# *THE JOURNEY TOWARDS DIGNITY & RESIDENT-CENTERED CARE:*

## SUMMARY RESULTS FROM THE CALL FOR LESS ANTIPSYCHOTICS IN RESIDENTIAL CARE

March 2015

This report shares the story of **CLeAR** (the Call for Less Antipsychotics in Residential Care), an initiative facilitated by the BC Patient Safety & Quality Council (BCPSQC), in partnership with the Shared Care Committee, to reduce the inappropriate use of antipsychotic medications in BC's residential care facilities. It shares results and learning from the initiative, and celebrates success and progress made by improvement teams across the province.

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# WHY FOCUS ON REDUCING ANTIPSYCHOTIC MEDICATIONS IN BC RESIDENTIAL CARE?

## The Challenge

*Imagine that your mother is living in a residential care facility and experiencing changes in behaviour and mood, loss of memory, and impaired thinking and communication skills. One night she was very agitated, unable to rest and given an antipsychotic medication which helped settle her. However, she continues to be given this medication and the mom you knew seems to be fading away…*

Today's generation of seniors – our mothers and fathers, grandmothers and grandfathers – are living longer, with a better quality of life than ever before. Residential care facilities strive to provide the best care possible for residents. However, seniors in long-term care are vulnerable to receiving potentially inappropriate medications, including antipsychotics[1]. The challenge is ensuring the safe and effective use of these medications, while limiting inappropriate use and serious side effects.

In 2013-2014, 30.2% of residents in Canadian residential care facilities were prescribed antipsychotic medications without a diagnosis of psychosis; in British Columbia, it is 32.5%[2]. There is also great variability between facilities, from near-zero rates to almost 100%. These variances may be due to differences in resident populations being served or can reflect inappropriate use of these medications and lack of alternative approaches to managing behaviour.

Many individuals living in residential care have dementia and experience the commonly-associated behavioural and psychological symptoms of dementia (BPSD). These behaviours are increasingly viewed as "responsive behaviours", a response to a cue or trigger and that person's attempt to communicate his or her unmet needs.

1 Rancourt, C. et al. (2004). Potentially inappropriate prescriptions for older patients in long-term care. BMC Geriatrics, 4 (9).

2 Canadian Institute for Health Information. (2014). Your Health System. Retrieved 2015, from http://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/008/2/C9001/

## An Opportunity for Improvement

There is a growing recognition that antipsychotic medications are being used in a population that exhibits responsive behaviour but without demonstrable psychosis or mood disorders. An opportunity exists to improve care for people with dementia and BPSD in residential care; to improve the experience of care for residents, their families, and staff through a relational quality of life approach; and to have, on balance, the most cost-effective approach to care as savings will be realized in better resident outcomes.

Evolving best practice emphasizes care relationships that are supportive and meet the needs of the residents in the last phase of life within residential care. Initiatives in the United Kingdom, Manitoba[3] and Alberta, as well as a small number of facilities in our own province, have successfully reduced the use of antipsychotics.

In BC, the momentum to address inappropriate use of antipsychotics has grown with the development of the Best Practice Guideline for Accommodating and Managing BPSD in Residential Care[4] and its related BPSD algorithm (http://www.bcbpsd.ca/). These resources were developed by a provincial collaborative group that originated and was led by Interior Health and included representation from all of the province's health authorities, the Ministry of Health, general and specialist physician partners, community pharmacists, and the BCPSQC.

Although the focus of the BPSD guidelines is on quality of life and caring relationships, there is also a related economic opportunity. In the United Kingdom, a population-based economic analysis examined the cost of prescribing antipsychotic medication versus non-pharmacological approaches[5]. Findings showed that, on balance, non-pharmacological approaches related to fewer falls and strokes, resulting in these approaches being more cost-effective.

3 Canadian Foundation for Healthcare Improvement (2014). Improving the lives of patients at personal care home in Winnipeg and beyond.

4 British Columbia Ministry of Health. (2012). Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care: A Person-Centred Interdisciplinary Approach. Retrieved 2015, from http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf

5 NHS Institute for Innovation and Improvement (2011). An economic evaluation of alternatives to antipsychotic drugs for individuals living with dementia.

The BPSD algorithm has proven to be a useful resource. It offers evidence-based tips and tools as well as non-pharmacological approaches[6] to person-centered dementia care. It outlines a stepped care approach with the following guidance on the appropriate[7] use of antipsychotics:

*If, after careful assessment, development of individualized person-centered care plans and implementation of non-pharmacological approaches for BPSD, there are ongoing verbal/physical aggression and/or psychotic symptoms related to dementia that is dangerous, distressing, damaging to social relationships and persistent, then antipsychotics may be considered, with ongoing monitoring and review instituted.*

There is an opportunity to decrease indications for the initiation of antipsychotic drug therapy and, when drugs are prescribed, to increase monitoring, reviewing, tapering, and discontinuation with follow-up.

6 E.g. providing structure, scheduling events to adjust for a resident's needs, involving relatives in care planning and shifting agitated residents into activities they like to produce a calming effect such as going for a walk or listening to music.

7 From the BC Health Quality Matrix, defined as care that is provided is evidence-based and specific to individual clinical needs (https://bcpsqc.ca/blog/knowledge/bc-health-quality-matrix/)

# CLeAR'S GOALS

**On January 18, 2013, the BCPSQC invited key stakeholders from across the province to join together in a day of visioning and discussion around the meaning of dignity in residential care, with a special focus on appropriate use of antipsychotics, the current state of antipsychotic use by people living in residential care in BC and an overview of work currently underway throughout BC, nationally and internationally to identify opportunities for alignment and learning from others.**

The ultimate goal of this session was envisioning an ideal state whereby appropriate use of antipsychotic medications can be achieved and framing a call to action that would ask teams from residential care facilities in BC to join.

This meeting formed the basis for the development of the CLeAR initiative. In June 2013, the BCPSQC invited residential care facilities, and those that cared for residents who experience BPSD, to join the call to action to improve care for this population. This learning and improvement initiative offered support through resources, improvement coaching, an opportunity to collectively learn and problem solve, as well as the development of new strategies to improve care for residents and their families. Together, they decided on the following goal:

***The aim of CLeAR was to achieve a province-wide reduction of 50% from baseline in inappropriate use of antipsychotics through evidence-based management of the behavioural and psychological symptoms of dementia for seniors living in residential care by December 31, 2014.***

This voluntary quality improvement initiative was designed to support interested inter-professional teams of residential care providers in their efforts to:

- address BPSD (within the context of provincial priorities, policies and initiatives);
- enhance support to achieve goals for work already underway versus creating new work;
- build capability and capacity for improvement in residential care; and
- bring the system together to create a vision of what we can achieve for residents with BPSD.

# THE APPROACH

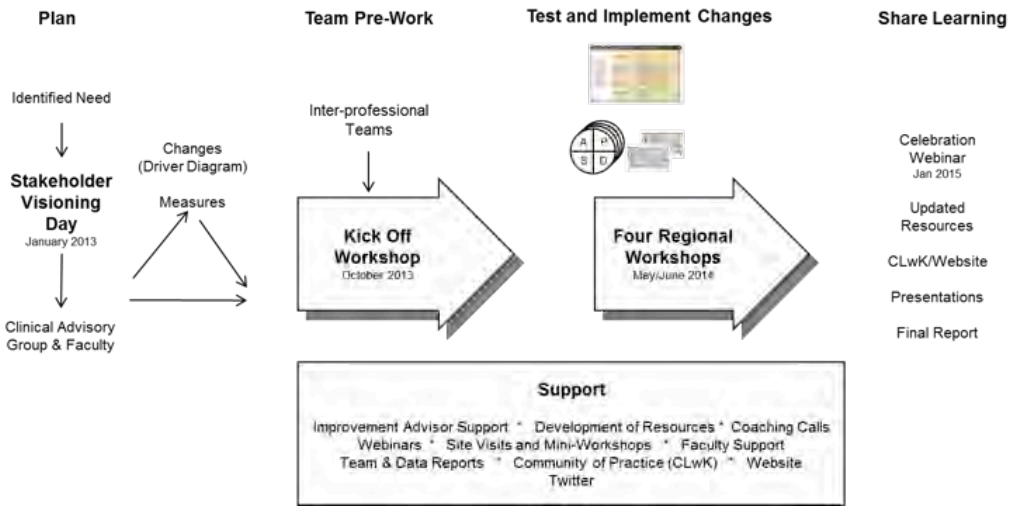
**The CLeAR initiative was facilitated by BCPSQC in partnership with the Shared Care Committee. CLeAR was envisioned as an action-oriented implementation of the provincial BPSD best practice guideline and algorithm, as well as related health authority and care facility approaches to enhance the dignity of seniors in residential care.**

Since many care facilities wanted to address best practice approaches to BPSD and the use of antipsychotic medications (or had already started doing so), this initiative was aimed at supporting and accelerating work already underway across the province.

