Geriatric Psychiatry: Therapeutic Model for Inpatient Care
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Executive Summary

The elderly population in industrialized countries will rise significantly by the next decade. In the United States alone the projected growth of the population 65 to 85 years old is expected to jump from 39.3 million in 2010 to 52.1 million by 2020. Currently in Canada a quarter of a million people have dementia and the number is expected to triple to 750,000 by 2031. In addition many seniors in this group also suffer from complex medical co-morbidities and other psychiatric disorders. These highly complex conditions require specialized services in virtually every sector of healthcare including community, acute, long-term and tertiary care.

Like many tertiary mental health facilities, Ontario Shores Centre for Mental Health Sciences (Ontario Shores) offers a wide range of inpatient, outpatient and outreach services. However, Ontario Shores is breaking new ground towards becoming a recognized centre of excellence in geriatric psychiatry in the province of Ontario having introduced it’s first ever therapeutic model of inpatient care and service delivery. This model is very unique in that it focuses on assessment, stabilization, treatment and reintegration under the overarching framework of the Collaborative Recovery Model.

Approximately two years ago an interprofessional best practices working group was convened with the task of raising the bar in the delivery of patient care. Several guidelines were used to inform this initiative including the Canadian Coalition of Seniors Mental Health, the Canadian Consensus on Dementia, the Registered Nurses Association of Ontario and the American Psychiatric Association. The therapeutic model is the culmination of research and innovation by the group and its objectives are as follows:

1. To define geriatric psychiatry inpatient services at Ontario Shores for our clients and external stakeholders.
2. To create best practice benchmarks to guide our care teams towards optimal service delivery.
3. To instil a sense of pride among our care teams as a recognized specialty at Ontario Shores.
4. To position Ontario Shores as a centre of excellence in geriatric psychiatry in Ontario.
5. To open new horizons for future education and research in the field of geriatric psychiatry.

This document begins with an introduction to Ontario Shores mission, vision, core values and the Collaborative Recovery Model. The geriatric psychiatry inpatient services are then detailed including criteria, population mix, common behavioural and psychological symptoms, quality data, treatment and therapy models specific to each unit. Specific clinical practice guidelines for dementia care were also developed as part of this project and the process of care is broken down week by week including interprofessional team involvement. Geriatric psychiatry assessments and a detailed overview of a wide array of therapeutic programs are also detailed. The document concludes with information about discharge supports along with an appendix of customized tools, educational initiatives, care process map and a patient story.

Overall, the therapeutic model is a comprehensive document that seeks to build our geriatric psychiatry inpatient services at Ontario Shores and define both internal capacity for our interprofessional teams as well as external capacity for our community stakeholders. The ultimate goal is to achieve excellence in patient care and the highest quality of living for the older adult suffering from both medical and psychiatric disorders.


Best Practices Working Group, Project Contributors and Advisors
Steve Mathew Co-Chair, Clinical Manager, Geriatric Psychiatry Program
Franzis Henke Co-Chair, Advanced Practice Nurse, Geriatric Psychiatry Program
Dr. Ian Dawe Physician-in-Chief
Dr. Laura Gage Medical Director
Dr. Robyn Waxman Psychiatrist, Special Services
Michelle Drapiza RN, Patient Care Facilitator, GDU
Brigitte Rudolph RN, Patient Care Facilitator, GPU
Jeannette Daubney Patient Care Unit Clerk, GPU
Satya Sukhai Social Worker, GDU and GPU
Sophie Wong Occupational Therapist, GDU and GPU
Chris Uranis RN, Psychogeriatric Resource Consultant
Melanie Kelly RN, Psychogeriatric Resource Consultant
Jan Katchaluba RN, Community Nurse Clinician
Angelica Germanese Recreation Therapist, GDU
Amanda O’Keefe Recreation Therapist, GDU
Vesna Brzovska Pharmacist, GDU and GPU
Elizabeth Southward RPN, GPU
Jennifer Yanta RPN, GDU

Project Sponsors
Sheila Neuburger Vice-President, Clinical Services Ontario Shores
Sheryl Bernard Administrative Director, Geriatric Psychiatry Program
Roxanne Cain Manager, Centralized Staffing and Scheduling
Introduction

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a tertiary care mental health hospital providing a range of specialized assessment and treatment services to those living with complex and serious mental illness. Exemplary patient care is delivered through safe and evidence-based approaches where successful outcomes are achieved using best clinical practices and the latest advances in research. Patients benefit from a recovery-oriented environment of care built on compassion, inspiration, and hope.

Ontario Shores also engages in research, education, and advocacy initiatives to advance the mental health care system and is accredited by the Accreditation Canada. Ontario Shores operates with the support of the Ministry of Health and Long-Term Care and local health integration networks (LHINs), and is regulated by the Public Hospitals Act, the Mental Health Act and other provincial and federal legislation. As part of its Geriatric Psychiatry Program, Ontario Shores has two inpatient geriatric units as well as outpatient clinics, outreach services and educational programs.

