Building & Leveraging a Community of Practice

Sue Turgeon MD, CCFP

Physician Lead, Residential Care Initiative

Vancouver Division of Family Practice

turgeons@mail.ubc.ca

Vancouver
Division of Family Practice
A GPSC initiative

Disclosure of Commercial Support

Dr. Sue Turgeon has not received any financial or in-kind support from any commercial organization.

Gaps in Residential Care GP Services 2013

- VDoFP Survey 2013 (Residential Care Committee):
  - 39% of responding facilities reported a house doctor expected to retire in 1 – 3 years
  - DoC's: chronic difficulty in finding GP's to take on care of new residents
  - DoC's and Admin: frustrated with inconsistent level of engagement from GP's
  - VCH: 30% decline in number of GP's doing Residential Care 2003 - 2013

Building the Foundation – Our Community of Practice

- Myth:
  - Urban physicians do not want to work in residential care
- Reality:
  - System barriers have prevented physicians from engaging in this work
  - Which facility needs a physician?
  - How does a physician build a financially viable panel?
  - Who will support/mentor a physician new to this work?
  - Who will help cover after-hours and for vacation?

Building the Foundation – Our Community of Practice

A community of practice is a network of individuals with common problems or interests who get together to explore ways of working, identify common solutions, and share best practiced and ideas.

Building the Foundation – Our Community of Practice

- Residential care dinner meetings – GP's and facility leadership
- Facility Attachment Agreements to formalize the house doctor model & build relationships with facility leadership
- Real time data as a basis for QI work at facility level
  - Transfer to ER
  - Admissions to hospital
  - Deaths at home rate
- Facility Leadership dinner meetings – Directors of Care, Administrators, Medical Co-ordinators looking at their own facility data

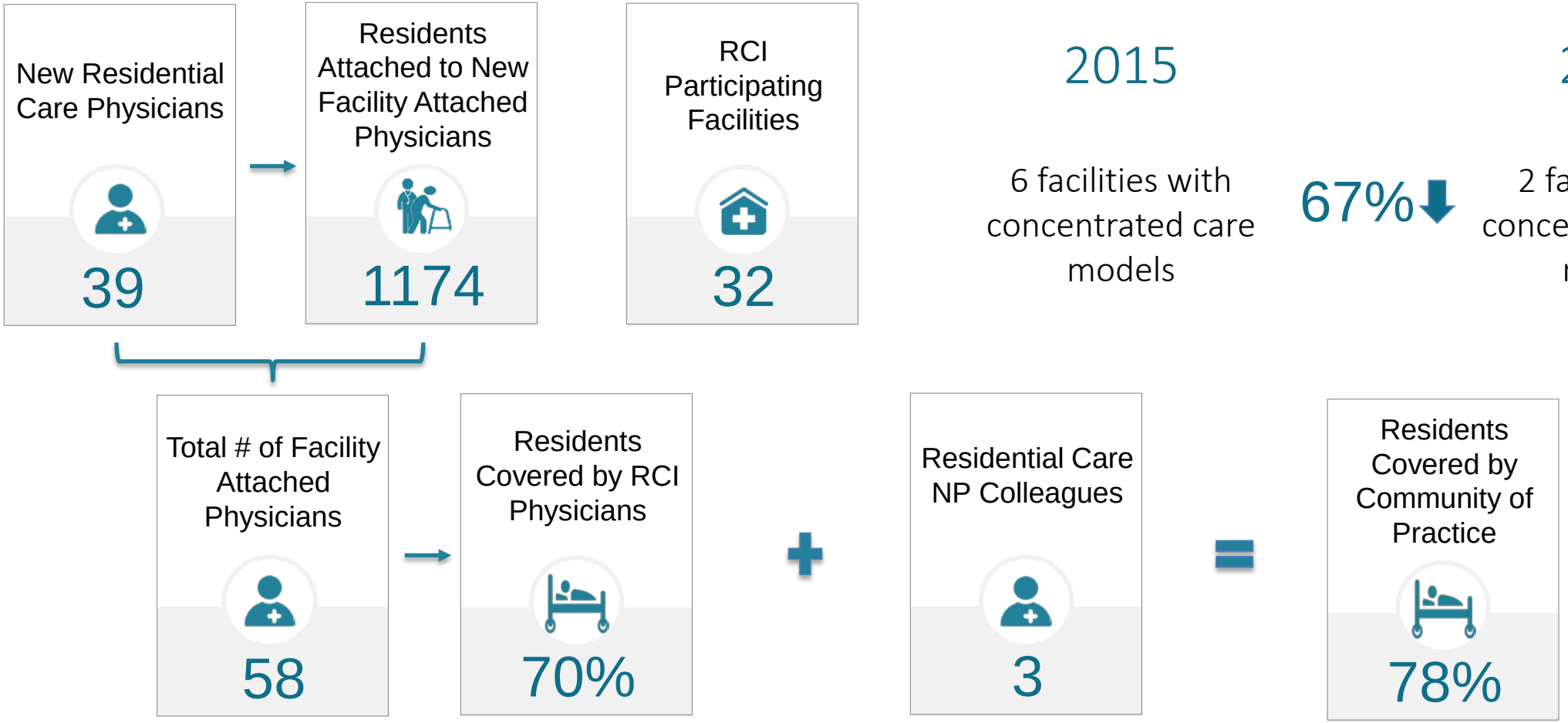
Building the Foundation – Our Community of Practice