Forty-eight residential care facilities across the province joined the CLeAR initiative. Of these, 15 were health authority owned and operated, 26 were affiliated sites and 7 were denominational facilities. See Appendix A for a list of participating teams.

In addition, over 90 organizational partners and 102 individual members enrolled. These are facilities and individuals that did not have active Improvement Teams, but may have participated in online learning and utilized CLeAR resources as they needed. A Partnership Alliance provided oversight and guidance to the initiative. Active clinical leadership was provided through our Faculty members and Clinical Advisory Group.

This diagram outlines the CLeAR approach.



## Team Pre-Work

CLeAR was aimed at those who work in and support residential care facilities. It encouraged the voluntary involvement of residents, family members, staff, family physicians, specialist providers, and inter-professional care delivery teams to develop care approaches that reduce distress from BPSD. When Improvement Teams enrolled, they committed to:

- Sharing resources and guidelines;
- Working towards care redesign;
- Learning about quality improvement;
- Receiving improvement coaching and support;
- Participating in local, regional and provincial learning activities;
- Learning and problem-solving with others;
- Supporting the development of new strategies to improve care for residents;
- Learning from initiatives that have already dramatically reduced the use of antipsychotics;
- Applying evidence-based guidelines and implementing within their local context;
- Testing new ideas;
- Sharing what they've learned with each other; and
- Contributing to the provincial aim of antipsychotic reduction.

## Kick-Off Workshop

In October 2013 over 170 people, including 45 improvement teams, faculty members and other stakeholders, came together in Vancouver, BC, for a one-day "kick-off" of CLeAR. The purpose was to learn about best practices and develop further capability around improvement. Teams were introduced to strategies and changes to try at their facility and given resources such as a Culture Change Toolbox[8], a Driver Diagram[9], and a data collection spreadsheet. Comments from participants include:

*"This is an opportunity to speak up to colleagues, educate, and become leaders"*

*"It's about more than antipsychotics"*

*"Now I have energy that I'll take back to my workplace"*

*"We're starting to break out of the norm and step away from our comfort zones"*

8 A guide that contains tools that can be used as the focal point for a shift in culture – designed specifically for use in residential care facilities

9 A powerful tool to translate a high level improvement goal into a logical set of underpinning drivers and change ideas

## Testing and Implementing Changes and Support

Over the next six months, teams refined their goals, identified interprofessional team members, assessed their processes and began testing changes locally. Physicians were engaged at residential care homes as appropriate, supporting staff in medication reviews and titration, discontinuation and monitoring. Teams shared their progress monthly through data and team reports. Teams continued to test and adapt their changes as they learned, identified new areas of opportunity and addressed barriers to improvement. BCPSQC Improvement Advisors (IAs) provided support to teams via coaching calls, report feedback and site visits and hosting webinars on topics ranging from data collection to family engagement. Teams learned improvement strategies like how to test changes, create culture change and strategies for sustainability. Resources were developed to address common challenges. A community of practice on CLWK.ca was launched in March 2014 to help teams connect and share.

During this time, faculty members supported CLeAR by:

- Providing guidance, expert advice and education;
- Providing clinical expertise and perspectives to inform the identification and development of resources, tools, clinical information and other related materials;
- Participating in webinars, online discussions and meetings with teams on an ad hoc basis; and
- Responding to questions on clinical issues via email or the online community of practice.

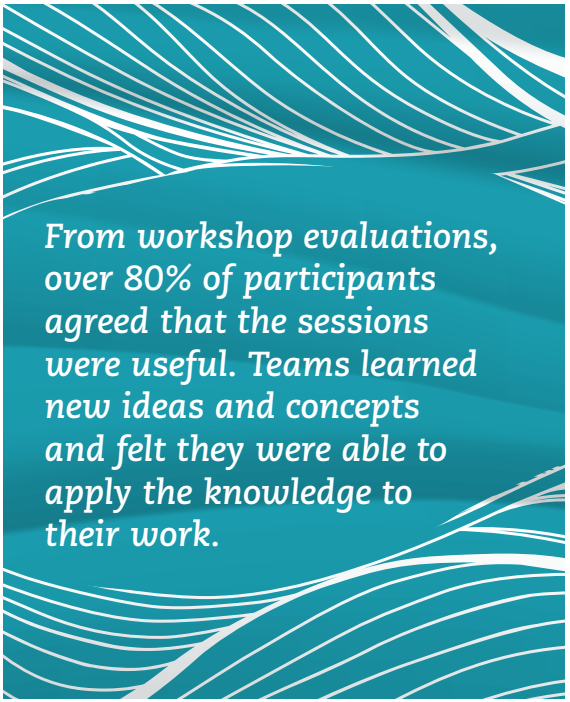
*"My ah-ha moment involved a nurse who I initially saw as resistive to antipsychotic reductions. I noticed her bring up the subject in a medication review with our Medical Director and she pursued the possibility of reductions for the client they were discussing. I felt the glimpse of culture change."*

MAPLEWOOD HOUSE

## Regional Workshops

In May and June 2014, over 150 participants from improvement teams attended one of four Regional Workshops to:

- Celebrate their hard work and success to date;
- Assess progress;
- Hear new ideas from CLeAR faculty and other teams;
- Share and learn how to build upon successes and overcome barriers;
- Build upon improvement skills;
- Look at pivotal change ideas (including the driver diagram and BPSD algorithm); and
- Continue to build a local community for ongoing sharing, learning and sustainability of the work.




*"(The most useful part of today's session was) the discussion groups around the flipcharts and interacting with the residential care staff, networking, looking at all the storyboards, stealing ideas to take back to our facility, the stories, especially sharing the challenges and difficulties."*

PARTICIPANT

*"Sharing ideas from other sites - gets creative juices going…So many great ideas – (it was) inspiring."*

PARTICIPANT

*"I found it all useful and informative! The 'Overcoming the Barriers' section gave me ideas on how to work on change implementation and introducing the BPSD (guidelines) in our workplace."*

PARTICIPANT

Appendix B highlights examples of team storyboards that were shared at the Regional Workshops. After the workshops, improvement teams continued to test and implement changes at their facility and apply what they had learned.

The CLeAR journey, history and timelines are described visually at the following link http://ow.ly/Kda4p

# RESULTS

**Improvement teams have made significant progress towards their goals by adapting existing knowledge to their own environments, with many individual facilities seeing dramatic reductions in their use of antipsychotic medications.**

***From the CLeAR Post-Initiative Survey, 79% of respondents were satisfied with their progress in reducing the use of antipsychotics and 66% of them felt their teams accomplished the goals they originally set out to achieve.***

## Aggregate Results

In aggregate, there was a steady decline in any antipsychotic use in participating teams, from 38% in October 2013 to less than 32% in December 2014. This steady decline has led to evidence of special cause variation[10], as seen in the first control chart on the next page with 8 consecutive points decreasing and one point below the lower control limit, indicating a statistically significant reduction and improved results.

10 Variation resulting from causes that are not part of the system (process or product) all the time or do not affect everyone, but arise because of specific circumstances

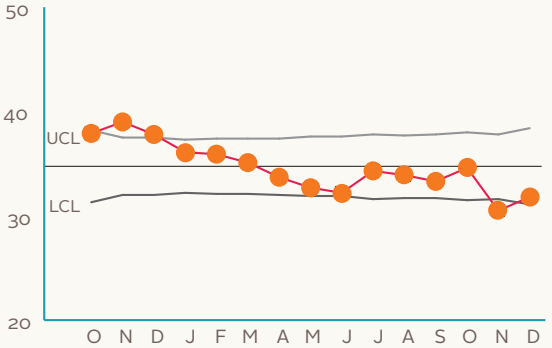
Achieving a 50% reduction for the entire province was challenging. Aggregate measures average individual improvement efforts achieved by each team. There was also variation in the number of teams who shared their data each month, from 20 to 38 teams.