Mission

We provide leadership and exemplary mental health care through specialized treatment, research, education and advocacy.

Vision

Recovering Best Health, Nurturing Hope, Inspiring Discovery

Recovering Best Health

Our specialized care focuses on individual paths to recovery and mental wellness. Our highly skilled staff are leaders in promoting optimum well-being. Our comprehensive services and innovative practices are integrated with our community partners.

Nurturing Hope

Our advocacy with the community eliminates the stigma of mental illness. Our commitment to care extends beyond the scope of client recovery to educating and informing our families and communities. We proudly embrace diversity and offer individualized care.

Inspiring Discovery

We are avidly leading new developments and research in collaboration with other organizations. We lead the international mental health care community in safety and innovative practices. Our relationships with the private sector provide unique opportunities to be innovative.

Core Values

We aim for Excellence - through leadership and learning, we achieve exceptional performance in all we do, while fostering an environment of optimism, hope and recovery.

We encourage Innovation - through research and creative approaches, we support the advancement of mental health care.

We value Safety - we provide a safe and healing environment for our clients and a sense of security for our patients’ families, our employees and the community at large.
We Respect all individuals - encouraging diversity and treating everyone with dignity, while embracing the rights, beliefs, opinions and contributions of others.

We are a Community - we work together as one team, and with families, providers and the public as our partners, while maintaining mutual trust, transparency and shared purpose to enhance our patients’ quality of life.

Care Philosophy: Collaborative Recovery Model

Ontario Shores employs the Collaborative Recovery Model (CRM) as its overarching philosophy of care. This new paradigm challenges philosophies of mental health care and treatment. Collaborative Recovery is a strength and abilities based model to enable the patient in achieving their own goals towards recovery.

Self-help, mutual-help, self-determination, family involvement, resiliency, choice, justice, responsibility, skill building, a positive culture for healing, a focus on strengths and possibilities, community involvement, education and role development (Mental Health Commission, New Zealand, 2006)

Two Guiding Principles of CRM:
1. Recovery as an individual process
2. Collaboration and autonomy support

Four Components of CRM:
1. Change enhancement
2. Collaborative strengths and values identification
3. Collaborative visioning and goal striving
4. Collaborative action and monitoring

Concept of Unconditional Positive Regard

Recovery describes mental health care from a strengths and resilience perspective, which allows for new and creative ways to work with patients that honour their skills, competencies and talents as opposed to their deficits.

Overview of Inpatient Psychogeriatric Services at Ontario Shores

Vision for Geriatric Psychiatry Program
To be the leader in geriatric psychiatry care in the Central East LHIN.

Key strategies:
Educational Initiatives
• Durham College partnership/Interprofessional Psychogeriatric Best Practices course January 2010 and September 2010 (will be offered bi-annually). A recovery focused geriatric psychiatry certificate program open to Ontario Shores staff and external participants.
• Shared Journey December 2009 - January 2010. Internal week long staff training on CRM.
• PIECES training Spring 2010. Certificate program for nursing staff on specialized geriatric psychiatry assessment (continue to support staff to attend PIECES training).
• Montessori training Spring 2010. Interprofessional Certificate program on abilities based activities based on Montessori Principles.
• CBT training Fall 2010. Interprofessional training program on introductory cognitive behavioural therapy principles.

**Best Practices Initiatives**
• Geriatric Psychiatry Steering Committee: mandate is to develop best practices at the corporate and regional level.
• Psychogeriatric Best Practices Working Group: mandate is to operationalize best practices on the inpatient unit level.

**Geriatric Psychiatry Unit (GDU)**

Provides specialized services to meet the mental health needs of individuals:
• 65 years of age
• Moderate to severe dementia
• Challenging behaviour(s)
• Behaviour management strategies
• Goal of reintegration to community or long-term care

**Population Mix (November 2010)**
44% Dementia Alzheimer Type  
22% Schizophrenia or Primary Psychotic Disorder  
13% Huntington Disease  
9% Frontotemporal Dementia  
4% Vascular Dementia  
4% Dementias secondary to Anoxic Brain Injury  
4% Dementias secondary to Acquired Brain Injury

**Admission Criteria GDU**
• 65 years of age or over with a dementia diagnosis
• Younger patients will be considered on a case by case basis
• Behavioural and Psychological Symptoms that are unmanageable in the community
• Schedule 1 hospitals
• Long-Term Care Facilities
• Community

