Seniors’ Health Capacity Building: Our Journey to a Registered Nurses Association of Ontario Best Practice Spotlight Organization Designation

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Objectives

1. To discuss the leadership role and accountabilities of the Clinical Nurse Specialists related to the strategies.

2. To discuss the engagement and capacity building strategies of the Emergency Department, focusing on the health of the seniors’ and their support network while obtaining and maintaining the Registered Nurses Association of Ontario (RNAO) Best Practice Organization Spotlight designation.

3. To describe the unique strategies to empower patients, families and members of their support network in our journey.
• Opened in 1963, Mackenzie Health serves over 600,000 people in Southwest York Region

• 491 Beds:
  – 355 budgeted acute care inpatient beds
  – **average number of admitted Seniors is 260 with 180 in acute care**

• **Annual Budget of $269 million**

• Second largest employer in Southwest York Region
  – 2,279 staff (April 2013)
  – 401 physicians (April 2013)
  – 92,000 volunteer hours per year (April 2013)

• Registered Nurses Association of Ontario Best Practice Spotlight Organization
Mackenzie Health

- Regional leader in Stroke, Chronic Disease & Seniors’ Health, Chronic Kidney Disease, Domestic Abuse and Sexual Assault
- Two-hospital model of care: Future Vaughan Hospital
- Emergency Department
  - 90,000 ED visits per year, with an average of 270 Seniors per day
2013 Fiscal Year Emergency Department Encounters

Total # of ED patients under 75 of age
86% (N=77993)

Total # of patients ≥75 of age
14% (N=12164)

Total # of patients ≥75 of age admitted
26% (N=3167)

Total # of patients ≥75 of age discharged
74% (N=8988)
Advance Practice Nurses- Geriatric Emergency Management (GEM)

- In 2003, Mackenzie Health was one of eight hospitals selected to participate in a pilot project sponsored by the Regional Geriatric Program. One FTE of an APN - CNS

- Goals of the project
  - Develop and implement a new model of care for Seniors in the ED (60% clinical)
  - Improve care to the Seniors in the ED
  - Build capacity (40%)

- In 2003 we had one CNS – GEM, in 2009 we received funding for a second GEM, 2 NPs and in 2011 returned to 2 CNSs in the role
Geriatric Emergency Management

- Currently state: Two full-time Advanced Practice Nurses, funding through Regional Geriatric Program and Central LHIN

- Provides targeted consultation support and management recommendations for the care of older adults in the Emergency Department (ED) over the age of 75 years

- Referrals to in patient and out-patient services such as specialized geriatric services and community resources

- Communication with the patient’s primary care physician

- Case finding of high risk Seniors and identification of geriatric syndromes

- Follow-up telephone calls post ED discharge
Continuum of Care

Emergency Department
(Geriatric Emergency Management Nurse)

Patient

In-patient Unit
(Seniors’ Health Clinical Nurse Specialist)

Community
(Geriatric Outreach Team)

Long-term Care
(Nurse Led Outreach Team)
Model of Advanced Practice Nursing

Clinical Service
Knowledge ↔ Practice

Patient

Program Pillars
→ Program components
○ Integrated, specialized care

Clinical Practice

Program Development

Leadership

Ambassadors

Research

Collaboration

Community Partnership

Program Evaluation

Education

Novice

Vision for Seniors’ Health

Expert

*Mackenzie Health

Advanced Practice Nursing

- Advanced Practice Nurses (APNs) include Clinical Nurse Specialists (CNSs) and Nurse Practitioners (NPs)

- CNSs and NPs have different roles
  - Clinical Nurse Specialists spend most of their time in professional development and organizational leadership, research and educational activities with less time in direct clinical practice
  - Nurse Practitioners spend most of their time in direct patient care
GEM- Clinical Practice

- Conduct comprehensive Gerontological assessment using screening tools and clinical assessment in a holistic manner
- Provides targeted consultation support and management recommendations for the care of seniors
- Provides support and teaching to older adult patients and families to facilitate access to information for decision making
- Conduct follow-up phone call post discharge from ED
GEM - Research