Other factors affected these measures at the individual facility level. The population in a residential care facility is not static. Teams found they would make progress on discontinuing antipsychotics for an individual resident, but when that resident died, a new admission would often arrive on antipsychotics. Their data appeared "flat" even though they had made progress with individual residents. Some teams started tracking "Number of new admissions on an antipsychotic". Not only did it help to put their outcome data in context, these additional measures helped to inform teams where to take action. An early review suggests that 20 to 80% (average 50%) of new admissions arrive in residential care on an antipsychotic medication.

In addition, the outcome measures do not take into account the number of residents that had their dosage reduced. As a result, several teams started tracking "Percentage of residents on a reduced dose" as even small reductions in the use of antipsychotics can lead to improvements in quality of life.

## PERCENT OF RESIDENTS PRESCRIBED TO RECEIVE ANY ANTIPSYCHOTIC

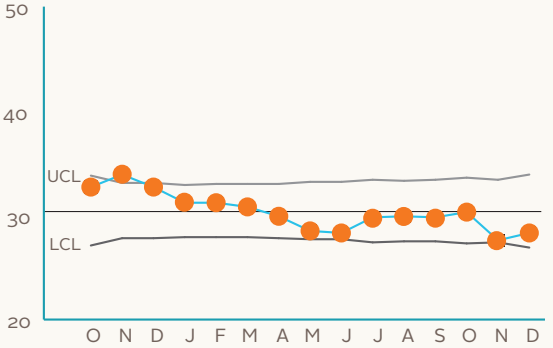
*Provincial Aggregate*




**PROVINCIAL ANY:** % of residents prescribed an antipsychotic within participating facilities submitting reports and is calculated by counting the total number of residents prescribed any type of antipsychotic divided by the total number of residents.

## PERCENT OF RESIDENTS PRESCRIBED TO RECEIVE AN ANTIPSYCHOTIC REGULARLY

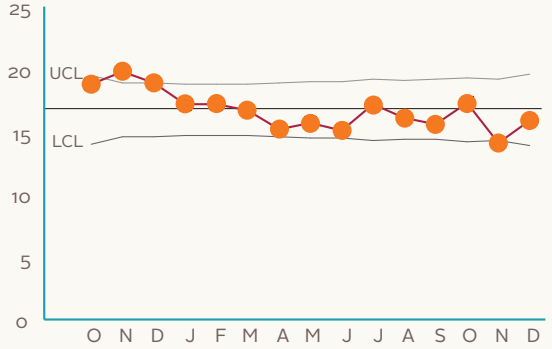
*Provincial Aggregate*




**PROVINCIAL ANY REGULAR:** the % of residents on an antipsychotic prescribed to be given regularly in participating facilities submitting reports and is calculated by counting the total number of residents with an ordered regularly given antipsychotic divided by the total number of residents.

## PERCENT OF RESIDENTS PRESCRIBED TO RECEIVE AN ANTIPSYCHOTIC PRN

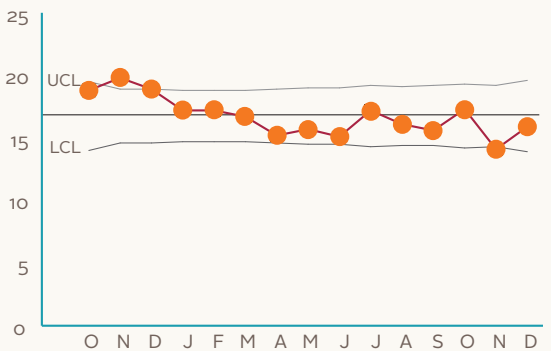
*Provincial Aggregate*




**PROVINCIAL ANY PRN:** the % of residents with an antipsychotic prescribed to be given PRN[11] in the participating facilities submitting reports and is calculated by counting the total number of residents with a PRN antipsychotic divided by the total number of residents.

## PERCENT OF RESIDENTS PRESCRIBED TO RECEIVE AN ANTIPSYCHOTIC BOTH REGULARLY AND PRN

*Provincial Aggregate*




**PROVINCIAL BOTH PRN AND REGULAR:** the % of residents with both PRN and regular antipsychotics prescribed in the participating facilities submitting reports and is calculated by counting the total number of residents with both PRN and regular antipsychotics divided by the total number of residents

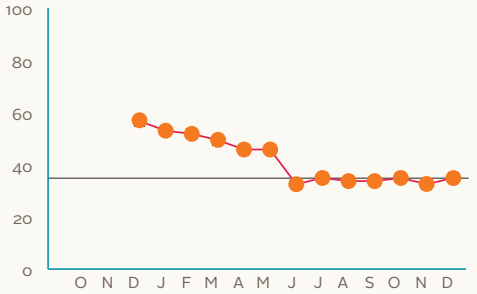
11 Pro re nata (PRN) - A Latin term that means "as required"

*Multiple measures, including qualitative data and stories, are important to understand the system and to learn if changes are leading to improvement.*

# Sample of Team Results

## CEDARVIEW LODGE

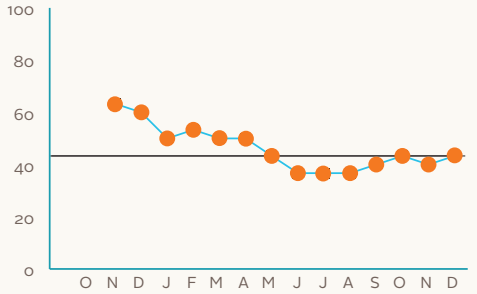
**% OF RESIDENTS ON ANTIPSYCHOTIC (ALL)**




**CEDARVIEW LODGE IN NORTH VANCOUVER, BC,** focused on pain management, coaching care team members on applying alternative interventions, improved communication between members of the care team (frequent huddles). It also instituted continuous monitoring of resident behaviour and implemented a new Standard of Practice for new admissions. As a result, the team reduced its use of all antipsychotic medication from 60% to less than 35% and PRN usage has dropped in half. Of those residents remaining on antipsychotics, the team recognizes that almost half have diagnoses indicating appropriate use.

## CHRISTENSON VILLAGE

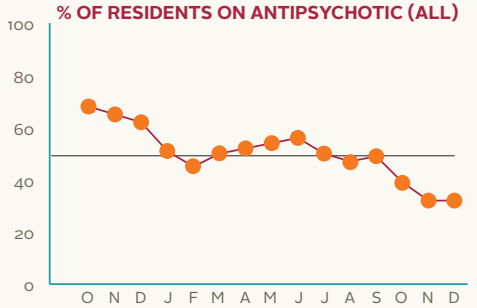
**% OF RESIDENTS ON ANTIPSYCHOTIC (ALL)**




**CHRISTENSON VILLAGE ON THE SUNSHINE COAST, BC,** used several non-pharmacological approaches, such as increasing the amount of recreation time spent with residents using a recreation student, more 1:1 time, and creating summer vegetable and perennial gardens. In addition, nurses and physicians were provided with education about alternatives, weekly huddles were implemented and behaviour and sleep tracking worksheets were used to understand residents better. As a result, the percentage of residents on all antipsychotic medications decreased from over 60% to 40%

## COTTONWOODS ETHEL GLEN

**% OF RESIDENTS ON ANTIPSYCHOTIC (ALL)**



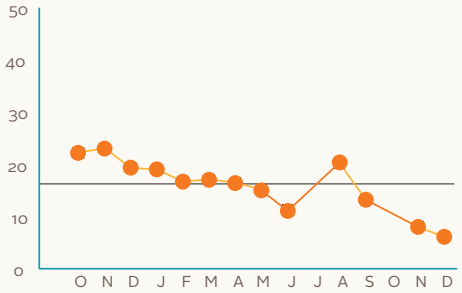

**COTTONWOODS ETHEL GLEN IN KELOWNA, BC,** implemented timely medication reviews and is currently testing preprinted orders. Discussions have been built into care conferences. All antipsychotic use has dropped in half and most of those that remain are being treated for appropriate indications. All others have been tapered or discontinued and there have been no new prescriptions to start an antipsychotic.

