Name: _____

Improving Resident Quality of Life:

The CFHI Appropriate Use of Antipsychotics Collaborative Family Partner Meeting

November 12, 2019 | 4:30PM - 7:30PM
Capital Hotel, St. John's, Newfoundlad and Labrador

Labrador-Grenfell Health
Central Health
Eastern Health
Western Health
Health PEI
One Island Health System
Canadian Foundation for Healthcare Improvement
Fondation canadienne pour l'amélioration des services de santé
Newfoundland Labrador

IMPROVING RESIDENT QUALITY OF LIFE: THE CFHI APPROPRIATE USE OF ANTIPSYCHOTICS (AUA) COLLABORATIVE

The Canadian Foundation for Healthcare Improvement (CFHI) hosted the Appropriate Use of Antipsychotics (AUA) Collaborative, in partnership with the Government of Newfoundland and Labrador (NL) and Health PEI, between January 2018 - November 2019.

The AUA is a person-centred approach to care that engages people living with dementia, their families, and staff to respond to individual unmet needs based on the personal history. The approach includes reviewing the appropriateness of antipsychotic medication and understanding the underlying issues and causes of behaviours, such as pain. Residents are provided with individualized alternative activities that are meaningful and enjoyable, like exercise, pet or music therapy. This also provides an opportunity to create supportive environments that help the person to feel calm, safe, and comfortable.

Antipsychotic medications are often used to help manage behaviours related to dementia in long term care, for example agitation and aggression. However, there is a lack of evidence to support their effectiveness for people who do not have a diagnosis of psychosis and a risk of significant side effects such as confusion, dizziness and stroke or even death.

Through the Collaborative, CFHI and the provinces provided funding, training, coaching support, tools and resources to empower all 39 long term care (LTC) homes in NL and the 9 publicly funded LTC homes in PEI to improve dementia care by implementing the AUA Approach.

The results of the collaboration include:

- In Newfoundland and Labrador, 52 percent of residents who were prescribed antipsychotic medication, but did not have a psychosis diagnosis, had their medication reduced or discontinued (30 percent discontinued, and 22 percent reduced dose).
- In Prince Edward Island, 53 percent of residents who were prescribed antipsychotic medication, but did not have a psychosis diagnosis, had their medication reduced or discontinued (25 percent discontinued, and 28 percent reduced dose).
- No change in aggressive behaviours among these residents, such as resistance to care, and physically or verbally abusive behaviours.

Many staff and families have reported residents are better able to participate in their activities of daily living, for example: eating without assistance, engaging in recreational activities and engaging in interactions with families and care providers. Along with these improvements, many staff report greater satisfaction at work and feel that they are making real positive changes in the lives of their residents.

Congratulations!

ABOUT THE CANADIAN FOUNDATION FOR HEALTHCARE IMPROVEMENT

The Canadian Foundation for Healthcare Improvement supports partners to accelerate the identification, spread and scale of proven healthcare innovations. We work shoulder-to-shoulder with you to improve health and care for everyone in Canada.

CFHI is a not-for-profit organization funded by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada. While our work expands across the country, we respectfully acknowledge that the CFHI office is situated on the unceded traditional territory of the Algonquin Anishnaabeg people.

FAMILY PARTNER MEETING

As a family member of someone who lives in a long-term care home in Newfoundland, and as someone who is familiar with the Appropriate Use of Antipsychotics initiative, we are pleased to welcome you to this meeting to discuss:

- Overview of the AUA Collaborative – What the province is doing and why
- Effective partnerships with family
- Effective communication
- Long term success of the AUA Approach – How do we do it together?

QR CODES

In an effort to make resources easier to access and share, we're using QR Codes throughout this workshop. Before scanning the QR Code, make sure that your smartphone has a QR Code reader app installed. Note that devices running on iPhone iOS 11 or later and most Android smartphones already have a QR Code reader built-in to the camera app. If not, iPhone and Android users can download the *QR Scanner & Barcode Reader* from the Apple App Store or Google Play store.

To use the QR Code, simply open your camera app and focus on the QR Code like you're going to take its picture. You will see the QR Code displayed on your phone screen and be prompted to access the resource website automatically.

