AN HQO INITIATIVE

ResidentsFirst

Advancing Quality in Ontario Long-Term Care Homes

Quality Improvement Road Map to

EMERGENCY DEPARTMENT UTILIZATION

Ontario

Health Quality Ontario

Residents First: On the Road to Quality Improvement

Residents First is a provincial initiative that promotes quality improvement for and by the long-term care (LTC) sector. The initiative is supported by the Government of Ontario and is being implemented in partnership with Ontario's Local Health Integration Networks (LHINs) over a period of five years.

Residents First begins and ends with residents. The vision for this initiative is that each resident enjoy safe, effective and responsive care that helps them achieve the highest potential of quality of life. Residents First supports enhancing a workplace culture where staff – from leadership to the front lines – are jointly engaged in a continuous journey toward quality improvement. The initiative is focused on achieving tangible and measurable improvements in LTC homes, based on internationally recognized indicators of quality. Residents First will provide people working in long-term care with knowledge, training and tools to support them in making quality improvements aimed at enhancing safety and promoting changes that make a positive difference in the well being of residents.

Residents First is being launched in 2010. The goal is to reach all homes within five years.

Residents First partners include:

- Concerned Friends of Ontario Citizens in Care Facilities
- Institute for Safe Medication Practices Canada
- Local Health Integration Networks
- Ontario Association of Non-Profit Homes and Services for Seniors
- Ontario Association of Residents' Councils
- Ontario Family Councils' Program
- Ontario Health Quality Council
- Ontario Long-Term Care Association
- Ontario Long-Term Care Physicians
- Quality Healthcare Network
- Registered Nurses' Association of Ontario
- Seniors Health Research Transfer Network

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1. The Starting Point – Facing the Challenge of Emergency Department Utilization

Welcome and congratulations! By picking up this road map to managing Emergency Department Utilization, you are taking the first step towards improving resident outcomes. This road map aims to support teams participating in the Residents First collaboratives and other quality improvement (QI) projects focused on preventing avoidable Emergency Department visits.

Emergency Department visits among seniors exact a high cost to individuals and the province's health care system. For an individual, it can mean the beginning of a loss of independence and a serious deterioration in their quality of life.

But there is a growing body of research pointing the way to improve Emergency Department Utilization that can help residents remain in their LTC home for as long as possible.

The good news is that Emergency Department visits can be prevented! But how do you get there from here? Here's your road map.

2. The Benefits to Your Residents

This road map will guide you to your destination of making quality improvements in preventing avoidable Emergency Department visits. As in any journey, you must be prepared for stops or possible detours along the way. You will need to refer back to the map throughout the journey to help maintain your focus and keep you on track.

By following this road map, you can achieve a number of benefits for your residents. Here are some examples:

- Improved Emergency Department Utilization by decreasing the number or residents with re-occurring ED visits, and decreased hospital admissions.
- Improved work practices and resident experience by involving resident and family in the choice regarding Emergency Department visit for acute change in condition.
- Improved interdisciplinary team approaches to care – improve staff awareness through evidence-based practices.
- An improved resident centred care approach (care plan interventions, acute change in condition episodes and management of chronic conditions are consistent with resident's goals, values, needs, wishes, preferences, and lived experiences).

3. The Journey to Improving Emergency Department Utilization

3.1 Assembling Your Team

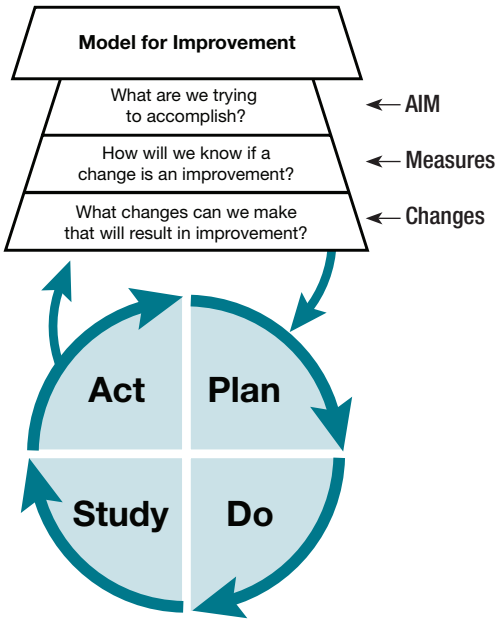
Quality improvement is a team effort. So, you have to start by assembling an LTC Emergency Department Utilization Improvement Team in your home. You may want to include those who can bring energy and commitment to your team. You may already have teams in place, however you may want to consider assembling a team that includes members from Nursing and Allied Health along with a PSW and a Manager. If appropriate, include a resident or family member.

