Delivering Exemplary Care in Geriatrics: The Journey of One Organization

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Joseph and Wolf Lebovic Health Complex

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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

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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

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Geriatric Journey Timeline and Enablers

2005	• Geriatric Services Review and Recommendations • Joined NICHE	
2006	• Geriatric Resource Nurse (GRN) Role Implemented	
2007	• Geriatric Strategy Developed • Geriatric Steering Committee Established	
2008	• Geriatric Emergency Management Program	
2009	• Inpatient Interprofessional Consult Team Established • Part Time Geriatrician Recruited	
2010	• GRN goes Interprofessional • Organizational Education Plan Launched	⟸ Acute Care for Elders Research Grant
2011	• Acute Care for Elders (ACE) Unit Implement • MAUVE Volunteer Program Established	⟸ Katz Gift to ACE Program
2012	• Ambulatory Geriatric Medicine Program • Complex Patient Management with Home Care	
2013	• Safe Patient/Safe Staff™ Program launch • Geriatric Strategy Refresh	⟸ SPSS™ Research Grant
2014	• Urban Telemedicine Program • Community Para-medicine Program	⟸ National 3M Innovation Award Niche Exemplar Status
2015	• Amalgamation - Sinai Health System	⟸ Magnet® Designation Southbridge Gift to SP/SS™ National Safety Award

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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

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IHI - Execution of Strategic Improvements

Figure 1. A Framework for Execution

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Nolan TW. *Execution of Strategic Improvement Initiatives to Produce System-Level Results.* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007. (Available on www.IHI.org)

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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)

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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)

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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

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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

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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

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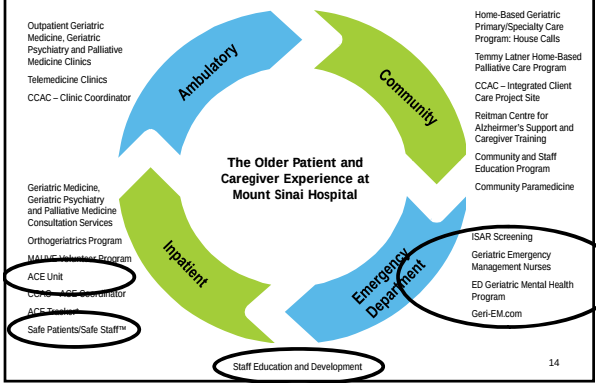
The Mount Sinai Geriatrics Continuum



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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.

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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

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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

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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

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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

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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

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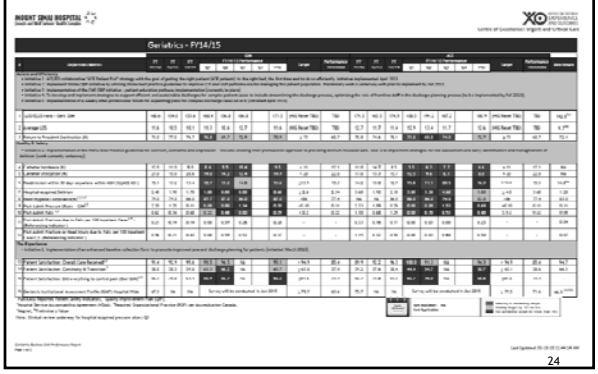
ACE/Geriatrics Program Metrics



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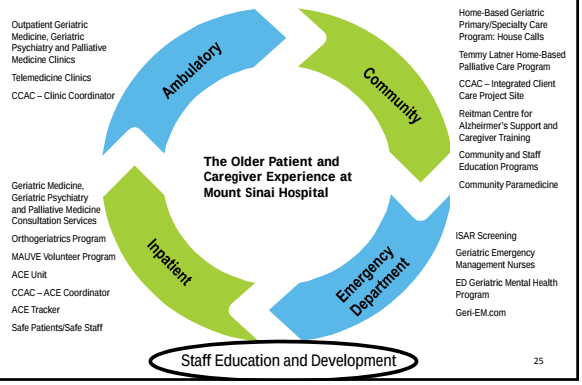

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Geriatric Education Plan

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"

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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

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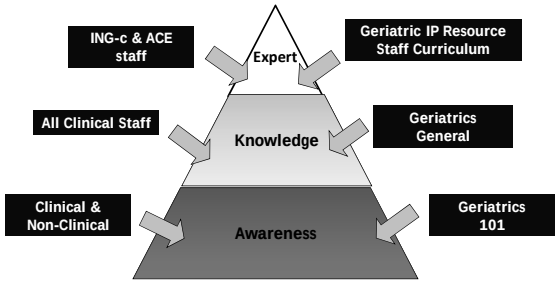
A 3-TierApproach



