CAPITAL DISTRICT HEALTH AUTHORITY
DISTRICT MEDICAL ADVISORY COMMITTEE
QUALITY SUBCOMMITTEE REPORT

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THE CARE PATH FOR PATIENTS WITH ACUTE BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA WITH A FOCUS ON THE APPROPRIATE ROLE OF THE EMERGENCY DEPARTMENT

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EXECUTIVE SUMMARY

All responsible adults in the province of Nova Scotia, including health care leaders, the government, and the general public, need to become more aware, concerned, and vocal about the need to prepare for what has been called the "Silver Tsunami". Going forward, the Capital District Health Authority (CDHA) will need to give a consistent and clear message to the Nova Scotia Department of Health (DOH) regarding the urgent need for a shift in health care spending toward community and chronic care if we are to begin to rise to meet the needs for care of the growing number of elderly Nova Scotians.

More spending is inevitably required in chronic care and community care in order to meet the needs of an aging population. This will almost certainly mean that some tough decisions, including shifting spending from acute care, hospital costs, and/or new technologies. Consensus is needed on the rationale for adjusting our patterns of spending if we are to make any real progress in meeting the health care needs of our aging population.

Based on the ongoing demographic shift, dementia care and the challenging aspects of this care will become intensified. Systemic solutions to address these issues are needed. Health promotion/prevention measures to prevent or delay the onset of dementia and need for institutionalization are also required (*Rising Tide*, Alzheimer Society, 2010).

A Subcommittee of the District Medical Advisory Quality Committee (the Committee) was formed to examine the current resources available for dementia care in CDHA and the shortfalls in existing resources that lead to inappropriate use of hospital resources (including excessively long stays in the Emergency Department (ED) of patients whose main problem is dementia, and difficulty discharging patients with dementia from inpatient beds), and to make recommendations on how to improve the system of care for patients with behavioural and psychological symptoms of dementia (BPSD).

SUMMARY OF RECOMMENDATIONS

The Committee urges the rapid implementation of the three underlined recommendations, followed by purposeful and planned implementation of the remainder. Background for each recommendation is provided in the main body of the report.

A) How to Approach the Management of BPSD

#1a: That CDHA develop an administrative structure to overcome "silos" of care and diffusion of responsibility for the care of patients suffering from acute BPSD, and for planning the integration of long-term care (LTC) needs with the acute care system. It is suggested that this administrative structure include a coordinator for urgent placement of patients with dementia, an advisory council comprising experts in geriatric care, and the Challenging Care Needs Network (CCNN).

#1b: That CDHA work with the DOH to create policies that support this structure. (underlined for emphasis as a preferred option for urgent implementation)

B) Home/Community Recommendations

#2: A public education campaign is needed to increase awareness of the need for families in the community to be prepared for difficult decisions, and avoid risks to patients associated with acute care in hospital. Families should not need to turn to the ED in order to have care needs met that should be provided in the community.

#3: The Alzheimer Society recommends that a navigation system for caregivers be implemented to make the path of care for those caring for seniors at home easier to manage (see *Rising Tide* for details).

C) LTC Recommendations

#4: One or more of several established models for acute stabilization of and crisis intervention for BPSD in the community should be adopted in Nova Scotia in order to avoid further escalations in the inappropriate use of the acute hospital care system. The options include:

a) Specialized care teams in LTC facilities
b) Challenging behaviours assessment and stabilization units
c) Mobile crisis BPSD team for LTC and community
d) Mobile nurse practitioner model — immediate consultations for urgent/emergent BPSD
e) *Home First* program with active case management by Home Care

#5a: More LTC beds will be required than are currently being built and more intensive community management plans, services and resources will be required to compensate for the LTC shortfalls.

#5b: LTC beds must be optimally utilized to allow care of patients with BPSD. The recently added beds have been designed to allow care of patients with dementia, and some of the new units could be designated for care of BPSD. New policies will, however, also be required for optimal bed utilization.

#6: Education about dementia should be provided to a broad range of staff in acute care, community-based care, and LTC facilities in order to increase capacity significantly.

#7a: All patients in nursing homes should be properly assessed with written documentation by the associated family physician before transfer to the ED. There should be direct telephone communication between the Nursing Home Medicine physician and the ED physician prior to transfer to explain the rationale, provide information regarding the patient's baseline, and indications for further investigations/consultations/care/disposition.

#7b: Family education/discussion of appropriate care should occur in LTC to ensure that excessive and inappropriate interventions do not take place (with attention to personal directives when they exist); LTC facilities will need to work directly with care coordinators to develop a consistent approach to these discussions with those living in LTC.

#8a: A more proactive approach to BPSD should be taken by each nursing home with the identification of a care coordinator in each facility to assume responsibility for monitoring all cases posing care challenges to LTC staff in order to develop care plans and intervene early.

#8b: That PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, and Social learning initiative) have strong and clearly delineated relationships to the other elements of the health care system in order to promote better integration of services.

D) Hospital/Acute Inpatient Care Planning Recommendations

#9: Systemic barriers to the flow from acute care to community care must be addressed and eliminated without delay. These include an urgent placement or movement mechanism for the more challenging cases to a good-fit environment within LTC:

- nursing homes "refusing" patients should become an exceptional event;
- "unclassifiables" should cease to exist (to permit this major step, some environments in nursing homes will require modification);
- the "30-day-rule" should be thoroughly reassessed;
- patients with stabilized BPSD should be discharged from hospital without delay; and
- a CDHA coordinator for urgent placement of patients with dementia is needed to match clinical need with the appropriate level of care.

