

Introduction of “Collaborative Care Model” to enhance quality of care in Psychiatric Intensive Care Unit

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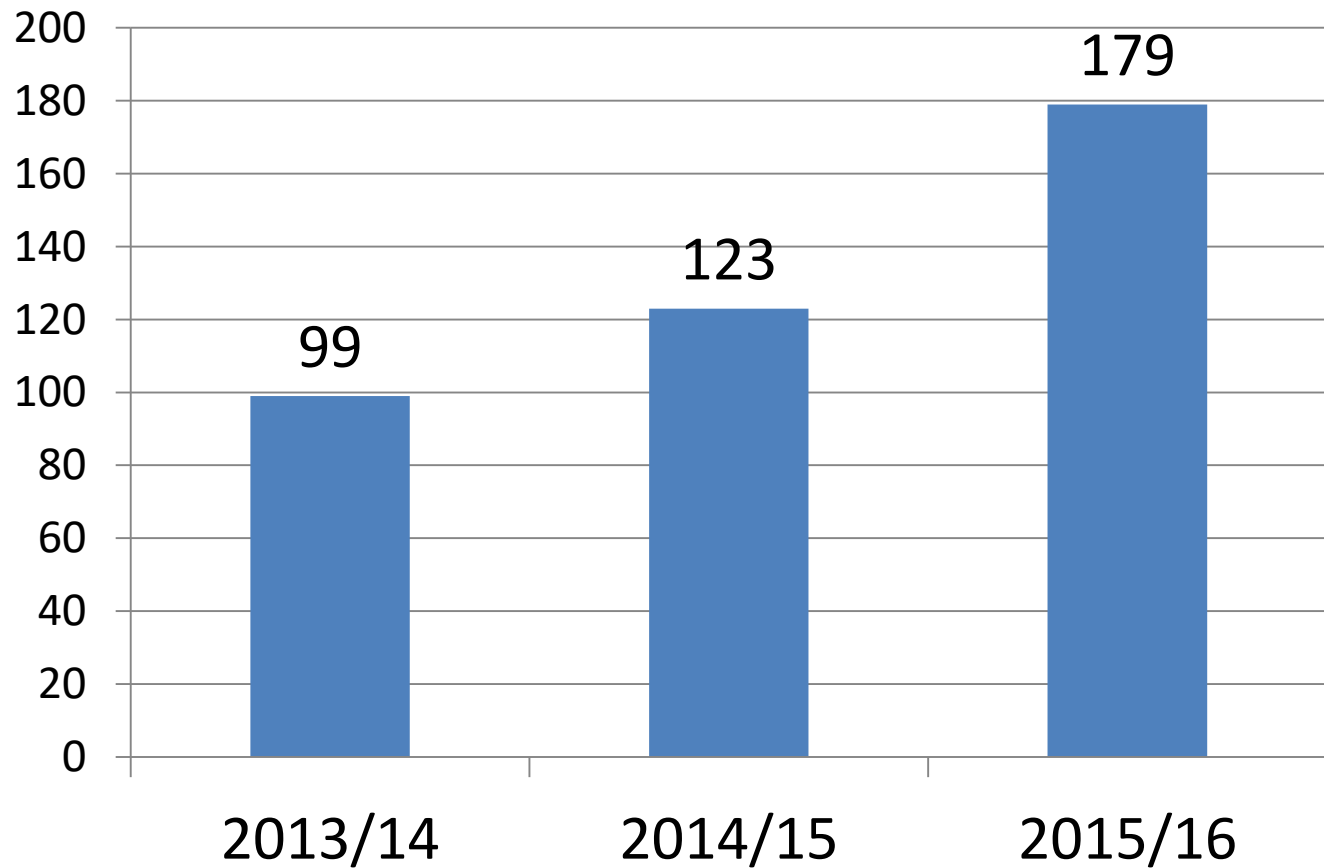
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Drivers for change

