CLeARing a Path to Improved Care for Residents with Dementia

Wednesday, November 16, 2016

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Call for Less Antipsychotics in Residential Care

QUALITY CAFÉ
Your Monthly Dose of Quality

Welcome!

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Improvement Advisor

CLeAR =

Call for **Le**ss **A**ntipsychotics in **R**esidential Care

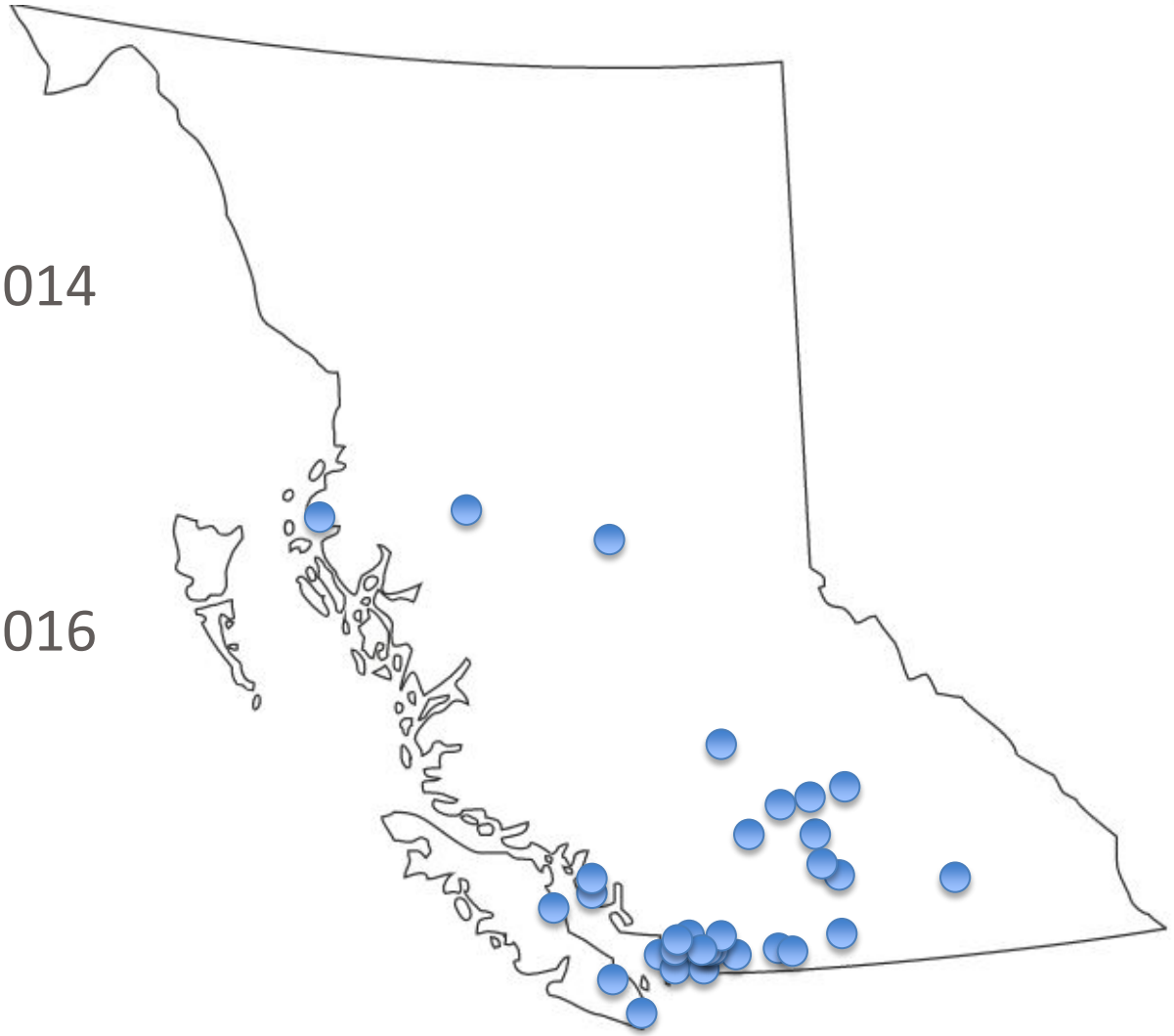
Care Home Participation

<u>Wave 1:</u>

Sep 2013 – Dec 2014
(48 teams)

<u>Wave 2:</u>

Sep 2015 – Dec 2016
(40 teams)



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Why a Collaborative Model?

- Foster learning across different sites and organizations
- Positive (but limited) evidence suggests they work
- BMJ study:
  - Examined 72 publications describing health care quality improvement collaboratives
  - 74% showed improvement in areas such as patient care & organizational performance
  - Limitations and variation across projects makes analysis complex

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Reference: Evidence for the Impact of Quality Improvement Collaboratives: Systematic Review. BMJ 2008;336:1491. http://www.bmj.com/content/336/7659/1491

Ten Considerations

1. Appropriate subject selection
2. Participant-defined objectives
3. Clear roles and expectations
4. Facilitate team building
5. Enable mutual learning
6. Motivate and empower teams
7. Measurable and achievable goals
8. Build capacity around measurement
9. Plan and learn for sustainment
10. Plan and learn for spread

Reference: Ovretveit, J. et. al. Quality Collaboratives: Lessons from Research. Qual Saf Health Care 2002;11:345-351. http://qualitysafety.bmj.com/content/11/4/345.full

Today's Learning Objective:

By the end of this session, participants will be able to identify some key factors for success in supporting teams within a collaborative model.

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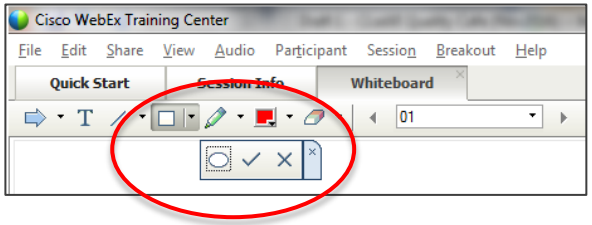
Quick Poll



Have you been involved in a collaborative before?

YES:

NO:

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CLeAR's Support Model

How do teams participate?

- Action & Improvement Teams
  - Matched with an Improvement Advisor
  - Monthly check-ins and data submissions
- Organizational Partners
  - Access to webinars and resources
  - No monthly connections or submissions

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CLeAR's Support Model cont.

- How does BCPSQC support teams?
  - Monthly check-in calls
  - Monthly feedback on reports/data submissions
  - Monthly educational webinars
  - In-person workshops (kick-off + 5 regional workshops)
  - In-person site visits (1-4 per site over the course of 1.5 years)
  - Bi-weekly newsletters
  - Resource/tool development

Memes!