**Common Behavioural and Psychological Symptoms GDU**
• Aggression, resistance to care, violent behaviour  
• Sexual behaviours:  
  • Expressive / disruptive / aggressive
  • Altered sleep wake cycle
  • Depression
  • Anxiety
  • Disinhibited behaviours
  • Psychotic symptoms:  
    • Hallucinations
    • Delusions
    • Illusions
  • Wandering
  • Rummaging and hoarding
  • Exit seeking
  • Ingestion of foreign substances
  • Intrusive behaviours
  • Perseveration
  • Multiple forms of agitation
Therapy and Treatment on GDU
• Person Centred Care (T. Kitwood)
• Pharmacological treatment
• Behaviour Management (stressor reduction model)
• Abilities based care (Enablement: Dawson, Wells, Kline)
• Montessori activities and Snoezelen therapy

Clinical Practice Guidelines for Dementia Care

Although the general model of care described previously is used on both geriatric psychiatry units, a specific care model has been created for GDU through the review and amalgamation of the most relevant clinical practice guidelines for the assessment and treatment of individuals with behavioural or psychological symptoms in the context of moderate to severe dementia. Additionally, certain tools have been created to facilitate the implementation of these clinical practice guidelines. Implementation initiated April 2011.

1. Provide education to patients and families about dementia, inquire about caregiver education and support needs, problem behaviours of the individual with dementia and effect on the caregiver, assist in recruiting other family members and formal community services to assist in caregiving role and refer to specialized dementia program like Alzheimer’s Society (B,3). (Grade A, level 1) (level 1 – APA)(Level C – CCSMH)

2. Perform a diagnostic evaluation to identify the specific etiology of the dementia, which may include a psychiatric, medical and neurological evaluation, that may guide treatment decisions as well as to reveal any treatable psychiatric or general medical conditions that might be causing or contributing to the dementia, especially delirium (APA- I)

3. Recommended laboratory studies include a CBC, lytes, Ca, renal, LFTs, B12 and thyroid function (APA)

4. There is fair evidence to support the selective use of CT or MRI scanning in the work-up for dementia- per 1999 guidelines (grade B, level 2) and to rule in concomitant cerebrovascular disease that can affect patient management (grade B, level 2).

There is fair evidence to support the use of SPECT scanning in the evaluation of questionable early stage dementia or those with frontotemporal dementia (grade B, level 2).

5. Assessment of BPSD should include careful documentation of behaviours and target symptoms, search for potential triggers or precipitants, recording of consequences of the behaviours (Level 2 – APA) (Level C – CCSMH), evaluation to rule-out treatable or contributory causes, and consideration for the safety of patients, caregivers and others in the environment (Grade B, level 3). Carefully evaluate medical, psychiatric, environmental or psychosocial problems that underlie BPSD and treat these first if safe and possible (Level 1 – APA);

6. In severe depression, psychosis or agitation that puts patients or others at risk use pharmacologic treatment concurrently (Grade B, level 3) (Also APA) (Level C – CCSMH)

7. Individualized behaviour therapy should be considered where the goal is to manage behaviour symptoms (Level C- CCSMH). Use individualized treatment plans (Level 1 - APA) (level C – CCSMH) a. Communication (Level B – CCSMH)
b. Dressing (Level B – CCSMH)
c. Mealtime (Level D – CCSMH)
d. Bathing (Level A – CCSMH)
e. Activities (Level B – CCSMH)

8. Cholinesterase inhibitors are viable treatment option for most with mild-severe AD (Grade A, level 1) (Level 1 – APA), PDD (Level 1 - APA), DLB (level 2 – APA), VaD (Grade B, level 1), and mixed AD + CVD (Grade B, level 1); may improve behaviour (Grade A, level 1)

9. Can use Memantine for moderate-severe AD (Grade B, level 1)(APA – II) – may improve behaviour. Can also combine memantine with cholinesterase inhibitors in moderate-severe AD (Grade B, level 1)

10. Atypical antipsychotics are an appropriate first-line pharmacological treatment option (to be used in addition to non-pharmacological management) for agitation/aggression/psychosis that causes marked risk, disability, or suffering – weighing risk of CVEs/mortality (Grade A, level 1) (Level 2 -1 – APA) (Level B – CCSMH)

11. Medications for BPSD should normally be initiated at a low starting dose and then subsequently titrated carefully based on the patient’s response and the presence of adverse effects (Grade B, level 3)

12. SSRIs can be used for treatment of severe depression (Grade B, level 3); Use antidepressant –SSRI may be preferred (Level 2 – APA); First-line antidepressants are SSRIs, Venlafaxine, Bupropion, and Mirtazapine (Level B – CCSMH)

13. Assess capacity to consent to specific decisions such as treatment (Grade A, level 3)

14. Physical restraints are rarely indicated and should only be used for patients who pose an imminent risk of physical harm to themselves or others and reasons for their use should be carefully documented (Level 1 – APA)