- Addressing staff concerns about staffing on night shift
- Providing opportunities to nurses and other interprofessional team members to work to their full scope of practice
- Enhancing quality of care in PICU; one of the major outcome indicators being reduction in rate of restraints use

of Restraints Use Incidents in PICU



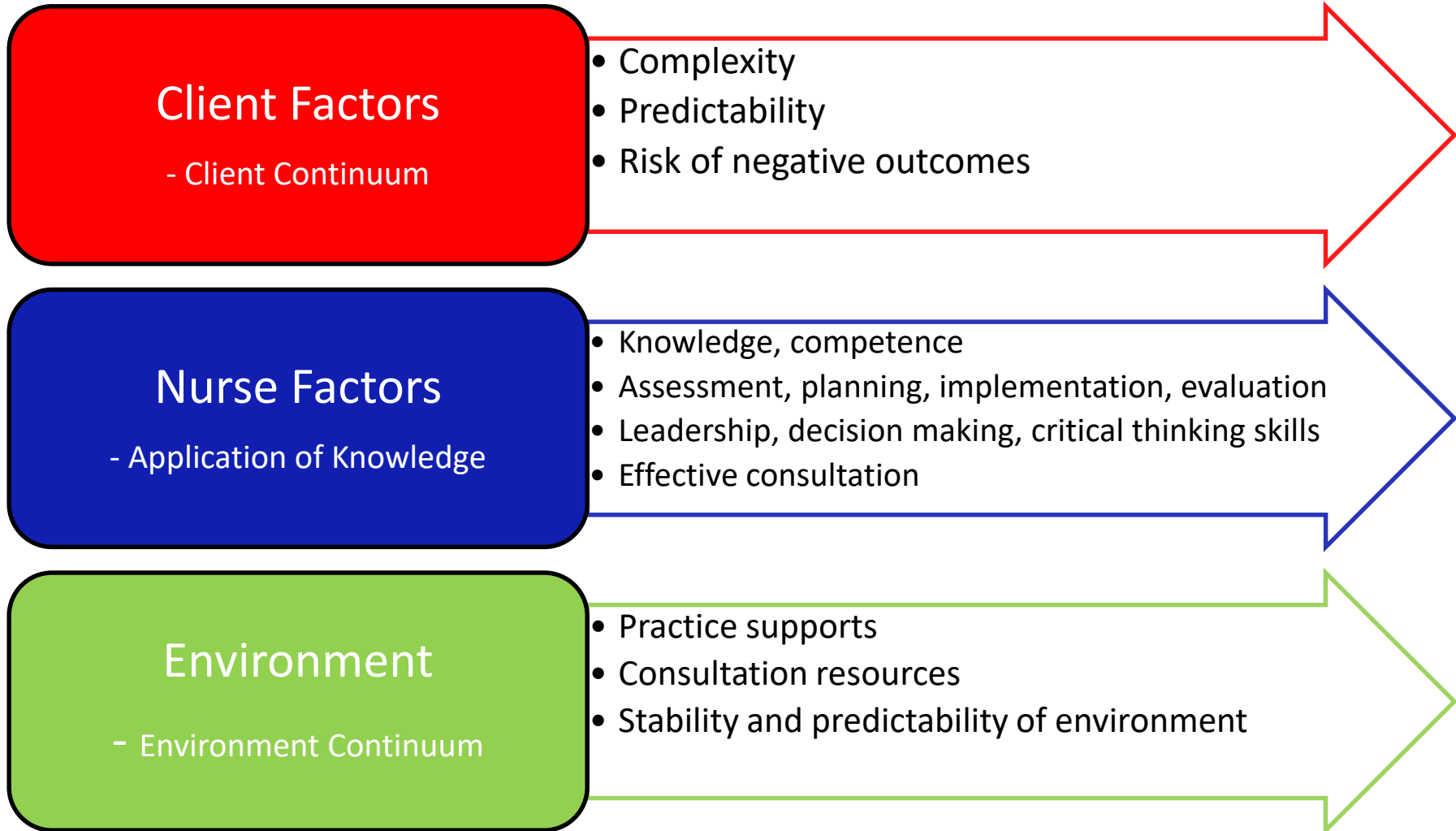
“The practice of restraint puts both patients and staff at risk for injury and death. Moreover, restraints can be traumatic even when they do not result in injury and death” (Mohr, Petty, & Mohr, 2003)