- Residential Care selling points
  - Challenging work with frail elders
  - Gets you out of the office for less structured work environment
  - Work with nursing and allied colleagues
  - Automatic coverage by city wide After-hours Care program
  - Additional income from RCI stipends
- Recruitment sources
  - New to practice Division events
  - Fast facts notices
  - Vancouver Division recruitment and retention team
  - Word of mouth

Building the Foundation – Matching & Mentorship

- Phone call with interested physicians about RCI expectations and opportunities
- Guided in person introductions to facility & facility leadership
  - Panel size expectations / development
  - Care conference schedules
- Mentorship – 6 hours of paid time to review key topics in residential care (Goals of Care; Frailty; Recognition of end of life; Polypharmacy; Work flow and Billing) with a seasoned colleague who also gets paid

Matching and Mentorship program results:



2015

6 facilities with concentrated care models

67%⬇

2018

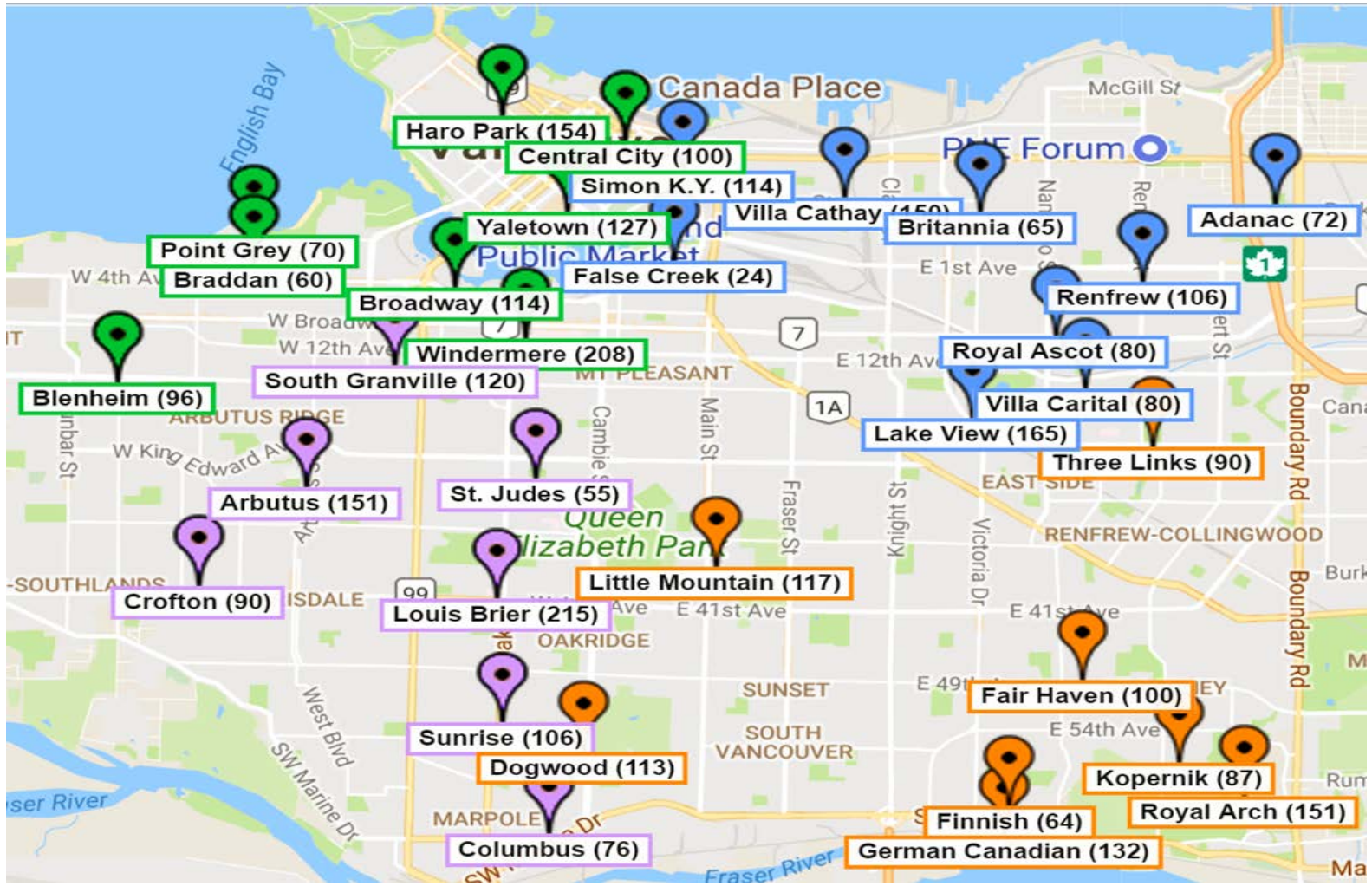
2 facility with concentrated care models

Leveraging the Foundation – After-hours Care

Standardized After-hours Care for Vancouver RCI facilities

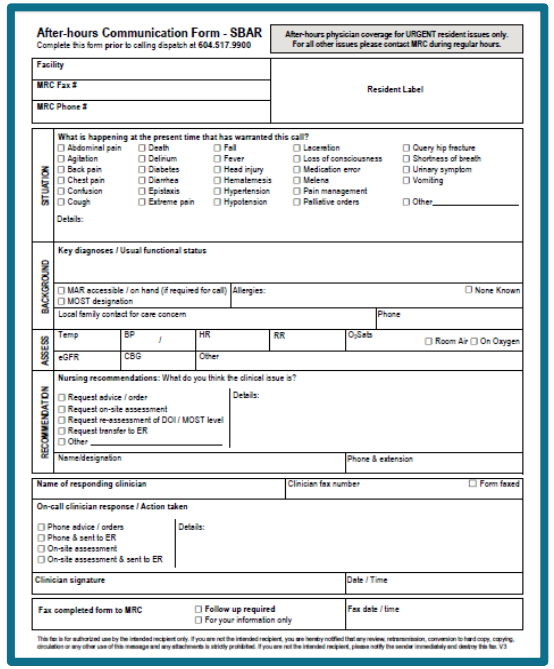
- Step-wise development of a city wide after-hours care program (Vancouver RCI-After-hours Care)
- RCI Physicians cover ALL beds in their sector, not just RCI beds
- VCH Residential Care NP's welcomed into the call group
- Central dispatch centre – able to patch calls directly to clinician
  - 82% of calls answered within 5 minutes; 88% within 15 ….
  - 10% of calls result in an on-site assessment
  - 10% of calls result in transfer to ER and are followed up on for QI