It is recommended that you include someone with training in quality improvement facilitation so they can support you on your journey.

Navigation Checklist

Consider these questions as you are starting out and remember to reflect on them throughout your journey.

1. What are you trying to accomplish?
2. How will you know a change is an improvement?
3. What changes can you make that could lead to an improvement?



Your team is your vehicle.

Your team will plan and implement the improvement to fit the context of your home by:

- gathering baseline measures;
- conducting small-scale tests of change using PDSA, "Think BIG, test SMALL;"
- studying outcomes of changes before planning next action steps; and
- helping successful changes become standard practices and lessons learned.

Quality improvement flourishes when there is support from the leadership to:

- guide, support and encourage the improvement team; and
- ensure the sustainability of the team's effective changes.

3.2 Setting A Course for a Specific Destination

It is important for you to be very clear on the specific goals you are trying to achieve regarding Emergency Department Utilization in your LTC home. First, consider your current circumstances. Then consider how you would like to improve them. Commit to achieving the improvement within a set timeframe. Set a target that will stretch your capability and make sure you keep in mind a level of improvement that will add value to residents.

Your aim is your ultimate destination.

Be sure to pinpoint your destination and establish a schedule for getting there.

The AIM of _____ (your LTC Home) Emergency Department Utilization Improvement Team is to decrease the necessity for Emergency Department visits experienced by any resident by 25% (from a baseline of _____ to _____ per month) by _____ (date).

3.3 Charting Your Progress

Improvements need to be measured. You need to be able to effectively track the changes that are occurring in your home and assess their impact on quality improvement.

Your measures are your signposts. There are a number of different areas that are measured in order to adequately assess the effectiveness of your efforts in improving Emergency Department Utilization. Measure actual outcomes as well as the processes and mitigating steps that are in place to improve Emergency Department Utilization. These additional measures will act as indicators to help flag you when you are going off the path. The chart that follows describes the most relevant outcome, process and balancing measures.

Outcome Measures

1. Number of visits to the Emergency Department each month by cause: fall; potentially preventable deterioration in condition; other. Note: other reasons for ED visits will be tracked but not reported to Residents First.

2. Of the residents that went to the ED from the LTC home, percentage of residents who have multiple Emergency Department visits within a 30 day period.

Process Measures

3. Percentage of residents at high risk for an ED visit who had a change in condition documented on the Shift to Shift report (or progress notes) in the 24 hours prior to ED visit.

   (High risk residents are defined as those admitted to the LTC home within the last 30 days; re-admitted to the LTC home from an ED visit or hospitalization within the last 30 days; those who have experienced a change in medication, change in treatment plan or significant change in condition (as per RAI MDS) within the last 7 days).

4. Percentage of residents with an ED visit in the previous month for whom a transfer package accompanied the resident to the ED visit.

   (Transfer package should include: Reason for initial transfer, any high risks identified with related care plan interventions, medication list, medical history, and most recent assessments).

5. Percentage of residents re-admitted to the LTC home in the previous month who have an ED or hospital discharge record that accompanies the resident back to the LTC home (or comes in a timely manner).

   (ED discharge record should include: Record of care and services received, discharge diagnosis, medications administered, diagnostic test results, response of resident to treatments, recommendations for follow up, consultation reports).

6. Percentage of residents re-admitted to the LTC home in the previous month with follow-up care documented in the physician's orders and care plan within a 24 hour period.

7. Percentage of all residents in the LTC home who have an up-to-date care plan (10% sample).

   (Up-to-date care plan includes all risk assessments complete and family and resident engagement).

Balancing Measures

8. Percentage of residents with worsening mobility (locomotion, transfer, and walk in corridor ability) (mid-loss ADL) compared to previous month.