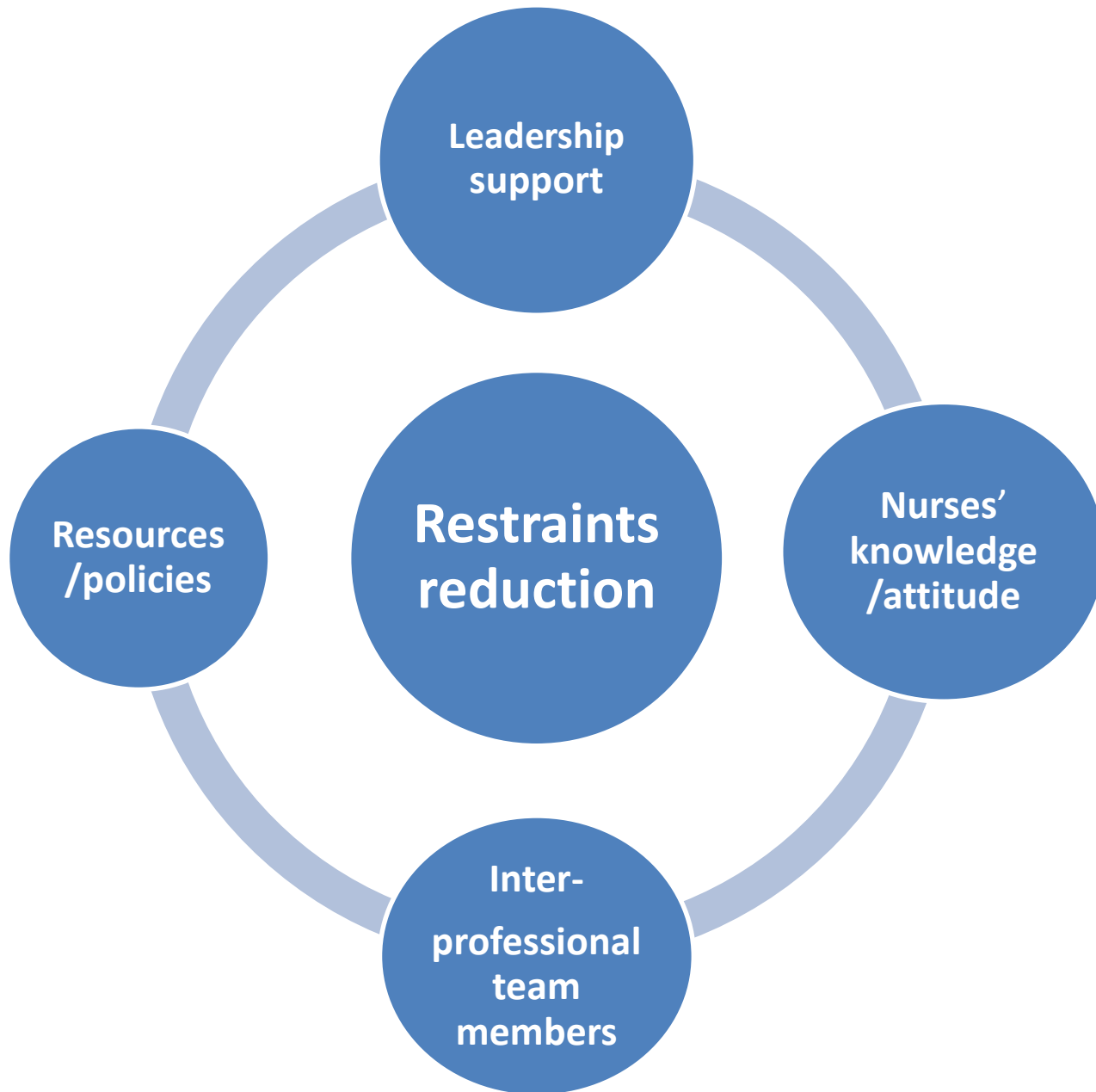
“There is empirical evidence showing that use of seclusion and restraint has led to psychological harm, physical injury, and even death for both the clients subjected to these events and the staff members who apply these techniques” (Sivak, 2012)