Leveraging the Foundation



Leveraging the Foundation – After-hours Care

Standardized After-hours Care communication SBAR



After-hours Communication Form - SBAR
Complete this form prior to calling dispatch at 604.517.9900

After-hours physician coverage for URGENT resident issues only. For all other issues please contact MRC during regular hours.

Facility
MRC Fax #
MRC Phone #
Resident Label

SITUATION
What is happening at the present time that has warranted this call?
☐ Abdominal pain ☐ Death ☐ Fall ☐ Laceration ☐ Query hip fracture
☐ Agitation ☐ Delirium ☐ Fever ☐ Loss of consciousness ☐ Shortness of breath
☐ Back pain ☐ Diabetes ☐ Head injury ☐ Medication error ☐ Urinary symptom
☐ Chest pain ☐ Diarrhea ☐ Hematemesis ☐ Melena ☐ Vomiting
☐ Confusion ☐ Epistaxis ☐ Hypertension ☐ Pain management
☐ Cough ☐ Extreme pain ☐ Hypotension ☐ Palliative orders ☐ Other
Details:

BACKGROUND
Key diagnoses / Usual functional status
☐ MAR accessible / on hand (if required for call) ☐ MOST designation
Allergies: ☐ None Known
Local family contact for care concern
Phone

ASSESS
Temp | BP / | HR | RR | O_2Sats ☐ Room Air ☐ On Oxygen
eGFR | CBG | Other

RECOMMENDATION
Nursing recommendations: What do you think the clinical issue is?
☐ Request advice / order
☐ Request on-site assessment
☐ Request re-assessment of DOI / MOST level
☐ Request transfer to ER
☐ Other
Details:
Name/designation | Phone & extension

Name of responding clinician | Clinician fax number | ☐ Form faxed
On-call clinician response / Action taken
☐ Phone advice / orders
☐ Phone & sent to ER
☐ On-site assessment
☐ On-site assessment & sent to ER
Details:
Clinician signature | Date / Time
Fax completed form to MRC ☐ Follow up required ☐ For your information only | Fax date / time

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☐ Other _____

Details:

Name/designation | Phone & extension

Leveraging the Foundation – After-hours Care

VRCI-AC Shift Reports

Vancouver Division of Family Practice
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Vancouver Division of Family Practice: Residential Care Initiative

VRCI After-hours Care Shift Report

Shift Start Date: 20 April 2018

Physician Name [redacted]

Call #	Facility	MOST	Clinical Issue	Action Taken	Comments
1	[redacted]	2	confusion	Phone: Advice	
2	[redacted]	3	abdominal pain	Phone: Advice	
3	[redacted]	3	Sudden death	Phone: Advice	
4	[redacted]	3	SOB and HTN	On-site: Visit	Changed to MOST M2 averted transfer
5	[redacted]	3	Edema legs	Phone: Advice	
6	[redacted]	2	UTI and Respiratory infection	Phone: Advice	
7	[redacted]	3	Abdominal pain	On-site: Visit	Initially patient wanted hospital transfer but averted
8	[redacted]	3	Fall	Phone: Advice	No injury
9	[redacted]	3	Fall	Phone: Advice	No injury
10	[redacted]	2	Otitis media	Phone: Advice	
11	[redacted]	3	Temporary LOC	Phone: Advice	Spoke with family averted transfer
12					
13					