• Engage in Quality Improvement Initiatives
• Develop research proposals with Senior friendly focus
• Dissemination of our work externally
• Utilizes nursing research to support the implementation of best practices in the care of older adult patients in ED and in patient units
GEM- Education

- Professional development through facilitation of educational sessions (including Gentle Persuasive Approach training)
- Masters prepared for advanced nursing practice
- Support the Canadian Nurses’ Association Gerontological and Emergency Nursing Specialty Certification
- Develop educational material to promote health literacy and senior friendly concepts
GEM- Collaboration

- Inter-professional team collaboration (including Social Work, Physiotherapist, CCAC) to increase coordination of care for elderly patients in the ED

- Partners with community resources to enhance care for older adults (including family practitioners, hospice palliative team, retirement/long-term care)

- Liaison with the circle of care within the organization (including GOT, NLOT, CNS, BSO)

- Participate in CLHIN GEM activities to support role

- Participate in organization committees (including Nursing Advisory Council, APNs, Senior’s Day Planning Committee)
GEM- Leadership

- Project Managers for Senior Focused Best Practices in Hospital
- Advocate for & develop systems related to evidence based care for older adults
- Lead development & implementation of best practice guidelines (3 D’s, Hypertension, mobility, ACE Philosophy)
- Coach, mentor and support staff through Nursing and PCA Mentorship programs
- Participates in ED quality improvement initiatives to facilitate the delivery of best health care services
Transitions of Care

- Goal: to increase communication across the continuum of care to facilitate seamless transitions.
  - Working task force initially of APNs
  - Recently invited the Manager of Patient Navigation to join APN working group
  - Provided an opportunity to trial various tactics – standardized SBARD tool for LTC, weekly teleconferences to facilitate transitions
  - Pilot of LACE index within a small defined group
Seniors’ Health Advanced Practice Nurse Team

Angela Chan, RN, MN, GNC(C) & Jessica Coulis, RN, BScN, MSc
Angela and Jessica provide specialized consultation support and management recommendations for the care of seniors in the Emergency Department. The GEM nurses help seniors access appropriate services in order to maximize their functional status and independence in order to remain living at home. The GEMs promote best practices in the care of seniors through staff consultation and education.

*How to refer?* Emergency Department staff member, physician and patient/family can request.

Catherine Petch, RN, MN, GNC(C) & Judy Smith RN, BScN, Med (DE), ENC(C)
Judy and Catherine provide clinical consultation for admitted patients over the age of 65 independently and in collaboration with the Geriatricians. Consultation may be triggered by new or sudden onset confusion or delirium; dementia with responsive behaviors; frequent falls; complex family or social issues; and end of life. The CNSs advance Senior-Focused Best Practices throughout hospital.

*How to refer?* Any staff member, physician, patient or family member can request clinical consultation. The CNSs can be paged through locating.

Bella Grunfeld, NP-PHC & Oyin Talabi, MN NP-Adult, GNC(C)
Bella and Oyin provide outreach services to residents in Long Term Care homes where they address their emergency health situations and provide treatment, as required, to prevent unnecessary transfers to the hospital. The NPs provide clinical leadership and mentorship to the nurses in long term care and facilitates implementation of evidence based care, as well as, provides education and support to build capacity in providing care for seniors with complex health needs.

*How to refer?* Any staff member or physician can contact the NPs for an outreach follow up visit of residents from LTC.

Michelle Cleeland R.N., M.N., GNC(C)
Michelle offers in-home non-urgent visits for seniors 65 of age and older. A home visit allows the outreach team to see and help with problems related to physical abilities, memory and safety through an in-depth assessment. The team works with the client and their care providers to maintain their independence and health while staying at home or retirement setting. The team consists of a CNS, occupational therapist and social worker.