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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)

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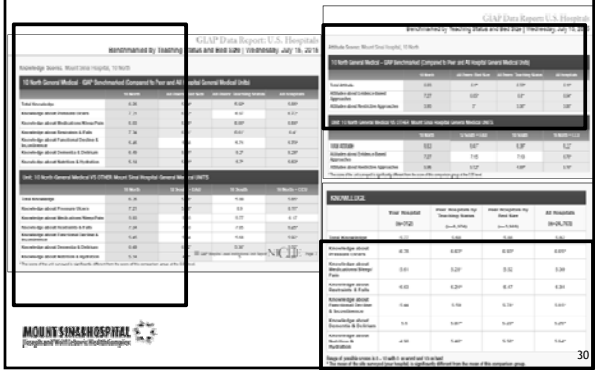
Evaluation of our Efforts



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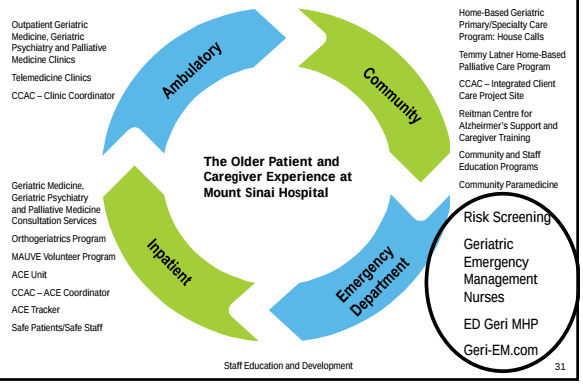

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ED: *Identifying* the Needs

- 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.

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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

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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

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(Sinha et al, Annals of Emergency Medicine, 2011)

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

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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/

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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

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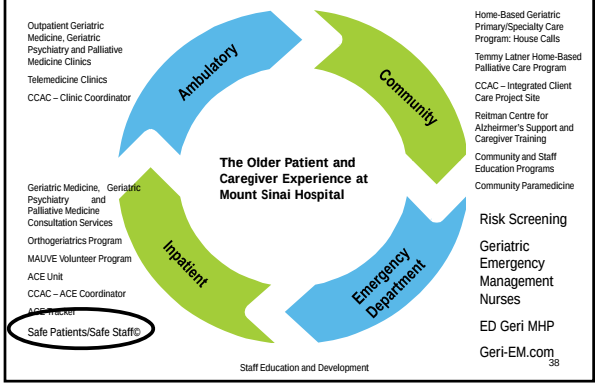

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Highlights from the Literature

- **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

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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

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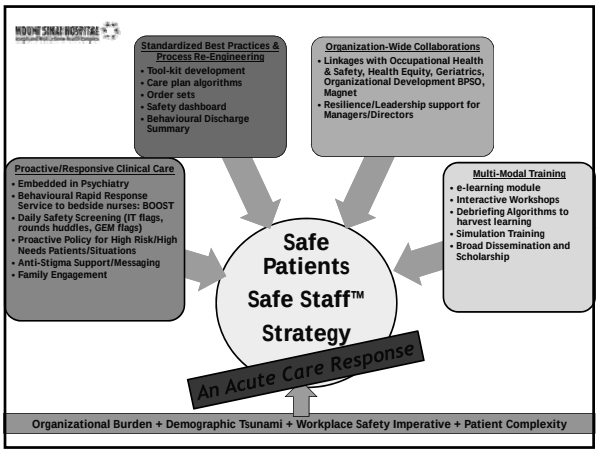

Proactive/Responsive Clinical Care

- 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

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Low Tech Screening and Proactive Case-Finding

High Risk/High Needs Policy
for Proactive Psychiatric Consultation
Safe Patients/Safe Staff

What is this?
To better attend to patient and staff health and safety, the MSH MAC 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)

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Higher Tech Screening- EMR/EHR Daily Safety Report