Leveraging the Foundation – Sudden or Acute Events

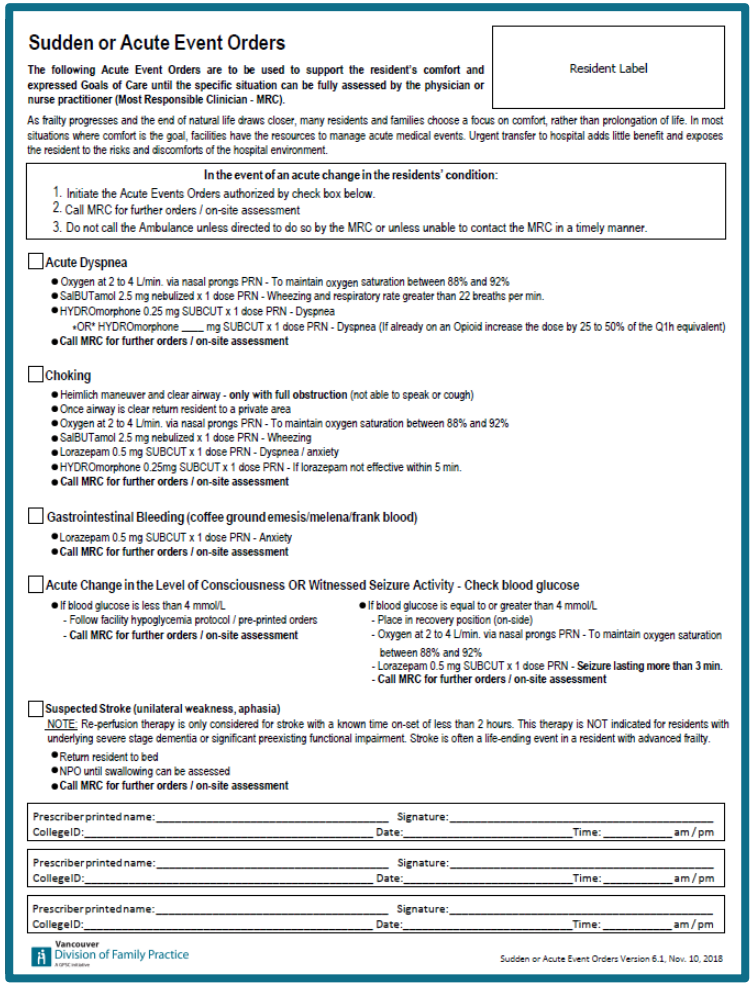
Sudden or Acute Event Orders

- Chart Audits: 20% of transfers to ER occurred BEFORE calling MRC
- 16% of these transfers were M-2, many with conditions potentially manageable at the facility (fever/dyspnea/bleeding)
- The Sudden or Acute Event Orders were developed in close collaboration with our VCH partners who provide training sessions for front line staff
- Clinicians and leadership meet for a review of the orders prior to implementing in a facility

Leveraging the Foundation – Sudden or Acute Events

Sudden or Acute Event Orders

- One page – resident specific
- Multiple signature lines
- Includes:
  - Acute Dyspnea
  - Choking
  - Gastrointestinal Bleeding
  - Acute Change in the Level of Consciousness OR Witnessed Seizure Activity



Sudden or Acute Event Orders

The following Acute Event Orders are to be used to support the resident's comfort and expressed Goals of Care until the specific situation can be fully assessed by the physician or nurse practitioner (Most Responsible Clinician - MRC).

Resident Label

As frailty progresses and the end of natural life draws closer, many residents and families choose a focus on comfort, rather than prolongation of life. In most situations where comfort is the goal, facilities have the resources to manage acute medical events. Urgent transfer to hospital adds little benefit and exposes the resident to the risks and discomforts of the hospital environment.

In the event of an acute change in the residents' condition:

1. Initiate the Acute Events Orders authorized by check box below.
2. Call MRC for further orders / on-site assessment
3. Do not call the Ambulance unless directed to do so by the MRC or unless unable to contact the MRC in a timely manner.