#10: Willow Hall should be utilized as a specialized acute care and consultative resource for other inpatient units. A consultation from the Seniors Mental Health (SMH) team is required

prior to transfer to Willow Hall, and transferring units should be prepared to accept patients back following stabilization.

#11: If transitional care units (TCUs) are to be closed, good communication to the relevant groups should be provided in advance, with opportunities for feedback. Any savings from the closing of these units should be redirected to increase capacity in the community. TCUs or similar structures to be established in the place of the existing TCUs will need to be made broadly accessible in order to free acute care beds for appropriate use.

E) ED Flow Recommendations

#12: Community services are needed to respond more urgently to those individuals with high levels of acuity due to dementia and frailty. Without a triage plan, the seamless care of patients who present to the ED with dementia or frailty will be suboptimal. The ED physician should triage any cases of BPSD to determine the underlying cause for presentation, and based on the presentation, decide whether a consultation is required. Services available include: neurology, geriatric medicine, internal medicine, family medicine, psychiatric emergency service (PES), or the ED social worker. While not providing direct consultation in the ED, following disposition from the ED, the SMH team and psychiatry consult/liaison (C/L) team would be available for consultation as indicated, C/L usually within 24 hours, and SMH usually within 72 hours for urgent cases. Appropriate communication between the ED and community-based services will be essential for the appropriate treatment of such patients. In addition, the recommended BPSD management services within the ED should arrange disposition of cases not suitable for admission to hospital.

#13: If it is judged that a patient with BPSD requires admission as a result of serious risk to self or others, the patient should be admitted. If necessary, suitable transfers should be arranged by the coordinator for urgent placement of patients with dementia in order to permit admission.

#14: <u>An urgent BPSD management team (with input from specialists with training in geriatric care) should be established to work with the ED staff for appropriate disposition and to provide direct follow-up and linkage to community resources, among other responsibilities.</u>

INTRODUCTION

In 2007, the American Geriatrics Society used the term "Silver Tsunami" to sound the alarm on the pending impact of an aging population on an already stressed health care system. (This term had been coined in 2001 by Susannah Fox of the Pew Internet & American Life Project: "Wired Seniors, A fervent few, inspired by family ties.") The poor fit of acute medicine, high technology, and increased specialization and hospital-based health care spending in meeting the needs of an aging, chronic-care population is of substantial concern.

Canada's aging population brings an increased prevalence of diseases of old age such as dementia, and associated increased pressures on the long-term care (LTC) system. The Alzheimer Society predicts that the prevalence of dementia in 2038 will be 2.3 times that of 2008, i.e., an increase from 480,600 (1.5% of population) to 1,125,200 people (2.8% of population).

The "Baby Boomers" begin to turn 65 years of age in 2011, and thus we have yet to experience the expected exponential rise in the requirements for care of seniors. In addition, Nova Scotia has the second oldest population in Canada and we are already seeing the effects of our aging population and increased needs for dementia care. The increased presence in the Emergency Departments (ED) of high acuity patients with chronic care needs not being managed in the community is an early indicator of the problems to come.

The province of Nova Scotia, including the public, the government, and health care leaders, including the District Medical Advisory Committee (DMAC) and the senior administration of the Capital District Health Authority (CDHA), need to become far more aware, concerned, and vocal about the need to prepare for the Silver Tsunami here in Nova Scotia. While steps have recently been taken to increase LTC capacity, previous decades had seen reductions in community health care and human resource spending.

DMAC and CDHA will need to give a consistent and clear message to the Department of Health (DOH) regarding the urgent need for a shift in health care spending toward community and chronic care if we are to meet the Silver Tsunami with success.

The increased spending required in chronic care and community care will likely mean some tough decisions, including shifting spending away from acute care, hospital costs, and/or new technologies in the future. Consensus on the need to shift spending will be needed if we are to make any real progress in meeting the health care needs of the aging population of Nova Scotia. Based on sheer numbers, dementia care and the challenging aspects of care will become intensified. Systemic solutions to address these issues are needed. Health promotion/prevention measures to prevent or delay the onset of dementia and need for institutionalization are also required (*Rising Tide*, Alzheimer Society, 2010).

Behavioural and psychological symptoms of dementia (BPSD, i.e., agitation, aggression, psychosis, mood, and personality changes) are ubiquitous in dementia, with most patients expressing some BPSD at some point in their disease progression. Concurrent delirium in dementia can also exacerbate BPSD. While most BPSD is mild and typically manageable in LTC

facilities or elsewhere in the community, BPSD will predictably worsen in some situations such as undiagnosed delirium, lack of individualized care plans, and poor fit between client and environment. These factors and the general lack of education and training in the management of BPSD are modifiable and amenable to systemic improvements and a BPSD strategy in LTC.

However, even if the best strategies are implemented, there will remain a percentage of patients with severe BPSD requiring more intensive care or stabilization. If continuing care and acute care operate separately and without coordination, the system will have gaps in its ability to provide acute responses to crisis situations arising in LTC, such as acute BPSD. A strategy for acute response in the community for the management and stabilization of these patients is required, and the ED route is clearly a poor fit for a chronically ill, frail, and palliative population usually in the latter stages of dementia.