PLANNING



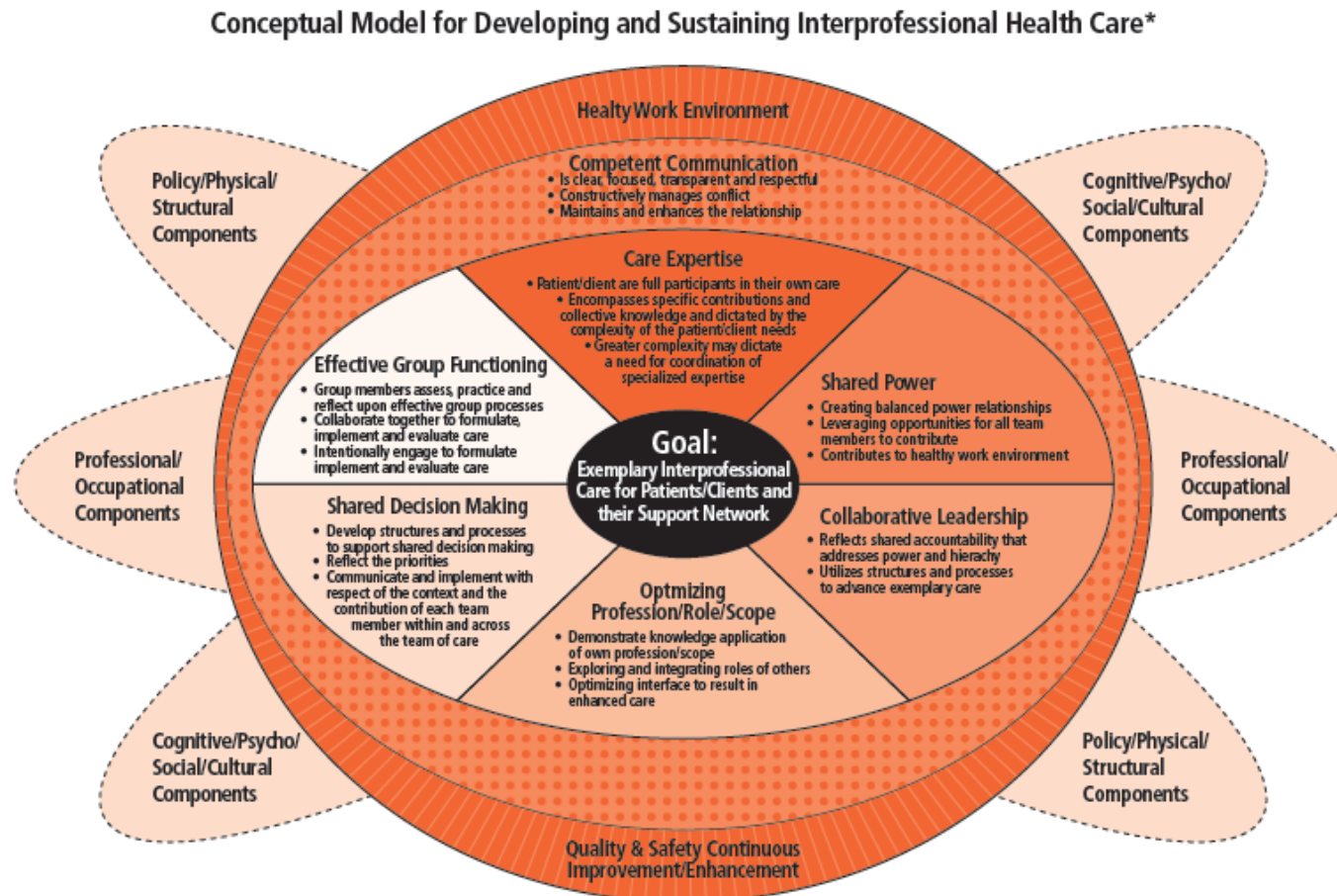
Three Factor Framework





Interprofessional Model of Health Care Delivery

Figure 2. Conceptual Model for Developing and Sustaining Interprofessional Health Care