☐ **Acute Dyspnea**

- Oxygen at 2 to 4 L/min. via nasal prongs PRN - To maintain oxygen saturation between 88% and 92%
- SalBUTamol 2.5 mg nebulized x 1 dose PRN - Wheezing and respiratory rate greater than 22 breaths per min.
- HYDROmorphone 0.25 mg SUBCUT x 1 dose PRN - Dyspnea
  - +OR* HYDROmorphone ____ mg SUBCUT x 1 dose PRN - Dyspnea (If already on an Opioid increase the dose by 25 to 50% of the Q1h equivalent)
- **Call MRC for further orders / on-site assessment**

☐ **Choking**

- Heimlich maneuver and clear airway - **only with full obstruction** (not able to speak or cough)
- Once airway is clear return resident to a private area
- Oxygen at 2 to 4 L/min. via nasal prongs PRN - To maintain oxygen saturation between 88% and 92%
- SalBUTamol 2.5 mg nebulized x 1 dose PRN - Wheezing
- Lorazepam 0.5 mg SUBCUT x 1 dose PRN - Dyspnea / anxiety
- HYDROmorphone 0.25mg SUBCUT x 1 dose PRN - If lorazepam not effective within 5 min.
- **Call MRC for further orders / on-site assessment**

☐ **Gastrointestinal Bleeding (coffee ground emesis/melena/frank blood)**

- Lorazepam 0.5 mg SUBCUT x 1 dose PRN - Anxiety
- **Call MRC for further orders / on-site assessment**

☐ **Acute Change in the Level of Consciousness OR Witnessed Seizure Activity - Check blood glucose**

- If blood glucose is less than 4 mmol/L
  - Follow facility hypoglycemia protocol / pre-printed orders
  - **Call MRC for further orders / on-site assessment**
- If blood glucose is equal to or greater than 4 mmol/L
  - Place in recovery position (on-side)
  - Oxygen at 2 to 4 L/min. via nasal prongs PRN - To maintain oxygen saturation between 88% and 92%
  - Lorazepam 0.5 mg SUBCUT x 1 dose PRN - **Seizure lasting more than 3 min.**
  - **Call MRC for further orders / on-site assessment**

☐ **Suspected Stroke (unilateral weakness, aphasia)**

NOTE: Re-perfusion therapy is only considered for stroke with a known time on-set of less than 2 hours. This therapy is NOT indicated for residents with underlying severe stage dementia or significant preexisting functional impairment. Stroke is often a life-ending event in a resident with advanced frailty.

- Return resident to bed
- NPO until swallowing can be assessed
- **Call MRC for further orders / on-site assessment**

Prescriber printed name:_____ Signature:_____
CollegeID:_____ Date:_____ Time:_____ am / pm

Prescriber printed name:_____ Signature:_____
CollegeID:_____ Date:_____ Time:_____ am / pm

Prescriber printed name:_____ Signature:_____
CollegeID:_____ Date:_____ Time:_____ am / pm

Vancouver Division of Family Practice

Sudden or Acute Event Orders Version 6.1, Nov. 10, 2018

Facility Leadership: 2018

"We now have enough house clinicians to manage all new admissions - finding an admitting physician used to take considerable time and energy. On-call coverage is clearer." (Facility Leader)

"Families and residents do not tell me during resident council that they can't see there doctor, a complaint that was heard before." (Facility Leader)

"We survey our residents annually and the indicator for medical treatment went from 77.7% in 2015 to 90.7% satisfaction in 2016." (Facility Leader)

We now have "a unified team approach to addressing gaps in practice and processes in regards to care outcomes for our residents." (Facility Leader)

Physicians: 2018

"The RCI promotes best practice/clinical model that would best serve our residents in LTC facilities. The RCI recognizes and understands the gaps in delivering medical care to residential care clients and try to come up with sustainable solutions to the problems." (GP)

"I think there's a much stronger sense of the Residential Care community. Both from the facility leadership, the Directors of Care, the administrators, certainly the medical coordinators, and many of the physicians in residential care." (GP)

Questions