The time is right to develop a plan for severe BPSD in the community. In recent years there has been a considerable effort in CDHA to improve the system and provide more integrated and appropriate care for individuals suffering from the BPSD.

In spite of this work, it still is not uncommon for patients with acute and severe BPSD to be brought to one of the EDs for assessment and subsequent appropriate care. There have been at least half a dozen such cases at QEII in the last six months (verbal communication, Dr. Sam Campbell). These patients tend to remain in the EDs for excessively long periods while there is much discussion on disposition. This is harmful to the patient and wasteful of resources and staff time.

The purpose of this document is to outline guiding principles and areas of strengths to build upon, identify gaps in care in the community and in the acute care sector, and provide recommendations regarding a multi-pronged strategy for BPSD in CDHA, with a special focus on the ED.

This report provides:

1) a review of existing resources and strengths in planning pertinent to BPSD;
2) a review of significant obstacles in the system and gaps in resources for the management of BPSD in the community, inpatient units, and the ED;
3) recommendations in each sector aimed at closing existing gaps and removing systemic barriers to BPSD management; and
4) specific suggestions on a path for the care of persons with acute BPSD who come to the ED.

RESOURCES FOR BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA

Long Term Care Planning: Recently Developed Strengths

In preparation for the growing number of seniors requiring LTC in Nova Scotia, the strategy for LTC has been to add more beds in new facilities that are architecturally designed to support care of the challenging behaviours that can accompany dementia, increase the human resources for more custodial care through continuing care assistants (CCAs), and decentralize continuing care (CC) to each district.

In recognition of the need for increased acute service capacity for care in LTC, the DOH has also supported the initial implementation of a Nursing Home Medicine program, with a "physician per floor" model offering 24 hour medical coverage (funded to June, 2010 in CDHA, but not yet accepted as a desired model in all health districts). The fiscal element of the rationale for the physician per floor model recognized the high cost of transferring patients in LTC to EDs.

Nova Scotia purchased the PIECES (Physical, Intellectual, Emotional, Capabilities, Environment, and Social) program from Ontario in 2004 in order to increase our capacity for BPSD management in LTC. The PIECES Learning Initiative is a comprehensive training strategy to enhance the ability of LTC facility staff to provide care to individuals with complex physical and cognitive/mental health needs with associated behavioural disturbances.

Nova Scotia has only recently completed PIECES implementation, after a significant lag-time between the initial period of education in LTC which occurred in 2004, and hiring the challenging behaviours resource consultants (CBRCs) in the last year. In CDHA, there are now two PIECES CBRCs but the program will need some more time to be fully operational. Quality assurance/performance indicators are also currently being developed. Of note, the target audience for LTC education in 2004 was registered nurses (RNs), limited to just a few from each facility. Since then LTC has seen a shift toward the provision of care by more licensed practical nurse (LPN) positions and fewer RN roles. An updated education strategy for PIECES for LPNs in LTC would therefore now appear to be indicated.

The LTC strategy for Nova Scotia also included human resources for the ED to help redirect patients with BPSD — it is not clear exactly what will be implemented or when this will occur. Geriatric navigators were recently introduced at the Dartmouth General Hospital (DGH) and time will tell how effective this service proves to be.

Summary of Partners and Resources for Management of BPSD:

1) Department of Health with its many programs (those more pertinent to this report are individually described in this list)
2) Individual families
3) Caregivers NS
4) Alzheimer Society

5) Respite care
6) Adult Protection NS
7) Continuing care
8) Victorian Order of Nurses
9) Urgent Placement System:
    a. for those in community, there is a process for urgent placement to the “first available bed in the province”
    b. for those in LTC, the process for reclassification is cumbersome and protracted rather than “urgent” but occasional exceptions have been made on an urgent basis to bypass reclassification when handled in less than 30 days
10) Mobile Crisis Team: currently not staffed or trained in BPSD response, but does offer crisis response times
11) Urgent Care Clinic: currently staffed for urgent psychiatric follow-up for those who do not have follow-up. Not staffed or trained in BPSD response, but with similar model this could be a useful approach to closing a gap in LTC.
12) Family physicians
    a. in community practices
    b. in nursing homes
    c. in community health units
13) Community neurologists
14) Seniors Mental Health
    a. Consultation Team (response within a few days for urgent cases)
    b. Willow Hall (back-up resource for other inpatient units, and a tertiary acute care resource for the province)
15) Transitional care units
16) Emergency departments
17) Psychiatric Emergency Service at Queen Elizabeth II Health Sciences Centre
18) Nursing homes
19) Division of Geriatric Medicine, CDHA
20) Division of Neurology, CDHA
21) Division of General Internal Medicine, CDHA
22) Department of Psychiatry, especially General Psychiatry, CDHA
23) PIECES Program — only in community
24) Challenging Care Needs Network — only in hospital
25) Complex case managers
26) Department of Psychiatry Queen Elizabeth II Health Sciences Centre Consult/Liaison Service
27) Department of Psychiatry Dartmouth General Hospital Consult/Liaison Service
28) Department of Community and Social Services
29) Dartmouth General Hospital Geriatric Navigators
30) Kings Regional Rehabilitation Centre — MacArthur Unit
31) Emergency Health Services

