HQBC
HEALTH QUALITY BC

Getting Everyone Involved

Better Medication Use in Long-Term Care

Together, we can transform the experience of our loved ones living in Long-Term Care (LTC) homes by reimagining the role of medications used to manage behaviours. Strong engagement is the foundation for sustainable, person-centered care approaches that will make positive change to enhance the quality of life for those living in LTC.

Strategies for an Interdisciplinary Approach for Medication Use in LTC

Behaviour Support Team

LTC is the test of a team supporting a person in their last chapter of living. Valuing other's voices and input is critical. There are many opportunities an interdisciplinary team can realize for finding the "just right" role for medication in a person's life story. When everyone can help find the best fit for the role of medications, we all do better, especially the person making the most of their last home.

- Build and trust your team. Develop facility-based teams, identify roles and responsibilities for each member to discuss medication management. This improves communication between staff, physicians, pharmacists, allied health, and specialists.

Weekly Plan of Care (WPOC)

Using PIECES training and education, WPOC is an interdisciplinary practice that supports the movement from a task-based approach to an approach that utilizes the Residential Assessment Instrument (RAI) outcomes and Clinical Assessment Protocols (CAPs) on a quarterly basis to inform the best care decisions for each resident.

- Implement a staffing model that includes Care Coach roles, coupled with processes to support interdisciplinary WPOC. Ensure roles and responsibilities are clear.
- At care conferences, utilize a standardized "About Me"[1] template to introduce person in care and set a person-centred tone for the meeting.
- Schedule bi-weekly informal check-ins with Clinical Nurse Leader and Manager.
- Ensure open-door policy exists to discuss behaviours and Care Coach action.
- Use a standardized referral form[2] for staff to request a Care Coach review for residents with behaviour concerns.

Involving Family

Implement a multi-pronged approach that includes the resident's loved ones or family member(s) on the care team. The family member(s) know the resident and have the best insight for alternative ways to deal with situations other than medication. Loved ones want to trust the home that their family members are in, and this trust grows when they are involved and part of the care team.

- Hold a care team meeting as soon as possible to discuss strategies for the resident, ideally before the resident moves into LTC if there is a suspicion that psychosis or dementia is present. Having a proper diagnosis will ultimately result in better care.
- If a resident lives in another community, having a care meeting might not be possible prior to moving in. Ensure an open-door approach during the process of moving in as the resident is settling in. This can be helpful for the team to learn together. Scheduling a care conference within the first month helps optimize shared learnings and build a foundational plan that looks at the year ahead.

Contributions to document: Wendie Nickel, Patient Partner; Dr. Greg Andreas, Medical Director; Kailee MacIsaac, LTC Clinical Pharmacist, Jamie Sudyko, CNL

- Once the resident is in LTC, and they have an episode or an expression of need that is new, the family should be contacted immediately to provide possible strategies and insights to deal with the situation. Sometimes just the resident hearing their family member's voice (e.g. video chat with iPad) could be used to provide contact between the resident and the family member to help with the situation.

Medication Management

Anyone can suggest a medication change.

- This can be suggested on a list in the medication room or at a weekly round.
- Doses can then be titrated, side effects noted along with how medications relate to activity, diet, cognition, disease trajectory, etc. Different perspectives and constant monitoring add value to managing the medication(s).

What Matter's to You (WMTY)

Make the medication fit with a person's story.

- Find, and encourage the sharing of a person's story. It's so much easier once we do. Greater understanding of story gives greater understanding of medications needed.
- A WMTY focus helps us see the person, their frailty trajectory, and their story, as well as our part in supporting it and our own best story. Asking this question cuts to the core of a meaningful conversation about where medication fits – or not.
- Design care conferences to tease out how WMTY fits with each part of the team for the year ahead. It can be useful to have a care conference cheat sheet[3] to help staff with preparation and examples of open-ended questions to understand each resident's unique story.