*"Our team now views a PRN antipsychotic as a last resort. The staff are trying various alternative techniques and interventions prior to administering a pill"*

ROSEWOOD MANOR

## DELTA VIEW LIFE ENRICHMENT CENTRE

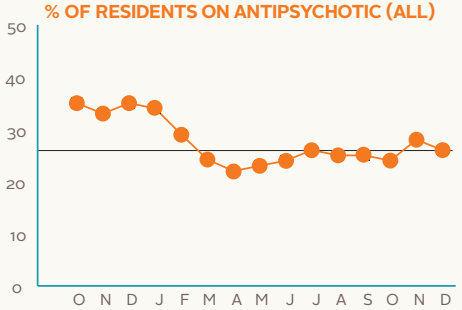
### % OF RESIDENTS ON ANTIPSYCHOTIC (ALL)




**DELTA VIEW LIFE ENRICHMENT CENTRE IN DELTA, BC,** reduced its use of all antipsychotics from more than 20% to 6%, while the use of PRN antipsychotics has dropped to zero and has been maintained for the last 4 months. The team uses the BPSD algorithm and built in guidelines, tools and resources into the daily work. Behaviour pattern records were helpful to understand when and why various behaviours start. Also, staff members conduct safety huddles and uses learning boards to reinforce a safety culture and improve communication and teamwork. The team was supported by visible, interactive leadership.

## FAIR HAVEN BURNABY

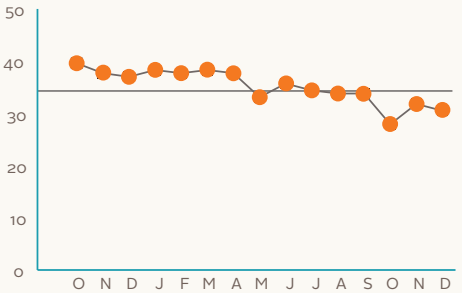
### % OF RESIDENTS ON ANTIPSYCHOTIC (ALL)




**FAIR HAVEN UNITED CHURCH HOMES IN BURNABY, BC,** initiated conversations between nurses and physicians and involved their recreation department in developing programs for residents. The team was able to reduce their usage from 35% to 26%.

## ROSEWOOD MANOR

### % OF RESIDENTS ON ANTIPSYCHOTIC (ALL)




**ROSEWOOD MANOR IN RICHMOND, BC,** focused on 1:1 review of medications and behaviours with care staff, developing individual care plans and trying alternative methods of responding to behaviours (e.g. aromatherapy). Staff received education in P.I.E.C.E.S.[12] and the Gentle Persuasive Approach[13] (GPA). The team has received positive feedback from family members and demonstrated a decrease in staff injuries.

*"Every behaviour has a reason and if the resident is unable to communicate what it is that is bothering them, it is our job to figure it out. We've become detectives in a way."*

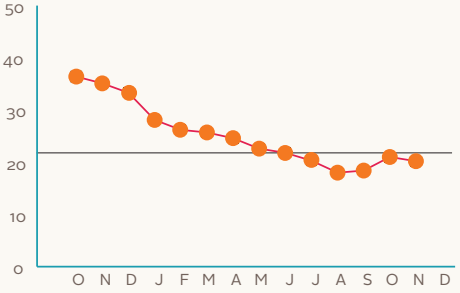
ROSEWOOD MANOR

12 P.I.E.C.E.S. (Physical, Intellectual, Emotional, Capabilities, Environment, Social) - a best practice learning and development initiative that provides an approach to understand and enhance care for individuals with complex physical and cognitive needs and behavioural changes.

13 GPA Education delivers basic understanding of dementia and its relationship with a person's responsive behaviours. Students learn to apply emotional, environmental and interpersonal communication strategies that diffuse challenging behaviours.

## WINDERMERE CARE CENTRE

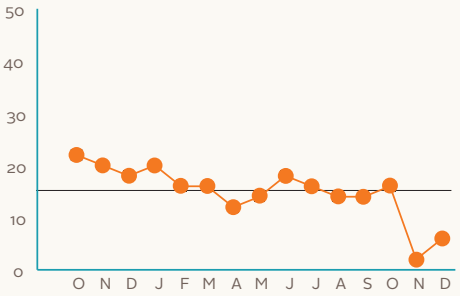
### % OF RESIDENTS ON ANTIPSYCHOTIC (ALL)




**WINDERMERE CARE CENTRE IN VANCOUVER, BC,** reviewed its antipsychotic usage with a multidisciplinary approach with a focused medication review process between nursing and pharmacy. Simultaneously, the residents on lowered dose of antipsychotics or discontinued antipsychotics were supported by the Montessori Program offered by recreation. As a result, the percentage of residents on antipsychotic continually dropped from 36% in October 2013 to 18% in December 2014.

## FRASER HOPE LODGE

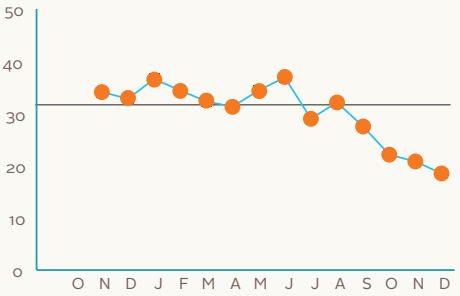
### % RESIDENTS ON ANTIPSYCHOTIC (PRN)




**FRASER HOPE LODGE IN HOPE, BC,** reduced its use of PRN antipsychotics through improved medication reviews and tracking for tapering of resident medications. As a result, the use of all antipsychotics dropped in half and, in particular, PRN usage is almost zero.

## HAWTHORNE CARE CENTRE

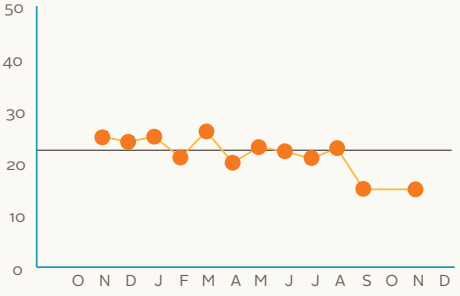
### % OF RESIDENTS ON ANTIPSYCHOTIC (REGULAR)




**HAWTHORNE CARE CENTRE IN COQUITLAM, BC,** reduced its use of antipsychotics by conducting monthly rounds with the Mental Health Team and instituting weekly Interdisciplinary Team 'Huddles' aswell as 12-week reviews of all antipsychotic orders. Staff participated in Caring Journey, P.I.E.C.E.S and Gentle Persuasive Approach (GPA) education.

## FAIR HAVEN VANCOUVER

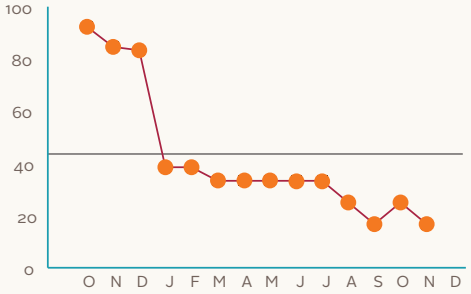
### % OF RESIDENTS ON ANTIPSYCHOTIC (PRN)




**FAIR HAVEN UNITED CHURCH HOMES IN VANCOUVER, BC,** initially focused on providing additional staff education and training on antipsychotic medications. As the education and learning were taking place, the team made progress on the use of PRN antipsychotics. Through leadership from a small team of nurses dedicated to CLeAR, the whole care team was involved near the end of the summer and, by November 2014, they had reduced PRN antipsychotic usage by 40% compared to the previous year.

## AUGUSTINE HAVEN

**% RESIDENTS ON ANTIPSYCHOTIC (PRN)**




**AUGUSTINE HAVEN HOUSE IN DELTA, BC,** implemented behaviour and sleep charting, reviewed rationale for using antipsychotics with specific residents and gradually tapered several residents. As a result, the team reduced its use of antipsychotic PRN from a high of 90% to below 20%.

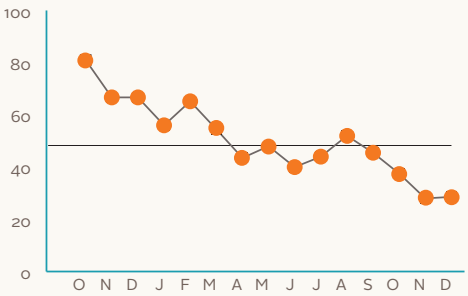
## Additional Data

Some teams were starting to collect additional data, such as percentage of residents on a reduced dose, to learn about their changes.