*How to refer?* A physician must sign the GOT referral form for billing purposes; however, this can be initiated by any staff upon discharge.
Synergistic Communication: Facilitating Care Transitions for Older Adults with Multiple Complex Conditions

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Purpose:
The primary objective of this project was to explore opportunities to improve transitions of care, specifically communication, for older adults, living with complex chronic diseases or acute care needs between the hospital and community.

“Synergistic Communication: Facilitating Care Transitions for Older Adults with Multiple Complex Conditions” was initiated at Mackenzie Health (MH) by the Seniors Health Advanced Practice Nurses. There was an opportunity to examine and improve synergies between internal and external health care providers and agencies.

The challenges addressed by the Advanced Practice Nurses (APNs) were the processes surrounding communication and transfer of accountability of patients across the continuum of care. A gap was identified in communication between various community partners influencing the ability of the APN to facilitate care planning and transitions between levels of care. This was highlighted when multiple members of the team were involved with the same family during a care episode crossing several levels of care. The team is anticipating there will be enhanced communication as a result of Mackenzie Health’s leadership in the establishment of Southwest York Region Health Link.

Next Steps:
1. Mackenzie Health has identified senior’s health and chronic diseases as an area of focus. The vision that Mackenzie Richmond Hill Hospital will become the Seniors Centre of Excellence. As one of the lead agencies in the Southwest York Region Health Link Mackenzie Health will play a key role in ensuring older adults receive the right care, at the right time in the right place.
2. The organization is also using visual patient flow tools which will have an icon indicating the patient is from a LTC facility. The use of the inpatient algorithm promotes timely dialogue to prevent increased lengths of stay for LTC residents allowing all barriers to overcome prior to the estimated discharge date.
3. SWOT analysis will be undertaken for patients being discharged back to the community and retirement home to identify opportunities to enhance communication.
4. Collaborate with established team developing health links Southwest York Region.

Outcomes:
Performance indicators and outcomes have been tracked using various organizational reporting tools in addition to those of the Regional Geriatric Program Outcomes:

- New processes were developed and implemented, including an inter-facility transfer check list, and promoting transfer of accountability to and from LTC facilities in a clear, consistent, standardized manner. The use of this tool has been embedded into new inpatient and outpatient flow algorithms. Several new SQIs were created to identify seniors transferred from LTC to the Emergency Department (ED). In addition these SQIs provide a daily list of all patients 65 years of age and older who have been admitted to MH.
- A total of 4168 patients and families from the CLHN received the services of the Seniors Health APNs from June 2012 till July 2013.

Patient/Client Testimony:
“I wanted to just send you a quick note to say thank you for your help and support during my father’s recent admission to Mackenzie Health. It was a stressful time for Michael, and family, and your practical advice and empathy were very much appreciated. Michael has been at Markham LTC for just over a week now, and (touch wood) seems to be settling in better than I expected.”
(A grateful daughter)

“I met a lady in line at the cafeteria today and we got chatting about her dad, and his experience as a patient in the hospital. I didn’t get her name, but her dad is 81 and was in the ED for three days and she gave me feedback that I thought you would like. She told me that her dad was a complicated patient due to his previous medical conditions and that her dad was referred to you during his stay in the ED. She had nothing but high praise for the service that you provided. She said that your compassion and caring made the difference for her family. She had an ED nurse in BC. She was touched that you took the time that her dad needed to answer questions and that you took the time to speak with her daughter. What you did really made a difference in his care and also with his family. She said nothing but lovely things to say” (A MH employee)

Process:
The APNs actively facilitate transitions of seniors and their families across the care continuum ensuring home safety with linkages to appropriate support services. Our key partners include: physicians, internally and externally in private practice or family health teams, Community Care Access Centre, Alzheimer’s Society, Behavioural Support of Ontario, Parkinson’s Society, OASIS, Doorways to Care, Psychogeriatric Resource Consultants, local retirement homes, who provide respite care, and Ontario Shores. The integration of community support services results in improved well-being and quality of life for older adults and their families.

