BC PATIENT SAFETY & QUALITY COUNCIL
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Clear

Improving care for seniors living with dementia in long-term care

Driver Diagram: A Guide for Success

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Clear Driver Diagram: An Introduction

This driver diagram is a framework that can help us achieve our goal. Every piece of it may not be relevant to you, but we hope that you will find it to be a practical resource.

How does it work?

Primary Drivers
These are key areas that research shows we need to address in order to reach our goal.

Secondary Drivers
These are the actions we can take to successfully implement primary drivers.

Change Ideas
These are specific changes that can help us implement secondary drivers.

You can see how one level flows into the next. These are ideas that help us reach our goal by breaking it down into manageable pieces.

Want to know a bit more about how driver diagrams work? Check out a helpful video from the Institute for Healthcare Improvement at http://youtu.be/A2491BJcyXA.

AIM	PRIMARY DRIVERS	SECONDARY DRIVERS
To reduce the rate of antipsychotic use in residents without a diagnosis of psychosis in participating care homes across the province from baseline to the national average (21.8%) by the end of the Clear initiative.	1 Appropriate antipsychotic use in residential care	» Reduced use of antipsychotics: scheduled and PRN
		» Improved medication needs assessments, prescribing and medication review processes
		» Communication with care team and caregivers prior to decision to start new medication
	2 Best practice management for residents with BPSD	» Use BPSD Algorithm and Guidelines
		» Non-pharmacological interventions tested and reviewed before starting antipsychotics
		» Use alternative communication and care delivery strategies to reduce BPSD
		» Involve family/caregivers in learning about residents and best responses to reduce distressed reactions
	3 Enhance teamwork workplace and workflow	» Develop and support an environment of respectful communication, teamwork and learning
		» Support sharing and communication between team members
		» Implement administrative leadership walkarounds
	4 Resident care planning for quality of life and safety	» Expand "care team" definition to include family/caregivers and all interprofessional team members
		» Implement team communication tools for consistent care approach and delivery of person-centred care
		» Work with staff to develop, implement and evaluate effective person-centred, individualized care plans

PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
1 Appropriate antipsychotic use in residential care	Reduced use of antipsychotics: scheduled and PRN	Use antipsychotic medications only when appropriate and following recurrent assessment Antipsychotic medications will be considered only after non-pharmacological strategies have been trialed and reviewed[1, 2] 1 Except in situations of significant risk or distress: http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf 2 Non-Pharmacological Interventions listed in the BPSD Algorithm: http://bcbpsd.ca/docs/part-1/Nonpharmacological%20Interventions%20Final%20Draft%20July30.pdf
	Improved medication needs assessments, prescribing and medication review processes	Enhance interprofessional medication review processes: » Complete medication reconciliation on admission and at each transition » Assess need for antipsychotic medications within established timeframe after admission » Institute more frequent medication reviews and ensure reviews include antipsychotic medications » Implement monitoring and reviewing tools following changes in medication and/or behaviour » Complete a best practice/enhanced review every 6 months and with RAI updates Reduce number of medications (pill burden): » Introduce Shared Care Polypharmacy Risk Reduction Initiative, Clinical Algorithm and Antipsychotics Drug Advisory sheet » Introduce BC BPSD Algorithm and Guidelines Educate Physicians and Nurse Practitioners on prescribing: » Host meetings to learn/share about antipsychotic reduction and BPSD Algorithm as practice support tool
	Communication with care team and caregivers prior to decision to start new medication	Use appropriate assessment processes, including resident, family/caregivers and interprofessional team members: » Introduce BPSD Algorithm and Guidelines » Build standardized BPSD Algorithm and Guideline tools into assessment/review processes » Implement interprofessional team meetings » Implement focused team huddles in units/villages/homes » Include resident and family/caregiver in care planning and medication use discussions » Timely referral to, and consultation with, mental health team Discuss, obtain and record consent for use or changes of antipsychotic medications with family/caregivers

PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
2 Best practice management for residents with BPSD	Use BPSD Algorithm and Guidelines	Use a defined and organized approach for assessment and care planning for older adults with responsive behaviours linked to dementia: » Introduce the BPSD Algorithm as the basis for BPSD recognition and assessment of each resident in care » Identify resources within the BPSD Algorithm that can be used within your home » Implement BPSD Algorithm
	Non-pharmacological interventions tested and reviewed before starting antipsychotics	Include non-pharmacological strategies* in person-centred care plans for all residents with dementia: » Develop a process for trialing therapies and evaluating effectiveness for each resident **Some examples of non-pharmacological strategies include:* » *Music and Memory programs (using MP3 players)* » *Aromatherapy* » *Changes to the physical environment* » *Teepa Snow "gentle approach" videos for staff education* » *Recreational activities*
	Use alternative communication and care delivery strategies to reduce BPSD	Adopt an assessment model and BPSD Algorithm process to support reduction of distressed reactions to care
	Involve family/ caregivers in learning about residents and best responses to reduce distressed reactions	Work with family/caregivers and care team to plan person-centred responses to BPSD during care delivery, and document in care plan: » Develop a collaborative process to involve family/caregivers and direct care staff to recognize and interpret potential trigger events » Develop plan for coping strategies for trigger events/ situations » Develop a defined process to share assessment findings from all family/caregivers and care team members, and include responses in care plan
		Enhanced education about dementia and BPSD for all staff: » Include residents/families/caregivers in education opportunities at site about dementia and BPSD
		Enhanced education using a standardized, person-centred approach to care delivery for all staff interacting with residents

PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
3 Enhance teamwork and communication in workplace and workflow	Support of positive workplace culture through effective teamwork and communication	BPSD awareness and skills training for all new staff at orientation and repeat on a yearly basis: » Ongoing staff training to reinforce the importance of non-technical skills in care » Application of electronic tools, including BPSD e-Learning resources, and other research-based references for ongoing staff education » Create a teamwork agreement which outlines how each member will contribute to effective teamwork and communication and what to do when conflict arises* » Participate in the Teamwork and Communication Action Series that is embedded in Clear in order to improve culture within the team Use the BCPSQC Culture Toolbox as a guide and reference for staff: http://ow.ly/jZKM30hHw29
	Facilitate standardized communication channels between team members	Provide feedback to staff on the strategies used to reduce BPSD: » Identify local champions who can support staff around daily care challenges » Implement at least one structured communication tool for your team (e.g., huddles)* » Facilitate and implement unstructured communication techniques within your team* » Support staff and share learning through a "debrief" following incidents resulting in harm associated with BPSD
	Implement leadership walkarounds	Have leadership spend time with direct care staff, residents, families/caregivers to hear about issues and concerns on the unit/village/home (be visible, engaged and interactive with staff): » Ask questions, such as: » What can I do to help? » What do you need to make this better? » How could we have done this another way? » What matters to you? Enhance communication practices with staff and clients through regular, weekly communication

* This step will be outlined in the Teamwork & Communication Action series

PRIMARY DRIVERS	SECONDARY DRIVERS	CHANGE IDEAS
4 Resident care planning for quality of life and safety	Expand "care team" definition to include family/ caregivers and all interprofessional team members	Record, communicate and follow up on observations from all levels of staff (nurses, care aides, pharmacists, Director of Care, housekeeping, etc.) and family/caregivers: » Develop interprofessional resident care planning sessions » Complete "Getting to Know Me" with resident and family/caregivers, using pictures and stories, upon admission[1] » Ensure ongoing family/caregiver involvement in behaviour interpretation and devising care plans, reviews and approaches for residents with BPSD 1 BPSD Algorithm "Getting to Know Me" form: http://bcbpsd.ca/docs/part-1/Getting%20to%20Know%20Me%20Revised.pdf
	Implement team communication tools for consistent care approach and delivery of person-centred care	Enhance access to/reference to care plan by all staff
		Institute daily huddles at specific times to address residents' distressed reactions; focus on immediate outcome improvements
		Post visual cues (e.g. laminated cards) at points of care delivery to remind all team members about successful approaches to enhancing comfort and reducing stress for resident
	Work with staff to develop, implement and evaluate effective person-centred, individualized care plans	Implement the use of standardized, evidence-based tools to assess and monitor behaviours: » Implement targeted daily checklists to record triggers and distressed reactions for a resident exhibiting BPSD » Use behaviour tracking sheets
		Use a defined process to share assessment findings and person-centred care plan with all care team members
		Develop strategies to ensure that all care team staff access person-centred individualized care plan on a daily basis
		Embed meaningful resident measurement and improvement strategies into care delivery and post results for all to view
		Investigate pain management approaches before starting antipsychotics

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