CHALLENGES IN THE MANAGEMENT OF BPSD AND RECOMMENDATIONS

Management of Dementia: Mismatch between Clinical Needs and Level of Care

The list of partners and resources potentially available for the care of a given patient with dementia with or without BPSD is long and it is clear that while there is often cooperation between the various providers of care, there is a lack of overall coordination of resources. This situation results in gaps in care, and both under- and over-provision of care. There are, for example, patients suffering from dementia who remain in hospital in spite of the fact that their conditions have stabilized, while at the same time there are patients with acute BPSD in the community or nursing homes who may be able to benefit from assessment and treatment in hospital. The number of players and the lack of clearly demarcated roles and responsibilities foster a diffusion of responsibility.

To provide some concrete examples of the need for coordination of efforts, if new beds are being opened in LTC, good communication is needed to all consultant groups to ensure preparedness for providing services (geriatric medicine, psychiatry, palliative care, etc.) and to seek feedback regarding the need for expanded service and human resources needs. This currently is not being done even though new beds are being opened, and it appears that no single person has responsibility for this. If the TCUs are to be closed, good communication to the relevant groups supporting placement in the community should be provided in advance with opportunities for feedback on how consultant services will be provided. Of note, it is likely that a shortfall of several thousand LTC beds will still remain in the next decades under the current LTC strategy, and thus a decision to close beds would need to consider the potential need to reopen TCUs again. Any savings from these units closing, even if temporarily, should be redirected to increase capacity in the community, such as in the recommendations listed below in this document, with appropriate stakeholder involvement from Geriatric Medicine, Psychiatry and Family Medicine as well as LTC. All of these efforts require good coordination, communication, and planning, and at this time, there seems to be no one person responsible for bringing these various systems and stakeholders together.

Recommendation #1a: That CDHA develop an administrative structure to overcome "silos" of care and diffusion of responsibility for the care of patients suffering from acute BPSD, and for planning the integration of LTC needs with the acute care system. It is suggested that this administrative structure include a coordinator for urgent placement of patients with dementia, an advisory council comprising experts in geriatric care, and the Challenging Care Needs Network (CCNN).

#1b: That CDHA work with the DOH to create policies that support this structure.
(underlined for emphasis as a preferred option for urgent implementation)

Where Patients with Acute BPSD Receive Care

Problems arising from acute BPSD presentation to the ED will not be solved in isolation from the rest of the system, and community solutions and systemic barriers to smooth patient flow must be addressed. Strategies are needed to address the potential for acute BPSD arising in any environment. Appropriate levels of human resources will be required.

Patients with acute BPSD might be found:

- at home;
- in nursing homes;
- in hospital wards; and
- in the ED.

BPSD may be equally severe in all locations. Long stays in the ED environment are particularly unsuitable in the case of BPSD, and these can lead to deterioration in the health and wellbeing of the patient, and contribute to unsafe back-logs of other patients presenting to the ED who then cannot be seen quickly enough. There are a limited number of potential dispositions for patients with BPSD following assessment in the ED. Successful placement of a patient with acute BPSD at home is unlikely, and in nursing homes and hospital wards usually requires the development of an individualized care plan which can take days to weeks to complete.

Long stays in hospital wards are also less-than-ideal for patients with dementia: there is the increased risk of acquiring hospital-acquired infections; quality of life may be poor, with inadequate areas for ambulation and recreation, perhaps lasting for months and even years; and inpatient beds are often used inappropriately, preventing use by patients who urgently need an acute care setting for the management of their illnesses. Despite the acknowledgement that long hospital stays are undesirable, extended hospital admissions are typical for patients with BPSD. Even after behaviours are stabilized, these patients are frequently excluded from nursing home placement due to classification and nursing home admission policies. Thus, admitting patients from the ED to the hospital significantly impedes the flow of other patients from the ED into the hospital by utilizing acute care beds for long periods of time. To understand the issue of flow, one must consider the larger picture. There are typically two to 11 patients waiting in the ED for internal medicine beds on a daily basis because no beds are available for admission on medicine wards. The existence of long stay BPSD patients on internal medicine services will therefore increase the number of patients in the ED waiting for admission to acute care, thus significantly reducing ED flow.

Community Care at Home: Gaps and Recommendations for BPSD Management

1) Public Education Campaign in BPSD and Advance Care Directives

For those patients with dementia whose care is provided by families living in the community, visits to the ED are often precipitated by behavioural and psychological disturbances which overwhelm the caregiver. At that point, the family usually reaches a point of caregiver burnout,

and usually no previous discussion has taken place regarding palliative approaches to late stage care. These patients often end up in hospital and families usually expect their loved one to received intensive care, aggressive treatment, and community placement. Since placement is not always available, there are usually long wait times, and at times patients will live out the rest of their lives in hospital.

A coordinated effort is needed by Family Medicine, Geriatric Medicine, Geriatric Psychiatry, the Department of Health Promotion and Protection, the Department of Health, the Department of Seniors, Caregivers NS, and the Alzheimer Society to implement an effective public awareness campaign regarding the need for early decisions on appropriate care. Case-finding of high risk families and efforts at early intervention should be made in order for community-based solutions to be found in a timely manner, and thereby avoid inappropriate trips to the ED.