The SeniorsHealth team is strategically aligned to ensure specialized geriatric services are available for patients across the care continuum. The Central LHIN and the Regional Geriatric Program are key partners, supporting externally funded positions and in knowledge translation activities. Late in 2012, the CLHN provided a one-time education grant that motivated Mackenzie Health APNs to offer organizational wide, workshops in Gentle Persuasive Approaches in Dementia Care. These workshops provided staff with the opportunity to learn about techniques for dementia care used in Long Term Care (LTC).

Nurse Lead Outreach Team (NLOT) (1609) residents referred to NLOT avoided an Mackenzie Health ED visit

Geriatric Outreach Team (GOT) Referrals
47% Mackenzie Health 29% Physician-private Practice
13% GEM 11% Others

Geriatric Emergency Management Nurses (GEM)
1675 patients/families were assessed either through face to face assessments or follow up phone calls and 580 referrals were made to community partners.
LTC Patient’s Journey (out-patient)

Transfer of Long Term Care Resident to Mackenzie Health Hospital
Out-patient

Long Term Care Resident

Emergency Department
- Daily SCL census at 0600
- If NROT, GEM & CNS of LTC are notified within 24 hrs at Min
- Assessment by Emergency Department
- GEM consult generated by date and NROT at Emergency Department
- MD delegate to inform LTC of transfer back to LTC if patient has expired in ED
- Return LTC with completed TOA by primary nurse & DI printed report
- LTC notifies NLOT as appropriate

TOA from LTC

Mackenzie Health

Radiology
- Clinic
  - Fracture, gout, peritonitis, MOCC

Dialysis
- Resident seen and returns to LTC with completed TOA

LTC notifies NLOT as appropriate

Criteria for GEM referral
Nutrition care issues related to:
- Gastrointestinal (GI) issues
- Behavioral (ADEs, wandering, relapse, agitation, aggression)
- Family support
- End of life/ethical issues

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Registered Nurses Association of Ontario Best Practice Spotlight Organization Designation

- The organization’s candidacy journey began in April 2010.

- The plan was to implement 17 Clinical and Healthy Workplace Best Practice Guidelines over the next 3 years.

- Mackenzie Health was awarded Spotlight designation in April 2013 and has just submitted our annual report with 21 BPGs implemented.
• Assessment and Management of Foot Ulcers *
• Assessment and Management of Pain
• Assessment and Management of Stage I to Stage IV Pressure Ulcers *
• Assessment and Management of Venous Leg Ulcers *
• Client Centered Care *
• Care giver strategies for older adults with delirium, dementia and depression *
• Collaborative Practices Among Nursing Teams
• Cultural Diversity
• End of Life Care during the Last Days and Hours
• Establishing Therapeutic Relationships *
• Nursing Management of Hypertension *
• Preventing Constipation in the Older Population

• Prevention of falls and Fall Injuries in the Older Population *

• Professionalism

• Promoting Continence – using Prompted Voiding

• Promoting Safety: Alternative Approaches to the Use of Restraints

• Reducing Foot Complications for People with Diabetes *

• Risk Assessment and Prevention of Pressure Sores *

• Screening for delirium, dementia and depression in the older adults *

• Stroke Assessment across the Continuum *
Systems, Processes and Tactics

- RNAO supports- Best Practice Champions Workshops
  - BPSO teleconferences and supports
- Project management structure to support rollout and ongoing sustainability– bi-monthly Project Charter updates to NAC
  - work plans, timelines, unit based supports.
- Development of a Policy and Procedure structure and process including templates
- Development of a Patient Education Committee to review all educational documents
- Development of a course management learning system
In ED we focused on:

- Falls
- Prevention of Pressure Ulcers
- 3 Ds.
- Stroke Assessment – Accreditation Canada’s Stroke Services Distinction award
- Professionalism
Journey to Spotlight: Taking the Road Less Traveled

“Two roads diverged in a wood, and I —
I took the one less traveled by,
And that has made all the difference.”
— Adapted from Robert Frost, The Road Not Taken, 1919

Evaluation

- Patient Satisfaction
- Prevalence Studies
- Incident Reports
- Hospital Databases
- Chart Reviews
- Self-report Surveys
- Interviews
- Focus Groups
- Observational Studies
- Staff Satisfaction
- Access to Resources
- Professional Achievements