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Strategic Guidance

- Clinical Faculty Advisory Group
  - Regional representation (all health authorities, professional groups)
  - Assist with education on webinars & at workshops
  - Our “go-to experts” re: questions from teams, guiding directions
  - Meets monthly
- Partnership Alliance
  - Provincial representation (key stakeholder organizations)
  - 2-way communication about what’s happening with their work and ours, to ensure alignment
  - Meets quarterly
- Office of the Seniors Advocate
- Ministry of Health

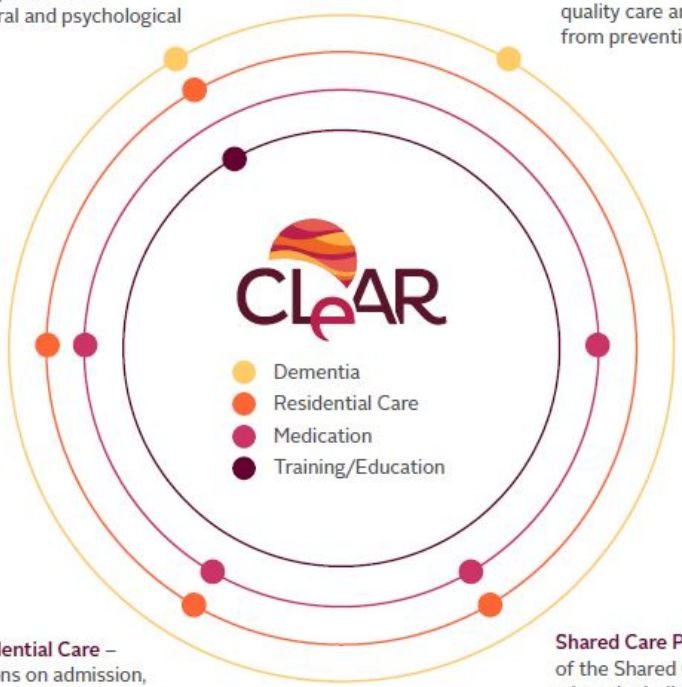
It's All Connected…

P.I.E.C.E.S. Initiative – The P.I.E.C.E.S. (Physical, Intellectual, Emotional health, Capabilities, Environment, Social self) initiative is part of the enhancement of dementia care training for residential care providers within British Columbia. This training provides a framework for assessment and supportive care strategies for clients with behavioural and psychological symptoms of dementia.

Provincial Dementia Action Plan – outlines province-wide priorities for improved dementia care through health system and service re-design work currently underway in BC. The plan supports collaborative action by individuals, health professionals, health authorities, and community organizations to achieve quality care and support for people with dementia, from prevention through to end of life.

General Practice Services Committee Residential Care Initiative – aims to ensure that each patient in a residential care home has a dedicated family physician. For this initiative, a dedicated family physician is defined as one who delivers care according to five best practice expectations:

- 24/7 availability and on-site attendance, when required;
- Proactive visits to residents;
- Meaningful medication reviews;
- Completed documentation; and
- Attendance at case conferences.



Clinical Care Management: 48/6 in Acute Care – focuses on screening, assessment and care planning for 6 care areas in the first 48 hours of an acute hospital stay. The 6 care areas are: functional mobility; cognitive function; bladder and bowel management; nutrition and hydration management; pain management; and medication management.

Medication Reconciliation in Residential Care – reconciliation of seniors' medications on admission, discharge, and transfer of care is known to improve seniors' wellness. Health care providers need much education and support to implement medication reconciliation as part of everyday practice.

Shared Care Polypharmacy Risk Reduction – an initiative of the Shared Care Committee. Polypharmacy occurs when the individual theoretical benefit of a medication is outweighed by the collective negative benefit of the number of medications a senior is taking. The initiative aims to improve the quality of life and decrease hospital admissions for the seniors' population, through de-prescribing unnecessary medications and preventing adverse drug reactions.

Uses for Measurement

Different uses:

- ***Improvement***
- Accountability
- Research

Purpose of data collection in CLeAR:

- Measure progress towards a ***goal (aim statement)***
- Understand if changes are making improvements
- Communicate and take action on what is learned

Reference: Solberg LI, Mosser G, McDonald S. (1997) The three faces of performance measurement: Improvement, Accountability and Research. Journal of Quality Improvement, 23(3).

Three Faces of Performance Measurement

Aspect	Improvement	Judgement or Accountability	Clinical Research
Measurement Aim	Improvement of care process, system, and outcomes	Comparison, choice, reassurance, spur for change	New knowledge
Methods (Test observability)	Test observable	No test, evaluate current performance	Test blinded or controlled
Bias	Accept consistent bias	Measure and adjust to reduce bias	Design to eliminate bias
Sample Size	"Just enough" data, small sequential samples	Obtain 100% of available and relevant data	"Just in case" data
Flexibility of hypothesis	Hypothesis flexible; changes as learning takes place	No hypothesis	Fixed hypothesis
Testing strategy	Sequential tests	No tests	One large test
Determining if a change is an improvement	Run charts or control charts (statistical process control methods)	No focus on change	Hypothesis tests (T-tests, F-tests, Chi-square), p-value
Confidentiality of the data	Data used only by those involved in improvement	Data available for public consumption	Research subjects' identities protected

Creating an Aim Statement

Aim statement:

- To achieve a ***33% reduction*** in antipsychotic use amongst participating care homes through evidence-based management of the behavioural and psychological symptoms of dementia by December 31st, 2016.

Outcome measure of interest:

- Percent of residents prescribed an antipsychotic

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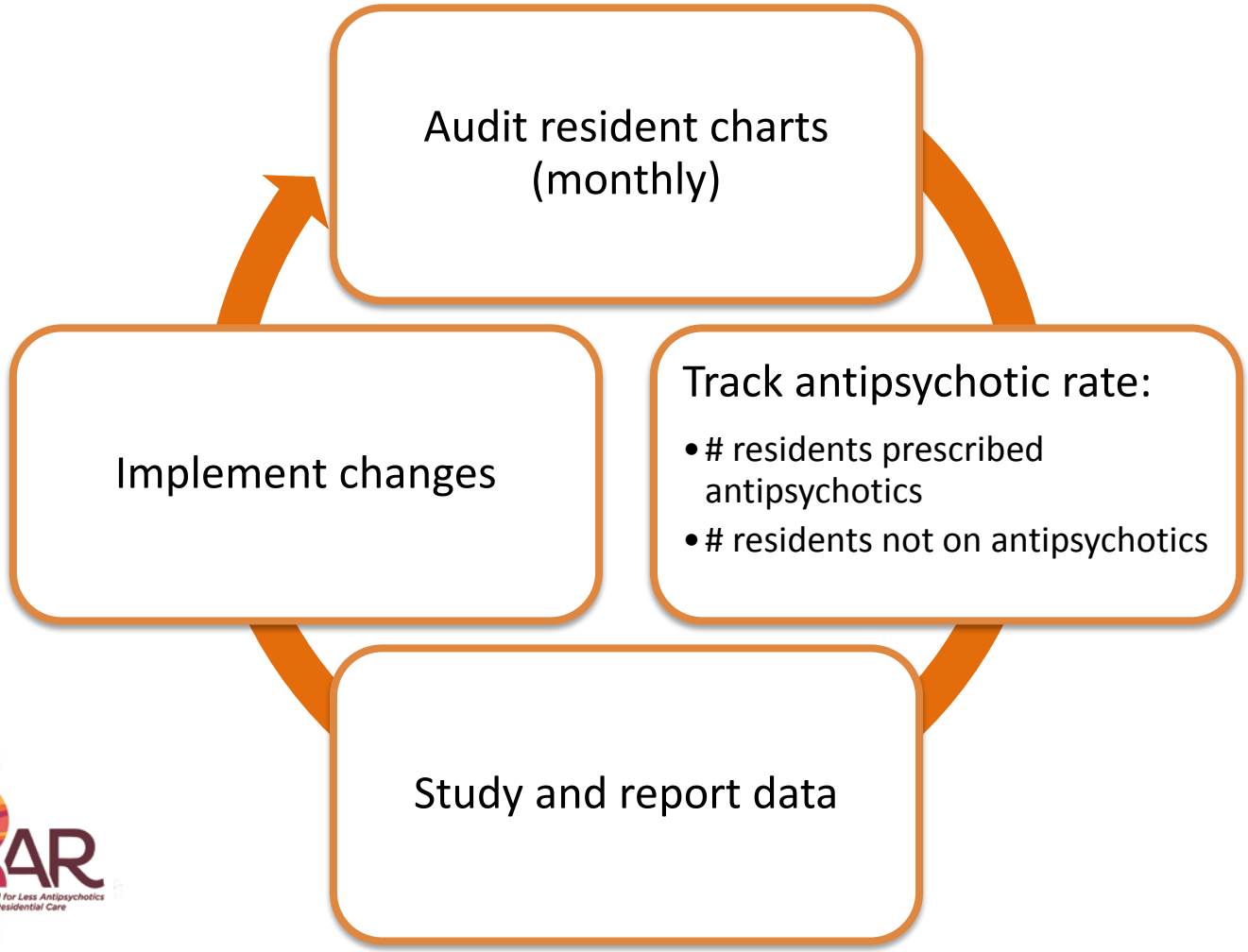
Original Measurement Strategy



Lessons from CLeAR Wave 1

What we learned:

- New admissions were offsetting our results
- Cumulative progress was not available
- Teams were interested in using more measurement:
  - collecting more robust data!
- There was opportunity to further develop measurement capability and capacity

This doesn't make sense…

We're not seeing progress…

Good, but what about…

Development of Measurement Tool

Design

- Understand the need and requirements
- Design with the users in mind

Test

- Test with potential users and experts
- Make adjustments as needed

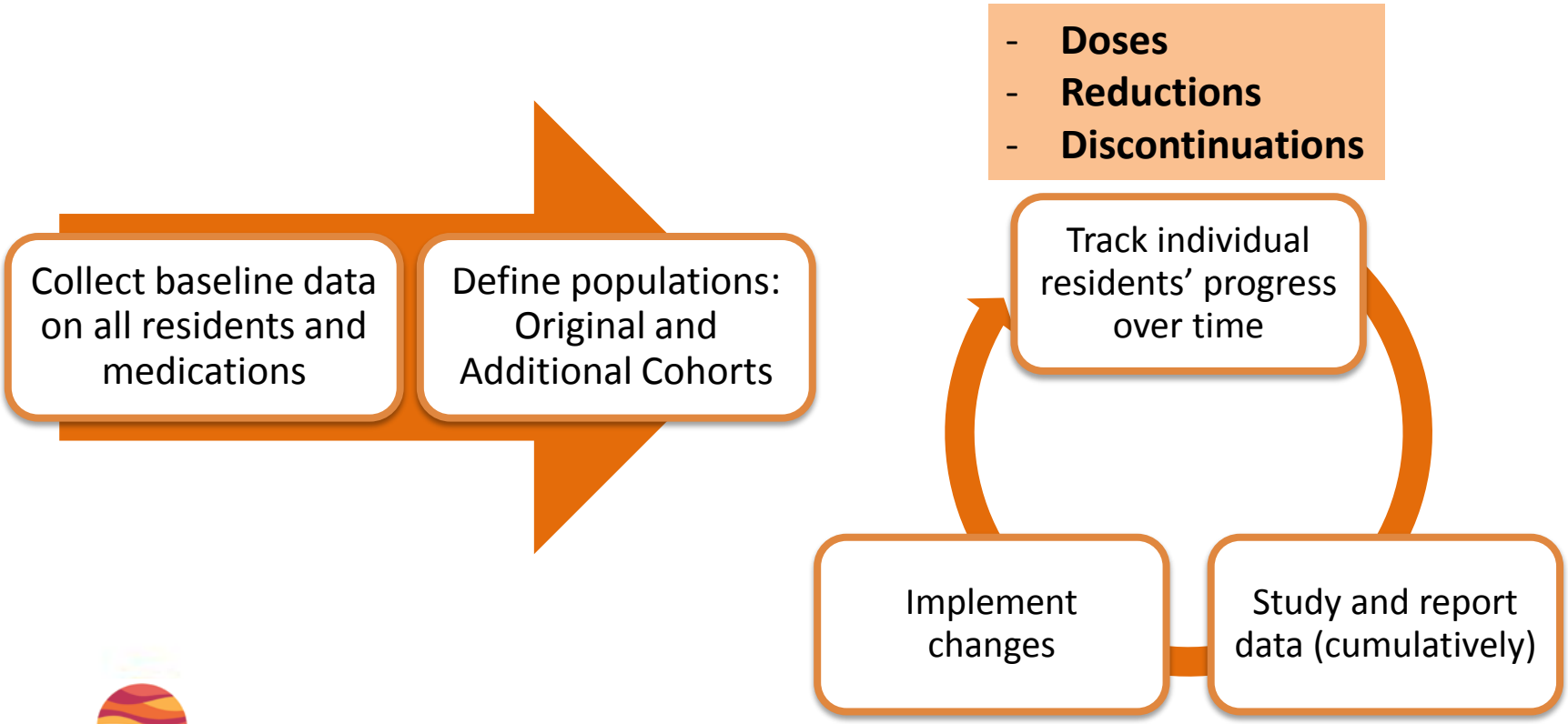
Rollout

- Build capacity and comfort using the tool: instructional webinars, 1:1 calls, virtual support/availability

Support

- Ongoing support: reminders, check-ins, “standardization with local adaptation”

New Measurement Strategy



Provincial Aggregate

- We have up to eleven months worth of data:
  - 30 to 40 teams submit consistently
  - We have connected with most teams and have been providing them updates