**GLACIER VIEW LODGE IN COMOX, BC,** created a standard new admission process that requires new residents have their diagnosis reviewed and a quality behavioural assessment to ensure that existing medications are appropriate. The team targeted improvements in behavioural assessments, including increasing behaviour tracking, better consistency of charting and better utilizing these assessments to enhance care planning. These changes enabled the team to reduce antipsychotic doses in more residences with confidence. By December 2014, over half of residents on an antipsychotic in the facility were on a reduced dose.

## OVERLANDER RESIDENTIAL CARE

**% RESIDENT ON ANTIPSYCHOTIC (PRN)**

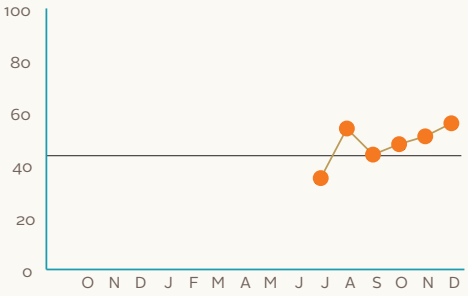



**OVERLANDER RESIDENTIAL CARE IN KAMLOOPS, BC,** modified its living environment, reviewed room assignments and engaged residents with meaningful indoor and outdoor projects such as gardening, helping with meal times and building projects. As a result of its work, the use of PRN antipsychotics has plummeted from 80% to less than 40%, and it is still decreasing.

**Appendix C shows results for all CLeAR teams that shared their data.**

## GLACIER VIEW LODGE

**% OF RESIDENTS ON REDUCED DOSE**




*"Nurses no longer ask for antipsychotics as soon as behaviours emerge."*

WINDERMERE CARE CENTRE

# IMPACT FOR RESIDENTS, FAMILIES AND CAREGIVERS AND STAFF

The number of residents on an antipsychotic has decreased in many facilities. However, what is even more striking is the impact for individual residents, their families and caregivers and staff. In turn, this has an impact on organizational culture.

## For Residents

*"When we first heard about CLeAR, we were very afraid of the potential aggression from residents but in the end that's not what we are seeing. What we see is more personality and quality of life."*

CARE AIDE, MAPLEWOOD HOUSE

*"We are changing the culture of our facility to provide more person-centered individualized care that addresses the needs of each resident."*

DIRECTOR OF CARE, PINEGROVE PLACE

*"We are honoring the PERSON."*

JOHANNA TRIMBLE, FACULTY MEMBER

## For Families and Caregivers

*"He laughed for the first time in years."*

SPOUSE OF A RESIDENT PARTICIPANT

*"Families were thrilled with the idea of trying different methods of care and creating alternatives to medication."*

ROSEWOOD MANOR

*"(The resident's) desire to socialize with staff and family became more frequent, resulting in a greater quality of life. Her husband has also benefited, as his interactions with her are more joyful and meaningful."*

LPN, RESIDENCE AT CLAYTON HEIGHTS

Participants were routinely asked how well CLeAR equipped them with new skills, knowledge, and tools to continually work towards improving quality of care for residents.

*Over 90% of respondents in two anonymous surveys agreed that they had built new skills and knowledge for improvement and over 80% indicated that they were comfortable leading and carrying out quality and safety initiatives in their organization.*

## For Staff and Organizations

*"I have a significant increase in information seeking from staff. They come asking about social histories of our residents so they can better know the reasons for some of the behaviours. Why does she always want to sweep? Well she was a hostess at the local restaurant for 30 years."*

MAPLEWOOD HOUSE

*"When we engaged staff in addressing concerns regarding resident responsive behaviours, we learnt about information that we would otherwise have not been privy to. The staff themselves took ownership in the strategies when they helped develop them."*

THREE LINKS CARE CENTRE

*"We are changing the culture of the facility and I feel that the staff are eager to learn new ways of improving the quality of life for our residents. We are much more open to new ideas now."*

PINEGROVE PLACE

The impact of CLeAR was also described in a powerful "Lend a Hand Campaign" held in December 2014. Staff in participating facilities was encouraged to think about the impact of their efforts in previous year and what legacy the CLeAR initiative left behind. Those stories are included in the following: http://ow.ly/JHftf

*"By implementing the CLeAR principles, it forced the staff to think outside the box."*
**ROSEWOOD MANOR**

*"CLeAR has positively impacted our persons in care and their family as we saw people become more alert and involved in their daily lives."*
**RESIDENCE AT CLAYTON HEIGHTS**



# CHANGES TESTED AND IMPLEMENTED BY PARTICIPATING TEAMS

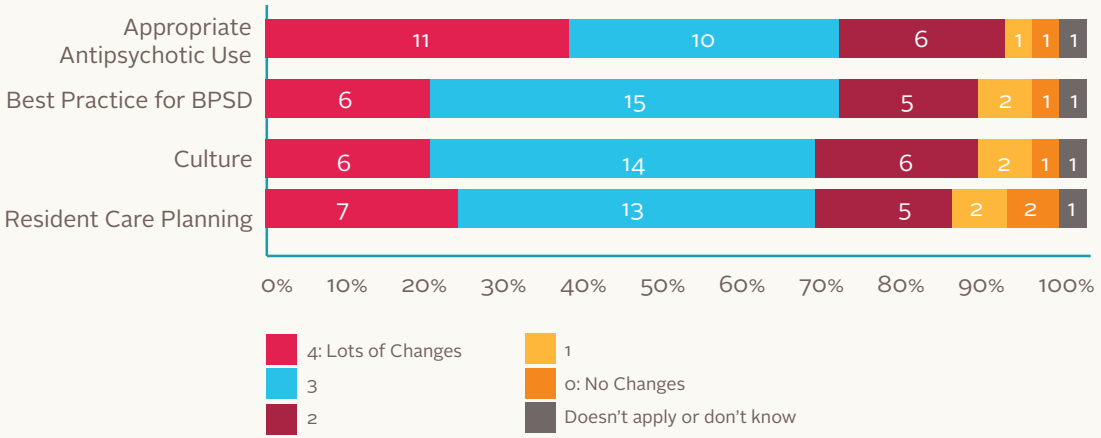
**So, how did improvement teams achieve these significant results? To achieve the aim of CLeAR, four strategies (drivers) were identified and shared with improvement teams at the Kick-Off Workshop. These strategies are grounded in evidence and refined based on experience of facilities that have significant results in this area.**

Improvement teams tried a number of changes throughout the initiative. Below are results from the CLeAR Post-Initiative Survey that identified which changes teams tested at their facility and how many changes within that driver they had tried.

## *The four primary drivers include:*

1. Appropriate antipsychotic use in residential care;
2. Best practice management for residents with BPSD;
3. Culture: enhance teamwork and communication in workplace and workflow; and
4. Resident Care Planning for quality of life and safety.

The full Driver Diagram is available on the CLeAR Resources page of BCPSQC's website, www.bcpsqc.ca.



## Examples of Changes

**Below are just a few examples of how improvement teams adapted the general concepts into specific ideas that worked for their facility. Additional team examples are available on CLWK.ca.**

The improvement team at **KIWANIS PAVILION IN VICTORIA, BC,** delivered education about dementia and BPSD by developing an interactive board game called *Ain't Misbehavin',* to share important lessons with staff, residents, families and caregivers. During a broader educational event at the facility, the team set up the board game at a booth where everyone could play and learn about dementia and BPSD!

The team at **KIWANIS CARE CENTRE IN NORTH VANCOUVER, BC,** focused on expanding the care team definition. It involved all members of the interprofessional team, including a community pharmacist who worked closely with staff at the facility. This linkage brought additional expertise to the team and provided staff with another advocate.

To combat staffing challenges, the **VICTORIA CHINATOWN CARE CENTRE (VCCC) TEAM IN VICTORIA, BC,** shifted staff and increased activities to the evening hours during "sundowning." These changes allowed for decreased disruptive behaviours during this time.

**EAGLE RIDGE MANOR IN COQUITLAM, BC,** developed a symptom flow sheet to better understand patterns in responsive behaviour. A copy is available on the **CLWK website**.

For Residential Care Week in September, **COTTAGE WORTHINGTON PAVILIONS IN ABBOTSFORD, BC,** made dementia education a focus. It offered frequent viewings of a video from Teepa Snow, a dementia and Alzheimer's care expert who trains and helps agencies, facilities, and families, and provided informal opportunities for staff to participate in discussions around dementia care. This all took place among several staff appreciation events throughout the week.

