Geriatric Psychiatry Services

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What is Waypoint?

- Fully accredited 301-bed psychiatric hospital
- Acute and longer-term psychiatric inpatient and outpatient services
- Specialty areas:
  - Admission & Assessment
  - Geriatrics
  - Concurrent Disorders
  - Psychosocial Rehabilitation
  - Forensics
  - Dual Diagnosis
  - Outpatients
Area of Service
What is Geriatric Psychiatry?

Geriatric Psychiatry

- Dementia with Severe Behaviours
- Psychiatric Illness with Specialty Population
- Psychiatric Illness with Dementia
- Psychiatric Illness
26 bed unit
Specialized tertiary psychiatric assessment and treatment for the elderly with serious mental illness
Referrals received from long term care, hospital or a community physician for assessment and will return to the care of the referring agency once discharged
Interdisciplinary team approach
Variable length of stay (usually up to 90 days)
Partner with internal and external resources to provide the most appropriate services to meet patients needs

Support and education to families and stakeholders about complex elder care issues.

Service coordination and transitional discharge

Comprehensive assessment using measurable outcomes and individualized treatment plans
Some assessment examples our program offers are:

- Comprehensive Fall Risk Assessment
- Suicide Risk Assessment
- Dementia Observation Scale (DOS)
- Geriatric Depression Scale (GDS)
- MoCA, MMSE
- Individualized Collaborative Treatment Plans
- Risk Behavioural Management Plans
- Comprehensive Medication Assessment
- OT Functional Assessment
- Overt Aggression Scale
21 question screening tool of indicators and protective factors completed on:

- Admission
- Post fall
- Reassessment
- Prior to discharge

3 levels of risk (low, moderate, high) with visual cue clearly displayed

Intervention tree with suggestions to mitigate risk for each level
# Screening Tool

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## Waypoint Centre for Mental Health Care

**FALLS RISK SCREENING TOOL**  
Appendix A (CC 2-175-01) Falls Risk Screening and Interventions (See guidelines on back)

<table>
<thead>
<tr>
<th>Reason for Screening:</th>
<th>Admission</th>
<th>Post fall</th>
<th>Reassessment</th>
<th>Discharge</th>
</tr>
</thead>
</table>

## TO SCORE INDICATORS OF FALLS RISK:

Record a number for each question. If any component of the indicator is present record the full score. If none present, score is 0.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score Value</th>
<th>Actual Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Symptoms of Acute Confusion/Disorientation/Delirium/Sleep Disturbance/Intoxication</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates Unsafe Transfers, Mobility, Possibly Related to Impulsivity, Poor Judgment or Neglecting Required Assistance</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. History of Fall in Past Month</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4. Fear of Falling (as evidenced by patient/caregiver report, patient becomes upset upon transfers, etc.)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5. Poly Pharmacy (defined as four or more prescribed medications)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6.a Age 65-79</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>6.b Age 80+</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Change in Living/Sleeping Environment in Past Seven Days</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>8. Previous Fall(s) Within the Past Two Years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>9. History of Cardiovascular Condition (e.g. cardiac arrhythmia, transient ischemic attacks, stroke, orthostatic hypotension, heart attack)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10. Presence of Acute Illness (e.g. infection, hypoxia, glycemic instability or other acute illness)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11. History of Neurological Disorder (e.g. Parkinson’s Disease, previous head injury, seizure disorder, Huntington’s Disease, Multiple Sclerosis, Extrapyramidal Signs)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
### Screening Tool