- 3483 residents in total:
  - 2704 Original Cohort (admitted before Sep 30th 2015)
  - 929 Additional Cohort (admitted after Sep 30th 2015)

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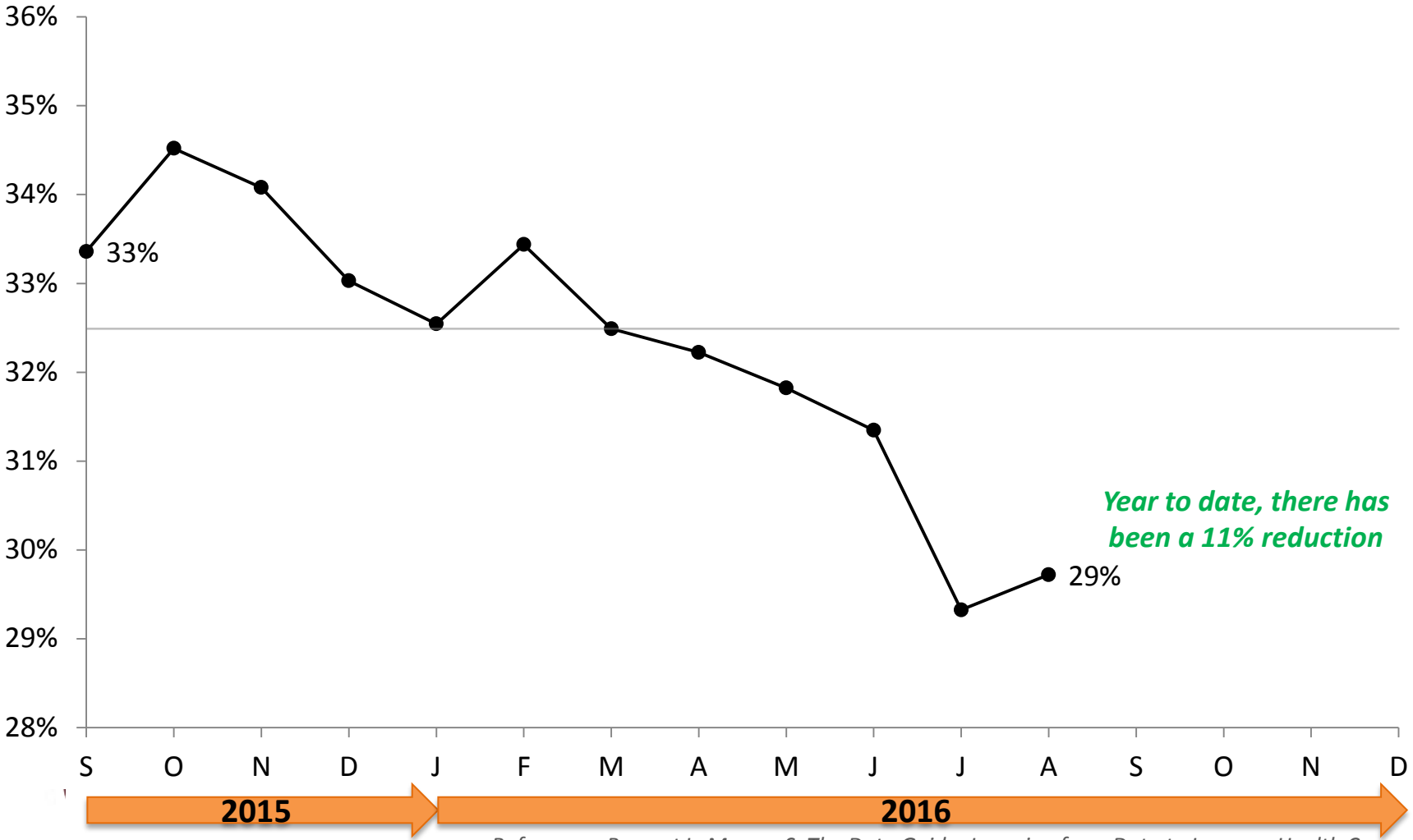
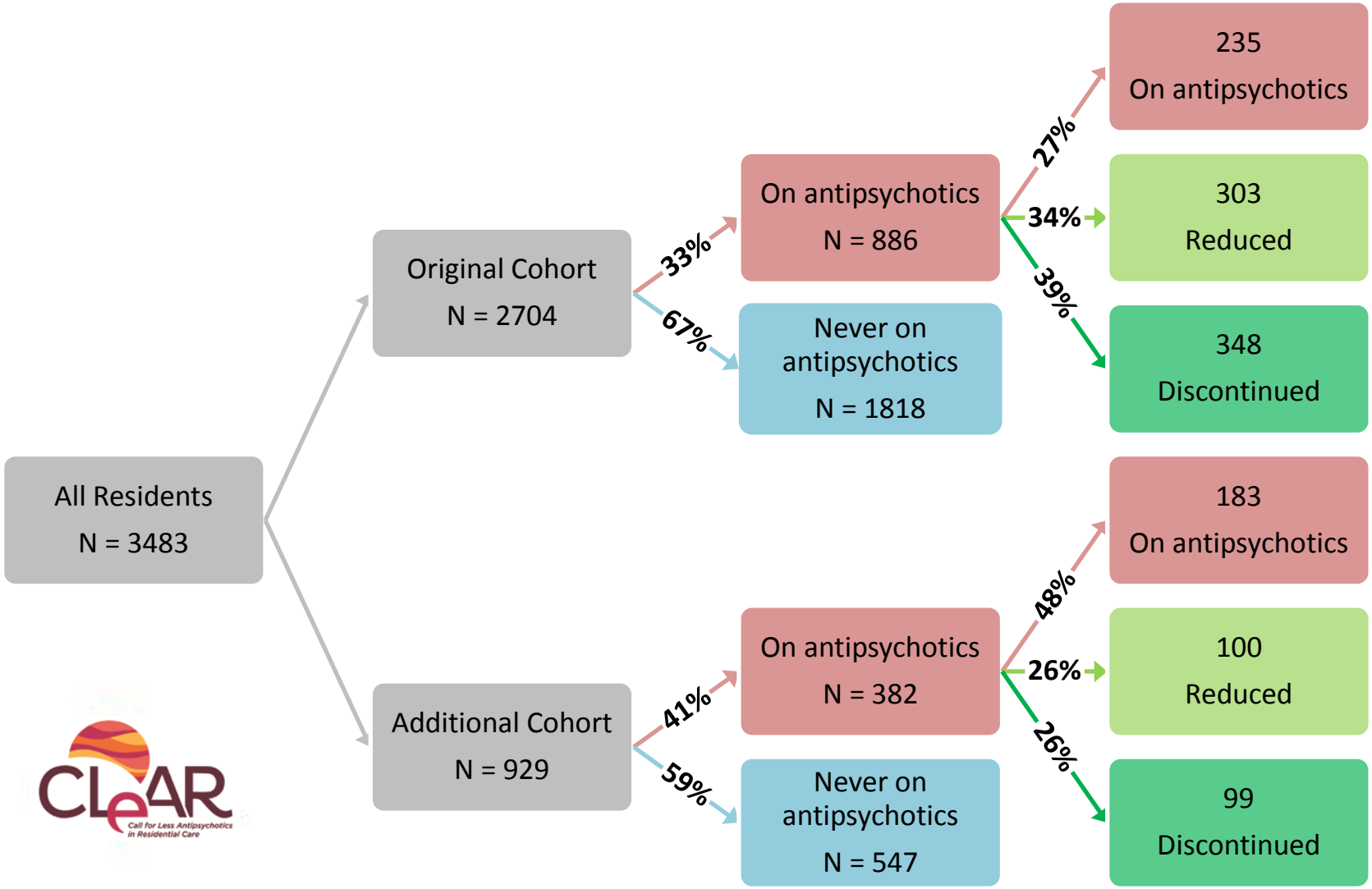
Residents prescribed any antipsychotics