*Adapted from the National Competency Framework and the RAO Model for Healthy Work Environments for Nurses

Six Key Domains

- Care expertise
- Shared power
- Collaborative leadership
- Optimizing profession, role and scope
- Shared decision making
- Effective group functioning

<http://rnao.ca/sites/rnao-ca/files/DevelopingAndSustainingBPG.pdf>

Competent Communication

“Competent communication – openness, honesty, respect for each other’s opinion, and effective communication skills – is part of all domains of interprofessional practice” (Humphreys and Pountney, 2006)



Planning future state: A typical day in PICU

- Patient assignment
- Transfer of accountability
- Patient assessment by nurses and physician
- Bullet rounds
- Implementing care plan
- Structured Recreation Program
- Documentation

Implementation Phase

- Needs assessment (PICU competencies self assessment)
- PICU orientation to prospective RPNs
- Analysis of patient population for 4 weeks prior to the education day
- Organized a PICU education day in April; 2 parts (content and structured simulation)

Implementation

Roll out plan:

1. Availability of Patient Care Manager and Clinical Resource Leader, especially during shift change, for first 4 weeks
2. On-going consultation with interprofessional practice team
3. On-going analysis of actual and potential concerns
4. Availability of unit supervisors during weekends to support this transition
5. Dedicated social worker for PICU patients
6. Introduction of “PICU clinical practice champion” role

Physicians' role

When covering PICU as MD on-call:

- Provide support and consultation to nurses by facilitating discussion around use of non-pharmacological interventions, including use of relaxation tool kit and Structured Recreation Program.
- Encourage nurses to utilize these interventions as alternatives to environmental and mechanical restraints
- Do not provide “PRN restraints” orders. As per “Least Restraints policy”, restraints are only to be used as emergency intervention and therefore does not qualify as standing PRN orders.

Changes in PICU

- Daily bullet rounds focusing on interprofessional care planning, patient care issues including any use of restraints and use of non-pharmacological interventions
- Implementation of “Relaxation tool kit”
- Structured Recreation Program
- Chalk board for each patients to encourage patient’s and family engagement through daily goal setting

Collaborative Levels



Steps to mitigate potential challenges

- Hesitation to accept RPNs due to high acuity:
 - Analysis of patient population, based on CPR model was conducted for 4 weeks prior to implementation phase and weekly analysis was shared with RNs.
 - CNO's 3 Factor framework was used as a guiding framework to explain patient and nurses' related factors.
 - Actual patients' profiles were used for group exercises in the education session

Steps to mitigate potential challenges

- Concerns about having to supervise or monitor RPNs:
 - Discussion about scope of practice (discussion and video included)
 - Used simulation to highlight levels of consultation
 - Material related to leadership skills was included in the education session; providing consultation, providing and seeking feedback
 - Interprofessional team members (SW, OT, PICU physicians) participated in education session and simulation exercises.

Steps to mitigate potential challenges

- Lack of ownership by PICU staff to embrace change

Introduction of PICU Clinical practice champion role:

- To provide clinical support and mentorship to nursing staff working within the PIOUS unit.
- The focus is on supporting the team to maintain practice standards, by tracking and monitoring progress on safety, quality and clinical practice initiatives

Analysis

Success:

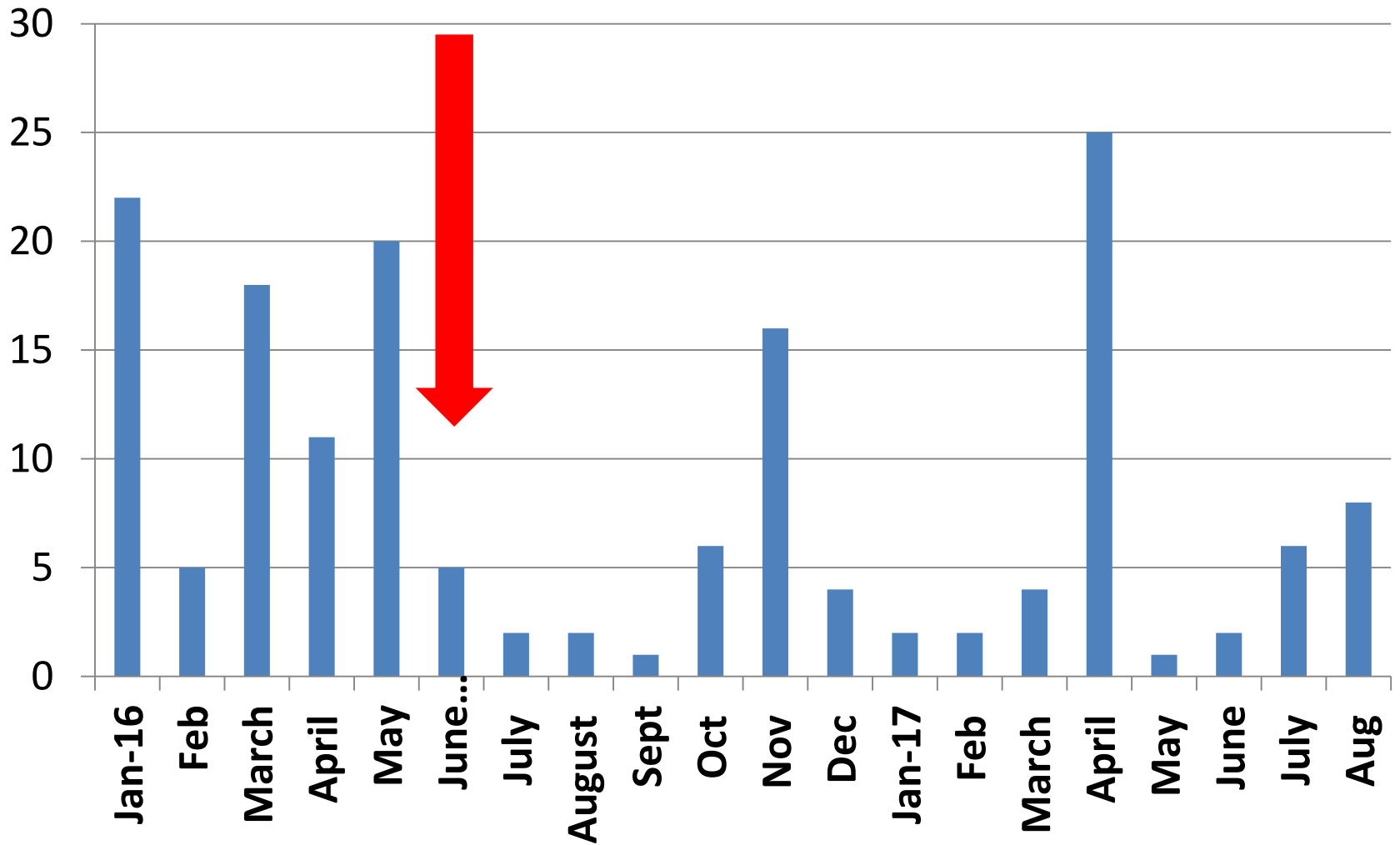
- We did not need to replace RPNs with RNs on any shift due to acuity in PICU (as anticipated by few RNs)
- Successful implementation of bullet rounds, interprofessional care planning and behaviour activation program
- RPNs are taking more active role in care planning and Structured Recreation program.
- PICU clinical champion role is well received

