the needs of staff and the organization
A 3-Tier Approach

- Expert
- Geriatric IP Resource Staff Curriculum
- All Clinical Staff
- Geriatrics General
- Clinical & Non-Clinical
- Geriatrics 101

Education Plan Details

Geriatrics 101
✓ Frontline staff, non-direct care staff, and non-clinical staff
✓ Basic considerations when working with older people
✓ Aging Sensitivity

Geriatrics General
✓ All direct care staff on medicine, surgery, cardiology
✓ Builds on Geriatrics 101
✓ Why Geriatric Nursing
✓ Age-related Changes

Geriatric Interprofessional Resource Curriculum
✓ ACE staff* + Interprofessional Geriatric Committee members
✓ 19 hours of online modules; case review
✓ 3 day workshop on Delirium, Dementia and Behaviours (2013)

Evaluation of our Efforts
ED: Identifying the Needs

- Increased volumes
- More older adults live alone in our geographical area.
- An ED encounter for a frail older adult is a sentinel event.
- The ED environment is counter-intuitive to the Geriatric Philosophy of Care.
- Continuity of care for older patients requires support that is not available with a typical ED visit.

ED: Responding to the Needs

- Risk Screening and Notification
- Strong inter-professional approach to older patient assessment
- Partnerships with Community Care Providers and Home Health Care
- Unique Avenues for Communication of High Risk Patients
- Linking with the Inpatient Providers (i.e. Geriatrics Consults, ACE Unit Team) through the GEM Flag System
Geriatric Emergency Management (GEM) Nurses

• GOAL
  - Improve care of older patients in the ED
  - Maintain optimal level of independence and well-being

• ROLE
  - Provide specialized geriatric assessment/interventions
  - Engage in capacity building initiative with patients, families, ED staff, and the community
  - Close partnerships with community health care providers, ED MDs and home care services to avoid unnecessary admissions
  - Case management and interprofessional collaboration

Features of our Senior Friendly ED

• Pre-Printed “Hold Orders”
• Specialised Geriatric Services (SGS) Linkages
• GEM Nurse Documentation and Flagging System
• Home-based Primary Care and Intensive Case Management Clients - Email Notification Systems
• Geriatric Education Tailored to ED clinicians
• Geriatric Focussed Policies + Procedures
• Inter-professional Approach to Care

ED RN Education

• Geri - EM versus NICHE Modules
  - 3.75 hours
  - Content focused on common and atypical ED patient presentations
  - Significant impact on geriatric knowledge as measured by GIAP

http://geri-em.com/
Key Accomplishments

- All Emergency Nurses completed Geri-EM education
- Development of Senior Friendly protocols and policies
- Collaborative approach to care
- Processes and Structures are nurse driven

The Mount Sinai Geriatrics Continuum

The Older Patient and Caregiver Experience at Mount Sinai Hospital

What we were hearing...

"I got kicked and scratched for no reason. I am just trying to do my job."

"We’re a hospital, not a nursing home."

"These patients should be transferred to Psychiatry- or Geriatrics."

"We already fixed the medical problem."
“We need more help at the bedside for these patients...”

“We need to keep ourselves and our patients safe”

“and we need it as soon as they get here...we can’t wait a week to figure it out”

“we need support to safely discharge these patients”

Highlight from the Literature

- Recent Review (Mukadam and Sampson, Int. Psychogeriatrics, 2011)
  - Wide-ranging prevalence of patients with dementia in Acute Hospital setting 12.9-63%
  - Patients with dementia are older, require more nursing care, have longer hospital stays and are more at risk of delayed discharge/functional decline

- Prospective Cohort Study of BPSD in the Acute Hospital (Sampson et al, British Journal of Psychiatry, 2014)
  - 65% of patients with DEMENTIA had clear Behavioural and Psychiatric Symptoms of Dementia (BPSD) on admission assessment
  - 75% demonstrated BPSD at some point during their admission
  - 57% with BPSD exhibited aggression; 44% activity disturbance; 33% sleep disturbance
  - BPSD most common in: men, from residential care, with superimposed delirium