Reference: Provost L, Murray S. The Data Guide: Learning from Data to Improve Health Care. Associates in Process Improvement and Corporate Transformation Concepts; 2010.

Progress to Date (Sep – Aug)



Lessons Learned

The data is very telling…

What does this mean?

Measurement isn't easy!

We don’t always have the time…

Let’s look into that…
Let’s start tracking this…

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Lessons Learned

- In your experience, what are some things that have helped teams achieve their goals?

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Driver Diagram

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

Things to Consider

Possible Non-Pharmacological Approaches for Behaviours[2]

BEHAVIOUR	UNDERLYING REASON	POSSIBLE APPROACHES
1. Seeking an exit from a unit or facility	• Dementia process • Looking for home/ family / familiar surroundings due to loneliness • Following staff or visitors who are leaving the unit • Lack of meaningful stimulation • Exploring/moving about/ restlessness	✓ Camouflage doorway/doorknob/elevator/flooring to alter perception of environment ✓ Explore and validate the resident's feelings ✓ Avoid insisting on reality orientation ✓ Use distraction or re-direction techniques ✓ Engage resident in a meaningful conversation/activity from previous life experiences ✓ Consider impact of noisy environments ✓ Use simple signs and way-finding cues (e.g. words/pictures) ✓ Use signs to provide instructions if they can still read e.g.: do not enter, stop ✓ Personalize rooms with resident's important belongings ✓ Reassure resident to feel safe and secure ✓ Provide rummage boxes/activity aprons
2. Entering into other resident's rooms uninvited	• Looking for bathroom • Fatigue • Inability to recognize their room • Seeking human contact	✓ Assess resident's for a unmet physical need e.g. hunger, thirst, bathroom, fatigue ✓ Provide assistance to help resident make social connections ✓ Use of visual cues to help resident find their room ✓ As above in #1
3. Verbal and/or physical aggression toward others	• Disinhibition due to dementia • Behaviour of other residents • Not understanding actions of caregivers • Approach of caregiver (body language, voice tone)	✓ Be vigilant and proactive to maintain personal safety and safety for other residents ✓ Immediately: • Stop task • Remove self &/or others from resident's personal space • Be aware of your surrounding environment ✓ De-escalate the situation by: • Responding calmly; use non-threatening body posture • Don't react: argue, give a defensive response, rationalize • Validate: acknowledge their feelings • Give directions/instructions • Keep it short and simple • Recognize the difference between venting and abusive language ✓ After the resident has de-escalated: • Seek clarification for the behaviour • Allow time and try another approach • Redirect • Check for triggers: o Check for unmet needs o Check your approach o Check the environment

Using Data to Inform Improvement

CLeAR DATA SUBMISSION: MONTHLY SNAPSHOT

	2015				2016											
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Residents in Care Home	24	24	24	24	24	24	24	24	24	24	25	24	23	23	23	0
Monthly Count: Residents on Antipsychotics																
Any	18	16	16	16	15	14	11	12	12	11	10	9	9	9	9	0
Scheduled	16	14	14	14	14	13	11	12	12	11	10	9	9	9	9	0
PRN	7	6	6	5	4	3	2	2	2	2	2	2	2	2	2	0
Monthly Percent: Residents on Antipsychotics																
Any	75%	67%	67%	67%	63%	58%	46%	50%	50%	46%	40%	38%	39%	39%	39%	0%
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Monthly Count: New Admissions (Residents)																
Admitted on Antipsychotics	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Total New Admissions	1	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0

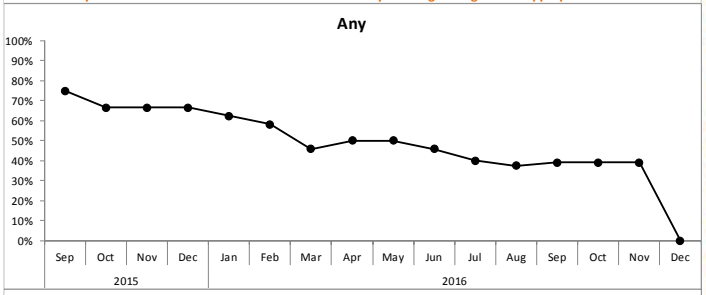
Cumulative Count: Residents Antipsychotic Use	Reduced	Discontinued	Total
Original Cohort	9	8	24
Additional Cohort	0	1	4
Total Residents	9	9	28

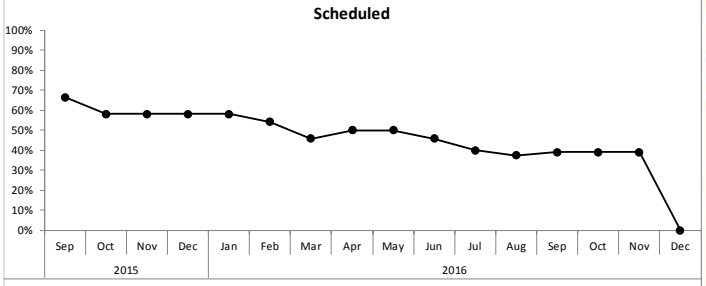
Cumulative Count: Medications (Prescriptions)	Reduced	Discontinued	Total
Scheduled Antipsychotics	5	20	34
PRN Antipsychotics	-	9	11
Total Prescriptions	5	29	45

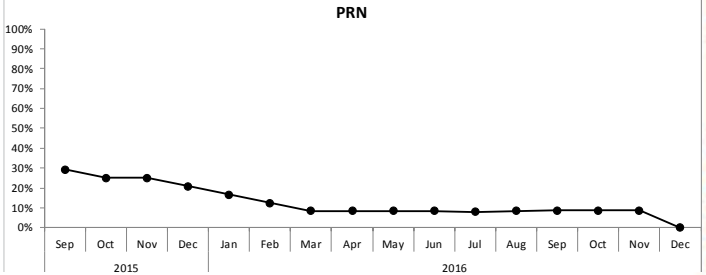
Change orange cell below to select latest month (data point)

Run Charts | Last Month to Display: 15 Dec-16

Note: Monthly calculations on leftmost tables are hidden unless you change orange cell to appropriate month.