Analysis

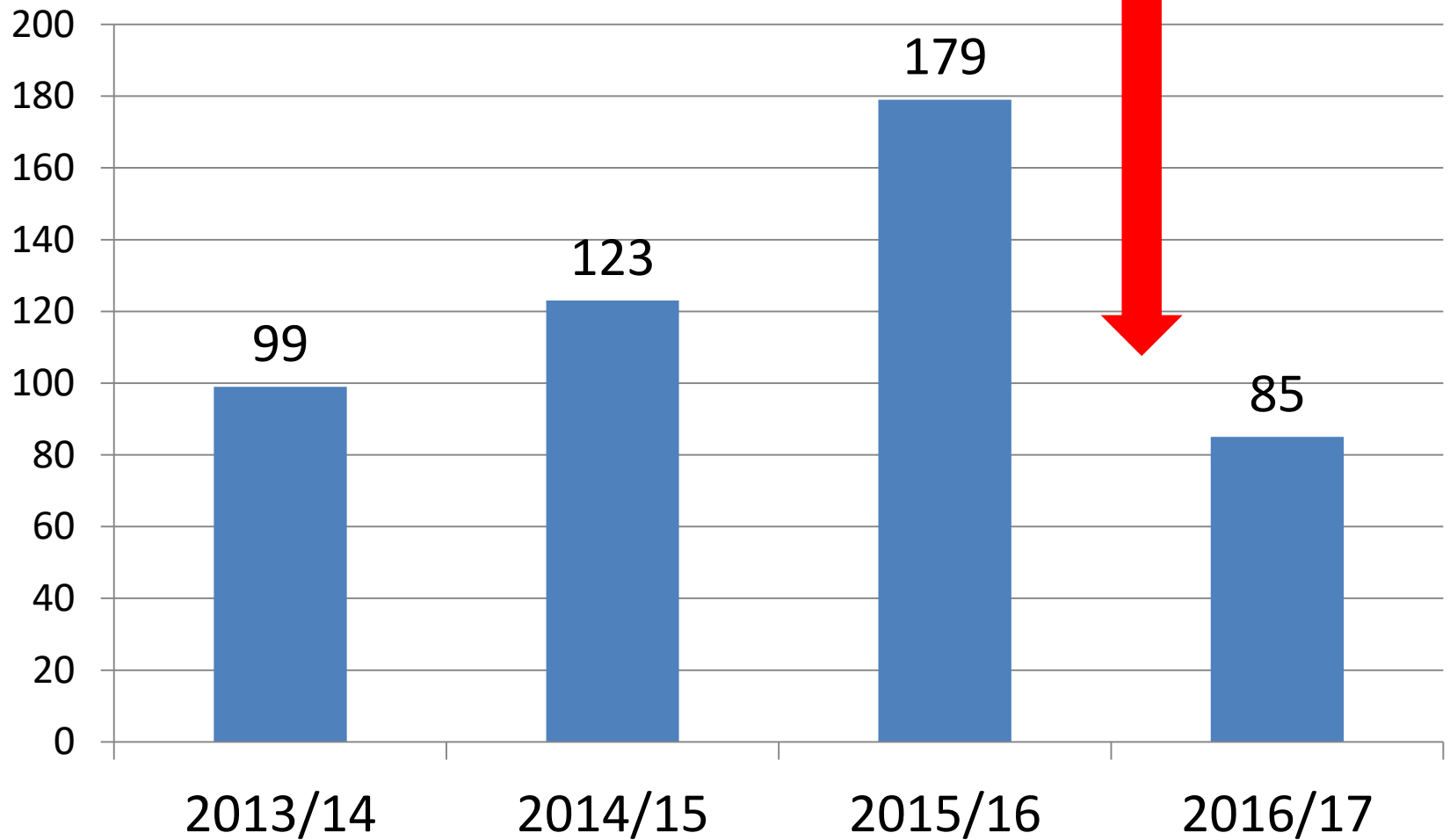
Challenges:

- Expertise vs. willingness
- Lack of active participation by few RNs in Structured Recreation program
- Current changes in management due to hospitals merging – staff and physicians turnover

of Restraint use incidents from Jan 2016 – Aug 2017



of Restraints Use Incidents



Recommendations

- Involvement of frontline staff from the first step
- Buy in from senior management team
- Drivers for change – impact on practice
- Involvement of interprofessional team members
- Coaching and mentoring using various teaching strategies
- Presence of leadership team members

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QUESTIONS