15. Structured recreational activities for increasing engagement (Level C – CCSMH), including:
   - Individualized exercise programs which also have impact on functional performance (Grade A, level 1), walking activities and physical activities (level C-CCSMH)
   - Self-affirming interventions (e.g. validation, reminiscence) for increased self-worth and overall well-being (Level C – CCSMH) (Grade C, level 2)
   - Social contact intervention (e.g. art therapy, music therapy, pet therapy, one-to-one) and recreational activities for minimizing sensory deprivation, social isolation, provide distraction, physical contact and induce relaxation (Level C –CCSMH) (APA level)
   - Sensory/relaxation interventions (e.g. music, snoezelen (C, 2), aromatherapy (C,2), massage and touch therapy (C, 2) to reduce behavioural symptoms, stimulate senses and enhance relaxation (Level B – CCSMH)

16. The use of medications with anticholinergic effects should be minimized in persons with AD (Grade D, Level 3)

17. Patients with mild to moderate dementia, when hospitalized, should be identified as being at increased risk for delirium. They should be offered multicomponent interventions including:
orienting communication, therapeutic activities, sleep enhancement strategies, exercise and mobilization, provision of vision and hearing aids, and/or oral repletion of dehydration to decrease their risk of developing delirium. (Grade B, Level 2)

Clinical Practice Guidelines Developed by Dr. I Fischler, Dr. L Gage, Steve Mathew, Clinical Manager and Franzis Henke, Advanced Practice Nurse – see appendix for sources

**Geriatric Psychiatry Unit (GPU)**

Provides specialized services to meet the complex mental health needs of seniors:
- Over age 65
- Serious mental illness
- Behaviour modification and dialogue based individual and group therapies
- Goal of reintegration to community or long term care

**Population Mix (November 2010)**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia or Primary Psychotic Disorder</td>
<td>40%</td>
</tr>
<tr>
<td>Dementia (mild-moderate severity)</td>
<td>24%</td>
</tr>
<tr>
<td>Depression</td>
<td>16%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>8%</td>
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<tr>
<td>Personality Disorder</td>
<td>4%</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>4%</td>
</tr>
<tr>
<td>Alcohol induced-persisting Dementia</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Admission Criteria GPU**

- 65 years of age or over with a psychiatric disorder that is refractory to treatment
- Younger patients will be considered on a case by case basis
- Schedule 1 hospitals
- Long-Term Care Facilities
- Community

**Common Behavioural and Psychological Symptoms GPU**

- Aggression, resistance to care, violent behaviour
- Wandering
- Rummaging and hoarding
- Exit seeking
- Intrusive behaviours
- Staff splitting/Manipulation
- Attention seeking
- Paranoia

- Sexual behaviours:
  - Expressive / disruptive / aggressive
  - Depression
  - Seclusive behaviours
  - Mania
  - Anxiety
  - Suicidal
  - Psychotic symptoms:
    - Hallucinations
    - Delusions

**Therapy and Treatment GPU**

- Pharmacological treatment
- Behaviour modification approaches
- Dialogue based therapies:
  - CBT individualized and small therapy groups
## General Treatment Plan Overview
*(assessment, stabilization, treatment, reintegration)*