Care Staff Team at Joseph Creek Care Village - Interior Health

Strategies I will try with my care team:

_____

_____

_____

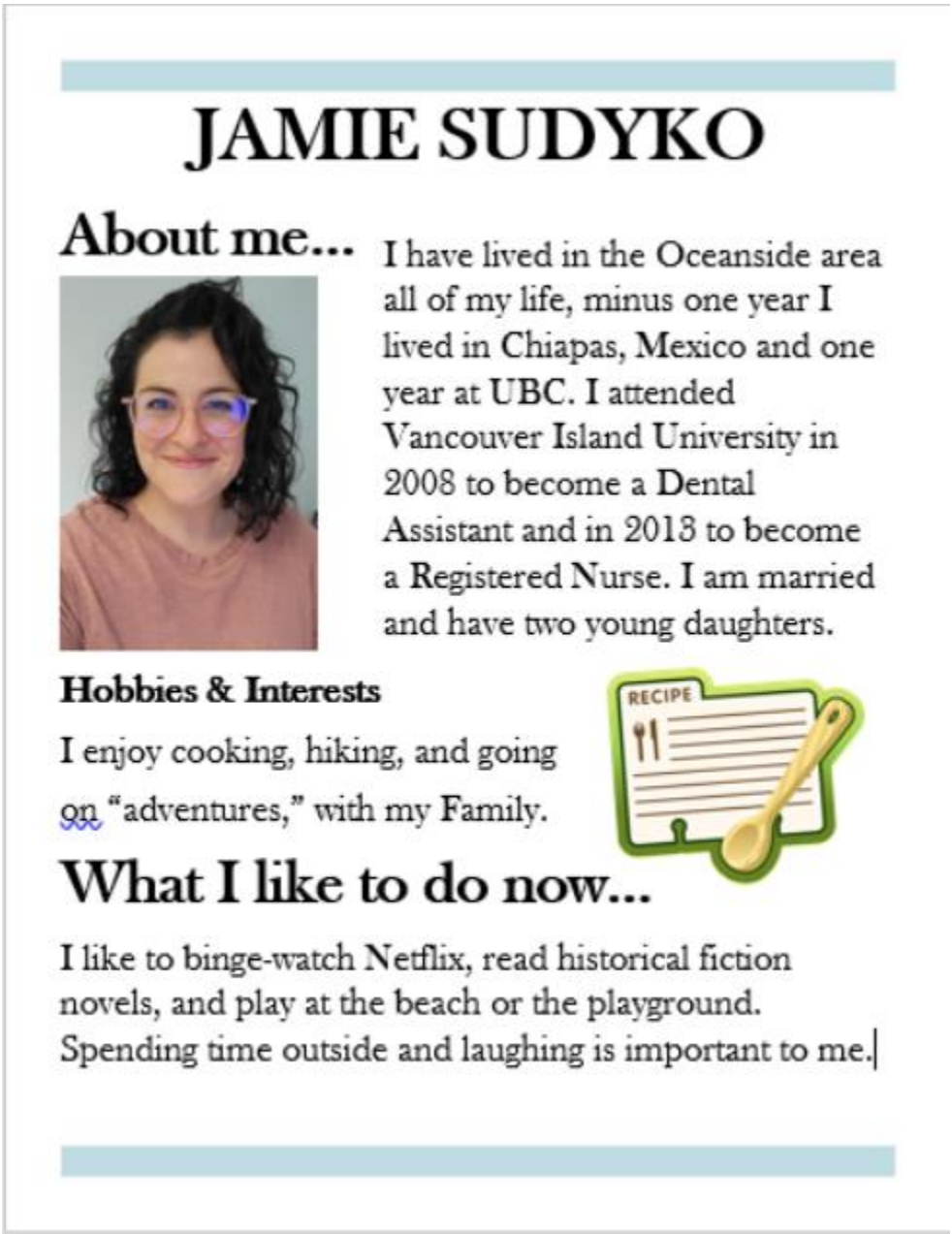
_____

_____

_____

Resources

1. **"All About Me" Template**
    - Complete during admission with resident and families.
    - Use at care conferences and post outside resident bedrooms.



JAMIE SUDYKO

About me...

I have lived in the Oceanside area all of my life, minus one year I lived in Chiapas, Mexico and one year at UBC. I attended Vancouver Island University in 2008 to become a Dental Assistant and in 2013 to become a Registered Nurse. I am married and have two young daughters.

Hobbies & Interests

I enjoy cooking, hiking, and going on "adventures," with my Family.

What I like to do now...