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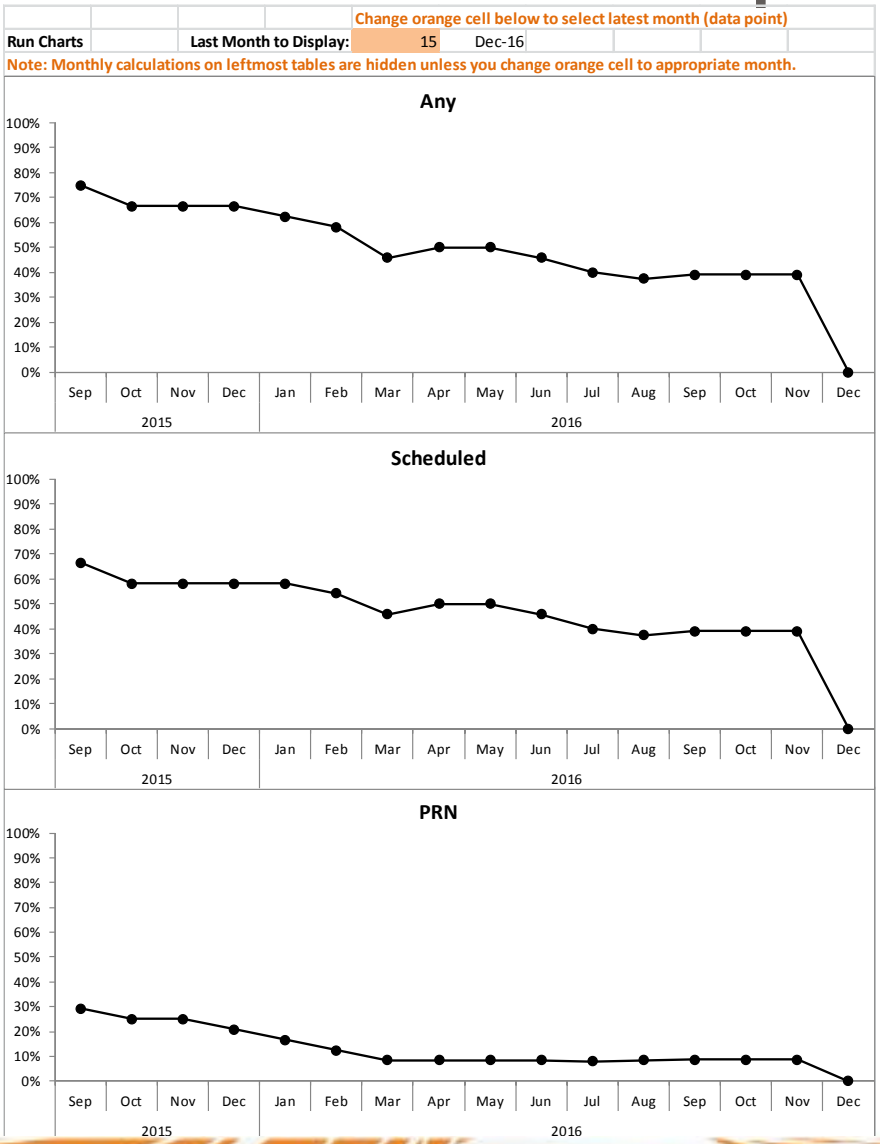

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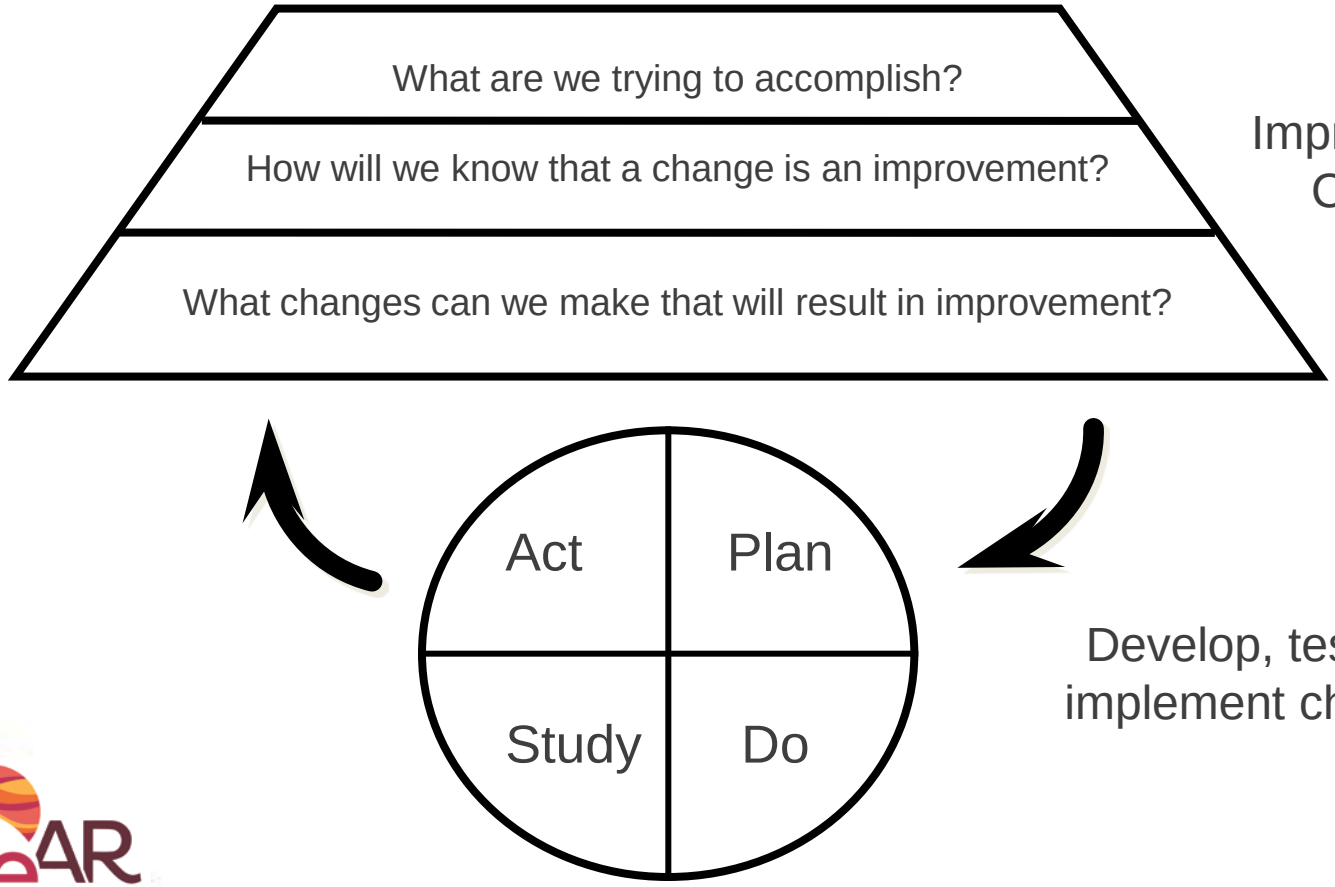
What is a PDSA?