AGENDA

TIME	DESCRIPTION	LEAD(S)
4:30	Welcome and Introductions	Cynthia Sinclair John Flood
4:45	Overview of AUA Collaborative – What the province is doing and why	Cynthia Sinclair
5:00	Effective Care Partnering	Cynthia Sinclair John Flood
5:30	**DINNER**	
6:00	Effective Communication	Cynthia Sinclair John Flood
6:30	Long Term Success of the Appropriate use of Antipsychotics Approach – How Do We Do It Together? Continued Discussion in Areas of Interest	Cynthia Sinclair
7:30	Adjourn	

TOOLS AND RESOURCES TO SUPPORT APPROPRIATE USE OF ANTIPSYCHOTICS (AUA)

Looking for more resources and tools to support Appropriate Use of Antipsychotics in your setting, such as the Quality Improvement tools you need to prepare you or your organization to implement the improvement? Contact the Canadian Foundation for Healthcare Improvement, at info@cfhi-fcass.ca. We can help!

How Antipsychotic Medications are Used to Help People with Dementia: A Guide for Residents, Families and Caregivers. The Centre for Effective Practice and the Canadian Foundation for Healthcare Improvement created this resource to inform appropriate use of antipsychotics and person centred approaches to care.

Website: deprescribing.org. This website was developed and is supported by Dr. Barbara Farrell and Dr. Cara Tannenbaum – a pharmacist and physician who work with older people and are concerned about the risks associated with medications in this population – and their research teams at the Bruyere Research Institute (Ottawa) and Universite de Montreal. The deprescribing.org website has resources to support evidence-based appropriate deprescribing of several medications, including the safe deprescribing of antipsychotic medications.

Five Questions to Ask About your Medications when you see your doctor, nurse, or pharmacist. The Canadian Patient Safety Institute partnered with the Institute for Safe Medication Practices Canada, Patients for Patient Safety Canada, the Canadian Pharmacists Association, and the Canadian Society for Hospital Pharmacists to create a list of top questions to help patients and their caregivers have a conversation about medications with their healthcare provider.

Alzheimer Society Canada All About Me & All about me: a Conversation Starter. The Alzheimer Society Canada created the All About Me and All About Me: A Conversation Starter resources to help people with dementia to tell healthcare providers about themselves – their needs, likes, dislikes and interests. Knowing more about the person with dementia helps care providers build relationships and support personalized care.

Alzheimer Society Canada PC P.E.A.R.L.S.: 7 key elements of person centred care. Through its culture change initiative, the Alzheimer Society of Canada aims to improve the experience of longterm care for people with dementia and their families, and is working with others to provide useful strategies, tools and tips that can help put the principles of person centred care into practice. The Alzheimer Society of Canada identified seven key elements of delivering person-centred care, which are outlined in the P.E.A.R.L.S. resources on their website.

Alzheimer Society Canada: Meaningful Engagement of People with Dementia. People who are experiencing dementia have the right to live in homes that support their interests. With this in mind, this resource guide was developed to provide tools, resources and strategies to assist organizations in promoting meaningful engagement with people who have dementia.

The BSO-DOS© Observation Tool. Provides objective and measurable data about a person living with dementia. The data collected can be utilized by clinical teams and care partners to identify patterns, trends, contributing factors and modifiable variables associated with responsive behaviours and personal expressions. This information is useful in the development and evaluation of tailored, person-centred interventions to address unmet needs through activities, environments, approaches and/or medications. The BSO-DOS© and its supporting resources are available at **www.brainexchange.ca/BSODOS**. Resources include BSO-DOS© tool; start up checklist; user guide; resource manual; and an instructional video.

EFFECTIVE COMMUNICATION BETWEEN CAREGIVERS AND FAMILIES: BASIC PRINCIPLES

MUTUAL RESPECT

- Exchange information.
- Respect each other's insights and ideas.
- Develops a climate of trust; non-blaming.
- Focus on the needs and values of the individual rather than the needs and values of staff or family.
- Focus on the person's strengths and commit to work together to find creative solutions to care issues.

HARMONIZED GOALS

- Common understanding and agreement on the care plan.
- Discussion should include options, risks, benefits, as well as individual preferences and expectations.

A SUPPORTIVE ENVIRONMENT

- Staff and family members are approachable and willing to listen and engage.
- A nurturing environment that supports shared decision making.

APPROPRIATE DECISION PARTNERS

- Have the right people at the right time together to discuss and make decisions.
- Decisions focus on the needs, values and preferences of the individual rather than the needs and values of staff or family.