**OVERLANDER RESIDENTIAL CARE IN KAMLOOPS, BC,** experimented with and made numerous changes to the physical environment to make it more welcoming and comfortable for residents.

As a result of improvement teams' efforts, a list of "High Impact Changes" was created as a companion to the CLeAR Driver Diagram. Both are available as ongoing resources for current and future improvement teams on the BCPSQC website.

*"Regular reminders and education for staff is required to maintain the CLeAR initiative, especially if there is staff turnover or casual staff working. The team's goal is to touch base with each neighbourhood on a monthly basis to reinforce the reduction of inappropriate antipsychotic use."*

RESIDENCE AT CLAYTON HEIGHTS

*"We identified that some behaviours are pain related, and were subsequently able to decrease antipsychotic use by dealing with pain control."*

PINEGROVE PLACE

## High Impact Changes

**By trying and refining ideas in the driver diagram, improvement teams found some changes worked better for their facility, staff and residents. The following changes seem to have made the most difference:**

### 1 APPROPRIATE ANTIPSYCHOTIC USE

- Use antipsychotic medications only when appropriate and following recurrent assessment
- Enhance inter-professional medication review processes; specifically, review antipsychotic medications more frequently **

### 2 BEST PRACTICE MANAGEMENT FOR RESIDENTS WITH BPSD

- Introduce BPSD Algorithm as the basis for the BPSD recognition and assessment, using case studies, quizzes, etc. to make the algorithm accessible
- Trial and review non-pharmacological strategies before considering antipsychotic medications
- Enable a change in staff responsibilities to address resident needs 24/7: e.g. sit with residents and talk, play cards, etc
- Deliver enhanced education about dementia and BPSD for all staff/residents/families/caregivers **
- Match staff composition to resident needs 24/7: e.g. more staff at the end of day during "sun-downing"

### 3 CULTURE: ENHANCE TEAMWORK AND COMMUNICATION IN WORKPLACE AND WORKFLOW

- Implement focused team huddles on units **
- Support an environment of respectful communication, teamwork and learning: e.g. use Culture Toolbox **
- Identify local champions to support staff during challenging care situations
- Debrief with staff following incidents with harm associated with BPSD
- Have leaders spend time with front line staff, residents, families to hear about issues and concerns on the unit **

### 4 RESIDENT CARE PLANNING FOR QUALITY OF LIFE AND SAFETY

- Track, communicate and follow-up on observations from all levels of all staff, family and caregivers
- Develop inter-professional resident care planning sessions
- Implement behaviour tracking for a residents exhibiting BPSD
- Involve family and/or caregivers in all of the above: e.g. resident behaviour tracking, inter-professional care planning and care reviews **

** *These changes may be considered an "enabler" for the other changes.*

*"The most effective change has been the teamwork and communication enhancement and the involvement of other teams such as recreation"*

Participating Team

# Development of Shared Resources

**Common challenges and opportunities were identified across facilities and ideas to address them could be used by participating teams.**

One common source of ideas was videos from Teepa Snow, which improvement teams received at the regional workshops.

**THE EAGLE RIDGE MANOR** team shared its "Music and Memory" program on a webinar (http://ow.ly/JHgno) which triggered connections between other teams using music therapy and inspired additional facilities like **TABOR HOME** in Abbotsford, BC, and **FRASER HOPE LODGE** in Hope, BC, to try it as well. Fraser Hope Lodge in particular is working towards becoming certified in Music and Memory (https://musicandmemory.org/). The CLeAR team coordinated a "Giving the Gift of Music" Campaign near the holidays to help families identify meaningful gifts for their loved ones.


The following resources are available on the CLWK (http://ow.ly/JHgHs) or BCPSQC (http://ow.ly/JHgL8) websites for continued use by current and future improvement teams:

## *Change Ideas Resources*

- BPSD algorithm tools
- Driver Diagram
- Driver Diagram Worksheet
- High Impact Changes
- Practice Recommendations for Initiation, Titration and Tapering of Antipsychotic Medications
- Webinar Recordings
- Culture Change Toolbox
- Stories

## *Improvement Tools*

- Improvement Charter Worksheet
- PDSA Testing Ideas Worksheet
- Data Collection Tool
- Measurement Guide
- Storyboard template
- Postcard from the Future

*"We plan to use the PDSA[14] worksheets for every initiative – evidence for our next Accreditation!"*

GLACIER VIEW LODGE

14 Plan-Do-Study-Act, a cycle for learning and improvement based on the scientific method.

# SUSTAINABILITY AND NEXT STEPS

*Sustainability is when new ways of working and improved outcomes become the norm. Not only have the process and outcome changed, but the thinking and attitudes behind them are fundamentally altered and the systems surrounding them are transformed in support. In other words it has become an integrated or mainstream way of working rather than something 'added on'.*[15]

## Improvement Teams Perspective

Teams learned about sustainability strategies throughout the CLeAR initiative, such as making changes part of daily work, continued measurement, education and training, alignment with organizational priorities, leadership support, documentation as well as internal and external communication.

*"We will continue our work even as the CLeAR project comes to an end."*

THREE LINKS CARE CENTRE

## *Teams will continue to be supported by BCPSQC through:*

- Continued access to CLWK, a public website that houses clinical and improvement tools and resources developed through CLeAR (http://ow.ly/JZC6g)
- Stories, webinar recordings and videos (http://ow.ly/JHgL8)
- Having access to progress and final reports that summarize results that can be shared

Teams also have the ability to connect with each other through their CLWK community of practice.

*"The awareness and learning will be ongoing and far reaching!!!"*

AUGUSTINE HOUSE/HAVEN HOUSE

*"Upon completion of the CLeAR initiative, the standing legacy that it has brought to our facility is one of individuality. All behaviour has meaning! Staff now ask the questions: 'WHY? Who is this person?'"*

MAPLEWOOD SENIORS CARE SOCIETY

15 Maher L, Gustafson D, Evans A. (2010). NHS Sustainability Model. NHS Institute for Innovation and Improvement. http://www.institute.nhs.uk/sustainability

## A Systems Perspective: Spread and Alignment Opportunities

There is significant work underway across the province that aligns with the goals of appropriate and reduced antipsychotic use in residential care.

***In the post-initiative survey, over 80% of respondents agreed that they knew more about other initiatives as a result of being involved in CLeAR and agreed that CLeAR met its goal of creating opportunities for existing initiatives to work together.***

There continues to be a need to leverage the opportunities for stronger coordination and alignment on the medicate-related initiatives underway in residential care including:

- Shared Care Polypharmacy[16]
- Medication Reconciliation in Residential Care
- Clinical Care Management: 48/6[17] in Acute Care
- Seniors Action Plan
- Dementia Action Plan

BCPSQC is involved with or connected to each of these initiatives and is committed to achieving greater "alignteration" (alignment and integration) between them. Work is already underway to connect improvement teams from CLeAR with the Shared Care Polypharmacy initiative, as well as incorporating CLeAR resources into the Polypharmacy education materials.

Other linkages exist with the expansion of Medication Reconciliation into acute care and 48/6 addressing care transitions to the community, including the involvement of some CLeAR teams. These and other alignment opportunities will develop over time.

Forty-eight out of 280 potential residential care facilities in BC participated in CLeAR. It is important to learn the lessons of CLeAR, what worked and what could be improved, to plan for any future spread activities. This reflection is well underway and will continue between BCPSQC and its partners. Concurrently the Ministry of Health is finalizing an updated Provincial Dementia Action Plan that will also inform future activities in this area. Stay tuned!

In the meantime, a new quality improvement opportunity in residential care and assisted living is available. BCPSQC is inviting teams from across the province to implement Releasing Time to Care (RT2C)[18], also known as the Productive Ward. RT2C is led by staff providing care to residents and supports them to lead improvements in their work environments. This program has been shown to improve resident experience and health outcomes while also supporting the development of communication, problem-solving and quality improvement skills. See the RT2C page on BCPSQC's website for more information: http://ow.ly/KddAC.

16 Polypharmacy occurs when the individual theoretical benefit of a medication is outweighed by the collective negative benefit of the number of medications a senior is taking.