<table>
<thead>
<tr>
<th>Week</th>
<th>Health Care Discipline</th>
<th>Plan</th>
</tr>
</thead>
</table>
| One  | Psychiatric Nursing    | • Interview with family and patient  
|      |                        | • Mental Health history  
|      |                        | • Nursing Physical Assessment  
|      |                        | • Review status  
|      |                        | • Review MAR  
|      |                        | • Review mobility  
|      |                        | • Need for safety devices  
|      |                        | • Braden scale  
|      |                        | • CAM on each admission  
|      |                        | • Falls Risk Assessment  
|      |                        | • Choking Risk Assessment (New)  
|      |                        | • Consents obtained  
|      |                        | • Close observations x 72h  
|      |                        | • ADLs assessment x 7 days to assess behavioural triggers  
|      |                        | • Behavioural Profile  
|      |                        | • Initiate individualized collaborative plan of care  
|      |                        | • Vital signs  
|      |                        | • Monitor response to environmental change  
|      |                        | • RAI after 72 hrs  
|      |                        | • Kardex – treatment plan discussion  
|      |                        | • **Psychogeriatric** Assessment Tools  
|      |                        | • Social interaction  
|      | Medical                | • Full diagnostic assessment  
|      |                        | • Physical exam  
|      |                        | • Review capacity – forms 33 and 31  
|      |                        | • Review status ie. Voluntary, involuntary, informal  
|      |                        | • Mini mental state exam  
|      |                        | • Review management of life threatening illnesses  
|      |                        | • Discuss advanced directives and DNR status  
|      |                        | • Diagnostic procedures  
|      |                        | • Obtain consent  
|      |                        | • Blood work  
|      |                        | • Urinalysis  
|      |                        | • Swabs for MRSA, VRE and ESBL  
|      |                        | • ECG, Chest x ray  
|      |                        | • Vital signs  
|      |                        | • Discuss treatment plan with patient, family or SDM if applicable  
<p>|      |                        | • Obtain consents  |</p>
<table>
<thead>
<tr>
<th>Week</th>
<th>Health Care Discipline</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>One: Psychiatric Observation</td>
<td>Pharmacy</td>
<td>• Medication reconciliation on admission</td>
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<tr>
<td></td>
<td></td>
<td>• Medication review Appropriateness:</td>
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<td></td>
<td></td>
<td>- (i) Safety (drug interactions, appropriate use of</td>
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<tr>
<td></td>
<td></td>
<td>- anticholinergic medications in elderly, indications, side effects</td>
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<tr>
<td></td>
<td></td>
<td>- dosage.)</td>
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<tr>
<td></td>
<td></td>
<td>- (ii) Cost effectiveness, (correct usage and patient convenience)</td>
</tr>
<tr>
<td>Weeks One and Two: Allied</td>
<td>Social Work and</td>
<td>• Meeting with family</td>
</tr>
<tr>
<td>Health</td>
<td>Interprofessional Team</td>
<td>• Social history and psychosocial assessment</td>
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<tr>
<td></td>
<td></td>
<td>• Emotional support</td>
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<tr>
<td></td>
<td></td>
<td>• Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Interprofessional team meeting/patient conference within 72 hours</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td>• Mobility</td>
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<tr>
<td></td>
<td></td>
<td>• Assistive Devices</td>
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<tr>
<td></td>
<td></td>
<td>• Functional Assessments</td>
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<tr>
<td></td>
<td></td>
<td>• Therapeutic surfaces</td>
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<tr>
<td></td>
<td></td>
<td>• Falls prevention interventions and equipment</td>
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<tr>
<td>Therapeutic Recreation</td>
<td></td>
<td>• One-on-one interview with patient and/or family</td>
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<td>• Snoezelen</td>
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<tr>
<td></td>
<td></td>
<td>• Montessori based activity</td>
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<tr>
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<td></td>
<td>• Group activities</td>
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<tr>
<td></td>
<td></td>
<td>• Social interaction</td>
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<td></td>
<td></td>
<td>• Music therapy</td>
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<tr>
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<td></td>
<td>• Pet therapy</td>
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<tr>
<td>Dietary</td>
<td></td>
<td>• Food preferences</td>
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<tr>
<td></td>
<td></td>
<td>• Diet</td>
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<td></td>
<td></td>
<td>• Texture</td>
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<td></td>
<td></td>
<td>• Swallowing assessment if necessary</td>
</tr>
<tr>
<td>Weeks Two and Beyond</td>
<td>Interprofessional Team</td>
<td>• Modification of individualized treatment plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• RAI/MDS completion</td>
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<td></td>
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<td>• Regular communication with family or SDM if applicable</td>
</tr>
</tbody>
</table>
Week Two and Beyond

Health Care Discipline
Interprofessional Team

Plan
- Medication changes
- Assessments as needed
- Occupational therapy
- Physiotherapy
- Dental assessment
- Pharmacy medication reconciliation on discharge
- Neuropsychologist consult
- Psychogeriatric Resource Consultant/Community Nurse Clinician Involvement
- Day in the Life tool/discharge and transitional supports

Developed by Meri Stankovic RN

Quality Data (November 2010)

<table>
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<tbody>
<tr>
<td>GDU</td>
<td>23</td>
<td>21</td>
<td>129</td>
<td>0</td>
<td>96-100%</td>
</tr>
<tr>
<td>GPU</td>
<td>25</td>
<td>31</td>
<td>148</td>
<td>0</td>
<td>96-100%</td>
</tr>
</tbody>
</table>

Psychoageriatric Assessment

PIECES
The PIECES framework of geriatric psychiatry assessment is employed on the inpatient units. PIECES includes a holistic assessment methodology which includes the: physical, intellectual, emotional, capabilities, environmental, social/cultural/spiritual aspects of patient care as detailed below.


Physical
Delirium
- * Confusion Assessment Method
- Relevant consults/tests
Disease
- Any new infections/illnesses or disease process?
Discomfort
- Are BOWELS moving well?
- * Pain Assessment
Disability
- Do eyes, ears or teeth need to be checked?
Drugs
- Sleep pattern

Intellectual
- Anosognosia, Aphasia, Apraxia, Amnesia, Agnosia, Apathy, Altered Perception, Executive Dysfunction
(stuck on small details, negative emotional control, disinhibition)
• * CPS / MMSE, Mini-Cog, Clock Test, MOCA
• Psychosis – hallucinations or delusions?

**Emotional**
- Adjustment, boredom, loneliness, abandonment
- Disorder of Mood – Depression
- Irritability, limited tolerance of others, self-esteem
• * Cornell Scale for Depression
• * SIG: E CAPS / GDS
• Disorders of Personality

**Capabilities**
- Frustration tolerance (Task Demands = Capabilities to negative frustrations)
- Difficulty with instructions - agnosia/apraxia?