Source: Associates in Process Improvement

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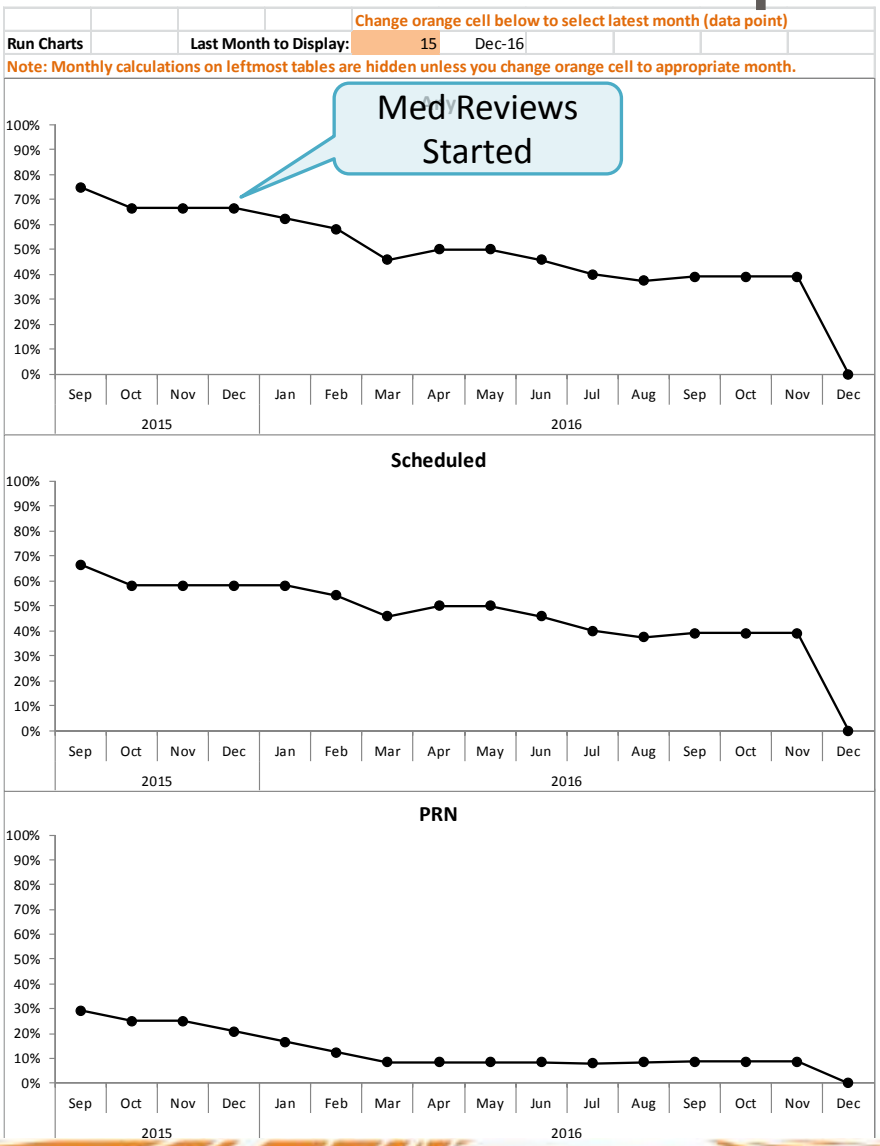

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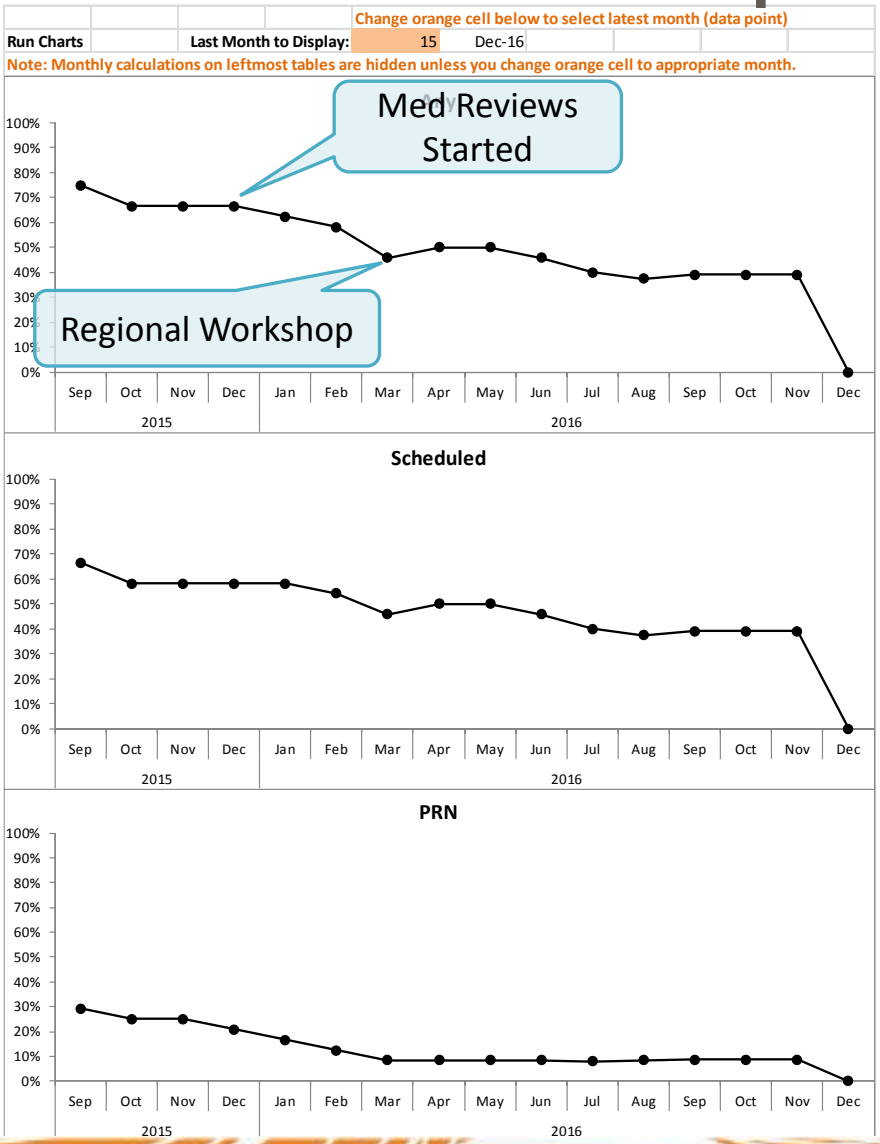