Recommendation #2: A public education campaign is needed to increase awareness of the need for families in the community to be prepared for difficult decisions, and avoid risks to patients associated with acute care in hospital. Families should not need to turn to the ED in order to have care needs met that should be provided in the community.

2) Support and Funding for Caregivers

The Alzheimer Society's *Rising Tides* document outlines the cost savings to the health care system that result from the care provided by families and caregivers. From a fiscal perspective alone, the health care system needs to do more to ensure that the mental and physical health of caregivers is protected throughout the process. Navigating the health care system and the maze of community resources is otherwise unnecessarily stressful for families at a time when caregivers are already under much stress.

Family physicians are often aware of the development of dementia in their patients and may be involved in providing care to such patients in community settings and in supporting the patients' caregivers. Thus family physicians are in the position to play an important role in the team of professionals providing care to the person with dementia still able to live in the community.

Recommendation #3: The Alzheimer Society recommends that a navigation system for caregivers be implemented to make the path of care for those caring for seniors at home easier to manage (see *Rising Tide* for details).

Long-Term Care Planning: Gaps and Recommendations for BPSD Management

An acute BPSD strategy is needed in LTC; regardless of optimal BPSD management and proactive early interventions, there will remain a small proportion of cases that will pose severe risks to clients and/or staff.

1) Urgent/Emergent Response to BPSD

The lack of urgent/emergent response to BPSD in the community constitutes a major gap in our current system, which will only grow larger as the population of seniors grows in size. In situations that have acutely escalated or including behaviours not responding to interventions, a strategy other than the ED is urgently needed. Possible models include:

a) Specialized care teams in LTC facilities (resourced, trained in handling the most challenging cases). This model has been found to have worked very well in The Cove Nursing Home in Cape Breton, i.e., "Level 3 Care". The cost is relatively low.

b) Challenging behaviours assessment and stabilization units in the continuing care sector — first proposed to government some time ago, and updated in September, 2008.

c) Mobile crisis BPSD team for LTC and the community — either as extension to the Mental Health Mobile Crisis team or SMH team, and with strong linkage between the services, but only if appropriate human resources are attached.

d) Mobile nurse practitioner model — immediate consultations for urgent/emergent BPSD.

e) Elements of the *Home First* program initiated in Ontario, in which home care coordinators and supervisors do more active case management such as seeing people more often and watching for decompensation. Those at most risk are tracked closely and interventions occur rapidly to avoid the ED. A team assesses those who come to the ED to rule out need for admission for medical reasons and address the issue of advance directives/appropriate care, and to provide follow-up for short-term respite in the community until longer term placements are arranged. The team would have pre-approval for any of the resources they feel are needed to wrap around someone for the short term. Emergency Health Services personnel are more involved in the evaluation and management of these cases in the community and thus bring only appropriate patients to the ED.

Recommendation #4: One or more of several established models for acute stabilization of and crisis intervention for BPSD in the community should be adopted in Nova Scotia in order to avoid further escalations in the inappropriate use of the acute hospital care system. The options include:

a) Specialized care teams in LTC facilities

b) Challenging behaviours assessment and stabilization units

c) Mobile crisis BPSD team for LTC and community

d) Mobile nurse practitioner model — immediate consultations for urgent/emergent BPSD.

e) *Home First* program with active case management by Home Care

2) Shortfall in Number of LTC Beds

More LTC beds and community resources are required to meet projected needs. An insufficient number of LTC beds are planned at present for the projected population changes. Across the province, only 1,320 beds are being added to approximately 6,000 already existing, yet projections indicate that the number of seniors will double and long-term care needs will increase by a factor of 2.5 within 20 years. Therefore, the projected shortfall of beds in Nova Scotia will likely be well over 4,000.

Recommendation #5a: More LTC beds will be required than are currently being built and more intensive community management plans, services and resources will be required to compensate for the LTC shortfalls.

Recommendation #5b: LTC beds must be optimally utilized to allow care of patients with BPSD. The recently added beds have been designed to allow care of patients with dementia, and some of the new units could be designated for care of BPSD. New policies will, however, also be required for optimal bed utilization.

3) BPSD Education Strategy in LTC

A key priority in CC (and the acute care sector too) should be to implement a strategy for additional education and skill development among all staff in understanding, assessing, and managing BPSD. This will allow staff to help identify problems early, and intervene via non-pharmacological strategies, utilizing PIECES challenging behaviour consultants when needed.

Recommendation #6: Education about dementia should be provided to a broad range of staff in acute care, community-based care, and LTC facilities in order to increase capacity significantly.

4) Physician Leadership for BPSD and Palliative Care

a) Physician support and leadership is urgently needed to increase capacity for effective BPSD management, including the use of non-pharmacological and pharmacological strategies. An education strategy for family physicians, in collaboration with the SMH team, Geriatric Medicine and the PIECES program should be developed as a top priority in order to prevent transfers from LTC to the ED. More active collaboration is required among Palliative Medicine, Geriatric Medicine, and the SMH team to ensure that interventions are coordinated and timely. Direct responsibility and communication between Nursing Home Medicine physicians and the ED is needed before transfers from LTC to the ED occur. An on-call rota of family physicians could, for example, be provided to the ED to enhance communication about treatment strategies and discharge.