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>History of Musculoskeletal Disorders/Injury (e.g. osteoporosis, myopathy, joint replacement surgery, previous fractures and sprains of bones or joints that impaired gait or balance)</td>
<td>1</td>
</tr>
<tr>
<td>13.</td>
<td>Generalized Weakness (e.g. poor endurance, dizziness, decreased strength)</td>
<td>2</td>
</tr>
<tr>
<td>14.</td>
<td>Impaired Mobility, Balance or Gait (e.g. shuffling, small steps, slow pace, or holds onto people or furniture, unsteady when standing or sitting)</td>
<td>2</td>
</tr>
<tr>
<td>15.</td>
<td>Diagnosis of Dementia or Depression</td>
<td>2</td>
</tr>
<tr>
<td>16.</td>
<td>Altered Nutrition/Altered Fluid Intake/Metabolic Disturbance (e.g. dehydration, water intoxication, anorexia, obesity, diabetes)</td>
<td>1</td>
</tr>
<tr>
<td>17.</td>
<td>Altered Elimination (e.g. incontinence, frequency, urgency, nocturia, diuretics, constipation)</td>
<td>1</td>
</tr>
<tr>
<td>18.</td>
<td>Sensory Impairment (e.g. vision, hearing, tactile losses)</td>
<td>1</td>
</tr>
<tr>
<td>19.a</td>
<td>Regular Medications in Last 24 Hours (antidepressants, antipsychotics, benzodiazepines, mood stabilizers)</td>
<td>1</td>
</tr>
<tr>
<td>19.b</td>
<td>Psychiatric meds (antidepressants, antipsychotics, benzodiazepines, mood stabilizers)</td>
<td></td>
</tr>
<tr>
<td>19.c</td>
<td>Cardiovascular meds (antihypertensives, diuretics, antiarrythmics)</td>
<td></td>
</tr>
<tr>
<td>19.d</td>
<td>Narcotic analgesics (opiates, anti-epileptics, anticholinergics)</td>
<td></td>
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<td></td>
<td>Muscle relaxants</td>
<td></td>
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<tr>
<td></td>
<td>Other sedative hypnotics</td>
<td></td>
</tr>
<tr>
<td>19.e</td>
<td>Use of any Medications in List Above (19a) as PRN or D&amp;R in Past Three Days</td>
<td>1</td>
</tr>
<tr>
<td>19.f</td>
<td>New Medication Started in Past Seven Days</td>
<td>1</td>
</tr>
<tr>
<td>20.</td>
<td>Immobile e.g., unable to initiate movement to get out of bed or any self movement</td>
<td>-3</td>
</tr>
<tr>
<td>21.</td>
<td>Consistently Performs Strength, Endurance, Flexibility, Balance and Mobility Activities on at Least a Three Day/Week Basis</td>
<td>-5</td>
</tr>
</tbody>
</table>

**Falls Risk Screen Total Score**
**Falls Risk Screening and Intervention Tree**

**Prepare**
- Universal Falls Risk Reduction Strategies: Safe Practice Standards
- Falls Risk Screen will be completed as per policy
- Document risk screen in chart
- Discuss results of screening tool and intervention plan with patient/SDM if family
- Staff education re risk factors and interventions to prevent and reduce risk
- Patients oriented to hospital accommodation, toilets, lighting
- Perform environmental scan
- Eliminate environmental risks, obstacles, and clutter
- Adequate lighting in all areas
- Stable/locked wheels on beds and furniture
- Grab bars beside toilets
- Beds and commodes locked when in use
- Avoid high gloss flooring finishes
- Monthly review of prescribed medication
- Clinical assessment by physician/nurse
- OT/Physio consult for patients with prescribed customized mobility equipment, footwear, mobility aids if currently used by patient. Assess and document