ADMISSION	PT_LOCATIO	VISIT NUMBI	PATIENT NA	AGE	MRN	FROM_PSY_I	FROM_GER	COMBATIVE	CLOZAPINE	RESTRAINT	SECURITY_FL	PROACTIVE_FLAG
##########	3A	2020-111-55	NO NAME	76 Years	000-000-000	0	0	1	0	0	0	0
##########	3A	2020-111-55	NO NAME	66 Years	000-000-000	0	0	1	0	0	0	0
##########	3A	2020-111-55	NO NAME	31 Years	000-000-000	0	0	0	1	0	0	0
##########	3A	2020-111-55	NO NAME	91 Years	000-000-000	0	0	1	0	0	0	0
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##########												0
##########												0
##########												0
##########	5C	2020-111-55	NO NAME	74 Years	000-000-000	0	0	1	0	1	0	0
##########	5C	2020-111-55	NO NAME	70 Years	000-000-000	0	0	1	0	0	0	0
##########	5C	2020-111-55	NO NAME	61 Years	000-000-000	0	0	0	1	0	0	0
##########	6A	2020-111-55	NO NAME	76 Years	000-000-000	0	0	0	0	1	0	0
##########	6A	2020-111-55	NO NAME	91 Years	000-000-000	0	0	1	0	1	0	0
##########	7D	2020-111-55	NO NAME	70 Years	000-000-000	0	0	1	0	0	0	0
##########	8A	2020-111-55	NO NAME	76 Years	000-000-000	0	0	1	0	0	0	0
##########	8A	2020-111-55	NO NAME	67 Years	000-000-000	0	0	1	0	0	0	0
##########	10B	2020-111-55	NO NAME	67 Years	000-000-000	0	0	1	0	0	1	0
##########	10B	2020-111-55	NO NAME	90 Years	000-000-000	0	0	1	0	0	0	0

If you chart it we will come…

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Standardized Best Practices and Process Re-Engineering

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

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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

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Multimodal Training

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

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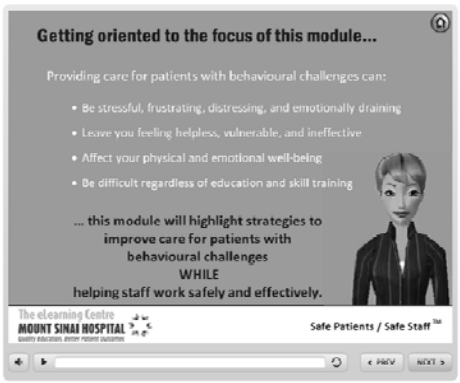
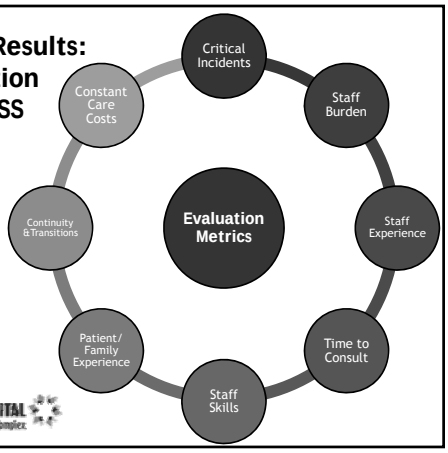


Achieving Results: Evaluation of SP/SS



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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*

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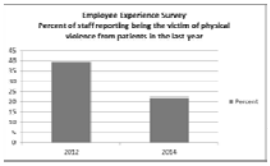
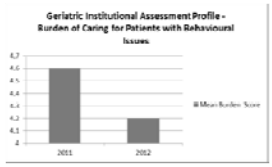
Improving Nursing Burden of Working with Patients with Challenging Behaviours

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





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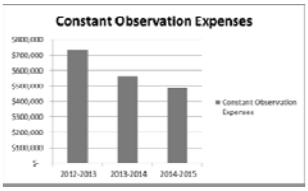
Financial Impact

- Constant observation is a strategy to manage patients with challenging behaviours
- 35% reduction over 2 years



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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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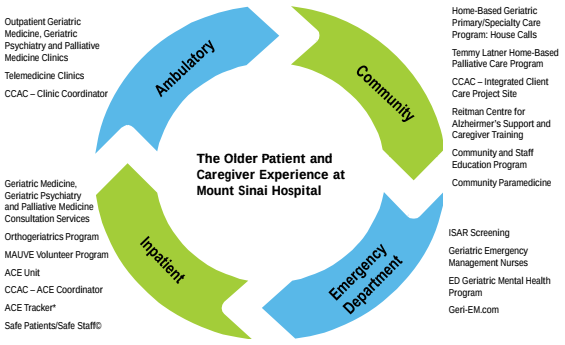

Staff Education and Development;

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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)

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Programmatic Lessons Learned

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

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Thank You!
Questions?

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