Recommendation #7a: All patients in nursing homes should be properly assessed with written documentation by the associated family physician before transfer to the ED. There should be direct telephone communication between the Nursing Home Medicine physician and the ED physician prior to transfer to explain the rationale, provide information regarding the patient's baseline, and indications for further investigations/consultations/care/ disposition.

b) Appropriate care and palliative care models in LTC urgently need to be developed and implemented. All clients admitted to LTC should have a comprehensive geriatric assessment to determine their level of frailty and general prognosis. Discussions with patients and family are needed to review expectations, likely prognosis, and appropriate plans if BPSD or other complications develop. Do not resuscitate (DNR) orders and other advance directives should be made clear on the charts. Palliative orders should be indicated on the chart where appropriate. Visits to the ED should be avoided in cases of severe dementia or frailty, as the prognosis for acute interventions is poor in these cases.

The Nova Scotia Personal Directives Act came into effect on April 1, 2010, and requires that home care coordinators meet with all patients in LTC and their families to discuss the content of the advance directives. Consistency in the approach to these discussions will be necessary to ensure that these discussions result in appropriate decisions.

Recommendation #7b: Family education/discussion of appropriate care should occur in LTC to ensure that excessive and inappropriate interventions do not take place (with attention to personal directives when they exist); LTC facilities will need to work directly with care coordinators to develop a consistent approach to these discussions with those living in LTC.

5. Strengthening the Effectiveness of Nursing Homes in Managing BPSD

a) Proactive Approach to BPSD

BPSD can be dealt with early to avoid escalations and ED visits. BPSD management needs to be proactive rather than reactive, with care plans established before peak escalation. There should be a "point person" or care coordinator in each LTC responsible for the management of behavioural disturbances (just as there is a nutritionist responsible for diet). This individual would have an idea of the clients with various levels of behavioural problems related to dementia at all times and would work actively and directly with PIECES managers, Nursing Home Medicine, Geriatric Medicine, the SMH team, and Palliative Medicine to ensure that interventions in LTC are coordinated and timely.

Recommendation #8a: A more proactive approach to BPSD should be taken by each nursing home with the identification of a care coordinator in each facility to assume responsibility for monitoring all cases posing care challenges to LTC staff in order to develop care plans and intervene early.

b) Formalize PIECES Relationships

There are now two PIECES managers in CDHA but there is no formal relationship between these PIECES personnel and other services — PIECES personnel operate independently.

It is, however, clear that PIECES personnel, the Physicians per Floor, Geriatric Medicine, and SMH personnel have complementary relationships in the nursing homes. In order to avoid "silos of care", it is suggested that clear relationships be established for PIECES staff, possibly with the medical director of the LTC facility or perhaps others. Clarity should also be established in the key affiliative relationships with geriatric medicine, SMH, etc.

Recommendation #8b: That PIECES have strong and clearly delineated relationships to the other elements of the health care system in order to promote better integration of services.

Hospital/Acute Inpatient Care Planning: Gaps and Recommendations for BPSD Management

1) Remove Systemic Barriers

Key systemic barriers like nursing homes "refusing" patients, "unclassifiables", and the "30-day-rule" need to be resolved and made to work for patients before these bottlenecks in the system intensify with growing numbers of seniors. Several elements of the 30-day-rule appear to be problematic, including the provision of payments to the nursing homes for vacant beds (thus patients may stay in hospital while a bed is vacant, because the bed is being paid for during the 30 day period), and the loss of the right to a previously occupied bed at the end of the 30 days. Thus LTC bed use is not maximized. Long wait-times for the classification process in alternative level of care (ALC) patients need to be streamlined and shortened. CDHA needs to be able to match the most challenging patients to a good-fit environment in a timely fashion. Linkage and smooth working relationships between key clinical decision-makers in each district with a mechanism for urgent placement and moving patients should be established to ensure a "good-enough" fit of environment for more challenging cases. In Ontario, the Ministry of Health and Long-Term Care has been working with nursing homes to abandon the policy of "right of refusal", and the Toronto Rehabilitation Unit, the mandate of which is to stabilize BPSD, insists that patients return to nursing homes within 45 days.

Of note, when patients are admitted from LTC facilities the province is essentially paying for two beds for one person — the one held at the nursing home and the acute care bed. The province also needs to look at why it is paying for LTC beds which are not filled within 48 hours (which occurs especially during holiday/slow times due to lack of available assessors, etc.). This under-funded and under-resourced area needs to change to facilitate timely (and more cost effective) flow.

The LTC application process is also due for an overhaul: the paperwork, which can be nursing home dependant, leads to delays in the application process itself (e.g., waiting for Canada Revenue Agency statements or families finding time to sign paperwork) and the medical forms

are not specific in goals of care which would be helpful downstream. Priority is often determined by date of application for LTC rather than urgency of need.