**Environmental**
- Noise, stimulation (over or under)
- Changes in environment/routine
- Privacy, Control, Confinement, Access to Outdoors

**Social / Cultural / Spiritual**
- Life story (work, likes, coping strategies)
- Trauma, Special Events
- Past/present relationships
- Personality and Behavioural History

**Assessment Tools**
**Depression** - Cornell, Geriatric Depression Scale (GDS), Montgomery Asberg Depression Rating Scale (MADRS)
**Agitation** - Dementia Observation System (DOS) Cohen Mansfield Agitation Inventory
**BPSD** - Customized BPSD tracking tool developed by Best Practices Committee
**Cognition** - Mini Mental State Exam (MMSE) Montreal Cognitive Assessment (MoCA)
**Delirium** - Confusion Assessment Method (CAM)
**Complex Symptoms** - Neuropsychiatric Inventory (NPI)
**Pain** - PAINAD scale; PQRST with Numerical Assessment Scale

**Documentation**
**Treatment Plan** - “Mutual Action Plan” includes; patient demographic information, health and functional status, patient story, goals, strengths, resources, barriers, goals and action plan (plan of care) and behavior profile (triggers and de-escalation techniques) (all collected in the Electronic Health Record)

**PIECES Discussion Notes** - Data collection form which includes tools used, risk assessment, holistic assessment checklist and action plan; these completed assessments are scanned into the patient’s electronic record

**Charting** - Progress Notes SOAPE (subjective, objective, assessment, plan and evaluation)
Electronic flow sheet/Clinical Information Panels
Therapeutic Interventions and Objectives

1. Consistent with Collaborative Recovery Model (CRM – Ontario Shores)
2. Evidence based
3. Patient education with a forum to provide feedback
4. Development of expertise on the team
5. Interdisciplinary approach
6. Symptom management
7. Coping techniques for patients
8. Motivational approach
9. Incorporates learners (students)
10. Holistic perspective
11. Works towards discharge planning and supports including community reintegration
12. Opportunities for research
13. Improves patient relationships with family, friends and other social supports
14. Social skills training
15. Increase staff understanding of patient experience

Group and Individual Programs

Environmental
- Dim lights
- Quiet environment
- Comfortable room
- Access to personal pictures and items
- Ensure privacy

Physical Activity
- Gym
- Games group
- Exercise
- Horticulture therapy
- Walking
- Dancing

Pharmacotherapy
- See CPG guidelines

Sensory Stimulation
- Tactile
- Aromatherapy
- Music therapy
- Pet therapy
- Engaging with media (TV or movies)

Discussion / Support / Working Groups
- Reality orientation
- Therapeutic reminiscing
- Leisure arts
Social Activity
• Armchair travel
• Remotivation
• Breakfast group
• Intergenerational
• Baking
• Community outings
• Doll therapy
• Special events

Specialized Activity
• Montessori
• Snoezelen

Life skills
• Psychosocial education and discussion
• Building social skills and life skills
• Coping strategies for patients
• Helps increase their well-being

Life stories
• Work with patients to talk about their wellness, values, strengths and goals
• Recovery based group focusing on wellness
• Patients write their own recovery stories
• Art expression

Life Review
• Reminiscing about family hobbies, weddings, careers
• Use of props and memory aids/cues

Relaxation
• Deep breathing
• Progressive Muscle Relaxation (PMR)
• Guided Imagery
• Emotions chart
• Vital signs pre and post
• Self rating scale
• Nursing staff can help with the group

Medication Group
• Provides supports for discharge
• Medication management
• Explain what happens in the brain and effect by medications
• Explain why the patient should stay on meds
• Any patient is welcome to attend group

One-on-one Therapeutic Interaction
Other comfort measures including warm blanket, sensory stimulation and patient engagement.
Discharge Planning and Supports

Pre-Discharge Meeting
When the patient’s discharge date is imminent, the interprofessional team will schedule a meeting to discuss the plan of care as well as behavioural profile. The purpose of this meeting is to prepare the patient and the receiving facility or family with the necessary information to facilitate a successful transition and discharge. This meeting typically includes:

- Patient and/or substitute decision maker
- Prime nurse
- Psychiatrist
- Social Worker
- Family Physician or other allied health clinician as required

Return to Independent Living
If the patient is being transferred back to their home to live independently, often our social worker and occupational therapist may assist this process by doing a home assessment to ensure the patient has the necessary skills and resources to care for themselves and live independently. Referral is also made for CCAC in-home supports along with other community agencies/programs (ie. Community Care Durham, ACTT Team).

Transfer or Return to Long-Term Care Home
In cases where the patient is returning to a LTC home, staff from the LTC home and associated geriatric psychiatry outreach team is also invited to the discharge meeting to ensure that supports are set up in advance. Teleconferences are also arranged in situations where face-to-face meetings are not feasible.