I like to binge-watch Netflix, read historical fiction novels, and play at the beach or the playground. Spending time outside and laughing is important to me.

Contributions to document: Wendie Nickel, Patient Partner; Dr. Greg Andreas, Medical Director; Kailee MacIsaac, LTC Clinical Pharmacist, Jamie Sudyko, CNL

2. Care Coach Referral Form Template

Trillium Lodge HCA

Care Coach Referral Form

Resident Name: _____ Unit: _____ Room Number: _____

What behaviors have you observed? Please circle "priority" behaviors:

_____

_____

_____

_____

What strategies have you tried in response to these behaviors?

_____

_____

_____

What tips and tricks have you learned in working with this resident? What works well when trying to reduce behaviors?

_____

_____

_____

What are some possible causes of these behaviours?

_____

_____

Are you willing to attend a 15 minute care planning meeting with CNL and Care Coach team?

If so, please provide your name: _____

Please give to Elaine, Unit Clerk, or place in CNL mailbox in front office when completed.

3. Care Conference Cheat Sheet

Plan before the Care Conference
Personally/ email/ phone, set date, time and ….. done by care home.

1) Share our goal of starting a conversation that carries through the year.
2) This meeting is 30 minutes! Not more. Plan to start and stop on time.
3) Get the team that knows this person at the table.
4) We need Rep 9 or substitute decision maker at the table. Not "family". See 1) for why.
5) Share and address issues before the conference that need to be dealt with. No one at the table should be blindsided by new information that should have been shared as part of a teams routine work.

At the Care conference meeting.

- Director of care/ nurse leads the structure. Physician facilitates. Team with person share the plan.
- Introduce the person- retired ....., avid .....
- Introduce who is at the table and relationship with .....

Use "open" questions, listen and connect with 4). Try and have them talk about their Mom/ Dad/…. as much as possible... Be ready to adapt. Listen and watch... adapt.

- What would he have been doing 10 years ago on an afternoon like this?
- What would she want us to talk about today?
- What is the most important thing we need to talk about?
- What would you like us to know about your Mother to give her the best care possible? (use if new to care home)
- What changes have you noticed since.....? (not their first care conference rodeo)
- How would she want us to support her with.....? (Behaviour issue, antipsychotics, lap strap conversation, falls..?) Person specific.
- How are you finding it's going for your Mother? (Much better question than....Do you have any concerns? One seems like there should be concerns, the other gives concerns, compliments and anything else space..... and most importantly we get crucial insight from their decision maker)
- What has your fathers spoken about that he would want to see in his last part of living?
- How much fun/ is he enjoying this part of his life?
- What would he want us to know as he gets frailer? (Avoid; "does he want everything done?")

Exploring this gets the MOST done aligning with living and the GOC articulated above.
Please add more questions that build good connection to this list. It is though listening that's the skill that carries the most for year ahead.

Be prepared to be surprised at how much information matching a motivated team at the table, curiosity and the listening for connection, brings to the conversation! Be clear about trajectory and prognosis. Have the NOK ask and talk about this; then they are part of the care team! Remember who this is about. Give them the agenda and they will give it back to you; as trust builds.

Connect what is coming from these answers with the best person in the room to add further value. The answers to these questions give us the understanding and connection to speak to "milestones" of dementia, what is going to happen next, ACP/ MOST etc. in an organic way that recognizes our roles in planning for a best possible last home.

- get standing orders/ labs done that support what comes from above.
- MOST updated from above conversation.
- tweak and trim medications that align with new plan.
- share the notes, resulting documentation with the physician office- MOST to IH. New meds to pharmacist if not present, if a med change occurred.

Most days the above works very well. Some days it feels like nothing goes or flows and on those days, gratitude for who is also with us at the table and the understanding that we are doing hard work and each person is there also to support each other! Thanks!

(Please consider doing and/ motivating your staff to do LEAP and Serious Illness Conversation course. Everyone wins when we share an approach that benefits all involved)

Contributions to document: Wendie Nickel, Patient Partner; Dr. Greg Andreas, Medical Director; Kailee MacIsaac, LTC Clinical Pharmacist, Jamie Sudyko, CNL

Additional Resources

All About Me Booklet - Alzheimer's Society

"What Matters to Me" – a new vital sign – Jason Leitch – Ted Talk