4. Different Paths to Improvement

Quality Improvement involves change on many levels. There is no one-size-fits-all solution to reaching your destination. Each home is unique. It is important for your team to discuss, explore and determine changes that can be made in your home to improve Emergency Department Utilization.

Consider your entire organization and approach to caring for residents to look for changes that can be made to support improvements in Emergency Department Utilization.

The following table sets out possible areas of focus and steps that you may want to take on your journey towards quality improvement.

Recognition and Assessment	Suggested Steps
Identify Emergency Department Utilization as an area for potential improvement in performance and practice.	• Determine baseline measures related to Emergency Department Utilization. • Determine areas for improvement/change ideas in current processes and practices related to Emergency Department Utilization. • Examine the current process for determining need for Emergency Department visits. • Understand common reasons for ED visits (Example: Pre-existing conditions that may pre-dispose residents to acute change in condition).
Engage Resident and Family	**Suggested Steps**
Provide education to residents and families about Emergency Department visits.	• Provide education about appropriate interventions to reduce necessity for Emergency Department visits, and the benefits of these prevention strategies. • Implement interventions that are consistent with the residents' goals, values, needs, wishes, preferences and risk factors. • Evaluate resident and family satisfaction using a regular satisfaction survey.

Care Planning for Prevention	Suggested Steps
An individualized plan of care is created with the resident, family and staff and is based on best practice evidence, and assessed risk while considering first the residents' values, beliefs, and preferences.	• Communicate to the resident, family and staff the resident's risk status (verbal, health record, care plan, shift change, risk rounds, care conferences, programming staff, outings with family etc). • Address resident psychosocial needs if Emergency Department transfer is warranted. • Understanding Advance Care Directives that impact ED utilization.
A well developed communication plan supports care planning for prevention strategies.	• Develop a hand over form or report which includes residents at high risk. • Include risk status and preferences related to Emergency Department transfers into discussions at all admission care conferences and annual care conferences. • Develop partnerships between hospital and LTC home to better understand each stakeholders' information needs. • Ensure effective risk communication to Emergency Department for residents who are transferred so that Emergency Department staff can continue risk prevention interventions to decrease avoidable problems due to lengthy stay. • Ensure effective communication from hospital to LTC home on re-admission for follow up to care received.

Improve Work Flow	Suggested Steps
Education in the following areas will enhance the development of routine practices in care that can impact Emergency Department Utilization.	• Conduct educational sessions during staff orientation at regular intervals on Emergency Department Utilization. • Ensure awareness and use of strategies to address potential change of status during regular hours and after hour/holiday support. • Access to GEM (Geriatric Emergency Management) Nurses or NP Outreach Programs where available. • Develop and implement strategies to manage chronic conditions.

Improving Work Flow *(cont.)*	Suggested Steps
	• Develop and implement strategies to manage sudden acute episodes or changes in condition. • Understanding signs and symptoms related to pre existing conditions. • Consider using tool categories of symptoms that may indicate acute change in condition. • Understand signs and symptoms that warrant involvement of medical staff. • Consider using tools that provide guidance on when to report changes in vital signs and laboratory values. • Provide education on: promoting safe mobility risk assessment, risk management, including post fall f/u alternatives to restraints, sensory impairment, continence education, pain management, palliative care etc. • Include fall injury prevention strategies, (example lifting a resident after a fall or safe transfer). • Educate all residents who have been assessed to be at risk and their family regarding their risk status. • Consider resident education materials that are available for distribution to residents and family. • Incorporate findings regarding causes of past Emergency Department transfers into education for residents and families.
Organizational support related to Emergency Department Utilization will support developing routine practices to address acute change in condition.	• Ensure definition and identification of status change events in the LTC home. • Regularly review (annually) the existing policy in your LTC home related to acute change in condition and supporting chronic conditions. • Review organizational Emergency Department transfer policy, including roles and responsibilities of each healthcare provider).

Improving Work Flow *(cont.)*	Suggested Steps
Environmental factors for reducing Emergency Department Utilization.	• Provide access to supplies and equipment to meet the complex care needs of residents. • Provide education on the use of equipment and supplies.