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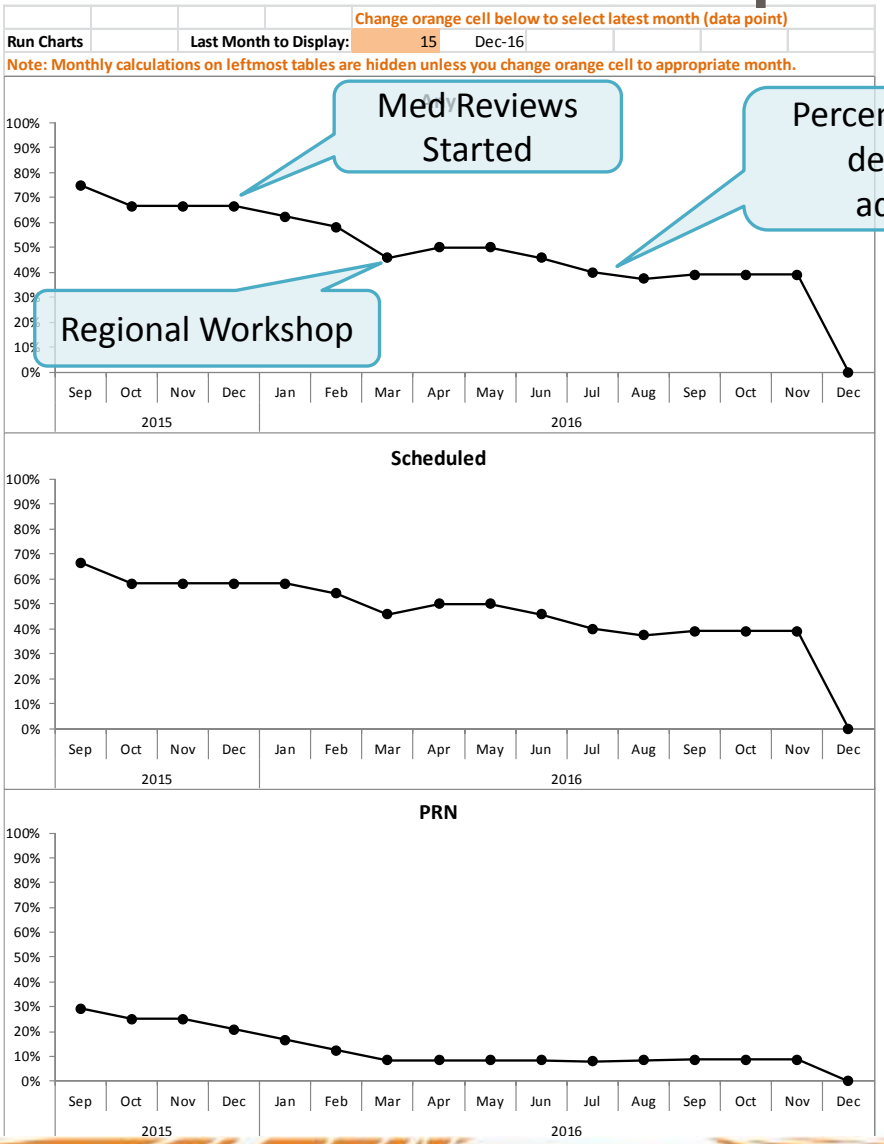

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Calculating the percentage change:
Started at 75%

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Now at 39%

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To calculate the percentage increase:

First, work out the difference (decrease) between the two numbers you are comparing. Then divide the increase by the original number and multiply the answer by 100.

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PRN	7	6	6	5	4	3	2	2	2	2	2	2	2	2	2	0
Monthly Percent: Residents on Antipsychotics																
Any	75%	67%	67%	67%	63%	58%	46%	50%	50%	46%	40%	38%	39%	39%	39%	0%
Scheduled	67%	58%	58%	58%	58%	54%	46%	50%	50%	46%	40%	38%	39%	39%	39%	0%
PRN	29%	25%	25%	21%	17%	13%	8%	8%	8%	8%	8%	8%	9%	9%	9%	0%
Monthly Count: New Admissions (Residents)																
Admitted on Antipsychotics	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Total New Admissions	1	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0

Cumulative Count: Residents Antipsychotic Use	Reduced	Discontinued	Total
Original Cohort	9	8	24
Additional Cohort	0	1	4
Total Residents	9	9	28

Cumulative Count: Medications (Prescriptions)	Reduced	Discontinued	Total
Scheduled Antipsychotics	5	20	34
PRN Antipsychotics	-	9	11
Total Prescriptions	5	29	45

75% - 39% = 36%

(36% / 75%) x 100 =

48% decrease in medications

Using Data for Improvement

CLeAR DATA SUBMISSION: MONTHLY SNAPSHOT

	2015				2016											
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Residents in Care Home	24	24	24	24	24	24	24	24	24	24	25	24	23	23	23	0
Monthly Count: Residents on Antipsychotics																
Any	18	16	16	16	15	14	11	12	12	11	10	9	9	9	9	0
Scheduled	16	14	14	14	14	13	11	12	12	11	10	9	9	9	9	0
PRN	7	6	6	5	4	3	2	2	2	2	2	2	2	2	2	0
Monthly Percent: Residents on Antipsychotics																
Any	75%	67%	67%	67%	63%	58%	46%	50%	50%	46%	40%	38%	39%	39%	39%	0%
Scheduled	67%	58%	58%	58%	58%	54%	46%	50%	50%	46%	40%	38%	39%	39%	39%	0%
PRN	29%	25%	25%	21%	17%	13%	8%	8%	8%	8%	8%	8%	9%	9%	9%	0%
Monthly Count: New Admissions (Residents)																
Admitted on Antipsychotics	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Total New Admissions	1	1	0	0	0	0	1	1	0	0	1	0	0	0	0	0

Cumulative Count: Residents Antipsychotic Use			
	Reduced	Discontinued	Total
Original Cohort	9	8	24
Additional Cohort	0	1	4
Total Residents	9	9	28

Cumulative Count: Medications (Prescriptions)			
	Reduced	Discontinued	Total
Scheduled Antipsychotics	5	20	34
PRN Antipsychotics	-	9	11
Total Prescriptions	5	29	45

What has been done to engage, inspire and facilitate improvement?

fitbit

CLeAR
Call for Less Antipsychotics in Residential Care

Thank you!

CLeAR
Call for Less Antipsychotics in Residential Care