Lessons Learned

1. BPSO candidacy is a commitment to practice despite competing priorities.
2. Development of a systematic and thorough approach to dissemination of BPGs positively affects patient care, staff and organizational outcomes.
3. Evidence-based practice is foundational to creating a culture that values patient safety, and quality outcomes.
4. BPSO candidacy is a catalyst to support an interprofessional approach to patient care, education, and practice.
5. E-learning is a key strategy to support knowledge to practice.
6. Initial practice changes are driven through BPG implementation; however, sustainability in outcomes requires leadership and infrastructure.

Sustainability

17BPGS

- E-Learning
- E-Documentation
- Medical Directives
- Policy & Procedures
- Senior Leadership Support
- Knowledge Transfer Strategies

E-Learning

E-Documentation

Medical Directives

Policy & Procedures

Senior Leadership Support

Knowledge Transfer Strategies

Tactics to support patient care

You Can Help Prevent Delirium

What is delirium?
Delirium is a sudden onset of confusion which starts within hours or days. Any older adult (over 75 years of age) admitted to the hospital is at risk. Delirium can be prevented and treated.

What to look for?
A person with delirium can act confused and:
- be restless and upset
- not make sense
- slur their speech
- act differently
- drift between sleep and wakefulness
- have trouble concentrating
- see or hear things that are not there
- be unaware of surroundings
- mix up days and nights
- be forgetful

Ways to Help

Social Support
- encourage use of glasses/hearing aides
- talk about current events and surroundings
- read out loud
- speak simply and clearly
- provide routine
- reduce noise
- keep curtains open during the day
- use night lights at night
- visit regularly
- bring in photographs, calendar and clocks
- promote rest and sleep
- promote activity
- avoid restraints
- check with health care provider on how you can help with exercises and safe activity
- encourage use of non-skid footwear
- tell health care provider if pain relief is needed
- encourage activity during the day
- After checking with health care provider:
  - encourage and help with eating
  - offer fluids frequently

A caregiver’s comment:

“I saw that poster on the bathroom door and it describes exactly what has been happening to my mother for the last 3 days.”

Building Positive Inter-Professional Relationships in Health Care: A Collaborative Initiative for Patient Safety and Quality Work Environments (TIPS)
Final Summit Meeting: February 26 & 27, 2009, Toronto, Ontario
Learning can be fun!
Mackenzie Moves
Assess and implement mobility plan for patients, 65 and over, every shift

3 CN (Medicine)

- 53.5% of patients sitting up in chair/side of bed for lunch
- 39.2% of patients sitting up in bed for lunch

One Day Snap Shot
March 5, 2013

Mackenzie DOES Do It!
Screens all admitted patients, 65 and over, every shift for Delirium

Emergency Department
TARGET – 80%

- 4% of admitted patients over 65 years were screened for delirium when their stay was > 24 hours (12 out of 293 patient days)
- Dec. – 31%, Nov. – 2%, Oct. – 5%, Sept. – 3%

Has your patient been screened this shift?
Lessons Learned

• Metrics
  – Be realistic in identification of outcomes – for delirium we are still trying to identify data points to support # of hospital acquired deliriums
  – Metrics are not as available as one would expect, also ease of tracking metrics. (electronic health record vs. paper)

• Requires dedicated leadership and protected time

• Success is influenced by unit leadership and needs to be celebrated

• Branding material using the RNAO and BPSO logos
Tactics to support success

• Development of tools to support Senior Friendly Hospital structure
  ▪ GEM Assessment Tools, TRST, Confusion Assessment Method paper tool with REAP interventions, Falls assessment tool, ED Tracking Board with GEM column to flag

• Knowledge Translation Activities
  ▪ 7th Annual Seniors’ Clinic Day, Seniors’ U. ED mentorship, NENA and ENA standards, TNCC courses

• Morning Bullet Rounds – interprofessional with GEMs, PCC, PT and CCAC
Quick reference cards

Has my patient been out of bed today?