17 An initiative that focuses on 6 care areas for seniors within 48 hours of admission to an acute hospital in order to reduce functional decline.

18 A module-based, self-directed quality improvement program. The aim is to improve care by taking away activities that don't provide value for residents and their families, and to re-invest saved time into making care better and safer.

# APPENDICES

# APPENDIX A: THANK YOU AND ACKNOWLEDGEMENTS

## Improvement Teams

**Each of these residential care facilities had committed and knowledgeable teams and individuals to make improvements possible locally:**

- Arrowsmith Lodge
- Augustine House/Haven House
- Bradley Centre
- Fair Haven United Church Homes-Burnaby
- Cedarview Lodge
- Christenson Village
- Columbus Residence
- Cottage and Worthington Pavilions
- Cottonwoods Care Centre
- Delta View Life Enrichment Centre
- Dr. Andrew Pavilion
- Dunrovin Park Lodge
- Eagle Ridge Manor
- Evergreen House
- Fair Haven United Church Homes-Vancouver
- Fir Park Village and Echo Village
- Fraser Hope Lodge
- Fraserview Care Lodge
- Glacier View Lodge
- Haro Park Centre
- Hawthorne Care Centre
- Heritage Village
- Hilton Villa Care Centre
- Kiwanis Care Centre – North Shore
- Kiwanis Pavilion
- Maplewood House
- Mission Memorial Hospital Campus of Care
- Nanaimo Seniors Village
- Nelson Jubilee Manor
- Overlander Residential Care
- Pinegrove Place
- Pleasant View Care Home
- Purdy Pavilion – UBC Hospital
- Renfrew Care Centre
- Rosemary Heights Seniors Village
- Rosewood Manor
- Royal City Manor
- Shaughnessy Care Centre
- Suncreek Village
- Tabor Home
- Talarico Place
- The Residence at Clayton Heights
- Three Links Care Centre
- Trinity Care Centre
- Victoria Chinatown Care Centre
- Village by the Station
- Windermere Care Centre
- Youville Residence

## CLeAR Faculty and Clinical Advisory Group

**The following people generously gave their time, knowledge and experience to design this initiative. Without them, this work would not be possible.**

**CHRIS RAUSCHER (CHAIR)**
Clinical Lead, Senior's Care, BCPSQC

**ANN MARIE LEIJEN**
Director of Care, Cheam Village, Glenwood

**ANDREA FELZMANN**
Clinical Practice Leader,
Vancouver Coastal Health

**BARBARA RADONS**
Nurse Practitioner, Fraser Health

**BETTY MURRAY**
Patient Partner,
*Patients as Partners* | Patient Voices Network

**CAITLIN MCFADDEN**
Medical Director, General Practitioner,
Yucalta Lodge

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Geriatric Psychiatrist, Interior Health

**CHRIS HUNTER**
Pharmacist, Reid's Prescriptions

**CINDY REIGER**
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Access & Flow, Interior Health

**DENA KANIGAN**
Director of Care, Castleview Care Centre

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Populations, Interior Health

**ELIZABETH DRANCE**
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Providence Health Care

**FARIA ALI**
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**GINA GASPARD**
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**JOHANNA TRIMBLE**
Member of the Public

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New Vista Care Home

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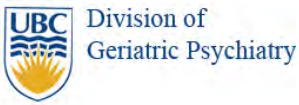
**TREVOR JANZ**
Regional Residential Care Medical Director
& GP, Interior Health

**WENDY CARMICHAEL**
Manager, Residential Services,
Kiwanis Village

## Partnership Alliance

The Partnership Alliance represented key stakeholders in the system and provided overall guidance to CLeAR. They helped to find and create opportunities for alignment between partner organizations, groups and CLeAR as well as share ideas to take action through their own networks and organizations.





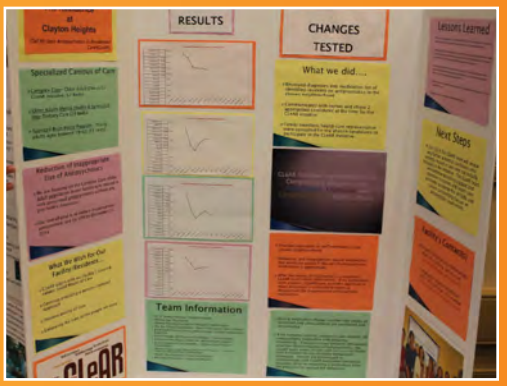







# APPENDIX B:
# EXAMPLE OF STORYBOARDS





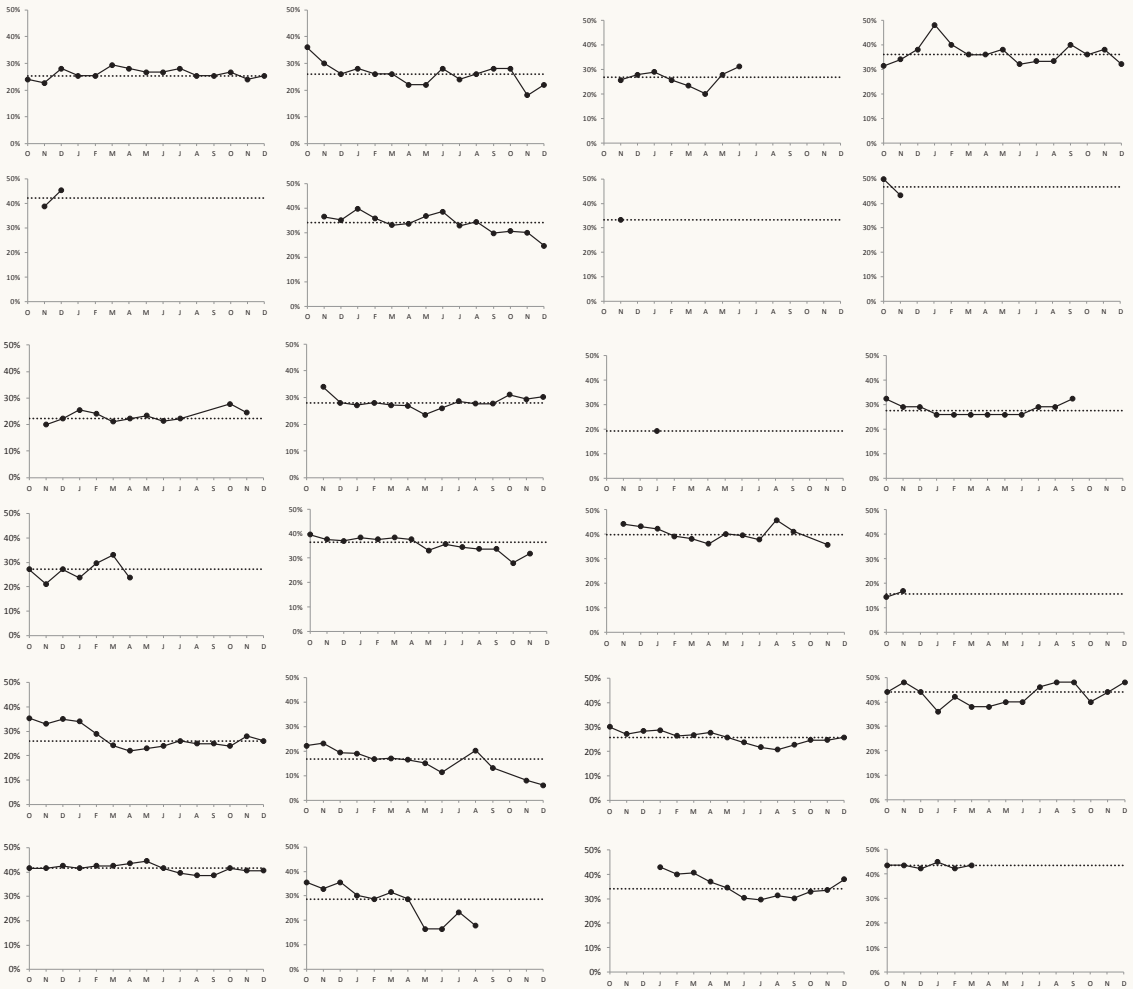
# APPENDIX C: RESULTS FOR ALL TEAMS

These graphs show results for CLeAR teams that shared their data for "Percentage of Residents on ANY antipsychotic". There are similar charts for the other three outcome measures (regular, PRN and both).