Day in the Life
The Day in the Life tool is a patient story written in the first person by the patient’s prime nurse to communicate successful treatment tips relative to ADL care and behaviour management strategies. See example in appendix section.

Outreach: Community Nurse Clinician and Psychiatrist
Ontario Shores Community Nurse Clinicians (CNC) and Psychiatrists provide clinical assessment and consultation support to LTC homes post discharge in some cases to follow the progress of the patient and make further recommendations.

Outreach: Psychogeriatric Resource Consultant
The Psychogeriatric Resource Consultant (PRC) is also available to help assist the LTC home with translating the care plan to their setting as well as focus on building staff capacity through education to better manage the patient upon return.
Appendix:

I) Care Process Map: Geriatric Psychiatry Assessment and Intervention

II) BPSD Tracking Tool

III) Interprofessional Psychogeriatric Best Practices Educational Program in partnership with Durham College

IV) A Day in the Life: Patient Story

V) Evidenced Based Practice: References

I) Care Process Map: GDU and GPU

Behavioural and Psychological Symptoms: Assessment and Intervention

BPS Referral → Patient Care Facilitator → PIECES Resource Nurse/Allied Health Clinician or Nursing Team → Psychogeriatric Assessment → Documentation in MAP and Behaviour Profile → Care team selects 1 or more of intervention options:

1) Environmental Interventions
   - Dimming lights, quiet environment, comfortable room environment, access to personal property, privacy

2) Physical Activity
   - Gym, group, exercise, horticulture, walking, dancing

3) Pharmacotherapy

4) Sensory Stimulation
   - Tactile, aromatherapy, music therapy, pet therapy, engaging with media (TV or movies)

5) Discussion/Support/Working Groups
   - Reality orientation, therapeutic reminiscence, leisure arts

6) Social Activity
   - Armchair travel, re-motivation, breakfast group, intergenerational, baking, community outings, doll therapy, special events

7) Life Skills Group
   - Psychoeducation focused on well-being and coping

8) Life Stories Group
   - Recovery based on strengths, values, well-being, and art expression

9) Life Review Group
   - Reminiscing through use of props

10) Medication Group
    - Medication management and discharge supports

Evaluation

- Is there a decrease in BPS?
- End process or continue to monitor
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<th>Time</th>
<th>Antecedent</th>
<th>Behaviour</th>
<th>Immediate</th>
<th>Intervention</th>
<th>Programs</th>
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Antecedents

Activity
• Bathing
• Toileting
• Other personal care
• Meal time
• Use of lift
• Structured/recreational activity
• Family visiting
• Time off of unit

Mobility
• Use of any type of physical restraint
• In bed

Environment
• Noisy unit
• Interaction with verbally/physically aggressive or intrusive co-patients
• In room, quiet environment (Understimulation)

Perceptual / cognition
• Responding to internal stimuli (i.e. evidence of visual or auditory hallucinations)
• ‘Cognitive’ delusions (i.e. ‘house is not one’s home’ delusion)
• Paranoid or jealous delusions

Behaviour
Physically aggressive behaviour
• Hitting/Slapping
• Biting
• Grabbing/Pinching/Twisting
• Scratching
• Kicking
• Spitting
• Pulling Hair
• Throwing object
• Destroying property
• Pushing/shoving
• Making threatening gestures
• Self injury

Verbally aggressive behaviour
• Cursing
• Threatening
• Yelling/Screaming

Sexually disinhibited / aggressive behaviour
• Inappropriate sexual comments
• Trying to kiss
• Trying to touch breasts/genitals/buttocks
• Inappropriate disrobing
• Public masturbation

**Agitation**
• Pacing
• Exit seeking
• Crying
• General restlessness
• Constant unwarranted request for attention or help
• Eating/drinking inappropriate substances
• Rummaging/hoarding
• Calm
• Sleeping
• Other

**Immediate Intervention**

**Non-pharmacological**

**Environment**
• Space/alone time
• Move to quieter area
• Allow/assist to walk
• Go outside
• Move to common area
• Adjust lighting

**Activity**
• One-on-one
• Books / colouring
• Music
• Singing
• Doll / stuffed animal
• Tactile objects
• Watch TV
• Aromatherapy
• Snoezelen

**Physical Needs**
• Toileting
• Food
• Drink

**Communication**
• Reassurance/orientation/distraction
• Communication strategies (i.e. direct in simple steps, one person talking, explain as you go, use patients name etc)

**Care specific**
• Two staff to provide care
• Three staff to provide care
• Four or more staff to provide care
• Sponge bathing
• Cover with warm towels/blanket
• Give something to hold
• Communication strategies (i.e. direct in simple steps, one person talking, explain as you go, use patients name etc)
• Other

Pharmacological
Refer to CPG guidelines

III) Interprofessional Psychogeriatric Best Practices Educational Program in Partnership with Durham College

Course Description
This 42 hour course is open to all healthcare providers. Content will include education on the physiology of normal aging, the geriatric giants, best practice assessment and care based on the Canadian Coalition of Seniors Mental Health Best Practices, management of aggression through use of montessori approach to dementia care, dialogue based therapy, activity based learning, snoezelen and other psychogeriatric best practice education. The underlying framework of the Collaborative Recovery Model will be presented with explanation of how to embrace the recovery philosophy when caring for older people living with mental illness. This course will include an eight hour practicum. For RNs and RPNs this course can be used as the elective component of the Mental Health Certificate course.