Recommendation #9: Systemic barriers to the flow from acute care to community care must be addressed and eliminated without delay. These include an urgent placement or movement mechanism for the more challenging cases to a good-fit environment within LTC:

- **nursing homes "refusing" patients should become an exceptional event;**
- **"unclassifiables" should cease to exist (to permit this major step, some environments in nursing homes will require modification);**
- **the "30-day-rule" should be thoroughly reassessed;**
- **patients with stabilized BPSD should be discharged from hospital without delay; and**
- **a CDHA coordinator for urgent placement of patients with dementia is needed to match clinical need with the appropriate level of care.**

2) BPSD Stabilization

Willow Hall can be utilized as a resource for transfer from other inpatient units for acute BPSD stabilization for the most challenging cases, and transferred back as soon as stabilization has occurred. Willow Hall is a 19 bed acute geriatric psychiatry unit and tertiary resource for both Capital District and the province, and is a consultative resource for the most challenging cases in the province. Willow Hall is not a residential unit, nor exclusively a dementia care unit as it serves a full spectrum of late life mental disorders: severe depression, psychotic illnesses, bipolar disorders, late onset schizophrenia, and conditions requiring ECT, in addition to dementias, usually those with prominent psychiatric presentation requiring acute stabilization. A consultation from the SMH team is needed before transfer to Willow Hall.

The 30-day-rule reduces the ability of Willow Hall and other inpatient units to discharge patients back to nursing homes when they are ready to leave the unit. It usually takes several months for complex challenging behaviours in the context of dementia to settle down. Loss of bed, reclassification, etc., constitute unnecessary obstacles to patient flow through acute care. A lower length-of-stay (LOS) is a goal of Willow Hall, and if transfer to TCUs were an option, this unit could achieve a higher rate of patient turnover (i.e., look after more patients).

Recommendation #10: Willow Hall should be utilized as a specialized acute care and consultative resource for other inpatient units. A consultation from the SMH team is required prior to transfer to Willow Hall, and transferring units should be prepared to accept patients back following stabilization.

3) Transitional Care Units

TCUs are currently located in the QEII (Victoria General) and DGH. Patients in the TCUs are awaiting placement in nursing homes or possibly other community placements. The TCUs

provide a route for stabilized patients to be discharged from hospital; the existing TCU at DGH will be maintained while the one at QEII will be decommissioned.

Psychiatry units including Willow Hall have high numbers of patients declared ALC and lower than optimal turnover. The large number of ALC patients currently residing in the CDHA Mental Health Program (MHP) beds (about 25–30%) makes it very difficult to admit patients with BPSD to these beds — usually 40–50 non-forensic beds are occupied by ACL patients, out of a total of about 160 non-forensic MH beds; and the MH acute inpatient system operates close at a very high level of occupancy. QEII has a smaller proportion of ALC patients, lately around 3–4% and DGH has about 10–15%. The placement of ALC patients is much faster from medical/surgical beds than from mental health beds — on average about 1.5 mental health ALC patients are placed per month, an order of magnitude less than the medical/surgical beds. All inpatient beds within the hospital providing stabilization of BPSD, however, should be given priority to ensure flow of patients back to community placement.

Recommendation #11: If TCUs are to be closed, good communication to the relevant groups should be provided in advance, with opportunities for feedback. Any savings from the closing of these units should be redirected to increase capacity in the community. TCUs or similar structures to be established in the place of the existing TCUs will need to be made broadly accessible in order to free acute care beds for appropriate use.

Emergency Department Planning: Gaps and Recommendations for BPSD Management

If the preceding recommendations for home, nursing home, and inpatient units are adopted, there should be fewer cases of BPSD presenting to the ED. Some cases, however, will continue to present. When they do, the ED stay of a person with BPSD should last only as long as her/his need for a thorough assessment. There are several possible clinical situations involving agitation in an older person, each requiring different consultants. Those services offering ED consultations include: neurology, geriatric medicine, internal medicine, family medicine, and DOP/MHP psychiatric emergency service (PES). Other resources include the social worker in the ED, and linkages to community resources including adult protection, Caregivers NS, etc.

1) Streamline Care Pathway Based on Triage by the ED Physician

The ED physician should determine the most likely reason for the BPSD presentation, and direct the case accordingly in order to streamline care.

a) Cases of true delirium in LTC: the family physician from the nursing home should already have assessed the patient and communicated directly with the ED physician to explain the rationale for assessment in the ED of a diagnosed or suspected acute medical condition presenting as a delirium and the clinical issues including baseline functioning and the goals of assessment. If after assessment the ED physician decides that referral for consultation is required for the management of the acute medical condition, consultations should be directed to the appropriate specialty service.

b) Acute psychiatric decompensation from LTC or community: those with known chronic primary mental illness living in LTC or at home (with or without dementia) with acute decompensation of psychiatric illness should be seen by PES staff. Admission to psychiatry units may be appropriate for some such patients.

c) Decompensation in the caregiver/provider's ability to cope in the absence of a medical or acute psychiatric indication for admission: these cases should be redirected for community management and a visit to the ED or admission to hospital should be avoided. When such cases arrive at the hospital, social work should help to triage the situation and review community supports and possible placement including short-term respite, placement in private facilities, collaboration in follow-up by appropriate services, adult protection, linkage to urgent placement options, etc. There is a serious risk that presentation to the ED will become a venue for faster and easier placement into long-term care. As such, a nursing home triage system needs to attend to patients and families with extremely difficult problems that cannot be managed at home.