**Identify**
- Falls Risk Screen on all MHCP patients as per policy
- If score is 0 - 2
  - ID as LOW RISK FOR FALLS
    - Implement Falling Leaf designation GREEN
    - Proper Footwear available and worn
    - Address polypharmacy
    - Suitable seating height
    - Minimize use of psycho-tropics and benzodiazepines
- AND
- If score is 3 - 6
  - ID as MODERATE RISK FOR FALLS
    - Consider all of the options in the green section AND Implement Falling Leaf designation YELLOW
    - Falls treatment and rehabilitation program
    - Apply anti-slip strips or tape where needed
    - Apply leaf signage as applicable to program
    - OT/Physiotherapist to conduct gait and transfer assessment
    - OT/Physiotherapist to conduct Timed Up and Go (TUG) assessment
    - Develop rest and walking routines for exercise
    - Provide Calcium and Vitamin D supplementation as needed
    - Provide patient training about rising slowly from bed and chair
- AND
- If score is 7 or greater
  - ID as HIGH RISK FOR FALLS
    - Consider all of the options from both Green AND Yellow sections AND Implement Falling Leaf designation RED
    - Increased patient observation levels
    - Increased ward surveillance (floor monitor)
    - Maintain strength through exercise
    - Establish continence routines if indicated
    - Makes to sit when voiding when dizzy
    - OT/Physiotherapist to conduct an assessment to provide therapy, equipment, customized seating, mobility aids
    - Orient confused patients and move them closer to an area of staff supervision
    - Use position beds on wheelchair if indicated
    - Use of High-Lo Beds; floor mats at bedside
    - Care foam chairs for applicable patients
    - Bath tills with lifts; mechanical lifts
    - Hip Protectors, helmets, non-slip socks
    - Chair/Bed Alarms
    - Raised toilet seat

**Act**
- Choose from among the interventions listed to fit the risk score
- Document falls risk on Kardex, Risk Identification Sheet and in chart notes
- Document all interventions in treatment plans

**Evaluate**
- Patient Status Post Fall:
  - Patient Fall Incident
    - Injury Evident, Major or Minor
    - Avoid moving patient but provide comfort measures
    - Assess extent of injury such as head injury, fracture, Musculo-skeletal or soft tissue damage
    - Assess changes in range of motion
    - Assess appropriate vital signs
    - Immediately notify MD and Nurse Manager, Program/Shift
    - Notify family or SDM
    - Prepare for possible transfer to General Hospital
    - Continue assessment and documentation until Physician/Ambulance arrives
    - Repeat Falls Risk Screen

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**Waypoint**
**CENTRE for MENTAL HEALTH CARE**
**CENTRE de SOINS de SANTÉ MENTALE**

Advancing Understanding. Improving Lives.
Avancer la comprehension. Améliorer la vie.
Specialized tertiary psychiatric assessment for the elderly with serious mental illness
Consultative model of care
Team is comprised of registered nurses, psychiatrists, and a community support worker
Comprehensive assessment of presenting symptoms and care needs, diagnosis, and recommendations for treatment and non-pharmacological interventions

System navigation and service coordination with local resources

Education and capacity building regarding serious mental illness and complex health issues in the elderly
Specialized psychiatric assessment for seniors with mental illness or early stages of dementia living in their own home, retirement home, or LTC facility

Interdisciplinary team approach

Psychiatric care, monitoring and support

Cognitive assessment and monitoring of progression of dementia and mental illness

Groups on memory enhancement, exercise, recreational, cultural & spiritual activities, socialization, and local community outings
Specialized psycho-geriatric response team to Long Term Care (LTC)

Wrap around service; BIRT team member on site within 24 hours of acceptance for assessment

Interdisciplinary team
Alternative to hospitalization
Comprehensive assessment of resident to understand behavioural triggers and determine interventions
Strict focus on non-pharmacological interventions
Assist LTC homes to build capacity building related to severe behaviours
Collaborative model with regular follow-up, care conferences, and support for the care team during course of service
Eligibility for service:

- Diagnosis of Dementia
- Pattern of high risk behaviours
- Behaviours are increasingly aggressive / violent
- Engaged in high risk acts towards self or another person
Referrals from a Physician or Health Practitioner should be forwarded to:

Fax (705) 549-0266
Email gspintake@waypointcentre.ca

For any questions or general inquiries, please call:
Intake Coordinator
(705) 549-3181 ext 2047
Part of the Behavioural Supports Ontario (BSO) provincial strategy

GOAL: simplify access to services in a timely fashion

NSM focus on the “tipping point”

Older adults with cognitive impairments and their families (caregivers) with complex health issues, responsive (challenging) behaviours

3 mobile support teams
http://www.behaviourchange.ca/
Questions?