Rationale
Psychogeriatric care is a specialized field of mental health care. The recovery philosophy of care ensures that practitioners and patients work together in collaboration. The treatment plan of patients is based on their values and strengths and goals are set in collaboration to progress patients towards their idea of the best possible quality of life as they see it. This course is written with the hope that interprofessional teams will learn how to use each team members strengths and values within the therapeutic alliance to assist patients in progressing towards their goals. Using adult education principles participants will be guided in using evidence based assessment/diagnostic tools needed to provide care to the psychogeriatric population. There will be an eight hour practicum project that allows real time practice in putting new learning into practice.

Course Specific Outcomes
1. Enhance the therapeutic relationship by using best practices in psychogeriatrics within the Collaborative Recovery Model framework.
2. Review a case within a interprofessional team context, exploring best practice assessments and treatment planning based on patients' values, strengths and goals.
3. Utilize specific psychogeriatric assessment tools including (but not limited to) the Confusion Assessment Method, the Geriatric Depression Scale and the Mini Neurocognitive exam.
4. Describe the montessori approach to Dementia Care, dialogue based therapy, activity based learning, snoezelen, and other programming methods that meet the needs of older individuals living with a mental illness.
5. Articulate a clear understanding of the process of normal aging and how this can impact the health and safety of the older person.
6. Communicate clearly, concisely and correctly in the written, spoken, and visual form that fulfills the purpose and meets the needs of the audience.
7. Use a variety of thinking skills to anticipate and solve problems.
8. Analyze, evaluate, and apply relevant information from a variety of sources.
9. Show respect for the diverse opinions, values, belief systems, and contributions of others.
10. Interact with others in groups or teams in ways that contribute to effective working relationships and the achievement of goals.

**Sequence of Instruction**

**Week** | **Intended Learning**
--- | ---
1 | Pathophysiology and psychosocial model of aging and introduction to the Recovery Model of care
2 | Dementia and related screening tools (CCSMH best practice guidelines)
3 | Delirium, Depression and related screening tools (CCSMH best practice guidelines)
4 | Psychopharmacology
5 | Psychosis and anxiety and related assessment tools
6 | Agitation and related assessment tools
7 | Behaviour management - behaviour modification
8 | Dialogue based therapies
9 | Abilities based programming and applying the recovery model
10 | Final exam and outline for clinical placement
11 | Combine weeks 11 and 12 - Clinical placement at Ontario Shores (Geriatric Psychiatry Inpatient Units)

**IV) A Day in the Life – Patient Discharge Story**

**Example:** A Day In The Life Of Ms. B

Hi my name is Mrs. B but most people call me ______________

I am totally dependent for hygienic care. I like to have my hair fixed neatly. I am often not happy to have my care done and I will frequently be resistive and curl into a fetal position while care is being done. I will also scratch, pinch and attempt to bite although I have no teeth. The staff has found it helpful to keep my nails short and also place socks on my hands during care so that I can’t scratch anyone.

I am incontinent of both bladder and bowel and rely on you to keep me clean and maintain my skin integrity. I have acidic BMs and this causes my buttocks to become red and bleed if not attended to quickly.

I do not weight bear well but can be pivot transferred with 2 staff – with caution. I have been known to let my knees buckle and lower myself to the floor during transfers.

I sometimes sleep well at night and enjoy sleeping in till 1100hrs. At other times I crawl out of my Hi-Lo bed onto the floor and will eventually settle to sleep in my Broda chair. I wear thigh straps while seated in my Broda chair as I tend to slide down.
I eat my meals seated in my Broda chair with the table top in place. I can feed myself and the staff gives me one item at a time as I have been known to throw my food and drinks onto the floor or at other people. I enjoy drinking Ensure, especially chocolate.

The staff sometimes find me a calm and quiet place to sit in my Broda chair as I have been known to reach out and scratch others if they enter into my personal space.

I usually take my meds whole with a drink or if I am having a bad day crushed with pudding.

I enjoy music, Elvis Presley is a favourite! I enjoy playing Bingo, and at times I am very pleasant and like to talk. I also like to watch old movies.

Written by Mary Elliott, RPN

V) Evidenced Based Practice: References