MackenzieMoves
It takes a team to do it!

Did you Know?
- Mobility is an essential lifestyle
- A decline in mobility can start within 2 days of hospitalization
- Mobilization is known to prevent Delirium, Functional Decline and Falls

Mobility ABC’s

A
Patient is able to
Ambulate
- Ambulate patient 3X/day
- Eat meals sitting in the chair
- Walk to bathroom

B
Patient is able to transfer from Bed to chair
- Up in chair 3X/day
- Preferably for meals
- Uplift or armrest for toileting
- Participate in care as much as possible

C
Patient Cannot stand to transfer
- Never lift to chair 3X/day
- Uplift or at side of bed for meals
- Bed in Chair position for meals

Has my patient been screened this shift?

Delirium Screening, Prevention and Interventions
All admitted patients 65 years and over
Opportunities
- Within 24 hours of admission & shift
- Environment
- Use REAP strategies
- Supports patients & families

Mackenzie DOES Do It!

CAM + when:
1. Sudden onset or fluctuation in confusion
2. Inattention/difficulty focusing AND either or both of
3. Disorganized thinking/rambling
4. Altered level of consciousness

REAP

Relate
- Use of hearing aids;
- Use of glasses;
- Frequent orientation;

Environment
- Encourage: noise reduction, family involvement, social interaction
- Discontinue unnecessary tubes;
- Keep curtains open during day;

Abilities
- Promote mobility;
- Enable self-care activities

Personhood
- Monitor fluid and nutritional intake
- Restrict naps
- Pain control
- Institute bowel/bladder routine
Welcome!

Welcome to the GEM website! The development of this e-resource is based on the feedback we received from YOU, the front and center of the patient experience, the nurses. This site is designed to help guide your decision making when working with seniors in the ED.
Assessing use of assistive aids

Treatment and Management

Which mobility aid to use?

*First find out how the patient was walking or transferring prior to admission/at baseline.

2-Wheel Walker

- If in doubt use this
- Their baseline: walked with a walker (2ww/RW)
- Unsteady when walking with a cane
- Handles of walker should be at the level of patient's wrists. You can adjust the height by pushing on the buttons at the legs of the 2ww. Improper height of walker does not give enough support, hence more assistance from you.
- Never have both hands on the walker during sit <-> transfer. One hand must be on the bed/arm rest to push/sit
- Do not let patient push the walker too far ahead that their feet no longer stay within the walker
- Do not let patient touch the front of the bar (too close to the walker)

Rollator Walker

- Only to be used as an assessment
- Advanced walker – faster and more steps (brakes) to remember when using this walker
- Never have both hands on the walker during sit <-> transfer. One hand must be on the bed/arm rest to push/sit
CNA Specialty Certification

Have you considered obtaining your specialty certification from the Canadian Nurses' Association (CNA)?

There is a specialty certification for Emergency Nursing and Gerontological Nursing! =)

Here are the benefits of the certification:

- Having the official CNA certification credential after your name indicates to patients, employers, the public and professional-licensing bodies that you are qualified, competent and current in a nursing specialty/area of nursing practice. It distinguishes you as a registered nurse who Cares to Be the Best! (CNA, 2013)
- It opens your opportunity to further your career in other positions
- It is considered an university credit toward your nursing degree

How do I apply to write the certification exam?

- The CNA certification exam takes place once a year in April. Application opens every September.
Successes

- Supportive leadership team
- Dedicated time during department specific orientation
- Maintaining 2 FTEs for GEM
- Huddle board
- Participate in Redevelopment project – voice from Seniors’
Challenges

- Knowledge Translation Teams
- High turn over of staff
- Work load
- Emergency patients vs. admitted holding patients
- Emergency Environment
- Metrics
In Summary

• Organizational support is key
• Build on existing systems, processes and structures
• Hardwire best practices into day to day patient care
• Engage and educate staff, patients, and families
• Celebrate your successes!
References


Comments?