Developing Routine Practices	Suggested Steps
Early risk identification and management will prevent acute change in condition.	• Ensure management of chronic conditions, such as diabetes. • Consider using acute change in condition determination tool. • Optimize pain management practices. • Detect behaviour changes and altered mental states in residents that may precede acute change in condition. • Ensure timely detection and treatment of infections. • Ensure timely identification of inadequate food/fluid intake to avert potential dehydration. • Investigate each fall or near fall to identify contributing factors and to prevent reoccurrence. • Identify residents who have fallen as high risk and implement appropriate interventions. • Develop a post fall documentation report including root cause analysis. • Test “Huddles” with the interdisciplinary team to discuss high risk residents and to identify any required changes to the care plan.

Design Systems to avoid Mistakes	Suggested Steps
A workplace culture where residents, families and staff can communicate suggestions and concerns.	• Collaborate with multidisciplinary team and partners for access to necessary resources to address change in condition. • Establish partnerships with community care, primary care, diagnostic services and paramedic services. • Use a PDSA approach to evaluating all tests of change. • Collect, report and analyze data for learning. • Establish a forum to review feedback, learning about changes and improvements to ED utilization in your LTC home (staff meeting, councils, huddles, newsletters, email notices). • Provide access to supplies and equipment. • Provide adequate support to LTC Emergency Department Utilization Improvement Team to facilitate activities.

5. Navigation Support

Here are some resources that may be of assistance to you on your quality improvement journey.

RNAO Best Practice Guidelines: Fall Prevention
http://www.rnao.org/Page.asp?PageID=924&ContentID=810

RNAO Best Practice Guideline: Care giving Strategies for Older Adults with Delirium, Dementia and Depression http://www.rnao.org/Page.asp?PageID=924&ContentID=797

RNAO Best Practice Guideline: Screening for Delirium, Dementia and Depression in the Older Adult http://www.rnao.org/Page.asp?PageID=924&ContentID=818

RNAO Best Practice Guideline: Client Centred Care
http://www.rnao.org/Storage/15/932_BPG_CCCare_Rev06.pdf
http://www.rnao.org/Storage/15/933_BPG_CCCare_Supplement.pdf

Regional Geriatric Program Central: Acute Change of Condition resources
http://www.rgpc.ca/best/subjects/acc.cfm

6. Conclusion

Congratulations! Now that you have taken this journey and reached your destination, you are ready to celebrate. Quality improvement is a continuous journey, and there is another destination waiting for you. You may choose to:

- reset your aim using the same topic and resident group;
- spread your success on this topic to a new resident group; and/or
- choose a new topic area of focus.

This is also a good opportunity to remind your team that you now have quality improvement tools and skills that you can direct to any improvement efforts in your home.

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Appendix: Paths to Improvement at a Glance

The diagrams which follow offer guidance on areas where change should be discussed and considered and possible steps to engage in order to bring these quality improvement changes to life.

Recognition and Assessment	Engage Residents/Family	Care Planning for Prevention	Improve Work Flow	Develop routine practices/Standardize	Design Systems to avoid mistakes
Determine baseline measures for ED utilization. Determine areas for improvement in process and practice.	Educate residents about options for services	Implement interventions that are consistent with resident values, needs, preferences and risk factors	Educate staff about ED utilization, contributing factors and signals for potential change in condition	Manage chronic conditions. Optimize pain management. Detect early behaviour changes and altered mental states.	Use a Plan Do Study Act approach to all tests of change
Identify common reasons for ED visits	Evaluate resident and family satisfaction using surveys	Communicate risk status with family and staff	Review policy in LTC home related to change in condition and ED transfer.	Timely identification and treatment of: • Infections • Inadequate food, fluid intake	Establish a process to review feedback, learning about changes and improvements to ED utilization
		Address resident psycho-social needs if ED transfer is needed	Establish partnerships with community care, primary care, diagnostic services, paramedic services and acute care.	Investigate contributing factors to falls to avoid re-occurence	
		Understand resident advanced care directives that impact ED utilization		Test huddles with inter-disciplinary team to discuss high-risk residents and any changes needed to the plan of care	
		Communicate risk status to support continuity of care from LTC home to ED			
		Follow up on ED transfer record unpon re-admission from hospital			
		Develop partnership between hospital and home			

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