Note: The SMH team is a specialized care team serving patients over age 65 who experience new onset psychiatric disorders or have complex medical/dementia problems complicated by psychiatric presentation. The SMH team has three major clinical service mandates: 1) non-urgent community outreach for patients in their homes or in nursing homes; 2) outpatient consultations; and 3) inpatient care on Willow Hall, as well as consults to other hospital wards. The team offers non-emergent BPSD follow up in the Capital District, and acts as an educational resource for SMH care in the Capital District and province. The SMH team is not staffed or set up as acute/ED response team, and without additional human resource support and a change in mandate in terms of outreach to the community, the SMH team cannot reliably function as an ED service as well. The SMH team remains available to consult on a patient admitted or a patient discharged back to the community, usually responding within a few days, and will be just one part of a system solution to BPSD management.

Recommendation #12: Community services are needed to respond more urgently to those individuals with high levels of acuity due to dementia and frailty. Without a triage plan, the seamless care of patients who present to the ED with dementia or frailty will be suboptimal. The ED physician should triage any cases of BPSD to determine the underlying cause for presentation, and based on the presentation, decide whether a consultation is required. Services available include: neurology, geriatric medicine, internal medicine, family medicine, PES, or the ED social worker. While not providing direct consultation in the ED, following disposition from the ED, the SMH team and psychiatry consult/liaison (C/L) team would be available for consultation as indicated, C/L usually within 24 hours, and SMH usually within 72 hours for urgent cases. Appropriate communication between the ED and community-based services will be essential for the appropriate treatment of such patients. In addition, the recommended BPSD management services within the ED should arrange disposition of cases not suitable for admission to hospital.

2) Disposition of Cases of BPSD

If admission for delirium or acute BPSD is required, then accessing a bed in the system is often a challenge that creates unacceptably long delays in the ED. Internal medicine is often short of available beds and the Family Medicine Community Health Unit (CHU) in the Halifax Infirmary already has many patients awaiting placement in nursing homes. The Abbie J. Lane 9th floor has a total of 25 beds — about 12 Geriatric Assessment Unit (GAU) beds, 10 Progressive Care Unit beds, and three Family Medicine beds. ALC and long stay patients decrease the effectiveness of the units to care for acutely ill and frail older patients.

The challenge of admitting patients with BPSD to an acute care hospital is that there is typically nowhere for them to be discharged to once their behaviours are controlled.

A brief stay in the ED for the careful planning of a suitable disposition for individuals with difficult BPSD may be required but this should last no longer than the end of the day following presentation. The precipitate admission of an individual with BPSD not meeting criteria for admission to the hospital should be avoided. Due to existing policies, such as a nursing homes' "right of refusal" and the need for classification, once individuals with BPSD are admitted to the hospital it is common for them to stay there until they pass away, even when behaviours are reasonably controlled. In hospital, due to a positive status of Methicillin-resistant Staphylococcus aureus (MSRA) and other problems, individuals admitted for BPSD frequently live behind a half door or in the inappropriate environment of an acute hospital ward, sometimes for years. Premature admission to the hospital without a definite discharge plan may impact flow in the ED as much as keeping someone in the ED to develop a reasonable discharge plan, because admission to hospital and subsequent long stays block beds for future admissions, and commits a person to a poor living situation for months or even years.

For the health of the patient and the wellbeing of the health care system (as it is currently configured) appropriate resources in the ED are essential to ensure appropriate disposition.

Recommendation #13: If it is judged that a patient with BPSD requires admission as a result of serious risk to self or others, the patient should be admitted. If necessary, suitable transfers should be arranged by the coordinator for urgent placement of patients with dementia in order to permit admission.

3) Additional Urgent Care Resources for BPSD Management in the ED

Closing care gaps in the ED for BPSD patients will require additional human resources. The LTC strategy for CDHA does not currently include ED consultants but should do so. These positions should ideally be filled by a social worker and a registered nurse with sufficient training in care of the elderly and support from SMH, geriatric medicine, and family physicians connected to the LTC system. They could function much like the urgent care team in psychiatry, providing follow-up for BPSD in LTC or in homes in the community for a few days until other resources are linked. A direct working relationship with continuing care would be essential.

Recommendation #14: An urgent BPSD management team (with input from specialists with training in geriatric care) should be established to work with the ED staff for appropriate disposition and to provide direct follow-up and linkage to community resources, among other responsibilities.

4) Summary of Recommended Care Path for Patients with BPSD in the ED

1) Patient is assessed by ED physician, then in consultation with the BPSD management team and the social worker in the ED.
2) Return to nursing home or home with a care plan developed by the specialized BPSD care team that is supported by community resources, such as PIECES coordinators, continuing care, staff in LTC, family medicine, geriatric medicine, and geriatric psychiatry as indicated within a few days.
3) When needed and possible, urgent placement in respite or LTC should be attempted. A similar pathway for urgent placement should be concomitantly developed in the community, as the home is the most appropriate place for assessment and fair decision-making.
4) If the steps above prove not to be feasible, the coordinator of urgent placement arranges admission. A stabilization unit should be available for the care of patients with very difficult behaviours. Any such unit will not be successful unless there is a workable plan for transfer to the nursing home once behaviours are stabilized. Willow Hall would remain an active resource when stabilization is not achieved.
5) With guidance from the coordinator of urgent placement, inter-unit and other exchanges/transfers should be accomplished in a speedy and efficient fashion with few players and cooperation rather delays from multiple refusals.
6) The DOH needs to revise their policies and procedures with regard to nursing home placement and acceptance.