Throughout the initiative, 38 teams reported their data at least once. By December 2014, 18 to 23 teams were submitting data consistently. There was some natural attrition, especially since this was a voluntary initiative. However, the data received was still useful in showing and tracking improvements for the teams involved.

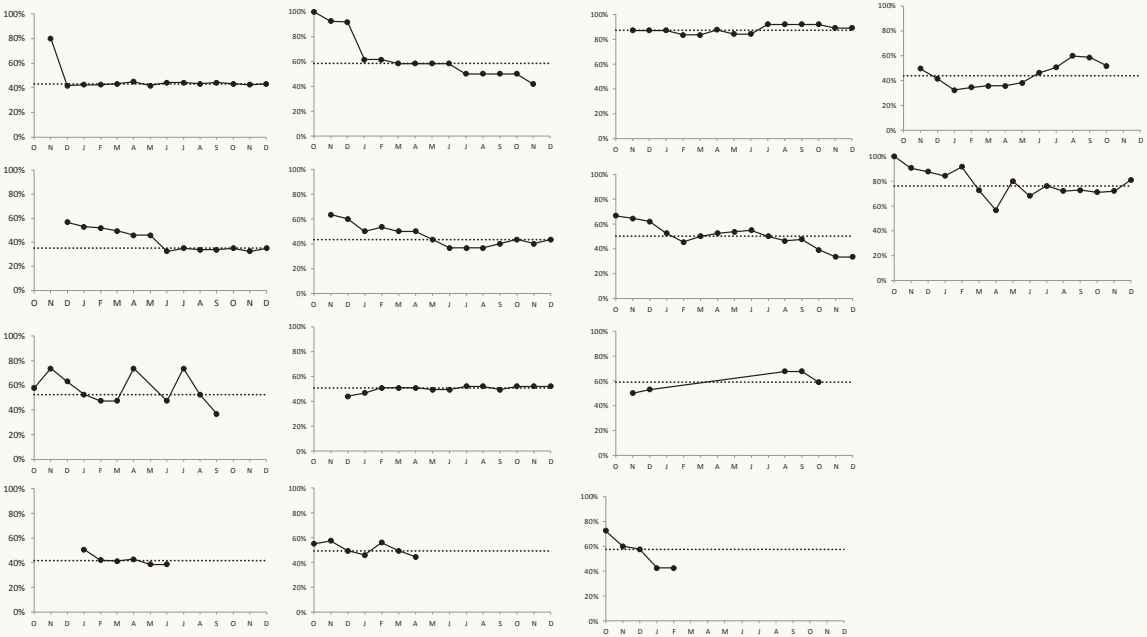
## PERCENTAGE OF RESIDENTS PRESCRIBED TO RECEIVE ANY ANTIPSYCHOTIC

*Facilities that started relatively lower levels of antipsychotic use (graph scaling 0-50%)*



## PERCENTAGE OF RESIDENTS PRESCRIBED TO RECEIVE ANY ANTIPSYCHOTIC

*Facilities that started with relatively higher levels of antipsychotic use (graph scaling 0 -100%)*



# APPENDIX D: GLOSSARY OF TERMS

**48/6**
An initiative that focuses on 6 care areas for seniors within 48 hours of admission to an acute hospital in order to reduce functional decline. The 6 care areas are: functional mobility; cognitive function; bladder and bowel management; nutrition and hydration management; pain management; and medication management.

**ACCREDITATION**
A process in which certification of competency, authority, or credibility is achieved

**APPROPRIATENESS**
From the BC Health Quality Matrix, defined as care that is provided is evidence-based and specific to individual clinical needs (http://ow.ly/KddZX)

**BEST PRACTICE**
Procedures that are accepted or prescribed as being correct or most effective

**BPSD**
Behavioural and Psychological Symptoms of Dementia

**BPSD ALGORITHM**
A practical, electronic decision support tool designed to assist physicians, nurses, clinicians, care staff and others in their assessment and care decisions for persons with BPSD (http://bcbpsd.ca/)

**CLeAR**
Call for Less Antipsychotics in Residential Care, provincial initiative facilitated by the BCPSQC

**CLWK**
Connecting Learners with Knowledge (https://www.clwk.ca/)

**COMMUNITY OF PRACTICE**
A group of people who engage in a process of collective learning in a shared domain

**CULTURE CHANGE TOOLBOX**
A guide that contains tools that can be used as the focal point for a shift in culture – and it is designed specifically for use in residential care facilities

**DEMENTIA**
A chronic, progressive disease of the brain that affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, judgment, and executive function

**DEMENTIA ACTION PLAN**
This plan outlines province-wide priorities for improved dementia care through health system and service re-design work currently underway in BC. The plan is intended to support collaborative action over the next two years by individuals, health professionals, health authorities, and community organizations to achieve quality care and support for people with dementia, from prevention through to end of life.

**DRIVER DIAGRAM**
A powerful tool to translate a high level improvement goal into a logical set of underpinning drivers and change ideas

**GENTLE PERSUASIVE APPROACH (GPA)**
Education delivers basic understanding of dementia and its relationship with a person's responsive behaviours. Students learn to apply emotional, environmental and interpersonal communication strategies that diffuse challenging behaviours.

**IMPROVEMENT TEAM**
A group of individuals within the organization with a goal and tasked with making changes that result in improvement, engaging staff and others along the way. An improvement team usually includes a day-to-day leader, staff involved in the care process and others. These teams are often interprofessional and multidisciplinary and may include patients, residents and families.

**LONG-TERM CARE**
A variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time

**MEDICATION RECONCILIATION**
Reconciliation of seniors' medications on admission, discharge, and transfer of care is known to improve seniors' wellness. Health care providers need education and support to embrace medication reconciliation as part of everyday practice.

**NON-PHARMACOLOGICAL APPROACHES**
Care should be person-centred and tailored to the individual; it should also be guided by the resident's background, likes and dislikes, culture, linguistic and religious factors, and life experiences, as well as by the skills and resources available at the residential care facility (e.g. providing structure, scheduling events to adjust for a resident's needs, involving relatives in care planning and shifting agitated residents into activities they like to produce a calming effect such as going for a walk or listening to music).

**PARTNERSHIP ALLIANCE**
This group represented key stakeholders in the system and provided overall guidance to the CLeAR initiative. Members helped to find and create opportunities for alignment between partner organizations, groups and CLeAR as well as shared ideas to take action through their own networks and organizations.

**PDSA CYCLE**
Plan-Do-Study-Act, a cycle for learning and improvement based on the scientific method. It is fully described in the book "The Improvement Guide: A Practical Approach to Enhancing Organizational Performances" by Langley et al.

**P.I.E.C.E.S.**
A best practice learning and development initiative that provides an approach to understanding and enhancing care for individuals with complex physical and cognitive/mental health needs and behavioural changes.

P.I.E.C.E.S. stands for Physical, Intellectual, Emotional, Capabilities, Environment, Social.

**POLYPHARMACY**
An initiative of the Shared Care Committee. In prototype form, polypharmacy occurs when the individual theoretical benefit of a medication is outweighed by the collective negative benefit of the number of medications a senior is taking. Polypharmacy is a stand-alone risk for morbidity and often causes increased incidences of transfers to acute care and falls. The aim of the initiative is to reduce overall pill count in the seniors' population.

**PRN (PRO RE NATA)**
A Latin term that means "as required"

**QUALITY OF LIFE**
The standard of health, comfort, and happiness experienced by an individual or group

**RELEASING TIME TO CARE**
A module-based, self-directed quality improvement program. It empowers care teams to improve their working environment to create a place where positive interaction, staff, family and resident engagement, and quality improvement become part of the way everything is done. The aim is to improve care by taking away activities that don't provide value for residents and their families, and to re-invest saved time into making care better and safer.

**RESIDENTIAL CARE**
24-hour professional care and supervision provided to adults in a supportive, secure environment

**SENIORS ACTION PLAN**
Response to the Office of the Ombudsperson's report on seniors care in British Columbia. The plan outlines actions to address many of the ombudsperson's findings and recommendations

**SHARED CARE COMMITTEE**
A joint committee of Doctors of BC and the BC Ministry of Health working to improve patients' health outcomes and their journey through the health care system

**SPECIAL CAUSE VARIATION**
Variation resulting from causes that are not part of the system (process or product) all the time or do not affect everyone, but arise because of specific circumstances

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