Organizing New Approaches To Care

- Proactive
  - Comprehensive Geriatric Assessment
  - Harm Reduction/Delirium Prevention

- Standardization
  - Order Sets
  - Care Maps
  - Screening

- Rapid Response/Rescue
  - Code Blue Rescue/Critical Care Response Teams
  - Behavioural Rapid Response Teams

- Multi-Component
  - HELP Program
  - Training "Care-Mapping" Non Rx Interventions
  - Cultural Change

09/10/15
Proactive/Responsive Clinical Care

- Interprofessional team embedded in Psychiatry
- Behavioural Rapid Response Service to bedside nurses – Behavioural Outcome Optimization Support Team (BOOST)
- Daily Safety Screening (Electronic Surveillance to identify at risk patients, IT flags, huddles)
- Proactive Policy for High Risk/High Needs Patients/Situations
- Anti-Stigma Support/Messaging
- Family Engagement

Low Tech Screening and Proactive Case-Finding

What is this?
To better attend to patient and staff health and safety, the MSH M/C approved the Policy for Proactive Support of High Risk/High Needs Patients Admitted to Non-Psychiatric units with Co-Morbid Psychiatric Illness

There are 5 triggers for proactive consultation

Patients transferred from a mental health unit (e.g. CAMH, TRI Behavioural Unit)
Patients treated with Clozapine
Patients with current or past aggression or behavioural challenges with staff
Patients with a CODE WHITE history (not a substitute for a code white)
 Patients on Mental Health Certificates (such as Form 1, Form 3)
Higher Tech Screening- EMR/EHR Daily Safety Report

### Standardized Best Practices and Process Re-Engineering

- Evidence-based care plan algorithms
- Patient Order sets
- Tool-kit development
- Behavioural Discharge Summary

### Organizational -Wide Collaboration

- Program integrated into MSH strategy through executive sponsorship and key partnerships
- Linkages with Occupational Health & Safety, Health Equity, Geriatrics, Organizational Development, Best Practice Spotlight Organization, Magnet©
- Resilience/Leadership support for Managers/Directors
Multimodal Training

- e-learning module
- Interactive Workshops
- Debriefing Algorithms to harvest learning
- Simulation Training

Achieving Results: Evaluation of SP/SS

Critical Incidents
Staff Burden
Staff Experience
Time to Consult
Staff Skills
Patient/Family Experience
Critical Incidents
Central Care Grids
Staff Experience of Violence/Burden

- Increased reporting of incidents:
  - Patient incidents
  - Staff incidents
  - Experience of violence not “just part of the job” - balance with Duty to Care

Improving Nursing Burden of Working with Patients with Challenging Behaviours

- Significant reduction of experience of violence
- Reduction in sense of burden in caring for these patients

Financial Impact

- Constant observation is a strategy to manage patients with challenging behaviours
- 35% reduction over 2 years
Additional SP/SS Early Wins and Accomplishments

- Reduced time from high risk/high needs patient admissions to SP/SS interventions
- Increased use of care-planning, debriefing
- Patient and Family experience - quantitative and qualitative
- Identification of burden/need ‘hotspots’ - prioritized for targeted support

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Programmatic Lessons Learned

- Innovation aligned with organizational vision, strategy, priorities
- Use models to frame strategy
- Don’t reinvent the wheel - use all available internal and external resources (i.e. NICHE)
- Capitalize on external drivers/forces (i.e. Senior Friendly Hospital Initiative)
Programmatic Lessons Learned

- High functioning, diverse teams
- Developing Coalitions - Internal and External
- Evaluation Outcome Focused
- Recognition - “of the village”
- Nurses leading change!

Thank You!
Questions?

Jocelyn Bennett  jbennett@mtsinai.on.ca
Rebecca Ramsden  rramsden@mtsinai.on.ca