THE RIGHT INFORMATION

- Information that is accurate, clear and understandable, and is presented in a timely way.

TRANSPARENCY & FULL DISCLOSURE

- Candid discussion about the limits of science and system.
- Openness about sharing adverse events and discussing next steps.

CONTINUOUS LEARNING

- Feedback on progress.
- Course correction as necessary.
- Share new information.

STAFF "KNOW" TOOL FOR COMMUNICATION WITH FAMILIES

By Cynthia Sinclair

K

Knowledge: What is the issue the family wishes to discuss?

- Listen carefully to what thr family has to say FIRST and determine exactly what they wish to know.
- Next, acknowledge family's concerns and communicate the team's observations regarding the issue. For example, "yes, the night shift has been reporting that your mother is not sleeping well and she is up frequently at night. We agree she seems very tired, we believe it's because she's not sleeping well." Or, "yes, we've noticed his intake is poor and he is losing weight. We appreciate your concern, because we too, are very concerned." Provide any update for the family. Keep information objective rather than subjective. For example, "we've been trying to encourage her to be more active during the day in an effort to get her sleeping better at night".
- The family may ask specific questions and staff should be prepared to provide factual information. If not possible at the time, set a date to get together to discuss the issue.

N

Need: What does the family need to know?

- Review with the family the care plan, including non-pharmacological strategies.
- Share any observations with respect to changes in the behaviour.
- This is the team's opportunity to review with the family any diagnoses, or changes in the resident's status (e.g., worsening medical condition, progressing dementia) and to probe families gently about what they understand about these conditions.
- This is an opportunity to provide some education about the medications, the disease, etc.
- Does the family understand the value of non-pharmacological approaches?
- Does the family understand that medications may not be appropriate to address a behaviour?
- Does the family understand how the medications work and affect the resident (behaviours, physical condition, etc.)?
- Does the family understand the condition and its progress (i.e. changes in behavior, terminal?).

O

Option: What options are available?

- Changes to the care plan, i.e. creation of a more personalized care plan that focuses less on medication to manage behaviors.
- Referrals to allied health, i.e. dietitian, occupational therapist, music therapist, recreation.
- Referral for a behaviour management assessment.
- Need for tests (behaviour mapping, labs, diagnostics, etc.)
- Medications (addition/reduction/discontinuation) and risks.
- Other options, e.g., increased surveillance; transfer to acute care; medical investigations.

W

What, Where, Who & When: Together with the family, identify and discuss the individualized plan for the resident

- What will the plan going forward will be? (should be very specific, including timelines)
- Where will the plan be carried out? (e.g., will hospitalization or transfer to another unit/room be required)
- Who will be responsible for implementation of this new plan? What will each team member's responsibility be? What is family's role and responsibility?
- When will we come back together to evaluate progress? Who will be responsible for contacting family/staff (it's often best to identify a specific person and time)? Will we get together in person, or by phone?

FAMILY KNOW TOOL

By Cynthia Sinclair

K

Knowledge: What exactly do you want to discuss with the team (be specific, and try to focus on one or two issues only) and what you already know about the issue you wish to discuss with the team:

- Last communicated care plan including person centred care strategies and medications
- Behaviour demonstrated (i.e. what you've seen and heard).
- Your loved one's routines (what is perhaps different lately).
- Conversations you've had with your loved one or other staff members.

N

Need: What information do you still need?

- Any medication changes of which you're not aware.
- Recent changes to the care plan.
- Newly observed behaviour changes in your loved one.
- Results from recent laboratory/diagnostic investigations.
- Any new/updated diagnoses.

O

Options: Discussion with the team should now focus on options available.

- Revised care plan to support the individual.
- Medications (addition/reduction/discontinuation) and risks.
- Other options e.g.: increased surveillance; transfer to acute care; medical investigations, etc.

W

What, Where, Who & When: A summary of the discussion which should clearly indicate:

- What the plan going forward will be (should be very specific, including timelines)?
- Where will the plan be carried out (i.e. will hospitalization or transfer to another facility or unit/room be required)?
- Who will be responsible for execution of this new plan? What will each team member's responsibility be? What is family's role and responsibility?
- When will we come back together to evaluate progress? Who will be responsible for contacting family/staff (it's often best to identify a specific person and time). Will we get together in person, or by phone?

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